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EMPIRICALLY GROUNDED CLINICAL GUIDANCE PAPER

Best practices for CBT treatment of taboo and unacceptable thoughts in OCD

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Abstract

Although general cognitive behavioural therapy (CBT) can help alleviate distress associated with obsessive-compulsive disorder (OCD), strategies tailored to targeting specific cognitions, feelings, and behaviours associated with OCD such as exposure and ritual prevention (Ex/RP) and cognitive therapy (CT) have been shown to be a significantly more effective form of treatment. Treatment of individuals with unacceptable/taboo obsessions requires its own specific guidelines due to the stigmatizing and often misunderstood nature of accompanying thoughts and behaviours. In this article, OCD expert practitioners describe best practices surrounding two of the longest standing evidence-based treatment paradigms for OCD, CT and Ex/RP, tailored specifically to unacceptable and taboo obsessions, so that clients may experience the best possible outcomes that are sustained once treatment ends. In addition, CT specifically targets obsessions while Ex/RP addresses compulsions, allowing the two to be highly effective when combined together. A wide range of clinical recommendations on clinical competencies is offered, including essential knowledge, psychoeducation, designing fear hierarchies and exposures, instructing the client through behavioural experiments, and relapse prevention skills.

Key learning aims

(1) To learn about the theoretical underpinnings of specialized approaches to treating taboo/unacceptable thoughts subtype of OCD with gold-standard CBT treatments, cognitive therapy (CT) and exposure and ritual prevention (Ex/RP).
(2) To learn about recognizing and identifying commonly missed covert cognitive symptoms in OCD such as rumination and mental compulsions.
(3) To learn how to assess commonly unrecognized behavioural symptoms in OCD such as concealment, reassurance seeking, searching on online forums, etc.
(4) To gain a nuanced understanding of the phenomenology of the taboo/unacceptable thoughts OCD subtype and the cycles that maintain symptoms and impairment.
(5) To learn about in-session techniques such as thought experiments, worksheets, fear hierarchies, and different types of exposures.

Keywords: behavioural experiments; behaviour therapy; cognitive therapy; exposure therapy; obsessive-compulsive disorder; taboo thoughts; unacceptable thoughts

Introduction

Obsessive-compulsive disorder (OCD) is a severe and disabling condition that interferes with occupational functioning, relationships, and life satisfaction. Research has identified four primary categories of OCD symptoms, termed symptom dimensions, where each dimension includes both obsessions and compulsions. These dimensions include (1) contamination and washing, (2) doubts about causing harm, (3) symmetry, arranging and counting, and (4) unacceptable and taboo obsessions (Abramowitz *et al.*, 2010; Williams *et al.*, 2013). This last category typically includes obsessions about aggression and violence, scrupulosity (morality or religion), and sexually deviant acts, and health concerns may also be included (Williams *et al.*, 2011; Williams and Wetterneck, 2019). Among those with OCD, it is estimated that 30.2% have sexual or religious concerns, 43.0% have moral concerns, 24.2% have harming concerns, and 14.3% have illness-based concerns, although these are not mutually exclusive (Ruscio *et al.*, 2010).

Although general cognitive-behavioural therapy (CBT) (e.g. identification and challenging of automatic thoughts) can help alleviate symptoms of OCD, strategies designed specifically for OCD such as exposure and ritual prevention (Ex/RP) and cognitive therapy (CT) specific to OCD (e.g. the need to differentiate between an intrusive thought and an automatic thought) have been shown to be significantly more therapeutic (e.g. Simpson *et al.*, 2008). Behavioural and cognitive theories and strategies will be presented independently and referred to as such (i.e. either Ex/RP or CT). Treatment of individuals with unacceptable/taboo obsessions has been a challenging area for clinicians and clients alike, and therefore best practice guidelines can help ensure a high standard of evidence-based care for those who are suffering.

History

The first study to psychometrically examine OCD symptom clusters was conducted by Baer (1994), who studied 107 OCD patients who had completed the Yale-Brown Obsessive-Compulsive Symptom Checklist (Y-BOCS; Goodman *et al.*, 1989). Principal components analysis of the results indicated three categories of OCD that he labelled symmetry/hoarding, contamination/checking, and pure obsessions. This last subtype included people with aggressive, sexual and religious obsessions, but no obvious compulsions (unacceptable/taboo obsessions). Thus, it was initially believed that those with these classic obsessions had no rituals, just their own troubled thoughts.

Early treatment trials which primarily utilized Ex/RP strategies typically did not include participants with such obsessions (i.e. unwanted, ego-dystonic intrusions of a sexual, aggressive or blasphemous nature) (Ball *et al.*, 1996). For those who could tolerate the treatment, it was a revolutionary approach that provided much needed relief (e.g. Kirk, 1983). However, for those who struggled with these obsessions, treatment outcomes were not as robust compared with those people who engaged in overt compulsions. Rachman (1983) commented that 'the main obstacle to the successful treatment of obsessions is the absence of effective techniques'.

With the cognitively focused reconceptualization of OCD (Salkovskis, 1985), researchers and clinicians had new methods by which to approach this OCD presentation. The cognitive model was further refined by Rachman (2002) specific to unacceptable/taboo obsessions. Following this conceptualization cognitively focused strategies and approaches were developed and tested with the aim of altering appraisals to ones that are neutral and not personally threatening (e.g. 'It's just a thought').

Level of evidence and expert opinion

Behaviourally focused treatments have a long history and have been tested upon hundreds of participants in randomized trials. It has been the gold standard psychological treatment for

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decades (e.g. Eddy *et al.*, 2004; Koran and Simpson, 2013). Cognitive treatments for OCD were devised in part as an extension of the cognitive influence of Beck (e.g. Beck *et al.*, 1987) and Clark (1986) and the success experienced with treating other anxiety and mood disorders. Additionally, it was hoped that cognitive treatments would improve upon the efficacy associated with the gold standard behavioural treatment. To date there has been no direct comparison of behavioural and cognitive treatments for unacceptable/taboo obsessions. In fact, there has been only one randomized controlled trial (RCT) specific to participants with unacceptable/taboo obsessions (Whittal *et al.*, 2010b). In that trial, Rachman's (2002) model was put to the test and was found to be highly effective (effect size $d = 2.34$) and durable over a one-year follow-up.

Purpose of this article

There are a number of areas where specialized skills may be necessary to successfully treat unacceptable/taboo obsessions in OCD. Skills are a step beyond knowledge as they require effort and training to put into practice. This is similar to the difference between declarative versus procedural systems of knowledge, as explicated by Bennett-Levy (2006), where the declarative system is concerned with 'knowing that' and procedural includes the 'how' and 'when' including hands-on therapist skills. The following sections describe the importance of both knowledge and skills in the areas of assessment, psychoeducation of clients, cognitive therapy treatment skills, and exposure and ritual prevention treatment skills. These competencies have been selected through the authors' own empirical investigation (e.g. Whittal *et al.*, 2010b), work with colleagues (Williams and Wetterneck, 2019), and clinical experiences (e.g. Bruce *et al.*, 2018). Although these guidelines may not apply to every clinical situation, they can serve as a resource for clinicians. This article assumes some basic skills in the ability to utilize cognitive and behavioural treatment techniques.

Specialty knowledge

There are a number of critical areas where specialized knowledge is necessary to understand unacceptable/taboo obsessions in OCD. The following sections describe the importance of knowledge in the areas of differential diagnosis, ability to recognize covert compulsions and OCD related avoidances, and the ability to provide appropriate psychoeducation around these issues.

Differential diagnosis of unacceptable/taboo obsessions

A major barrier to treating individuals with obsessive-compulsive disorder (OCD) is widespread difficulty in correctly identifying OCD symptomatology by mental health professionals, particularly with individuals whose obsessions and compulsions revolve around taboo themes such as paedophilia, sexual identity crises, and violently harming others. For example, in a study by Glazier and colleagues (2013), 38.9% of providers who were members of the American Psychological Association ($n = 360$) misdiagnosed clinical vignettes of OCD. More specifically, incorrect responses were significantly higher for taboo thoughts vignettes with obsessions about homosexuality at 77%; sexual obsessions about children at 42.9%; aggressive obsessions at 31.5%; and religious obsessions at 28.8%. Non-taboo obsessions such as contamination concerns were misdiagnosed at a rate of 15.8%, which was significantly less than taboo obsessions.

While all individuals with OCD find their thoughts distressing, the unacceptable/taboo obsessions subgroup often experience their thoughts as more distressing than other groups due to their stigmatizing and repugnant nature (Bruce *et al.*, 2018; Moulding *et al.*, 2014), and as a result, may be reluctant to share their obsessions with the clinician due to high levels of shame and guilt surrounding their internal beliefs (Glazier *et al.*, 2015). For example, some may believe that they are truly defective and that as a paedophile, criminal, or other

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dangerous person, they are likely to be punished, go to jail, be shunned by society or God should the world know their secret (Leins and Williams, 2018). With this population, clinicians must be careful not to misinterpret the content of clients' fears, obsessions and compulsions to mean the very thing that the client is not.

For example, if a client with paedophilia-themed OCD (P-OCD), explains that she is afraid she will sexually abuse her own child, the clinician may mistakenly see this as an expression of paedophilic desire, when in fact the opposite is true (see Bruce *et al.*, 2018). Similarly, a client with obsessions around stabbing their partner with a steak knife could be mistakenly assumed to be dangerous when the underlying problem of OCD rather reflects the *fear* of being dangerous (Williams and Wetterneck, 2019). At other times, a diagnosis of psychosis may be assigned if a client's obsessions and compulsions involve seemingly bizarre content such as beliefs around the devil, thought insertion, etc., which may be especially true for clients of colour (Ninan and Shelton, 1993; Williams *et al.*, 2017). Vella-Zarb and colleagues (2017) discussed differentiating OCD with paedophilic content from those with paraphilias and non-paraphilic sexual disorders.

Likewise, clients with health-related anxieties (e.g. worries that they may have an unlikely physical or mental illness), must be appropriately identified as having OCD rather than requesting more medical tests. Clinicians must not be derailed by seeking medical reassurance, which only fuels the OCD. Hyperfocus on bodily sensations should be identified as an obsession.

Overt versus covert compulsions

One of the most important skills for correctly diagnosing OCD is the ability to identify compulsions. OCD compulsions can generally be broken down into two categories: those that are *overt* and those that are *covert*. Overt compulsions are external behaviours that can be observed, such as washing hands or checking faucets. On the other hand, covert compulsions are internal, meaning they are not visible to the naked eye and may include behaviours such as internal dialogue, mental review, somatic checking, internal neutralization techniques, such as saying a prayer, or attempting to reverse intrusive thoughts by thinking the opposite (also known as mental 'undoing'), and a number of behaviours that largely fall under efforts at thought control including thought suppression and distraction (Williams and Wetterneck, 2019). Due to the undetectable nature of mental rituals, covert compulsions remain understudied and there is ample reason to suspect prevalence rates may be under-estimated due to reluctance to disclose information within this subgroup (Sibrava *et al.*, 2011). For this reason, it has also been mistakenly suggested that OCD patients who primarily engage in mental rituals may be less amenable to treatment (Whittal *et al.*, 2010b). Needless to say, covert compulsions present a unique clinical challenge and the ability to identify covert compulsions is of utmost importance in developing a treatment plan for individuals with unacceptable/taboo thoughts.

As previously noted, it was once speculated that there existed a subgroup of individuals with OCD who *solely* experienced obsessions (Williams *et al.*, 2011). They were referred to as 'Pure O', meaning purely obsessional, and it was believed that this group did not have compulsions at all (Williams and Wetterneck, 2019). As it turns out, this group *does* experience compulsive behaviour; however, compulsions were largely covert and more challenging to identify during assessment. Although it has been speculated that this population engages almost exclusively in mental rituals, it is now clear that this group also engages in overt compulsions such as reassurance-seeking (Leonard and Riemann, 2012; Williams *et al.*, 2011). They may also engage in somatic checking (i.e. checking their body to assuage fears), which can be overt or covert.

For example, for the client with P-OCD, this may mean checking if they become physically aroused in the presence of children. For the client with aggressive thoughts, this may involve checking the body to see if there is any evidence indicative of having engaged in violent behaviour (e.g. bruises or cuts on their hands or body). For those with religious obsessions, it

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could involve repeated reassurance seeking with family members or religious authorities. Covert compulsions may involve saying a prayer or saying a special word to neutralize an intrusive thought or designing a contingency plan in their head in case their obsessive fear was found out to be true (Williams *et al.*, 2011).

One study by Sibrava and colleagues (2011) found that in a group of adults with OCD, 12.9% primarily engaged in mental rituals as their compulsion ($n = 29$) and a further 20.4% endorsed the presence of covert compulsions but they were not primary ($n = 46$). Within the primary covert compulsion group, the most common obsession endorsed was over-responsibility for harm (e.g. fear of harming self/others, being responsible for something bad happening), which occurred at the rate of 41.4%, followed by offending God and sacrilegious thoughts at 20.7%. With regard to covert compulsions in this sample, praying was the most frequently endorsed, occurring at 48.3% followed by mental undoing of bad thoughts with good thoughts at 31%. Other important findings from this study include that individuals with primarily mental rituals exhibited greater overall severity at baseline, greater symptom chronicity, and demonstrated clinically impairing symptoms over 8 years earlier than those without primarily mental compulsions.

Assessment

Clinicians must have the ability to conduct a clinical interview to identify the unwanted thoughts, images or impulses that repeatedly occur, as well as the appraisals of these intrusions and neutralization strategies (e.g. thought suppression and mental rituals). To conduct a successful clinical interview assessing symptoms of OCD, it is important to utilize current and sound measures within the field such as the Yale-Brown Obsessive-Compulsive Scale, second edition (Y-BOCS-II; Storch *et al.*, 2010), the Diagnostic Interview for Anxiety, Mood and OCD and Related Neuropsychiatric Disorders (DIAMOND; Tolin *et al.*, 2018), and the Anxiety and Related Disorders Interview Schedule for DSM-5 (ADIS-5; Brown and Barlow, 2014).

In the format of a semi-structured interview, clinicians may find it useful to directly engage the client about their unwanted thoughts and fears (Rachman, 2003). For example, Rachman notes they may begin by asking the client for a full description of their troubling thoughts, followed by how frequently they occur, what triggers them, how such thoughts affect them (e.g. concentration, mood, work, etc.), and how they neutralize unwanted thoughts. In addition, he mentions that it is useful to get a comprehensive evaluation of the individual's fears by asking more specific questions as well such as why and when the client believes the unwanted thoughts began, if they have ever engaged in dropping concealment, and how they understand their symptoms more generally. Rachman also recommends incorporating the Personal Significance Scale (Rachman, 2003) into assessment, which attempts to gauge what the client understands their thoughts to mean (i.e. whether they believe their thoughts speak to their character).

Conversely, some clients have shared their obsessions with loved ones for the purpose of gaining reassurance that they are not bad and will not act on their fears. In these cases, it will be important to learn the extent of the reassurance-seeking as this tends to maintain or worsen symptoms and strain relationships. The Family Accommodation Scale can be a useful tool in assessing this problem, which has versions for a clinical interview, self-report, and family members (e.g. Calvocoressi *et al.*, 1999).

The Dimensional Obsessive-Compulsive Scale (DOCS; Abramowitz *et al.*, 2010) can also be a useful self-report instrument for clinicians to detect taboo or unacceptable thoughts. When using the DOCS to identify obsessions surrounding this kind of content, clinicians should pay particular attention to the second and third subscales: the Concerns about being Responsible for Harm, Injury, or Bad Luck subscale (category 2) and the Unacceptable Thoughts subscale (category 3). If a client scores high on these by indicating high levels of avoidance, engaging in the obsession through compulsion or rumination for a significant amount of time, indicating distress, impairment, and substantial difficulty disregarding such thoughts, the clinician may want to

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consider whether the client engages in covert compulsions and harbours other behaviours that are representative of endorsing unacceptable/taboo OCD. Clinicians should also consider the two new DOCS subscales focused on Sexually Intrusive Thoughts and Scrupulosity & Religious Concerns (DOCS-SIT; Wetterneck *et al.*, 2015; DOCS-SR, Wetterneck *et al.*, 2021).

While this may be obvious at times, at other times clinicians may want to confirm initial diagnosis by utilizing content-specific measures such as the Sexual Orientation Obsessions and Reactions Test (SORT; Williams *et al.*, 2018), which would be one measure that could be used for clients with sexual obsessions and the Penn Inventory of Scrupulosity (PIOS; Abramowitz *et al.*, 2002) for clients with religious and scrupulous concerns. The Obsessional Beliefs Questionnaire (OBQ44; Obsessive Compulsive Cognitions Working Group, 2005) may also be helpful to pinpoint specifically what taboo thoughts are causing distress for the client. Finally, clinicians can use the Personal Stress Scale (Cohen *et al.*, 1983) session by session to assess for any changes in distress.

Identification of OCD-related avoidances

Another symptom dimension of OCD that has been neglected and understudied is avoidance and avoidance behaviours (Starcevic *et al.*, 2011). In one study by Starcevic *et al.* (2011), it was found that in a sample of 124 OCD adults, 60% of the total sample reported avoidance. They also found that approximately 80% of those exhibiting avoidance endorsed contamination obsessions and more than 50% endorsed aggressive obsessions. Overall, it stands to reason that avoidance behaviours are extremely common in OCD and clinicians must assess for and be able to recognize avoidances as well as point them out to the client as maintaining the OCD.

One instance of how avoidance may manifest in individuals with unacceptable/taboo obsessions would be the individual with P-OCD who avoids children at all costs. If the individual has a family of their own, this may extend to their obsessions surrounding their own children, which can negatively affect relationships within the family and lead to developmental issues surrounding neglect as well as unmet needs for the child. Aggressive obsessions that overlap with paedophilic obsessions (e.g. fears that an individual will forcibly sexually abuse a child), can also manifest and lead to avoidance. For those with religious obsessions, they could be avoiding attending church, praying (or compulsive praying to alleviate anxiety as opposed to fostering a deeper spiritual connection), or not attending confession or communion. As such, the ability to identify avoidance behaviours is crucial to arriving at a correct diagnosis and tailoring treatment as needed.

Providing psychoeducation

As with any cognitive behavioural treatment, the first step is to provide psychoeducation. In this initial phase, clients should learn about the symptoms of OCD and how they present, the heterogeneity of the disorder and variance of obsessions and compulsions, and potential causes. Clinicians should also normalize symptoms citing the widespread prevalence of mental health challenges more generally, the ubiquity of unwanted intrusions in non-clinical populations (Rachman and de Silva, 1977; Radomsky *et al.*, 2013) as well as mention the treatability of OCD, and provide an overview of evidence-based treatments with a focus on CBT as the first line of treatment in mild/moderate cases and increasingly incorporating medications as the severity increases (Katzman *et al.*, 2014).

Difference between obsessions and compulsions

Fundamentally speaking, obsessions and compulsions can manifest in a variety of ways, which in turn contribute to the vast heterogeneity of possible symptom presentation for OCD (Williams *et al.*, 2013). Rachman (2007) notes that there are three major forms of psychopathology related to

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obsessions in OCD: thoughts, images and impulses. He notes that while these are distinctively different manifestations of OCD, they have several features in common, which are characteristic of OCD, such as their unacceptability, intrusiveness and recurring nature. As mentioned in Rachman (2007), one study conducted by Rachman and Hodgson (1980) notes that distress and uncontrollability emerged as the main factors of obsessions, and that obsessional impulses were rated as most unpleasant among the three as well as more intense and more difficult to deal with than thoughts and images. Their findings also indicated that intrusive images had shorter duration and that they were more easily broken by distraction while obsessional thoughts (e.g. rumination of past events and persistent worrying about future outcomes) were most common.

Rachman (2007) describes the forms of obsessions in the following way. Images may be visual and played out in one's head of particularly morally repugnant scenarios such as acts of incest, or causing someone permanent harm like blinding a child; obsessional thoughts may include beliefs such as that one may cause serious harm to their parents, or think blasphemous thoughts like having sex with Jesus Christ or Mother Mary; obsessional impulses, often more intense and frightening in nature, may include ideas about pushing an elderly person in front of an incoming train, exposing one's genitals in public, or impulses to rape a young child. Rachman notes that all of these obsessions are intrusive, unwanted, repugnant, objectionable, resisted by the client, are scary for the client, centre around fear of loss of control, involve avoidance, immorality, neutralizing attempts, agitation, and frustration, all to varying degrees. OCD obsessions are unwanted thoughts that are not reflective of what a person actually wants to do or be while mental compulsions are the act of mentally reassuring oneself, often by replaying a thought in one's head over and over, and/or reassuring themselves that their fear is not true (Williams and Wetterneck, 2019). Unlike other OCD symptom dimensions, the compulsions/neutralizations associated with classic/primary obsessions tend to be covert (as identified by Williams and Wetterneck, 2019) rather than overt compulsions that are associated with other OCD subtypes (e.g. doubting/checking and contamination/washing). However, like all manifestations of OCD, obsessions engender negative emotions and the compulsions/neutralizations are thought to be helpful in preventing the feared event.

Ubiquity of unwanted thoughts

Another important skill is the ability to provide psychoeducation around the normative nature of unwanted thoughts. More specifically, it is helpful to normalize the experience of unwanted, intrusive thoughts patients may be experiencing by describing the ubiquity of such thoughts with clients to help reduce feelings of shame. This benefits the client by depathologizing their experience, and can also help the clinician in arriving at a correct diagnosis by noting whether thoughts and impulses fall outside of the normal range of experience. For example, clinicians can directly address the fact that everyone experiences intrusive thoughts at times and it is a normal part of the human experience (Rachman and de Silva, 1978; Radomsky *et al.*, 2013; Renaud and Byers, 1999). A lot of thoughts appear to 'pop' into our head throughout the day and it may be useful to point out the phenomenological nature of thoughts as being more or less out of our control. This should be differentiated from *behaviour*, which *is* in our control, e.g. reacting to such thoughts by compulsing, neutralizing, etc. Rachman and de Silva (1978) were the first to report that a high percentage (approximately 80%) of non-clinical community-dwelling participants experienced unwanted intrusions. Salkovskis and Harrison (1984) replicated this finding when they reported that 88% of their sample of university students reported experiencing unwanted intrusions. More recently, Radomsky *et al.* (2013) collected data from 15 sites in 13 countries on six continents and reported that approximately 94% of the sample of 777 university students had experienced an unwanted intrusion in the previous 3 months. Each of

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these studies reported no frequency differences according to gender or nationality and the intrusions were reported as easy to dismiss.

Maintenance of obsessions

Psychoeducation is a crucial part of treating OCD. One of the most valuable pieces of information that a clinician can impart to the client is specifically about the process of OCD, i.e. the cycle of obsessions and compulsions and how triggers, intrusions, appraisals, emotions, and how the urge to engage in neutralization promotes a never-ending feedback loop. As Rachman (2007) points out, while neutralizing behaviours may feel good for the client temporarily, in the long run, rituals cause more damage than good because they help to maintain the patient's belief that the ritual played a role in preventing the feared outcome from occurring and that without the neutralizing ritual, the discomfort caused by the obsessions would not have dissipated. He notes that this may be related to a cognitive fallacy resembling confirmatory bias, and that as a result, a process that disconfirms such beliefs would be a helpful intervention strategy. For example, if a client fears they will hurt a child, rather than engaging in a neutralizing behaviour, they should resist and instead place themselves in a situation with a child repeatedly only to find that they never do act on their impulse. This is why exposure therapy is so important in breaking the vicious cycle of OCD. Compulsions strengthen the OCD and resisting compulsions weaken it.

Given the ubiquity of intrusions and the importance on the meaning or appraisal process, it stands to reason that primary obsessions can be addressed utilizing a cognitively informed approach to treatment (Whittal *et al.*, 2010b). Although unwanted intrusions occur in the general population at a rate of at least 90% (Rachman and de Silva, 1978; Salkovskis and Harrison, 1984), a fundamental difference between individuals with and without OCD is how the groups appraise their thoughts (Whittal *et al.*, 2010a). Whittal and colleagues note that while the latter do not think much of their obsessions and can conceptualize them as benign, those with OCD attach significant meaning to such thoughts, entertaining the perceived likely possibility that such thoughts indicate information about their character, i.e. that they are 'mad, bad, or dangerous' (Rachman, 2007). In sum, due to the normalcy of intrusive thoughts, clinicians should not focus on the occurrence of unwanted thoughts themselves, but rather how the client interprets/appraises the thoughts, keeping in line with a largely cognitive approach to treatment (Whittal *et al.*, 2010b).

The over-importance of thoughts in OCD

Therapists must have the ability to discuss the over-importance of thoughts and how they pertain to obsessions, because individuals with OCD have several cognitive distortions or mistaken beliefs, one of which includes assigning a great deal of importance and meaning to thoughts. As mentioned previously, everyone experiences intrusive thoughts, but a key differentiator between clinical and non-clinical populations is in the meaning given to these intrusions. Whittal and colleagues (2010a) note that the over-importance of thoughts is the basis for maintaining the obsession because the individual believes that the thought carries a great deal of significance, and therefore reflects their character and true self. Ching and Williams (2018) note that these thoughts are disturbing to these individuals because they find them inherently disgusting in nature. Similarly, Rowa *et al.* (2005) reported a relationship between values and obsessions in that the more firmly held the belief, the greater the likelihood of this belief being appraised in a negative and personally relevant manner.

Several other assumptions are often endorsed in this population, including the belief that having a negative thought increases the likelihood of that feared outcome occurring and that the thought of a morally reprehensible act is the same as doing it, two forms of *thought–action fusion* or TAF (Shafran *et al.*, 1996). Negative thoughts may also be mistakenly

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interpreted as important simply because they have occurred (Thordarson and Shafran, 2002). The latter is based upon a belief that all thoughts are important and as such there must be a reason why they occurred. Not surprisingly, this belief leading to dwelling/analysing/figuring out is typically not helpful.

Shafran *et al.* (1996) note that likelihood TAF can be directed toward others (e.g. the thought of loved ones dying in an accident increases the probability of it occurring) or the self (e.g. a thought of becoming ill increases the probability that it will occur) while moral TAF is the equating of thought and action morally (e.g. the thought of harming a loved one is estimated to be as bad as doing it, morally speaking).While all subgroups of OCD can endorse TAF and may try to rid themselves of having such thoughts through compulsive behaviours, this is especially true for those who endorse taboo and unacceptable thoughts such as sexual obsessions (Storch and Lewin, 2016). As such, it is not uncommon for patients to appraise an unacceptable/taboo thought as indicating desire (e.g. 'the real me bubbling to the surface').

The paradox of thought control

When non-clinical populations experience intrusive thoughts, they tend to find it easy to dismiss the thought in a neutral manner and may brush it off by simply thinking, 'what an odd thought' and subsequently by thinking, 'I would never do that' or 'everyone has weird thoughts from time to time' (Whittal *et al.*, 2010a). On the other hand, an individual with OCD is more likely to think, 'what if this [the intrusive thought] is who I really am or an indication of what I will do in the future?'. As a result, it is not uncommon for clients with OCD to engage in attempts to control their thoughts (e.g. thought suppression, distraction or avoidance of situations known to trigger obsessions) only to find that this perpetuates the OCD cycle. As a result, clinicians must be able to teach their clients about *the paradox of thought control* (Wegner *et al.*, 1987) considering that at large, individuals with unacceptable/taboo obsessions are obsessed with being in control of their thoughts, fearing they may lose control and act out in a way, which will lead to catastrophic consequences (Purdon and Clark, 2002; Rachman, 2003). The paradox of thought control is based upon the thought suppression work of Dan Wegner (i.e. the white bear suppression effect). If a thought is appraised in a negative personally relevant way, a common strategy to neutralize would be efforts at suppressing the thought. The work of Wegner and others (1987) highlights that thought suppression can result in a rebound effect such that it increases attention to the thoughts which results in experiencing an increased frequency of the unwanted intrusions.

From a therapeutic perspective, the role of the clinician is to provide experiences that will allow clients to come to the above conclusions themselves through an experiential exercise as opposed to the clinician verbally providing the information. In session, clients may find it helpful to be given an example such as the metaphor of the white bear (Wegner *et al.*, 1987), or any other descriptive scenario or animal such as a pink elephant. Wegner *et al.* (1987) found that when being told not to think of a white bear, subjects could not help but to go directly to it, demonstrating the paradoxical phenomenon of thought suppression. That is to say, when attempting to suppress a thought, one only makes the thought come more to the forefront. Similarly, trying to actively expel an unwanted intrusive thought may only help to fuel the fire. Thus, it is crucial for clinicians to be able to provide psychoeducation in this regard to show that accepting the thought is the more adaptive strategy rather than fighting or resisting it (Whittal *et al.*, 2010a).

Concealment maintains the problem

It is not uncommon for individuals with OCD to engage in the deliberate concealment of the content and frequency of their obsessions and compulsions (Newth and Rachman, 2001), especially when the individual believes the thought means they are 'mad, bad, or dangerous' (Rachman, 2007; Whittal *et al.*, 2010b). This is especially true for individuals with thoughts

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that are considered taboo or unacceptable in the society they are a part of. For example, in communities where individuals who identify as LGBTQ+ are shamed, or as in some countries, jailed or murdered, individuals with obsessions around changing sexual orientation may feel they can never speak to anyone about their thoughts, especially if they consider their thoughts to be reflective of their true self. Although concealment may appear to be an appropriate behaviour to the client, clinicians must be able to provide psychoeducation around how this only serves to perpetuate the OCD cycle.

Keeping obsessions a secret is not unusual for many clients with taboo or unacceptable thoughts, as they often believe they are guilty of a heinous crime or are a dangerous or immoral individual (Williams and Wetterneck, 2019). At the same time, they may be consumed by enormous guilt, which also maintains the OCD cycle. Newth and Rachman (2001) found that disclosure of obsessions in suitable environments such as therapeutic spaces or between close friends can provide room for a corrective experience. That is to say, it can be healing for the client to see that discussing their obsessions and compulsions does not shock people or result in assumptions being made about that individual's true character. Newth and Rachman also note that some causes of concealment include thoughts that people will reject them if they know their secrets, or that they will think they are crazy or dangerous, distrust/avoid them, and shame them.

Dropping concealment (Newth and Rachman, 2001) refers to a strategy whereby those who experience classic obsessions will conceal the content from everyone, even intimates. These individuals fear that if they tell someone, that person will think about them the way they think of themselves (e.g. that they are a monster). Concealing obsessions is conceptualized as a maintaining factor (e.g. 'the only reason that my partner hasn't abandoned me is that s/he isn't aware of my thinking'). Dropping concealment is a behavioural experiment whereby patients are asked to tell someone close to them about the content of the obsessions. This behavioural experiment is only completed if the patient has a close person who is non-critical and understanding. If there is not a high probability of success with the dropping concealment experiment, it is not conducted. The goal of the dropping concealment experiment is for the person to get feedback that the obsessions are not indicative of their character in the eyes of a person close to them.

Values versus obsessions

It is important that clinicians are able to discuss the relationship between personal values and the content of obsessions. While individuals' obsessions may seem arbitrary to the sufferers at first, upon further investigation, it becomes clear that they are very much rooted in one's own value system, and generally the very opposite of what the client finds meaningful and important (Rachman and Hodgson, 1980). A study by Rowa *et al.* (2005) found that individuals' most upsetting current obsession was evaluated as more meaningful and significant to the person as opposed to their least upsetting obsession, which was less personally significant. Furthermore, it was found that all obsessions arose in the context of life concerns or other issues they considered important. Indeed, upsetting thoughts are upsetting because they contradict important values the individual holds dear (Rachman and Hodgson, 1980).

Rachman and Hodgson (1980) noted this as particularly obvious in groups with scrupulous concerns regarding blasphemous thoughts. Such thoughts are disturbing because such individuals revere their religious teachings and holy figures a great deal. Another example would be someone with paedophilic obsessions. An individual with such concerns has a higher likelihood of experiencing obsessions over hurting a child because they value the welfare and safety of children and especially do not want to do harm. This understanding can be applied across multiple manifestations of OCD, is particularly evident for individuals with unacceptable/taboo thoughts, and is also seen in health-related and aggression obsessions.

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Cognitive treatment: key skills

Presenting the treatment model

One of the most important strategies in successfully treating obsessions and compulsions in groups with unacceptable/taboo thoughts is correcting the thought appraisal process and collaboratively targeting the maladaptive pattern of attaching significant meaning to intrusive, unwanted thoughts (Whittal *et al.*, 2010a, b). When a thought occurs, subsequent cognitive responses, i.e. negative automatic thoughts, may arise for the client, which then spawns a behavioural compulsion (Salkovskis, 1985). In Socratically discussing this process of cognitive-behavioural interchange, the clinician should highlight the link between the intrusive thought occurring, the meaning attached to it, why this is followed by rumination and/or anxiety, and how this results in a compulsion/act of attempted neutralization. Whittal and colleagues (2010a) provide a video illustration of how to present the cognitive model focusing on the importance of the appraisal process.

It also may be helpful to show the client the CBT triangle to explain how thoughts, feelings and behaviours are intricately, multi-directionally linked in OCD, and how breaking the cycle can happen when they accept their obsessional thoughts and resist compulsions. Randomized controlled clinical trials with CBT have demonstrated significant reductions in OCD symptoms and decreases in Y-BOCS scores, OCD-related cognitions, depression, and improvements in social functioning (Whittal *et al.*, 2010b) and a cognitive approach to treating OCD has also been found important for its abilities to target several cognitive domains thought to be key areas in maintaining symptoms such as inflated responsibility, over-importance of thoughts, need to control thoughts, and over-estimation of threats (Whittal *et al.*, 2010a).

Survey of unwanted intrusive thoughts

Clinicians may find surveys useful to demonstrate the normality of obsessions and unacceptable/taboo thoughts (Whittal and Robichaud, 2011). For example, using the list provided by Rachman and de Silva (1977), clinicians may ask their colleagues to fill out a brief survey asking if the individual has experienced any of the listed intrusions, and if so the associated appraisal. The goal of the survey is to verify the ubiquity of intrusions amongst people who do not have OCD and to bet information on the importance of the appraisal (i.e. experiencing an ego dystonic intrusion and being able to set it aside because 'it is just a thought'). Clients will often find it therapeutic to know that these thoughts are a normal experience, which can decrease the level of meaning they attach to such thoughts, decreasing the belief that they are unique, 'mad, bad, or dangerous'. Clinicians can encourage clients to keep a thought log whereby they take note of their distressing thoughts, the nature of the thought, its content, how much time they spend thinking about these thoughts, what they believe these thoughts say about them, and whether they neutralize the thought and if so, how and for how long (Williams and Wetterneck, 2019).

The problem of dwelling

Thoughts may be endorsed as overly important by individuals with OCD primarily for three reasons (Obsessive Compulsive Cognitions Working Group, 1997; Thordarson and Shafran, 2002): (1) the negative thought is believed to be reflective of the person's character, e.g. the thought is proof they are weird, bad, dangerous, criminal, etc.; (2) having a negative thought alone increases the likelihood of the feared outcome occurring, also known as TAF and potentially involving a degree of *magical thinking*, e.g. by thinking about one's mother being murdered she will be more likely to be murdered; and (3) negative thoughts are important simply because they have occurred.

The clinician may choose to begin treatment by providing psychoeducation around the hallmark feature of over-importance of thoughts in people with OCD. Furthermore, Whittal *et al.* (2010a, b) suggest that it may also be useful to discuss how the strong desire for thought

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control and demonstrated inability to do so helps to maintain the repetitive cycle between thoughts and dwelling on them. If a thought is deemed important because it occurred, continuing to dwell on it will serve to verify its importance. As such, clinicians should be able to converse with clients about how they endorse patterns of rumination and dwelling, which ultimately serve no function and may in fact be deleterious. Behavioural experiments illustrating how this cycle can be broken by committing to accepting thoughts as they come can assist in providing evidence that these thoughts, although distasteful, are just thoughts and not reflective of character or future action.

Challenging TAF by letting go of thoughts

Clinicians should be able to discuss methods to test the importance of thoughts including a behavioural experiment to alternate between letting thoughts come and go and compare that with fighting and dwelling. Several cognitive techniques can help to mitigate obsessive compulsive symptoms around thoughts such as the thought that what they fear they desire is possibly capable of coming true (Whittal and McLean, 1999).

One experiment designed to differentiate desire from the *fear* of desire that can be helpful includes having the clinician ask the client to think about their favourite food (Whittal *et al.*, 2010a, b). Just prior to eating the food, the client/patient is asked to write about how they feel being in anticipation of eating it (eager, excited, pleasurable, happy, etc.). Then, for comparison, the client is asked to think about how they are feeling in response to experiencing an obsession (repulsed, ashamed, scared, etc.). The point of the exercise is to allow clients to differentiate *fear* of desire and actual desire. One behavioural experiment that clinicians can use with clients includes asking clients to change their relationship with their thoughts throughout the day, going from fighting, resisting, and dwelling on them, to allowing them to come and go freely and accepting them when they refuse to go away (Yule and Whittal, 2017). As with all behavioural experiments, identifying associated predictions/feared consequences is important as it sets the stage for a discussion of the difference between what was predicted and what actually occurred. For this experiment, clinicians can tell clients to try fighting their thoughts for one day, and let them come and go the next. The goal of this exercise is to demonstrate that the more resistance one meets their thoughts with, the more they will appear and subsequently induce more distress.

Challenging TAF by testing the power of thinking

Individuals with OCD who endorse likelihood TAF may find it useful to test the power of their thoughts and thinking during session and outside session using a variety of behavioural experiments, which have the potential to act as interventions (Whittal and McLean, 1999; Whittal and Robichaud, 2011). One key feature of OCD is the distorted sense of power and meaning attributed to unwanted intrusive thoughts (UITs). Due to this mistaken belief, clients may believe such thoughts are both reflective of their true character, and able to influence the future (Thordarson and Shafran, 2002). That being said, thought experiments may provide a corrective experience for the client in helping them to realize that their thoughts are not as powerful as they fear they are (Whittal *et al.*, 2010a). For example, Yule and Whittal (2017) recommend that the clinician facilitates a kind of exposure that also incorporates an element of disconfirming likelihood TAF by asking the client to think of a feared outcome that is uncommon but not rare and observable. The clinician is typically the 'target' of these early thought experiments as they are someone the patient is seeing regularly but not in their inner circle. The client is asked to form an intention of this event occurring (e.g. the clinician chipping a tooth) and try to make it happen by virtue of thinking about it. Additionally, the client should not tell the clinician what the content of the thought is to prevent negating the

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outcome (e.g. 'my clinician was being careful because they knew I was thinking about them chipping a tooth'). TAF experiments increase in difficulty to continue to include people in the patient's inner circle and for people who are unaware that they are the 'target' (e.g. a neighbour or a co-worker). The goal of TAF experiments is to provide evidence that thoughts are not foreshadowing and are 'just thoughts'. The belief that thoughts increase the probability of events is almost always in the negative direction. For a small minority, TAF also functions in the positive direction (i.e. thinking about something positive increases the probability of the outcome). TAF experiments that involve something positive (e.g. buying lottery tickets and thinking about winning) are appropriate targets. Likewise, for those patients for whom it is difficult to select another human to test the power of thought, selecting an inanimate object is acceptable (e.g. a well-working appliance suddenly breaking) (Freeston *et al.*, 1996).

Challenging TAF using a continuum differentiating thoughts and actions

Clinicians need to have the ability to be able to challenge moral TAF using a continuum differentiating thoughts and actions experiment demonstrating that thoughts do not manifest in the real world simply by thinking of them, and moral TAF may be harder to disconfirm for clients who hold their assumptions tightly (Siev *et al.*, 2017). For those with religious obsessions, it may be useful to bring in a clergy member or member of the religious or spiritual community with whom the client identifies (Huppert and Siev, 2010; Pouchly, 2012). It would be wise to first have a conversation with this authority with the patient's permission. The goal of this conversation is to ensure that this individual will not exacerbate the OCD. For instance, in the example of blasphemous images such as urinating on religious artifacts, if the religious authority cannot make a distinction between OCD and true blaspheming, it may not be advisable to move forward with this conversation. In clients who have non-religious moral scrupulosity, the clinician's reassurance that simply by thinking about murdering someone is not the same as actually doing the deed may suffice. For clients who experience non-religious moral scrupulosity, it can also be useful to help the client develop a *badness* continuum whereby thinking about an action and engaging in the action are distinguished (e.g. thinking about cheating on a partner versus cheating on a partner) and asking where these individuals fall on the continuum. Invariably clients can distinguish between thoughts and actions for others which illustrates a double standard. Additionally, highlighting the role of intention is also useful (e.g. the difference between first degree murder, second degree murder and manslaughter and killing someone because they have jumped in front of a vehicle in a suicide attempt). Although the outcome is the same, the intent behind it is different which is typically easily pointed out by clients on a badness continuum (Whittal and McLean, 1999; Whittal and Robichaud 2011).

Behavioral experiments around thought suppression

Cognitive therapy can assist in restructuring the thought processes that maintain OCD by illustrating the paradox of thought control (Wegner *et al.*, 1987; Whittal *et al.*, 2010a). In session, clinicians can help to demonstrate that intentional thought suppression does not work, and results in the opposite result being achieved. For example, the clinician can ask the client to think of whatever they want to for 20 seconds, *except* a specific target image/thought (Whittal *et al.*, 2010a). In the subsequent 20 seconds, the client is invited to repeat the exercise without the suppression instructions. Alternatively, clinicians prime an image of their choosing (e.g. a pink polka-dotted elephant) and ask clients in the first trial to think about whatever they wish except the target thought/image and then to alternate it in the second trial by expecting it and allowing the target thought/image in. Typically Trial 1 results in a higher frequency of the target, thereby illustrating the paradox in thought control. Demonstrating

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this cognitive phenomenon helps to illustrate that a high frequency of taboo thoughts may be occurring for the client due to paradoxical thought suppression rather than because it speaks to their character. This in-session exercise can be replicated with an alternating day exercise using the obsessional content (e.g. day 1, 3, 5, go with Trial 1 of fight/dwell/suppress/push away and alternate on day 2, 4, 6 with Trial 2 of willingness and permissiveness. At the end of the day, a rating of severity of obsessions will hopefully illustrate the paradox.

Illustrating the maintaining role of attention

Another primary factor in maintaining OCD is attention, particularly as it pertains to over-importance of thoughts (Purdon and Clark, 2002). Due to attention bias, when something is personally meaningful to us, the more we begin to see of it, and this is true of both clinical and non-clinical samples (Yule and Whittal, 2017). For example, if someone starts thinking about wanting to buy a red convertible, it will appear as if more red convertibles are suddenly all around them when in fact all that is happening is a shift in attention and awareness. Such is also true of unwanted intrusive thoughts; the more meaning an unwanted intrusive thought has for an individual, the more they will notice them. As a result, attentional experiments can be a useful tool for treating clients with OCD around unacceptable/taboo thoughts.

Yule and Whittal (2017) note that one exercise clinicians can ask clients to do is to intentionally pay attention to any 'for sale' signs they notice throughout the week. Before beginning the exercise, the client is asked how many they remember seeing in the prior week. which is then compared with what happens if the person is in fact looking for the target object. It is also interesting to note the length of time it takes for the attention effect to decay. Specifically, clients are asked to no longer look for the signs, but to take note of them should they appear (Whittal and McLean, 2002). Patients will likely find that they notice more signs after priming themselves to look out for them even after they try to stop looking for them. Given the threatening meaning the clients place on the presence of the unacceptable/taboo intrusions, it is likely that they will be on guard for their presence which translates into being hypervigilant for triggers in their environment (e.g. children for individuals who experience OCD with paedophilic content), hypervigilance with their thoughts, or overfocus on their bodily sensation. Attention experiments with neutral items like 'for sale' signs is a facsimile of what occurs with more meaningful content such as unacceptable or taboo thoughts and results in the maintenance and exacerbation of the obsessions.

Strategies to create distance from obsessions

Data suggest that because OCD has a large cognitive component to it, thought experiments may be useful in providing corrective experiences to clients (Whittal *et al.*, 2010a). In doing so, clinicians may choose to normalize symptoms such as persistent uncertainty and perfectionism by providing analogies and metaphors (Yule and Whittal, 2017). For instance, the client may find the analogy of 'the cauldron of water' to be useful. Here, the clinician will invite the client to imagine a cauldron of water that has some brownish granular material in it, perhaps brown sugar, which makes it difficult to see the bottom of the pot. In wanting to see the bottom of the pot, the client may choose to take a spoon and stir it around to see if that makes things clearer only to find out that this is not brown sugar, it is silt, and by stirring, they have made the water murkier and harder to see through. In actuality, allowing the silt to settle allows one to see the bottom of the pot more clearly relative to stirring. This exercise should be used to communicate that one must accept that things will not be perfect, that ultimate certainty is not an option, and to stop analysing and thinking so that things are not made worse. It may be most helpful to incorporate mindfulness into this exercise by inviting the client to visualize the scenario and asking what they feel, smell, etc. Another metaphor that can be particularly helpful for contextualizing the nature of UITs for the client can be being tapped on the shoulder. In this

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metaphor, the client is encouraged to think about being tapped on the shoulder at a dance party, and being invited to the dance floor. The client has the choice to say no without pushing away, although the dance partner (like OCD) may persist in their request. Without trying to ignore or suppress the request, the client can choose not to go onto the dance floor (i.e. obsess).

Relapse prevention

Clinicians must be able to direct clients through the entire treatment program as well as highlight the importance of relapse prevention. Relapse prevention includes several components including reviewing skills learned throughout treatment, normalizing lapses, adjusting expectations around symptom reduction, and identifying stressors that could make a lapse more likely. In one study by Hiss *et al.* (1994), it was found that treatment groups that received relapse prevention remained improved at follow-up, whereas those who did not showed some return of symptoms. Relapse prevention can be delivered during the second phase of treatment following exposures whereby clients receive instruction on self-directed exposure and cognitive restructuring and plan for the changes in their lifestyle (Hiss *et al.*, 1994). It is best if the therapist can normalize relapse in OCD and describe ritual prevention as being important, as even after intensive and successful treatment symptoms do not completely go away. For example, in stressful situations, one may witness their anxiety increase to similar levels as prior to treatment and find themselves having urges to ritualize again and ritual prevention helps to mitigate this. Such situations do not need to be inherently negative to induce symptom relapse, e.g. a death of a loved one, and may also include positive experiences such as getting married, having a child, or entering into a serious relationship. Thus, during this phase clients are asked to identify possible stressors that may cause relapse, and setbacks should be conveyed as opportunities to practise skills learned during treatment. The ritual prevention section of training should also review important skills such as re-evaluating misconceptions, using the A-B-C mnemonic (antecedent-belief-consequence) for restructuring cognitive beliefs and self-guided exposures.

Behavioural treatment: key skills

Explaining the rationale for an exposure-based approach

When taking a more behavioural approach, clinicians must be able to explain the rationale for exposure and ritual prevention therapy (Ex/RP) with their clients, to help them to better understand why they are being asked to undertake such challenging work (Foa *et al.*, 1984). Ex/RP is best explained referencing the behavioural model approach, highlighting the essential tenet that deliberate exposure decreases anxiety gradually over time. To convey how this works to the client, the clinician may want to introduce the term *habituation*. It is advisable to use a metaphor such as watching a movie (e.g. Williams and Wetterneck, 2019). In this analogy, clinicians can explain that the first time one watches a horror movie it is indeed quite scary. The second time is, however, different in that you know when the scary scenes occur and what happens. The third time is even less scary than the second, and by the fourth time, the movie becomes entirely boring. It can be explained to the client that Ex/RP exposes one to their fears in a similar way with the end goal of making the fears no longer of interest or compelling.

Creating the SUDS Scale

Prior to beginning Ex/RP, clients should be invited to collaboratively complete a Subjective Units of Distress Scale (SUDS) with anchor points (Wolpe, 1969). For example, if the client has paedophilic obsessions, they could use the scale to rate the distress caused by having a small child sit on their lap while reading them a story (e.g. 90) versus the distress felt by walking past a kindergarten playground (e.g. 65) and so on. The need for this scale can be conveyed

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as a way for the therapist and client to be on the same page about what the client is most fearful of and so using the SUDS to label each situation from 0 to 100 can help to identify and quantify those fears more clearly. The clinician can explain that 0 would be the situation in which they are most relaxed or in a state of perfect peace, such as taking a walk in nature for some people, while 100 would be a state where the client would be so anxious they might feel like screaming, yelling or crying. Using examples from the client's OCD as anchor points for the SUDS is discouraged because these are expected to change over time (Williams and Wetterneck, 2019).

Constructing a hierarchy

It is essential that therapists are able identify activities/stimuli to target core fears, and thereby construct an exposure hierarchy based on SUDS ratings. The client's list of avoidances (ideally captured on the Y-BOCS-II) is a great place to start. Hierarchies are based on the things that the client tends to avoid and should be activities that can be predictably practised in session and at home. Items are listed from easiest to hardest on a scale of 0–100 (or 0–10 for children), and therapists typically start with items at a difficulty of about 50. It is advisable for the client to help make the hierarchy, but if the list of items is too daunting and anxiety-provoking for clients, therapists can simply introduce a new item at each session.

Flexibility is an important skill for utilizing exposure hierarchies effectively, and should therefore also be a focus of OCD competency (Williams *et al.*, 2014). Being flexible is necessary to allow clients to reach the appropriate anchor point by modifying the exposure in a way that makes the situation more or less anxiety-producing depending on the goal as a variety of scenarios may invoke differing levels of anxiety for the client. For example, if a client with sexual orientation obsessions is attempting an exposure and the level of distress is too high (like a 75 or 80), purchasing a gay magazine in a shopping mall that their friends go to regularly may be too difficult, and instead purchasing a gay magazine at a gas station, which may be easier for that person (more like a 45), would be a better place to start. Or, if the client indicates on their SUDS that they have a very high fear of speaking to LGBTQ+ people because they are afraid of being identified as gay, in the beginning of treatment, rather than having the client engage an LGBTQ+ person in conversation immediately, it may be best to endorse flexibility by having the client simply wave hello at first. Exposures can be combined for greater impact as clients master the items (Craske *et al.*, 2014). Further, as more is learned about the client and their OCD symptoms, it is often useful and necessary to revise the hierarchy.

In vivo *exposures*

It is critically important that therapists have skill in devising and conducting *in vivo* exposures in order to implement items on hierarchy, as these have been found to be extremely effective in several randomized trials (Foa *et al.*, 1984; Foa *et al.*, 1992; Steketee *et al.*, 1982). *In vivo* exposures are, as the name suggests, those that can be implemented in real life scenarios such as going to a playground, gay bar or entering a church or other place of worship (Williams and Wetterneck, 2019). It was also found that both gradual exposure and rapid exposure preceded by therapist modelling produced a slightly superior result (Röper *et al.*, 1975). Thus it is recommended that therapists model and demonstrate exposures to clients first. It is important to keep in mind that several pitfalls may arise during exposure to items on the client's hierarchy, including the clinician 'going too easy' on clients, skipping the most distressing situations, doing imaginal exposures when *in vivo* exposures should be done instead (and vice versa), providing reassurance, not addressing primary fears, ineffectively addressing mental compulsions, encouraging distraction during exposure, and failing to ascertain the need to work with those close in the client's life (Gillihan *et al.*, 2012).

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Association splitting

Association splitting, a concept with its roots in cognitive psychology, may also be an effective strategy (Ching and Williams, 2018; Moritz *et al*., 2007). With this technique, individuals are taught how to separate the associations and connections they make with various words and concepts relevant to their OCD. This works by interrupting the semantic network and disrupting automatic, unconscious associations with words. For example, for an individual with paedophilic obsessions, the word 'child' or 'playground' may be connected semantically to words like 'molestation' or 'paedophile' (Williams and Wetterneck, 2019). With association splitting, the client will weaken these associations by intentionally diverting their energy to connecting words like 'child' and 'playground' with positive words like 'joy' and 'fun'.

Explaining imaginal exposures

Clinicians must be able to present the rationale for imaginal exposures and explain why they are an important component of treatment. Providers may explain to the client that while *in vivo* exposures are very important, not all fears can be challenged in the external world and this is when imaginal exposures may be particularly helpful. For example, someone with sexual obsessions around enjoying sexual activities with a child cannot feasibly be carried out in the real world without significant harm being done, and so imaginal exposures are best for scenarios such as these. Similarly, other *in vivo* exposures are not advisable (e.g. defecating in a place of worship). Originally termed 'exposure in fantasy' (Foa and Goldstein, 1978; p. 822), imaginal exposures involve making a detailed story about a feared event coming true.

Ability to collaboratively construct an imaginal exposure

In addition to presenting the rationale for imaginal exposures, therapists must be able to construct an appropriate imaginal exposure script with their client. Imaginal exposures should take the form of a first-person narrative ranging anywhere between approximately three to five paragraphs and should vividly depict a catastrophe befalling the client, which the therapist and client develop collaboratively at first (Freeston *et al*., 1997). This script should be mindfully visualized and read aloud by the client, recorded, and listened to multiple times per day. In the beginning, the therapist and client should collaboratively construct the imaginal exposure script and follow several important guidelines around doing so such as using present tense, first-person language, centring on the worst case scenario, ensuring that no compulsions are present in the script, and being able to revise the script as needed to increase difficulty. The vividness and first-person perspective storyline format of the exposure have been shown to be effective (Foa *et al*., 1992).

For example, an exposure for someone with paedophilic obsessions may play out in the following way: 'I am on my way to work and am thinking about the beautiful curves on my 5-year-old niece; how nice her hair smells after she's come out of the shower, her body steaming . . .'. Towards the end of this exposure, the client would be saying things like, 'I cannot control myself and now that I am all alone with her in her bedroom I decide now is time I will do what I always truly wanted to do . . .', eventually ending the exposure with some sort of sexual activity and being sent to jail, shamed by society, disowned by family and friends, or whatever the client's most feared consequence would be. The best way to demonstrate this to the client may be by reading with them a previously constructed imaginal exposure. Clinicians should also point out to the client that increasing the taboo-ness of content and severity of consequences will increase the difficulty of the exposure with the goal of decreasing symptoms. However, for sexually explicit images or horrific violence, it not necessary to include imagery that is graphically detailed or more detailed than what the client is already mentally experiencing. For example, there is not usually a need to describe the

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details of having sex with a child beyond the fact the client did it, with more details surrounding how they felt about it than the act itself. Generally, it is the potential meaning of the material to the client that is most important for the success of the exposure. Also, it may take some trial and error to ascertain what combination of factors makes an exposure most effective for any specific client. Clinicians may also utilize chapters 5 and 6 from the *Sexual Obsessions in Obsessive-Compulsive Disorder* clinician handbook by Williams and Wetterneck (2019) for specific examples of appropriate imaginal exposures for individuals with sexual orientation and paedophile obsessions.

Imaginal exposures can also be used to help 'spoil' compulsions such as thinking, 'I want to have sex with a child' and imagining the act actually happening after having engaged in a compulsion like checking oneself for physical reactions after having walked by a child. At the same time, it is important for both the clinician and the client to be able to discern when an *in vivo* exposure should take place and when an imaginal exposure would be more appropriate (Gillihan *et al.*, 2012).

Discussing what was learned

Exposures can be highly anxiety-inducing for clients and are most likely to substantiate long-term gains when they are integrated and processed with the clinician afterwards (Craske *et al.*, 2014). It is most helpful for clients to be asked if what they worried about actually occurred, how they knew, and what they learned. For example, for a client with fears of hurting a baby, after being placed in a situation where they are exposed to the baby, the client might come to realize that the feared outcome did not occur, that they knew this because they did not hurt them when alone. They see first-hand that having unwanted intrusive thoughts about potentially hurting a child does not mean they will actually do it. It may also be similarly useful for clinicians to ask clients questions before embarking on an exposure, such as what their goal is in the situation, what they are worried might happen, and how likely they think this will happen (e.g. 80% likelihood). The idea is that this process will allow for a corrective experience by disconfirming beliefs and pointing out how they are over-exaggerated, unlikely and distorted.

Developing homework at the appropriate level

Ex/RP treatment is usually more intense than other CBT protocols, with the literature recommending at least two 90-minute sessions per week. Even so, clients are left on their own for the majority of the time. As a result, homework is essential for clients to help strengthen and integrate what was covered in session, and daily homework is recommended (Wheaton *et al.*, 2016). Homework should be challenging but not overly difficult and in the early stages of treatment, and should include the gradual implementation of behavioural techniques centred on Ex/RP principles, namely *in vivo* and imaginal exposures that increase in difficulty based on an individual's SUDS hierarchy. One measure that can help clinicians assess a client's engagement in exposures outside of session is the Patient Ex/RP Adherence Scale (PEAS; Simpson *et al.*, 2009). The PEAS will help the clinician determine three core areas: (1) the quantity of exposures, i.e. the percentage of assigned homework exposures that were attempted; (2) the quality of attempted exposures; and (3) the degree of success with response/ritual prevention, i.e. the percentage of urges to compulse and engage in neutralization strategies that the patience resisted.

Response/ritual prevention

Clinicians should be able to provide psychoeducation around ritual prevention with clients and explain compulsions using a cognitive-behavioural model (Foa *et al.*, 1984; Foa *et al.*, 1992). It

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would be helpful for conversations about ritual *prevention* to be prefaced with an introduction to *rituals* or compulsions more broadly like washing, checking, counting and reassurance-seeking. This could be discussed in a way that looks at how the OCD cycle is maintained by the use of compulsions, which only provide momentary relief as obsessions boomerang back in due course.

Clients would benefit from talking about how in the long-term, compulsions and rituals are not sustainable means for neutralizing distress caused by unwanted intrusive thoughts. They may also benefit from psychoeducation, specifically mental compulsions, which is especially true for those with taboo/unacceptable thought obsessions (Williams *et al.*, 2011). Clients can be told they should try to pay attention to see what mental compulsions they are performing, which can include ruminating over an event and replaying it on repeat in one's head, sometimes a hundred times or more in a given day. Therapists must instruct clients on resisting compulsions, as well as using exposure statements when they feel an urge to do their compulsions, and spoiling them if they do a compulsion, such as by making a mental exposure statement.

Clinicians should instruct clients on how to engage in mental exposure statements in conjunction with *in vivo* exercises when obsessions are persistent. Patients may also need to replace their covert mental rituals like mental rumination or checking with covert or overt exposure statements like, 'I really do love sexy children' or 'I am sure I have a deadly cancer' in order to counter automatic mental compulsions (Gillihan *et al.*, 2012). Therapists should communicate that if the client engages in a compulsion or neutralization behaviour, they can 'spoil' it by immediately re-exposing themselves to the triggering stimulus by invoking a mental exposure statement. For example, if a client with paedophilic obsessions compulses by checking their body for any physical sensations when walking by a child, they can spoil the compulsion by saying to themselves, 'Children turn me on'. Statements should be mental, or if said aloud, the client should do so privately.

Relapse prevention

Clinicians treating OCD should be able to teach relapse prevention to clients, as explicit relapse prevention procedures can be effective in helping clients maintain their gains (McKay, 1997). The best way to ensure relapse prevention is to make sure clients have learned and can apply all the strategies taught over the course of treatment. Clinicians must ensure that the client is able to devise their own *in vivo* and imaginal exposures as necessary. This includes making sure that the client has a working knowledge of the rationale behind exposures, how to incorporate specific elements such as first-person language for imaginal scripts, as well as when *in vivo* exposures are more appropriate than imaginal ones and vice versa. In addition, clients should know how to use exposures to spoil neutralizing behaviours (Hiss *et al.*, 1994).

Clients must be able to recognize various manifestations of OCD and understand that OCD can come back in a different form. It may be helpful for clients to know the four major themes of OCD (harm; contamination; symmetry; and unacceptable thoughts), as well as be able to recognize relationships between obsessions and compulsions (Williams *et al.*, 2013). Clients should also have an understanding of the role of stress in exacerbation of symptoms. This means that clients will understand that all forms of stress, positive or negative, have the potential to bring on OCD symptoms (Hiss *et al.*, 1994). For example, getting married or having a child may just as easily cause a relapse as a death of a loved one.

It is recommended that clinicians provide clients with written guidelines that discuss normative behaviours so that clients can differentiate their OCD from what is considered normal and healthy. For example, descriptions of thought appraisal and how individuals with OCD may

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endorse mistaken beliefs such as assuming that their thoughts mean they are strange, weird, evil, etc. should be given to the client (Williams and Wetterneck, 2019).

Lastly, clients should understand that it is okay to return to therapy if and when they are in need for booster sessions. Because OCD is a chronic condition, it is likely that at some point in their life, symptoms may become deserving of professional help once again. Knowing that it is up to them to seek help again can empower the client to take their mental health into their own hands (McKay, 1997).

Discussion

In sum, there are a variety of specific treatment techniques that clinicians should understand and utilize when treating individuals with unacceptable/taboo obsessions. These recommendations are informed by both CT and Ex/RP therapy as the two have considerable overlap in directing clients in how to interact with their thoughts, as well as how to challenge assumptions and break the cycle of OCD through behaviour modification techniques. Proper training and supervision specifically for OCD clients and even more so for the subgroup of individuals experiencing unacceptable/taboo obsessions will be paramount to mastering these clinical competencies. The International OCD Foundation offers excellent training through its Behavioral Therapy Training Institute (BTTI; www.iocdf.org). In addition, cultural considerations must be taken seriously as what is considered taboo or unacceptable varies from culture to culture (Williams *et al.*, 2020). Obsessional content may also be informed by specific religious practices and sociocultural value systems that are important to the community the client identifies with. Overall, clients with unacceptable or taboo obsessions, although once believed to be highly resistant to treatment, can find relief when therapy is conducted in a clinically competent manner and is tailored specifically to taboo themes.

Overall, there are many similarities and differences between CT and Ex/RP. Therapists can use either technique or a combination of both for excellent results. However, any approach used will require good training and supervision to master these important techniques.

Recommendations for further research

Although CT and Ex/RP are highly effective, there are still some clients who will not respond to these approaches. The promising work of Craske *et al.* (2014) and its application in OCD (e.g. Abramowitz and Arch, 2014; Arch and Abramowitz, 2015) may boost effectiveness, but still needs to be expanded upon and tested in larger trials. The behavioural and cognitive knowledge and competencies are detailed separately in this document, which is reflective of the natural history of the development and testing of the theories and treatments. It is not completely clear if cognitive treatments are equally efficacious to behavioural treatments or if they have an additive effect, and meta-analyses have shown conflicting findings (e.g. Öst *et al.*, 2015; Steketee *et al.*, 2019). In practice, it may not be an important question to answer. Rather, it would be useful to determine, at the stage of assessment, what types of psychological treatments would benefit particular obsessional individuals prior to initiating treatment.

Conclusion

OCD that features sexual, aggressive, moral, religious and health concerns may be frightening for clients and therapists alike. Fortunately, cognitive and behavioural approaches are highly effective, although they require specialized skill and knowledge to competently implement. Therapists should ensure they are familiar with the techniques described before working with people with

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OCD, but when therapists have good training, with proper application most clients will do very well.

Key practice points

(1) OCD that features sexual, aggressive, moral, religious and health concerns may be frightening or confusing for clients and therapists alike.
(2) Cognitive and behavioural approaches are highly effective, but require specialized skill and knowledge to competently implement.
(3) Therapists should ensure they are familiar with the techniques described before working with people with OCD.

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