Intrusive Thoughts, Magical Thinking and Fragmentation: A Psychoanalytic Reconsideration

Dr. Donna Mahoney, Ph.D. LCPC, Monica Hershman and Christine Betsill

The Family Institute and Northwestern University

Published in IFPE's "Other/Wise: Selected Papers From the 2022 IFPE Conference, Disruptions and Transformations." Issue 1 – Spring 2023. www.IFPE.org

"One trembles to think of that mysterious thing in the soul, which seems to acknowledge no human jurisdiction, but in spite of the individual's own innocent self, will still dream horrid dreams, and utter unmentionable thoughts" (Hermann Melville in Baer, 2001, p. 5).

Abstract

This paper examines the subjective lived experiences of people who suffer from intrusive thoughts, repugnant images and horrific temptations, sometimes referred to as "taboo obsessions" (Canavan, 2020, p. 8) that characterize what is termed obsessive-compulsive disorder in the Diagnostic and Statistical Manual (DSM-V-TR; APA, 2022). While much of the related literature highlights the cognitive-behavioral elements of the disorder, this paper underscores early developmental experiences of misattunement and resultant fragmentation states, which are theorized to underlie the intrusive thoughts. It also is postulated that cultural factors, particularly associated with religious beliefs, are either ignored or presumed to be associated with obsessive pathology. The etiological models, tracing Freudian Object Relations and cognitive-behavioral conceptualizations, are examined, noting the need to integrate thwarted mirroring and idealizing needs, notions that are associated with Psychoanalytic Self Psychology. A key contention is that Exposure and Response Prevention (ERP) treats the symptoms of intrusive thinking but often pathologizes certain aspects of the experience, like the use of magical thinking. An element of intrusive thinking that is often deemphasized, magical thinking can illuminate the need to idealize others instead of being regarded as a cognitive distortion that needs to be restructured. A brief clinical example will illustrate how to create reparative relational experiences and the heretofore walled-off affective experiences while bringing in crucial developmental events to transform the intrusive thinking and subjective distress.

Key words: unwanted intrusive thoughts, magical thinking, reparative emotional experience

Introduction

This paper considers what are termed "taboo obsessions" (Canavan, 2020, p. 8), when our minds are consumed by unwanted thoughts and repugnant or violent images. Edgar Allen Poe called the thoughts the imp of the perverse, adding that there is an unconquerable force that impels us to think what we should not think (Poe, 1984). As Baer (2001) notes, these thoughts generally fall into four categories: thoughts of pedophilia, aggression, sexuality and blasphemous religious thoughts. While cognitive-behavioral therapy, particularly exposure and response prevention (ERP) is the treatment of choice for OCD, this paper considers a view that addresses early developmental experiences and fragmentation states that are theorized to underlie the symptoms of the disorder. These early experiences often thwart the development of self-cohesion, leading the individual to ruminate and experience horrific temptations. The aim of this paper is to put forth a model of OCD that expands current thinking about the exclusive use of cognitive-behavioral models and offers ways to optimize therapy outcomes by incorporating developmental and affective factors. Particular attention will be focused on the aspect of magical thinking and the ways that it may be used to bolster the individual's diminished sense of self.

Definition and Diagnosis of OCD and Taboo Intrusive Thoughts

Obsessive-Compulsive Disorder (OCD) is characterized by recurrent thoughts and/or compulsions that are severe enough to be time-consuming, or that cause marked distress or significant impairment (APA, 2022). For purposes of this paper, the focus will be on a form of OCD that involves thoughts — intrusive, horrific thoughts and images of causing danger or harm to others or oneself. The thoughts are experienced as originating from within one's own mind

rather than outside of one's mind, which is characteristic of psychotic disorders like schizophrenia (Hyman & Pedrick, 2010). The term for this type of OCD was pure obsessional OCD, until it was recognized that some people may not perform overt compulsions, like counting or checking, but instead many have subtle (covert) mental rituals that serve to neutralize or counteract the discomfort of the unwanted, intrusive thoughts (Lam & Steketee, 1993).

The taboo intrusive thoughts are typically experienced as repugnant and unacceptable (ego-dystonic) by the person experiencing them, and they substantially interfere with the person's preferred thinking and behavior. In making a differential diagnosis, the distinction between intrusive thoughts and GAD (generalized anxiety disorder) is that worries in GAD usually involve catastrophic thoughts about low-probability events that have a basis in real-life events, whereas the content of obsessions is usually uncharacteristic of the individual's typical tendencies and may represent the antithesis of his or her ethics or morals (i.e., a devoutly religious person having thoughts of blasphemy).

Repugnant or taboo obsessions often give rise to compulsive rituals of thinking a "good" thought or a "safe" thought, engaging in ritualized religious prayer and, most frequently, performing some form of checking. Checking can take many forms, including the following:

- Checking that harm has not occurred or will not occur (i.e., scouring the newspaper for reports of hit-and-run accidents, or checking that knives are put away)
- Reassurance seeking, which is a form of checking by proxy (Purdon, 2004).

Historical Context

Sigmund Freud put forth a psychoanalytic account of obsessive-compulsive disorder which he termed obsessive neurosis (Gabbard, 2005). He proposed that obsessions were an outcome of repressed sexual, aggressive and blasphemous impulses. Freud's formulation was based on his analysis of the Rat Man (Freud, 1905/1955), whose central conflict for Freud centered on obedience and defiance. Freud believed that the Rat Man, fixated at the anal stage of psychosexual development, repressed his love/hate for his father as his oedipal rival.

OCD was first recognized in the modern psychiatric nomenclature in 1980, with the classification as an anxiety disorder in DSM-III (APA, 1980). Its classification as an anxiety disorder remained until publication of the DSM-5 (APA, 2013), in which it was moved to the OCRD (obsessive compulsive and related disorders) category based on research demonstrating etiologic dissimilarities between OCD and the anxiety disorders.

In 1966, Victor Meyer began using behavioral therapy to treat hospitalized patients with severe contamination fears (Hyman and Pedrick, 2010). He and his colleagues combined intensive exposure to feared objects, like bathroom doorknobs and faucets, with strict restrictions on washing and using the showers. Since then, exposure and response prevention has been considered the gold standard for the treatment of obsessions and compulsions, with numerous efforts made to demonstrate its efficacy with RCTs (randomized controlled studies).

Etiology

The etiology is complex, characterized in part by deficits in cortico-striato-thalamo-cortical (CSTC) circuitry. The caudate nucleus, part of the basal ganglia, controls the filtering of thoughts. In people with OCD, the caudate nucleus is not as effective at filtering, so the individual becomes overwhelmed with intrusive thoughts and urges (Hyman & Pedrick, 2010).

Generally, from a psychodynamic perspective, obsessive-compulsive symptom formation results from unconscious conflicts, usually between drive and conscience, desire and repulsion, appetite and prohibition, or initiative or guilt. Many psychoanalytic formulations were put forth, but we will only focus on a few selected theories. Fromm stressed how obsessive-compulsive preoccupation with orderliness, obstinacy and cleanliness represented mastery of a potentially intrusive world setting out to control patients' lives (Silverstein, 2007). Gabbard, viewing OCD from an object-relations framework, underscored the significance of extreme perfectionism as an attempt to live up to the expectations of a demanding parental environment (Gabbard, 2005).

From a Cognitive Behavioral perspective, obsessive-compulsive symptom formation results as unacceptable ideas and feelings that are much closer to the individual's conscious awareness rather than unconscious primitive drives like the psychodynamic perspective states (McFall & Wollersheim, 1979). Cognitive Behavioral formation argues that these unacceptable ideas and feelings are experienced as threatening because of the individual's active cognitive evaluation or assessment of them, which then is influenced by maladaptive beliefs that occur at the preconscious level (McFall & Wollersheim, 1979). There is a greater emphasis upon cognitive mediators in obsessive-compulsive disorders through the cognitive behavioral lens (McFall & Wollersheim, 1974). Specifically, the individual misappraises the thought as significant and threatening. The misappraisal evokes a threat response and leads the individual to attempt to resist the taboo thought while attempting to prevent the harmful events associated with the intrusion (Abramowitz, Deacon & Whiteside, 2019).

The Subjective Experience: Magical Thinking and Fragmentation

Fortunately, for most people, fleeting "bad thoughts" are nothing but a fleeting annoyance. Some of us may notice thinking about shouting out an obscenity in public or ramming into another car that cuts us off in traffic, but the thoughts are quickly dismissed and we move forward. But for the individual who suffers from "taboo obsessions," the thoughts are considered "thought crimes" (Lingiardi & McWilliams, 2017, p. 173) that plague them in the form of obsessive images and thoughts, propelling them to expiate guilt through mental and behavioral rituals that represent undoing and reaction formation. As Baer notes, the thoughts will "torment you with thoughts of whatever it is you consider to be the most inappropriate or awful thing you could do" (Baer, 2001, p. 9). Freud's "Rat Man," the 29-year-old lawyer, Ernst Lanzer, revealed the morbid idea that his parents knew his thoughts and that his wish to see a woman naked would cause his father to die (Magid, 1993). He also was distressed by the impulse to cut his own throat. He felt compelled to do all sorts of things to prevent his father's death from happening. Rituals and superstitions were designed to ward off the impending evil. He believed that his inner world was shocking and, if exposed, would lead to the destruction of others (Freud, 1909).

Compulsive behaviors are often thought to be a remnant of magical thinking of early childhood, when actions and impulses were incompletely differentiated (referred to as "thought-action fusion" in cognitive-behavioral nomenclature). Magical thinking or magical ideation can include beliefs such as thought transmission, astrology, spirit influences, good luck charms and superstitions ("knock on wood" or "step on a crack, break your mother's back"). A lengthier consideration of magical thinking will be discussed in a subsequent section of this paper, underscoring the importance of shifting away from a pejorative and solely pathological view of magical thinking.

The self-psychological literature also underscores the importance of the experience of fragmentation, or the lessened coherency of the self: Fragmentation results from the sense of disorganization and panic associated with the frightening or repugnant thoughts and images. Fragmentation is experienced when ruptures occur in important relationships in which the individual is embedded, and they are often revisited when ruptures occur in the therapeutic relationship. These fragmentation experiences also will be discussed further in the section about a self-psychological view of intrusive thoughts.

Magical Thinking Reconsidered: The Essential Inclusion of Multicultural and Developmental Factors

Magic has been used to characterize thinking that is thought to be illogical and irrational. It is a characteristic of young children, like in the theorizing of Jean Piaget and pre-industrialized cultures (Piaget, 1929). It was noted, however, that magical thinking, imagination and pretense appear to emerge in late infancy and early childhood, and they "provide a mutually supportive environment enabling each to flourish in its own right" (Rosengren & French, 2020, p. 43). Their definition entails an alternate form of causality, one that is not part of the accepted scientific explanations and one that is not used to describe everyday phenomena in the world. Research, as cited in Rosengren & French (2013), demonstrates that magical thinking remains present in the minds of both children and adults. Additionally, Subbotsky believes that magical thinking can open up a realm of what is possible and by doing so can stimulate creativity.

Religion also is sometimes associated with magical thinking in that belief in the existence of God, angels and miracles contains magical elements. Psychologists may consider religion as a form of magical thinking, suggesting that to uphold religious beliefs is illogical, irrational and

nonscientific. Boyer & Lienard (2007), for example, theorize that spiritual rituals are not rationally based and function as an attempt to provide attenuation for anxiety-based cognitive intrusions (Hagen, 2007). However, Williams, et. al. (2020) remind us that it is not uncommon for persons suffering from OCD to seek the support of spiritual and religious leaders. If the therapist holds the opinion that religion is causing or worsening the OCD, they may work to suppress the individual's beliefs to facilitate treatment. Doing so, however, often undermines trust and empathy, leading to conflict or early termination. They go on to recommend that the therapist work respectfully within the confines of the client's culture and religion, which will facilitate the treatment process (Williams, et. al, 2020). Clinicians can recognize that clients' religions do not cause OCD and accept the clients' legitimate practices. Religious practices can be integrated into the treatment, when possible, if the OCD does not interfere with carrying our religious life and differentiate OCD-driven behavior that is religious in nature from normative religious practices. The importance of respecting and acknowledging indigenous, cultural and traditional practices needs to be underscored as we approach the client's beliefs with a sense of being humble.

Cognitive Behavioral Treatment of Taboo Intrusive Thoughts

According to much of the research on the efficacy of treatment, the most effective and largely used cognitive behavioral treatment approach to intrusive thoughts is exposure with responsive prevention, or ERP (Abramowitz, Deacon & Whiteside, 2019; Barlow, 2011). Using ERP involves an exposure to a client's feared stimuli and then essentially "waiting" for the anxiety to decrease through familiarization (McKay et al., 2014). ERP has been the gold standard for intrusive thinking, OCD thinking and pathology. ERP treatment alters dysfunctional thoughts

with a restructuring of the person's internal discourse using the behavioral experiments that test the silliness of theories in everyday life (Achachi et al., 2017).

More specifically, the client learns to confront their taboo thoughts and external or other internal triggers (i.e., situations, objects or bodily sensations). The aim of ERP is to expose the client to the feared thoughts so they can learn new information that disconfirms the threat-based beliefs and appraisals, thereby enabling the person's ability to consider the thoughts as mere "mental noise" (Abramowitz, Whiteside, Deacon & Whiteside, 2019). The client also learns that the uncertainty associated with the thoughts is manageable. Exposure practice entails the client and therapist developing a hierarchy of presenting symptoms or fears, from least fear-producing to most fear-producing. Then the client is guided through exposure via their hierarchy until the greatest fear is voluntarily tolerated at a comfortable, safe pace (Abramowitz, Deacon & Whiteside, 2019; McKay et al., 2014). An essential implication is that exposure therapy aims for the client to learn to function in everyday life with intrusive thoughts.

A Self Psychological/Intersubjectivity Formulation of Taboo Intrusive Thoughts

Consistent with Kohut's formulations of most forms of psychopathology, Kohut (1971/1977) viewed obsessive-compulsive disturbances as disorders of the self, and its cohesiveness as the central issues to be understood and treated. He asserted that obsessions and compulsions are symptoms representing disintegration products.

Kohut considered it misguided to attribute crucial importance to aggression and sexuality in drive theory as an explanation of the irresistible urges of obsessive-compulsive behavior. The hypercathexis of thinking does not represent defensive undoing as much as it is meant to rid oneself of a sense of defectiveness. Undoing, for Kohut, also covers up this sense of

defectiveness by "filling it with frantic, forever repeating activity" (M. Tolpin & Kohut, 1980, p. 439). Kohut (1971/1977) differentiated between patients with a relatively cohesive sense of self, for whom anxiety signals conflict, and other patients with damaged self-cohesion, for whom anxiety represents a threat of fragmentation. Therefore, disintegration anxiety reflects self-object failure, leading to the anticipation of the breakup of the self. Sufficiently restored self-object functions via mirroring, idealization and twinship create the basis for repairing the fragmentation that threatens self-cohesion.

For Kohut, in relation to obsessive-compulsive disturbance, it was vital to understand the centrality of preserving self-cohesion in terms of the functions that orderliness, excessive preoccupation with detail and rigid tenacity serve. The patient's use of magical thinking also may function to revitalize an injured self by providing an illusory sense of power and control.

In the chapter entitled *The Two Analyses of Dr. L: A Self Psychological Perspective on Freud's Treatment of the Rat Man*, Kiersky and Fossage (Magid, 1993) argue that Ernst's core conflict was a concretization of his view that his inner world, if exposed, would be shocking and destructive to others. His disclosures do not shock or harm Freud, which, in and of itself, constitutes a therapeutic experience. Ernst's father beat him in a brutal fashion as a child until he was filled with a sense of rage and humiliation, leading Kiersky and Fossage to conclude that, transferentially, Ernst fears his own rage and Freud's retaliation. His obsessions and compulsions were seen as "an attempt to repair damage to the subjective sense of self and to the relationships in which he was embedded" (Magid, 1993, p. 128). When ruptures threatened the treatment, Freud was able to recover the connection through some act of concern, affection or generosity; it was these efforts, it is contended, that lead Ernst to establish a more cohesive sense of self.

Case Example: Transforming Dark, Tormenting Thoughts

This section presents an example of a client with disturbing obsessions and compulsions that were time-consuming and ineffective in the long run. The discussion will explore the integration of self-psychological principles to an ERP protocol for the treatment of taboo obsessions. A multiculturally sensitive, self-psychologically informed treatment will be emphasized, highlighting the benefits of exploring the relational and developmental issues. The "client" in this example represents an amalgam of client cases and is being used for illustrative purposes only.

Presenting Symptoms

Mark is a 22-year-old man who lives with his parents, both retired professionals, following the completion of his college degree program. Mark presented with disturbing, intrusive thoughts that started while he was away at college but worsened during the months prior to his entry into treatment. His intrusive thoughts and images included images of kissing everyone, regardless of gender and age, that he encountered walking down the street; thoughts of having sex with his male friends, despite his identification as heterosexual; distressing images of throwing himself on the train tracks at the station and driving into oncoming traffic; and fears that his mother would die unless he repeated magical numbers — and for Mark, the magical number was seven. He would count to seven and would do this seven times for 27 minutes. He also repeatedly prayed to rid himself of the "bad thoughts." Mark was aware that his mother seemed to be genetically predisposed to have anxiety, but he wasn't sure about his father. His

father was diagnosed with coronary artery disease around the time that he presented for treatment, leading Mark to "feel bad" for painting an unfavorable picture of his father to the therapist.

From therapy, he hoped for his symptoms to attenuate, and he hoped to learn coping strategies for his anxiety. Additionally, Mark wondered if his negative relationship with his father might be at the core of his symptoms, but he wasn't sure he should blame his father in that way without "things getting worse."

Relevant History

Related to his history, Mark, an only child, revealed that he grew up fearing his father due to his father's "extraordinarily high standards" and tendency to punish Mark when he was disappointed or disapproving of Mark's actions. His parents were staunch Catholics, which meant that his family attended church every Sunday and adhered to all the sacraments. His paternal grandfather immigrated to the United States from Ireland, and Mark recalls dreading visits with him. He knows, based on accounts from his father, that his grandfather used to beat his father, but he is unsure about the severity or duration of the abuse. His paternal grandmother passed away from breast cancer when he was a baby. As previously mentioned, Mark's father was diagnosed with coronary artery disease around the time that he presented for treatment, leading Mark to "feel bad" for painting an unfavorable picture of his father for the therapist.

Mark described a much more loving and nurturing relationship with his mother, an elementary school teacher who retired only a year prior to his entry into therapy. When he was a young child, he noted that he would run to her when his father raised his voice and threatened to hit him, though he did not recall being physically struck by his father. In addressing his

relationship with his mother during his adolescence, Mark recalled a particularly disturbing incident that involved screaming at his mother when he arrived home after consuming alcohol at a party. He was alone with her in the house when he expressed to her how angry he was that she failed to take more active efforts to protect him from his father's wrath. Tears filled his eyes as he remembered how frightened she looked when the incident occurred. The next day, he said, he avoided her "because I was so filled with guilt, I could not face her." His mother distanced herself from him for several days following the event, compounding his sense of enormous guilt "and feeling like a real shit."

Session Content

Mark agreed to take the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS), an assessment tool which identified that he primarily suffered from taboo sexual and violent unwanted thoughts. Repeating the magical number seven, along with repetitive praying, were identified as the compulsions that neutralized his anxiety. He read about Exposure and Response Prevention (ERP) strategies online, expressing fear about being exposed to the dreaded and shameful thoughts. The first few weeks of therapy entailed working on solidifying the therapeutic alliance, along with employing ERP strategies. Mark filled out a cognitive distortion list that pinpointed his tendencies to mainly employ all-or-nothing thinking, thought-action fusion and catastrophizing. Written narratives and motivational scripts, which described confronting progressively more disturbing images of driving into oncoming traffic, were utilized along with recorded audio describing anxiety-provoking scenes of kissing everybody on the street, falling onto the train tracks and driving into oncoming traffic. Another exposure task involved watching a movie or YouTube clips involving someone getting hit by a train until his tolerance to the feelings of fear increased. He also viewed clips of people driving into oncoming traffic.

The response-prevention aspect of the therapy proved to be the most challenging part of the process for Mark because it entailed his attempts to refrain from repeating the magic number seven and praying. Mark explained that he decided to leave the Catholic church, much to the dismay of his parents, and instead join a Bible-based Evangelical church. According to the Bible, he stated, seven is the basis of God's word, and it symbolizes completion and perfection. It is directly tied to creation in that God created the heavens and earth in six days, and He rested on the seventh day. Much anxiety was experienced, he expressed, when he tried to alter the number of times that he tried to repeat another number, following the therapist's suggestion (the therapist suggested trying to repeat the number five). "Unless I follow the Bible teachings to the letter, he uttered, I am a bad person." The number seven also "magically" protects his parents from dying, he added.

Psychoeducation about obsessive thoughts and intrusive thinking also was a component of the treatment. An example included addressing the cognition that "unless I follow the Bible teachings to the letter, I am a bad person." Earlier in this paper, it was pointed out that it is essential to distinguish between religious beliefs and the inflexible cognitions that characterize OCD. In fact, Abramowitz (2018), in *Getting Over OCD: A 10-step Workbook for Taking Back Your Life,* asserts that, when doing ERP, it is important to ask yourself whether the feeling of immorality is derived from your values or OCD. In this instance, Mark came to understand that his rigid adherence to following the Bible's teaching to the letter mainly served to reinforce rigid thinking that does not serve him well as he is attempting to overcome the intrusive thoughts. He agreed to work on lessening the time that he devoted to counting to the number seven, eventually decreasing the time spent to ten minutes.

Once Mark experienced a degree of symptom attenuation, the therapy seemed to enter a middle phase (Jacobs, 2017), or a working-through phase (Freud and Breuer, 1895/2004). He noted during one of the sessions that the images of having sex with men were puzzling to him because he had only dated women. Then he proceeded to relate that he dated a woman, Amanda, in college who was eventually "manipulative and controlling." What started out as "fun dates" morphed into terrifying experiences for Mark because he would receive texts from Amanda indicating that she was cutting herself and needed him to come to her dorm to help her. Mark stated that he never knew if she was suicidal or just wanting him to take care of her. Some of Mark's relational patterns are noted in the following exchange:

Therapist*: You sound so alarmed and terrified in remembering what happened with Amanda. Mark, remember how we talked about people sometimes following patterns in relationships? It reminds me of the sense of alarm and terror that you felt when you talked about your dad threatening to hit you when you were young. Does it make sense that there might be a link between your experiences with Amanda and with your father?*

Mark *(looking somewhat confused): Not really, Donna. Could you explain?*

Therapist*: Sure. Sometimes patterns form when we experience similar feelings in our current lives that we experienced in the past. Amanda's texts led you to feel like you had to figure out if there was real danger, just like when your dad would threaten to hurt you.*

Mark: *Oh boy! I get it now. I should have figured it out by myself. I told you at the beginning (of therapy) that I thought that my relationship with my dad could explain some things. But I don't want to blame him.*

Therapist*: Acknowledging your feelings about your dad doesn't mean that you're blaming him for what you're going through. We're working on these issues together in here, so you don't have to figure them out on your own.*

Cabaniss, et. al. (2017) discuss that transference is often embedded in innocuous comments. The therapist (DM) noticed that Mark commented about the therapist seeming to "like coffee like my mom likes coffee" and that she was "gentle like my mother." During a session when the therapist was five minutes late for the appointment, Mark quipped, "You're probably glad that you don't have to meet with me for the full hour." The therapist responded by saying, "Sorry that I'm late, and I wonder if you think there might be another reason why we're starting late." Addressing the issue with deeper exploration enabled the therapist and Mark to uncover his fear that the therapist will reject him and distance herself from him, just as his mother distanced herself from Mark's feelings and needs.

A Self-Psychological View of the Case Example

A self-psychological view of this case example is offered due to some of the aforementioned gaps associated with other viewpoints. Classical psychoanalytic explanations, like Freud's, underscored the connection between infantile sexuality and obsessive neurosis but failed to explore the need for relatedness and walled-off affect states, like disappointment and shame. Cognitive-behavioral approaches provide techniques and strategies for symptom alleviation but neglect the vital developmental and relational issues. This section will attempt to fill in some of the gaps related to developmental and relational factors.

Self psychology emphasizes the essence of human experience in relation to the person's need to organize one's subjective experience into a cohesive configuration. Self-objects are

objects whose functions are experienced as an aspect of the self, and they serve to maintain vigor, cohesion and internal harmony (Tolpin & Kohut, 1980). The theory underscores the importance of the parental capacity to respond to the child's healthy grandiosity through the process of mirroring and idealization needs, which give rise to healthy ideals (Kohut, 1977).

For Mark, who appeared threatened by his internal world, his tendency to respond in an anxious way to his affect states seems to be related to his proneness to fragmentation experiences. As Kohut (Tolpin & Kohut, 1980) noted, Mark was trying to protect himself from a sense of defectiveness via his frantic and repetitive intrusive thoughts. Additionally, he attempted to undo his "bad and tormenting" thoughts by repeating magical numbers and praying compulsively. These activities provided a sense of control and calmness, albeit temporary, as he tried to steady and soothe himself during his parents' emotional absence. He was filled with shame and guilt, blaming himself for the problems in his relationships with them. Kiersky and Fossage (Magid, 1993) explain that the lack of predictable emotionality, which is detrimental to children, leaves them feeling bad and feeling responsible for traumatic events when parents lose control and are inconsistent in their parenting. His mother, for example, distanced herself from Mark after he tried to express his anger toward her for not protecting him from his father's rage. His fear of the therapist distancing herself from him was revealed in the transference, along with her reassurance that she was not distancing herself from him.

Mark's decision to leave the Catholic church and join an Evangelical church ostensibly represents, on an emotional level, his need to detach from his parents who disappointed him, but it exacerbated the fear of losing his mother through death. The magical number seven would "undo the damage" of his thoughts of her death, temporarily assuaging his fear of loss. His fantasy was that his parents were powerful because they knew his thoughts, but according to

Kohut (1977), there were deficits in terms of mirroring and validating his feelings, and in providing idealizing and soothing functions. His parents were difficult to idealize because his father was abusive and his mother distanced herself from his intense feelings. The therapist appeared to be experienced as idealized because Mark experienced her as someone whose ideas should have occurred to him (related to his utterance that he should have figured out his relational patterns on his own). As Lee & Martin (1999) note, he appears to have an "open admiration for the therapist" (p. 143). They defined the idealized self-object as "the magical figure to be controlled and with which to be fused" (p. 140). His use of magical numbers may have been an attempt to merge with the magical figure as a source of comfort and calming.

The notion of "reparative relational experience" (Teyber & McClure, 2011, p. 27), defined as "providing a more satisfying response to the client's old relational patterns" (p. 27), appears to be relevant in that Mark experienced feelings of safety and the calming presence of the therapist, someone who was not put off by the contents of Mark's intrapsychic life. The therapist made concerted efforts to create the safe space to explore Mark's beliefs, feelings and values while sensitively approaching his decision to leave the Catholic church. Finally, Mark was free to address his feelings of anger and disappointment with his parents, and particularly his father, relatively free of the guilt associated with his father's recent health diagnosis.

Summary and Conclusions

Much of the research and scholarly investigations of intrusive thoughts have concluded that cognitive-behavioral interventions, and specifically Exposure and Response Prevention (ERP) protocols, are supported by vast empirical literature and are highly effective in reducing fear, avoidance behaviors and other anxiety-related phenomena. The key contention of these

authors, however, is that while CBT approaches effectively ameliorate the symptoms of intrusive thinking and the sense of uncertainty associated with these thoughts, the approaches deemphasize important early developmental precursors and fragmentation states that lie at the psychopathological core of intrusive thinking. Additionally, as the case example of Mark underscored, he not only needed to relinquish his reliance on rigid thinking to contain his fears but also to experience safe, consistent and reliable self-objects to disconfirm his belief that he would be rejected and shamed due to the perceived abhorrent nature of his thoughts and sense of defectiveness. The therapeutic relationship provided the opportunity for Mark to have a "corrective emotional experience" (Teyber & McClure, 2011, p. 389) in that he and the therapist co-created a safe space for the expression and sharing of his tormenting and unacceptable thoughts, feelings and images. In the therapeutic space, he was eventually free from the interpersonal dangers of his father's abusive and critical stance, and from his mother's tendency to withdraw from him.

Another aspect of intrusive thinking that is often neglected in the literature is magical thinking. A brief review of the existing literature revealed that it is often pathologized, viewed as a cognitive distortion reinforcing the sense of shame and humiliation that clients feel due to the magical thoughts that function to neutralize their obsessions. Religious beliefs that are often associated with religion may be suppressed to facilitate the treatment. It is essential for the therapist to practice with multicultural sensitivity and humility when religious, cultural and other contextual factors are introduced in the treatment. It is the assertion of these authors that these factors need to be acknowledged as crucial factors related to the treatment.

References

Abramowitz, J. (2018). *Getting over OCD: A 10-step workbook for taking back your life*. NY: Guilford Press.

Abramowitz, J., Deacon, B. & Whiteside, S. (2019). *Exposure therapy for anxiety: Principles and practice, 2nd edition*. NY: Guilford Press.

Achachi, O. & Bouvard, M. (2017). Intrusive thoughts in OCD patients, relapsed OCD patients, and non-clinical participants: A study in France. *Clinical Neuropsychiatry*, 384-392.

American Psychiatric Association (1980). *Diagnostic and statistical manual of mental disorders, (3rd edition)*. Washington, D.C.: Author.

American Psychiatric Association (2022). *Diagnostic and statistical manual of mental disorders, (5th Edition text revised)*. Washington, D.C: Author.

Baer, L. (2001). *The imp of the perverse: Exploring the silent epidemic of obsessive bad thoughts*. NY: The Penguin Group.

Barlow, D. (2011). *Unified protocol for transdiagnostic treatment of emotional disorders*. NY: Oxford Press.

Boyer, P. & Lienard, P. (2007). Why ritualized behavior? Precaution systems and action parsing in developmental, pathological, and cultural rituals. *Behavior and Brain Sciences*, 29 (6), 595-613.

Cabaniss, D. (2017). *Psychodynamic psychotherapy: A clinical manual, 2nd* Edition, U.K.: John Wiley & Sons.

Canavan, R. (2020). Where do we stand with OCD? Psychotherapist's recognition of, and treatment recommendations for, taboo intrusive thoughts [Unpublished doctoral dissertation]. Dublin Business School, School of Arts, Dublin.

Freud, S. & Breuer, J. (1895/2004). Studies in hysteria. *The Standard and Complete Works of Sigmund Freud*, 2: 21-47. London: Hogarth Press.

Freud, S. (1905/1953). Three essays on the theory of sexuality In *The Standard and Complete Works of Sigmund Freud, Vol. 7*. Translated and edited by Stachey, J. London: Hogarth Press, 1953, pp. 123-245.

Gabbard, G. (2005). *Psychodynamic psychiatry in clinical practice, 4th Edition*. Washington, D.C.: American Psychiatric Association.

Hagen, Joan (2007). *Multicultural and spiritual rituals: Meaning and praxis. Behavioral and Brain Science*, 29:6.

Hyman, B. & Pedrick, C. (2010). *The OCD workbook: Breaking free from Obsessive-Compulsive Disorder.* NY: New Harbinger Publications.

Jacobs, M. (2017). *Psychodynamic counseling in action, 5th Edition*. CA: Sage Publications.

Kohut, H. (1971). *The analysis of the self.* NY: International Universities Press.

Lee, R. & Martin, C. (1999). *Psychotherapy after Kohut: A textbook of self psychology*. NY: Routledge.

Lingiardi, V. & McWilliams, N. (2017). *Psychodynamic Diagnostic manual, 2nd Edition*. NY: Guilford Press.

Magid, B. (Ed.) (1993). *Freud's case studies: Self-psychological perspectives*. Hillsdale, NJ: The Analytic Press.

McFall, M. & Wollersheim, J. (1979). Obsessive-compulsive neurosis: A cognitive-behavioral formulation and approach to treatment. *Cognitive Therapy and Research*, 3, 333-348.

McKay, D. (2014). OCD or not OCD? A critical evaluation of OCD. *Current Psychiatry Reviews*, 10: 284-288.

Piaget, J. (1929). *The child's conception of the world*. NY: Kegan Paul.

Poe, E. (1984). *Edgar Allan Poe: Complete tales and poems*. NY: Castle Books.

Purdon, C. (2004). Empirical investigation of thought suppression in obsessive-compulsive disorder. *Journal of Behavioral Therapy and Experimental Psychiatry*, 35, 2, 121-136.

Rosengren, K. & French, J. (2013). Magical thinking. *Oxford Handbook of Development and Imagination*. In Taylor, Marjorie. *The Oxford Handbook of the Development of Imagination*. 1st ed. New York: Oxford University Press, 2013. Web.

Silverstein, M. (2007). *Disorders of the self: A personality-guided approach*. Washington, D.C.: APA.

Steketee, G. & Lam, G. (1993). Obsessive-compulsive disorder. In T.R. Giles (Ed.). *Handbook of Effective psychotherapy* (pp. 253-278). NY: Plenum Press.

Teyber, E. & McClure, F. (2011). *Interpersonal process in therapy: An integrated model, 6th Edition*. Belmont, CA: Brooks/Cole.

Tolpin, M. & Kohut, H. (1980). The disorders of the self: The psychopathology of everyday life. In Greenspan, S. and Pollock, G. (Eds.). *The Course of Life: Psychoanalytic Contributions Towards Understanding Personality Development, Vol. 1: Infancy & Early Childhood* (pp. 425-458). Washington, D.C.: National Institute of Mental Health.

Williams, M., Rouleau, T., LaTorre, J. & Sharif, N. (2020). Cultural competency in the treatment of obsessive-compulsive disorder: Practitioner guidelines. *The Cognitive-Behavior Therapist*, 13, 1-25.

The presenters may be contacted @

Donna Mahoney: dmahoney@family-institute.org

Monica Hershman: monicahershman96@gmail.com

Christine Betsill: christinebetsill2023@u.northwestern.edu