



Part 1—You can run but you can't hide: Intrusive thoughts on six continents



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ABSTRACT

Most cognitive approaches for understanding and treating obsessive-compulsive disorder (OCD) rest on the assumption that nearly everyone experiences unwanted intrusive thoughts, images and impulses from time to time. These theories argue that the intrusions themselves are not problematic, unless they are misinterpreted and/or attempts are made to control them in maladaptive and/or unrealistic ways. Early research has shown unwanted intrusions to be present in the overwhelming majority of participants assessed, although this work was limited in that it took place largely in the US, the UK and other 'westernised' or 'developed' locations. We employed the International Intrusive Thoughts Interview Schedule (IITIS) to assess the nature and prevalence of intrusions in nonclinical populations, and used it to assess ($n=777$) university students at 15 sites in 13 countries across 6 continents. Results demonstrated that nearly all participants (93.6%) reported experiencing at least one intrusion during the previous three months. Doubting intrusions were the most commonly reported category of intrusive thoughts; whereas, repugnant intrusions (e.g., sexual, blasphemous, etc.) were the least commonly reported by participants. These and other results are discussed in terms of an international perspective on understanding and treating OCD.

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1. Introduction

One of the key tenets of most contemporary cognitive-behavioural theories of obsessive-compulsive disorder (OCD) is that

intrusive thoughts, images and impulses are normative, common – even ubiquitous occurrences experienced by individuals both with and without OCD (Bouvard & Cottraux, 1997; Clark & Purdon, 1993; Purdon & Clark, 1994; Rachman, 1997, 1998; Salkovskis, 1985). These theories generally posit that the intrusions themselves are not problematic, but rather that the ways we react to, interpret, appraise and/or attempt to control them can cause distress, fear, guilt, avoidance, compulsions (both overt and

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covert), as well as a host of other symptoms including an increase in the frequency and/or duration of the intrusions themselves.

Since the 1970s, several studies have shown that unwanted, intrusive thoughts, images and impulses are experienced by the overwhelming majority of participants tested (indeed, nearly all participants in most cases reported some form of intrusion) across a number of different research sites (e.g., Purdon & Clark, 1993; Rachman & de Silva, 1978; Salkovskis & Harrison, 1984). In their landmark paper, Rachman and de Silva first distributed a questionnaire to 124 nonclinical participants (including students and hospital employees) enquiring about the presence of unacceptable thoughts or impulses. Of the 124 individuals surveyed, 99 reported the presence of such intrusions, although an additional five were reclassified as having intrusions based on their unsolicited statements about the nature of their thoughts; a total of 104 (or 84% of the sample) individuals were determined to experience unacceptable thoughts or impulses. The authors further reported that in this sample, there were no age- or sex-related differences in the experience of intrusions. The second study reported in the article employed an interview-based assessment strategy to compare the unacceptable thoughts and impulses reported by clinical vs. nonclinical participants. Impressively, the content of intrusions reported by nonclinical participants was largely indistinguishable from that reported by clinical participants. Six ‘judges’ who had experience working with ‘obsessional patients’ were asked to indicate whether the reported intrusions originated from a clinical or nonclinical individual. Results indicated that although the judges could identify many of the nonclinical intrusions reasonably well, their performance at discerning the intrusions reported by clinical participants was poor. The authors also conducted a number of comparisons between normal and abnormal intrusions in terms of frequency, distress, resistance, and other factors. Rachman and de Silva concluded that although there were important differences between normal and abnormal intrusions in terms of frequency and distress, there were important similarities in content – and crucially, that unacceptable thoughts and impulses were very common among those without a clinical problem.

Several replications of the above study have been conducted (e.g., Purdon & Clark, 1993; Salkovskis & Harrison, 1984), and generally demonstrated similar, if not higher proportions of nonclinical individuals reporting unwanted intrusions (e.g., 88.2% in the study by Salkovskis & Harrison, 1984). That said, there has been recent theoretical and empirical work which challenges the universality of unwanted intrusive thoughts, images and impulses (e.g., O’Connor, 2002). One such study (which re-evaluated the data collected by Rachman and de Silva (1978)) found that psychologists were able to distinguish between clinical and non-clinical intrusions beyond chance levels (Rassin & Muris, 2007). In a second study, Rassin, Cogle, and Muris (2007) found that while nonclinical participants endorsed intrusions, these were primarily those intrusions originating from previously tested nonclinical individuals; those participants who endorsed intrusions originating from individuals with OCD tended to have higher levels of OCD symptoms.

Despite the exceptions noted above, the generally well-replicated finding that intrusions nearly identical to those reported by individuals with OCD are also nearly universally experienced by nonclinical individuals was the foundation for the development of a theoretical understanding of the nature of intrusions in OCD. How can (almost) everyone experience unwanted intrusions, while only some develop OCD? Rachman (1997, 1998) suggested that “obsessions are caused by catastrophic misinterpretations of the significance of one’s intrusive thoughts (images, impulses)” (Rachman, 1997, p. 793). Inspired by the misinterpretation-based theory of panic (Clark, 1986), this concise and causal theory has

been the subject of great interest (e.g., Abramowitz, Nelson, Rygwall, & Khandker, 2007; Newth & Rachman, 2001; Purdon, 2002; Rassin, Merckelbach, Muris, & Spaan, 1999; Salkovskis et al., 2000), and has led to a cohesive and effective treatment (Rachman, 2003; Whittal, Woody, McLean, Rachman, & Robichaud, 2010). Indeed, two of the six initial belief domains (i.e., beliefs about the importance of and control over one’s thoughts) proposed by the Obsessive Compulsive Cognitions Working Group (OCCWG, 1997) are closely associated with elements of this theory, and are often the target of both behavioural and cognitive interventions for OCD (e.g., Abramowitz, 2006a; Clark, 2004).

These and other investigations provided important empirical information about the nature of intrusions, and led many to address the question of why intrusions are only problematic for some and not for others. Responses to this question have been most fruitful, and comprise some of the most widely-used cognitive-behavioural approaches to understanding and treating obsessions and other forms of OCD. One of the limitations of this early work on obsessions was that the data were collected in a single city without regard to international or cultural differences that may influence the nature and/or number of intrusions that may be experienced and/or reported. Although some work has been done to elucidate and compare the experience of intrusions and other OCD-relevant phenomena in Italy (Sica, Novara, & Sanavio, 2002a, 2002b), and between Italy, the United States and Greece (Sica, Taylor, Arrindell, & Sanavio, 2006), there is a clear need to test the hypothesis that unwanted intrusive thoughts, images and impulses are present and common in nonclinical populations, across cultures, around the world. This was the primary aim of the current study. A secondary aim was to assess the prevalence and nature of not only the intrusions themselves, but also of the interpretations/appraisals of and control strategies used to attempt to regulate these intrusions, as these form the core of many cognitive-behavioural theories of OCD (a cross-cultural/international examination of these appraisals is reported in Moulding et al., 2014).

In our work toward these aims, we recognised a problem in some previously-used assessment strategies employed to detect intrusions: the use of paper-and-pencil self-report measures has the capacity to capture cognitive phenomena which either are not robustly intrusive (e.g., worry, rumination) or are not distinguishable from the examples provided in the measure’s instructions (a commonly reported problem with the Interpretation of Intrusions Inventory; OCCWG, 2001, 2003, 2005). Although distinguishing between intrusions, worry and rumination can be challenging (e.g., Clark & Claybourn, 1997; Langlois, Freeston, & Ladouceur, 2000; Wahl et al., 2011; Watkins, Moulds, & Mackintosh, 2005) we felt that the best way to ensure that our study captured unwanted intrusive thoughts (rather than worries, rumination or other cognitive phenomena) was to employ a semi-structured interview with highly-trained interviewers (see Clark and Radomsky (2014) for information about the history and development of the International Intrusive Thoughts Interview Schedule (IITIS; Research Consortium on Intrusive Fear; RCIF, 2007)).

2. Methods

2.1. Participants

Seven hundred and seventy-seven university student participants in 15 cities across 13 countries and six continents volunteered to participate in the current study. They were compensated with course credit or entry into a cash draw. The sites were located in Africa (Makeni, Sierra Leone), Asia (Herzliya, Israel; Hong Kong; Ankara, Turkey; and Tehran, Iran), Australia (Melbourne), Europe (Chambery, France; Firenze/Padova, Italy; Thessaloniki, Greece; and Valencia, Spain), North America (Binghamton and Chapel Hill, The United States; Fredericton and Montreal,

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