

Classification and Treatment of Obsessional Slowness

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Obsessional slowness is regarded as an uncommon but severely disabling variant of obsessive-compulsive disorder. This paper examines the psychopathology, classification, pathophysiology and treatment of obsessional slowness. It argues that primary obsessional slowness does not require classification as a separate syndrome because it can be found to be secondary to recognised phenomena of obsessive-compulsive disorder or anankastic personality disorder. The treatment described in the literature is not thought to be successful in the long term, and controlled trials are required to evaluate new strategies and antidepressant medication.

Rachman (1974) first described 10 cases of 'primary obsessional slowness', and that paper was later elaborated on in a book chapter (Rachman & Hodgson, 1980). The main feature described was a meticulous concern for orderliness in which a patient would take hours to carry out daily tasks of self-care such as washing, shaving, brushing his teeth or getting dressed. The term 'orderliness' refers to the way patients tended to have a fixed pattern of undertaking tasks in a precise and 'correct' sequence. A case history was provided of a man who spent hours shaving single hairs in a precise order. Similarly, brushing his teeth involved preparing the toothbrush and paste meticulously and placing it in a set position. Rachman (1974) acknowledged that obsessional slowness can be secondary to rituals, but wanted to draw attention to a new syndrome. He proposed the term 'primary obsessional slowness' because the activities concerned were not rituals – there was no reduction in anxiety or dysphoria before or after the activity. He noted in such patients the relative absence of obsessional thoughts, and suggested that one of the possible purposes of the slowness was that it prevented the development of obsessions. All the cases studied had an anankastic personality and their estimate of objective time was normal. The treatment programme described for such patients involved prompting, pacing, and shaping with regular reminders of the passage of time.

Since then, a number of cases of primary slowness have been reported, by Bilsbury & Morley (1979), Bennun (1980), Clark *et al* (1982), Marks (1987a), and Hymas *et al* (1991). For example, Clark *et al* (1982) described an adolescent male who was concerned with performing tasks in the "correct manner", his feared consequence being that he would make a mistake and thus feel compelled to recommence the sequence. Marks (1987a) noted that obsessional slowness mainly affects self-initiated

actions and does not affect automatic behaviour such as driving a car or playing squash, in which a patient is continually responding to ongoing cues.

The concept of primary obsessional slowness has been generally accepted in textbooks (Gelder *et al*, 1983), although an unsigned editorial in the *British Medical Journal* (1974) questioned the existence of a separate syndrome. Ratnasuriya *et al* (1991) have conducted a retrospective case survey of 665 patients with obsessive-compulsive disorder (OCD) who were referred to the Maudsley Hospital over 15 years and concluded that 22 (3.3%) had features of slowness. In all but one, they identified other features of avoidance behaviour, ruminations or rituals. They state that the sample should have included the 10 patients originally described by Rachman (1974) as having primary obsessional slowness, but they could not be identified. A retrospective study based on clinical notes has serious flaws as the clinicians did not examine each patient in a structured interview and it was not mandatory to record all the findings. Khanna *et al* (1990) have conducted the only study to date on the clustering of symptoms in OCD. They recruited 410 patients over a decade and found *no* patients with obsessional slowness.

The aim of this paper is to provide some structure to the phenomenology of obsessional slowness as a means to its further understanding and in the development of new treatment strategies.

Classification

This paper will not argue for the term 'obsessional slowness' to be discarded – it is an extremely apt description of the excessive time spent by such patients initiating and completing a range of activities. However, the concept of a separate syndrome of 'primary' obsessional slowness is unnecessary for four main reasons, outlined below.

Firstly, the phenomena in the cases of primary obsessional slowness can be reanalysed as secondary to recognised avoidance strategies or rituals. The psychopathology in the cases described by Rachman (1974), Bilsbury & Morley (1979), Bennun (1980), Clark *et al* (1982), and Marks (1987a) can be regarded in part as avoidance of disorder, unmeticulousness, and inexactness.

Secondly, the components of obsessional slowness are usually multiple (see cases reported by Bennun, 1980; Marks, 1987a) – the excessive time spent completing an activity is not just related to orderliness or meticulousness, but usually a wide range of strategies adopted by the patient. None of the components of obsessional slowness are mutually exclusive; they may interact with one another in a complex fashion. The various components of the slowness may be difficult to determine – patients may have difficulty in articulating the nature of their obsession or their feared consequences and may be reluctant to disclose them because of embarrassment or stigma. However, every effort should be made to complete a full behavioural analysis in order to determine a rational treatment strategy.

Thirdly, there are patients who are concerned about orderliness and meticulousness, but are not excessively slow. It is more logical to organise the classification around recognised phenomena of OCD than to single out the orderliness and meticulousness.

Fourthly, the separation of a syndrome within OCD requires some validation against either brain pathology or neuropsychology or multivariate analysis to delineate subgroups of symptoms. None of this has yet been done. Hodgson & Rachman (1977) have used the Maudsley Obsessive Compulsive questionnaire to assess the extent of different types of obsessive-compulsive symptoms, and slowness was one of the four components delineated (together with washing, checking, and doubting). However, the items on the questionnaire do not make it clear whether the slowness is primary or secondary to other phenomena.

The concept of obsessional slowness is therefore wider, and needs to be viewed as an indication of the severity of the disorder and handicap suffered by the patient. It is regarded as *secondary* to a number of different components which can be determined by a more detailed behavioural analysis. The concept assumes the exclusion of either severe psychomotor retardation of a major depressive disorder or a major learning disability – either of which could be confused with obsessional slowness or in the presence of obsessional slowness could complicate the presentation.

Each of the components of obsessional slowness will now be considered in more detail. The list

provides a testable hypothesis for a prospective study on the phenomenology of obsessional slowness and a checklist for a clinician as each of the components may require a different treatment strategy.

Avoidance strategies

In a standard behavioural analysis, avoidance prevents the occurrence of an obsession and the concomitant anxiety or dysphoria, and is therefore reinforcing. Overt avoidance behaviour can easily be recognised: patients use numerous strategies to prevent touching or being close to a perceived contaminant or to prevent the transfer of a contaminant from one object to another. All these avoidance strategies may contribute to the slowness. The avoidance of mainly disorder and unmeticulousness is the key feature identified by Rachman (1974) and in other case reports. Rachman noted that the orderliness and meticulousness were not rituals as their execution was not preceded or accompanied by any significant anxiety or dysphoria. Anxiety occurred in “four out of ten of the patients *when they were speeded up* by a prompter”. It is not known whether the other six patients were able to maintain the same order or exactness under the time pressure and thereby continue to avoid anxiety. The lack of any anxiety may also be related to an anankastic personality in which there is frequently very little emotional life. Turner & Beidel (1989) also describe a treatment programme which created significant anxiety in the patients with obsessional slowness. Slowness due to meticulousness or orderliness may therefore be a form of avoidance as it prevents the concomitant dysphoria and is used to ensure either:

- (a) that an activity is done in the ‘correct’ manner or done just ‘right’, or
- (b) that no part of a sequence is left out and that no mistakes are made thus necessitating having to start all over again.

The behaviour of such patients merges with the perfectionism, rigidity, and meticulousness found in anankastic personality disorder which will be discussed later.

It seems that while some of the activities are performed slowly because of the correct order and meticulousness – for example shaving hairs in an orderly sequence to make sure none are left out – they may also be repetitive, in the sense that some patients may in addition shave the same area over and over again to ensure they are clean-shaven and perfect. Similarly a patient may rinse out a basin meticulously to ensure there are no hairs left in the basin and end by repeating the sequence several times to ensure that

it is clean. Established rituals in OCD are sometimes used to prevent anxiety. It thus becomes a matter of semantics whether they are termed rituals or avoidance behaviour or both. However, the primary aim of such strategies seems to be the short-term prevention of dysphoria which has implications for behavioural treatments.

Patients may have difficulty in articulating their feared consequences and do not appear to report any automatic thoughts during the activity. For some patients, the cognitive schema or dysfunctional assumptions may be summarised as – “I must be perfect, thorough, exact, clean and tidy at all times or it will be absolutely terrible”. In such cases there may be a close association with social anxiety or phobia – the patient may fear being rejected or isolated because of the perceived criticism of others if he was unclean or imperfect. This may be an important component of any behavioural analysis and require additional treatment.

I have observed other examples of avoidance behaviour in which a significant component of the slowness involved the patient remaining motionless in order to prevent the aggravation of his obsessional thoughts.

Case one

The patient was a 65-year-old man with a 52-year history of OCD which had fluctuated over the years. His main problem was obsessional thoughts in which named members of his family were killed or injured. This resulted in anxiety and guilt as he felt responsible for their death. The thoughts could be triggered by certain movements of his limbs so the patient reported that he would “get stuck” in certain positions for up to 5 hours – if he moved it would aggravate the obsessional thoughts which he believed might injure a member of his family. On occasions he neutralised the thoughts by a number of covert rituals which consisted of making an image of himself being killed or by repeating the phrases “Stop it”, or “It’s me” 13 times (there were 13 members of his family).

Covert avoidance is more difficult to observe. This strategy may involve the patient distracting himself. It is sometimes described by patients as compartmentalising unacceptable thoughts in one part of one’s mind. It is similar to physical avoidance of an external contaminant in which certain contaminated areas are cordoned off. These strategies may require intense concentration and therefore much time to maintain them.

Rituals

In a behavioural analysis, rituals are repetitive actions which reduce anxiety or dysphoria and are

therefore reinforcing. An excessive length of time may be spent completing an activity because of an overt ritual such as washing, checking, or repeating which thus contributes to the slowness.

Covert rituals are more difficult to determine because they cannot be observed and are more difficult to treat as they are portable by the patient. Patients may attempt to suppress or neutralise their obsessional thoughts (similar to an overt cleaning ritual) – this may require intense concentration and can lead to slowness. It is illustrated in the following case vignette.

Case two

The patient was a 30-year-old single unemployed woman who had a 12-year history of OCD. She was a practising Christian and her main problem was of blasphemous thoughts about Jesus Christ and God. She experienced guilt whenever the thoughts occurred, and avoided specific rooms where she believed she might “contaminate” the room by depositing her thoughts. She was excessively slow in her self-care and would arrive up to two hours late for out-patient appointments. She would remain motionless for up to three hours in the bathroom trying to concentrate on “clearing out” or suppressing her obscene thoughts and talking over them. She also performed various overt rituals such as hand-washing and checking to neutralise the thoughts which contributed to the excessive time she spent on self-care.

Other covert rituals include mental checking as reported by Bennum (1980) in which a patient with obsessional slowness went over the previous performance of his overt rituals or ordinary actions in his mind. The author suggests that the rituals provided a guiding function. Alternatively, a patient may be mentally planning a future ritual in minute detail.

Lastly, patients may be slow because they repeat in their mind or count an act a set number of times in order to erase or neutralise the obsession. An example of this can be found in case one.

Anankastic personality disorder

The relationship between OCD and anankastic personality disorder (or, in DSM-III-R, obsessive-compulsive personality disorder (American Psychiatric Association, 1987)) is a complex one and frequently debated. Most psychiatrists would agree that the two disorders may coexist or occur separately. Some would regard OCD and anankastic personality disorder as on the same continuum of psychopathology but they are listed as separate disorders in DSM-III-R and ICD-9 (World Health Organization, 1978).

Mavissakalian *et al* (1985) have suggested the obsessional slowness might result from hypertrophic

obsessive-compulsive personality traits. Reed (1985) has collated 33 attributes of an anankastic personality which have been described in the literature. Some of the traits overlap but half of them might be regarded as components of slowness. They include accuracy, concentration, stress on trivial details, doubt, inconclusiveness, indecisiveness, meticulousness, orderliness, over-categorisation, patterning, perfectionism, perseveration, persistence, precision, rigidity, rules, symmetry, thoroughness, and tidiness.

The criteria for obsessive-compulsive personality disorder in DSM-III-R are more restrictive but the components of slowness may be associated with three out of the ten criteria:

- (a) perfectionism that interferes with task completion
- (b) preoccupation with details, rules, lists, order, organisation, or schedules to the extent that the major point of the activity is lost
- (c) indecisiveness: decision making is either avoided, postponed or protracted, e.g. the person cannot get an assignment done on time because of ruminating about priorities.

Indecisiveness and procrastination can be discerned in a number of the reported cases of slowness. For example Marks (1987a) describes a man who took five hours to bath in the morning – a significant component of this was the time he took to *decide* to have a bath. Sometimes anankastic personality disorder is the only diagnosis in the absence of any significant features of OCD, as shown in the following case.

Case three

The patient was a 36-year-old single man who was a mathematics graduate and employed to work three days a week as a computer programmer. His main problem, which was of 17 years' duration, was an inability to observe any time-keeping or meet any deadlines. He was ineffective in his job but would often 'work' through the night. His employers had been remarkably tolerant of his behaviour and were the main instigators of the referral. The major reason for his slowness was that he would spend much time motionless, 'pottering' or procrastinating over decisions such as having a bath. He would become preoccupied with minor details and fail to complete the main purpose of his activity. He would spend much time collecting sets of items, such as free quiz cards, and hoarded a number of worn out or worthless objects or papers. There was no evidence of any need for orderliness or meticulousness. He was not clinically depressed but was restricted in his ability to express any emotion. All his life he was pessimistic and had low self-esteem. He said he would contemplate suicide if his mother, on whom he was very dependent, should

die. He was difficult to motivate to comply with any behavioural programme.

Pathophysiology of obsessional slowness

There is some evidence that most patients with obsessional slowness are male (Sanavio & Vidotto, 1985; Ratnasuriya *et al*, 1991). This suggests a genetic or biological predisposition to the condition (Comings & Comings, 1986).

At present, the most likely pathophysiology for obsessional slowness is in the neuronal loops between the basal ganglia and the frontal lobe (Wise & Rapaport, 1989). Central to the hypothesis is the concept of innate motor programmes in the basal ganglia and that the basal ganglia function is, in part, a gating mechanism for sensory input. There are reported cases of obsessional slowness in which basal ganglia dysfunction is manifested clinically as a movement disorder. For example, the patient reported by Clark *et al* (1982) had "multiple tics, writhing neck movements and jerking actions of his upper limbs". The association with basal ganglia dysfunction has been studied by Hymas *et al* (1991) and discussed by Lees (1989). They studied 17 adult in-patients with OCD who were selected by a questionnaire as being excessively slow in their self-care and initiating goal-directed behaviour. It is worth noting that their diagnostic criteria of slowness are wider than Rachman's (1974) original concept of primary slowness. All the patients had a number of soft neurological signs including a delay in initiating limb movements, difficulty in switching from one motor programme to another, difficulty in carrying out two motor acts simultaneously, speech and gait abnormalities, and a general clumsiness and distractibility. Similar neurological findings have been documented in adult patients with OCD (but not selected as excessively slow) by Hollander *et al* (1990) and in adolescents by Denkla (1988). If obsessional slowness is a more severe variant of OCD then the neuropathological abnormalities may be more likely to show up in such patients.

Basal-ganglia dysfunction may be important in the pathophysiology of obsessional slowness because of the slowness of thinking (sometimes described as bradyphrenia). Bradykinesia (slowness in movement) is normally an important component of basal-ganglia disorders, such as Parkinson's disease, but it is not seen in OCD. The slowness in movement in OCD is highly selective and related to rituals or avoidance behaviour. Bradyphrenia has been reported to occur in the absence of bradykinesia in some basal ganglia disorders (Laplane *et al*, 1984). They describe three patients recovering from an encephalopathy of whom

two showed compulsive counting without anxiety. In all patients, computerised tomography scans showed bilateral lesions of the basal ganglia, mainly within the globus pallidus.

The term subcortical dementia has subsumed the old term bradyphrenia, which describes the syndrome of slowness of thinking, initiating any activity, poor attention, and difficulty in making decisions (Rogers, 1986; Lees, 1989). Deficits in thinking time have been documented on neuropsychological testing in Parkinson's disease (Morris *et al*, 1988) and in frontal lobe lesions (Owen *et al*, 1990). Further research is being conducted on whether similar deficits in thinking time also occur in OCD and in patients with obsessional slowness.

Treatment implications

Controlled trials of treatments for patients with obsessional slowness will be difficult to organise because such patients are uncommon and such a study would therefore require multicentre cooperation. Furthermore, it has been stressed that such patients are heterogeneous with a number of different components to their slowness, so that ideally the subjects would need to be a closely defined homogeneous group. For example, subjects for one trial would need to be defined as "Obsessional slowness primarily related to avoidance of disorder and imperfection".

At present, behavioural psychotherapy is the most common treatment described for patients with obsessional slowness. The patients described by Rachman (1974), Bilsbury & Morley (1979), Bennun (1980), and Clark *et al* (1982) were treated by a combination of pacing, prompting and modelling. Patients are given a time limit in which to complete each task which is gradually reduced. At first the therapist should be present to encourage and prompt the patient. Unlike other patients with OCD treated by behaviour therapy, they have more difficulty in completing the task on their own and do not tend to retain many gains at long-term follow-up (Clark *et al*, 1982; Marks, 1987*b*). This may be because the treatment has been directed at the slowness rather than the underlying avoidance and rituals. In OCD, avoidance behaviour is best treated by self-exposure and the rituals by response prevention until habituation has occurred (Rachman & Hodgson, 1980; Marks, 1987*c*). The prompting and pacing described by Rachman (1974) may be interfering with the avoidance behaviour or rituals but may not be the most efficient means of exposure. A more detailed behavioural analysis is therefore required of all the strategies used by the patient before

any behavioural treatment, to determine what the patient is avoiding.

In the cases described in the literature, a strategy of prompting, pacing and modelling may initially help because at the faster speed the patient is no longer able to maintain the desired order or exactness. However, such strategies are too difficult to maintain when the patient is on his own. In theory, the main strategy for patients with orderliness, exactness, or meticulousness would be repeated exposure to disorder, inexactness or unmeticulousness. The target times may be a useful outcome measure but are incidental to the task of exposure to disorder and unmeticulousness. This requires testing in a controlled trial.

Covert rituals or ruminations are more difficult to treat because they are portable and more difficult to control. The most promising treatment for ruminations has been exposure to obsessional thoughts by audiotaped feedback. The patient is instructed to record his obsessional thoughts on a loop tape and to listen to the tape continuously with a pair of headphones without performing any overt or covert rituals (Salkovskis & Kirk, 1990).

The principles of exposure can also be applied to individuals with an anankastic personality disorder. The nature of all personality disorders is very rigid schema or personal rules. Once convinced of the need for change, the most powerful way of changing schema is to act repeatedly against them. So perfectionism is overcome by 'exposure' to imperfection; indecisiveness by 'exposure' to making decisions – the therapist may need to be quite ingenious to negotiate suitable tasks that are not too difficult but can be repeated and are of sufficient therapeutic potency to change the schema. The difficulty in anankastic personality disorder (and in the approximately 25% of cases of OCD who refuse treatment or drop out) is persuading the patient to carry out exposure tasks – a detailed rationale of the principles of exposure will not suffice to motivate such patients to comply. Cognitive challenges that are based on logic or empiricism as an adjunct to exposure are also usually unhelpful. Challenges based on pragmatism may be more fruitful (e.g., focusing on the disadvantages and advantages of their behaviour in the short term and in the long term to themselves and to others, or asking "If you continue to believe this, where will this lead?"). There is more resistance to change in personality disorders and the therapy is likely to be lengthier (Beck & Freeman, 1990). Another complication in patients with anankastic personality disorder can be the lack of any emotional life. Whether habituation to dysphoria can still occur in such individuals is not known.

There is one case report of obsessional slowness and extensive rituals in a boy being treated by a serotonergic antidepressant (fluoxetine) (Hamlin *et al*, 1989). In general such drugs have only a modest benefit in some patients with OCD and have a higher rate of relapse than behaviour therapy on discontinuation of the drug (O'Sullivan & Marks, 1991). Future controlled trials of obsessional slowness will probably require a combination of behaviour therapy and antidepressants to be tested.

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