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BRASIL
ABNORMAL AND NORMAL OBSESSIONS

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Summary—Three related, exploratory studies were carried out in order to ascertain the occurrence and nature of normal obsessions, and to relate them to abnormal obsessions. The subjects included 8 obsessional patients, and up to 124 non-clinical subjects.

Broadly, the findings were that normal obsessions are a common experience and they resemble the form of abnormal obsessions. They also show some notable similarities of content. However, normal and abnormal obsessions differ in several respects, including frequency, duration, intensity and consequences, among others.

With repeated practice, the frequency, duration and discomfort of obsessions are observed to decrease. Overall, the findings are considered to be consistent with the noxious stimulus cum habituation theory.

In the course of developing a theory to account for obsessions it became necessary to assume that all people experience a phenomenon akin to ‘clinical’ or ‘abnormal’ obsessions (Rachman, 1971). The first aim of the present investigation was to test this assumption.

Secondly, we set out to determine the similarities and differences between normal and abnormal obsessions. And finally, we attempted to gather some preliminary experimental data pertinent to that part of the theory which postulates that obsessions are subject to an habituation-like process.

In the earliest form of the theory it was proposed that obsessional material should be construed as (largely internal) noxious stimuli to which the person has failed to habituate. Such failures to habituate were assumed to be the result of a combination of factors including mood disturbance, pre-disposing hyper-sensitivity, specially significant material, heightened arousal and in a majority of cases, a precipitating event. Habituation to potentially or actually disturbing material was (presumably) facilitated by lowered arousal, stable mood, repeated presentations of evoking stimuli, prolonged exposures. The subsequent elaborations of the theory (Rachman, 1977; Rachman and Hodgson, 1978) are of marginal relevance to the present experiment and will not be taken up here.

The first study, which aimed to find out whether non-psychiatric subjects experience obsessions, consisted of a simple questionnaire survey. The second study, in which we sought to discover the similarities and differences between clinical (abnormal) and non-clinical (normal) obsessions, consisted of standardized interviews of obsessional patients and non-clinical subjects with obsessions. The third study, in which we tested whether obsessions can be formed to instruction and whether they show signs of habituation, consisted of a simple experiment carried out on clinical and non-clinical subjects.

For purposes of the investigations, obsessions were defined as repetitive, unwanted, intrusive thoughts of internal origin. A full discussion of this definition and its conceptual justification is provided elsewhere (Rachman, 1978, and Rachman and Hodgson, 1978).

STUDY I—NORMAL OBSESSIONS

A simple questionnaire was given to 124 normal people, inquiring about the presence or otherwise of intrusive, unacceptable thoughts and impulses, their frequency, and about whether or not these could be easily dismissed. The questionnaire inquired about thoughts and impulses separately.

The sample was not random, but was determined by easy availability. Most were students—postgraduate, undergraduate or professional—and some were employed as
research workers, nurses, clinicians etc. Fifty-seven of the sample were males, and 67 were females. Their age ranged from 16 to 51, with a mean of 27.7 years. The average age of the males was 28 years (range 19–51) and that of the females 27.5 years (range 16–45).

**Respondent's characteristics**

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age</td>
<td>28</td>
<td>27.5</td>
<td>27.7</td>
</tr>
<tr>
<td>Range</td>
<td>19–51</td>
<td>16–45</td>
<td>16–51</td>
</tr>
<tr>
<td>Number</td>
<td>57</td>
<td>67</td>
<td>124</td>
</tr>
</tbody>
</table>

Of the 124 respondents, 99 reported that they had either thoughts or images. Twenty-five responded negatively—i.e. they had neither thoughts nor impulses. In other words, 79.84 of the total sample of normals were positives, and 20.16 were negatives. This substantially confirms the first hypothesis of this investigation—viz. that non-psychiatric subjects commonly experience obsessions. There were no age or sex-related differences in presence or absence of obsessional experiences.

**Negative respondents.** No systematic study was made of the negative respondents. However, some of them made unsolicited comments and observations on the questionnaire forms and verbally. Five subjects emphasized that they did have obsessions of the type given in the examples in the questionnaire, but did not consider them to be unacceptable; they had therefore responded in the negative. Of these five, three admitted to having both thoughts and impulses of this sort, one to having thoughts only, and the other impulses only. One of the positive respondents, a female who had responded positively to impulses only, also indicated she had some of the thoughts in question, but did not consider them to be unacceptable.

The conclusion from these unsystematic data seems to be that people vary in the level of tolerance, or criterion, of what is an acceptable thought or impulse, and what is not. One subject stated that: ‘My criterion of what is unacceptable is high.’ Another subject observed that: ‘I do not consider these unacceptable. But they are by ethical standards of society.’

For the present purposes, it must be noted that 5 out of a total of 25 negatives in the sample would have been classed positives, if not for the problem of unacceptability. If the present frequency data are revised, by re-classifying these 5 subjects as positive, then 104 out of 124 (i.e. 84%) would be positives. The explanation of why 16% have no obsessions is unknown.

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td>47</td>
<td>57</td>
<td>104</td>
</tr>
<tr>
<td>(82.5)*</td>
<td>(85.1)</td>
<td>(83.9)</td>
<td></td>
</tr>
<tr>
<td>Negative</td>
<td>10</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>(17.5)</td>
<td>(14.9)</td>
<td>(16.1)</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>57</td>
<td>67</td>
<td>124</td>
</tr>
</tbody>
</table>

*Figures within brackets show the number in the cell as a percentage of the total in category—male, female, total.

**The nature of normal obsessions.** Of the 99 positive respondents, 32 had only obsessional thoughts, 14 had only impulses, while 53 admitted to having both. The male–female breakdown for these data is as follows:

<table>
<thead>
<tr>
<th></th>
<th>Thoughts only</th>
<th>Impulses only</th>
<th>Both</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male:</td>
<td>18 (40)*</td>
<td>5 (11.1)</td>
<td>22 (48.9)</td>
<td>45</td>
</tr>
<tr>
<td>Female:</td>
<td>14 (25.9)</td>
<td>9 (16.7)</td>
<td>31 (57.4)</td>
<td>54</td>
</tr>
<tr>
<td>Total</td>
<td>32 (32.3)</td>
<td>14 (14.1)</td>
<td>53 (53.5)</td>
<td>99</td>
</tr>
</tbody>
</table>

*Figures within brackets show number in cell as a percentage of the total position in the category—male, female, total.
The following figures are for positives for thoughts and impulses separately, *including* in each category those who had both.

<table>
<thead>
<tr>
<th></th>
<th>Thoughts</th>
<th>Impulses</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male:</td>
<td>40 (59.7)*</td>
<td>27 (40.3)</td>
<td>67</td>
</tr>
<tr>
<td>Female:</td>
<td>45 (52.9)</td>
<td>40 (47.1)</td>
<td>85</td>
</tr>
<tr>
<td>Total:</td>
<td>85 (55.9)</td>
<td>67 (44.1)</td>
<td>152</td>
</tr>
</tbody>
</table>

* Figures within brackets show number in cell as a percentage of total in category—male, female, total.

(Note that the totals here exceed the total cases, as some subjects had both thoughts and impulses, as indicated above). Evidently obsessional thoughts are somewhat more common than impulses.

The frequency of the occurrence of thoughts is given below. Also indicated in the table is the respective number of cases who found it was easy to dismiss the thought or not, including a 'doubtful' category.

### Frequency and dismissability of obsessional thoughts

<table>
<thead>
<tr>
<th></th>
<th>Easily dismissed</th>
<th>Not easily dismissed</th>
<th>Doubtful</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>10+/day</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>10+/week</td>
<td>13</td>
<td>3</td>
<td>0</td>
<td>16</td>
</tr>
<tr>
<td>10+/month</td>
<td>28</td>
<td>4</td>
<td>1</td>
<td>33</td>
</tr>
<tr>
<td>Less</td>
<td>27</td>
<td>4</td>
<td>2</td>
<td>33</td>
</tr>
<tr>
<td>Total</td>
<td>69</td>
<td>13</td>
<td>3</td>
<td>85</td>
</tr>
</tbody>
</table>

### Frequency and dismissability of obsessional impulses

<table>
<thead>
<tr>
<th></th>
<th>Easily dismissed</th>
<th>Not easily dismissed</th>
<th>Doubtful</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>10+/day</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>10+/week</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>10+/month</td>
<td>22</td>
<td>4</td>
<td>0</td>
<td>26</td>
</tr>
<tr>
<td>Less</td>
<td>31</td>
<td>4</td>
<td>0</td>
<td>35</td>
</tr>
<tr>
<td>Total</td>
<td>59</td>
<td>8</td>
<td>0</td>
<td>67</td>
</tr>
</tbody>
</table>

The patterns of frequency, and ease of dismissal, are similar for the two sexes. Impulses tend to be slightly less frequent in that, in the majority, they occur less than 10 times a month. Also, people seem to find impulses very easily dismissible, and obsessional thoughts easily dismissible. We were unable to identify any individual factors determining ease of dismissal. Cases positive for both, who found it difficult to dismiss thoughts did not necessarily find it difficult to dismiss impulses—or vice versa. The general tendency is for impulses to be more easily dismissible even in these cases, although numbers are too small to draw any firm conclusions.

To conclude Study I, obsessions (thoughts and/or impulses) are a very common experience. There are no sex or age-related differences in occurrence, and most thoughts and impulses are easily dismissed. There are individual variations in the threshold of acceptability of obsessional thoughts or impulses.

### STUDY II—SIMILARITIES TO ABNORMAL OBSESSIONS

The second stage of the investigation consisted of standardized interviews of a sample of the positive respondents, and a sample of clinical obsessionals—i.e. patients who had come for psychiatric help for their obsessions. Our aim was to collect detailed information about their obsessions and related matters, and to test the short-term effects of repeatedly provoking the obsessions. It was planned to compare the two groups
so that similarities and differences between them, with regard to the obsessions and their response to repeated evocation, could be explored.

The interview sessions were carried out by the same experimenter (P. de S.) for all subjects, clinical and non-clinical. The interview was a structured one, using a prepared schedule and a set of agreed guidelines for its use. After recording the essential background data and relevant data on the target obsession/s, the repeated evocation tests were given.

If a subject was unable to produce the obsession on request in one session, another session was arranged wherever possible. No subject was seen for this purpose more than thrice.

The non-clinical sample. A total of 40 subjects chosen from the positive respondents to the questionnaire, comprised the non-clinical sample. Although it was originally intended to choose the sample from among those whose obsessions had a frequency of at least 10 per week, the final sample was determined mainly by availability. It had the following composition:

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age</td>
<td>30.2</td>
<td>27.2</td>
<td>28.4</td>
</tr>
<tr>
<td>Number</td>
<td>16</td>
<td>24</td>
<td>40</td>
</tr>
</tbody>
</table>

The clinical sample consisted of eight subjects, as follows:

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age</td>
<td>42.8</td>
<td>38.3</td>
<td>41.1</td>
</tr>
<tr>
<td>Number</td>
<td>5</td>
<td>3</td>
<td>8</td>
</tr>
</tbody>
</table>

They were all obsessional patients who had come for psychiatric treatment and in whom the obsessions were either the sole complaint or one of the major complaints. They were from the Maudsley, Bethlem Royal, Guy's, and Queen Elizabeth II Hospitals.

Content analysis. The contents of the obsessions are reported below. Only current obsessions of the subjects have been included. Verbatim descriptions are given when the obsession concerned takes a particular, invariant verbal form. The presence of imagery is noted only when the image constitutes an essential and/or prominent part of the obsession. Circumstances of occurrence, and the specific target person or object, are given only when the content is inextricably bound up with them.

An obsession has been considered as a single, independent one, on the basis of the judgement of the subject himself. Sometimes, common themes with slightly varying details were reported; in such cases, the obsession has been considered as one. On the other hand, certain subjects reported more than one obsession with an underlying theme (e.g. violence), where the individual obsessions were reported to be independent and specific in terms of target person, object, circumstances etc. despite the common theme. These have been considered as individual units. The total number of obsessions exceeds the number of subjects as some of them reported several obsessions.

The obsessions of the clinical sample are given below. There is a total of 23, elicited from 8 subjects.

- Impulse to attack, or strangle, cats or kittens
- Impulse to strangle children, sometimes adults
- Impulse to jump out of window
- Impulse to attack and harm someone, especially own son, with bat, knife or heavy object
- Thought of ‘disgusting’ sexual acts with males (male subject)
- Impulse to look at buttocks of boys and youths (male subject)
- Thought whether he has been poisoned by chemicals
- Thought that his eyes will be/are harmed
Thought that he will get/has got cancer
Thought whether he has been affected by radiation
Thought ‘These boys when they were young’—a mechanically-repeated phrase
Thought of ‘bad’ people doing ‘all sorts of harm’, of a violent form, to ‘good’ people—i.e. family, relatives, religious persons
Thought that she might harm someone
Thought ‘I wish he/she were dead’, with reference to persons close and dear, also others
Thought of swear words, with large, clear images of the words in print
Impulse to utter swear words
Thought ‘Did I commit this crime?’, when reading or hearing reports of crime
Thought that he may become insane, and end up in an institution
Thought that he may go berserk all of a sudden
Thought that he might push someone under a bus or train
Impulse to harm girl-friend with physical violence
Impulse to physically attack and harm dog, mainly own dog, but also to some extent other dogs
Impulse to harm children with physical violence
The obsessions of the non-clinical sample are given below. There is a total of 58, from 40 subjects. In a very few cases, there was failure to record the content of a second (or third) obsession of the subject. A total of 7 have been omitted in this way (the second obsession of three subjects; the third of two subjects; and the second and the third of one subject).

Impulse to hurt or harm someone
Thought ‘what is the calorie content of that food?’
Impulse to jump on to rails, when tube train is approaching
Thought of intense anger towards someone, related to a past experience
Thought of accident occurring to a loved one
Impulse to say something nasty and damning to someone
Thought of harm to, or death of, close friend or family member
Thought of acts of violence in sex
Thought that something is wrong with her health
Impulse to physically and verbally attack someone
Impulse to do something—e.g. shout, throw things—to disrupt peace in a gathering
Impulse to jump in front of tube train, or bus
Thought of harm befalling her children, especially accidents
Thought that probability of air-crash accident to herself would be minimised if a relative had such an accident
Thought whether an accident, especially car accident, had occurred to a loved one
Impulse of violence towards objects
Impulse to buy unwanted things
Thought identifying himself with person executed, when reading or hearing reports of executions—‘How would I feel at that moment if I were him?’, also clear image sequence
Thought that she, her husband and baby (due) would be greatly harmed because of exposure to asbestos, with conviction that there are tiny asbestos dust particles in the house
Thought whether any harm has come to his wife
Impulse to shout at and abuse someone
Impulse to harm, or be violent towards children, especially smaller ones
Impulse to crash car, when driving
Thought ‘Why should they do that? They shouldn’t do that’, in relation to people ‘misbehaving’
Impulse to attack and violently punish someone—e.g. to throw a child out of bus
Thought whether any harm has come to his wife
Thought with clear visual image sequence, of walking along a crowded passage, and suddenly discovering that he is naked

Thought with image sequence, of the details of an accident that she had experienced

Impulse to say rude things to people

Thought about accidents or mishaps, usually when about to travel

Impulse to push people away and off, in a crowd—e.g. a queue

Impulse to attack certain persons

Thought of being aggressive towards some persons

Impulse to say inappropiate things—‘wrong things at wrong place’

Thought of hurting someone by doing something nasty, not physical violence—‘Would I or would I not do it?’

Impulse to hurt someone by saying something nasty, or deliberately shaming him/her

Impulse sexual impulse towards attractive females, known and unknown

Thought wishing that someone disappeared from the face of the earth

Impulse of violence towards a person

Thought that harm would have befallen to someone near and dear

Thought of ‘unnatural’ sexual acts

Thought wishing and imagining that someone close to her was hurt or harmed

Impulse to hurt, or harm, someone

Impulse to shake someone hard and shout at him/her

Thought of experience/s many years ago when he was embarrassed, humiliated, or was a failure

Impulse to violently attack and kill a dog

Impulse to violently attack and kill someone

Thought that she might do something dramatic like trying to rob a bank

Impulse to jump from top of a tall building or mountain/cliff

Thought of being violent towards a known person, causing harm, in revenge

Impulse to sexually assault a female, known or unknown

Impulse to say rude and unacceptable things

Thought of an embarrassing or painful experience he has had, with visual image sequence

Impulse to engage in certain sexual practices which involve pain to the partner

Impulse to be rude and say something nasty to people

Impulse to jump off the platform when a train is arriving

Thought of physically punishing a loved one

Thought that she might commit suicide

Clinical vs non-clinical. In an attempt to examine the similarity between the two types, a small sub-study was carried out to determine whether the obsessions of clinical and non-clinical subjects are discriminable on the basis of the content alone. For this purpose, the 81 obsessions were printed on cards, giving only the content (as summarised above). These were shuffled and given to six judges (five psychologists and one psychiatric nurse) who had clinical experience with obsessional patients, along with instructions to sort the 81 obsessions into 2 piles—normal and abnormal—in terms of whether they came from patients or non-patients. The number of correctly identified ‘clinical’ obsessions were 10, 13, 13, 10, 13 and 18 for the six judges. Their response as ‘clinical’, were as follows:

<table>
<thead>
<tr>
<th>Judges</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Correct positive guesses (out of 23 clinical obsessions)</td>
<td>10</td>
<td>13</td>
<td>13</td>
<td>10</td>
<td>13</td>
<td>18</td>
</tr>
<tr>
<td>58 Non-clinical obsessions judged to be clinical</td>
<td>13</td>
<td>10</td>
<td>10</td>
<td>13</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>58</td>
<td>58</td>
<td>58</td>
<td>58</td>
<td>58</td>
<td>58</td>
<td>58</td>
</tr>
</tbody>
</table>
It appears that the judges were not able to identify the clinical obsessions too well, but on the other hand they were moderately good at identifying non-clinical obsessions. From this we can conclude that clinical obsessions are not as readily discernible—even to experienced clinicians—as might be expected.

**DIFFERENCES BETWEEN THE CLINICAL AND NON-CLINICAL SAMPLE**

(a) *Number of obsessions at present*

<table>
<thead>
<tr>
<th></th>
<th>Clinical sample</th>
<th>Non-clinical sample</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Range</strong></td>
<td>1–7</td>
<td>1–3</td>
</tr>
<tr>
<td><strong>Mean</strong></td>
<td>2.9</td>
<td>1.45</td>
</tr>
<tr>
<td><strong>N</strong></td>
<td>8</td>
<td>40</td>
</tr>
</tbody>
</table>

(b) *Time since onset* *

<table>
<thead>
<tr>
<th></th>
<th>Clinical sample</th>
<th>Non-clinical sample</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Range</strong></td>
<td>1 yr–46 yr</td>
<td>3 m–24 yr</td>
</tr>
<tr>
<td><strong>Mean</strong></td>
<td>15</td>
<td>9.4 yr</td>
</tr>
<tr>
<td><strong>N</strong></td>
<td>8</td>
<td>40</td>
</tr>
</tbody>
</table>

* In cases where more than one obsession was present, the duration given is that for the one of which the duration was longest. It must also be noted that there is a difficulty in comparing the two samples on this, as the clinical sample was considerably older.

(c) *Overt compulsions unrelated to obsessions*

In the clinical sample, five (5/8) reported having compulsive behaviour (e.g., checking, washing), while in the non-clinical sample, eleven (11/40) reported having them.

<table>
<thead>
<tr>
<th>Other rituals</th>
<th>No other rituals</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Non-clinical</td>
<td>11</td>
<td>29</td>
</tr>
</tbody>
</table>

(d) *Other problems*

In the clinical sample, one (1/8) also had a social phobia, but none of the other 7 had psychiatric complaints (other than obsessional behaviour noted above). In the non-clinical sample none had any such condition.

(e) *Family*

Only one (1/8) person in the clinical sample said a parent was obsessional. One had an aunt who was obsessional. In the non-clinical sample nine (9/40) had parents described as obsessional. Three others had a close relative who was obsessional.

<table>
<thead>
<tr>
<th>Parent obsessive</th>
<th>Other close relative obsessive</th>
<th>No relative obsessive</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical</td>
<td>1</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Non-clinical</td>
<td>9</td>
<td>3</td>
<td>28</td>
</tr>
</tbody>
</table>

**CHARACTERISTICS OF THE OBSESSIONS**

Data were obtained in detail from every subject on one obsession. In cases of multiple obsessions, although it was hoped to obtain data on another obsession as well, in practice it was not possible to do this in detail. Thus, full data are available only on one obsession for each subject; and this was the one the subject considered to
be his/her current obsession. The form and content of all current obsessions were however recorded.

Clinical. The relevant data for the eight clinical subjects are given below.

Form. Three were impulses, and 5 were thoughts. Three (2 thoughts and 1 impulse) had invariant and clear visual imagery associated with them.

Overall duration. Mean of 15 years, range 1–46 yr.

Onset. Four subjects had a clear idea as to the onset. One had a vague and uncertain association with a certain event (father's death) with the onset of the obsession, and the other three had no idea as to the specific onset. Of the four who did claim clear memory of onset, in one it was change of residence and associated reservations and doubts (leading to impulses to harm son). In another, it was the death of known co-workers due to suspected radiation effects (leading to thought he may have been poisoned by chemicals); in one, it was a common sight of some children in a certain place at a certain time in his life (leading to a senseless thought about the same children); and in the other, the death of a known person which the patient's mother kept secret from her for some time (leading to the thought that she wished death to others).

Duration. Reported duration of each obsession varied from 2 sec to 5 min, with a mean of 80.7 sec. In five cases, the duration was 20 sec or less.

Frequency. Frequency of occurrence varied from 3 per day to 150 times per day, with a mean of 27. Five reported frequencies of 10 or more per day. Most said the frequency varied, especially in relation to mood (see below).

Repetitiveness. Only three described a tendency for the obsession to return immediately, or almost immediately, having occurred and gone away.

Resistance. Four reported high resistance to the obsession, three moderate resistance, and one low resistance. Two of those reporting moderate resistance and the one reporting low resistance stated that initially they had resisted strongly, but now they were 'used to it'. This decline in resistance over time has also been independently observed among other types of obsessional–compulsive patients (Rachman and Hodgson, 1978).

Provocation. Five said their obsessions occurred with no identifiable external provocation; one said that subjective anxiety was the provoking factor. Interestingly, all these five were thoughts, as against impulses. In the case of the three impulses, sight of the target/s (e.g. children) or associated stimuli (e.g. bats or heavy objects, where impulse was to attack child with such object), that is external stimuli, invariably triggered the impulse. Of these three subjects, one would also sometimes get the impulse without provocation, and another would also sometimes get the impulse at the thought of going out.

Senselessness. Only two subjects had obsessions that they considered senseless. One of these was the mere mechanical repetition of a string of words ('these boys when they were young'). The other was not senseless so much as vague.

Personal involvement. Five had direct personal involvement, one had no personal involvement at all (one referred to in the above paragraph), and in two the involvement was indirect (harm coming to people known; harm being wished by self to others).

Intensity. Subjectively felt intensity was high in six, and moderate in two. The latter, however, reported it was high initially but had weakened over time.

Meaning. All except one (whose obsession was a string of words), said it had meaning for him/her. (However, this variable proved to be difficult to assess properly, particularly as senselessness was also inquired into—see above).

Alienness to self. Six felt the obsession was quite contrary to their normal self. In one, it was in keeping with his nature—he was prone to worry and anxiety about everything, mainly his health, and his obsession was whether he had been poisoned by chemicals. The eighth felt her obsession (wishing death of others) was not entirely alien to herself; however, the thought aroused guilt.

Discomfort. The felt discomfort/anxiety/uneasiness, on a 0–100 scale, varied from 10 to 90, with a mean of 62. One (whose rating of discomfort was 10), reported that somatic reactions (palpitations, pain at back of neck) accompanied the obsession. She also said the subjective discomfort was 100 initially, but it had come down.