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## Global intrusive thoughts: A commentary



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## ABSTRACT

The main aims of this huge unprecedented multi-national study of intrusive thoughts were to ascertain the prevalence of the phenomenon, determine whether it is dimensional or categorical in nature, and the extent to which the thoughts reflect cultural differences. The answers to the first two questions were clear. Intrusive thoughts are extraordinarily prevalent and dimensional in nature. There were several national differences, especially in the frequency of certain thoughts, notably sexual and religious. However, the means of dealing with the thoughts were similar across countries. The use of a standardized interview for collecting the key information is a methodological advance but has limitations. Some gaps in current information about the intrusions are noted and six suggestions for further research are set out.

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The occurrence of intrusive thoughts is intrinsically interesting, and also has important implications for understanding obsessions. Intrusive thoughts interrupt the stream of consciousness and also can interrupt or disrupt ongoing behaviour. Most of the interruptions of the stream of consciousness are not too significant and are easily dismissed; they are transient. However, if the thought carries personal significance – if the person interprets it as being personally unacceptable or repugnant – it is disturbing and likely to return. For example, the thought of harming a vulnerable person, child or adult, is unacceptable and repugnant. Attempts to control the thought or block its recurrence are difficult. These uninvited, unwanted, and recurrent intrusive thoughts are the bedrock of clinical obsessions.

Not all uninvited thoughts are unacceptable. Some are pleasant, some amusing, and some can be creative. For example Mozart and Beethoven described how some of their musical thoughts “intruded”. Mozart’s often arrived fully formed, and Beethoven had many that “pounded into his head.”

The phenomenon of intrusive thoughts became a subject of considerable attention in the 1970s during the search for an explanation for obsessions. The treatment of observable compulsive behaviour, the other manifestation of OCD, had progressed well; but obsessions presented an awkward problem because of the barrier to studying patients’ thoughts. Under the shadow of radical behaviourism, which regarded thoughts as “private events”, not observable and outside the remit of scientific psychology, obsessions were inaccessible. Attempts to explain obsessions as maladaptive conditioned responses, and related approaches, floundered.

The infusion of cognitive construals enabled a fresh approach. The early research by de Silva and Rachman carried out at

the Institute of Psychiatry, London University, on patients with OCD led to the recognition that the content of some obsessions resembled common intrusions, and it was postulated that unwanted intrusive thoughts are commonly, perhaps universally experienced (Rachman & de Silva, 1978). Their studies on patients with OCD and on non-clinical participants supported the proposition and it was subsequently replicated with other samples (e.g., Salkovskis, 1985). This proposition was used as the basis for a cognitive theory of obsessions in which it was proposed that obsessions arise when a person seriously misappraises the personal significance of their intrusive thoughts/images/impulses (Rachman, 1997, 1998). Obsessions arise when a person misappraises intrusive blasphemous thoughts or unacceptable thoughts of harming people or unacceptable sexual thoughts as revealing very important and disturbing aspects of their personality and values. The intrusions misinterpreted by patients as revealing were classified as a trio: they mean that I am “bad, mad, dangerous” or a mixture of the three (Rachman, 2003).

The affected person recognises that the thoughts are their own products (not inserted thoughts) and they reject and resist them. According to the cognitive theory, the recurrence of obsessions is explained by the persistence of the maladaptive misappraisals of the significance of the intrusions. When these appraisals are replaced by benign realistic appraisals the obsessions do not recur (Whittal, Woody, McLean, Rachman, & Robichaud, 2010).

Obsessions can be thoughts, images or impulses, but the early research concentrated primarily on thoughts. This limitation is now being corrected by the surge of research into images; these powerful cognitions arise fully formed and are astonishingly stable and exceptionally upsetting (Rachman, 2007). It is regrettable that because of the timing of the Global study, prior to the surge, the prevalence and continuity of intrusive images were not studied in detail.

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This unprecedented multi-national study (Clark et al., 2014; Moulding et al., 2014; Radomsky et al., 2014) assessed the prevalence of intrusive thoughts of 777 students in 13 different countries, and explored the influence of cultural factors on the thoughts. Consistent with earlier research, the prevalence was extraordinarily high, and with some exceptions the content of the intrusive thoughts was comparable to findings from the UK, Canada and the US. In Part Three, some major differences in the content of the intrusive thoughts were recorded. In particular there were surprisingly low numbers of sexual intrusions, and religious intrusive thoughts, in some of the countries. Moreover, there were minimal differences between repugnant and non-repugnant intrusions. Overall there was a very high frequency of doubting intrusions. The original studies focused on unacceptable and distressing thoughts. It is interesting that despite the site differences in thought content, the means employed to deal with them were similar across sites.

The low incidence of sexual and religious intrusions is not fully consistent with the early research and especially not consistent with clinical obsessions. The most common contents of clinical obsessions are blasphemous thoughts, unacceptable sexual impulses/images/thoughts, and thoughts/impulses to harm vulnerable people. One possible explanation for the differences between the early research and the current studies might be the focus in the present studies primarily on the participants' reports of their *thoughts*, and the relative neglect of intrusive *images* and *impulses*. These differences, notably the very low incidence of intrusive sexual and religious thoughts, also have a bearing on the absence of any significant distinction between repugnant thoughts and non-repugnant thoughts. Most clinical obsessions have a repugnant or at least an objectionable quality, and the affected person resists the intrusion. Repugnance is not a common feature of doubting intrusive thoughts.

Recognising that much of the earlier work was dependent on the use of questionnaires and that this method has limitations, the authors of the present set of studies opted for a different methodology. The limitations are that questionnaires are self-reports, retrospective and that the content of the items is pre-selected. This is a particularly bothersome limitation because the contents of unwanted intrusive thoughts, and obsessions, are idiosyncratic (it should be mentioned that some of the early research also involved laboratory experiments.)

A strong feature of the present research is the use of standardized interviews because important details of the content and frequency of the intrusions can be elicited. The limitation of depending solely on interviews, no matter how skilfully crafted and standardized, is that the interviewers may not be consistent with each other; hence, it is the practice to obtain inter-rater reliability. This can be extremely time-consuming and even tedious.

There is an unusual obstacle to interviewing people about the content their obsessions or unwanted intrusions because many of the affected people regard their obsessions as repugnant, and fear that disclosures would reveal shameful aspects of their personality. In clinical samples the “concealment of obsessions” is common (Newth & Rachman, 2001), and it is likely to arise in a lesser form in non-clinical samples.

Given the various limitations of interviews and of self-report questionnaires, it might be advisable to use both methods in future research. The use of the Obsessive-Compulsive Inventory-Revised scale (OCI-R; Foa et al., 2002) for assessing OCD is a limitation of the Global study because the Scale is light on cognitions. Another problem arising from the selection of the OCI-R is that it was used as the dependent variable in some of the regression analyses. Moreover, there were very large differences in the mean OCI-R scores between some sites (e.g., a mean of 9.60 in Hong Kong and a mean of 30.92 in Sierra Leone).

The assessment of depression in the studies could have been improved by the addition of the Beck Depression Inventory

(Beck, Steer, & Garbin, 1988), and it might have added useful information about the association between depression and intrusive thoughts (Ricciardi & McNally, 1995).

The major findings on high prevalence and continuity are a valuable addition to knowledge of intrusive thoughts, and by extension to obsessions. The main advances are the compelling evidence of the widespread, indeed high universal prevalence of intrusive thoughts, and that the intrusions rest on a continuum; they are dimensional not categorical (see also Abramowitz, Fabricant, Taylor, Deacon, McKay and Storch (2014)). The findings of continuity of normal and abnormal intrusions, and the continuity of normal and abnormal obsessions, are important advances because years ago it was believed that the clinical occurrence of obsessions was a categorical pathological symptom, possibly indicative of psychosis.

The outcome of this huge undertaking provides an opportunity to consider the current status of knowledge about intrusive thoughts and to map out numerous questions that remain to be addressed. They fall into 6 categories as follows.

- (i) Additional information from studies of prevalence and continuity in non-clinical *community* participants, and clinical samples that include *patients* with OCD, and other forms of *anxiety disorder*, is needed.
- (ii) Additional information about the variations in the content of intrusions, with special reference to cultural factors, is required.
- (iii) Fresh attempts should be made to distinguish between the nature and effects of repugnant/objectable intrusions and non-repugnant intrusions.
- (iv) Given the recent findings on the nature and prevalence of imagery (Hackmann, Bennett-Levy, & Holmes, 2011; Rachman, 2007) research into unwanted and unacceptable intrusive *images* should be expanded.
- (v) As the authors of this special section of articles imply, the research provides a pre-condition for the essential experimental investigations of the cognitive theory of obsessions (Rachman, 1997, 1998).
- (vi) As the cognitive theory is the basis for cognitive therapy the results of the present research should be taken into account in current plans for testing the effects of the treatment in randomized controlled trials (Whittal et al., 2010).

A mysterious unexplored aspect of unacceptable and even repugnant thoughts is their restricted range: blasphemous, harming others, and unacceptable sexual images/thoughts. Curiously, other types of “sin” are rarely mentioned in studies of intrusive thoughts, and remarkably, the content of obsessions is restricted. Few OCD patients complain of troubling recurrent thoughts or images about greed, gluttony, avarice or envy.

A cultural study of the reasons for the imbalance between the commonly reported intrusive thoughts about blasphemy/sex/ harming others, and the rarity of reports of unwanted intrusive thoughts about other sins such as greed, gluttony, avarice, and envy, would be very interesting. In all, the phenomenon of intrusive thoughts, images, and impulses is fascinating and the Global study is a major advance.

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