Intrusive Thoughts in Clinical Disorders: Theory, Research, and Treatment
David A. Clark (Ed.). New York: Guilford Press (www.guilford.com). 2005, 255 pp., $35.00 (hardcover).

If I am asked about intrusive thoughts as a feature of a clinical disorder the first disorder that comes to mind is OCD. Given a moment I would add PTSD. After reading this book I would also add depression, insomnia, psychotic disorders and generalized anxiety disorder. The most startling addition to the list is unwanted thoughts experienced by sex offenders. Much of my own work is focused on OCD where intrusive thoughts are part of the experience of obsessions and central to the definition of the disorder. This book begins with a description of intrusive thoughts in non-clinical populations and then builds on this base with chapters devoted to how intrusive thoughts play a role in each of the clinical disorders listed above.

Years of research now confirm that unwanted intrusive thoughts are ubiquitous and that non-clinical populations and people with clinical disorders report intrusive thoughts with similar content and form. The cognitive model of OCD holds that the important difference between individuals with OCD and those without is in the frequency and experienced intensity of these thoughts. The differences in frequency and intensity are explained by the interpretation of the significance of the thoughts in the first place.

Intrusive thoughts in the form of images, memories and urges are more common in PTSD than lexical intrusions. Indeed intrusive recollections are common to trauma survivors but we lack a good theory of why some develop PTSD and others don't. As in OCD, efforts to avoid or suppress intrusions typically backfire and lead to the increased frequency and perceived intrusiveness of the trauma related intrusions. Treatments for PTSD such as prolonged exposure and stress inoculation training have been shown to be efficacious. Both frequency and intensity of trauma related intrusions decline in response to treatment. The addition of cognitive restructuring and psychoeducational interventions help reduce self-blame and other dysfunctional thoughts and normalize the experience of intrusive recollection.

Intrusive thoughts in depression are differentiated from negative automatic thoughts. The intrusive thoughts are often but not always negative, and like intrusive thoughts in non-clinical populations and in other disorders the impact depends on how intrusive thoughts are interpreted. The intrusions typically pop into mind and are often completely unrelated to the ongoing theme of thought. While the content may well be negative and serve to maintain depression the thoughts may also be quite anxiety-producing. Depressed individuals report higher frequency and intensity of both anxiety producing and depression maintaining intrusive thoughts than non-depressed individuals. Unlike anxiety disorders like OCD where intrusions are typically described as ego dystonic, individuals with depression tend to have intrusive thoughts that are consistent with their negative view of themselves, the world and the future. Models of cognitive vulnerability to depression hold that dysfunctional thoughts would precede depression. However research has not consistently supported these hypotheses. Formerly depressed people who are primed by minor downturns in mood do tend to show dysfunctional negative thoughts. Formerly depressed people are likely to experience and struggle with negative intrusive thoughts especially when in otherwise demanding situations. The implications for treatment include recognizing and dealing with depressive intrusions. Starting with the understanding that efforts to suppress intrusions will be likely to backfire alternatives (such as responding mindfully) would be expected to reduce the impact of the

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intrusions and contribute to the reduction in relapse. This is the explanation for the reduced relapse rate seen in people exposed to mindfulness-based cognitive therapy.

People struggling with chronic insomnia often have intrusive thoughts about not being able to sleep or possible consequences of sleep deprivation. Although insomnia is often part of the picture in people with anxiety disorders or depression and may be thought of as a secondary problem this particular conceptualization serves to obscure a more complex relationship between the problems and perhaps lead away from effective interventions. People with insomnia tend to experience unwanted intrusive thoughts before sleep onset and tend to attribute difficulty falling asleep to their level of cognitive arousal. In addition, these same people spend much of their day concerned about their insomnia and are likely to experience the same sort of intrusive thoughts about not being able to sleep and the consequences of sleep deprivation, which in turn contributes to their general level of anxiety and discouragement. The intrusive thoughts about sleep are shaped by the dysfunctional beliefs about sleep that are characteristically observed in people with insomnia. As we might expect attempts to suppress the thoughts are unsuccessful and disrupt sleep while alternative strategies such as mindfulness facilitate sleep onset.

Worry has characteristics in common with intrusive thoughts. Worry is often triggered by an intrusive thought and is usually experienced as uncontrollable. Worry is seen as a contributor to a range of psychological disorders and is one of the central complaints in generalized anxiety disorder (GAD). Worry is defined as a predominantly verbal process of contemplating potentially dangerous situations. Unlike obsessions worry tends to be ego syntonic and can be conceptualized as a response to intrusions which functions like a compulsion to attempt to reduce anxiety. People typically hold beliefs that worry serves some purpose such as helping prepare for or avoid danger while at the same time thinking of worry itself as uncontrollable and dangerous. The model presented includes two types of worry. Type I is the response to the initial “what if” intrusion. The individual attempts to generate coping responses and answers through worry until they reach an internal state they view as safe. Type II worry involves negative metacognitions about worry, such as “Worry is dangerous and uncontrollable,” leading to a sense of failure to cope and increased concern about the effect of worry on one’s mental or physical health. The type II worry has maintained the type I worry by removing the feeling of safety which in turn leads to a failure to learn that worry can be controlled or that worry is not dangerous. This triggers further uncertainty which leads to more worry. The therapeutic strategy derived from this model includes challenging negative metacognitions about worry, such as it's uncontrollability and danger, and the positive beliefs about worry such as it's value in coping with or preventing danger.

Intrusive thoughts are the material from which obsessions are made. As it is now clear that intrusive thoughts are a nearly universal experience then the question becomes how do we explain why some people develop obsessions from them and others don't. It seems that there are some vulnerability factors including high negative affect, an inductive idiosyncratic narrative where reasoning errors abound, but perhaps most important are faulty metacognitive beliefs. The intrusion is appraised and is guided by these faulty beliefs which include inflated responsibility, misinterpretation of the significance of a thought, thought-action fusion, exaggerated threat, the importance of control of thoughts and importance of ego dystonic thoughts. There are additional faulty appraisals of the significance of the failure to suppress or control intrusions. The treatment implications of this model include cognitive interventions focused on the process of inference, identification of the reasoning errors, and constructing a new narrative.

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Psychotic disorders are characterized by hallucinations and delusions. The book presents a cognitive model of psychosis which links hallucinations and delusions to intrusive thoughts. The model holds that both hallucinations and delusions can be seen as based in ordinary experiences where dysfunctional attributions and interpretation of intrusive thoughts leads to development of psychotic features. As an example, an intrusive impulse to throw a child across the room might be interpreted in a number of different ways. If it is seen as an indication of being tired and stressed it may be passed off as an understandable but unimportant thought. If the same impulse is experienced as a precursor to an unwanted action and the individual attempts to suppress it, then the urge may develop into an obsession. If the individual interprets the intrusion as sent by some outside force trying to control them by radio waves, then the intrusion is likely to develop into a psychotic symptom. The limited research that addresses the cognitive aspects of psychosis supports this model. Unwanted intrusive thoughts may be involved in both development and maintenance of psychosis. The dysfunctional attributions and interpretations are consistent with metacognitive beliefs found more commonly in individuals with psychotic diagnoses and those with high predispositions to hallucinations. Treatment strategies that follow from the model include normalization and development of alternative interpretations of intrusions and psychotic experiences as well as identifying and reevaluating metacognitive beliefs. These are the strategies that are applied in cognitive therapy for schizophrenia, an approach which has begun to accumulate substantial empirical support.

When I saw the title of the book and knew who edited it I expected a discussion of OCD and PTSD since I thought of them as disorders where intrusive thoughts are central features. When I was read chapters on depression, generalized anxiety, insomnia and psychosis I able to quickly see where the concept of intrusive thoughts was clearly helpful and a good fit with my concepts of these disorders. When I came to the chapter on sexual offenders I found the focus startling at first. I soon found myself thinking, “But of course!” The troubling intrusive thoughts in sexual offenders are not ones about carrying out sexual acts, but intrusions involving negative self appraisal which is most often global rather than about specific behaviors or traits. These intrusions contribute to more negative mood states which in turn increases deviant sexual fantasy and may increase the likelihood of re-offending. As with other types of intrusive thoughts, attempts to suppress these negative self-appraisals are at best unsuccessful and are likely to increase the frequency and salience of the intrusions. In contrast, efforts to increase positive self-appraisals may be effective in reducing the unwanted negative intrusions. If after treatment the sexual offender responds to the experience of deviant sexual fantasy as an indication of failure and this triggers an increase in the intrusive global negative self-appraisals then there is increased likelihood of an abstinence violation effect. Relapse prevention strategies may be effective in reducing this risk.

Sexual offenders do report intrusive unwanted thoughts about being caught and associated consequences such as being humiliated or imprisoned. While at first such thoughts might seem like a good thing these intrusions don't reduce the risk of offending behavior. In fact these thoughts may well habituate and drop in frequency over time. Ironically it appears that programs that identify offenders in the community lead to increased realistic concern about being identified which in turn may increase risk of re-offending resulting in increased risk to the community.

Intrusive thoughts are central features of a range of disorders that represent important challenges to the clinician. It is now clear that the intrusive thoughts themselves are ordinary events and they only become problems when they are interpreted in dysfunctional ways. This

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book reviews the relevant research and clearly describes the role of intrusive thoughts in a range of disorders and points to clinical strategies that can help us treat the disorders effectively. Cognitive therapy begins with a conceptualization of the individual and this book offers a valuable insight into the role of intrusive thoughts in a range of disorders. These are important concepts to include in our case conceptualizations.

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