ELSEVIER

Anxiety Disorders 22 (2008) 143–161

Journal of Anxiety Disorders

'I wash until it feels right' The phenomenology of stopping criteria in obsessive–compulsive washing

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Received 21 August 2006; received in revised form 16 February 2007; accepted 21 February 2007

Abstract

Recent elaborations of cognitive behavioral theory in OCD suggest that difficulties in deciding when to stop a compulsive action may be related to the use of counter-productive termination criteria by obsessional patients [Salkovskis, P. M. (1999). Understanding and treating obsessive–compulsive disorder. *Behaviour Research and Therapy*, *37*, s29–s52]. Such criteria are characterized by their subjective nature, i.e. a primarily *internal* reference point (e.g. 'just right' feelings), and are conceptualized as the ''top level'' of a general strategy involving elevated evidence requirements. Thirty-eight obsessional washers, 41 obsessionals with other problems and 43 healthy controls were interviewed about and rated two situations varying in the degree of urgency to wash; they also washed their hands in a behavioral test. Washers reported using subjective criteria more frequently and rated them as more important for the termination of the washes than the other groups in questionnaire, interview and laboratory data. Both obsessional groups considered more criteria before stopping than the healthy controls, suggesting that using multiple criteria is a general strategy. The data are consistent with the predictions of the elaborated cognitive-behavioral model of OCD. They indicate that the use of subjective criteria and elevated evidence requirements is affected by the perceived significance of the situation in a similar way for obsessional and non-obsessional individuals.

Keywords: Obsessive–compulsive disorder; Compulsions; Elevated evidence requirements; Stopping criteria

1. Introduction

Obsessive compulsive disorder (OCD) is a severe and persistent psychological problem with immense negative effects on the individual's social and working life as well as on their family (Bobes et al., 2001; Koran, 2000; Koran, Thienemann, & Davenport, 1996; Parkin, 1997). Patients suffer not only from marked anxiety and discomfort associated with their obsessional thoughts but also from the compulsive or neutralizing behavior that is performed in order to prevent the feared consequences from happening (Zaudig, 2006). Obsessional patients characteristically engage in repeated and/or prolonged episodes of compulsive behavior, feeling unable to stop repeating some action over and over again.

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doi:10.1016/j.janxdis.2007.02.009

Although other phenomena related to compulsions, such as the motivation to ritualize in the first place, or the anxiety reduction which follows it, have been extensively examined both theoretically and experimentally (Rachman & Hodgson, 1980; Rachman & Shafran, 1998; Salkovskis, Thorpe, Wahl, Wroe, & Forrester, 2003) factors influencing the termination of (and failure to terminate) compulsive activities have received comparatively little research attention. It has been proposed that the repetitiveness of some compulsive behavior, particularly checking, can be accounted for by poor memory for actions (Ecker & Engelkamp, 1995). However, when memory for OCD relevant stimuli is assessed this is found to be intact or event enhanced in OCD (e.g. Radomsky, Rachman, & Hammond, 2001). Data on memory in OCD suggests that the most consistent effects are low levels of *confidence* in memory for OCD related stimuli (Tolin et al., 2001).

The focus on the current study is on the difficulty people suffering from OCD have in stopping behaviors such as washing and checking once they have started what would otherwise be a normal activity. Rather than taking a memory perspective, we instead re-conceptualize the difficulty in stopping behavior as *a problem of decision making*, specifically the process of deciding that enough has been done. The idea that there are problems in decision making processes fit better with the basic phenomenology of OCD. The patient who has washed until their hands bleed does not report doubt that they have been washing or even how long they have washed, but instead report *being uncertain whether they have washed enough*.

This phenomenon can be understood by extending current cognitive theories of OCD, particularly those described by Freeston, Rheaume, and Ladouceur (1996), Rachman (1998) and Salkovskis (1999). The CB model is based on the idea that it is not the intrusive thoughts per se which leads to discomfort and compulsive actions, but the meaning that the person attaches to them. Only if an obsession is interpreted as indicating that one might be responsible for serious harm to oneself or others does it result in the range of reactions and responses characteristic of OCD. The CB-model (Salkovskis, 1999) proposes that a common response to fears of being responsible for harm is the use of potentially counterproductive ''stop criteria'', where the person actively seeks to achieve a particular *subjective or emotional state* as a way of deciding that they have completed an activity. This includes the deliberate seeking of a particular mood state, a sense of satisfaction or completeness and ''just right'' feelings as a way of deciding that it is appropriate to stop behavior. Such internal states are inherently more difficult for the person to evaluate than sensory input and it therefore takes longer to decide whether they have been met or not. The use of ''*just right*'' and other *subjective* states to decide on the termination of an action could be regarded as an example of the operation of ''Elevated Evidence Requirements'', motivated by the perception of importance of the outcome of the ''stop'' decision (Wahl & Salkovskis, submitted for publication). The idea of ''elevated evidence requirements'' has been discussed previously as an important maintaining factor in chronic worry (Tallis, Eysenck, & Mathews, 1991).

The addition of the concept of EER to cognitive theories of OCD suggests that not only is the *quality* of the criteria that are used to stop an action different for individuals with and without OCD – obsessional patients emphasizing *subjective* criteria – but also the *quantity* of criteria that are taken into consideration. We suggest that obsessional patients are likely to consider *multiple* criteria before they can reach a decision, whereas individuals without any obsessional problems consider only few criteria. Only if they are satisfied that all criteria have been met can they make a decision about whether to stop.

An implication of the active use of elevated evidence requirements is that the decision making process is controlled in the sense that it requires mental effort, is deliberate and conscious (McNally, 1995). Decision making at the end of a non-compulsive wash, on the other hand, would be relatively automatic, i.e. involve little or no mental effort, is not necessarily conscious and not deliberately initiated or terminated. We suggest that the deployment of elevated evidence requirements in decision making is not necessarily a pathological strategy or a generalized cognitive style. Instead, the theory suggests that everybody can and does use elevated evidence requirements given the right circumstances. The extent to which people require more evidence before reaching a decision varies according to the *perceived personal importance* of that decision. For most people, the decision about which sock to put on first requires little consideration of the factors involved. However, deciding whether to take a new job would normally lead to seeking a range of objective information (salary, conditions, location and so on) *combined with* the general felt sense of whether this was the right thing to do or not. Thus, the perception of personal significance and importance of any particular decision is likely to determine the extent to which more evidence is actively sought in order to reach a decision. The more important a decision is, the more likely it is that the evidence sought will include subjective (''it feels right'') elements. These subjective elements