OCD, Intrusive Thoughts and Pure Obsessions

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Introduction

Obsessive Compulsive Disorder (OCD) is characterized by the occurrence of unwanted intrusive thoughts, images and impulses, known as obsessions and repetitive attempts to neutralize the intrusive thoughts, images and impulses known as compulsions. Compulsions are acts which are deliberately repeated and performed in response to an obsession and can be manifested overtly, such as checking door locks, or covertly such as repeating magic words. Among several other categories of OCD is Pure Obsessions, a more conspicuous and troubling form of the disorder (Fao & Wilson, 2001; Rachman, 2003). Pure Obsessions, also called ruminations, is characterized by repetitive and intrusive thoughts, but not by any overt compulsions or rituals. Obsessions, the primary component of Pure Obsessions are thoughts, images, or impulses that are 1) inappropriate and intrusive that are persistent and recurring, and viewed as inappropriate and intrusive causing anxiety and distress; 2) different from real, everyday worrying about life issues; 3) attempted to be ignored, suppressed or dismissed; and 4) recognized as being a product of ones own mind (American Psychiatric Association, 1994). It is estimated that 20 to 30 percent of people who suffer from OCD experience no manifestation of compulsions (Wilhelm, 2003, Freeston et al., 1997; Rachman, 2003).

Over the last five decades, behavioral psychologists and subsequent cognitive psychologists have dedicated much research and attention to the iconic manifestations of OCD. However, until recent, little attention was given to Pure Obsessions. Prior to the development of cognitive techniques, Pure Obsessions proved particularly difficult for behavior therapists to treat because of the uniquely cognitive nature of obsessions (Rachman, 2003). Van Oppen and Emmelkamp (2002) noted that, “Until now, the treatment of pure obsessions can be summarized...
as difficult and often unsuccessful” (Rachman, 2003, p. 2). Rachman (2003) concluded that the main obstacle to the successful treatment of obsessions is the absence of effective techniques. Cognitive psychology, however, has provided new and powerful techniques for the successful treatment of almost every kind of anxiety and mood disorder, including intrusive thoughts and obsessions which have cognitive manifestations.

As stated, unwanted intrusive thoughts are the key component of Pure Obsessions. Rachman (2003) identifies the three cognitive manifestations of intrusive thoughts: 1) harmful or aggressive obsessions, characterized by thoughts that one might lose control and cause significant injury to oneself or another person, such as stabbing, strangling, or suffocating people; 2) sexual obsessions, characterized by fear of committing or engaging in inappropriate sexual activities or sexual activities that one finds repulsive, such as thoughts of molesting children, having sex with religious figures, and homosexual or heterosexual ideations; and 3) religious obsessions, characterized by fear of commiting blasphemy, such as having perverse thoughts during prayers and shouting obscene language in places of worship.

These intrusive thoughts, similar to intrusive thoughts in other anxiety and mood disorders, fall within a continuum of normalcy (Salkovskis, 1985; Teachman & Clerkin, 2007). Normal and obsessive intrusive thoughts are similar in form and content, but differ in intensity, length and distress (Rachman, 1997). Thus, the critical issues to examine are the cognitive processes that catalyze an intrusive thought into becoming an obsessive thought, and how therapists can successfully integrate cognitive therapies into practice.
Understanding Processes: The Five Belief Domains of Faulty Appraisals

The cognitive pathogenesis of obsessions is derived from catastrophic misinterpretations of intrusive thoughts (Rachman, 1997). These misinterpretations can be divided into several belief domains, with the major domains identified by the Obsessive Compulsive Cognitions Working Group (OCCWG) as: over-importance of thoughts and the need to control thoughts; overestimation of threat; excessive responsibility; intolerance of uncertainty; and perfectionism (Wilhelm, 2003).

The Over Importance of Thoughts

The over importance of thoughts is characterized by the following beliefs: 1) if one has a thought, the contents of that thought must be significantly important and personally meaningful; 2) having a thought is the moral equivalent of wishing that thought to come true; and 3) having a thought somehow increases the likelihood of it coming true (OCCWG, 1997).

Overestimation of Threat

Overestimation of threat is the faulty appraisal of the estimation of danger. Individuals with obsessions often judge situations to be dangerous, as opposed to safe, until proven otherwise (Wilhelm, 1997).

Excessive Responsibility

Some intrusive thoughts arise from “responsibility beliefs,” the idea that if one has any influence over an undesirable event, then they assume complete responsibility for stopping it from happening (OCCWG, 1997). Many excessively responsible individuals are prone to obsess over causing an undesirable event as well as being responsible for not stopping an undesirable one (OCCWG, 1997). Individuals with obsessive thoughts are more likely to have thought biases
present in their cognitive functioning (Shafran et al., 1996). A thought bias manifests itself in two ways: 1) the presumption that if one has responsibility over something, then there is a strong likelihood of a catastrophic event happening; and 2) the presumption that one will be held accountable for a catastrophic event, though he or she has no possible control (Shafran et al., 1996).

Intolerance of Uncertainty

Intolerance of uncertainty is characterized by difficulty with decision making and epistemological reasoning. An obsessive individual may take longer to categorize information and often seek affirmation and confirmation in doing so (OCCWG, 1997). This need presents a specific cognitive dilemma when an individual is confronted with questions that have no certain answer, such as “Am I in love?” or “Is this the right career move?” (Foa & Wilson, 2001).

Perfectionism:

Perfectionism is the need for correctness and precision and is often associated with the compulsive behaviors of ordering and symmetry.

Depending on the predisposition of an individual towards the obsessive belief domains, intrusive thoughts can remain psychometrically normal or escalate into obsessions. For example, when intrusive thoughts are first perceived by a healthy individual, they may describe the contents of intrusive thoughts as immoral or disgusting, but interpret the thought as meaningless and personally insignificant, thus neutralizing it from his/her mind. However, affected individuals may interpret the same thought as dangerous, personally important, and revealing something hidden about his or her character. By ascribing excessive importance to the thought, the individual may perceive that having this thought may move them to action. (Rachman, 1997).
Understanding Theory: The Cognitive Appraisal Model of Obsessions

The cognitive appraisal model of obsessions has emerged as a promising approach to treating Pure Obsessions. This model is constructed upon two key premises. The first premise is that intrusive thoughts are a universally experienced phenomena. The second premise is that faulty appraises of intrusive thoughts, not the thought itself, leads to obsessions (Julien et al., 2007; Salkovskis, 1985; Rachman, 1997). The cognitive appraisal model indicates that intrusive thoughts are experienced by almost all people but cause distress only to some (Salkovskis, 1985). For some obsessive individuals, intrusions activate pre-existing schemas and lead to negative self evaluations by means of specific automatic thoughts (Salkovskis, 1985). For example, an individual might have an intrusive thought about smothering a newborn baby. The automatic thoughts that this cognitive intrusion may produce are linked to one or more of the obsessive belief domains, such as the need to control thoughts (Salkovskis, 1985). An inability to control one’s thoughts may indicate to the individual that he or she may secretly intend to carry the thought out (Salkovskis, 1985). Thus, it is the ideation about the intrusive thought that causes distress, not the intrusion itself.

The First Premise

Julien et al. (2007) identified three conditions that are necessary for the validity of the first premise (the universality of intrusive thoughts) of the cognitive appraisal model. The first condition they identified was that intrusive thoughts had to be present in the non-clinical population. The second condition is a correlation between the frequency of intrusive thoughts and frequency of obsessions. The third condition is the distinctiveness between intrusive thoughts and automatic thoughts.
In order to demonstrate the validity of the first premise, Julien et al. (2007) reviewed relevant clinical literature to determine if intrusive thoughts are a normative of the general, non-clinical population. They found thirteen articles which examined the universality of intrusive thoughts. They found that 93% of non-clinical individuals have had the experience of an intrusive thoughts (Julien et al., 2007).

The second condition necessary for the validity of the first premise is the correlation between the frequency of intrusive thoughts and the frequency of obsessions (Julien et al., 2007). Since the cognitive appraisal model assumes that obsessions are fundamentally derived from intrusive thoughts, the correlation between frequency of intrusive thoughts in OCD individuals should be greater than that of individuals with other anxiety and mood disorders (Julien et al., 2007). Julien et al. (2007) found little statistically significant evidence to support a greater correlation between intrusive thoughts in people with obsessions than those with other clinical disorders. One possible explanation is that OCD is categorized as an anxiety disorder, and obsessions are often co-morbid with anxiety (Salkovskis, 1985; Julien, et al., 2007). Thus, it would seem natural that individuals with anxiety would express a high degree of intrusive thoughts.

The third necessary condition for the validity of the first premise is the disambiguation between intrusive thoughts and the automatic thoughts seen in other mental health disorders (Julien et al., 2007). Many psychological disorders are described in part by the presence of cognitive intrusions or negative automatic thoughts. However, intrusive thoughts present in OCD are characterized as ego dystonic in nature and opposed or opposite to one’s normal desires or beliefs where automatic thoughts are ego syntonic and align with ones belief system (Clark,
Purdon, 1995). For example, a depressed individual may have the automatic thought “I always screw up,” a thought that is in accordance with his or her “failure schema” (Salkovskis, 1985).

Intrusive thoughts, however, are distressing because of the dystonicity between the intrusive thought and what an individual deems to be acceptable. Intrusive thoughts are never elusive or teetering between consciousness (Salkovskis, 1985). Rachman (1981) suggests the necessary and sufficient indicator for the identification of an intrusive thought is “the subjective report that it is interrupting an ongoing activity; the thought, image or impulse is attributed to an internal origin, and is difficult to control” (p. 89). Beck (1995) explains automatic thoughts as reasonable or plausible and that the patient accepts “their validity without question and without testing out their reality or logic” (as cited in Salkovskis, 1985).

Significant differences between intrusive thoughts and automatic thoughts can then be identified: intrusive thoughts are intrusive, easily accessible and diametrically opposed to an individuals belief system; automatic thoughts are reasonable, elusive to consciousness and consistent with an individuals belief system (Salkovskis, 1985).

The Second Premise

The second premise of the cognitive appraisal model is that faulty appraisals of intrusive thoughts, not the thoughts themselves, lead to obsessions (Julien et al., 2007). In efforts to support the validity of this claim, Julien et al. (2007) proposed several conditions including: the generality hypothesis; the specificity hypothesis; and the response to treatment hypothesis. The specificity hypothesis argues that people with intrusive thoughts should believe one or more of the obsessive belief domains more strongly than individuals with other anxiety or mood disorders (Julien et al., 2007). If faulty appraisals propel intrusive thoughts into obsessions, then
the faulty appraisal belief domains should be upheld more strongly in an OCD individual than in other populations (Julien, et al., 2007). To prove that faulty appraisal belief domains are upheld more strongly in individuals with OCD, Teachman and Clerkin (2007) researched the degree to which individuals held belief domains by artificially manipulating OCD individuals ideations regarding morality. Earlier studies had demonstrated the cognitive component of OCD by intentionally manipulating an individual’s perception as to the importance of specific unwanted thoughts (Teachman & Clerkin, 2007). If variations related to the importance of a specific thought were suggested to a vulnerable individual, the individual was likely to report a change in their OCD related symptoms (Teachman & Clerkin, 2007).

The generality hypothesis suggests that OCD symptom subtypes should correlate with one or more belief domains (Julien et. al, 2007). Empirical data suggests that correlations cannot always be found throughout all subtypes of OCD, but can be found in individuals suffering from pure obsessions (Yao et. al, 1999). The belief domain with the highest correlation to pure obsessions is responsibility and threat.

The response to treatment hypothesis argues that if faulty appraisals of intrusive thoughts push the intrusive thoughts into obsessions, then therapy targeting ones adherence to one or more of the obsessive belief domains should decrease the presence of obsessions. Julien et al. (2007) researched relevant clinical data and found evidence to support the contention that cognitive therapy which targeted obsessive belief domains decreased the prevalence and intensity of obsessions.

The increasing amount of research concerning intrusive thoughts and Pure Obsessions is leading cognitive psychologists and clinical social workers to a more thorough understanding of
the disorder. Understanding the two premises of the cognitive appraisal model has lead psychologists and clinical social workers to classify intrusive thoughts as a regular occurrence in one’s stream of consciousness. In essence, the stimulus that produces intrusive thoughts can be from one’s environment and identifiable, or can be intrinsic and seemingly arise without provocation. The external or intrinsic stimuli produce an intrusion or a doubt in one’s mind that is subjectively abhorrent to the individual’s belief system (Salkovskis, 1985; Rachman, 1997). By nature, this intrusive thought is ego dystonic, but has not yet met classification for obsession (Salkovskis, 1985). Depending on the individual schema, the intrusive thought may be regarded as significantly and personally important or may cause no affect disturbance and be neutralized successfully and permanently from the person’s mind (Rachman, 1997). If the intrusive thought interacts in diametric with specific pre-existing schema, it will activate negative automatic thoughts or negative self appraisals about the existence of the thought (Salkovskis, 1985). These automatic thoughts, such as “I should never have immoral thoughts” or “if I have the thought of doing something it is as morally bad as doing it” are ego syntonic and in line with the individual’s core belief schematic (Salkovskis, 1985). In turn, the negative self appraisals will lead to affect dis-regulation or mood disturbance.

**Integrating Theory and Practice: Treatment Indications**

It has long been understood that cognitive treatment for obsessions relies heavily on the acceptance paradox. In essence, the very thought which is feared the most is the thought that must be confronted rather then avoided (Burns, 2006) Early therapies which targeted intrusive thoughts relied mostly on thought suppression and replacement techniques (Purdon, 1999). It is understandable why a person who has an intrusive thought may try desperately to rid themselves
of it in response to the distress it causes. Similar to compulsions, neutralization of unwanted thoughts has some positive effect and is therefore incorporated by the distressed individual. Neutralization, however, often has an adverse paradoxical effect of reinforcing the primary fear and perceived outcomes thereby escalating the obsessions (Foa & Wilson, 2001).

The act of avoiding a thought subtly indicates to the individual that the thought must be important and effectively emboldens the thoughts power (Rachman, 1997; Shafran, 1996). When an individual confronts an intrusive thought he or she objectifies the thought and determines that it has less importance, which decreases thought-action-fusion (Burns, 2006).

The acceptance paradox has its root in the behavioral concept of exposure and response prevention (Burns, 2006). This technique exposes a vulnerable individual to activating stimuli, but requires refusal to commit neutralizing cognitions or behaviors. Over time, the thought burns itself because no power is given to it through compulsions (Burns, 2006). Exposure and response prevention can be more difficult for pure obsessions because of the inherent lack of overt compulsions (Foa & Wilson, 2001). An exposure technique helpful for intrinsic intrusive thoughts is imaginal exposure or flooding. An individual, rather then attempting to replace a bad thought with a good thought, should “flood” his/her mind with the intrusive thought (Burns, 2006; Foa & Wilson, 2001).

Other therapeutic techniques have been developed around research that indicates a strong link between co-morbid dysphoria and the worsening of obsessions (Salkovskis, 1985). Often, there are self deprecating/self loathing characteristics associated with depression which can cause the individual to feel guilty about being depressed (Salkovskis, 1985). This guilt can activate schemas of excessive responsibility, (the responsibility for one’s own thoughts).
Deductively, it has been proposed that cognitive therapy aimed at confronting an individual’s depressive automatic thoughts can have a “trickle down” effect on obsessive symptoms (Salkovskis, 1985). Ultimately, the majority of treatment should be focused around decreasing the individual’s cognitions regarding the importance of intrusive thoughts. Cognitive treatment must include confronting and challenging the beliefs one holds regarding intrusive thoughts.

**Case Example: Pure Obsessions**

**Presenting Problem**

Patten is a 29-year-old British male who was treated in 2003 following five months of distressing intrusive thoughts. Patten explained that he could not rid himself of the thought that God was calling him to quit his new job, travel to Iraq, track down Sadaam Hussein and convert him to Christianity in order to prevent the otherwise imminent attack by the United States. Patten reported that if he did not follow through, it would prove that he did not have genuine Christian faith and that God would hold him responsible for all the loss of life during the war.

Patten disclosed that he felt extreme anxiety and distress whenever he heard a news report or read a newspaper regarding the build up of US and British troops in the Middle East. He disclosed that he was suffering from depression and feelings of condemnation over the fact that he had not yet followed through with “what God told him to do.” He reported sleeping often and not being able to enjoy activities because his thoughts would ruin them.

Patten believed the only way to rid himself of these thoughts was either to give into them or wait until the war started. He explained that once the war started he could be sure that there would be no conceivable way to get into the country or find Sadaam Hussein, effectively relieving him of his responsibility. Secretly, Patten hoped for war, which only caused him more
guilt for thinking such an abhorrent thought. Patten denied any thinking rituals or overt compulsions other than avoiding newspapers and news reports.

Patten described himself as usually anxious, especially in social situations and especially with girls. He reported always feeling keenly aware that people were judging him and looking down on him, waiting for him to make a mistake so they could criticize him. He remembered always giving extensive physical and mental energy trying to measure up to his peers, feeling that if he could not measure up, they would reject him. Patten expressed feelings of low self-esteem and low intrinsic self worth. He reported no significant problems with his parents.

**Early Childhood Data**

Patten was raised in a conservative Christian home and was devoutly religious. He was often praised by teachers and other adults about how sincere and honorable he was. He believed that one gains respect through sincere acts and was heavily praised for sincerity in his faith, morals, speech and conduct. Patten reported largely basing his sense of worth on these types of praises. Patten remembered how difficult it was trying to keep a “spot tight” image and reported having to participate in an increasing number of religious activities in order to continue receiving accolades. Patten revealed believing that these religious acts earned him favor with God. Though he often felt intense pressure and distress over the type and amount of religious activities, he continued them for fear of divine repercussions.

Patten remembered attending church camps as a child and listening to preachers vividly depict scenes of hell. He reported being taught the idea that it was his responsibility to convert people and prevent them from going to hell. He remembered being given the image of judgement day, and his friends being dragged down to hell screaming and asking him why he never converted them. He stated that he was so impacted by this idea that he wrote a song where the
Life produces a stimuli which triggers an intrusive thought. The intrusive thought is ego dystonic with one’s worldview. The dystonic thought is attended to by the individual because of a preexisting adherence to an OCD belief domain, (i.e. overestimation of danger). The thought is misinterpreted as being important. The individual has automatic thoughts (ego syntonic) (i.e. I should always be in control of what I think about). The individual feels guilt secondary to automatic thoughts. The guilt feeling reinforces the OCD belief domain (over-Importance of thoughts) which brings the intrusive thought back into consciousness, restarting the cycle. The automatic thought (ego syntonic) interacts with one’s held cognitive schema producing more feelings of guilt, emboldening the power of the intrusive thought.
chorus repeated, “he’s burning in hell, he shouldn’t be but I fell.”

Intrusive Thought:
- You must go to Iraq in order to prevent the war
- You alone will be held responsible for the Iraq war
- You should prevent the war and any loss of life
- God will reject you if you do not go to Iraq
- You will probably go to hell if you do not go to Iraq

Dystonicity with belief system:
- God is loving and his favor is unmerited
- If God wanted you in Iraq he would give you a desire to go
- God does not reject those he loves
- You will be held accountable for something you have no involvement in
- You are responsible for the actions of others

Interaction with Belief Domains
- Inflated sense of responsibility
- Thought-Action-Fusion
- Over importance of thoughts (sincerity)
- Intolerance of uncertainty

Catastrophic Misinterpretation

General
If I don’t prevent something bad from happening it is equally as bad as causing it

Specific
If I don’t do something to prevent the war, it is equally as bad as starting it

General
Having a thought is equally as bad as carrying it out

Specific
Wanting the war is equally as bad as causing the war

General
Having a thought gives it’s contents credence

Specific
The intensity of these thought shows they are genuinely from God

**General**
To have any peace about a decision I must know for certain it is correct

**Specific**
If God does not want me in to Iraq, he will make it impossible for me to go, i.e. start the war.

**Automatic Thoughts**
- You always fail everyone

You are not good enough
- You are not doing enough
- You are a fraud

**Cognitive Distortions/Self Defeating Beliefs**

- **Dichotomous Thinking**- You are either accepted or rejected, in or out, faithful or faithless
- **Pleasing Others**- I should always try to please others even if it make me miserable in the process
- **Approval Addiction**- I need everyones approval to be worthwhile
- **Performance Perfection**- I must never fail or make a mistake
- **Worthlessness**- I am basically worthless and inferior to others
- **Superman Syndrome**- I should always be strong and never weak
- **Perceived Narcissism**- The people I care about are demanding, manipulative and powerful

**Achievement Addiction**- My worth as a human being depends on my achievements, intelligence talents and status.

(Self Defeating Beliefs: Burns, 2006)

**Feelings/Emotions**
- Depressed, Anxious, Stressed

**Actions**
- Try to replace intrusive thought with a positive thought
- Avoid Newspapers and News Reports
- Try to dismiss or reject intrusive thoughts
References


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