Neutralizing Increases Discomfort Associated With Obsessional Thoughts:
An Experimental Study With Obsessional Patients

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Cognitive–behavioral theories suggest that the development of neutralizing is crucial in the development and persistence of obsessional problems (OCD). Twenty-nine patients with a Diagnostic and Statistical Manual of Mental Disorders (4th ed., American Psychiatric Association, 1994) diagnosis of OCD were randomly allocated to 2 conditions. Both listened to repeated recorded presentations of their intrusive thoughts and either neutralized (experimental group) or distracted themselves (control). Discomfort was rated during this 1st phase and then during a 2nd phase without neutralizing or distraction. The experimental group showed a similar level of discomfort in the 1st phase, which significantly reduced during the period compared with controls. The experimental group experienced significantly more discomfort during the 2nd phase, and significantly stronger urges to neutralize and distract at the end of this phase than controls.

The most striking feature of the phenomenology of obsessive–compulsive disorder (OCD) is the occurrence of consistent neutralizing behavior in response to intrusive cognitions. Although intrusive thoughts are an everyday phenomenon in people who do not suffer from OCD (Rachman & de Silva, 1978; Salkovskis & Harrison, 1984), the consistent occurrence of compulsive behaviors and mental compulsions (neutralizing thoughts) is only observed in those who do. People not suffering from OCD do neutralize from time to time but do so only intermittently, whereas not neutralizing in response to an intrusive thought is the exception in OCD patients. It has been suggested by those who favor biological theories that such compulsive behavior is a phenomenon closely akin to motor tics, with covert neutralizing being a type of “mental tic” (Rapoport & Wise, 1988). By contrast, cognitive–behavioral theories of OCD are based on the idea that neutralizing is an intentional reaction motivated by the way in which the person interprets the occurrence and content of intrusive thoughts as a sign that he or she might be responsible for preventing some avoidable negative consequences for him- or herself or for other people (Forrester, Wilson, & Salkovskis, 2002; Freeston & Ladouceur, 1997; Rachman, 1998; Salkovskis, 1996b, 1999).

From such a cognitive–behavioral perspective, neutralizing is an attempt on the part of the person to prevent consequences related to intrusive (obsessional) cognitions or at least to do something that discharges what this person believes to be his or her responsibility. Engaging in neutralizing is conceptualized as a type of safety-seeking behavior (Salkovskis, 1991, 1996a, 1996b), which can be counterproductive for three main reasons. First, neutralizing may prevent the person from discovering that his or her fears do not come about (“There was no gas explosion because I made sure that the gas was turned off”); “My mother did not die but that was because I said the prayer”). Second, neutralizing can increase preoccupation by the person focusing on ideas of harm and his or her perceived responsibility to prevent it (sometimes, but not always, linked to the occurrence of further intrusion; Wroe, Salkovskis, & Richards, 2000). Third, when safety-seeking behaviors take the form of thought suppression and neutralizing, there is likely to be an increase in frequency of intrusions (Salkovskis, 1999; Salkovskis & Campbell, 1994; Salkovskis, Richards, & Forrester, 1995).

The psychological account of the importance of neutralizing activity received considerable support from early experiments that demonstrated that compulsive behaviors such as checking and washing resulted in immediately reduced discomfort experienced by patients with OCD. It was also found that such discomfort was subject to spontaneous decay over a longer period if the person did not engage in their neutralizing behavior (Rachman, de Silva, &
As a result of holding beliefs about thought participants who were likely to be vulnerable to obsessional problems neutralizing was equivalent to overt compulsive behaviors (Rachman, 1976; Salkovskis & Westbrook, 1989; Wolpe, 1958), the probable functional nature of this link has only recently been demonstrated (Rachman et al., 1996). In their study, Rachman, Shafran, Mitchell, Trant, and Teachman (1996) showed that participants who were likely to be vulnerable to obsessional problems as a result of holding beliefs about thought—action fusion (believing in some actual or moral equivalence between thinking about harm and causing that harm) responded to covert neutralizing in similar ways to that seen in obsessional patients. That is, there was evidence that neutralizing produced rapid relief but that anxiety declined to comparable levels without neutralizing after a delay of 20 min. These findings closely match those obtained with compulsive checking rituals (Rachman et al., 1976). The cognitive—behavioral theory goes further than this, however. It specifies that threat-motivated neutralizing activity is associated with shorter term relief of discomfort but also with a longer term enhancement of subsequent discomfort and increases in the urge to engage in further neutralizing (Salkovskis, 1989a, 1998). To test this hypothesis, we conducted a study on a group of people who, although not suffering from clinical OCD, reported experiencing frequent, unpleasant, and unacceptable intrusions with the tendency to neutralize these (Salkovskis, Westbrook, Davis, Jeavons, & Gledhill, 1997). Over 1,000 nonclinical participants were screened to obtain a final sample of 28 participants, who were then allocated to one of two conditions: neutralization or distraction.

Participants were asked to respond to their intrusions each time they occurred (using a loop tape, presentation being in the person’s own voice on headphones so that the voice was lateralized, i.e., heard as if coming from “inside your own head”) either by using their usual neutralizing response or by counting backward for a strictly comparable period. Ratings of discomfort were taken during this procedure (first phase) and during identical presentations of the same thought without neutralizing or distracting (second phase). Results showed that the group who neutralized during the first phase experienced significantly more discomfort during the second phase and significantly stronger urges to neutralize and distract. There was also evidence that engaging in neutralizing responses during the first phase made it difficult to stop neutralizing during the second phase.

The choice of a control condition is an important issue. In pilot work, it has been noted that simply asking participants to listen resulted in the occurrence of neutralizing, particularly in obsessional patients. Furthermore, the key to habituation is exposure to the intrusive thought. Theoretically and practically, any subsequent neutralizing response is likely to have the effect of distracting the person from their intrusion, and therefore, decreasing habituation. This means that the appropriate control is a low demand task that distracts the person to roughly the same degree as neutralizing would. We therefore chose a counting task as the control, which could be set up to last the same time period as the person’s usual neutralizing response.

Recently, another group (Kyrios, Wright, & Hordern, 2001) sought to replicate the effects that were obtained in Salkovskis et al. (1997). The participants in that experiment were 6 OCD and 30 nonclinical participants; experimental conditions were naturally occurring neutralizing, and the refocusing condition occurred while a participant listened to personally relevant intrusion on a loop tape. The refocusing condition used was different to that used by Salkovskis et al. (1997), who required a brief period of counting following each presentation of the taped intrusion to match the neutralizing response. In the Kyrios et al. study, participants counted backward over the entire period. Also, Kyrios et al. crossed over the conditions and analyzed both periods together. The results of this study almost matched those obtained by Salkovskis et al. Discomfort levels significantly decreased during neutralizing but not during refocusing. During the subsequent listening phase, the group who had previously neutralized had significantly more discomfort than those who had refocused. In addition, the urge to neutralize was significantly greater in the listening phase for the same group. This finding also replicates the previous study.

The present study was therefore intended as a clinical extension of Salkovskis et al.’s (1997) study, with the participants being patients diagnosed as suffering from OCD. The prediction was that prior neutralizing of the occurrence of intrusive thoughts would result in a short-term reduction of discomfort in those neutralizing during the first phase. In addition, the group that had previously neutralized would experience higher levels of discomfort during the second (listen only) phase than would the control (counting) group. Use of the neutralizing response was also predicted to increase the subsequent urge to engage in yet further neutralizing.

**Method**

**Overview**

Intrusive thoughts and the associated neutralizing thoughts were elicited from obsessional patients. While listening to repeated, audiotaped presentations of their individual intrusions, participants were asked either to neutralize as normal or to distract by counting for a comparable period. The clinicians who carried out the diagnostic assessment were trained in the use of the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-IV; First, Spitzer, Gibbon, & Williams, 1997), and reliability was assessed posttraining. Reliability was checked using videotapes and was found to be 100% for the diagnosis itself. Discomfort associated with the intrusion was assessed at intervals throughout the procedure using a visual analog scale (VAS). After a pause, the tape was played again, but this time participants in both groups were required to listen without deliberate response other than recording further ratings of discomfort.

**Participants**

Thirty participants were recruited from patients diagnosed with OCD according to Diagnostic Statistical Manual of Mental Disorders—fourth edition (DSM-IV: American Psychiatric Association, 1994) criteria and who were referred for treatment to the OCD treatment team in the Department of Psychiatry, University of Oxford, England. The assessment was conducted by experienced clinicians using the SCID-IV. The clinicians who carried out the diagnostic assessment were trained in the use of the SCID-IV, and reliability was assessed posttraining. Reliability was checked using videotapes and was found to be 100% for the diagnosis itself. Participants were selected only if they could report an identifiable intrusive thought and if they engaged in some form of mental neutralizing. They also had to confirm that listening to their own intrusive thoughts on an audiotape in the laboratory would cause them discomfort and that they would be able to neutralize using their normally occurring neutralizing response. Participants were excluded if they would usually neutralize by counting or had a history of psychotic disorder. One participant did not complete the experimental procedure satisfactorily, as it became clear
during the course of the experiment that he had not understood the instructions; he is not included in the analyses reported here. Participants were randomly allocated to the neutralizing or distracting condition using sampling without replacement. Table 1 shows the characteristics of the participants who successfully completed the experiment.

On the basis of independent t tests, neither the neutralizing nor the distracting group differed on age or baseline levels of anxiety: Both groups were measured by the Beck Anxiety Inventory (BAI; Beck, Epstein, Brown, & Steer, 1988); the State–Trait Anxiety Inventory (STAI; Spielberg, Gorsuch, Lushene, Vagg, & Jacobs, 1983); the Beck Depression Inventory (BDI; Beck, Ward, Mendelsohn, Mock, & Erbaugh, 1961); and the Maudsley Obsessive Compulsive Inventory (MOCI; Hodgson & Rachman, 1978). There were, however, significant differences between groups on the MOCI total score, t(27) = 2.12, p = .043, and on the Washing subscale, t(13.1) = 2.50, p = .025 (adjusted for unequal variances).

### Measures

Discomfort ratings during the experiment were based on a 0–100 VAS anchored on 0 (no discomfort at all) to 100 (the most uncomfortable I have ever felt). Between the two audiotal presentations, participants completed a questionnaire set including the BDI, the MOCI, the BAI, and STAI. After each phase of audiotal presentations, the participants also completed a questionnaire (the postpresentation questionnaire) in which they made retrospective VAS ratings (referenced to During the time the tape was playing) of (a) the strength of any urge to neutralize or put right, (b) the strength of any urge to distract themselves from the thoughts, and (c) the overall discomfort during that period. Participants were also asked to complete VAS ratings to indicate how much the neutralizing or counting relieved their anxiety, discomfort, or both.

### Procedure

Prior to the experiment, participants were seen by a clinician to identify the most troublesome intrusive thought usually occurring as part of the participant’s OCD and associated mental neutralizing. The identified intrusion and its subsequent neutralizing activity were written down on a form devised for this purpose. The experiment started and participants were asked to fill in the STAI State subscale. If necessary, experimenter and participant elaborated on the intrusive thought together, retaining its important content, so that it lasted for about 20 s when spoken out loud. Once this short script had been constructed and written down, the participant recorded the written version of the intrusion verbatim onto a 30-s audiotape loop. A rating of discomfort on a 100-point VAS was then taken to be a baseline.

Participants in the neutralizing condition were given the following instructions:

> What I’m going to do is ask you to listen carefully to the tape on the headphones. Each time you hear the thought, I would like you to immediately think the neutralizing thought. I will be asking for ratings of how uncomfortable the thought made you feel every now and then; when I show you the card please point to the number which best describes how you felt during the time you just heard the thought. This will take less than 10 minutes.

Participants in the distracting condition were given the following instructions:

> What I’m going to do is ask you to listen carefully to the tape on the headphones. Each time you hear the thought, I would like you to immediately count backwards from 20 like this: 20, 19, 18… I will be asking for ratings of how uncomfortable the thought made you feel every now and then; when I show you the card, please point to the number which best describes how you felt during the time you just heard the thought. This will take less than 10 minutes.

Once these instructions had been given, the experimenter ensured that the participant fully understood what was required of him or her. Participants were then asked to put on their headphones, and the tape was started. Participants heard 16 presentations of their intrusion in all. On Presentations 1, 4, 8, 12, and 16, the participants were shown the card with the VAS for discomfort, and ratings were recorded. The card was presented after the end of the intrusion, that is, in the period just after neutralizing had occurred. The VAS card was marked with the words During the time you just heard the thought at the top.

After 16 presentations, the participants removed the headphones and were asked to rate their current discomfort on the VAS. Then they completed the postpresentation questionnaire and the questionnaire set containing the BDI, BAI, MOCI, and STAI State subscale. The time interval between the two phases of presentations took an average of 15 min. Immediately before the audiotal thought was presented for a second time, participants were asked to rate their discomfort on a VAS as a new baseline. This time all participants were given the same instructions as follows:

> I’m going to ask you to listen to the same tape. This time, just listen carefully to the tape. When I show you the card, then please tell me the rating which best describes how you felt during the time you just heard the thought. We don’t want you to (neutralize/count) during this part of the experiment; just listen to the tape.

The experimenter again sought to ensure that the participants fully understood the requirements of this phase, and the tape began as soon as the headphones were in place. Ratings of discomfort were again recorded at Presentations 1, 4, 8, 12, and 16, with the same timing as in the previous phase. Once the taped sequence was over, participants were asked to fill in the STAI State subscale and complete the postpresentation questionnaire again. They were then debriefed and the experiment ended.

### Treatment of Data

The main analysis was a repeated measures analysis of variance (ANOVA), with two repeated measures factors (first vs. second tape session and the five ratings taken during each of these sessions), with the experimental manipulation as a between-subjects factor. For the postpresentation questionnaire variables only the first of these repeated measures

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### Table 1

<table>
<thead>
<tr>
<th>Measure</th>
<th>M for condition</th>
<th>SD for condition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Count</strong></td>
<td><strong>Neutralize</strong></td>
<td><strong>Count</strong></td>
</tr>
<tr>
<td>Age</td>
<td>31.0000</td>
<td>33.6667</td>
</tr>
<tr>
<td>STAI before experiment</td>
<td>49.2143</td>
<td>48.5000</td>
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<td>STAI during experiment</td>
<td>56.6429</td>
<td>48.0667</td>
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<td>STAI after experiment</td>
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<td>BAI</td>
<td>19.8462</td>
<td>19.8667</td>
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<tr>
<td>BDI</td>
<td>19.8462</td>
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<td>MOCI total</td>
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</tr>
<tr>
<td>MOCI checking</td>
<td>6.2727</td>
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<td>MOCI washing</td>
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<td>0.6429</td>
</tr>
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<td>MOCI slowness</td>
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<td>1.4667</td>
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<tr>
<td>MOCI doubting</td>
<td>4.3333</td>
<td>5.0000</td>
</tr>
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</table>

**Note.** STAI = State-Trait Anxiety Inventory; BAI = Beck Anxiety Inventory; BDI = Beck Depression Inventory; MOCI = Maudsley Obsessive-Compulsive Inventory.
factors was used. An ANOVA was conducted using the SPSS (Version 10.0. General Linear Model) procedure. Planned comparisons were carried out using the appropriate t tests. Preexperiment measures were analyzed using independent t tests.

Results

Overview

Results of the analysis of discomfort indicated that during the first period (during which the patients had been neutralizing or counting each time they heard their intrusive thought), a decrease in discomfort over the presentation sequence occurred only in the group who used their normal neutralizing strategy. At the end of this period, there was no significant difference in absolute level of discomfort. However, during the second presentation sequence (during which they were required not to respond by neutralizing or counting), prior neutralizing was associated with an increased level of discomfort relative to that period’s baseline. The urge to neutralize during this second period was also elevated in patients who had neutralized during the first period relative to those who had counted.

Discomfort Ratings During the Presentation of Intrusive Thoughts

The repeated measures ANOVA, Session (first vs. second presentation) × Repeats (Ratings 1–5) × Experimental Condition (neutralizing vs. distracting), detected no significant main effects (session, F < 1; repeats, F[4, 108] = 1.11, p > .30; experimental condition, F < 1). The interaction between repeats and experimental condition was not significant (F < 1), whereas the Session × Experimental Condition interaction was significant, F(1, 27) = 12.50, p < .001, as was the Session × Repeats interaction, F(4, 108) = 2.92, p < .05. These were in turn modified by a Session × Repeats × Experimental Condition interaction, F(4, 108) = 3.60, p < .01. This interaction remained significant once the analysis was adjusted for autocorrelation (epsilon coefficient = 0.45; Greenhouse Geisser, p = .038). The results of the discomfort variable are shown in Figure 1. The pattern of significant results is unchanged if the discomfort rated prior to the first session is used as a covariate.

Planned comparisons were carried out using paired t tests on the discomfort level for the first and second session baseline to the final presentation. For the distracting condition, the difference was not significant for the first, t(13) = 0.39, p > .70, or the second session, t(13) = 1.00, p > .30. For the neutralizing condition, there was a significant decrease in discomfort during the first session, t(14) = 2.60, p < .025, and a significant increase in discomfort during the second session, t(14) = −3.10, p < .01. Further planned comparisons using independent t tests provided partial confirmation of this. Thus, the fifth (final) rating in the second presentation series was significantly higher for the neutralizing group compared with the distracting group, t(27) = 2.10, p < .05. However, the comparison of the same point for the first series only indicated a trend, t(27) = 1.85, p = .076.

As a subsidiary analysis, the first presentation of the first session and the last presentation of the second session were compared across groups in an ANOVA to establish whether there was an overall change in response to the obsessional thought over the
course of the total of 32 presentations of the patient’s obsessional thought. The only significant result in this analysis was the Group × Session interaction, \( F(1, 27) = 6.30, p < .025 \). Multiple comparisons indicate that there was a significant across-session decrease in discomfort in the distracting group, \( t_{\text{paired}}(13) = 2.50, p < .05 \), whereas there was a nonsignificant increase in the neutralizing group, \( t_{\text{paired}}(13) = -1.20, p > .20 \). As shown above, the neutralizing group rated their discomfort as significantly higher at the final presentation than did the distracting group.

Postpresentation Questionnaire Results

These results are summarized in Table 2. The urge to neutralize was rated both after the experimental phase (first presentation, during which patients either neutralized or distracted) and after the second presentation, during which they were asked to do neither. Repeated measures ANOVA of these results indicated no effect of session (\( F < 1 \)) but a significant effect of group, \( F(1, 27) = 11.40, p < .0025 \), which was modified by a significant Session × Group interaction, \( F(1, 27) = 4.50, p < .05 \). Multiple comparisons (Bonferroni-corrected \( t \) tests, using an alpha of .025) indicated that the urge to neutralize was significantly higher in the group who had neutralized after the neutralizing phase, \( t(27) = 4.10, p < .0001 \). This rating was no longer significant after the listen-only phase, \( t(27) = 2.20, p = .039 \). Within group, there was no significant change in urge to neutralize between the first and the second sessions for the distracting group, \( t(13) = -2.20, p = .049 \), or in the neutralizing group, \( t(13) = 0.99, p > .30 \).

An ANOVA of the urge to distract from the intrusions indicated a significant main effect of session, \( F(1, 27) = 7.13, p < .025 \). There was no group effect (\( F < 1 \)), but the Group × Session effect was marginal, \( F(1, 27) = 3.66, p = .066 \). Overall, there was evidence of an increased urge to distract in the second session.

Ratings of relief of anxiety and discomfort indicated a significant main effect of session, \( F(1, 26) = 18.20, p < .0001 \), with no group effect and no interaction (\( F_s < 1 \)). This reflects the fact that both counting and neutralizing as carried out in the first session were associated with greater anxiety relief than doing nothing was in the second session.

Discussion

The results of the present study indicate that neutralizing an obsessional (intrusive) thought is associated with an apparent decrease in discomfort (relative to a distraction control) while such neutralizing is in progress. This decrease does not occur in patients instructed to engage in a comparable period of nonneutralizing distraction. However, when the obsessional thought is presented again a short while later under identical conditions for each group, the patients who had previously engaged in their normal neutralizing experienced a greater increase in discomfort than did those who had distracted. There was also evidence that prior neutralizing, rather than meeting the patient’s need for this activity, was associated with the maintenance of a significantly higher level of urge to neutralize compared with those who had been asked to engage in counting rather than neutralizing. There was some evidence that having done such counting may have slightly increased the urge to neutralize. The rating of the urge to distract from the intrusion was relatively increased during the second presentation of the intrusion in all patients, with a nonsignificant trend suggesting that this may be more marked in those who previously neutralized. Surprisingly, both neutralizing and counting were rated as producing considerable relief of anxiety, and there was no evidence of differential anxiety reduction.

The period involved in this experiment was relatively brief (10 min), and the situation was relatively artificial (i.e., a tape recording of the intrusive—obsessional thought). However, every effort was made to increase the ecological validity of the experimental procedure. It is undoubtedly the case that the thought presentation evoked considerable distress in most patients. The use of the patient’s naturally occurring obsessional thought and neutralizing—covert ritual adds to the validity, and the fact that the participants heard their own voice utter the thought in headphones so that the sound was lateralized both add to the match between the patients’ naturally occurring obsessional problem and the procedures used here. To find an effect such as the one noted here, obtained in such a brief period, suggests that the effect is a powerful one. Note also that the procedure used closely matches a technique that has been found to be clinically helpful in the treatment of obsessional ruminations (Freeston et al., 1997; Salkovskis, 1983; Salkovskis & Westbrook, 1989). However, we cannot rule out the possibility that the differences observed may have arisen from undetected differences in the effort required to neutralize as opposed to counting.

Table 2

<table>
<thead>
<tr>
<th>Item</th>
<th>M</th>
<th>SD</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urge to neutralize first time</td>
<td>21.4286</td>
<td>64.0000</td>
<td>26.8492</td>
<td>29.4715</td>
</tr>
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<td>Urge to distract, first time</td>
<td>37.1429</td>
<td>34.6667</td>
<td>29.9817</td>
<td>33.3524</td>
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<td>Discomfort during tape</td>
<td>51.4286</td>
<td>51.0000</td>
<td>25.2170</td>
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<td>Relie of anxiety, first time</td>
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</tr>
<tr>
<td>Urge to neutralize second time</td>
<td>33.2143</td>
<td>57.3333</td>
<td>31.8414</td>
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</tr>
<tr>
<td>Urge to distract, second time</td>
<td>40.0000</td>
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<td>Discomfort during tape</td>
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<td>Relief of anxiety, second time</td>
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<td>31.3333</td>
<td>35.6494</td>
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</table>
The results of the present study substantially replicate the work previously conducted with nonclinical participants (Salkovskis et al., 1997). The Salkovskis et al. (1997) study used almost identical methodology with people selected from the normal population who experienced frequent intrusions and who reported a tendency to neutralize their intrusions. Points of similarity include the relative reduction of discomfort associated with active neutralizing, the subsequent increase in discomfort in the same group, and an overall elevation in the urge to neutralize during the second phase. These results have recently been replicated by another group, again using participants largely drawn from the nonclinical population (Kyrios et al., 2001).

The cognitive theory of OCD highlights the importance of motivated neutralizing (including both overt and covert responses to intrusive cognitions). The experimental demonstration of the impact of preventing compulsive behavior was a key factor in the development of behavioral treatments in the 1970s (Rachman, 1976). By implication, such studies have suggested that the development of neutralizing responses was an important factor in the persistence of obsessional problems, but the present study is the first direct demonstration of this in obsessional patients. It has been argued (Freeston, Ladouceur, Rheaume, & Leger, 1998; Rachman, 1976, 1993, 1997, 1998; Salkovskis, 1985, 1989a, 1989b, 1999) that cognitive factors are key in motivating responses involved in the maintenance of OCD and that the use of instructions to respond in the absence of such motivation (from threat, responsibility, etc.) are unlikely to reveal much about clinical OCD. The present study is important in this context because it demonstrated that, although concurrent ratings of discomfort did not change during the distracting phase, there was evidence that participants perceived a reduction in anxiety as measured by the questionnaire administered after the experimental phase. This rating of anxiety relief did not differ significantly from that noted after neutralizing.

Future research should evaluate whether naturally occurring neutralizing has longer term effects, as the present study (and previous ones) has only evaluated effects over shorter periods. Naturally occurring neutralizing has been used because it has clear ecological validity. The cognitive theory would predict that a neutralizing response that was provided by the experimenter would not have the same effects, as the motivated nature of neutralizing is important. That is, one of the effects of neutralizing is to maintain or increase the perception of responsibility for preventing harm. Clearly, future research is needed to directly address this important issue.

The present results are consistent with the assertion that neutralizing responses are involved in the maintenance of distress associated with obsessional thoughts. One of the effects of apparently successful efforts to neutralize obsessional thoughts is to further increase the person’s urge to use it more. These findings validate the clinical assertion that, in OCD, the solution has become the problem (Salkovskis, 1999). That is, the way the obsessional patient tries to respond to intrusive thoughts ultimately becomes more of a problem than the intrusive thoughts themselves, and it becomes so in a pernicious and self-sustaining way.

References


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Call for Nominations

The Publications and Communications (P&C) Board has opened nominations for the editorships of Comparative Psychology, Experimental and Clinical Psychopharmacology, Journal of Abnormal Psychology, Journal of Counseling Psychology, and JEP: Human Perception and Performance for the years 2006–2011. Meredith J. West, PhD, Warren K. Bickel, PhD, Timothy B. Baker, PhD, Jo-Ida C. Hansen, PhD, and David A. Rosenbaum, PhD, respectively, are the incumbent editors.

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