

Understanding Obsessions

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When people discuss OCD, they often talk about washing, checking, hoarding and other compulsive behaviours. This is probably because these aspects of OCD can be highly visible to friends, family members and sometimes even to passers-by in the street. A common symptom of OCD that is almost always invisible is the obsession.

Obsessions are defined as unwanted, intrusive thoughts, images or impulses that cause significant distress or interference in everyday life. They tend to fall into one of three fairly well established categories: aggressive, blasphemous and sexually repugnant obsessions. What is interesting about this definition is that it does not correspond well to how we use the word “obsession” in common language. Someone who is ‘obsessed’ with cars or with an attractive neighbour would not receive a diagnosis of OCD because these kinds of thoughts have a pleasurable quality to them. Obsessions as they exist in OCD are NOT pleasurable; they are almost always repugnant, distressing and cause a great deal of anxiety and fear. This provides one way to distinguish between someone who has intrusive thoughts about the possibility that they might “lose control and go on a murderous rampage” and someone who actually would like to kill people.

One of the most fascinating research findings about intrusive thoughts is that we all seem to have them. A landmark paper published in 1978 showed that over 90% of people *without OCD* reported having occasional intrusive thoughts about a variety of violent (aggressive), religious (blasphemous) and/or sexually repugnant themes. These thoughts were indistinguishable from the kinds of obsessions reported by people diagnosed with OCD, except that those with the diagnosis reported that their thoughts were much more frequent, distressing and difficult to dismiss. In fact, when a list of unwanted, intrusive thoughts, images and impulses reported by people with OCD and people without OCD were given to mental health professionals (e.g., psychiatrists, psychologists), the professionals could not tell which thoughts came from which group. That is, the content of obsessions is not unique to those suffering from OCD. This finding has been replicated many times and was very important to the development of new ways of thinking about and treating obsessions.

Since it seems that almost everybody has unwanted, intrusive thoughts, but only some people are troubled by them to such a degree that they would receive a diagnosis of OCD, researchers and theorists tried to develop an explanation (and an associated treatment) for this problem. We now believe that obsessions are caused by misinterpreting these intrusive thoughts as being particularly significant or meaningful to the person. That is, most of us simply disregard unwanted intrusive thoughts as odd, silly or unimportant; and consequently, most of us do not suffer from obsessions. Those who do suffer from obsessions tend to report that their unwanted intrusive thoughts are highly significant and very indicative of what kind of person they are. For example, someone not troubled by obsessions, who has an unwanted thought about harming their spouse, is very likely to ignore it. Someone with obsessions is likely to interpret these thoughts as indicating that they are a risk to their partner, dangerous and a potential murderer. It is no wonder that people who interpret their thoughts as signifying that they are a potential murderer,

sexual molester and/or truly evil (in a religious context), go on to experience extreme fear and anxiety.

Effective treatments for obsessions generally include medications and/or cognitive-behaviour therapy (CBT). Although the combination of medication and CBT is often used in the treatment of OCD, evidence suggests that each approach is effective on its own. However, there is some evidence that supports the idea that CBT may be more effective than medications in the long run as it seems to protect against relapse, whereas medications do not. For information about medication-based approaches, please contact your family physician. For information about CBT for obsessions, please contact a psychologist who specializes in this approach. Newer cognitive-behavioural treatments for obsessions typically help the client/patient to develop and test out other (less threatening and more rational) interpretations of their intrusive thoughts. Once an individual begins to adopt a more benign interpretation of their thoughts, their obsessions, as well as associated distress and avoidance, tend to decrease dramatically.

The above theory and treatment were both developed following extensive research. We believe that the best treatments are those built upon strong research findings. If you are interested in learning more about research in OCD, please contact the Foundation, who can tell you about ongoing research projects in various parts of Quebec. Your participation could help in the development of new and effective treatments.