



Review article

Obsessional thoughts in normal adults

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Abstract

Intrusive thoughts are inevitable and universal phenomenon. However it is also observed in psychiatric population and considered cardinal features of anxiety disorders including obsessive compulsive disorder. The main aim of the present study was to examine the content and frequency of normal and abnormal obsessional thoughts in normal young adults. Specific objectives of the study were to examine content and frequency of these thoughts and explore the methods used to deal with obsessional thoughts. For the present study, 60 community dwelling healthy young adults formed the sample. The tools used were Socio demographic Questionnaire, Semi structured interview, Modified Mini Screen, Intrusion questionnaire, General health Questionnaire, Padua Inventory-WSUR, Yale Brown Obsessive Compulsive Severity Scale and Hamilton depression scale. The results revealed intrusive/ obsessional thoughts were often experienced by normal participants. Further, normal group endorsed both normal and abnormal obsessions and the content of the normal group was similar with that of the clinical population. However, there seemed to be significant difference in the frequency of these thoughts among the normal population and clinical population. Normal population employed functional thought control method to deal with their daily obsessions.

INTRODUCTION

Thought is the process of reasoning and interpretation of whatever an individual perceives from his environment (Omoriegie & Carson, 2023). Repeti-

tive thoughts, which occur repeatedly and persistently over a duration in an individual, are a common phenomenon even in non-clinical populations (Audet et al., 2023). The content of these thoughts can be pleasant or unpleasant depending

on the person, and their frequency may be influenced by how much importance the individual attaches to them or by affective factors like emotional stability and perceived control

Obsessive thoughts are uncontrollable thoughts which are distressing, perceived as coming from within the individual and are intrusive in nature causing distress and anxiety to the individual who may or may not be accompanied by any neutralizing behaviour in an attempt to reduce the discomfort or level of anxiety (Brock et al., 2025). Obsessive compulsive disorder (OCD) is clinically heterogeneous and has a wide symptom dimensions (Cervin et al., 2022).

As outlined in the DSM-5 (2013), Obsessive-Compulsive Disorder (OCD) involves the presence of either obsessions, compulsions, or both. Obsessions are defined as recurring and intrusive thoughts, urges, or mental images that are perceived as distressing and unwanted. In contrast, compulsions involve repetitive actions—either behavioral or mental—that a person feels obligated to perform, typically as a response to obsessive thoughts or according to strict, self-imposed rules. The DSM-5 also includes a group of conditions under Obsessive-Compulsive and Related Disorders, which are similarly characterized by ongoing fixations and repetitive behaviors aimed at managing those fixations. Some of these conditions, such as trichotillomania (compulsive hair pulling) and excoriation disorder (compulsive skin picking), are specifically defined by repeated body-focused behaviors and continued attempts to control or reduce them.

According to ICD-10 (1992), obsessional thoughts are ideas, images, or impulses that enter the individual's mind again and again in a stereotyped form. They are almost invariably distressing (because they are violent or obscene, or simply because they are perceived as senseless) and the sufferer often tries, unsuccessfully, to resist them. They are, however, recognized as the individual's own thoughts, even though they are involuntary and often repugnant. Compulsive acts or rituals are stereotyped behaviours that are repeated again and again. They are not inherently enjoyable, nor do they result in the completion of inherently useful tasks.

Rachman (1981) defined unwanted intrusive thoughts “as repetitive thoughts, images, or impulses that are unacceptable and/or unwanted are accompanied by subjective discomfort”. According to Rachman, the necessary and sufficient conditions for a thought to be considered intrusive are that it interrupts an ongoing activity, is attributed to an internal origin, and is difficult to control (Clark, 2005). Rachman & Shafran (1998) obsessive compulsive disorders are characterised by intrusive quality, unacceptability, subjective resistance, and uncontrollability and are ego-dystonic. The salient characteristics of compulsions include: a repetitive, stereotypic, and intentional action a subjective pressure or urge to perform a diminished sense of voluntary control the goal of preventing or reducing distress or a dreaded consequence.

Although extensive research has been conducted on obsessive-compulsive disorder (OCD) and intrusive thoughts in clinical populations, there is a

significant lack of empirical data examining the occurrence, content, and coping mechanisms of obsessional thoughts in non-clinical or healthy individuals, particularly in the Indian context. Most existing studies are focused on Western populations, limiting cultural generalizability. Furthermore, very few studies have explored how normal individuals differentiate between acceptable and distressing thoughts and how they adaptively manage these intrusions in daily life. The present study addresses this gap by comparing the nature and frequency of both normal and abnormal obsessional thoughts in healthy adults and highlighting the coping strategies they employ.

MATERIALS AND METHODS

The present study was descriptive. Total 78 clinical and non clinical individuals participated in the study i.e. 60 non clinical and 18 clinical individuals. The normal young adults belonged to 18- 25 years of age range and with minimum education being up to 10th standard. None of them had any psychiatric and neurological illness. The Clinical group were also selected based on the inclusion and exclusion criteria, with minimum education being upto 10th standard and none had any other major psychiatric and neurological illness (other than Obsessive Compulsive disorder). Both the groups were screened using the Modified Mini Screen (Brandau et al., 2005) and General Health Questionnaire- 12 (Goldberg, 1978).

The sample for obsessive compulsive disorder individuals was taken from Gautam Hospital and Research Centre (GHRC), Jaipur; whereas normal controls were from the community. Test was conducted on individual basis. No time limit was given

for the participants. However usual time for most of the participant to finish was one hour. The participants were assured that their answers would be kept confidential. It was emphasised that each and every item should be answered and that there is no right and wrong answer. SPSS 17.0 (Statistical package for the Social Sciences) was used to analyse the obtained data. Socio demographic details such as age and education were analysed using Mean, Standard Deviation and gender, marital status, occupation and substance used were analysed using frequencies and percentages. Mean and standard deviation of the two groups were calculated and they were compared using t-test.

RESULTS

In normal group, majority of the people participated in the study were female (56.7%), were Hindus (73.3%), belonged to middle socioeconomic status (90%) and non smokers (73.3%), half of the participants consumed alcohol (50%) and all of them were students and unmarried with no history of psychiatric illness, treatment history and past history of medical illness.

In clinical group, the same results were observed on religion, socioeconomic status, non smokers and past history of medical illness. Whereas, majority of the participants were male (61.1%), housewife (27.8%), had treatment history (88.9%), non alcohol drinkers (88.9%) and all of them had history of psychiatric illness. The mean age of the normal group was 21.47 (SD= 2.09), and mean age of clinical group was 31.28 (SD=11.10). Mean for education in normal group was 14.95 (SD= 1.09) and mean for education in clinical was 13.94 (SD= 2.18).

Table 1: Types of intrusive thoughts endorsed by the normal group

Sl. no	Category	Frequency
1	Career	38
2	Family	15
3	Personal relationship	12
4	Marriage	8
5	Self	4
6	Past failure	3
7	Health issues	3
8	Cleanliness	3
9	Trust issues	2
10	exams	2
11	financial	2
12	fear of hurting someone close	2
13	guilt feelings	2
14	self care	1
15	dying in an accident	1
16	chopping someone's head	1
17	physical fitness	1
18	grudges	1
19	lack of confidence	1
20	doubting if doors are locked	1
21	fear of accident	1
22	earthquake	1
23	fear of losing someone close	1

24	wanting to have food from the plate of others	1
25	slapping the opposite sex	1
26	sex	1
27	body image	1
28	doubting if anything is left behind before leaving	1
29	visualising nightmares	1

Table 1.1 Techniques used by normal group to deal with the intrusive thoughts

Sl. no	Dealing with thoughts	frequency
1	Share with friends or family	26
2	Listening to music	18
3	Watch T.V or videos	9
4	Physical exercise/going for walk	9
5	Playing games	6
6	studying	4
7	sleeping	4
8	self motivation	4
9	smoking	2
10	working towards goal	2
11	internet surfing	2
12	cleaning	2
13	cry over it	2
14	taking care of skin	1
15	drinking alcohol	1
16	household work	1

17	checking doors	1
18	cooking	1
19	thinking how to accept it	1
20	going out	1
21	think something else	1
22	sketching	1
23	sitting alone	1
24	pinching oneself	1

As shown in table 1 and 1.1, in normal group majority of the population (38) gets thoughts related to career, followed by family (15) , personal relationship (12) , Marriage (8), Past failure (4), self; Health issues; Cleanliness (3) , Trust issues; exams; financial; fear of hurting someone close; guilt feelings; self care (2), dying in an accident; chopping someone's head; physical fitness; grudges; lack of confidence; doubting if doors are locked; body image; earthquake; sex; doubting if anything is left behind before leaving; visualising nightmares; wanting to have food from the plate of others and fear of losing someone close fear of accident (1)

And the methods they use to deal with these thoughts are “Share with friends or family” (26), “Listening to music” (18), “Watch T.V or videos; Physical exercise/going for walk” (9), “playing games” (6), “studying; sleeping; self motivation” (4), “working towards goal; internet surfing; cleaning; cry over it” (2), “taking care of skin; pinching oneself; household work; checking doors; cooking; thinking how to accept it; going out; think something else; sketching; sitting alone; drinking alcohol” (1).

Table 2: Normal and abnormal intrusions in normal and clinical group.

Items		Normal group (N=60)				Clinical group (N=18)			
		Yes		No		Yes		No	
		N	%	N	%	N	%	N	%
1.	To attack or strangle cats.	2	3.3	58	96.7	1	5.6	17	94.4

2.	To strangle children and some-times adults.	11	18.3	49	81.7	2	11.1	16	88.9
3.	To jump out of the window	15	25	45	75	0	0	18	100
4.	Disgusting sexual acts with an-other man.	6	10	54	90	1	5.6	17	94.4
5.	To look at buttocks of boys and youths.	10	16.7	50	83.3	2	11.1	16	88.9
6.	Have I been poisoned by chemi-cals?	7	11.7	53	88.3	0	0	18	100
7.	My eyes are or will be harmed.	24	40	36	60	6	33.3	12	66.7
8.	I have or will have cancer	30	50	30	50	7	38.9	11	61.1
9	I may have been affected by radia-tion	15	25	45	75	3	16.7	15	83.3
10	These boys when they were young.	26	43.3	33	55	5	27.8	13	72.2
11	Bad people do all sorts of harm	40	66.7	20	33.3	16	88.9	2	11.1
12	I might harm someone	31	51.7	29	48.3	7	38.9	11	61.1
13	Wishing a close, dear person dead	14	23.3	46	76.7	8	44.4	10	55.6
14	Seeing swear words in clear print	16	26.7	44	73.3	2	11.1	16	88.9
15	To utter swear words	35	58.3	25	41.7	8	44.4	10	55.6
16	Did I commit this crime?	11	18.3	49	81.7	3	16.7	15	83.3
17	I may go insane	17	28.3	43	71.7	13	72.2	5	27.8
18	I may go berserk all of a sudden	25	41.7	35	58.3	12	66.7	6	33.3
19	I might push someone under a bus.	8	13.3	52	86.7	4	22.2	14	77.8
20	To harm girlfriend	2	3.3	58	96.7	2	11.1	16	88.9
21	To physically attack and harm own dog.	0	0	60	100	1	5.6	17	94.4

22	To harm children with physical violence	5	8.3	55	91.7	2	11.1	16	88.9
23	To attack and harm someone with bat.	10	16.7	50	83.3	5	27.8	13	72.2
24	To hurt or harm someone	23	38.3	37	61.7	8	44.4	10	55.6
25	What is the calorie content of that food?	36	60	24	40	8	44.4	10	55.6
26	To jump on rail	8	13.3	52	86.7	2	11.1	16	88.9
27	Intense anger towards someone	14	23.3	46	76.7	12	66.7	6	33.3
28	Of accident occurring to a loved one	26	43.3	34	56.7	7	38.9	11	61.1
29	To say something nasty and damning	34	56.7	26	43.3	9	50	9	50
30	Harm or death to a close friend	16	26.7	44	73.3	8	44.4	10	55.6
31	Violent sexual acts	5	8.3	55	91.7	3	16.7	15	83.3
32	Something is wrong with my health	36	60	24	40	16	88.9	2	11.1
33	To physically or verbally attack someone	24	40	36	60	6	33.3	12	66.7
34	To do something to disrupt	15	25	45	75	4	22.2	14	77.8
35	To jump in front of train or bus	8	13.3	52	86.7	5	27.8	13	72.2
36	My children may get harmed	4	6.7	56	93.3	8	44.4	10	55.6
37	If a relative is in an air-crash, the probability that I will be is minimised	14	23.3	46	76.7	5	27.8	13	72.2
38	Has a loved one been in an accident?	23	38.3	37	61.7	9	50	9	50
39	Violence towards objects	11	18.3	49	81.7	2	11.1	16	88.9

40	Buy unwanted things	32	53.3	28	46.7	5	27.8	13	72.2
41	How would I feel at that moment if I were him?	37	61.7	23	38.3	6	33.3	12	66.7
42	Me and my family will be harmed due to asbestos in the house	14	23.3	46	76.6	11	61.1	7	38.9
43	Has any harm come to my partner?	25	41.7	35	58.3	7	38.9	11	61.1
44	To shout at and abuse someone	30	50	30	50	8	44.4	10	55.6
45	To harm small children	2	3.3	58	96.7	2	11.1	16	88.9
46	To crash car when driving	13	21.7	47	78.3	3	16.7	15	83.3
47	Why should they do that; they shouldn't do that! In reaction to people "misbehaving"	51	85	9	15	15	83.3	3	16.7
48	To attack or violently punish someone, e.g. throw a child out of the bus	5	8.3	55	91.7	1	5.6	17	94.4
49	Seeing oneself clearly walking naked through the crowd	5	8.3	55	91.7	2	11.1	16	88.9
50	Detailed images of an experienced accident	31	51.7	29	48.3	5	27.8	13	72.2
51	To say rude things to people	23	38.3	37	61.7	7	38.9	11	61.1
52	To attack certain persons	16	26.7	44	73.3	5	27.8	13	72.2
53	To think about accidents when travelling	4	6.7	56	93.3	0	0	18	100
54	To push people away in a crowd	4	6.7	56	93.3	0	0	18	100
55	To be aggressive towards some persons	35	58.3	25	41.7	9	50	9	50
56	To say inappropriate things	26	43.3	34	56.7	12	66.7	6	33.3

57	Would I say something nasty or not?	34	56.7	26	43.3	11	61.1	7	38.9
58	Sexual impulse towards attractive females, known and unknown	17	28.3	43	71.7	3	16.7	15	83.3
59	To say something nasty to hurt someone, or deliberately shaming someone	16	26.7	44	73.3	3	16.7	15	83.3
60	Wishing that someone disappeared from the face of the earth	25	41.7	35	58.3	3	16.7	15	83.3
61	“Unnatural” sexual acts	7	11.7	53	88.3	2	11.1	16	88.9
62	Wishing someone close is hurt	17	28.3	43	71.7	6	33.3	12	66.7
63	To hurt or harm someone	19	31.7	41	68.3	3	16.7	15	83.3
64	To shake someone hard and shout at him/her	21	35	39	65	4	22.2	14	77.8
65	To violently attack and kill a dog	1	1.7	59	98.3	1	5.6	17	94.4
66	I might do something dramatic like trying to rob a bank	17	28.3	43	71.7	0	0	18	100
67	To jump from the top of a tall building or mountain/cliff	21	35	39	65	2	11.1	16	88.9
68	Being violent towards a known person, causing harm in revenge	16	26.7	44	73.3	4	22.2	14	77.8
69	To sexually assault a woman, known or unknown	3	5	57	95	2	11.1	16	88.9
70	To engage in sexual practices which involve pain to the partner?	5	8.3	55	91.7	2	11.1	16	88.9

Table 2 shows that for normal obsessions in normal group, majority (85%) of the participants reported of getting thought of “people misbehave” followed by “identifying with an executed person” (61%),

and so on, with “harm small children” (3%), and “kill a dog” (1%) the least, and when it comes to abnormal obsessions, majority of the population (66%) endorsed or reported of getting thoughts of

“bad people do all sorts of harm to good people” followed by “to utter swear words” (58%), and “harm children physically” (8%), and “strangle cats; harm girlfriend physically” (3%), being the least. In clinical population when it comes to normal obsessions, majority of the population (88%) of the participants reported getting thoughts of

“something wrong with my health” followed by “people misbehaving” (83%) and so on, and “Seeing swear words in clear print; To harm girlfriend with physical violence.; To harm children with physical violence; To look at buttocks of boys and youths” (11%) being the least.

Table 3: Comparison between normal group and Clinical group on Padua inventory- WSUR

items		response	Normal group (N=60)		Clinical group (N=18)	
			N	%	N	%
1.	I feel my hands are dirty when I touch money.	Not at all	47	78.3	9	50
		A little	12	20	7	38.9
		Quiet a lot	1	1.7	1	5.6
		A lot	0	0	0	0
		Very much	0	0	1	5.6
2.	I think even the slightest contact with bodily secretions (perspiration, saliva, urine, etc) may contaminate my clothes or somehow harm me.	Not at all	31	51.7	9	50
		A little	17	28.3	3	16.7
		Quiet a lot	9	15	4	22.2
		A lot	2	3.3	0	0
		Very much	1	1.7	2	11.1
3.	I find it difficult to touch any object when I know it has been touched by strangers or by certain people.	Not at all	33	55	5	27.8
		A little	14	23.3	2	11.1
		Quiet a lot	10	16.7	6	33.3
		A lot	3	5	2	11.1
		Very much	0	0	3	16.7
4.		Not at all	14	23.3	3	16.7

	I find it difficult to touch garbage or dirty things	A little	23	38.3	6	33.3
		Quiet a lot	15	25	2	11.1
		A lot	6	10	2	11.1
		Very much	2	3.3	5	27.8
5.	I avoid using public toilets because I'm afraid of disease and contamination.	Not at all	15	25	7	38.9
		A little	18	30	3	16.7
		Quiet a lot	16	26.7	1	5.6
		A lot	4	6.7	1	5.6
		Very much	7	11.7	6	33.3
6.	I avoid using public telephones because I'm afraid of contagion and disease	Not at all	43	71.7	10	55.6
		A little	12	20	3	16.7
		Quiet a lot	4	6.7	1	5.6
		A lot	0	0	1	5.6
		Very much	1	1.7	3	16.7
7.	I wash my hands more often than necessary.	Not at all	41	68.3	5	27.8
		A little	11	18.3	1	5.6
		Quiet a lot	6	10	3	16.7
		A lot	2	3.3	4	22.2
		Very much	0	0	5	27.8

On Padua inventory, majority of the normal population (80%) reported of getting thought of “When I read I have the impression and have missed something important and must go back and reread the passage atleast two or three times.” Followed by “When I handle money, I count and recount it several times” (79%) and the least thought, “At certain

moments I'm tempted to tear off my clothes in public” (10%) and “I sometimes have an impulse to hurt defenceless children or animals” (3%). Whereas, majority of the clinical population (89%) reported of getting thought of “If an animal touches me, I feel dirty and immediately have to wash myself or change my clothing”, followed by “I keep checking forms, documents,

checks, etc., in detail to make sure I have filled them in correctly” (78%) and “I sometimes feel the need to break or damage things for no reason; Seeing weapons excites me and makes me think of violent thoughts; At certain moments I’m tempted to tear off my clothes in public” (12%), “I sometimes have an impulse to hurt defenceless children or animals” (11%) are the least thought occurring to them.

DISCUSSION

The aim of the present study was to examine the content and frequency of normal and abnormal obsessions in normal healthy adults. Majority of the participants in the normal group were female (56.7%) as the method for sampling was accidental, the female group were more easy to find and convenient for the researcher. Whereas in clinical population majority were male (61.1%). In normal group participants were all students but in the clinical population, participants were mostly housewives (27%), None of the normal group participants was married but, for the clinical population, 50% were married and 50% unmarried, half of the participants consumed alcohol in the normal group whereas, 89% of the participants in the clinical group were non alcohol drinkers . In both the groups, participants were mostly Hindus, belonged to middle socioeconomic status, non smokers and had no history of any other medical illness.

The reason for the difference in age, education, occupation and marital status in the present study is because the study focused only in the normal young adults.

Most of the normal group endorsed thoughts related to career, family, personal life and marriage,

this can be due to the fact that majority of the participants are students and are mostly in their final year of their education after which they have plans of starting their career and look after their family. Also, since the social norms demands for a person their age to get settled after getting a job, they further reported that the thought of getting the suitable life partner is one of the things they prioritized at this stage of their life.

This can be further supported by (Muris et al., 1997) who examined abnormal and normal compulsions in a sample of 150 normal subjects and found that a majority of them (54.7%) indicated that they had such rituals. While these rituals were less frequent, less intense, and less often associated with negative affect than the compulsions of a sample of patients with obsessive-compulsive disorder, findings indicated that there is continuity between abnormal and normal compulsions.

On the 70 Intrusions by Rachman and deSilva, that the participants get both abnormal and normal obsessions with normal intrusions. In the present study, majority of the participants experienced normal and abnormal thoughts, studies by (Belloch et al., 2013; Clark & Radomsky, 2014; Rachman & de Silva, 1978) has also found similar results.

The content of obsessions found in normal population is similar to that of clinical population like, dirt, contamination, doubt and anger that is consistent with the existing literature (Clark & Radomsky, 2014; Purdon & Clark, 1994; Rassin & Muris, 2007).

It has been also found that majority of the participants used adaptive coping strategy to deal with normal and abnormal obsessions. (Freeston et al.,

1991; Purdon & Clark, 1994). Majority of the participants frequently used methods like sharing with friends and family members, listening to music, watching television or videos etc. which seemed common in the normal population.

CONCLUSION

The present study highlights that intrusive and obsessional thoughts are not limited to clinical populations but are also experienced by healthy individuals. The findings reveal that normal adults often report both normal and abnormal obsessions, with content closely resembling those seen in clinical cases—such as concerns related to contamination, harm, doubt, and aggression. However, these thoughts occur with lesser frequency and intensity among non-clinical individuals. The differences in demographic characteristics between the groups, particularly in age, marital status, and occupation, reflect the sampling focus on young adults. Importantly, most participants employed adaptive coping strategies, such as social sharing, distraction through media, and physical activity, to manage these intrusions. These results support existing literature suggesting a continuum between normal and pathological obsessions, underscoring the importance of context, frequency, and coping mechanisms in differentiating between them. Future research should explore these patterns in diverse cultural and age groups to better understand the underlying cognitive and emotional processes.

LIMITATIONS

The sample size of the present study was small. Both the groups were not comparable in terms of size, age and education. There were not much available data on the variables in the Indian

context. Hence, some cultural attributes such as scales used were not culturally equipped for the sample group. Since only self report measures were used, there can be occurrence of response bias in the study. Other psychiatric centres could have been contacted for the data collection of clinical population. The study should be conducted on a larger, representative sample including of age. Intrusive thoughts in other psychiatric population can also be assessed.

CONFLICT OF INTEREST

The authors confirm that there are no conflicts of interest associated with the publication of this manuscript.

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REFERENCES

1. American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders (4th ed., Text revision). Washington, DC: Author.
2. Audet, J., Bourguignon, L., & Aardema, F. (2023). What makes an obsession? A systematic-review and meta-analysis on the specific characteristics of intrusive cognitions in OCD in comparison with other clinical and non-clinical populations. *Clinical Psychology & Psychotherapy*, 30(6), 1446–1463. <https://doi.org/10.1002/cpp.2887>
3. Belloch, A., Roncero, M., García-Soriano, G., Carrió, C., Cabedo, E., & Fernández-Álvarez, H. (2013). The Spanish version of the Obsessive-Compulsive Inventory-Revised (OCI-R): Reliability, validity, diagnostic accuracy, and

- sensitivity to treatment effects in clinical samples. *Journal of Obsessive-Compulsive and Related Disorders*, 2(3), 249–256. <https://doi.org/10.1016/j.jocrd.2013.05.001>
4. Brandau, H., Michal, M., Wiltink, J., Wild, P. S., Münzel, T., & Beutel, M. E. (2005). Modified Mini Screen (MMS). Screening instrument for mental disorders in primary care.
 5. Brock, H., Rizvi, A., & Hany, M. (2025). Obsessive-Compulsive Disorder.
 6. Cervin, M., Miguel, E. C., Güler, A. S., Ferrão, Y. A., Erdoğan, A. B., Lazaro, L., Gökçe, S., Geller, D. A., Yulaf, Y., Başgöl, Ş. S., Özcan, Ö., Karabekiroğlu, K., Fontenelle, L. F., Yazgan, Y., Storch, E. A., Leckman, J. F., do Rosário, M. C., & Mataix-Cols, D. (2022). Towards a definitive symptom structure of obsessive-compulsive disorder: a factor and network analysis of 87 distinct symptoms in 1366 individuals. *Psychological Medicine*, 52(14), 3267–3279. <https://doi.org/10.1017/S0033291720005437>
 7. Clark, D. A., & Rhyno, S. (2005). Unwanted Intrusive Thoughts in Nonclinical Individuals: Implications for Clinical Disorders.
 8. Clark, D. A., & Purdon, C. (2009). Mental control of unwanted intrusive thoughts: A phenomenological study of nonclinical individuals. *International Journal of Cognitive Therapy*, 2(3), 267–281.
 9. Clark, D. A., & Radomsky, A. S. (2014). Introduction: A global perspective on unwanted intrusive thoughts. *Journal of Obsessive-Compulsive and Related Disorders*, 3(3), 265–268. <https://doi.org/10.1016/j.jocrd.2014.02.001>
 10. Clerkin, E. M., Magee, J. C., & Parsons, E. M. (2014). Evaluating change in beliefs about the importance/control of thoughts as a mediator of CBM-I and responses to an ICT stressor. *Journal of obsessive-compulsive and related disorders*, 3(4), 311–318.
 11. Freeston, M. H., Ladouceur, R., Thibodeau, N., & Gagnon, F. (1991). Cognitive intrusions in a non-clinical population. I. Response style, subjective experience, and appraisal. *Behaviour Research and Therapy*, 29(6), 585–597. [https://doi.org/10.1016/0005-7967\(91\)90008-Q](https://doi.org/10.1016/0005-7967(91)90008-Q)
 12. Goldberg, D. P. (1978). *Manual of the General Health Questionnaire*. NFER Publishing.
 13. Muris, P., Merckelbach, H., & Clavan, M. (1997). Abnormal and normal compulsions. *Behaviour Research and Therapy*, 35(3), 249–252. [https://doi.org/10.1016/S0005-7967\(96\)00114-3](https://doi.org/10.1016/S0005-7967(96)00114-3)
 14. Omoregie, J., & Carson, J. (2023). Reductive mechanisms for unwanted intrusive thoughts: exploring affectivity in clinical and non-clinical samples. *Mental Health and Social Inclusion*, 27(1), 51–65. <https://doi.org/10.1108/MHSI-06-2022-0040>
 15. Purdon, C., & Clark, D. A. (1994). Perceived Control and Appraisal of Obsessional Intrusive Thoughts: A Replication and Extension. *Behavioural and Cognitive Psychotherapy*, 22(4), 269–285. <https://doi.org/10.1017/S1352465800013163>
 16. Rachman, S., & de Silva, P. (1978). Abnormal and normal obsessions. *Behaviour Research*

- and Therapy, 16(4), 233–248.
[https://doi.org/10.1016/0005-7967\(78\)90022-0](https://doi.org/10.1016/0005-7967(78)90022-0)
17. Radomsky, A. S., & Alcolado, G. M. (2010). Don't even think about checking: Mental checking causes memory distrust. *Journal of behavior therapy and experimental psychiatry*, 41(4), 345- 351.
 18. Radomsky, A. S., Alcolado, G. M., Abramowitz, J. S., Alonso, P., Belloch, A., Bouvard, M., et al. (2014). Part 1— You can run but you can't hide: Intrusive thoughts on six continents. *Journal of Obsessive-Compulsive and Related Disorders*, 3(3), 269-279.
 19. Rassin, E., & Muris, P. (2007). Abnormal and normal obsessions: A reconsideration. *Behaviour Research and Therapy*, 45(5), 1065–1070.
<https://doi.org/10.1016/j.brat.2006.05.005>
 20. Taylor, S. (2005). Dimensional and subtype models of OCD. Concepts and controversies in obses- sive-compulsive disorder, 27-41.
 21. Tripathi, R., & Mehrotra, S. (2010). Reflections on Repetitive Intrusive Thoughts: Diagnostic Dilem- mas and Beyond. *Journal of the Indian Academy of Applied Psychology*, 36(2), 197-206.
 22. World Health Organization. (1992). The ICD-10 classification of mental and behavioural disorders: Clinical descriptions and diagnostic guidelines. Geneva: World Health Organiza- tion.