
Cognitive-Behavioral Treatment of Repugnant Obsessions

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Obsessions often occur in the form of repugnant sexual, aggressive, or blasphemous thoughts, images, impulses, or doubts. This article describes the phenomenon of repugnant obsessions and reviews the cognitive-behavioral model of obsessive-compulsive disorder (OCD). Caveats and recommendations are provided and a case illustration is presented. Repugnant obsessions are highly amenable to treatment; but developing an idiographic conceptualization of the client's obsessive-compulsive cycle is important. Treatment resources are presented throughout. © 2004 Wiley Periodicals, Inc. *J Clin Psychol/In Session* 60: 1169–1180, 2004.

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Obsessions often take the form of unwanted, repugnant thoughts that are a profound violation of the individual's morality and values. Few studies actually examine prevalence of obsessions according to content, so published rates of repugnant obsessions are few. In a sample of 44 patients, 50% had aggressive obsessions and 32% had sexual obsessions (Rasmussen & Tsuang, 1986). Patients who have aggressive and unacceptable obsessions tend to exhibit the greatest symptom severity, when compared to individuals who have contamination, symmetry, or hoarding obsessions (Abramowitz, Franklin, Schwartz, & Furr, 2003). However, cognitive-behavioral treatment has been as effective for this subtype of obsessive-compulsive disorder (OCD) as it has for all other symptom subtypes (except hoarders, who responded less well to treatment than the others).

The manifestation of OCD is highly idiosyncratic, and individuals who have OCD typically use a variety of strategies to manage their obsessions and compulsions,

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depending upon situational factors, mood state, and expectations about what will be most effective in a given set of circumstances (Ladouceur et al., 2000). It is important, then, to ensure that a detailed understanding of each client's OCD is achieved before developing a treatment plan (Salkovskis, 1999). Therefore, it is worthwhile to review the phenomenology of repugnant obsessions.

Phenomenology

Examples of repugnant obsessions include thoughts, images, or impulses of harming an innocent or helpless loved one (e.g., throwing a baby off a balcony, kicking an elderly person, swerving into the next lane while driving); sexual obsessions (e.g., thoughts of touching someone else sexually against his or her will, images of sexually molesting one's baby); and obsessions that violate religious beliefs (e.g., images of having sex with Jesus, swearing in church, committing sinful acts). Repugnant obsessions can also take the form of doubt, such as "Did I run over someone without realizing it?" or "What if I didn't check the baby food jar lid for dents carefully enough and the jar I used was dented and contains botulism, which survived the cooking process, and I've accidentally poisoned my child?" Examples of doubts about sexuality include "Am I gay but I haven't realized it yet?", "Did seeing that [repugnant] image arouse me sexually?", "What if I molested my baby!" Religious doubts include "Have I offended God?", "Did I just sin?", "Did I contaminate that prayer with an impure thought?"

Repugnant obsessions tend to give rise to compulsive rituals of thinking a "good" or "safe" thought, engaging in ritualized and excessive prayer, and, most frequently, performing some form of checking (e.g., Abramowitz et al., 2003). Checking can take various forms, including the following:

- Checking that harm has not occurred (e.g., scouring the newspaper and television for reports of hit-and-run accidents, closely monitoring one's body for signs of sexual arousal)
- Checking to ensure that harm will not occur (e.g., checking that the knives are safely in the knife block and that the car is to the right of the yellow line)
- Seeking reassurance, which is a form of checking by proxy

Obsessions that take the form of a doubt tend to give rise to reassurance. The reassurance can be manifested as self-reassurance—for example, rationalization (perusing homosexual pornography on the Internet and attempting to determine whether one is more aroused by it than by heterosexual pornography, scouring religious texts to determine whether a particular action or thought was sinful)—and as reassurance seeking, for example, asking child every few minutes whether he/she is feeling well, asking a close friend or spouse whether he/she thinks one is gay or perverted. Often the goal of reassurance is to obtain 100% certainty as to whether the obsession is accurate. Some patients report that they would feel relief even if they were to determine that the obsession is accurate because they would then be certain as to how to proceed. For instance, if a person knew he/she was definitely a pedophile he/she could arrange for someone else to care for a child and thus feel less conflicted about assigning care.

Repugnant obsessions are also associated with significant avoidance of thought triggers and targets of the repugnant obsessions. Examples include avoiding places where there are knives, food preparation, care of a child, driving, certain colors (e.g., red because it is associated with blood), contact with members of the same sex, religious ceremonies, and temptations of sin. Triggers for the obsession can become quite generalized (Rachman, 1998),

such that a person with obsessions of stabbing his son may begin to avoid all sharp objects. In addition to avoidance of external thought triggers individuals who have OCD engage in strenuous attempts at internal avoidance of the thought or attempts to suppress the thought.

Why Repugnant Obsessions Persist: The Cognitive-Behavioral Model

According to cognitive models obsessions give rise to negative appraisal that evokes distress and drives compulsive acts, suppression, and avoidance. Three different types of appraisal play an important role in the persistence of repugnant obsessions:

- Overvalued appraisals of responsibility (e.g., “any influence over outcome = full responsibility for outcome,” “failing to prevent harm is just as wrong, morally, as actually causing harm”) (Salkovskis, 1989, 1999)
- Thought–action fusion (e.g., “The more I have this thought the more likely it is to come true,” “Having a morally repugnant thought is the moral equivalent to committing a morally repugnant deed”) (Rachman, 1997, 1998)
- The importance of thought control (e.g., “Failing to control thoughts is a sign of mental weakness and instability,” “Failures in thought control potentiate loss of control over any or all other domains of functioning”) (Purdon & Clark, 1999)

Individuals who have repugnant obsessions may also be very concerned that the thought is evidence that highly repugnant personality characteristics are emerging and may become dominant (e.g., “Maybe I am a homicidal maniac at heart!”) (Purdon & Clark, 1999).

Other kinds of appraisals and predictions can certainly play a role in OCD. Often beliefs about the need to engage in rituals can be important targets in therapy (e.g., “If I don’t perform the ritual I will be plagued by the thought continuously and eventually will have a nervous breakdown”) (Wells, 1997). Appraisals about becoming anxious (e.g., “Anxiety is dangerous”) can maintain compulsions for some clients (Freeston, Rheaume, & Ladouceur, 1996). Some patients have difficulty engaging in treatment because of their appraisal of what it would mean to recover from OCD; for example, they may believe “It would mean that my life has been wasted for the past X years,” or “If I get better now it means that all the rituals I do are meaningless and I will look like a fool.” It is useful to examine these fears and predictions and evaluate them realistically.

This appraisal leads to a negative affective state, and the compulsive ritual is performed to ameliorate that state. Any reduction in the ameliorative state or any appraisal that the affective state will escalate if the ritual is not performed serves as negative reinforcement for its performance. Ritual performance can increase distress, especially if the person is unable to achieve the desired state (e.g., of feeling reassured, of having “undone” the ritual, of having prevented harm). Furthermore, even if the ritual does not always lead to relief, it typically has offered some relief at least some of the time, and therefore its use is intermittently reinforced, and intermittent reinforcement schedules are, of course, the most difficult to extinguish. In order to avoid having the obsession altogether, and hence avoid the negative affective state and the need to engage in the ritual, individuals who have OCD avoid obsession triggers, stimuli that make the affective state more intense, and avoid the obsession itself (e.g., engage in thought suppression). Avoidance ensures that there is no new learning about the obsession. Furthermore, thought suppression leads to hypervigilance to thoughts and thought cues, which is mentally exhausting. Inevitable failures in thought control during suppression are likely to enhance the appraisal that the thought is meaningful and requires control.

Assessment

It is important to develop a comprehensive inventory of the obsession content, all ameliorative strategies used to cope with the distress it evokes, and the situations, people, places, and so forth that are avoided because of it. Patients who have OCD are often reluctant to admit the content of their obsessions, especially repugnant ones, especially after they have been told that the therapist is obligated to break confidentiality if he/she believes the client is a danger to self or others. Gentle, nonjudgmental inquiry about the basic content of the obsessions is important.

It is helpful to clients to monitor their obsessions, compulsions, and avoidance every day for a week, recording the occurrence of each on a form. Clients typically require some instruction about how to identify and distinguish all three. We have found it useful to define *obsessions* as “thoughts that keep coming back to you, even though you do not want them, and that are distressing and/or disturbing.” *Compulsions* are defined as “mental or behavioral coping strategies you feel compelled to perform in order to try to reduce the distress or discomfort caused by the obsession and/or to prevent a bad outcome.” *Avoidance* is “any person, place, object, color, sensation, or situation you avoid in order to reduce the chance of having the obsession or to reduce the amount of distress you might feel if you were to have the obsession.” Examples are provided of each, drawing from the diagnostic assessment (e.g., the target obsessions and compulsions on the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS) or the client’s verbal report).

We use two self-report measures of obsessional beliefs and appraisals. The Obsessional Beliefs Questionnaire (OBQ) and the Interpretation of Intrusions Inventory (III) have items designed to assess the range of cognition implicated as important in cognitive-behavioral models. The measures have been validated in clinical and nonclinical samples and have demonstrated good psychometric properties (OCCWG, 2001). The OBQ contains items framed in the form of general beliefs, whereas the III contains a subset of items from the OBQ that are framed in terms of situational, immediate appraisal of each occurrence of the obsession. For the purposes of treatment, the III is probably more useful as it assesses situational appraisal.

When assessing violent and sexual obsessions, ensuring that the “obsession” is truly an obsession, and not a thought characteristic of a paraphilia or violent behavior, is of course important. People who have exploitative paraphilias or antisocial tendencies in fact act on thoughts about committing the action. To establish a differential diagnosis determining the extent to which the thought is ego-dystonic is important. This can be accomplished by asking whether the person has ever voluntarily generated fantasies about committing the act and which, if any, acts that are consistent with the thoughts (e.g., violent behavior, sexually exploitative behavior) he/she may have committed. In the case of sexual obsessions the therapist should also ask whether the individual has ever become sexually aroused by the thoughts or has masturbated in response to them.

It is also important to determine whether the primary focus of the concern about having the thought reflects self-interest (e.g., acting it out and getting caught) or concern for the “victim” (e.g., harming someone). Often individuals who have exploitative paraphilias and/or antisocial tendencies have significant difficulty appreciating the destructive impact of their act on the victim. Individuals who have OCD, on the other hand, are exquisitely sensitive to the potential for harm to the victim were the act to be committed, and this sensitivity makes the thought especially upsetting and repugnant. Individuals who have OCD are also most likely to avoid situations that might evoke action consistent with the thought, whereas individuals who have antisocial tendencies or exploitative paraphilias may well seek out situations in which they could potentially act it out. One

individual I assessed wondered whether he was a pedophile and had actually tested himself by tickling a little girl he encountered at the grocery store on the chest to determine whether he found it arousing. When in doubt, and when possible, forensic assessments can be helpful in making differential diagnoses.

Educating the Client to the Model

We begin by educating the client about the cognitive-behavioral model of OCD, using the data the client has collected to piece together the roles appraisal, compulsive rituals, avoidance, and thought suppression play in the persistence of the disorder. These data elucidate the internal logic of the problem and its solution. Often clients feel much less “crazy” when they understand the problem, and the treatment itself then makes more sense to them. Furthermore, therapeutic rapport is much stronger when the client is confident that the therapist truly understands her/his fears. If family members are involved in the ritual (e.g., if they are regularly asked to provide reassurance), arranging for them to sit in for part of the session, explaining the treatment rationale to them, and telling them that they will be asked to stop providing reassurance are often helpful. They are often concerned and want to know what they should do instead.

Active Intervention: Exposure

Encouraging exposure can be a hard sell for patients who have repugnant obsessions because the perceived “awfulness” of the potential harm is so high. We explain to individuals that if they take no risks of the sort required in exposure, then one can pretty well guarantee that they will continue to suffer from OCD. However, if they do take a number of exceptionally small risks, there is an excellent chance that they will be much freer of OCD in the near future.

In treatment of repugnant obsessions it can be difficult to determine the risk to which the client should be exposed. The treatment can be especially tricky when the client's obsessions occur in the form of doubts and when the client experiences obsessions involving violence or exploitation of loved ones. A general rule is that clients should be exposed to what they fear. If they are afraid of a thought or image, expose them to the thought or image. This exposure can be accomplished by the client's writing out the thought or scene in vivid detail, and reviewing it again and again, or writing it again and again. The therapist can also ask the client to read a detailed description of the image into a tape recorder and play the tape repeatedly. This method, also referred to as *audiotaped habituation*, is especially helpful for clients who use mental compulsions or neutralization such as rationalizing, saying ritualized prayers, or thinking a “good” thought, as the continuous repetition of the obsession prevents completion of the mental ritual. A client who is afraid of losing control and acting on an impulse should be exposed to the situation in which the impulse occurs. For example, if the urge is to swerve into the other lane while driving, the client should drive and experience the urge as often as possible without engaging in compulsions or avoidance. In cases of violent or exploitative obsessions, the goal is not to desensitize individuals to the idea of hurting a loved one or of a loved one's being harmed. Take the example of an obsession of sexually molesting one's child. The parent's concerns about the consequences to the child of experiencing sexual abuse are quite rational. What is irrational about the obsession is the fear that *the thought itself* is the vector by which harm might occur.

If the obsession is a doubt, then the client needs to be exposed to the sense of uncertainty without engaging the doubt. The client needs to experience the doubt without

entertaining it as an idea that requires *any* kind of response: that is, go about their day with the sense of doubt but without doing anything at all to ameliorate it. Often people who have obsessional doubts ask how they are to know whether a doubt is real. We have found it useful to tell clients that if it feels like OCD, it is OCD. Second, we recommend that if the doubt is not strong enough to evoke an action consistent with the doubt it is unreasonable (e.g., the doubt as to whether you have accidentally hurt someone does not lead you to want to drive to the police station to confess). Third, if the concern driving the anxiety has been derived through more than one “what if,” we deem it unreasonable. For example, “What if I left crumbs behind on the table and what if the next person who sits down has a peanut allergy and what if he/she touches my crumbs and has an anaphylactic reaction and does not have an epi-pen and dies—it would be my fault!”

Active Intervention: Cognitive Restructuring

Treatment refusal and dropout rates for OCD may be improved if we can “detoxify” the obsession before attempting exposure and use cognitive techniques in tandem with exposure to enhance its impact on detoxifying the thought’s meaning (Salkovskis, 1999). The process of detoxification relies on cognitive restructuring and behavioral experiments to change the personal meaning of the obsessional thought. When planning the cognitive component, several caveats are in order. First, individuals who have OCD often overestimate the probability of a threat; therefore, developing a realistic view of the probability of the feared event is helpful. However, many individuals who have OCD continue to experience distress about the obsession as long as the chance of the feared event is not absolutely and certainly 0%, especially if the perceived awfulness of the threat is high (Salkovskis, 1999). Cognitive restructuring around the actual probability of the threat may be helpful initially, especially if the estimation is based on erroneous information, but once the probabilities have been established, further discussion is likely to serve as reassurance. Cognitive restructuring instead must focus on overvalued beliefs about responsibility, about the meaning and importance of thoughts, and about the meaning of thought control.

Second, cognitive restructuring around the “truth” of the obsessional thought is likely to be quite unproductive (e.g., trying to prove categorically that someone is not a child molester): it is almost impossible to prove the null hypothesis. The problem in the preceding example is not that such individuals erroneously think they are child molesters, but rather that they think they *could be* child molesters and that they must behave cautiously until they have 100% certainty that they are not, have not been, and never will be a danger to children (99% certainty is seldom good enough). By the time individuals enter treatment they probably have accumulated every iota of evidence for and against the idea that they are child molesters and use this balance sheet as a form of self-reassurance or self-recrimination. Thus, cognitive restructuring aimed at establishing the validity of the doubt is at best fruitless; at worst it assists the client in the elaboration of the reassurance ritual. Salkovskis (1999) states the OCD problem that needs to be addressed quite eloquently: “Maybe you are not dangerous, but you are very *worried* about being dangerous” (p. S35).

Finally, when treating religious obsessions sensitivity to the client’s religious values is important. Treatment should focus on irrational and exaggerated concerns about the meaning of the thoughts, but not beliefs about religion itself. We also advocate involvement of the client’s spiritual leader as a means of establishing acceptable guidelines for religious practice (e.g., frequency of prayer and other religious practices), just as when

treating contamination fears one might consult a medical professional to establish acceptable guidelines for maintaining good hygiene. The therapist and client can then agree to accept the spiritual leader's guidelines for religious practice and use these standards when reducing rituals such as repetitive prayers.

Useful analyses of the difference between religious observance and religious obsession are found in the *Obsessive-Compulsive Foundation Newsletter* (vol. 17, winter 2003). The message is that the sense of certainty is absent or present, and that if it is absent, one is "off the hook" for compensating for the perceived transgression. Taking the doubt (e.g., "maybe I sinned") seriously by actually questioning reality (e.g., "Am I certain that I didn't sin?") and attempting to determine whether or not the doubt is valid is prohibited. This reasoning is similar to the notion of not allowing individuals who have OCD to try to prove the null hypothesis.

With these caveats in mind, there are a number of specific restructuring techniques for OCD to address the kind of appraisal relevant to repugnant obsessions (see Freeston, Rheume, & Ladouceur, 1996; Salkovskis, 1999; Steketee, 1999; van Oppen & Arntz, 1994). The following case example illustrates the use of cognitive techniques in combination with exposure in treatment of repugnant obsessions.

Case Illustration

Presenting Problem/Client Description

Mr. X was a 64-year-old loving grandfather who reported obsessions involving harm to his grandchildren. About 1 year before his assessment Mr. X was preparing a salad for his grandchildren when suddenly he experienced a sudden urge to stab the youngest in the neck with his paring knife. Mr. X was horrified by the thought, and his horror escalated when the thought recurred. He began to replace it with an image of his grandchildren playing safely and happily. Mr. X started to question his personality, wondering whether he had always been a psychopath and never known. He spent hours daily tallying up evidence that he was a psychopath and evidence that he was not a psychopath. This activity afforded him some relief from his anxiety until the obsession recurred and his doubts returned. The impulse soon became thoughts ("Stab my grandchild!", "Kill my grandchild!"). When the thoughts or impulses occurred, Mr. X would try as hard as possible to banish them from his mind. The fact that they returned despite his best efforts was interpreted as evidence that the thought was meaningful. Mr. X declined to be alone with the children and if they visited would not handle any sharp implement. Soon he found it difficult to be in the same room with them even when someone else was present and there were no sharp objects in the area. He began to have difficulty looking at the color red, as it reminded him of blood. He could not watch TV because of concern that he might see a depiction of a violent act that might "give him ideas." When he sought treatment Mr. X had narrowed his range of activities quite severely, being afraid to be out in public lest he act on an aggressive impulse toward a child he saw on the street. His Y-BOCS score was in the moderate to high range.

Case Formulation

Mr. X's obsessional thought evoked enormous distress because he believed: (1) that he would not be having the thought unless there was a part of him that wanted it to occur; (2) that the more he had the thought the more likely he was to lose control and act on it; (3) that the thought might be prophetic, much as the central character in the movie *The*

Shining had visions of murder months before it happened; and (4) that even having the thought without acting on it was immoral, making him an immoral person. Mr. X was highly invested in not having the thought as its absence would signify that he might not be a monstrous psychopath. Therefore, he avoided thought triggers and tried to banish the thought once it, or anything similar to it in theme or content, entered his mind. His attempts at suppression made him hypersensitive to thought cues and when he experienced thoughts while he was actively suppressing his belief that the thought was meaningful and requiring of action intensified. Mr. X's attempts to reassure himself were unsuccessful because of his underlying beliefs about the meaning of the thought's recurrence, but the temporary reduction in anxiety they resulted in was reinforcing enough that he continued to use it as a coping strategy on a regular basis.

Course of Treatment

The 16-session treatment sessions were held for 2 hours weekly for 14 weeks and then biweekly for sessions 15 and 16 and sessions. They were conducted by the author and a cotherapist. Treatment began by obtaining a detailed description of thoughts, emotions, compulsions, neutralizing, and avoidance based on diaries of these events over 1 week. This information was used to inform Mr. X about the treatment model. Information about OCD, its course, and the effectiveness of cognitive behavior therapy was provided, along with the treatment description. The next session was spent offering Mr. X normative information about violent and repugnant thoughts. We gave Mr. X a list of violent and repugnant thoughts reported by a nonclinical sample of university students (see Clark, 2004) and explained that thoughts of this kind are experienced by many people. We then provided information about attentional processes and thought processes, noting that we all have numerous thoughts throughout the day but that we are geared to attend to thoughts most relevant to our immediate goals, such as the goal of being a loving grandfather.

Mr. X was then asked to identify the extent to which obsessional thoughts other than his target obsessions bothered him now or had bothered him in the past. He reported that he had had a number of other repugnant thoughts in his life but said that these had not bothered him because he was not afraid of acting on them. We explored this idea with him in light of his recent knowledge that attentional processes are drawn to thoughts that have immediate relevance for current goals. He understood the point that the obsessional thoughts may be perceived as significant simply because they reflect current concerns, not because they truly are significant. Mr. X was relieved to learn that his thoughts were not wholly aberrant and was willing to entertain the idea that it was not the thought itself that was the problem, but rather his interpretation of it. We asked him to keep track of the intensity of the thought and his level of belief in the idea that having the thought potentiated action as homework.

Mr. X returned the following week and reported that his belief that the thought was harmful was more intense when his grandchildren were visiting and when he was tired or already anxious. We used this information to illustrate that the thought's meaning is not static, but varies according to a number of factors. Therefore, it did not represent truth. During this session we also addressed Mr. X's beliefs about the meaning of failures in thought control. At assessment, Mr. X believed that if his thought returned despite his efforts to control it, it must have an important meaning and should not be ignored or discounted. We asked Mr. X to try to suppress thoughts about a white bear for several minutes; he was unable to do so perfectly. We discussed current research on thought suppression in light of this experience, noting that even if suppression does not lead to a

paradoxical increase in frequency, it is almost never fully successful. Negative interpretations of failures of thought control (e.g., "I'm going crazy," "The more I have this thought when I'm trying to get rid of it the more likely it is that it is meaningful") make the thought seem more important than it may actually be. Furthermore, failures in thought control lead to a decline in mood state, which makes negative thoughts even more accessible and credible. Homework for the week was to monitor all thoughts, including strange, silly, nonsensical thoughts, as well as thought appraisal and moods.

The next week, Mr. X reported that he had experienced numerous strange, silly, and unexpected thoughts and recognized that this past week was not an exception, but that in the past he simply ignored such thoughts because he deemed them unimportant. We discussed the differences in his obsessional thoughts and again explored the idea that the obsessional thoughts in and of themselves are not a problem; but rather, his appraisal of their meaning makes them so. We also addressed Mr. X's conviction that having thoughts of violence made him immoral by asking whether having the strange, silly thoughts he reported made him strange and silly. Finally, we discussed Mr. X's ability to monitor and control every unacceptable, immoral thought that might enter his mind. Mr. X agreed that such a task would be exceedingly difficult, if not impossible, and that he would likely be able to concentrate on little else should he attempt it. We then discussed whether, in light of this realization, his conclusion that he was immoral for "allowing" such thoughts to enter his mind was a fair one.

We then discussed Mr. X's readiness to begin exposure. We sketched out a hierarchy of feared thoughts and situations. The hierarchy was based on level of anxiety experienced if the usual ritual (e.g., rationalizing, thought replacement) was prohibited along with avoidance strategies (e.g., keeping his hands in his pockets at all times, avoiding looking at his grandchildren's necks, avoiding touching them). We identified situations in which experiencing the impulse would be moderately upsetting, quite upsetting, and overwhelmingly upsetting (e.g., having the impulse while in his home near knives with the children absent versus present). Mr. X was asked to flesh out the hierarchy during the next week and to be prepared to begin exposure in the next session.

The following week, Mr. X was ready to engage in exposure. He wrote out all of his thoughts related to the impulse to stab his grandchild on a sheet of paper, the least anxiety-evoking thought ("Pick up a knife") followed by the most ("Kill Y [grandchild's name]"). Mr. X read the first sentence aloud over and over again. He was encouraged to attend to the meaning of every word rather than simply recite the words automatically. Mr. X had significant difficulty doing so at first, shaking visibly, his voice trembling and his brow sweating. However, after about 15 repetitions he began to feel bored and his mind began to wander. He then read the next sentence in the list aloud over and over again, and, so on until he reached the most difficult sentence. Throughout the therapist acted as coach and facilitator, keeping Mr. X focused on the source of his anxiety, taking anxiety ratings, and making encouraging statements such as "You're doing really well. If you can keep going this exercise is really going to pay off for you."

At the end of the session we processed his progress, specifically discussing what about these stimuli had changed that he could tolerate them with considerably less anxiety. Mr. X reported that he was beginning to believe that the thoughts might just be thoughts rather than prophetic warning signs or indications of character flaws. As such, he was not as afraid of them or the consequences of speaking them aloud. For homework Mr. X was asked to begin exposure to the next items in his hierarchy (while continuing to practice the items handled that day). These included staying in the same room as his grandchildren, handling knives when his grandchildren were absent, and wearing something red without attempting to preempt or suppress thoughts the color triggered.

In the next session, Mr. X reported that he had had initial success with the exposure but found it more difficult if he had recently seen or was soon to see his grandchildren. Mr. X reported that he had become increasingly concerned that speaking his thoughts aloud would lead him to lose control and act on the thoughts. He also became concerned that speaking the thoughts aloud might make the act seem more palatable or attractive, given that he might actually have psychopathic tendencies. He found himself retreating to the more cautious strategy of avoiding the thoughts rather than risking harm to his grandchildren by expressing the thoughts aloud. Mr. X said that if he knew certainly he was not a psychopath he would be able to practice exposure without fear.

We did some cognitive restructuring about Mr. X's perceived need for 100% certainty that he was not a homicidal maniac before he would feel fully safe in having the thoughts. We acknowledged that we did not know for certain that the probability of him being a homicidal maniac was 0%, just as we did not know absolutely that his wife or his neighbor was not a homicidal maniac. We pointed out that the difference between people who have OCD and those who do not have OCD is that the latter are able to live in accordance with the obvious balance of probabilities and dismiss as unimportant the potential for events of very low probability. As a result, people who do not have OCD are able to accept educated risks and not organize their life around fending off negative events of minute probability. We drew up an agreement that from this point forward Mr. X would act according to the balance of probabilities. For example, he would behave as if he were *not* a homicidal maniac and therefore did not need to take precautions to protect others from his potential actions.

We agreed to address Mr. X's other concerns during exposure and in his homework for the upcoming week. Mr. X had taken in some articles that were red and read aloud the thoughts about harming his grandchildren while looking at or holding the items. Mr. X was asked to keep track of how much he wanted to stab his grandchildren as he read aloud the thoughts. Over the course of the exposure exercise Mr. X reported no change in his desire to commit the murderous act: that is, his desire to stab his grandchild was absolutely and confidently zero, although he had spoken aloud the thoughts many times. To address Mr. X's concern that having the thoughts increased the likelihood of harm to his grandchild we asked him to spend the next week trying to make himself win the lottery by thinking about winning it. Finally, to address his concern that having thoughts about an inappropriate act led to loss of control over behavior, we asked Mr. X to go to a grocery store and try to make himself lose control by thinking about yelling something inappropriate. Mr. X was also to continue exposing himself to the color red, to read the newspaper without avoiding articles describing violence, and to continue reading aloud his thoughts.

At the next session Mr. X reported that he had been unsuccessful in winning the lottery and unsuccessful in embarrassing himself in the grocery store. He also found that he was able to tolerate news stories about violence and that he was now quite bored reading his thoughts aloud. In this and the next several sessions, Mr. X continued his exposure to thoughts, gradually decreasing his avoidance and increasing the level of risk he was willing to take. He took sharp implements to the session, starting with a paring knife and eventually an axe, and read aloud his thoughts about violence while handling the implements. Between sessions he allowed himself to experience the thoughts in the presence of his grandchildren and eventually he was able to have the thought of stabbing his grandchild while chopping food in the kitchen while his grandchild was present. Mr. X also began to interact with his grandchildren much more and agreed to stay with them even when no other adult was present. Mr. X began to watch action shows on television and was able to rent violent movies.

Outcome and Progress

By session 16, Mr. X worried far less about having the thoughts and impulses involving stabbing and found that he no longer had the need to try to preempt their occurrence. His ability to concentrate improved, and he was able to reengage in many of the activities that were previously too difficult. As Mr. X's range of activities increased, he noticed that the thoughts occurred far less frequently and when they did occur they required little or no response from him. Mr. X was finally able to enjoy his grandchildren again without concerns that he was a danger to them. His score on the Y-BOCS was now in the non-clinical range.

Clinical Issues and Summary

Mr. X reported obsessions of stabbing his grandchildren. At the time of treatment he was unable to spend time with them and was preoccupied with attempts to suppress and control his obsessions. Cognitive restructuring targeted beliefs that having the thought meant he was a psychopath, that the more he had the thought the more in danger he was of losing control and acting on it, and that having the thought meant he was immoral. This work was complemented by exposure to the obsessions themselves (note, not exposure to the idea of his grandchildren's being murdered) and to situations, people, colors, and objects he currently avoided in order to prevent the obsessions. Mr. X was highly responsive to treatment; his symptoms were nonclinical by the end of treatment.

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