Cytowanie: Bolek-Kochanowska M: Terapia poznawczo-behawioralna w leczeniu zaburzeń obsesyjno-kompulsyjnych z przewagą myśli obsesyjnych. Psychiatr Psychol Klin 2025; 25 (3)

Received: 07.12.2023
Accepted: 18.09.2024
Published online: 17.10.2025

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Cognitive behavioural therapy in the treatment of pure obsessional obsessive-compulsive disorder

Terapia poznawczo-behawioralna w leczeniu zaburzeń obsesyjno-kompulsyjnych z przewagą myśli obsesyjnych

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https://doi.org/10.15557/PiPK.2025.0027

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Abstract

Obsessive-compulsive disorder (OCD) characterised by predominant obsessive thoughts without accompanying overt compulsions is traditionally referred to as pure obsessional OCD ("Pure O"). Its prevalence is relatively low, accounting for only about 2–4% of all OCD cases, which is why it is often omitted from studies evaluating the effectiveness of therapeutic interventions. The limited research available suggests that cognitive behavioural therapy offers relief to individuals struggling with "pure" obsessive thoughts, although its efficacy tends to be lower compared to other OCD subtypes. Patients struggling with this condition often experience intense shame, and alongside obsessive thoughts, they frequently exhibit covert compulsions or neutralising behaviours. Given the unique challenges faced by patients with this form of obsession, it is advisable to adjust standard therapeutic protocols for obsessive-compulsive disorder and tailor intervention strategies to better address their specific needs. The paper explores how obsessive thoughts are conceptualised within cognitive-behavioural models, offers recommendations for clinical practice, and outlines ways of adapting selected cognitive-behavioural techniques for working with patients experiencing pure O. It also reviews findings on the effectiveness of various CBT approaches in treating this subtype of OCD and highlights limitations that should be taken into account when interpreting and generalising the results. Due to the limited number of clinical descriptions of Pure O in Polish literature and the diagnostic challenges associated with this subtype of obsessive-compulsive disorder, the aim of this paper is not only to outline therapeutic approaches for working with patients experiencing pure obsessional symptoms, but also to promote greater awareness of the condition among clinicians and therapists. By doing so, it seeks to improve the chances of affected individuals receiving an accurate diagnosis and effective treatment.

Keywords: cognitive behavioural therapy, obsessions, obsessive-compulsive disorder

Streszczenie

Zaburzenie obsesyjno-kompulsyjne z dominacją myśli obsesyjnych bez towarzyszących im jawnych kompulsji jest tradycyjnie nazywane pure obsessional OCD (pure O). Jego rozpowszechnienie jest niewielkie, stanowi zaledwie około 2–4% wszystkich przypadków zaburzenia obsesyjno-kompulsyjnego, co sprawia, że często było pomijane w badaniach nad efektywnością oddziaływań terapeutycznych. Z nielicznych prac z tego zakresu wynika, że terapia poznawczo-behawioralna przynosi ulgę pacjentom zmagającym się wyłącznie z myślami obsesyjnymi, jednak jej efektywność jest niższa niż w innych rysach zaburzenia obsesyjno-kompulsyjnego. Pacjenci borykający się z tym problemem często doświadczają nasilonego wstydu, a obok myśli obsesyjnych często obecne są u nich ukryte kompulsje lub zachowania neutralizujące. Ze względu na swoiste trudności, z jakimi zmagają się ci pacjenci, zaleca się modyfikowanie standardowych protokołów terapeutycznych dotyczących zaburzenia obsesyjno-kompulsyjnego i dostosowywanie technik terapeutycznych do ich potrzeb. W artykule omówiono sposób konceptualizacji myśli obsesyjnych w modelach poznawczo-behawioralnych, przedstawiono rekomendacje dla praktyki klinicznej i sposób dostosowywania wybranych technik poznawczo-behawioralnych w terapii pacjentów z pure O, przytoczono wyniki badań nad skutecznością różnych wariantów terapii poznawczo-behawioralnej w pracy z tym zaburzeniem oraz wskazano ograniczenia, które należy mieć na uwadze przy interpretacji i uogólnianiu wniosków z tych badań. Ze względu na niewielką liczbę opisów klinicznych pure O w polskim piśmiennictwie oraz wiążące się z tym zaburzeniem trudności diagnostyczne celem artykułu było nie tylko

nakreślenie sposobu pracy terapeutycznej z pacjentami doświadczającymi tej postaci zaburzenia obsesyjno-kompulsyjnego, ale także rozpowszechnianie wiedzy na jej temat w środowisku diagnostów i terapeutów, aby zwiększać szanse zmagających się z nią pacjentów na uzyskanie trafnej diagnozy i skutecznej terapii.

Słowa kluczowe: terapia poznawczo-behawioralna, myśli obsesyjne, zaburzenie obsesyjno-kompulsyjne

INTRODUCTION

Of all diagnosed cases of obsessive-compulsive disorder (OCD), only around 2–4% represent OCD with a predominance of obsessive thoughts, traditionally referred to as primarily obsessional OCD or pure obsessional OCD ("Pure O") (Foa et al., 2016; Williams et al., 2011). Due to the low prevalence of this OCD subtype and the limited availability of theoretical literature – particularly in Polish – clinicians and therapists are often unaware of its specific clinical presentation, which may lead to diagnostic errors and reduced effectiveness of therapeutic interventions. As emphasised by Williams et al. (2022), treating patients with Pure O requires the use of therapeutic techniques specifically designed to address the challenges typical of this subtype, including feelings of shame and experiences of stigmatisation.

The aim of this paper is to examine the clinical characteristics of OCD with a predominance of obsessive thoughts and to explore the therapeutic interventions dedicated to this presentation within the framework of cognitive behavioural therapy (CBT). The article describes the typical content of obsessive thoughts characteristic of Pure O, highlights diagnostic challenges, and describes the specific difficulties faced by individuals affected by this condition. It then discusses selected cognitive models of the disorder and the therapeutic strategies associated with them. Finally, the article reviews research on the effectiveness of various CBT approaches focused on treating obsessions and covert compulsions.

PURE O IN THE CONTEXT OF OBSESSIVE-COMPULSIVE DISORDER; HISTORY, CLINICAL PRESENTATION, AND DIAGNOSTIC CHALLENGES

The clinical picture of OCD comprises both obsessive thoughts and compulsive behaviours. Although psychiatric classifications such as DSM-5 and ICD-11 allow for an OCD diagnosis when only one of these symptoms is present, in typical cases both are observed (Gałecki and Szulc, 2023; Krzanowska and Kuleta, 2017; Morrison, 2016). Obsessions are persistently recurrent, time-consuming, unwanted thoughts, impulses, or images. They are intrusive and ego-dystonic, and their occurrence is associated with anxiety and a subjective sense of resistance (Bryńska, 2007; Rachman, 2003; Wells, 2010). Obsessions constitute a core aspect of the clinical phenomenology of OCD and typically precede compulsive behaviours.

Compulsions, in turn, are repetitive, involuntary actions undertaken to reduce anxiety. They may take an overt form (e.g. hand washing or organising) or a covert one. The latter include mental acts such as praying, counting, repeating phrases internally, or reviewing past events. However, they may also manifest in less obvious ways, including body checking, slowing down movements, or seeking reassurance (e.g. soliciting comfort from others through questioning or confessing, self-reassurance, or compulsive information seeking). In addition to compulsions, common responses to obsessions in OCD include avoidance, attempts to suppress or distract from intrusive thoughts, and various forms of mental neutralisation (Bryńska, 2007; Rachman, 2003; Wells, 2010; Williams et al., 2011, 2022).

Statistical analyses used to cluster OCD symptoms typically yield between three and five categories (Bloch et al., 2008). One of them was the Pure O factor identified by Bear (1994), which encompassed obsessions of aggressive, religious, and sexual content – and, most importantly, did not include any overt compulsions. The aggressive content of obsessions within this subtype may include fears of suddenly losing control and violently attacking another person; failing to fulfil a duty, resulting in harm or death to someone else; accidentally poisoning someone; unknowingly hitting a pedestrian and fleeing the scene; or losing sanity and committing suicide. Sexual content, in turn, may involve fears of molesting a child, exposing oneself in public, engaging in sexual activity with an inappropriate partner, changing one's sexual orientation, becoming pregnant or impregnating someone, or experiencing unwanted sexual imagery. Blasphemous or religious obsessions may include fears of performing sacrilegious gestures in sacred spaces, contaminating prayers or religious rituals with impure thoughts, or experiencing recurring doubts about having committed a sin or moral transgression (Abramowitz and Jacoby, 2014; OCD Center of Los Angeles, 2012; Rachman, 2003; Williams and Wetterneck, 2019).

The term "Pure O" has become firmly established in clinical terminology. In addition to the previously described themes, it also encompasses obsessive fears of not loving one's partner or being in a relationship with the wrong person, writing inappropriate content in a letter or email, and recurring thoughts that question the nature of the self or reality (OCD Center of Los Angeles, 2012).

A meta-analysis conducted by Bloch et al. (2008) challenged the notion that obsessive thoughts classified as Pure O are independent of compulsions. It demonstrated that obsessive thoughts frequently co-occur with compulsive checking,

among other behaviours. In their factor analysis, Williams et al. (2011) demonstrated that the Pure O dimension is associated with compulsive mental rituals and reassurance-seeking behaviours.

At present, most specialists question the existence of obsessions in isolation from compulsions, arguing that obsessive thoughts without overt rituals are typically accompanied by covert compulsions or more subtle neutralising behaviours. In clinical literature, the term "Pure O" is increasingly being replaced by the designation "OCD with intrusive thoughts of unacceptable or taboo content". In the ICD-10 diagnostic classification, this condition is categorised as OCD with predominantly obsessional thoughts or ruminations, whereas in ICD-11 it has been incorporated into the general category of OCD (Gałecki and Szulc, 2023; Williams and Wetterneck, 2019; Williams et al., 2011). In the remainder of the article, the terms "Pure O", OCD with taboo thoughts, and "OCD with predominantly obsessional thoughts" are used interchangeably.

Patients suffering from OCD with taboo thoughts often experience difficulties in obtaining an accurate diagnosis. Glazier et al. (2013) demonstrated that mental health professionals are considerably more likely to assign incorrect diagnoses when presented with this type of obsession. The cited authors reported that this problem affects up to 77% of obsessions related to homosexuality and 42.9% of sexual obsessions, whereas contamination-related obsessions are misdiagnosed in only 15.8% of cases. From a diagnostic standpoint, obsessions involving aggressive impulses are particularly challenging, as they must be carefully differentiated from suicidal ideation and genuine intent to harm others (Kuhl Wochner, 2012).

Glazier et al. (2015) further found that patients with OCD with taboo thoughts are more likely to feel ashamed of their symptoms. They often fear stigmatisation and, in some cases, involuntary hospitalisation, which often requires implementing therapeutic strategies focused on reducing shame. The literature also reports of a more severe course of Pure O (Sibrava et al., 2011) and poorer therapeutic outcomes compared to other OCD patients, including longer treatment durations (Fisher and Wells, 2008; O'Connor et al., 2005; Williams et al., 2014). Furthermore, Krebs et al. (2021) found an increased risk of suicide among patients experiencing taboo thoughts, and Cervin et al. (2022) confirmed these findings, noting additionally that obsessive sexual and religious thoughts represent distinct risk factor for suicide.

COGNITIVE MODELS OF OBSESSIVE-COMPULSIVE DISORDER

The development of OCD is significantly shaped by cognitive beliefs and metacognitive processes. Over time, successive theoretical models explaining the origins of the disorder have elaborated upon earlier frameworks, consolidating existing knowledge regarding the cognitive mechanisms implicated in OCD development (see also Bryńska, 2007).

Rachman's cognitive model

One of the most influential concepts for the contemporary understanding of OCD is Rachman's (2003) notion of thought–action fusion (TAF). Individuals with OCD often believe that experiencing intrusive thoughts is morally equivalent to actually performing the unacceptable acts those thoughts involve. Furthermore, they may be convinced that merely thinking about a potential negative event increases its likelihood of occurring. According to Rachman (2003), intrusive thoughts become obsessions when the individual interprets them as meaningful and assigns them personal significance. Those affected by OCD frequently interpret the presence of intrusive thoughts as evidence that they are morally corrupt, evil, dangerous, or mentally unwell. Since obsessions cause considerable discomfort and psychological resistance, individuals feel compelled to neutralise, correct, counteract, or atone for them. These attempts at neutralisation (like compulsive behaviours) bring temporary relief. However, they also serve as a maintaining mechanism of the disorder by indirectly reinforcing faulty causal interpretations (Rachman, 2003).

Among the factors maintaining the disorder is the progressive broadening of situations perceived as threatening. This process occurs because obsessions are frequently triggered by external stimuli (e.g. a knife). A faulty, catastrophic interpretation of the intrusive thoughts that arise in such moments (e.g. "If I'm having these thoughts, it means I'm dangerous") leads to the assignment of threatening meaning also to otherwise neutral triggers (e.g. "Knives are dangerous because I might harm a child with one"). As a result, the number of triggers increases, and the frequency of obsessive thoughts rises. Another maintaining mechanism is emotional reasoning. When experiencing anxiety and tension in response to intrusive thoughts, patients conclude that a real threat must exist. Thus, the catastrophic interpretation of anxiety contributes to the catastrophic interpretation of the intrusion itself. Some patients may also interpret the persistence and frequency of intrusive thoughts as evidence of their importance and meaning. This interpretation may help explain the mechanism through which rare intrusions with absurd content are maintained (Rachman, 2003).

Wells and Matthews' metacognitive model

According to the model proposed by Wells and Matthews, two categories of beliefs play a fundamental role in the maintenance of OCD. The first includes three types of fusion that expand upon Rachman's (2003) concept of TAF, offering a broader and deeper framework. In addition to TAF (e.g. "Thinking about harming someone means I will do it"), Wells emphasises the importance of thought–event fusion (e.g. "Perverse thoughts will turn me into a deviant") and thought–object fusion (e.g. "My disgusting thoughts can contaminate objects"). Wells (2010) suggested that, at the metacognitive level, some individuals with OCD

 DOI: 10.15557/PiPK.2025.0027

operate within a mental model of experience that blurs the boundary between internal and external events. As a result, may be convinced that their obsessions accurately reflect reality. When metacognitive beliefs are activated in response to an intrusive thought, the thought is appraised as harmful, eliciting feelings of anxiety, disgust, guilt, or discomfort. These emotional reactions signal perceived danger and trigger the need to engage in a coping strategy (e.g. neutralisation).

Another key aspect in the development and maintenance of the disorder involves beliefs about the necessity of engaging in threat-control strategies (Fisher and Wells, 2008; Wells, 2010). Individuals with OCD believe that engaging in such behaviours is beneficial, and that refraining from them will lead to negative consequences, such as persistent anxiety. However, these coping strategies escalate psychological difficulties and maintain the disorder by preventing the re-evaluation of dysfunctional beliefs. Using them increases the frequency of intrusions due to three mechanisms: (1) intensification of obsessions resulting from attempts to suppress them; (2) sustained preoccupation with mental events, leading to an overestimation of internal experiences relative to external ones. This, in turn, undermines the patient's confidence in their memory, heightens doubt, and promotes checking behaviours; (3) expansion of stimuli associated with compulsions (Wells, 2010).

Although these general theoretical models do not differentiate between specific OCD subtypes, the mechanisms they propose help explain the emergence and persistence of obsessions. They also provide a foundation for developing more detailed models tailored to particular forms of obsessive content.

COGNITIVE BEHAVIOURAL THERAPY FOR OBSESSIVE-COMPULSIVE DISORDER WITH TABOO THOUGHTS

Given the diversity of obsessive thought content and the specific challenges faced by individuals experiencing them, an increasing number of researchers and clinicians advocate for tailoring therapeutic protocols to the particular OCD subtypes (Albińska, 2022; Williams et al., 2022).

Specificity of cognitive behavioural therapy in working with patients experiencing taboo thoughts

In cases of Pure O, therapeutic efforts are directed toward modifying catastrophic (pseudo-causal) interpretations of obsessive thoughts, encouraging more adaptive cognitive appraisals and fostering a more detached attitude toward them. A central role in therapy is played by cognitive techniques, which are supported by exposure tasks and behavioural experiments, alongside encouragement to abandon avoidance, concealment, thought suppression, internal debates, and neutralisation strategies (Rachman, 2003; Wells, 2010).

At the outset of the therapeutic process, it is crucial to conduct a comprehensive assessment to identify the content of intrusive thoughts and uncover mental compulsions. Shame commonly associated with taboo thoughts can make patients reluctant to reveal the content of their obsessions (Glazier et al., 2015; Williams et al., 2022). Moreover, patients may initially be unaware of the importance of disclosing mental compulsions to the therapist or may not recognise them as a symptom (Williams et al., 2011). Consequently, normalisation of symptoms plays a particularly important role. It alleviates feelings of shame and increases hope for the effectiveness of the therapeutic process. It may be helpful to use a questionnaire (e.g. assessing the prevalence of unwanted thoughts of specific content in the general population) or to read a pre-prepared list of themes found in "normal" intrusive thoughts. In some cases, it may be appropriate to cite examples of well-known and widely admired individuals suffering from OCD, with a view to highlighting that experiencing obsessive thoughts does not reflect a person's character (Rachman, 2003; Williams et al., 2022).

Since patients with Pure O often attempt to suppress intrusive thoughts, which paradoxically intensifies their symptoms, therapy should focus on reducing efforts to control thoughts in favour of accepting them. Rachman (2003) notes that reducing catastrophic interpretations of obsessions allows patients to abandon suppression attempts, which in turn decreases the frequency of obsessive thoughts. This effect can be achieved through Socratic dialogue combined with experiments/behavioural techniques that help patients independently recognise the detrimental impact of thought suppression.

Williams et al. (2022), drawing on empirical research, theoretical reviews, and their own clinical experience, developed detailed recommendations for adapting CBT to work with taboo thoughts. They propose modifications to OCD treatment protocols that include, among others, the use of techniques such as:

- exposure experiments designed to demonstrate to patients exhibiting TAF that their thoughts do not possess causal power;
- behavioural experiments involving the patient disclosing the content of their obsessive thoughts to trusted individuals (when such thoughts are concealed due to fear of rejection or stigmatisation);
- exercises for distinguishing anxiety about experiencing desire from genuine craving – by comparing the emotions felt while anticipating the fulfilment of a real desire (such as eating a favourite meal) with those accompanying obsessive thoughts (aimed at addressing anxiety related to engaging in desired behaviours):
- attentional experiments demonstrating the mechanism of heightened perception of stimuli that are given significance;
- association-splitting techniques aimed at deliberately disrupting existing connections within the patient's semantic network between words linked to their obsessions,

while intentionally forming new, positive associations (Williams et al., 2022).

Williams et al. (2022) proposed an adaptation of standard exposure and response prevention (ERP) therapy (see also Foa et al., 2016) to address the needs of patients struggling with taboo thoughts. The authors emphasise the importance of clearly explaining the rationale for exposure-based treatment to patients and clarifying the concept of habituation. A particularly valuable strategy in the treatment of Pure O may be imaginal exposures. This is because not all intrusive fears can be addressed through real-life exposure without posing a potential risk of harm to others (e.g. obsessions with sexual or blasphemous content). The script for imaginal exposure should be carefully developed in close collaboration between the patient and the therapist to ensure that it accurately represents the core anxiety-provoking themes. However, in therapeutic work with taboo thoughts imaginal exposure alone should not be relied upon whenever *in vivo* exposure is clinically appropriate. Williams et al. (2022) emphasise the effectiveness of *in vivo* exposures and the importance of planning them even for this group of patients (e.g. visiting a playground, an LGBTQ+ bar, a church, etc.).

Rachman (2003) reports that when working therapeutically with individuals experiencing taboo thoughts (particularly those involving harm to others), it is important to consider that this group often struggles with expressing anger. During therapy focused on obsessive content, cognitive reattribution may help the patient release feelings of guilt; however, this process may also uncover hostility toward others and feelings of anger. In such cases, it is advisable to expand the treatment plan by incorporating strategies that focus on uncovering the sources of the emotion and developing skills for safely expressing and managing anger.

Patients experiencing taboo thoughts may benefit from a metacognitive therapy protocol that emphasises restructuring dysfunctional beliefs related to rituals, checking, or neutralisation, and incorporates detached mindfulness exercises to reduce obsessive rumination. This protocol relies primarily on verbal reattribution techniques aimed at reducing beliefs that reflect thought–action fusion, as well as exposure with response prevention targeting the dismantling of beliefs about feared consequences associated with specific stimuli. A particularly important aspect of this approach is the identification of all neutralising strategies – including covert mental rituals – and the subsequent discontinuation of their use (Fisher and Wells, 2008; Wells, 2010).

An interesting alternative to classical exposure based on fear habituation is the model proposed by Craske et al. (2014), which employs techniques grounded in inhibitory learning. In this form of exposure, the primary goal is not simply to reduce anxiety during the session, but to disconfirm the client's negative expectations about how the exposure will unfold. After completing the exercise, it is important that the patient reflects on and articulates the discrepancy between the feared scenario and the actual course of the exposure. This process allows for the consolidation of new learning regarding the previously anxiety-provoking stimulus and the safety of the response. Craske et al. (2014) indicate that the treatment of obsessions may be particularly effective through deepened extinction. This approach involves simultaneous exposure to as many fear-associated stimuli as possible (following prior individual exposure to each one). Jacoby and Abramowitz (2016) suggest that in the case of taboo thoughts, disconfirming the patient's expectations during exposure sessions may be more difficult due to the long-term nature of the feared consequences or their unobservable character (e.g. "I'll go insane," "I'll go to hell"). In such cases, it is more effective to shift the focus of exposure away from the content of obsessive thoughts and toward the patient's response style (e.g. tolerating distress). However, the effectiveness of such modified exposure in treatment of individuals with Pure O remains to be empirically verified.

EFFECTIVENESS OF COGNITIVE BEHAVIOURAL THERAPY IN WORKING WITH PATIENTS EXPERIENCING OBSESSIONS WITHOUT OVERT COMPULSIONS

To date, few studies have examined the efficacy of CBT in patients suffering from OCD with taboo thoughts. O'Connor et al. demonstrated that individual CBT is significantly more effective for this group, resulting in a 68% reduction in symptom severity compared to a 38% reduction achieved through group therapy.

Williams et al. (2014), investigating the effectiveness of ERP therapy in a group of patients with OCD, found that it reduced symptom severity by approximately 43%. However, its efficacy was lower in the subgroup of patients with taboo thoughts (particularly among those experiencing religious/moral obsessions).

Research has also been conducted on the effectiveness of metacognitive therapy protocols in treating patients with OCD, including those with Pure O. Fisher and Wells (2008) demonstrated the considerable effectiveness of this method, producing comparable outcomes in patients presenting with both overt and covert compulsions. Andouz et al. (2012) also confirmed its efficacy in individuals with Pure O. However, it should be noted that both studies were conducted on very small patient cohorts.

CONCLUSIONS AND IMPLICATIONS FOR FUTURE RESEARCH

When working with patients who experience obsessions without overt compulsive behaviours, clinicians should exercise particular caution and implement a comprehensive diagnostic assessment. Most individuals with this clinical presentation exhibit certain – often subtle – neutralising behaviours aimed at counteracting their obsessions. Regardless of whether or not these behaviours can ultimately be identified, CBT provides patients with predominant

 DOI: 10.15557/PiPK.2025.0027

obsessive symptoms with therapeutic techniques designed to reduce the anxiety or discomfort associated with their experience.

The few studies conducted to date on the effectiveness of CBT in treating Pure O OCD confirm its overall efficacy, particularly in the context of individual therapy. However, caution is warranted when generalising conclusions from these studies, as they were typically conducted with very small sample sizes (particularly in research on the effectiveness of metacognitive therapy). It is also worth noting that none of these studies were carried out in Poland, despite the fact that taboo thoughts are a symptom partially shaped by cultural context. For example, Williams et al. (2017) report that obsessive concerns about sexual orientation occur mainly in the United States, where they are identified in approximately 10% of patients with OCD. To date, no comparable findings have been reported in European populations. The authors also highlight differences in the content of obsessive thoughts among followers of different religions. There is, therefore, a need to investigate the prevalence of taboo obsessions in the Polish population and to replicate studies on the effectiveness of therapeutic interventions specifically targeting them.

The specific content of taboo thoughts may pose challenges for less experienced therapists, particularly when constructing an appropriate exposure hierarchy or deciding on the form of planned exposure (imaginal vs. *in vivo*). In such cases, it is advisable to consult detailed treatment protocols or manuals addressing specific types of taboo thoughts, which have become increasingly available in recent years. For example, Abramowitz and Jacoby (2014) presented a model of scrupulosity that expands upon the issues discussed in this paper by incorporating the role of religious beliefs and intolerance of uncertainty in the development of this OCD subtype. Williams and Wetterneck (2019) developed a clinical manual focused on the diagnosis and treatment of sexually themed obsessions.

Conflict of interest

The author does not declare any financial or personal links with other persons or organizations that might adversely affect the content of the publication or claim any right to the publication.

Author contribution

Original concept; collection and/or compilation of data; writing of manuscript; critical review of manuscript; final approval of manuscript. MBK.

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