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Clinical obsessions in obsessive–compulsive patients and obsession-relevant intrusive thoughts in non-clinical, depressed and anxious subjects: Where are the differences?

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Abstract

Contemporary cognitive models of obsessive–compulsive disorder (OCD) assume that clinical obsessions evolve from some modalities of intrusive thoughts (ITs) that are experienced by the vast majority of the population. These approaches also consider that the differences between ‘‘abnormal’’ obsessions and ‘‘normal’’ ITs rely on quantitative parameters rather than qualitative. The present paper examines the frequency, contents, emotional impact, consequences, cognitive appraisals and control strategies associated with clinical obsessions in a group of 31 OCD patients compared with the obsession-relevant ITs in three control groups: 22 depressed patients, 31 non-obsessive anxious patients, and 30 non-clinical community subjects. Between-group differences indicated that the ITs frequency, the unpleasantness and uncontrollability of having the IT, and the avoidance of thought triggers obtained the highest effect sizes, and they were specific to OCD patients. Moreover, two dysfunctional appraisals (worry that the thought will come true, and the importance of controlling thoughts) were specific to OCD patients. The OCD and depressed patients shared some dysfunctional appraisals about their most disturbing obsession or IT (guilt, unacceptability, likelihood thought would come true, danger, and responsibility for having the IT), whereas the non-obsessive anxious were nearer to the non-clinical participants than to the other two groups of patients. The OCD patients showed an increased use of thought control strategies, with overt neutralizing, thought suppression, and searching for reassurance being highly specific to this group.
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Keywords: OCD; Obsessions; Intrusive thoughts; Worry; Automatic negative thoughts dysfunctional appraisals; Thought control strategies

Introduction

As pointed out by Rachman and de Silva (1978) nearly three decades ago, ‘‘in the course of developing a cognitive theory for obsessions, it became necessary to assume that all people experience a phenomenon akin to clinical and abnormal obsessions’’. This assumption has been included in current obsessive–compulsive

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disorder (OCD) cognitive formulations (Clark, 2004; Rachman, 1997, 1998, 2003; Salkovskis, 1985, 1989), since they postulate that clinical obsessions evolve from a modality of intrusive thoughts, images or impulses that are also experienced by the vast majority of people (Purdon & Clark, 1999). Therefore, a clinical obsession can be understood as an extreme variant of a normal intrusive thought (It) (Clark, 2005). However, it is important to mention that just the mere experience of having an unpleasant and/or unwanted IT does not indicate a clinically significant obsession. Cognitive OCD proposals also hypothesize that the transition from normality to obsessive pathology first depends on the individuals attaching dysfunctional appraisals or misinterpretations to their ITs. Subsequently, the subject is engaged in a variety of neutralizing responses that are counter-productive.

The work of Rachman and de Silva (1978) constitutes the pioneer empirical support for the universality of ITs with typical obsessive contents. Nevertheless, this conclusion was based on a detailed comparison between non-clinical ITs and the obsessions reported by a reduced clinical OCD group of participants ($n = 8$), in the absence of statistical analyses, and the findings had been overvalued by many authors, as has been recently pointed out by Rassin and Muris (2006). Nevertheless, the fact is that subsequent to the aforementioned Rachman and de Silva study, a considerable amount of empirical research has verified that between 80% and 90% of non-clinical participants reported having intrusive thoughts, images or impulses whose contents are, in many instances, similar to those reported by OCD patients. In these studies, a variety of instruments were utilized to identify the ITs experienced by non-clinical participants: Intrusive Thoughts and Impulses Survey (Niler & Beck, 1989), Intrusive Thoughts Questionnaire (Edwards & Dickerson, 1997), Distressing Thoughts Questionnaire (Clark & de Silva, 1985), Cognitive Intrusions Questionnaire (Freeston, Ladouceur, Thibodeau, & Gagnon, 1991), and Obsessional Intrusions Inventory (Purdon & Clark, 1993, 1994a, 1994b). (e.g., Belloch, Morillo, Lucero, Cabedo, & Carrió, 2004; Clark & de Silva, 1985; Edwards & Dickerson, 1987; Freeston et al., 1991; Freeston, Ladouceur, Thibodeau, & Gagnon, 1992; Niler & Beck, 1989; Parkinson & Rachman, 1981; Purdon & Clark, 1993, 1994a, 1994b; Reynolds & Salkovskis, 1991; Salkovskis & Harrison, 1984). In fact, the aforementioned critical study by Rassin and Muris (2006) also reveals that some clinically significant obsessive contents are hardly distinguishable from their non-clinical counterparts. However, as far as we know, there are no data about the differential characteristics between normal and abnormal ITs, such as their frequency, associated unpleasantness, cognitive appraisals about their appearance or contents, or the strategies displayed to keep them under control. As a result, some of the key assumptions of current OCD cognitive formulations are only partially supported by empirical evidence.

On the other hand, it remains unclear to what extent all the investigated intrusive phenomena are obsession-relevant, or actually analogous to the clinical obsessions. In their revision of the empirical literature on ITs, Clark and Purdon (1995) concluded that many of the measures employed did not offer guaranties of assessing truly OCD-relevant ITs, and, hence, these measures had important construct validity problems. In the assessment of intrusive thoughts analogous to obsessions (obsession relevant intrusive thoughts, OITs) there has frequently been confusion between obsessive themes and worry-like concerns. Clark and O'Connor (2005), using interview measures of OITs, found that only 11% of the non-clinical participants spontaneously referred to OITs, while the majority of ITs referred to anxious or worrisome thought content. Some empirical studies have postulated that the egodystony/egosyntony dimension referring to the thought content is a key feature in differentiating obsessive thoughts from the more commonplace problems characteristic of worry (Langlois, Freeston, & Ladouceur, 2000a, 2000b; Turner, Beidel, & Stanley, 1992). In order to offer a valid measure of OITs, Purdon and Clark (1993, 1994b) designed the Revised Obsessional Intrusions Inventory (ROII), which has proved to be a useful instrument for adequately differentiating between OITs and worry (Purdon & Clark, 1994a, 1994b; Morillo et al., 2003).

Apart from ITs with worry-related contents, there is another variant of ITs that is typically experienced by depressed patients. The relationship between depressive mood and the experience of ITs is well documented, since Beck (1967, 1976) reported that depressed people experienced negative thoughts, whose contents were mainly centered on negative opinions about the self, the world, or the future, and he labeled them "automatic negative thoughts". From the OCD literature, depressive mood has been associated with an increased frequency, intensity and uncontrollability of intrusive thoughts (Clark, 2002; Rachman & Hodgson, 1980), as well as with a greater tendency to misinterpret the significance of the thoughts, or to endorse dysfunctional appraisals (Freeston & Ladouceur, 1993; Rachman, 2003). Moreover, current OCD cognitive models assume

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