



PERGAMON

Behaviour Research and Therapy 40 (2002) 383–400

**BEHAVIOUR
RESEARCH AND
THERAPY**

www.elsevier.com/locate/brat

Over-valued ideas: a conceptual analysis

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Accepted 7 February 2001

Abstract

Over-valued ideas are truly a neglected area of psychopathology with few experimental studies published. There is a different emphasis in the USA and Europe regarding their definition. For authors in the USA an over-valued idea has become shorthand for ‘poor insight’ in the middle of a continuum of obsessional doubts to delusional certainty. Compared to negative thoughts, obsessions and delusions, they are often more resistant to any treatment. A better understanding of over-valued ideas is required if advances are to be made in therapy and for the development of appropriate measures to evaluate the efficacy of novel treatments. A cognitive behavioural model of over-valued ideas is presented which draws upon the philosophical distinction between beliefs and values. It is argued that over-valued ideas are associated with *idealised values*, which have developed into such an over-riding importance, that they totally define the ‘self’ or identity of the individual. Idealised values are also characterised by the *rigidity* with which they are held. Such patients are unable to adapt to different circumstances and ignore the consequences of acting on their value. This analysis leads to a discussion of predictions that can be tested and various strategies that can be used in cognitive behaviour therapy. © 2002 Elsevier Science Ltd. All rights reserved.

Keywords: Body dysmorphic disorder; Obsessive compulsive disorder; Cognitive behaviour therapy

1. Introduction

Over-valued ideas are an important but truly neglected area of psychopathology with few experimental studies. This paper explores over-valued ideas for several reasons. Firstly, there is a lack of agreement as to what precisely constitutes an over-valued idea. Consensus is required to facilitate research and the development of innovative therapies. Definitions of an over-valued

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idea also have relevance for the debate over classification of various disorders. For example Body Dysmorphic Disorder (BDD) has two variants, with or without a delusional disorder in DSMIV, or sub-types of Obsessive Compulsive Disorder (OCD), which is classified as with or without poor insight. Morbid jealousy is however only regarded as a delusional disorder with no room for non-delusional jealousy. Secondly, whereas negative thoughts, obsessions and delusions have been amenable to cognitive behaviour therapy or pharmacotherapy, over-valued ideas are one of the last frontiers in therapy. They are generally more resistant to change with any treatment. They are regarded as a poor prognostic indicator in OCD in most studies (Foa, 1979; Foa, Abramowitz, Franklin, & Kozak, 1999; Neziroglu, Stevens, Yaryura-Tobias, & McKay, 2001) but not all (Lelliott, Noshirvani, Basoglu, Marks, & Monteiro, 1988). Over-valued ideas dominate the clinical picture of anorexia nervosa or bulimia (Cooper & Fairburn, 1993), body dysmorphic disorder (Veale et al., 1996), the litigious paranoid state (Kraepelin, 1905), gender dysphoria (Huxley, Kenna, & Brandon, 1980) and apotemnophilia (Money, Jobaris, & Furth, 1977; Bruno, 1997; Fisher & Smith, 2000). Apotemnophilia is a rare disorder in which individuals believe that one or more limbs do not seem to belong to them. They are a different group to those who fantasise about amputation of a limb as a sexual fetish. Apotemnophilia has more similarities to gender identity disorder and is different to BDD, in which one or more limbs may be aesthetically displeasing and there is strong desire to change appearance. Over-valued ideas are also described in some patients with morbid jealousy (de Silva, 1997; Cobb, 1979), obsessive compulsive disorder (especially hoarding) (Steketee, Frost, Wincze, Greene, & Douglass, 2000), hypochondriasis (Salkovskis & Warwick, 1985) or pseudocyesis (Fennig, Chelban, Naisberg-Fennig, & Neumann, 1993). Patients with pseudocyesis believe themselves to be pregnant (when they are not). Women undergoing fertility treatment would rarely develop pseudocyesis but some place an enormous investment in the importance of children. Other women when unable to conceive or adopt a child, may become severely depressed and commit suicide. They may hold, strongly, beliefs about being a failure which could be regarded as an over-valued idea.

A better understanding of over-valued ideas is required if advances are to be made in cognitive behaviour therapy and for the development of appropriate measures to evaluate the efficacy of novel treatments. This article borrows ideas from philosophy and cognitive models of emotion to develop a model for an understanding of over-valued ideas and strategies for treatment.

2. Definitions

DSMIV describes the concept of an over-valued idea as “an unreasonable and sustained belief that is maintained with less than delusional intensity (i.e. the person is able to acknowledge the possibility that the belief may or may not be true). The belief is not of one that is ordinarily accepted by other members of the person’s culture or sub-culture” (American Psychiatric Association, 1994). The definition is echoed by a number of American authors (Hollander, 1993; Kozak & Foa, 1994; Neziroglu, McKay, Yaryura-Tobias, & Stevens, 1999; Phillips & McElroy, 1993) who emphasise the *strength* of a belief as one of the key criterion for an over-valued idea. The term ‘over-valued idea’ has thus become, for American authors, a shorthand for *poor insight* in the middle of a continuum of obsessional doubts to delusional certainty. In this continuum patients at one end of the continuum with obsessional doubts are regarded as having *good insight*

and those at other end of the spectrum with delusions have *no insight*. DSMIV adds one other criterion: that the belief is abnormal compared to other members of the person's culture.

The older European concept of an over-valued idea is, however, broader and emphasises a number of dimensions other than the strength of the belief and abnormality (Wernicke, 1900; Jaspers, 1959; Hamilton, 1974; McKenna, 1984). An over-valued idea was generally conceptualised by such authors as an isolated sustained belief, which are as follows:

- a. Is held *strongly*, with less than delusional intensity.
- b. Usually *preoccupies* the individual's mental life, compared to many delusions.
- c. Is *ego-syntonic*, compared to most obsessions.
- d. Often develops in an *abnormal personality*.
- e. Is usually *comprehensible* with knowledge of the individual's past experience and personality.
- f. The content is usually regarded as abnormal compared to the general population (but not bizarre as some delusions).
- g. Causes disturbed functioning or distress to the patient and others.
- h. Is associated with a *high degree of affect* (e.g. anxiety or anger when there is a threat to the loss of their goal or object of the belief).
- i. Compared to many delusions, is more likely to *lead to repeated action* which is considered as justified.
- j. Could progress to a delusion.
- k. Patients may not to seek help from mental health services but may be brought to the attention of the services by a concerned relative or another agency.
- l. Have some similarities to passionate religious or political convictions where the individual usually remains functional.

This does not mean that these criteria are a checklist for whether a belief is an over-valued idea or not. It describes how over-valued ideas were historically conceptualised and described by various European authors. It is therefore much broader than the more recent American definitions. An example of how an over-valued idea fits with the European description is in anorexia nervosa in which an underweight individual may believe she is too fat. Such patients may hold such beliefs with extreme tenacity but they are not considered delusional. This may however be the bias of a diagnostic system, which dictates that such beliefs cannot be delusional because anorexia nervosa is not a psychotic disorder. Such beliefs preoccupy the individual's mental life and can be described as ego-syntonic. Anorexia Nervosa often develops in an abnormal personality (especially obsessional, histrionic, and schizoid) (Smart, Beumont, & George, 1976), and is generally understandable with knowledge of the individual's past experience. The desire for slimness is not abnormal compared to the general population but the need for the degree of self-control is abnormal. There is a high degree of affect when the goals are threatened. Such beliefs cause impaired functioning with a high mortality and are a great distress to others. The belief is acted on repeatedly with further dieting and exercise to lose weight. A minority may progress to other delusions of schizophrenia (Hsu, Meltzer, & Crisp, 1981, 1983). Lastly it is the relatives of such patients who may force patients to seek help.

One could examine the typical beliefs of each of the disorders listed above to see how they

compare with European conceptualisation. However in this article, I wish to review progress since the reviews of McKenna (1984) or Kozak and Foa (1994), develop a cognitive model and consider strategies for therapy. In the past 20 years, there has been little experimental data to validate the clinical observations of the descriptive psychopathology. There has only been one study comparing the characteristics of delusions in schizophrenia with the over-valued ideas in anorexia nervosa and religious beliefs (Jones & Watson, 1997). They examined beliefs according to whether they were initial or derived beliefs. Initial beliefs were based principally on observation. They were defined as primary and immediate, stable, spontaneous and akin to 'I know' statements involving a high degree of certainty. Derived beliefs are secondary and formed by degrees, fluid, dependent upon a person's will, requiring introspection and imagination (with less input from perception), and held with varying levels of conviction. For example, the belief that democracy is a superior form of political organisation to oligarchy is a derived belief as it depends upon an abstract proposition that cannot be asserted solely on the basis of perception and conviction. Jones and Watson (1997) found that schizophrenic delusions were differentiated from anorectic over-valued ideas by a number of variables. Delusions exhibited qualities of an initial belief. The anorectic over-valued idea (such as 'I feel fat') although occasionally an initial belief in terms of its content was typically held in the form of a derived belief because it was rated as less truthful than a delusion. It also depended on the use of imagination, was slower to develop and required focused thought. This study helps us to refine some of the characteristics of an over-valued idea. In my analysis, I shall first consider the philosophical distinction between beliefs, values and evaluations and then relate this to over-valued ideas.

3. Normal beliefs and values

Philosophers have for many years distinguished beliefs and values and debated the relationship between the two (Hudson, 1970). A belief (or an inference) is something thought to be true because of observation or evidence. It can often be subjected to empirical testing or logic to derive facts, which tend to be objective and universally agreed. By contrast, a value is something thought to be good or important to an individual. Hence strongly held values are the principles on which one will not yield and are not subject to empirical testing. Normal values may be divided between those that are terminal (e.g. the importance of happiness) and those that are instrumental (e.g. the importance of being honest). Values (like beliefs) are on a continuum in terms of the degree of importance attached. Some values might be viewed as extreme (e.g. those values held by a racist organisation or an orthodox religious group) but they are not classified as a mental disorder.

Evaluations (or attitudes) are associated with values. They are a rating of an event or person on a scale of good and bad. In comparison to beliefs, values or evaluations are not subject to empirical testing. They are more difficult to measure or challenge because they are subjective and personal. Sometimes beliefs are influenced by a value. For example, beliefs about the risk of HIV and sexual behaviours are influenced by values regarding excitement and stimulation (Chernoff & Davidson, 1999). The reverse may also occur, in which values are influenced by beliefs. For example, a belief that there has been an increase in the incidence or severity of HIV infection may increase values about the importance of caution, restraint or self-discipline. The

division between beliefs and values is often confused and has had little impact on psychiatry or psychotherapies. They are however like two sides of a coin. They are a neglected distinction in descriptive psychopathology and may be important in the development of innovative therapies.

4. Abnormal beliefs

In abnormal mental states, the inference goes beyond the data available in the development of negative thoughts or delusions. Delusions are based upon beliefs that may arise ‘out of the blue’ or more usually are a misinterpretation of an abnormal perception. They are regarded as absolutely true and are conceptualised as on a continuum with normal beliefs and considered to be multi-dimensional (Peters, Joseph, & Garety, 1999). Most negative or catastrophic thoughts in depression and anxiety disorders are ‘beliefs’. The estimates of the probability of the feared consequences in various anxiety disorders are derived from such beliefs. For example, a patient with panic disorder may misinterpret the sensation of feeling dizzy with the belief that he is likely to collapse (Clark et al., 1997). The strength of such beliefs tends to be state dependent. Obsessions are also beliefs, which are based on the abnormal interpretation of a normal intrusive thought or urge usually with the added dimension of an over-inflated sense of responsibility (Salkovskis, 1999).

Beliefs are thus conceptualised as having a spectrum of conviction from an obsessional doubt to delusional conviction with over-valued ideas being held with less than delusional certainty (Phillips, Kim, & Hudson, 1995). Defining an over-valued idea as a belief being held with less conviction than a delusion is at first attractive but it ignores the multi-dimensional aspects of an over-valued idea described by the European psychopathologists. It ignores the experimental data that highlight the role of imagination and introspection over time, the association with affect and the likelihood of repeated action.

5. Abnormal evaluations

In abnormal mental states, the evaluations are more extreme than normal ratings on a continuum of good or bad (or some variant such as awfulness or evilness). Fulford (1991) has described ‘evaluative delusions’ which are usually associated with an affective disorder. Here the judgement of good or bad is so extreme that it defies credibility. An example, is a depressed man, who, because he had forgotten to give his children their pocket money (a fact), believed that he was a deeply wicked sinner (an evaluation of himself). Frequently both beliefs and evaluations occur together. They are two sides of a coin although more attention is often paid to one rather than the other. For example, the patient with panic disorder, who *believes* that feeling dizzy means that he will collapse, might *evaluate* the cost of collapsing as ‘absolutely terrible’. Traditional cognitive therapy has emphasised the role of *beliefs* and collaborative empiricism in collecting evidence for and against a belief by Socratic dialogue (e.g. the belief that dizziness would mean collapsing) and behavioural experiments to test out the belief. Rational Emotive Behaviour Therapy (REBT) draws a greater theoretical distinction between a belief and an evaluation (Wessler & Wessler, 1980). The emphasis in REBT is on helping patients to dispute the evaluation of a belief.

Hence in the above example a patient might be helped to challenge the evaluation of collapsing as ‘absolutely terrible’ with a goal of rating it on a continuum as, e.g. very unpleasant but not the end of the world. Cognitive therapists may also ‘decatastrophise’ the evaluation of a belief without necessarily making the theoretical distinction between the two. There has never however been a controlled trial to determine whether challenging beliefs or evaluations is more effective in different disorders. The key issue at least in anxiety disorders is probably whether a patient will test out or strengthen their alternative belief or evaluation repeatedly in a series of behavioural experiments.

REBT also distinguishes between the evaluation of an event or ‘it’ being rated on a continuum of ‘good’ to ‘bad’ as opposed to the ‘self’ being rated on the same continuum (Wessler, 1988). This is described as the thinking error of ‘personalisation’ in cognitive theory (Beck, 1967) and may be questioned by the use of logic. Thus in both cognitive therapy and REBT, rating an event will tend to be associated with healthy emotions and behaviours whereas rating the self is related to dysfunctional emotions and behaviours. For example, if a person evaluates his girlfriend leaving him as a failure in their relationship and an unfortunate event, then he is likely to have a normal feeling of sadness. However if he personalises and evaluates *himself* as a failure and unfortunate wretch, then he is likely to feel depressed and hurt and to act by withdrawal and isolation.

6. Abnormal values

The *values* that exist in an abnormal mental state are not usually described in psychopathology or cognitive theories but are related to evaluations. Cognitive theories usually describe *values* in the form of rules or demands (e.g. “I must be accepted by everyone all the time”). This rule would be related to valuing the importance of social acceptance.

I propose that over-valued ideas are *beliefs* that are associated with specific *values*, which have become dominant and idealised. In addition, I will argue that the value has become excessively identified with the self. In order to differentiate a value from a belief, I will continue with the common usage of the term ‘over-valued idea’ to refer to the *belief* that is held with less than delusional conviction and that usually preoccupies an individual’s mental life (e.g. “I feel fat” in anorexia). I will use the term ‘idealised value’ to refer to the *value* that has become dominant and excessively identified with the self (e.g. the importance of self-control in anorexia).

7. Identification of the value with the self

The first characteristic of an over-valued idea is the excessive identification of the value with the self or the ‘personal domain’. The term, personal domain, was first used by Beck (1976) to describe the way a person attaches meaning to events or objects around them. At the centre of a personal domain are a person’s characteristics, his physical attributes, his goals and values. Clustered around are the animate and inanimate objects in which he has an investment such as his family, friends, and possessions. An idealised value occurs when one of the values develops into such over-riding importance that it defines the ‘self’ or identity of the individual or becomes at the centre of a personal domain. This has been described in chronic anorexia nervosa, when a

patient defines her identity in terms of her anorexia nervosa (Garner, Vitousek, & Pike, 1997). One could also describe the self in terms of a restricting and ascetic object. The thinking error is similar to that described for personalisation in which the value has over-generalised from one aspect to (almost) the whole of the self. Other values that have become idealised in various disorders with the way the self is processed are listed in Table 1.

8. Self as an ‘object’

The term ‘object’ as in the self as a social ‘object’ in social phobia (Clark & Wells, 1995) or the self as an aesthetic ‘object’ in BDD was first used in the psychodynamic sense by Freud. Others developed it as shorthand in object relations theory for the transformation of inter-personal relationships into the internalised representations of relationships. I have used the term in the more narrow meaning of Clark and Wells (1995) in the way a person views himself from a particular spatial perspective (that is outside the self as an observer) which is more likely to occur in social phobia than healthy controls (Hackmann, Surawy, & Clark, 1998; Hackmann, Clark, & McManus, 2000). I am proposing that many of the disorders with over-valued ideas have similar recurrent images with a perspective of the self as an observer but this will need to be tested empirically.

Closely related to ‘self as an object’, but confusingly similar is the ‘object mode’ of information processing (Wells, 2000). Wells (2000) has described this as part of the Self-Regulatory Executive Function (S-REF) model, which is a framework for understanding cognitions and information processing in various mental disorders. It is based on three interacting levels of cognition which consist of: (1) A stimulus driven lower level network of processing units which function outside of conscious awareness, and the products which may intrude into consciousness. Processing at this level is not highly dependent upon cognitive resources and is largely reflexive. (2) A level of on-line processing, which is involved in the conscious appraisal of events and the control of thoughts and actions. This is dependent on attentional resources for execution of processing and its activities are amenable to varying degrees of conscious awareness or voluntary control. (3) A store of self-knowledge (beliefs) in long-term memory, for which online processing is dependent upon for its execution to guide it. These three different levels support at least two ‘modes’ of information processing, the ‘object mode’ and the ‘meta-cognitive mode’. (In this context, mode refers to the perspective the individual has with respect to his thoughts and beliefs.) When in object mode, appraisals are taken as unevaluated and accurate representations of the self or events and have to be acted upon. The goal here is to eliminate threat and execute threat reducing behaviours (e.g. worry). This is the default mode of routine cognitive operations. When in meta-cognitive mode, the individual is distanced from thought, and thoughts and perceptions can be appraised and not necessarily accepted as direct representations of reality. Here, the goals are to modify thinking and execute meta-cognitive behaviours (e.g. redirect attention). The meta-cognitive mode is diminished in mental disorders but those with idealised values appear to have extra difficulty in switching to this meta-cognitive mode.

Normal cognitive processing involves complexity and flexibility in implicit views of the self. For example, I might view myself as a psychiatrist or teacher when I go to work, as a father when I return home, as a biological object when I consult my doctor about a serious illness and

Table 1
Disorders and associated idealised values, processing of self and typical beliefs

Disorder	Idealised value(s) ("The importance of...")	Processing of self	Typical beliefs (over-valued idea)
Anorexia nervosa	Self-control (especially of weight and shape), and in some patients of perfectionism and asceticism (Fairburn et al., 1999, p. 142)	Self as an anorexic (Garner et al., 1997, p. 146) or restricting and ascetic object	"I feel I'm fat"
Apotemnophilia	Disabled body	Self as a deformed object in which one or more limbs have become surplus to requirements and externalised	"My limb does not belong to me. I need to be amputated to be comfortable"
Body Dysmorphic Disorder	Appearance (and in some patients) perfectionism and being socially accepted)	Self as an aesthetic object (and social object in social situations)	"My nose is crooked and ugly"
Gender dysphoria	Correct gender	Self as a deformed object in which the sexual characteristics are externalised	"I feel I am the wrong sex"
Hypochondriasis	Health	Self as a vulnerable or flawed biological object (Salkovskis, personal communication)	"I think I have cancer of the throat"
Obsessive Compulsive Hoarding	Possessions	Self as a custodian or caretaker in which one's possessions are at the centre of his/her personal domain	"I think my jewellery is lost"
Obsessive Compulsive Disorder (order)	Order, symmetry, precision, meticulousness	Self as a living machine (Reich, 1945, p. 167)	The ornaments must be placed "just so"
Obsessive Compulsive Disorder	Prevention of harm	Self as a pivotal agent for preventing or causing harm (Salkovskis, 1999, p. 170)	
Morbid jealousy	Fidelity	Self as small in which one's partner is at the centre of his/her personal domain	"I think my wife is having an affair"
Litigious paranoid state	Justice, fairness, security	Self as a campaigner at war with those defrauding or conspiring against him/her	"The insurance company owes me thousands of pounds in compensation"
Pseudocyesis	Children	Self as a biological object in which children are at the centre of one's personal domain	"I feel pregnant"
Social phobia	Social acceptance	Self as a social object (Clark and Wells, 1995, p. 137)	"They think I'm stupid and worthless"

so on. There is complexity and flexibility in the views of my self, which are not associated with any particular view. Idealised values are associated with a view of the self that is identified with specific values. For example, in compulsive hoarding, the individual's possessions have become of paramount value and importance to the self. In this regard, a patient described to me his possessions were like a shell on his back and not surprisingly had great difficulty in throwing away part of 'himself'. Another example is in morbid jealousy in which the patient might define a large part of his identity by his partner. He demands that his partner has to be the most important part of his life and she may be regarded as part of his 'self'. Hence the enormous investment in the threat of losing part of one's self. This conceptualisation has not been highlighted in previous cognitive models of jealousy (Bishay, Tarrier, Dolan, Beckett, & Harwood, 1996). Further research will be required to determine if the same processing of the self occurs in all types of morbid jealousy or whether it depends upon the strength of the belief and severity of the disorder (e.g. only in delusional disorder) (Cobb, 1979). In other disorders, such as apotemnophilia or gender dysphoria, a part of the body (e.g. a limb or the sexual characteristics) appears to have become externalised or placed far away from the centre of the personal domain and no longer as part of their self. Hence there is enormous investment in getting rid of that part of their body.

9. Rigidity of an idealised value

A second characteristic of idealised values is the *rigidity* with which they are held. This is different from the conviction of an over-valued idea (the *belief*) that is described as being held extremely *strongly*. The emphasis on an idealised value is inflexibility. Such patients are unable to adapt to different circumstances and ignore the consequences of acting on their value. Thus if the low weight and starvation diet threatens the health or survival of a patient with anorexia nervosa, the person fails to adapt her value of the importance of self-control and continues in the same starvation diet. In this regard, Ramsay, Ward, Treasure, and Russell (1999) found few differences between being compulsorily detained compared to voluntary patients with anorexia nervosa except an increased death rate (10 out of 79 compulsorily detained patients versus 2 out of 78 voluntary patients) a mean of 5.7 years after admission. One retrospective hypothesis is that the importance of self-control to the patients was held more rigidly in the compulsorily detained group at admission and that this persisted long after discharge.

10. Abnormal values in different disorders

Some values (such as perfectionism) might cut across several disorders (e.g. in some patients with anorexia nervosa, OCD or BDD). Also patients with the same disorder may hold variants of the same value. For example, for BDD patients who value the importance of appearance, some may value perfection or symmetry. Others may value more the importance of social acceptance and desire for a 'normal' appearance that allows them to blend in with others.

Values are likely to be multi-dimensional and the exact characteristics will depend on the disorder and individual concerned. Idealised values can also occur in sub-types of other conditions such as OCD or paranoid states. It is thus important to define the form and content of the idealised

values in these sub-types and how they may be differentiated from those without an idealised value (or where it is held less rigidly). For example, there are a group of patients, especially in OCD and hypochondriasis, who hold over-valued ideas with near certainty about causing harm to themselves or others (Salkovskis & Warwick, 1985). The value, namely the desirable end state of health in hypochondriasis, is not abnormal compared to the general population but the *degree of importance* attached to the value and *the degree of identification* with the self has become abnormal. Interestingly, hypochondriacal patients as a whole do not differ in healthy behaviours (e.g. the frequency of exercising, not smoking or eating healthily) from other patients, but there may be a sub-type of hypochondriacal or chronic fatigue patients who value health excessively. They might hold *beliefs* such as suffering from ‘total allergy syndrome’ which has taken over their identity.

There is a sub-type of OCD patients preoccupied with order, symmetry and precision who believe that they have to have things ‘just so’, ‘complete’, or never make a mistake. They are sometimes associated with obsessional slowness (Rachman & Hodgson, 1980; Veale, 1993). Hoarding and order or symmetry has also been identified as sub-type of OCD on a principal component analysis and associated with obsessive–compulsive personality disorder and tics (Baer, 1994). They are often associated with discontent or irritation rather than excessive anxiety. They usually do not articulate any feared consequences or beliefs (such as causing harm) but the values about the importance of order and precision can become a dominant aspect of their identity.

Table 1 also includes social phobia, which is not normally associated with over-valued ideas. However, patients at the severe end of the spectrum of social phobia often have beliefs with near delusional certainty about what others are thinking and this may sometimes be misdiagnosed as paranoid psychosis. Sometimes other ‘normal’ values such as the importance of having children or achievement may dominate the identity of the individual. When such an individual fails to achieve a cherished value (e.g. if a woman does not get pregnant after repeated infertility treatments or an individual fails an exam), then they may become severely depressed and suicidal. Such beliefs may be held extremely strongly and regarded as over-valued ideas. This also raises questions about the diagnostic criteria of various personality disorders, which are normally defined by behaviour. One issue may be whether some personality disorders should also be defined by the values that have become dominant. This was partly attempted by Beck and Freeman (1990) or Young (1990) in their approach to defining ‘schemas’ in various personality disorders which are a mixture of beliefs, assumptions, rules and values.

This analysis of idealised values leads to a number of predictions that can be empirically tested:

1. Where an idealised value is present, the strength of the conviction in a belief should be correlated with the rigidity of the value and the degree of identification with the self. Thus the greater the identification of the value with the self, then the greater the likelihood of a delusional belief. However, not *all* delusional beliefs are associated with idealised values — e.g. some OCD patients hold delusional beliefs which are bizarre in content and have no recognisable values associated with their beliefs (O’Dwyer & Marks, 2000; Insel & Akiskal, 1986).
2. The strength of a belief may fluctuate more compared to an idealised value, which is more stable. For example the strength of belief for a patient with BDD might increase if his mood deteriorates and he confronts a mirror for several hours and focuses his attention on his internal body image. Similarly the strength of the belief may subside if the person’s mood has improved

and is not focused on his body image. In such situations, the rigidity of the *values* about the importance of appearance may remain stable or not fluctuate as much as the strength of the *beliefs*.

3. Patients who hold an idealised value after a treatment that reduces the strength of the belief (but whose values remain rigid) are more likely to relapse than those patients whose values have become more flexible and less identified with the self. The direction of permanent change may also be important if the values diminish before the belief. For example a patient with litigious paranoia may after treatment still believe he is being swindled but decide that his values about justice and fairness were no longer so important.

4. The absence of an idealised value will preclude the development of a disorder or make it considerably less dysfunctional. A person can believe he is ugly or that his nose is big and crooked but the absence of a value about the importance of appearance would exclude the development of BDD. For example, a well-known female politician in the UK has said publicly that she views herself as ugly, but believes that appearance to be an irrelevant and unimportant value (Gerrard, 1999). This approach is likely to be an important means of coping in those who are facially disfigured and viewed as ugly. They are likely to have adapted well if they believe that appearance was not their most important value or means of defining their identity and have other positive attributes. Such patients may still be anxious about others teasing them publicly but are far less dysfunctional compared to a patient with BDD who has an idealised value about the importance of appearance and an internal aversion to their self.

11. Diagnostic issues

I have argued that the abnormal beliefs are of secondary importance to the idealised value. At present the diagnostic classifications only focus on *beliefs*. For example, in BDD, I have argued that the idealised value (the importance of appearance) is crucial for the beliefs about appearance to have any significance (e.g. that one's 'nose looks crooked and too red'). In some cases, the belief may be held with poor insight (an over-valued idea) and in others no insight (delusional). DSMIV classifies BDD on the strength of such beliefs as to whether there is an additional (or in ICD10, an alternative) diagnosis of a delusional disorder. This classification is illogical. Phillips, McElroy, Keck, Hudson, and Pope (1994) found no difference in the characteristics between delusional and non-delusional BDD patients and both groups may respond equally well to an SSRI (Phillips, Dwight, & McElroy, 1998). Furthermore, patients are not just disturbed by what their appearance is, but also by what it is *not* or what it should be. I would therefore argue that the strength of the belief in appearance is therefore merely an indicator of the severity of the disorder and there is little justification for adding another diagnosis of delusional disorder. If this logic were applied to the other disorders with over-valued ideas, then they would virtually all require a delusional variant depending on the strength of the belief. It is also questionable if in disorders such as BDD or anorexia nervosa, whether body image (an experience with visual, verbal and somato-sensory components) can be represented solely as a *belief* (Ben-Tovim, 1998). What is of more importance in such disorders is the identification of the idealised values with the self and the rigidity with which they are held. This might be a more logical means of classification!

12. Measurement of over-valued ideas

Three scales have been developed for the measurement of over-valued ideas. Eisen et al. (1998) have developed the Brown Assessment of Beliefs Scale (BABS) which has a number of dimensions including the degree of conviction, perception of other's views of beliefs, explanation of differing views, the fixity of the belief, attempts to disprove the belief and insight concerning the belief. The scale was designed not to be content specific and to cover a range of disorders. As previously discussed, they conceptualise beliefs on a continuum of insight that ranges from good insight to *poor insight* (over-valued ideas) and *no insight* (delusional thinking). Over-valued ideas occur when the patient acknowledges the possibility that the belief may or may not be true. However factual accuracy or truthfulness is not an issue for values as it is an emotional and subjective judgement.

Neziroglu, McKay, Yaryura-Tobias, and Stevens (1999) have also developed an over-valued idea scale which is more specific for beliefs in OCD. There is some over-lap between this scale and the BABS as both measure similar dimensions. Lastly, Foa et al. (1995) have described a "Fixity of beliefs" questionnaire which assesses the degree to which OCD patients recognise their obsessions and compulsions to be unreasonable. None of these scales have face validity for measuring values for which a different approach is required.

13. Measurement of idealised values

Instruments for the measurement of normal values exist (Rokeach, 1973) in which respondents are asked to rate the importance of a list of values such as 'happiness' or 'health'. However most of the values such as the importance of appearance or possessions listed in Table 1 are not included in such questionnaires as they are generally regarded as 'abnormal'.

The measurement of idealised values across various disorders is currently under development by the author and may be important for evaluating efficacy of innovative therapies. The three dimensions in the measurement of idealised values are the degree of importance attached to the value, the rigidity with which it is held and the strength of identification with the self. An underlying assumption in the degree of importance attached is that values are finite and if enormous importance and mental energy is attached to one value then it will influence the importance attached to other 'normal' values such as 'happiness' or 'family security.'

The rigidity of a value can be measured by the degree to which it causes functional handicap. We normally conceptualise the functional handicap of a disorder by the degree to which it interferes in occupational, social or other important areas of functioning. In measuring idealised values, we can measure the degree to which a patient is prepared to risk or sacrifice certain domains in his life such as his or her occupation, savings, health or relationships in pursuit of their value. When severe, it may be measured by the degree to which a patient is prepared to end their life or murder others if they cannot obtain their goal. For example a patient with obsessive-compulsive hoarding defined her identity through her possessions. She was virtually housebound, as she had to guard her possessions. She would not allow anyone into her flat and spent the day checking her memory whether anything was lost. She had completely cut herself off from all relationships and friends. The flat was regarded as a fire hazard but she said that if her flat were to catch fire,

she would stay with her possessions rather than escape and be left with nothing of her 'self'. In another example of severe morbid jealousy, a patient may murder his partner if he believes he will lose her.

An example of a patient with a less rigid idealised value is a man with a litigious paranoid state who pursued an insurance company that he believed had acted unfairly and defrauded him. He risked his home and savings in legal fees, separation from his wife and isolation from his children in pursuit of his claims. He stressed the importance of fairness and justice above all values. He justified the loss of his family, as he believed he would eventually win his case and his children would benefit from his compensation. After hospitalisation as an involuntary patient and substantial pressure from his family, he agreed to give up the court case (although it remains to be seen whether this is only temporary). His family made a condition of him returning that he dropped the case.

14. Treatment of idealised values

Patients with rigid idealised value do not always seek help from mental health services. They may be pursuing inappropriate help from other agencies (e.g. the courts, cosmetic surgeons, and social services) and then be brought to the attention of the mental health services by concerned relatives or another agency. Such patients often do not view themselves as suffering from a mental disorder and may become angry and frustrated with clinicians that do not help them pursue their goals. The one exception to this appears to be gender dysphoria or apotemnophilia in which patients are helped to pursue their goal of changing sex or having a limb amputated. Although in gender dysphoria a lot of effort is made to determine whether a patient is serious about wanting to change sex, no attempt is made to question the value of being the right sex to the person's identity or to re-integrate the person's body back into the self. A similar situation may exist with apotemnophilia in which the desire to be disabled has led their body to be an externalised part of the self and in which amputation might have benefit.

Engagement and motivational interviewing is therefore crucial before any therapy for idealised values. The focus on motivational interviewing is on the functional disability of their value and the potential benefits of an alternative and less rigid value. Paradoxically, those patients who have to seek help because they want to keep their partner or family or occupation may in fact have a better prognosis. This is not usually the case for disorders where success is more dependent upon the individual 'wanting' to change rather than being pressured by others. Hence, those patients with idealised values who have no spouse or family, or are who financially comfortable are more likely to drop out of treatment, as the motivation to change appears less and they can adapt their life to suit their values (so long as it does not interfere with society).

15. Pharmacotherapy for over-valued ideas

There is a paucity of randomised controlled trials in either pharmacotherapy or psychotherapy in disorders with over-valued ideas. Many of the disorders are associated with an affective disorder and there is some evidence that serotonin reuptake inhibitors (SRI) have a superior efficacy com-

pared to noradrenergic reuptake inhibitors in BDD (Hollander et al., 1999). Benefits of a SRI are described in open trials in refractory anorexia nervosa (Gwirtsam, Guze, & Yager, 1990; Kaye, Weltzin, & Hsu, 1991) and morbid jealousy (Gross, 1991). A review of SRIs and behaviour therapy in OCD suggested that SRIs may be more effective in reducing over-valued ideation (Abel, 1993). However, these studies did not use a reliable measure of over-valued ideas. It is not known what effect SRIs have on idealised values or whether relapse is more likely to occur in those patients whose values have not altered. There are no RCTs comparing a SRI against an anti-psychotic drug although the latter are still often used for disorders with over-valued ideas because the strength of a patient's belief is mistakenly viewed as a delusion. However anti-psychotics are not helpful when prescribed alone in disorders such as anorexia nervosa or BDD (Phillips et al., 1994). The strong association between depression and over-valued ideas and anxiety disorders would suggest that SRIs are the first line of pharmacological treatment but this needs to be evaluated in RCTs.

16. Cognitive behaviour therapy

For cognitive behavioural therapies, this analysis of over-valued ideas would suggest that it is important to identify the idealised value and the importance to the person's identity. Patient formulations require a more sophisticated conceptualisation that too often begins with a view of the self as 'worthless' without really identifying the values that are important to the individual.

Patients should therefore have a clear formulation of their problem and agreed goals, which should include an alternative value that is more adaptive or flexible and not identified with the self. It is hypothesised that cognitive behaviour therapy will be more effective in treating an over-valued idea if it targets for change the associated value rather than the beliefs. In my experience, helping a patient to first identify the value and then question the disadvantages or functionality of the value compared to an alternative (as in motivational interviewing) is initially the most effective strategy. It is also important to emphasise that idealised values (in comparison to beliefs) can usually only be reduced in small degrees over time. Motivational interviewing has been described as an important component of treating anorexia nervosa, in which the clinician helps the patient to focus on the disadvantages and consequences of their restrictive diet and to externalise their anorexic values so that is no longer identified with the self (Treasure & Ward, 1997).

Patients with obsessional hoarding, have similar difficulties in losing a major part of their 'self' which has become their dominant value. The fundamental thinking error in an idealised value is over-generalisation in which a patient identifies his 'self' with the value and all the other aspects of their identity are diminished. In this regard, a patient may be helped questioning the logic of their position. This is described in the concept of 'Big I' and 'Little i's' whereby the self or 'Big I' is defined by thousands of 'Little i's' in the form of other identities, values, likes and dislikes, and characteristics since they were born (Lazarus, 1977; Dryden, 1998). The patient is encouraged to focus on all the other functional values and identities to develop a more flexible and complex view of his self.

In some disorders such as apotemnophilia or gender dysphoria, one of the 'Little i's' (parts of the body) may have become externalised or farther from the personal domain. In theory, strategies are required to re-integrate the parts of the body back in to the self. In cases of morbid jealousy

or obsessional hoarding, one of the ‘Little i’s’ (one’s partner or possessions) may need to become less close to the centre of the personal domain so that healthy boundaries can be formed with one’s partner or possessions. Reverse role-play or two chair techniques (Greenberg, 1979) can be used to strengthen an alternative value in which the patient can practice arguing the case for an alternative value whilst the therapist (or the patient in two-chair techniques) sitting in another chair argues the case for their idealised value. Newell and Shrubbs (1994) have described reverse role-play for BDD patients although the content of their role-play is on the *beliefs* about their appearance rather than the *values* about the importance of appearance.

I have argued that it is more effective to target the idealised values for change in over-valued ideas and to question: (a) the functionality of the value; and (b) the logic of identification of the value with the self. By contrast, Salkovskis, Forrester, Richards, and Morrison (1998) argue that there is no difference in approach to helping patients with over-valued ideas in OCD compared to other obsessions. That is the therapist works collaboratively with a patient to ascertain the evidential or historical basis for the *beliefs* and then evaluates the evidence for these beliefs against more realistic alternatives. However this is not generally accepted in other disorders such as anorexia nervosa or body dysmorphic disorder where it is regarded as unhelpful to question beliefs such as being too fat or defective. I have argued that these beliefs are related to a failure to achieve an unrealistic standard or value. Even if a patient collects overwhelming evidence from others *and* believes that others do not think they are fat or defective, they are still more concerned with their own values than any external standard. Therefore in OCD, I believe the answer will depend on whether the over-valued idea is associated with an idealised value (such as the importance of possessions, order, precision or perfectionism) when I would argue it is more effective to question the value on their functionality and by the use of logic. If there is no idealised value, then standard empirical testing as described by Salkovskis et al. (1998) will be more helpful. Ultimately a randomised controlled trial is required.

Indeed as always further research is required to answer these and other questions in evaluating the efficacy of treatment, the relationship between beliefs and values and the development of scales to measure idealised values.

Acknowledgements

I would like to thank Michael Beary, Paul Gilbert, Kevin Gournay, Fugen Neziroglu, Katherine Phillips, Paul Salkovskis and Windy Dryden for their helpful comments.

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