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Cognitive therapy in the treatment of obsessive–compulsive disorder

David Veale

Behaviour therapy, namely exposure and response prevention, has for many years been the treatment of choice for most patients with obsessive–compulsive disorder (OCD). However, at least 25% of patients with OCD refuse exposure and response prevention or drop-out early. Of those who do comply, about 75% make reasonable gains and maintain them in the long-term. This means that 50% of patients who are offered treatment by exposure and response prevention either refuse, drop-out or show little improvement. Many patients find exposure distressing and this is probably the main reason for dropping-out early. Treatment failures tend to be associated with a depressed mood, over-valued ideation, slowness, mental compulsions and severe degrees of avoidance.

Selective serotonin reuptake inhibitors (SSRIs) in high doses for prolonged periods of time have been the main alternative treatment to exposure and response prevention. Controlled trials have found SSRIs to be as effective as exposure and response prevention in the short-term, but there is high rate of relapse on discontinuation of the drugs. Long-term use may mean unacceptable side-effects such as anorgasmia, which can be difficult to treat. The combination of exposure and response prevention and SSRIs has not been fully evaluated, but in the long-term does not appear to confer any extra benefit for most patients unless they are also depressed. There is, therefore, still much progress to be made in the treatment of OCD. It is within this climate that cognitive therapy for OCD is being developed and evaluated.

Evidence-based practice means that exposure and response prevention is still the treatment of choice for most practitioners treating patients with OCD. The number of controlled trials and the research into exposure and response prevention for OCD is very large compared to cognitive therapy. The application of cognitive therapy to OCD is also more difficult than exposure and response prevention, which can now even be delivered by computer (Greist *et al*, 1998). Early controlled trials have, however, found cognitive therapy alone to be as effective as exposure and response prevention (Van Oppen *et al*, 1995). Most practitioners would not, however, consider 'throwing the baby out with the bath water'. Further research will be required to determine when the combination of cognitive therapy and exposure and response prevention is more effective, for which type of OCD symptoms and whether the combination reaches the parts that exposure and response prevention or SSRIs do not reach. The most pessimistic outcome is that all treatments are equally successful and that the same treatment failures remain. My own clinical experience suggests that the addition of cognitive therapy is helpful in those patients with predominantly obsessional thoughts, concerning for example: aggression, sex, blasphemy or moral scruples, and checking compulsions. Cognitive therapy may have less to add to patients with obsessional urges for order, symmetry or contamination (especially when there are few feared consequences), tic-like compulsions (for example to touch or tap) and obsessional slowness.

Cognitive–behavioural model of emotional disorders

Cognitive–behavioural models of emotional disorders are based upon the meaning that individuals attach to events as a result of their core beliefs and attitudes and how these interact with the emotion and behaviour to maintain the problem.

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Negative automatic thoughts are the most superficial appraisal in which meaning is given to specific events. Events can be either internal, for example a patient who has an intrusive thought about murdering someone, or external, for example hearing a news report about a serial killer. Both of these events (by themselves innocuous and normal occurrences) will be interpreted in a catastrophic manner according to the patient's assumptions and core beliefs.

Core beliefs are regarded as the most fundamental level for organising information and are often difficult to articulate. They are relatively enduring and are regarded by the individual as absolute truths when they are activated. An example of a core belief for an anxiety disorder is 'I am vulnerable'. Core beliefs give rise to intermediate beliefs, which are more conditional to specific situations. These include various assumptions (for example in OCD 'If I have a thought then it must mean that I want it to happen') and rules (for example, 'I absolutely must not make a mistake').

Using a 'downward arrow' technique on the thoughts can usually identify a patient's assumptions and core beliefs. This involves asking the patient to assume the worst and that the thought is true. The therapist should then ask what the most anxiety-provoking thing about the thought is or what it means to the individual. In the example above, the patient might believe that if he has thoughts about harming others violently, then he must be a danger. In this case it was extremely anxiety-provoking as it would be the complete opposite to the values and importance that he attached to being kind, considerate and helpful to others at all times.

Assessment

Therapy should begin with a detailed assessment and formulation of the problem that is developed collaboratively between therapist and patient. This allows both to understand the development and maintenance of the disorder and how the patient's current cognitions, emotion and behaviour interact. The model would then be reviewed to determine its applicability to past and present experiences.

The clinical assessment in OCD requires a detailed knowledge of:

(a) The nature of the obsessions and the degree of insight or over-valued ideation; the frequency of their occurrence and the triggers for the obsessions.
(b) Appraisal of the obsessions and the perceived reason for their frequent occurrence. The assumptions and rules about the intrusive thoughts may be inferred or assessed by a self-report measure being developed by the Obsessive–Compulsive Cognitions Working Group (1997).
(c) The main emotional consequences or distress (for example anxiety, guilt or disgust).
(d) The avoidance behaviours which aim to prevent the obsessions from being activated.
(e) The compulsions (both overt and covert), the neutralising and other safety behaviours which aim to reduce or prevent the emotional distress.
(f) The degree of family involvement in the avoidance behaviour and compulsions.
(g) The patient's account of previous treatments (including medication) or strategies that they have used, if any, and their attitudes to such treatments. A patient's interpretation of why earlier treatments or strategies did or did not help can sometimes be revealing. Patients may also report that they have received cognitive–behavioural therapy, but this may have been inadequately delivered.

The Yale–Brown Obsessive–Compulsive Checklist is helpful in making a list of the various obsessions and compulsions, as a step to defining the severity of the symptoms and to assist in the definition of the problems and goals (Goodman *et al*, 1989). The clinical assessment may be supplemented by detailed self-monitoring of the intrusive thoughts or urges and their appraisal on standard thought records. Each of the three systems (cognitions, emotions and behaviour) will now be considered in more detail.

Cognitions in OCD

The textbook definition of an obsession is a recurrent intrusive thought, image or urge, which causes anxiety and is ego-dystonic. The most common obsessions include those of contamination, harm, aggression, injury, order, symmetry, blasphemy and sex.

The cognitive–behavioural model of OCD begins with the observation that unwanted intrusive thoughts, images or urges are almost universal in the general population and that their content is indistinguishable from clinical obsessions (Rachman & de Silva, 1978). The difference between normal intrusive thoughts and obsessional thoughts is the meaning that OCD patients attach to the occurrence and/or content of the intrusions.

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One of the core cognitions in OCD is an over-inflated sense of responsibility for harm or its prevention. Responsibility is defined here as:

> "the belief that one has power that is pivotal to bring about or prevent subjectively crucial negative outcomes. These outcomes may be actual, that is having consequences in the real world, and/or at a moral level" (Salkovskis *et al*, 1995).

'Thought–action fusion' (TAF) is one example of inflated responsibility and the importance attached to intrusive thoughts, which has two components: moral TAF and likelihood TAF. Moral TAF is the belief that thoughts are morally equivalent to actions (for example, 'thinking about being a paedophile is the same as being a paedophile'). Likelihood TAF is the belief that thinking about something increases the likelihood of its occurrence, either to oneself or others. Once an intrusive thought or urge has been appraised as dangerous or immoral, then a process of selective attention to the thought occurs. This has the effect of increasing awareness of the thought, by decreasing the threshold for its detection and magnifying its occurrence.

Moral or likelihood TAF appears to be on a continuum in the normal population so that high levels of TAF are not limited to patients with OCD. For example, researchers have managed to select students with high levels of TAF by asking them to write the sentence "I hope that (the name of a close relative) dies in a car accident". This manipulation was found to increase subjective probability that the event would occur. Obsessional problems are thus on a continuum of normal human experience and not just mental illness. Similarly, superstitious thinking is very prevalent in the normal population and may be a more extreme form of TAF in OCD. In this instance, certain numbers may become associated with causing harm. This then leads to avoidance of activities that contain a certain number or repeating of actions a magical number of times in order to prevent harm from occurring.

Other components of an inflated responsibility in OCD are:

(a) The belief that foreseeing the possibility of a negative outcome gives the patient a sense of agency, meaning that he thinks that he has chosen to bring something about.
(b) The belief that errors of omission are as morally bad as errors of commission, especially if one can foresee perceived harm (Salkovskis *et al*, 1995).

For example, for an patient with OCD to find broken glass on a pavement and think of leaving it for a child to be harmed is regarded by the patient as being as bad as putting it there in the first place. This is different from the normal population who believe that they are more culpable for errors of commission than omission. Not taking action thus becomes an active decision and the patient becomes responsible for all the potential dangers that he or she can foresee.

Patients with OCD have a number of other thinking errors that are not necessarily specific to OCD but in combination with an inflated responsibility lead to anxiety and compulsive symptoms. These thinking errors include an overestimation of the likelihood of harm and a belief about being more vulnerable to danger. Other important beliefs include an intolerance of uncertainty, ambiguity and change and the need to control. In other patients, the need for perfectionism and excessive concern over mistakes are especially relevant. Such patients tend to believe that there is a perfect solution for doing anything. Beliefs in OCD are discussed in more detail in a paper by the Obsessive–Compulsive Cognitions Working Group (1997).

Emotion in OCD

The emotional consequences are difficult for some patients to articulate. Theoretically, if a patient believes he or she may be responsible for a catastrophic event in the past then the main emotional consequence is of guilt. An example is a patient who after driving down a dark road develops an obsession about whether he or she might have killed a cyclist who did not have any lights. If the sufferer believes that he or she is responsible for preventing harm or catastrophe in the future, then the main emotion will be of anxiety. Another example is that of a patient with OCD who thinks he or she may have left an electrical appliance switched on and that this might lead to a fire. Other patients might experience an emotion of disgust, especially when they think they could have been in touch with a perceived contaminant like dog faeces (Phillips *et al*, 1998). The emotion of disgust is under-researched but often occurs in specific phobias, OCD, anorexia nervosa and body dysmorphic disorder. It is associated with a reflex narrowing of the nostrils, raising of the upper lip and wrinkling of the brow.

Many patients with OCD also feel depressed with the appraisal of loss and responsibility and many of the secondary problems caused by the handicap. Because of the range of emotions, it is not surprising that some patients find it difficult to articulate and untangle the main emotion associated with the obsession and find it easier to label their emotion as 'discomfort'.

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Avoidance behaviours

Avoidance or escape from situations or activities is one type of safety behaviour that prevents anxiety. Safety behaviours are purposeful activities that are directed in OCD at preventing harm or reducing responsibility for harm. A patient who wears gloves and avoids touching perceived contaminants is preventing anxiety, but this maintains the fear of being contaminated and disconfirmation of his or her beliefs that he or she will be harmed. Assessment will be required of all the situations or activities avoided and rated on a scale (for example, from 0–100 in Standard Units of Distress (SUDs)) according to how much distress would occur if the patient confronted the situation without avoidance.

Neutralising behaviours

Neutralising is another type of safety behaviour which aims to 'undo' the perceived harmful effects of the obsession and is usually covert. It resembles compulsions but is not identical. Neutralising behaviours are strategies adopted by the patient, whereas compulsions are largely involuntary, repetitive and are seldom resisted.

Both neutralising behaviour and compulsions are commonly anxiety- or guilt-reducing. They are therefore reinforced because they are effective in the short-term. Other safety behaviours include various mental activities such as trying to be sure of the accuracy of one's memory, or trying to suppress or distract oneself from unacceptable thoughts. Patients with OCD are thus regarded as 'trying too hard' to prevent bad events from happening, which they think they are able to stop. All such safety behaviours are crucial in the maintenance of obsessional symptoms and prevent disconfirmation of the feared consequences. They may also increase the symptoms. For example, thought suppression leads to a paradoxical enhancement of the frequency of the thought in a rebound manner – the so-called 'white-bear' effect where individuals are instructed not to think about white bears. There will then be a paradoxical increase in the number of such thoughts.

Assessment requires a rating of predicted distress so that a hierarchy of dropping safety and neutralising behaviours may be included in therapy along with an understanding of how they interact with the obsessions and the distress experienced.

Compulsions

Compulsions are defined as repetitive behaviours or mental acts that he person feels driven to perform. They function as reducing anxiety and distress. Common compulsions include washing, checking, reassurance seeking, ordering or hoarding. Examples of mental (or covert) compulsions include repetition of a prayer, counting or repeating words silently. They are generally more difficult to resist or monitor than overt compulsions as they are portable and easy to perform. The term 'rumination' usually covers both the obsession and any accompanying neutralising or mental compulsions.

The early experimental studies of Rachman & Hodgson (1980) established that compulsions, especially cleaning, were reinforcing because they 'worked' and reduced discomfort in the short-term. Checking compulsions had a similar function to cleaning but tended to be slightly less successful at reducing discomfort. No experimental studies have been done on more complex compulsions such as reassurance seeking, ordering or hoarding. Compulsions do not always 'work' by reducing anxiety and may only be intermittently reinforcing. Alternatively, compulsions may function as a means of avoiding discomfort as in examples of obsessional slowness (Veale *et al*, 1993).

Richards & Salkovskis (P. M. Salkovskis, personal communication, 1998) have examined the cognitive component of compulsions and the criteria that patients with OCD use to terminate a compulsion compared with healthy controls. They found that patients with OCD tended to terminate compulsions on the basis of subjective criteria such as feeling 'comfortable', 'right' or 'totally sure', whereas healthy controls used more external criteria such as seeing a light is switched off or their hands being clean. The criteria used by patients with OCD are problematic and an important factor in the maintenance of compulsions.

Assessment requires a rating of predicted distress if the compulsion was resisted so that a hierarchy may be generated; the feared consequences of resisting the compulsion; and the criteria used for terminating the compulsion.

Exposure and response prevention

I shall give a brief overview of the principles of exposure and response prevention in order to high-

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light some of the differences that might occur with the integration of cognitive therapy. A more detailed account of exposure and response prevention may be found in standard textbooks (Steketee, 1993). Whatever approach is taken, patients should have clearly defined problems and goals which they wish to achieve in therapy. Progress should be rated at regular intervals and the obstacles to change should be identified. With exposure, a hierarchy of feared situations is generated so that graded exposure may begin to those situations that are the least anxiety-provoking. Repeated self-exposure to the feared stimuli will usually lead to habituation and extinction of the feared response. Self-exposure is as effective as therapist-aided exposure, although in severe cases therapist-aided exposure may be required to start therapy and speed-up compliance. The key issue is that the patient subsequently takes responsibility for the exposure and the perceived risk.

Exposure should be combined with response prevention, which involves instructing the patient to resist the urge to carry out a given compulsion and wait for the ensuing anxiety to subside. Patients are never forced to stop a compulsion but may be gently cajoled and persuaded. In severe cases, compulsions may be reduced gradually (for example, a target of two hours of washing reduced from three hours). Alternatively, patients are asked initially to delay their response as long as possible. If a patient is unable to resist a compulsion to wash his or her hands, then he or she is usually asked to re-expose himself or herself to the feared stimuli – for example, re-contaminating himself or herself by touching a toilet seat and thus negating the effect of the compulsion or neutralising.

Cognitive therapy for obsessions

Patients with predominantly obsessional thoughts and mental compulsions have traditionally been difficult to treat by exposure and response prevention. Exposure to intrusive thoughts has been attempted by audio-taped feedback of the obsessions on a loop tape, but has had mixed success and some patients refuse to participate (Salkovskis & Kirk, 1989). Audio-taped exposure may still be used in cognitive therapy but after detailed preparation and as a behavioural experiment.

The first step in cognitive therapy after the assessment is to develop a shared formulation of the problem, which should provide a positive explanation for the patient's symptoms (and not just reassurance that the feared consequences will not occur) and how the symptoms are being maintained. This involves identifying the main thinking errors and trying to develop an alternative explanation that allows patients to test out their beliefs about their intrusive thoughts and responsibility. A cognitive model of OCD may be discussed and examples of patient's symptoms should be used for each of the vicious circles that maintain the obsessions (see Fig. 1).

The initial strategy is designed to educate and to normalise the occurrence of intrusive thoughts. The patient might be presented with a long list of intrusive thoughts drawn from a community sample or examples that the therapist has personally experienced. They would discuss the similarities of intrusive thoughts between patients with OCD and healthy controls, that is, the content of the thoughts does not differ but the degree of distress, effort and duration does. Patients learn that they should be having intrusive thoughts and that they are part of the human condition. Indeed intrusive thoughts are necessary for problem-solving and thinking creatively. It is emphasised that the problem lies not with the intrusive thoughts themselves but with the meaning that the sufferer attaches to those thoughts and the various strategies that he or she adopts to try to neutralise them.

The patient may be further engaged in the model by an explanation that intrusive thoughts become obsessions if the person interprets them as being of great personal significance. Examples of unwanted intrusive thoughts that are trivial may be compared to those that are distressing.

The therapist may educate the patient about the various themes for obsessions and a discussion may ensue as to why other intrusive thoughts do not distress them. The dialogue should reveal that the content of their own obsession is closely connected to their own values and how the supposed 'victims' in obsessions relating to harm are usually helpless (e.g. the elderly, people with disabilities, the young). It therefore makes the intrusive thought even more immoral or repugnant to the sufferer (Rachman, 1998).

In the next part of the educational component, the therapist would explain the counter-productive nature of safety behaviours, neutralising and compulsions. Patients tend to believe that their distress will continue unless they carry out a safety behaviour or a compulsion. This can be tested out in a behavioural experiment by asking the patient deliberately to form one of the less disturbing obsessions. On one occasion, they would be encouraged to neutralise the obsession and on the other to resist the temptation and to monitor the degree of distress that occurs on both occasions.

Subsequent discussion might focus on the paradoxical effect of thought suppression on the frequency of the intrusive thoughts. This may lead to an

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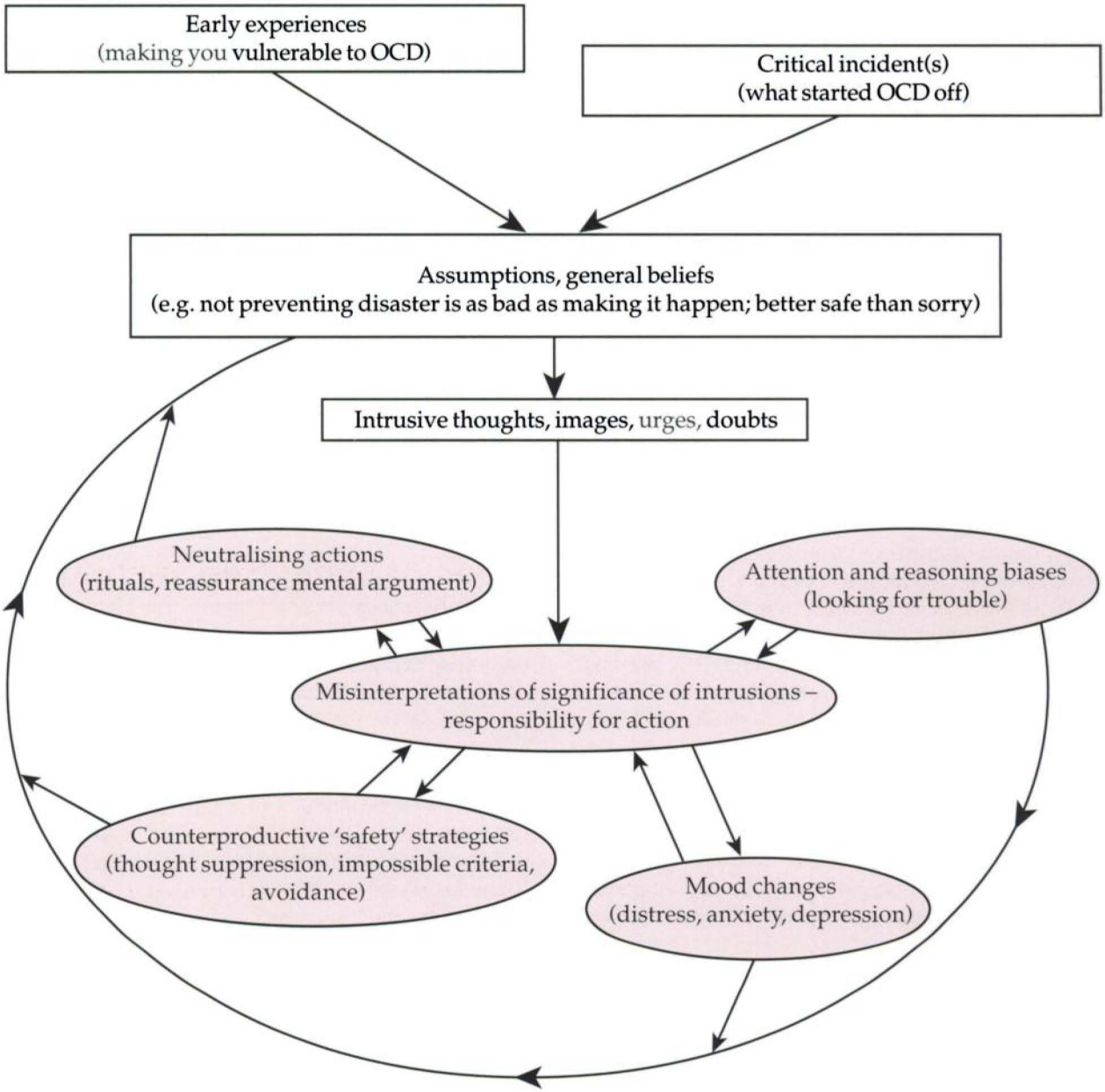

Fig. 1 Psychological factors maintaining threat beliefs in obsessive–compulsive disorder (Salkovskis *et al*, 1998)

experiment that involves asking the patient to record the frequency of a neutral thought under two conditions, with or without thought suppression. This may later be extended to their own intrusive thought.

A strategy in the long-term is to help the patient distance him- or herself from the thoughts, so that it becomes like watching cars pass by on a road. The patient thus acknowledges the thoughts, but does not try to suppress them (in this example, stand in the road and try to stop the cars) or engage with the thoughts (for example, get into a car and drive it). This will paradoxically decrease the frequency of the thoughts.

In cognitive therapy of other emotional disorders, it is often possible to help the patient disconfirm their hypotheses in a behavioural experiment.

This is not usually the case in OCD; for example, a sufferer was extremely distressed because she experienced intrusive thoughts about being a paedophile and child murderer. She avoided being alone with children and near kitchen knives, because of the fear she might stab a child. She had found it difficult even to articulate the thoughts to

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the therapist. In everyday life, she tried to suppress the thoughts or reassure herself and replace them with 'positive thoughts'. How does the patient prove to herself that she will not one day be a murderer? The dangers are commonly judged to occur at some relatively distant time in the future, and cannot, therefore, be tested out in an experiment. In this case, two alternative hypotheses would be generated and then discussion would ensue on the evidence that best fits the hypothesis. In this example, the first hypothesis might be that the person really is a child murderer who will end up in Broadmoor. The second hypothesis is that the person is very worried about being a child murderer and cares very deeply about children. In this case, she was able to predict that if the first hypothesis was true and she really was a child murderer, then she would be feeling excited at the prospect of murdering children. If, however, the second hypothesis were true then she might be feeling very worried and frightened about abusing or murdering children. In addition, the treatment strategy should be to reduce such worries (and not to reduce the risk to her children). The therapist would discuss the thinking error of TAF and over-inflated responsibility. The patient would be helped to differentiate between thoughts and willed actions.

Therapists may also have to do homework – in this case I established for the patient that no one with OCD had ever been admitted to Broadmoor over the past 10 years. We reasoned that of all the patients with OCD in the UK, at least one other patient must have had intrusive thoughts about being a child murderer, but none had ever acted upon them. In another experiment of TAF, I volunteered to concentrate very hard on the thought and write down the thought that my family would be killed in a road traffic accident before the patient was able to test the thought out for herself.

Subsequent sessions involved behavioural experiments to test out the alternative hypothesis – being with children alone and later with a kitchen knife in the vicinity. This is akin to traditional 'exposure' but because of the detailed discussion and experiments on the nature of intrusive thoughts, it was now acceptable and less distressing. The model is presented in some detail and referred to throughout treatment – the aim is not just to change the symptom but also the patient's understanding of their symptoms and to explain why some strategies do not work and why their symptom levels increase or decrease.

Beliefs about responsibility

Cognitve therapy may also be used in patients to challenge some of the assumptions and beliefs about responsibility and to help develop alternative assumptions and rules that do not generate distressing emotions. A pie chart can be used to challenge the patient's degree of responsibility (Van Oppen & Artnz, 1994). In this procedure, the patient and the therapist list all the factors contributing to a catastrophic event. After a circle (pie) is drawn, the patient fills in the pieces of the pie according to the

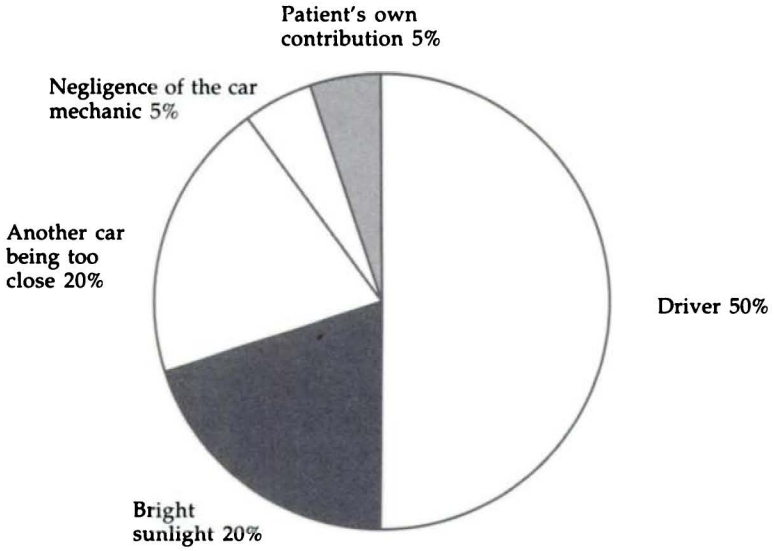

Fig. 2 Responsibility pie chart

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importance of each contributory factor, with the patient's perceived contribution drawn last. For example, a patient with OCD believed that he could be responsible for causing a road traffic accident. He feared that his compact discs might be positioned in his room in such a way as to reflect sunlight onto drivers of oncoming cars in the road outside his house. This led to marked avoidance and checking behaviours which he had difficulty resisting. The patient thought he alone would be responsible if sunlight was deflected onto the driver's eyes and the driver of the car would not be able to ignore or take evasive action if there was a potential hazard. The therapist and the patient came up with the following contributory factors to an accident: the driver, bright sunlight, another car being too close and the negligence of a car mechanic. The patient drew these contributions as pieces of pie on the board, respectively 50, 20, 20 and 5% . As can be seen from Figure 2, only 5% of the pie was left for his own contribution. The patient's attention was thus focused on the factors contributing to the catastrophic event and he was able to see that his influence was much smaller than he had imagined. This then led to a dialogue on other thinking errors and an alternative view on the degree of his responsibility.

Beliefs about intolerance of uncertainty

The need for certainty is a common theme in OCD especially for events in the distant future which are impossible to disprove. For example, a patient with OCD might demand to know for certain whether he or she is HIV-positive despite repeated reassurance from negative tests or positive explanations for his or her symptoms. There is always a nagging doubt in such patients – for example, the blood sample could have been accidentally switched, there could be a new type of HIV which has not yet been discovered, the sero-conversion has not yet occurred, and so on. Such patients demand a 100% guarantee or absolute certainty, which is of course impossible. However, while he or she continues to believe that he or she has to be 100% certain, he or she will focus on the possible doubts. Of course such doubts are possible but highly improbable. It is important not to get bogged down in the detailed analysis of probabilities but to help patients recognise the link between the demand for certainty and their distress. This will help a patient to step back and focus on the low probability of bad events rather than their feared consequences.

Patients can be helped to tackle their beliefs using humour; suggesting that there are only two guarantees in life – death and taxes! A third guarantee described by rational emotive behaviour therapists is that while the patient continues to demand a guarantee that a feared consequence will not occur, then they will continue to disturb themselves with their symptoms for the foreseeable future. The alternative philosophy is to prefer strongly to have a guarantee, but to recognise that this is impossible and as a result be rid of the obsession and anxiety.

Beliefs about terminating compulsive behaviours

Patients with OCD tend to use problematic criteria such as being 'comfortable' or 'totally sure' to terminate a compulsion (P. M. Salkovskis, personal communication, 1998). Patients can be taught that they are diverting increasing amounts of attention and trying too hard to determine the indeterminable (e.g. whether one can be totally sure that everything had been done to make something clean).

Patients who check their memory have special difficulty. They are demanding to have a perfect or

Box 1. Good practice points for cognitive–behavioural therapy in obsessive–compulsive disorder

- Patients should have clearly defined problems and goals, which they wish to achieve
- There should be shared formulation of the problem that provides a positive explanation for the symptoms
- Do not become engaged in requests for reassurance and argue about minor probabilities – refer the patient to their formulation and the cognitive–behavioural model of OCD and use a Socratic dialogue
- Do not give up using exposure and response prevention but integrate it with the cognitive approach
- Ensure that patients do not incorporate new appraisals as a new covert compulsion or way of neutralising

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'totally clear picture of everything they have done and in the right order'. Socratic questioning can be used to realise the impossibility of this demand and how each check creates further ambiguous data and more scope for doubt.

The criterion of 'feeling comfortable' is particularly impossible to achieve when confronting disturbing fears about the harm that a person may cause. In this case, it is important to try to help patients to focus their attention away from their subjective feelings and towards the external world (e.g. what they can see with their eyes or feel with their hands). Alternatively, patients may be shown that demanding to feel comfortable or confident before they can terminate a compulsion or confront a fear is akin to putting the cart before a horse. Patients need to learn that they have to do tasks uncomfortably and unconfidently before they can feel comfortable and confident.

Hazards of cognitive therapy in obsessive–compulsive disorder

A hazard of cognitive therapy in inexperienced hands is that the therapist becomes engaged in the subtle requests for reassurance and arguments about minor probabilities. In such cases, it is especially important to use Socratic dialogue to help the patient generate the information needed by a behavioural experiment or to ask the patient how a colleague or relative would think or act. Most of the problems stem from challenging the intrusive thoughts and not the appraisal. It is always important to relate requests for reassurance or more information to the patient's own formulation and the cognitive model of OCD.

Another potential hazard is for patients to incorporate alternative appraisals of intrusive thoughts as a new way of neutralising (or another mental compulsion). Freeston *et al* (1996) sometimes teach patients the following criteria to distinguish between an adequate appraisal and neutralising:

(a) Adequate appraisal always means allowing a person to act in an appropriate non-neutralising manner, which usually means confronting the situation or thought.

(b) Adequate appraisal does not need to be repeated each time the person is confronted with the thought or situation – if the person finds herself repeating the same analysis, then she is probably giving herself reassurance or neutralising the situation.

(c) New information is useful in appraising new situations adequately, while excessive information-seeking or checking on previously obtained information is nearly always a sign of neutralising.

Finally, a patient can always delay the cognitive analysis until he or she is not feeling anxious or trying to reduce responsibility.

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Multiple choice questions

1. Neutralising an intrusive thought or image:
   a leads to a short-term increase in anxiety
   b is a voluntary strategy adopted by the patient
   c aims to 'undo' the perceived harm
   d prevents disconfirmation of the thought
   e is the same phenomenon as a compulsion.

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2. Cognitive style in OCD includes:
   a thought–action dissociation
   b intolerance of uncertainty
   c over-inflated sense of responsibility for harm
   d finishing washing ritual when he or she can see that ones hands are clean
   e over-estimation of the likelihood of harm.

3. Compulsions in OCD:
   a function by increasing anxiety or discomfort
   b may function as a means of avoiding discomfort
   c can be resisted by focussing attention away from subjective feelings and towards what the patient can see or touch
   d can be almost involuntary
   e can be mental acts.

4. Unwanted intrusive thoughts and images:
   a are indistinguishable in content between OCD patients and the normal population
   b can be suppressed in the long-term
   c differ in the meaning OCD patients attach to their occurrence and/or content compared to the normal population
   d are necessary for thinking creatively and problem-solving
   e are almost universal in the general population.

5. Assessment for cognitive–behavioural therapy in OCD includes:
   a degree of family involvement in avoidance and compulsions
   b degree of insight or over-valued ideation
   c high-risk behaviours
   d emotional consequences of the obsession
   e motivation to change.

MCQ answers

1	2	3	4	5
a F	a F	a F	a T	a T
b T	b T	b T	b F	b T
c T	c T	c T	c T	c F
d T	d F	d T	d T	d T
e F	e T	e T	e T	e T

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