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The Movement of Hostility During the Course of Obsessive-Compulsive Symptoms

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Abstract

The relationship between the changes of obsessive and compulsive symptoms with hostility patterns was examined in seventy three patients. It was found that the changes of both ruminative and compulsive symptoms were more closely associated to extrapunitive changes than to the intropunitive ones. Score changes of compulsive symptoms were more closely related to those of extrapunitiveness than the ruminative symptoms.

Keywords

Hostility, Obsessive symptoms, Compulsive symptoms.

Introduction

Purpose of the present study was to examine the possible relationships between obsessive-compulsive symptoms and hostility attitudes with the passage of time in psychiatric patients. Before any attempt to study these phenomena it is important to acknowledge their presence in a variety of manifestations: from obsessive-compulsive traits of personality to the obsessive-compulsive symptoms.

Obsessive-compulsive symptoms are broadly regarded as two groups of psychiatric phenomena closely related. Obsessions are experienced as absurd, bizarre, irrelevant or obscene thoughts or feelings. Compulsions are thoughts or actions which the patient feels compelled to think or carry out in a stereotyped and ritualistic way. Both are distracting and repetitive and although the person resists he cannot get rid of them.

The psychoanalytic approach [1] focus on the content of obsessional disorders and interpret them in terms of defenses against underlying libidinal or aggressive drives or both combined in an anal-sadistic form. As it was pointed by Freud "the alteration of love and hate in the same person and the early separation of the two, usually results in repression of the hate. Then commonly follows a reaction to the hate in the form of un-wanted tendencies, horror of bloodshed etc. When the two attitudes are of equal strength there results a paralysis of thought expressed in the clinical symptom known as folie de doute. Obsessive phenomena signify a violent effort to overcome the paralysis by the utmost insistence".

Learning theory indicates that an obsessional thought produces anxiety because it is associated with an unconditioned anxiety-provoking stimulus. Compulsions are established when the individual discovers that the compulsive act reduces the anxiety attendant to an obsessive thought. Eventually the reduction of anxiety serves to reinforce the compulsive act. Walker [2] however expressed the view that the compulsive act does not really reduce anxiety, on the contrary often increases it.

From another perspective it is proposed that there is a phylogenetic process of ritualization with the primary function to prevent the harmful effects of aggression by inducing mutual understanding between the members of species [3]. It is questionable whether this process is fully developed in humans, although obsessive compulsive phenomena (as neutralizers of aggression) have been claimed to be more often associated with certain types of cultural practices in the forms of rituals related to various social inhibitions and moral precepts [4-6]. Other studies however, give partial support to this view [7].

Regarding the aggressive content of obsessive-compulsive symptoms, it was found in patients suffering from obsessive-

compulsive neurosis [7] that the great majority of them had thoughts of destruction, violence, death or injury, and many had a fear or urge to cause physical harm to self or others. The aggressive content of obsessive-compulsive symptoms differs substantially from the concept of hostility which is an attitude and a part of the personality structure [8].

It has been observed [8-10] that obsessional patients show a predilection for intropunitive responses. Dalbiez [11] emphasizing the role of guilt in this neurosis called it guilt neurosis. Also patients with ruminative or compulsive symptoms scored higher on in-tropunitiveness when compared with other neurotic patients [12,13]. This was attributed to that obsessive-compulsive neurosis retains higher levels of anxiety and/or depression which are responsible for the lowering of the patient's self-esteem. Others [6] found that obsessive-compulsive patients reported the same scores on guilt in the HDHQ [14] as depressed patients but higher scores on acting-out hostility.

These studies were carried out in single measurements. It is not only of importance to know the level and structure of hostility in patients reporting certain psychiatric symptoms but it is also of interest to know its movement during the course of symptomatology. The study of hostility and psychiatric symptoms during the course of psychiatric symptoms could reveal more subtle types of relationships between them.

Patients and Methods

The present study was carried out in the Psychiatric Department of St. Mary's Hospital Medical School, London, in a series of consecutively admitted inpatients. Criteria for inclusion were age between 16 and 65 years and the ability to cooperate in the testing procedure. All kinds of psychiatric disturbance were accepted except organic brain disease and mental deficiency. A minimum acceptable time interval of three weeks was established between the two measurements. The rationale for this time limitation is the hypothesis that a substantial change in psychopathology occurs in no less than a certain period of time.

The used psychometric instruments were the Hostility and Direction of Hostility Questionnaire (HDHQ), and the Ruminative symptoms and Compulsive symptoms scales of the Delusions Symptoms States Inventory (DSSI). The HDHQ is a well known and widely used instrument [14]. This is an attitudinal measure of hostility having little implication of actual or aggressive behaviour physically expressed. It reflects a readiness to respond with aggressive behaviour and a tendency to evaluate persons, including the self, in negative and unfavourable terms. It consists of 52 items presented in five subscales. Three subscales, Acting-Out Hostility (AH), Criticism of Others (CO), and Paranoid Hostility (PH), are measures of Extrapunitiveness. Two subscales, Self-Criticism (SC) and Guilt (G) measure Intropunitiveness. Total hostility is the sum of the five subscales. The Direction of Hostility score indicates a balance between introverted and extraverted hostility and is obtained by the formula: (AH+CO+PH)-(2SC+G) with positive scores indicating Intropunitiveness and negative scores Extrapunitiveness. Generally, the accepted norms for Total Hostility in normal popu-lations are between 12-14 [14] but higher norms have also been suggested.

The DSSI [13,15] is a descriptive rather than a specifically diagnostic instrument. Its items represent salient features of particular clinical conditions. It has no relevance to mental subnormality, to symptomatology resulting from organic brain disease nor to traits of personality disorder. It contains 84 items, divided into twelve subscales of seven items each. These subscales are: state of anxiety, state of depression, state of elation, phobic symptoms, compulsive symptoms, ruminative symptoms, conversion symptoms, dissociative symptoms, delusions of contrition, delusions of grandeur, delusions of persecution, and delusions of disintegration. The Ruminative symptoms and Compulsive symptoms scales were considered for the present study. The total score for these subscales is the sum of the scores of their items (range 0-21) and the cut off score is 3.

The two questionnaires were administered during the first days after admission and completed again when the decision for the patient's discharge was reached. Since all the cases were first tested within a week or so after admission, they were virtually under no treatment, except in so far as some might have been on medication as out patients.

The statistical analysis was carried out using the Statistical Package for the Social Sciences, SPSS/PC+. For the ordinal variables the nonparametric rank order correlation coefficient Kendall's τ-b [16,17] was used. Briefly, Kendall's τ-b, is a coefficient of association that makes no assumptions about the normality of the underlying distribution of the data (other than that can be seen as categories ranked in order), it is appropriate for the ordinal level of measurement (e.g. rank on one to three on a rating scale) it does not give undue value to outlying scores, gives coefficients of rank ordered correlations and a level of statistical significance and allows a partial correlation coefficient to be calculated if necessary.

Results

One hundred and thirty two patients completed the first battery of scales and 73 patients (53.3%) the second. From the 59 patients who failed to complete the second series, 38 were discharged before the lapse of the minimum acceptable time interval of three weeks and the remaining 21 because either of their psychiatric condition or because they refused, in various ways, to continue their cooperation. Regarding their clinical status on the first measurement, fifty two were in-patients, fourteen day patients and seven out patients. On the second measurement five of the in-patients became day patients.

The group of the participated patients in both measurements consists of 32 males and 41 females. The mean age of the participants was 35.2 years (s.d 12.2, min.17, max. 68). The mean time elapsed between the two assessments was 42.4 days (s.d. 24.1). The clinical diagnoses given to the 73 patients who participated in both measurements is presented in table 1. Descriptive statistics

are presented in table 2. Inferential statistics are presented in table 3. A general conclusion coming from these results is that there is a lowering of the scores of all scales in the second measurement.

Clinical Diagnoses	Males (N=32)	Females (N=41)
Neurotic Depression	7	22
Schizophrenia	18	6
Schizoaffective Disorder	1	4
Personality Disorder	2	3
Bipolar Illness (Depression)	-	2
Bipolar Illness (Manic)	1	1
Psychotic Depression	2	-
Anxiety state	-	2
Anorexia Nervosa	1	1

Table 1: Diagnoses given to the participated patients.

	First Measurement	Second Measurement
	mean (sd)	mean (sd)
Compulsive symptoms	2.36 (2.84)	1.64 (2.73)
Ruminative symptoms	3.86 (4.10)	2.85 (3.44)
Acting Out Hostility	5.31 (2.45)	5.44 (2.66)
Criticism of Others	5.18 (2.45)	4.92 (2.84)
Paranoid Hostility	2.44 (2.42)	2.05 (2.15)
Self Criticism	7.01 (2.52)	6.89 (2.63)
Guilt	3.75 (1.95)	3.36 (1.97)
Extrapunitiveness	12. 93 (5.29)	12.41 (5.85)
Intropunitiveness	10.77 (3.89)	10.25 (4.03)
Total Hostility	23.70 (7.33)	22.66 (8.23)

Table 2: Descriptive statistics of the scores obtained in the first and second measurement.

	Ruminative symptoms		Compulsive symptoms	
	Ken-dall's τ-b	p	Ken-dall's τ-b	p
Acting Out Hostility	.168	.018	.237	.002
Criticism of Others	.045	.285	.107	.090
Paranoid Hostility	.267	.001	.305	.001
Self Criticism	.086	.142	124	.061
Guilt	.143	.038	179	.013
Extrapunitiveness	.184	.011	.254	.001
Intropunitiveness	.127	.057	.187	.010
Total Hostility	.212	.005	.277	.001

Table 3: Correlations of CS and RS with hostility.

A general conclusion coming from these results is that there is a lowering of the scores of all scales in the second measurement.

Ruminative symptoms (RS): Statistically significant positive correlations of RS with acting-out hostility, paranoid hostility, guilt, total extrapunitiveness and total hostility scores were detected, but only with paranoid hostility and total hostility the correlations are of a higher significance.

Compulsive symptoms (CS)

Statistically significant positive correlations with acting out hostility, paranoid hostility, guilt, total extrapunitiveness and total intropunitiveness score changes were detected, with the correlations with acting-out hostility, paranoid hostility and total extrapunitiveness being highly significant.

Discussion

It should be pointed out that the purpose of the present study was to examine the relationships between score changes after a lapse of time. This is a different approach than that used in other studies, previously mentioned, where the relationships between hostility and obsessive-compulsive symptoms were examined in single measurements.

Although obsessive-compulsive disorder is regarded as a single psychopathological entity, it seems that there are important differences between obsessive and compulsive symptoms not only from phenomenological aspect but also with respect to their relationship to hostility.

As it comes from the results of the present study ruminative symptoms on changing are strongly related to the changes of total and projected hostility and to a lesser degree to acting-out hostility and total extrapunitiveness. The association with intropunitive responses is not statistically significant, except the correlation with guilt which is very weak. On the other hand compulsive symptoms found to be much more closely related to these hostility subscales. Both, obsessive and compulsive symptoms, go with extra-punitive responses to a much greater degree than intropunitive ones. The difference however is that compulsive symptoms are more closely related to total extrapunitiveness than ruminative symptoms. There is a considerable resemblance between compulsive and ruminative symptoms regarding the order of the extrapunitive subscales they are associated with, projected hostility being most closely associated and followed by acting-out hostility whereas criticism of others is not related to both.

The observed loose relationship between introverted hostility and these symptoms could be an interesting finding. It has been observed [18] that obsessional patients infrequently commit suicide despite the frequency with which suicide may figure in obsessional thinking. Gittleson [19] showed that the presence of obsessions during depression "protected" the depressive patients against suicidal attempts. He suggested that the phenomenological form of the obsession (not its content) and its persistence in this form was the essential "protective" factor. It could therefore hypothesized that producing obsessive and compulsive symptoms could be a way of increasing high levels of externally directed hostility and keeping intropunitiveness down. This may help these patients to overcome the potentially harmful effects of intropunitiveness especially the dangerous delusional guilt.

The view expressed by numerous authors that obsessional patients prefer to direct their hostility predominantly inwards [6,9-14] is not necessarily in contradiction with the findings of the

present study since patients reporting obsessive and compulsive symptoms obviously retain to a considerable degree their levels of intropunitiveness even after the improvement of their symptoms.

An attempt to explain the differences between obsessive and compulsive symptoms regarding their relationship to extrapunitiveness could be based on the phenomenological distinction between these symptoms. The compulsion is an act which temporarily reduces the anxiety induced by an obsession which is a mental event. Akhtar [4] suggested that those who display no compulsions seem to tolerate their obsessive urges better and hence have greater ego-strength than those who are obliged to perform some kind of compulsive act and he suggested a prognosis related hierarchical continuum in obsessive compulsive neurosis [20,21].

The differences found in the present study between obsessive and compulsive symptoms could be understood if the motor activity implied in compulsive phenomena were a factor more closely related to extrapunitiveness. It was argued by Foulds that if the scores in personality inventories were a consequence of particular forms of illness it would be expected for them to covary with changes in illness status.

Since there was not found any significant correlation between ruminative symptoms and the hostility subscales acting-out hostility, criticism of others, total extrapunitiveness, self-criticism, guilt and total intropunitiveness, it could be assumed that these hostility patterns are expressions of the patients' personality structure.

The same holds for the subscales criticism of others, self-criticism, guilt and total in-tropunitiveness for those reporting compulsive symptoms. On the other hand in patients reporting compulsive symptoms, the total hostility scores and the hostility subscales of acting-out hostility, paranoid hostility, total extrapunitiveness are so closely related to the symptom changes that one can assume that these hostility features are not related to the personality structure but to the course of symptomatology.

The same holds for projected hostility and total hostility for the patients reporting ruminative symptoms.

Conclusions

The findings of the present study suggest that certain psychiatric symptoms have an almost parallel movement with certain hostility patterns. These hostility patterns could be regarded as not being part of the personality structure. Other hostility patterns are not related to symptom change and could be regarded as being part of the personality structure. This suggests that certain psychiatric symptoms may be responsible for the development of specific hostility attitudes.

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APPENDIX

DSSI/R Compulsive and Ruminative symptoms scales.

Compulsive Symptoms
Recently I have been unnecessarily careful about carrying out even simple tasks.
Recently I have been unable to stop myself from counting or tapping things or uttering phrases quite pointlessly.
Recently I have had to keep checking things again quite unnecessarily.
Recently I have kept having to wash again and again.
Recently I have felt compelled to do things in a certain order, or a certain number of times, to guard against something going wrong.
Recently I have had to wash things again and again to make absolutely certain that they were safe.
Recently I have felt compelled to keep touching things.

Ruminative Symptoms
Recently I have had nagging douts about nearly everything that I have done.
Recently I have been afraid of the thought that I might make a physical attack on someone.
Recently I have had an unreasonable fear that I might forget to do something, and then something really awful might happen.
Recently I have had nagging fears that someone close to me might be killed or seriously injured.
Recently nasty thoughts or words have kept running through my mind against my will.
Recently I have been worried by the thought that certain things might have been lying around.
Recently I have had persistent feelings of having left something unfinished without knowing that.