Seeking certainty: a grounded theory of morality in obsessive-compulsive disorder

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Abstract

Morality has long been associated with obsessive-compulsive disorder (OCD) in the literature, however remains underspecified in current theoretical frameworks. Despite significant advances in research, OCD remains one of the most difficult disorders to treat (Clark, 2015), suggesting there is much about this heterogeneous disorder that is not fully understood. Recent research examining self-processes in OCD has indicated morality may play an important role in OCD and further investigation is needed. Striking parallels have also been drawn between OCD symptoms and phenomena such as moral self-regulation, and moral cleansing, in the field of moral psychology. This study aimed to understand people with OCD's experiences of morality and to develop a theoretical model based on their qualitative accounts. Grounded theory methodology was used to inform data collection and analysis. Twelve adults with experience of OCD took part in semi-structured interviews. Analysis led to development of a theoretical model with seven overarching theoretical codes: conceptualising morality, holding rigid moral values as part of identity, experiencing moral uncertainty, seeing the world in black and white, fear factor, seeking certainty, and feeling ambivalent about OCD. A sequential structure was used to indicate process and illustrate interrelationships between theoretical codes in the model. Feedback loops and circular relationships were also identified. Experiencing moral self-uncertainty and a fragile sense of self were identified as central features of participants' experiences. The findings indicate incorporating concepts such as moral self-uncertainty, dichotomous thinking, and fear of self and others, into current theoretical frameworks may be helpful in

facilitating treatment innovation; approaches able to explore self-processes may be particularly relevant for OCD. The developed model is discussed in relation to existing theory and recent research findings. The strengths and limitations of the study are outlined along with suggestions for further research.

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Chapter 1: Introduction

Overview

Obsessive-compulsive disorder (OCD) is a complex heterogeneous condition affecting up to 3% of the population in the United Kingdom (UK; NICE, 2005). Despite a proliferation of research in recent years a significant proportion of individuals do not appear to benefit from current treatment approaches suggesting there is much still to be understood about OCD and the many ways in which it is experienced by individuals. This study aimed to explore how morality is experienced by people with OCD using a qualitative approach. Moral issues have long been associated with OCD however are not fully specified in current theoretical frameworks. Recent research into self-processes in OCD has indicated morality may play a central role in the condition. Concurrently, moral psychology research has found moral self-regulation behaviour to be strikingly similar to the types of behaviours seen in OCD. This chapter discusses the current theoretical frameworks in addition to recent self-process, and emotion research in OCD. Literature from moral philosophy and psychology are then reviewed with the argument that exploring these fields can provide useful insights into the experience of morality. The use of qualitative methodology to research OCD is also discussed before the proposed study and the study aims are presented.

Obsessive-compulsive disorder

Obsessive-compulsive disorder is characterised by the presence of obsessions or compulsions (American Psychiatric Association [APA], 2013; World Health

Organization [WHO], 2011). Obsessions are defined as unwanted and persistent intrusive thoughts, ideas, images, impulses, or doubts, which evoke significant distress (APA, 2013). Although exceptionally heterogeneous, obsessions typically concern contamination, responsibility for harm, sex and morality, violence, religion, and symmetry and order (McKay et al., 2004). Compulsions are conceptualised as deliberate, goal-directed behaviours hypothesised to function as strategies to reduce, control, or resist the distress caused by obsessions (Abramowitz & Jacoby, 2014). Compulsive rituals can include excessive decontamination, checking, repetitive routine acts, and ordering, as well as covert mental rituals or neutralising strategies such as repeating certain words or phrases, thought suppression, praying, brief subtle actions, and distraction (APA, 2013). Whilst individuals can find these strategies helpful in the short term, paradoxically they appear to increase the persistence of obsessional thoughts and compulsive urges, and are therefore thought to contribute to the maintenance of the disorder (Salkovskis, 1989).

Obsessive-compulsive disorder is generally classified into four symptom dimensions: contamination, harm, symmetry, and unacceptable thoughts (Abramowitz et al., 2010). The heterogeneity in the content and presentation of obsessions and compulsions provides a significant challenge for classification systems, theoretical frameworks, and treatments (McKay et al., 2004; Starcevic & Brakoulias, 2008). In the current *Diagnostic and Statistical Manual for Mental Disorders* (DSM-5; APA, 2013) OCD is no longer classified as an anxiety disorder, instead it is included in a new novel diagnostic class, the obsessive-compulsive and related disorders (OCRDs), based on the overt presentation of repetitive symptoms.

This shift in classification has been widely criticised by those arguing the essence of OCD is in the functional aspects of symptoms, and the relationships between them, not merely their repetitive nature (Abramowitz & Jacoby, 2015).

Previously listed as one of the top ten causes of disability worldwide (Murray et al., 1996), the condition has been identified across a wide range of populations (Swinson, Antony, Rachman, & Richter, 2001); cultural context appears to influence content and presentation, rather than occurrence (Radomsky et al., 2014; Weisman et al., 1994). The UK prevalence of OCD is estimated to be approximately 1.1% (Torres et al., 2006) with age of onset typically between adolescence and early adulthood (Anholt et al., 2014). OCD is highly comorbid with depression and anxiety disorders (Tükel, Polat, Özdemir, Aksüt, & Türksoy, 2002) and shares many demographic features with a range of other serious mental health conditions (Kessler, Chiu, Demler, & Walters, 2005). It can result in significant social and occupational impairment (Slade, Johnston, Browne, Andrews, & Whiteford, 2009) in addition to physical health complications (Drummond et al., 2012; WHO, 2011).

Currently the most common form of psychological treatment is cognitive behavioural therapy (CBT) with exposure and response prevention (ERP; National Institute for Clinical Excellence [NICE], 2005). Although CBT has been found to be effective (NICE, 2005; Öst, Havnen, Hansen, & Kvale, 2015), high attrition and low symptom reduction rates (Fisher & Wells, 2005; Olatunji, Cisler, & Deacon, 2010), suggest significant gaps in our understanding. Despite a proliferation of research in

recent decades, OCD remains one of the most difficult disorders to treat and current treatment innovations are lagging (Clark, 2015).

Theoretical frameworks

Behavioural. Behavioural theories hypothesise obsessions are conditioned stimuli, which trigger anxiety (Rachman & Hodgson, 1980). Compulsions are seen as maladaptive coping strategies used to manage this anxiety, preventing extinction of the feared stimuli (obsessions), and thus maintaining the disorder (Rachman & Hodgson, 1980). Behavioural theories provided the foundation for ERP (Foa, Steketee, & Ozarow, 1985); a behavioural approach that uses exposure to anxiety-provoking stimuli, whilst preventing use of compulsions, to allow for habituation. It has been used extensively to treat OCD albeit with limited effectiveness (Abramowitz, Taylor, & McKay, 2005). Behavioural approaches have been criticised for failing to differentiate OCD from other anxiety disorders or account for symptom heterogeneity. The finding that many individuals with OCD cannot recall a conditioning experience (Taylor et al., 2006) further undermines the theory, illustrating it provides a somewhat oversimplified conceptualisation of a complex condition.

Psychodynamic. Psychodynamic theories argue obsessions and compulsions are defensive reactions to unconscious emotional conflicts, an intolerance of internal emotional experiences (Gabbard, 2001; Moritz, Kempke, Luyten, Randjbar, & Jelinek, 2011). The anxiety experienced by people with OCD is hypothesised to be as a result of hidden feelings of anger, or latent aggression, coming close to surfacing (Malan,

1995). Latent aggression is defined as hostility or aggression towards others that manifests in a disguised form not always consciously available, as opposed to openly expressed (Moritz et al., 2011). Unacceptable impulses and thoughts are managed by adopting opposite impulses: hypermorality and over-responsibility (Kempke & Luyten, 2007), a defence mechanism labelled reaction formation (Fenichel, 1945). When intrusions return they are thought to be experienced as ego-alien and highly distressing due to the individual's hypermorality (Moritz et al., 2011). In support of psychodynamic theories studies have found associations between OCD symptoms and elevated levels of latent aggression (Bejerot, Ekselius, & van Knorring, 1998; Moritz et al., 2011; Whiteside & Abramowitz, 2005), perception of threat from anger (McCubbin & Sampson, 2006), and ambivalent attitudes towards significant others (Moritz et al., 2008). Despite these findings there is currently insufficient evidence to suggest psychodynamic therapy is an effective treatment for OCD.

Neuropsychological. Structural abnormalities in the cortico-striato-thalamo-cortical circuitry, dorsolateral prefrontal cortex (DLPFC), and the parietal cortex (Huey et al., 2008; Pauls, Abramovitch, Rauch, & Geller, 2014), neuropsychological deficits in the domain of executive functioning (Pauls et al., 2014), and abnormalities in cognitive flexibility (Gruner & Pittenger, 2017) have also been proposed as etiological theories of OCD. However, inconsistencies and difficulties determining direction of causation undermine neuropsychological findings (Abramovitch & Cooperman, 2015; Gruner & Pittenger, 2017), supporting those who argue OCD is better accounted for by cognitive biases and not by conceptualising it as a neurological disorder (Mancini & Barcaccia, 2014).

Cognitive. It is a well-established cross-cultural finding that the majority of people experience unwanted intrusions (Julien, O'Connor, & Aardema, 2007; Rachman & de Silva, 1978; Radomsky et al., 2014). Cognitive theories argue in OCD these intrusions are misinterpreted as a result of dysfunctional beliefs and maladaptive appraisals (Rachman, 1997; Salkovskis & Warwick, 1985). Reliance upon ineffective strategies, such as thought suppression and compulsive behaviours, to manage the ensuing distress, is hypothesised to exacerbate the frequency and impact of intrusions, reinforcing the dysfunctional beliefs and maintaining the difficulties (Clark & Beck, 2010; Rachman, 1998; Salkovskis & Warwick, 1985).

Cognitive theories consider three domains of dysfunctional beliefs to be central to OCD: Responsibility/Threat Estimation, Perfectionism/Certainty, and Importance/Control of Thoughts (Obsessive Compulsive Cognitions Working Group [OCCWG], 2005). The associations between dysfunctional beliefs, negative appraisals of intrusions, and OCD symptoms are well supported empirically (Steketee, 2011), and cognitive theories of OCD have paved the way for the development of CBT for OCD which focuses on challenging dysfunctional beliefs and appraisals (Clark, 2004; Salkovskis & Millar, 2016). Cognitive constructs that have received significant interest, and have considerable empirical support, include inflated responsibility (Salkovskis et al., 2000), intolerance of uncertainty (Gentes & Ruscio, 2011), and Thought-Action Fusion (TAF; Rachman, 1993).

Despite dominating research and treatment in the last 30 years (Salkovskis & Millar, 2016) cognitive theories have also faced a number of substantial criticisms.

Firstly, elevated dysfunctional beliefs are not always reported (Tolin, Worhunsky, & Maltby, 2006) and they appear to have poor specificity to OCD when considered with other conditions, especially other anxiety disorders (Abramowitz, Whiteside, Lynam, & Kalsy, 2003). Cognitive theories also fail to explain why some intrusions are appraised as significant and distressing whilst others are not (Melli, Aardema, & Moulding, 2016). After finding non-clinical participants rarely experienced pathological intrusions, Rassin, Cougle and Muris (2007) argued people with OCD may actually be more vulnerable to experiencing bizarre, distressing, and unacceptable intrusions; distress may therefore be due to excessive intrusions, and their content, rather than pathological interpretations.

Cougle and Lee (2014) argue many processes positioned as central within cognitive models are epiphenomena. For example, the proportion of variance in symptoms accounted for by responsibility, a central component of Salkovskis's model (Salkovskis, 1989; Salkovskis & Warwick, 1985), appears to vary considerably (Wilson & Chambless, 1999). Responsibility for harm can often be seen as intuitive in the context of everyday behaviour and a large proportion of research fails to make a distinction between pathologically inflated responsibility and normative moral responsibility (Cougle & Lee, 2014; McCubbin & Sampson, 2006). A number of studies have also found symptom change to precede a change in responsibility ratings and dysfunctional beliefs (Olatunji, Davis, Powers, & Smits, 2013; Overton & Menzies, 2005; Whittal, Woody, McLean, Rachman, & Robichaud, 2010; Woody, Whittal, & McLean, 2011), casting doubt on the direction of causation. Perhaps most importantly, there is a growing recognition CBT has not yet led to the significant

improvements in treatment efficacy that were initially hoped for (Clark, 2015; Cottraux et al., 2001; Cougle & Lee, 2014; Whittal, Thordarson, & McLean, 2005).

Metacognitive. Metacognitive models hypothesise three types of metacognitive knowledge contribute to the aetiology and maintenance of OCD: thought fusion beliefs, beliefs about the need to perform rituals, and criteria that signal rituals can be stopped (Myers, Fisher, & Wells, 2009; Wells, 2013). All three constructs have been found to positively correlated with OCD symptoms (Solem, Myers, Fisher, Vogel, & Wells, 2010). In metacognitive models TAF is not conceptualised as a cognitive distortion, as Rachman (1997) proposed, but as part of a set of metacognitive beliefs in which TAF is differentiated from Though-Event Fusion (TEF) and Thought-Object Fusion (TOF; Solem et al., 2010). Thought-Action Fusion is believing that thinking alone can make someone take action, TEF involves believing that thinking can cause events, and TOF involves believing thoughts and feelings can be transferred to objects.

Support for the model comes from findings indicating metacognitive beliefs can explain incremental variance in OCD symptoms even after controlling for responsibility and perfectionism (Fisher, 2009; Myers et al., 2009). Additionally, a number of treatment studies have found changes in metacognitions predict treatment outcomes (Fisher & Wells, 2008; Rees & van Koesveld, 2008; Solem, Håland, Vogel, Hansen, & Wells, 2009).

Self-processes. Many authors have argued it is the ego-dystonic nature of intrusions that causes distress in OCD (Clark & Purdon, 1993; Purdon & Clark, 1999;

Rowa, Purdon, Summerfeldt, & Antony, 2005). Intrusions are conceptualised to be ego-dystonic when their content is inconsistent with an individual's sense of self or interpreted as revealing hidden aspects of the self, which threaten the individual's preferred self-view (Rachman, 1997). A cognitive triad of views about the self, others, and the world is central to cognitive theory (Beck, 1979) however the role these enduring cognitive-affective structures play has been somewhat overlooked in traditional cognitive theories of OCD (Doron et al., 2012a; Doron & Kyrios, 2005). Self-processes are seen by many researchers to be a logical extension of current theories as they are thought to be able to shed light on why some intrusions are appraised as significant, and experienced as distressing, increasing the likelihood they will develop into obsessions (Aardema & O'Connor, 2007; Ahern, Kyrios, & Moulding, 2015; Bhar & Kyrios, 2007; Clark & Inozu, 2014; Clark & Purdon, 1993; Doron & Kyrios, 2005; Melli et al., 2016; Rowa et al., 2005). Incorporating the self into theoretical frameworks of psychopathology also provides further avenues for expanding treatments and enhancing outcomes (Bhar & Kyrios, 2007; Kyrios et al., 2016; Kyrios, Hordern, & Fassnacht, 2015).

Sensitive self-domains. Crocker and Wolfe's (2001) model of contingencies of self-worth argues a number of self-domains contribute to an individual's global self-worth. Self-worth is enhanced when an individual perceives competence in their valued domains, whilst perceived failures result in negative emotions such as sadness, anger, and shame (Tangney, Miller, Flicker, & Barlow, 1996). A sensitive self-domain is defined as one an individual feels is important to their positive self-view yet also incompetent in (Doron & Kyrios, 2005). People are thought to be

particularly aware of threats to their sensitive self-domains and so intrusions implying failure in these areas are more likely to be perceived as significant and distressing, and therefore develop into obsessions (Doron & Kyrios, 2005). Interestingly, an inflated sense of responsibility has been linked with a high degree of conscientiousness and social obligation (Salkovskis, Shafran, Rachman, & Freeston, 1999; Salkovskis, 1989) implying an individual is more likely to attribute an increased importance to these specific self-domains.

Building on earlier non-clinical findings (Doron, Kyrios, & Moulding, 2007) Doron, Moulding, Kyrios, and Nedeljkovic (2008) found increased sensitivity in the self-domain of morality was associated with higher OCD symptoms and OCD-related beliefs. Further empirical evidence for this sensitivity is illustrated by the finding that people with OCD are more likely to make negative moral inferences about themselves following intrusions compared with controls (Ferrier & Brewin, 2005). Additionally, threats to moral self-perceptions trigger OCD-like cognitions (Abramovitch, Doron, Sar-El, & Altenburger, 2013) and increase urges to engage in OCD-like behaviours (Doron, Sar-El, & Mikulincer, 2012). It is important to note these effects were only seen when participants were given specific self-relevant, negative information as opposed to other-relevant or positive information.

Neural correlates of moral sensitivity in OCD have also been identified (Harrison et al., 2012). Patients with OCD were shown to have significantly increased activation compared with controls in the ventral frontal cortex during a moral decision-making task, a brain area previously associated with disgust processing

(Moll, Zahn, de Oliveira-Souza, Krueger, & Grafman, 2005). A striking feature of this study was that OCD participants did not differ on their subjective ratings of moral dilemmas compared with controls despite the significant difference in neural activation identified, indicating potential difficulties with interoceptive awareness in OCD (Vicario, 2013).

Self-ambivalence. A number of researchers have also argued self-ambivalence provides a useful framework for understanding OCD (Ahern et al., 2015; Bhar & Kyrios, 2007; Bhar, 2005; Guidano & Liotti, 1983; Perera-Delcourt, Nash, & Thorpe, 2014). Guidano and Liotti's (1983) original theory drew upon attachment and cognitive-developmental approaches and is based on three core features: holding contradictory self-views, an uncertainty about self-worth, and a preoccupation in verifying one's self-worth.

The self-ambivalent individual, hypothesised to endorse both positive and negative self-evaluations, is thought to seek confirmation of either self-view in their environment. A resulting over attentiveness to thoughts and behaviours increases the vulnerability to feeling threatened by unwanted intrusions challenging a valued self-view (Kyrios et al., 2016). Rigid beliefs around morality are argued to develop in order to protect a valued self-view, with compulsions and neutralising strategies used to reinstate self-worth by providing evidence of adherence to high moral standards (Guidano & Liotti, 1983). In support of this approach, Ahern, Kyrios and Meyer (2015) found self-worth increased and distress decreased in a non-clinical sample immediately after neutralising strategies were employed in response to

being presented with idiosyncratic unwanted intrusions, but that the opposite was true subsequently. The temporary nature of these solutions is thought to emphasise to the individual that they must try harder, be more vigilant, and essentially become obsessional (Kyrios et al., 2016).

The development of the Self Ambivalence Measure (SAM) has provided empirical evidence linking self-ambivalence and OCD, and more specifically a self-worth reliant upon meeting high moral standards (Bhar & Kyrios, 2007). Ahern, Kyrios & Moulding (2015) also found self-ambivalence about self-worth moderated the relationship between high moral standards and OC symptoms in a non-clinical sample, suggesting ambivalence about moral self-worth may constitute a particular vulnerability to OCD. Additionally, Bhar, Kyrios, and Hordern (2015) found resolution of self-ambivalence predicted positive treatment outcomes in CBT for OCD.

Feared self. A further avenue examining self-concepts in OCD is the notion of the feared or dangerous self (Melli et al., 2016). In their inference-based model, O'Connor, Aardema and Pelissier (2005) suggest negative self-themes in areas the individual doubts or fears themselves guide intrusions and appraisals. A fear or distrust of self emotionally charges the intrusion content increasing vulnerability to obsessions (Aardema & O'Connor, 2007). The Fear of Self Questionnaire (FSQ; Aardema et al., 2013) has been shown to have a strong relationship with obsessional symptoms in both non-clinical and clinical samples (Melli et al., 2016). The measure includes items relating to feared self-beliefs, as well as several items referring to morality. Despite significant correlations with other self-construct measures such as

the SAM (Bhar & Kyrios, 2007), Inferential Confusion Questionnaire-Expanded Version (ICQ-EV; (Aardema, Wu, Careau, O'Connor, & Dennie, 2010), and the Self-Trust Questionnaire (STQ; Pasveer, 1997), the authors (Aardema et al., 2013) argue the FSQ makes a unique contribution to predicting symptoms of OCD.

Feared self-beliefs are also thought to interfere with reasoning processes in OCD by increasing vulnerability to doubt (Nikodijevic, Moulding, Anglim, Aardema, & Nedeljkovic, 2015), which in turn has been suggested to affect the ability to accurately perceive and experience internal states in OCD (Lazarov, Cohen, Liberman, & Dar, 2015). When considered together these findings suggest individuals with OCD may have an increased vulnerability to misinterpret emotionally charged unwanted intrusions due to a mistrust or doubt of themselves, which inhibits emotional processing.

Emotion in OCD. Emotional appraisal in OCD has been somewhat overlooked by the literature which has predominantly focused on appraisals of cognitions and physical symptoms. McCubbin and Sampson (2006) argue there is a parallel between the intolerance of unwanted thoughts and the intolerance of unwanted emotions in OCD. Avoidance of affect may actually be responsible for the emphasis placed on thoughts, as opposed to emotions, by people with OCD (Clark & Purdon, 1993; McCubbin & Sampson, 2006).

Higher levels of perceived threat from emotions, measured using the Perceptions of Threat from Emotion Questionnaire (PTEQ), has emerged as a stronger indicator of obsessionality than both responsibility and TAF (McCubbin &

Sampson, 2006; Smith, Wetterneck, Hart, Short, & Björgvinsson, 2012). More specifically, threat from anger, anxiety, guilt, and disgust have all been identified as significantly correlated with OCD symptom dimensions (Smith et al., 2012). Examining understanding of emotion, attention to emotion, negative reactivity to emotion, and ability to repair mood states Stern et al. (2014) found OCD symptom distress was significantly related to poor understanding of emotions and a fear of both positive and negative emotions. Whilst this was an unexpected finding, the authors hypothesised experiencing any emotion may be related to a more general fear of losing control (Moulding & Kyrios, 2006; Stern et al., 2014).

A poor understanding of emotions is thought to diminish an individual's confidence in controlling their emotions leading to a fear of emotional states and the use of maladaptive coping strategies (Turk, Heimberg, Luterek, Mennin, & Fresco, 2005). Low distress tolerance has been found to correlate with OCD symptoms (Robinson & Freeston, 2014). It has been suggested compulsions prevent confrontation of distressing emotion and inhibit access to alternative information (Calkins, Berman, & Wilhelm, 2013). In support of this, Coleman, Pieterefesa, Holaway, Coles and Heimberg (2011) found negative emotional reactivity and maladaptive management of emotions were significantly related to checking behaviours. Additionally, treatment focussing on emotional regulation found improvements correlated with a decrease in OCD severity (Allen & Barlow, 2009).

McCubbin and Sampson (2006) suggest OCD is more often described as an anxiety disorder due to difficulties in clearly naming the form of distress. The

phenomenon of patients with OCD reporting 'not just right' experiences is thought to further illustrate this (Smith et al., 2012). Alexithymia, an inability to identify and describe your own emotions, as well as differentiate between emotions and body sensations (Aleman, 2005), has been linked to OCD, with the externally orientated thinking dimension appearing to have the most empirical support (Robinson & Freeston, 2014). In OCD, alexithymia is hypothesised to limit the mental representations of emotional states and result in the use of compulsions to regulate affect (Carpenter & Chung, 2011).

A cognitive account of OCD might suggest difficulties identifying or tolerating internal states may intensify the problem of the emotions generated by dysfunctional beliefs in response to unwanted intrusive thoughts (Johnson-Laird, Mancini, & Gangemi, 2006). Alternative accounts however suggest affect precedes cognition (Haidt, 2001; Zajonc, 1984), implying obsessional symptoms are post hoc attempts to rationalise distressing, intolerable, and confusing internal experiences.

Specific emotions in OCD. In addition to emotional appraisal difficulties a number of specific emotions have been identified as having particular significance in OCD. The cognitive literature conceptualises anxiety as the core emotion in OCD. As might be expected, an elevated level of anxiety sensitivity (AS), the fear of experiencing anxiety, has been identified (Calamari, Rector, Woodard, Cohen, & Chik, 2008; Taylor, Koch, & McNally, 1992), however findings vary with some studies indicating a lower level than in other anxiety disorders (Robinson & Freeston, 2014). In the psychodynamic literature, anger is of primary importance (McCubbin &

Sampson, 2006), and more recently guilt, disgust, and shame have all been suggested to play a crucial role. It is noteworthy these four emotions are all considered moral emotions (Haidt, 2003).

Guilt. In non-clinical samples inducing guilt has been found to lead to a number of OCD-like symptoms including checking behaviours (D'Olimpio & Mancini, 2014), increased threat perception (Gangemi, Mancini, & van den Hout, 2007), and intrusive thoughts (Niler & Beck, 1989). In recent years guilt has been indicated to play a significant role in OCD by a number of studies (Chiang, Purdon, & Radomsky, 2016; Shapiro & Stewart, 2011). Lopatka and Rachman (1995) found concern about a harmful event was reduced in people with OCD when the responsibility for the event was attributed to someone else, regardless of the outcome. This led researchers to conclude the concerns of people with OCD were not about the consequences of an action, but about being held responsible for it, which was hypothesised to represent a specific form of guilt (Mancini & Gangemi, 2004, 2015).

Two distinct forms of guilt have been identified; deontological guilt (DG) is thought to arise from having violated one's own moral rules, whilst altruistic guilt (AG) concerns appraising one's conduct as not being altruistic. Neuroimaging evidence has illustrated distinct patterns of activation for each, with DG associated with the insulae and the anterior cingulate cortex (ACC), and AG the medial prefrontal cortex (Basile et al., 2011). Differing activation patterns in neuroimaging studies between people with OCD and controls when processing DG (Basile, Mancini,

Macaluso, Caltagirone, & Bozzali, 2014) has led to the conclusion that people with OCD may have an increased sensitivity to DG (Mancini & Gangemi, 2015).

D'Olimpio et al. (2013) found OCD patients were more prone to feelings of guilt and disgust compared to controls and other anxiety disorder patients, and this sensitivity directly correlated with OCD symptom severity. Interestingly, DG was only significantly related to disgust in the OCD group. Using the recently developed Fear of Guilt Scale (FOGS) Chiang et al. (2016) found scores predicted OCD symptom severity to a greater extent than measures of trait guilt, depression, and inflated responsibility beliefs. Chiang et al. (2016) argued individuals with OCD fear guilt due to their sensitivity in the self-domain of morality (Doron et al., 2008) and self-ambivalence (Bhar & Kyrios, 2007), as guilt represents failure in a key self-domain. Other authors have also argued people with OCD use guilt as a source of information about threat and performance (Gangemi, Mancini, van den Hout, 2007). The indication DG activates the insula (Basile et al., 2011) also seems particularly relevant as it is an area of the brain associated with disgust, self-reproach, and self-loathing (Mancini & Gangemi, 2015; Rozin, Haidt, & Mccauley, 2000).

Disgust. Disgust has a well-established role in OCD (Berle & Phillips, 2006) and appears likely to play a role across the DSM-5 OCRD cluster (Fontenelle, de Oliveira-Souza, & Moll, 2015). Disgust is also thought to be a multifactorial construct (Ludvik, Boschen, & Neumann, 2015) with disgust propensity (DP) describing the degree to which individuals differ on how likely they are to experience disgust, and disgust sensitivity (DS) the degree of distress caused by experiencing the emotion of

disgust (Ludvik et al., 2015). Both DS and DP have previously been linked to OCD symptoms (Berle & Phillips, 2006) however, DS may be more general across anxiety disorders, and DP more specific to OCD (Goetz, Lee, Cougle, & Turkel, 2013; Olatunji, Tart, Ciesielski, McGrath, & Smits, 2011) potentially representing a specific risk factor (Widen & Olatunji, 2016). Examining youth treatment for OCD Knowles et al. (2016) found strong correlations between reductions in DP and OCD symptoms.

Neuroimaging has indicated people with OCD have increased activation in areas associated with processing disgust facial expressions and disgust inducing stimuli (Harrison et al., 2012; Shapira et al., 2003; Stein, Liu, Shapira, & Goodman, 2001). In the context of research outlining how disgust can be elicited in relation to immoral acts, in addition to physical stimuli (Borg, Lieberman, & Kiehl, 2008), some authors have suggested it follows that it would be implicated in some forms of OCD notably harm and unacceptable thought symptom dimensions (Smith et al., 2012).

Shame. Reviewing shame across the OCRDs Weingarden and Renshaw (2015) found symptom-based shame to be particularly relevant to OCD with numerous anecdotal studies referring to the shame experienced in response to obsessions and their interpretations. Both clinical (Cougle, Lee, Horowitz, Wolitzky-Taylor, & Telch, 2008) and non-clinical groups (Simonds & Thorpe, 2003) have indicated feelings of shame are more likely in response to violent or sexual obsessions, indicating possible variation depending upon obsession content. Shame has also been implicated in maintaining, and exacerbating OCD symptoms potentially contributing to self-concealment (Wheaton, Sternberg, McFarlane, & Sarda, 2016), and acting as a

barrier to accessing treatment (Marques et al., 2010). Interestingly, Olatunji, Cox and Kim (2015) found the relationship between shame and compensatory behaviours, such as compulsions, was uniquely mediated by self-disgust in their OCD sample.

Anger. Anger has been linked with OCD symptoms in a number of studies (Radomsky, Ashbaugh, & Gelfand, 2007; Whiteside & Abramowitz, 2004, 2005). Individuals with OCD checking compulsions appear to report greater levels of trait anger but not anger expression (Radomsky et al., 2007), and a number of other studies have also identified latent aggression to be particularly relevant in OCD (Bejerot et al., 1998; Moritz et al., 2011). In a path analysis predicting severity of OCD symptoms, Moosavi et al. (2012) identified guilt to be the strongest predictor, however hidden aggression predicted guilt, which in turn predicted excessive responsibility. Similarly, Moritz et al. (2011) found, along with a higher disclosure of latent aggression, OCD patients also reported increased calculating behaviour, and interpersonal distrust compared with controls.

Theoretical frameworks: summary. A wide range of theoretical frameworks for OCD have been proposed. Cognitive appraisal theories have dominated the literature over the past few decades advancing our understanding of this complex condition and contributing to development of CBT for OCD. However, whilst there is substantial evidence for key cognitive constructs playing a central role in OCD, the theory is also unable to account for a variety of research findings. A number of authors have suggested lack of improvement in treatment efficacy is due to current theoretical models being underspecified (Fisher & Wells, 2005; Olatunji et al., 2010),

and failing to account for a number of constructs that are potentially crucial factors: self-constructs and moral issues (Chiang et al., 2016; Doron et al., 2008). Self-processes have provided a promising area of research (Clark & Inozu, 2014) and are seen to have the potential to expand current cognitive theories by addressing a number of shortfalls. Morality has been identified as a sensitive self-domain in OCD (Doron et al., 2008) and there is growing evidence that threats to moral self-perceptions induce a range of OCD-like symptoms (Abramovitch et al., 2013; Doron et al., 2012b). Research exploring self-ambivalence in OCD has also provided support for a theory implicating a self-worth reliant upon meeting high moral standards is particularly relevant to OCD (Bhar & Kyrios, 2007; Guidano & Liotti, 1983).

Despite indications emotional appraisal plays a prominent role in OCD there has been a continued focus in the literature on cognitive and behavioural aspects of the condition, perhaps best illustrated by DSM 5's recent reclassification of OCD (APA, 2013). A growing number of studies suggest moral emotions play a significant role in OCD, particularly guilt, disgust, shame, and anger, however this emotional complexity also appears to be missing from current models.

There is a growing need for a broader conceptualisation of OCD in order to maintain the momentum in theoretical development and treatment innovation (Cougle & Lee, 2014). The following section examines how morality, and moral emotions, are conceptualised within moral philosophy and psychology literature. The aim is to consider whether these ideas can contribute to our understanding of

OCD in the context of emerging findings indicating the relevance of morality in the condition.

Theories of morality.

'*Morality dignifies and elevates because it ties us all to something greater than ourselves: each other*' (Haidt, 2003, p. 26)

Moral philosophy, concerned with both the ontology (origin) and epistemology (knowledge) of morals, has predominantly focused on reasoning; both Plato and Aristotle presented models in which the head was seen to rule over the foolish slave of passion (Haidt, 2003). Later, Hume (Raphael, 1969) claimed the opposite was true, as did Freud (1953) who argued the ego is the servant of the id and reasoning is mere rationalisation. Two philosophical systems of morality became well established: deontological, and consequentialism or utilitarianism; the former bases ethics on adhering to an established set of rules, whilst the latter considers the merits of actions in isolation.

Potentially as a result of the cognitive revolution in psychology, the beginning of modern moral psychology is often attributed to Kohlberg's (1969) cognitive moral development theory, in which moral reasoning is central to predicting moral behaviour. Building upon Piaget's (1932) child development work on understanding of fairness and rules, Kohlberg's stage theory provided a conceptual framework outlining an individual's progressive understanding of justice. Whilst reasoning had long been the focus of moral philosophy, Kohlberg's work cleared the way for a cognitive revolution in moral psychology by establishing that morality, just like

language, could be studied as a system of underlying cognitive constructs. Moral psychology research was subsequently dominated by what Haidt (2013) terms *rationalism*, the belief that understanding moral reasoning is the key to understanding the underlying mental structures of moral knowledge. However, as the field developed intellectual movements such as the affect revolution, and cultural psychology, challenged Kohlberg's, and later Turiel's (1983) individual-centred views on morality (Haidt, 2013).

Dual-process theories. Dual-process theories of moral judgement outline how two distinct, and potentially competing, appraisal systems rule moral decisions (Greene, Sommerville, Nystrom, Darley, & Cohen, 2001); one intuitive and emotional, the other cognitive and rational. These appraisal systems are argued to represent the deontological and utilitarian systems established in moral philosophy (Greene, Morelli, Lowenberg, Nystrom, & Cohen, 2008). Evidence for this approach has come from fMRI studies indicating the two forms of appraisals are represented in distinct regions of the brain (Greene et al., 2001; Vicario, 2016). Emotional appraisals have been found to correspond with activity in the anterior cingulate cortex (ACC), superior temporal gyrus (STG), and insula, whilst cognitive, utilitarian appraisals correspond with activity in the temporoparietal junction and dorsomedial prefrontal cortex (Hutcherson, Montaser-Kouhsari, Woodward, & Rangel, 2015). Further, patients with damage to the ventromedial prefrontal cortex (VMPC) or fronto-temporal dementia (FTD), areas associated with emotional processing (Damasio, Tranel, & Damasio, 1990), appear more likely to make utilitarian decisions in moral dilemma studies (Koenigs et al., 2007).

Dual-process models have been criticised for relying on evidence from moral dilemma tasks, most commonly different variations of the trolley problem (Thompson, 1986). These tasks pit deontological and utilitarian options against each other, treating them as inversely related dimensions of a bipolar continuum, which many argue is not the case (Conway & Gawronski, 2013; Gray & Schein, 2012; Kahane, 2015). A further criticism of dual-process models is their failure to consider the effect of affective realism and the context in which judgements are made (Bloom, 2011; Carnes, Lickel, & Janoff-Bulman, 2015).

Social Intuitionist Model. Returning to the ideas of Hume and Freud, Haidt (2001) proposed a Social Intuitionist Model (SIM), challenging the causal role of moral reasoning by arguing it is a post hoc social construction after a moral judgement has been made (Haidt, 2001). Growing evidence of the role affect and automaticity played in moral judgement, and an emphasis on social and cultural influences, was used by Haidt to outline how moral judgements are caused by quick automatic moral intuitions, whereas moral reasoning is a conscious effortful process used to justify an already-made judgement to others. In support of his theory Haidt (2012) cites findings that inducing disgust (Wheatley & Haidt, 2005) or evoking concepts of cleanliness in a variety of ways (Helzer & Pizarro, 2011; Zhong, Strejcek, & Sivanathan, 2010) can change people's moral judgements. Responding to critics (Saltzstein & Kasachkoff, 2004), Haidt emphasised that whilst reasoning continues to be an important, on-going process, it is not the driving force of moral judgements; instead reasoning is something that happens in relation to others, in a social context.

Both the SIM and dual-process theories have been fiercely criticised by some who contend whilst there is clear neurological evidence of the recruitment of emotional structures during moral decision-making tasks it is insufficient to suggest causation (Huebner, Dwyer, & Hauser, 2009). Huebner et al. (2009) claim fast unconscious processes operating over causal-intentional representations mediate moral judgements; emotion is argued to serve only to motivate moral action and not to contribute to moral computation.

Moral Foundations Theory. Early moral psychologists (Kohlberg, 1969; Turiel, 1983) concluded justice and care were the foundations of morality, which was primarily about protecting individuals. As the field diversified it became clear morality was a broader and more complex concept than had been proposed by secular westerners (Haidt & Graham, 2007).

Analysing cross-cultural moral discourse Shweder (1990) outlined three moral ethics each based on a different ontological assumption: autonomy, community, and divinity. The ethic of autonomy was seen to correspond with Kohlberg and Turiel's individual-centred moralities incorporating rights, justice, fairness, and freedom, with the assumption that the world is made up of individuals protecting themselves from harm from others. The ethic of community assumes the world is a collection of groups for which morals serve to protect the integrity of the roles defining the group's identity and structure, and incorporates duty, respect, loyalty, and interdependence. The ontological position of the ethic of divinity assumes that a God or gods exist and moral regulation therefore serves to protect

the soul and spirit from degradation through self-control (Shweder, Much, Mahapatra, & Park, 1997).

Aiming to identify the psychological systems that provide the foundations of the moral intuitions described in the SIM, Haidt and Joseph (2004) examined Shweder's three ethics together with a number of other seminal works on morality (Brown, 1991; Fiske, 1992; Schwartz & Bilsky, 1990). From this analysis came the Moral Foundations Theory (MFT; Haidt & Joseph, 2004), which is currently seen as the dominant map of the moral domain. The MFT postulates that there are innate foundations of morality: harm/care, fairness/reciprocity, in-group/loyalty, authority/respect, and purity/sanctity, and more recently liberty/oppression (Iyer, Koleva, Graham, Ditto, & Haidt, 2012). MFT theorists are keen to emphasise their use of innate means a universal psychological preparedness (Seligman, 1971) as opposed to the finished product of adult morality (Haidt, 2013).

Originally designed to examine cross-cultural constructions of morality based on differing configurations of moral foundations, the MFT has also been used in political psychology (Haidt & Graham, 2007). It has however, also faced criticism for not replicating well across ethnic or religious groups (Davis et al., 2016; Davis, Dooley, Hook, Choe, & McElroy, 2017). Suhler and Churchland (2011) criticise the model for being contrived, ambiguous, and inconsistent, claiming it is inadequate as a scientific account of morality.

Model of Moral Motives. In their Model of Moral Motives (MMM) Janoff-Bulman and Carnes (2013) distinguish between proscriptive motives that protect

against bad (avoidance) and prescriptive motives that provide good (approach) whilst recognising the fundamental motivational distinctions between different established social contexts; intrapersonal, interpersonal, and collective (Brewer & Gardner, 1996). The MMM therefore has a 2 X 3 cell structure with six distinct moral motives; self-restraint/moderation (self-protect), industriousness (self-provide), not harming (other-protect), helping/fairness (other-provide), social order/communal solidarity (group-protect), and social justice/communal responsibility (group-provide).

Comparing the MMM with the MFT Janoff-Bulman and Carnes (2013) propose that the individualising foundations, which correspond with Shweder's ethic of autonomy, harm/care and fairness/reciprocity parallel the interpersonal column in the MMM. Whereas the three remaining binding foundations (Haidt & Graham, 2007), ingroup/loyalty and authority/respect corresponding with the ethic of community, and purity/sanctity with the ethic of divinity, are argued to fall into the group column, specifically the proscriptive (group-protect) cell. The MMM therefore expands the MFT with the addition of motives specifically focused on the self, both proscriptive (self-protect) and prescriptive (self-provide), and a prescriptive group motive (group-provide), labelled self-restraint/moderation, industriousness, and social justice/communal responsibility respectively.

Investigating the role of context upon perceived moral norms, Carnes et al. (2015) identified a powerful and unique influence over people's beliefs about morality and the applicability of moral principles in different contexts. The addition

of the self-column in the MMM also provides an interesting convergence with another rapidly expanding area of moral psychology, the moral self.

The moral self and social-cognitive theory of moral identity. A further issue with Kohlberg's (1969) cognitive moral development theory is known as the judgement-action gap (Walker, 2004); the relationship between moral development and moral behaviour is weak, variable, and inconsistent (Blasi, 1980). Research has therefore since aimed to provide a more comprehensive framework for understanding moral behaviour by investigating the moral self. Moral self research, rejecting the notion it is a result of abstract moral reasoning, views morality as being at the heart of what it is to be a person (Narvaez & Lapsley, 2009; Solomon, 1992). Blasi (1983) first proposed a self-model of moral functioning whereby moral action results from the extent to which morality is integrated into one's sense of self. A moral self is comprised of goals, values, and ideals, which all motivate behaviour consistent with these notions.

The field focuses on explaining both how morality is internalised into a person's sense of self and identity based on deeply felt concerns, commitments and attachments, essentially *who* a person is, and how this internalised morality subsequently influences cognitive and affective self-regulatory capacities relating to decisions and behaviours, essentially *how* a person acts. These two constructs are referred to as the *having* and *doing* sides of the moral self (Jennings, Mitchell, & Hannah, 2015). The *having* side is seen to develop through the cognitive construction of beliefs about the self through social interactions (Harter, 1999),

whilst the *doing* side is seen to underscore the executive agency of the self, taking responsibility, making decisions, and initiating action, thereby taking control of itself and the environment (Aquino & Reed, 2002; Baumeister, 1998). Individuals are hypothesised to try and maintain consistency between their moral self-concepts by aligning their behaviour with their values (Aquino & Reed, 2002; Blasi, 1983). Accordingly, a moral identity self-discrepancy has been identified as provoking negative emotion, guilt, and shame (Stets & Carter, 2012).

A key player in this post-Kohlberg social-cognitive field is Aquino and Reed's (2002) two-dimensional model in which moral identity is conceptualised as a network of moral trait associations. The two dimensions are *internalization* and *symbolization*, which correspond to private and public aspects of the self and can be seen to overlap to some degree with the *having* and *doing* parts of the moral self more broadly discussed by Jennings et al. (2015). The accessibility of an individual's moral self schema and therefore the subjective experience of a moral identity is hypothesised to be captured by *internalization*, whilst the importance an individual places on presenting a moral self as a way of affirming their morality is captured by the *symbolization* dimension (Boegershausen, Aquino, & Reed, 2015). Interestingly, both deontological and utilitarian inclinations in moral dilemma tasks are positively related to moral identity *internalization* (Aquino & Reed, 2002; Conway & Gawronski, 2013).

Social-cognitive models of moral identity also argue situational cues can influence information processing by activating or deactivating an individual's

schemas (identity or knowledge structures) with some schemas more available for activation than others. This is seen to account for the intra-individual stability and coherence of an individual's moral character and for the variation in moral behaviour across different situations (Boegershausen et al., 2015). Reviewing studies using Aquino and Reed's (2002) model Boegershausen et al. (2015) found moral identity *internalization* interacted more with situational cues for prescriptive moral outcomes whilst both *internalization* and *symbolization* were equally important in their interaction with situational cues for proscriptive moral outcomes. Whilst their review distinguishes between proscriptive and prescriptive moral outcomes, unlike in the MMM, Boegershausen et al. (2015) failed to distinguish whether the situational cues concern the self, others, or the group.

Moral self-regulation. A number of phenomena provide interesting insights into how moral self theories play out in everyday life. Two well established concepts, moral self-licensing (Blanken, van de Ven, & Zeelenberg, 2015; Effron & Conway, 2015) and moral cleansing (West & Zhong, 2015), are hypothesised to be part of a moral self-regulation process (Sachdeva, Iliev, & Medin, 2009). Moral licensing describes how acting virtuously appears to license an individual to act less-than-virtuously later (Merritt, Effron, & Monin, 2010). This effect has been found in a number of studies where people made more prejudiced decisions or reduced their charitable behaviour following the chance to reject prejudiced statements, endorse a minority group, or select an environmental product (Effron, Cameron, & Monin, 2009; Khan & Dhar, 2006; Mazar & Zhong, 2010; Monin & Miller, 2001). A feeling of

cleanliness has also been found to render harsher moral judgements (Lobel et al., 2015; Zhong et al., 2010).

In contrast, moral cleansing describes the opposite effect, when moral self-image is threatened, unrelated compensatory behaviour appears to act as a way to regain or restore moral self-worth (Ahern et al., 2015; West & Zhong, 2015). An early study found when participants were forced to act unethically they were later more compliant in a different context, leading researchers to conclude their behaviour was intended to bolster self-image rather than repair harm done (Carlsmith & Gross, 1969). The concept of moral cleansing is now well recognised with compensatory behaviours falling into three categories: restitution cleansing, behavioural cleansing, and symbolic cleansing (West & Zhong, 2015). The phenomenon is further illustrated by a study discussed previously in which threats to moral self-perceptions increased urges to engage in contamination related behavioural tendencies (Doron et al., 2012b). Crucially, these effects only appear to occur when the moral self is threatened and not when a general moral schema is activated (Sachdeva et al., 2009).

Moral-self regulation research provides further evidence moral behaviour is influenced by social context as well as an individual's behavioural history, more than reasoning between good and bad. It relies upon two core assumptions; people desire a positive moral self-image and that this image can be influenced and changed through behaviour (West & Zhong, 2015). Not only is it difficult to ignore the parallels with many OCD symptom presentations, these findings also resonate with

self-ambivalence theories in which individuals with OCD are hypothesised to seek to evidence of a positive or valued self-image through adhering to strict moral standards in their behaviour (Guidano & Liotti, 1983).

Moral emotions. Haidt (2003) defines a moral emotion as one that can be seen to have two prototypical features: disinterested elicitors and pro-social action tendencies. In their communicative theory of emotions Oatley and Johnson-Laird (2011) argue emotions serve as a form of communication within and between individuals, enabling cooperation, competition, and disengagement with others. The theory is based on the premise that emotions are feelings that change our judgements. Basic emotions, which include anger, fear, and disgust, are seen as useful because they enable us to foster social behaviour and respond to events, that we place importance upon (Oatley & Johnson-Laird, 2011). Four families of moral emotions have been identified: the other-condemning (contempt, disgust, and anger), the self-conscious (shame, guilt, and embarrassment), the other-suffering (compassion), and the other-praising (gratitude and elevation), with the former two families having received the most attention in the moral literature (Haidt, 2003).

Rozin, Lowery, Imada, and Haidt (1999) proposed contempt, anger, and disgust directly correspond to violations of Shweder's (1990) ethics of community, autonomy, and divinity in their CAD triad hypothesis. Shame, guilt, and embarrassment are also argued to be moral emotions due to their action tendencies to make individuals conform to social rules (Haidt, 2003). Although seen to have both common and distinct neural underpinnings (Bastin, Harrison, Davey, Moll, &

Whittle, 2016), shame, guilt, and embarrassment are not identified as basic emotions by Oatley and Johnson-Laird (2011).

A number of observations strengthen the argument for the involvement of emotions in moral judgements; moral violations often evoke strong emotions, emotions often lead to moralisation, and moral action is often emotionally motivated (Huebner et al., 2009). Although the direction of causation is contested there is substantial evidence emotional structures in the brain are activated during moral judgement tasks (Greene et al., 2001; Harrison et al., 2012; Huebner, 2015; Huebner et al., 2009; Hutcherson et al., 2015) and moral emotions, notably disgust and guilt, appear to have a remarkable influence on moral judgement and decision-making.

Disgust. In their review of the relationship between disgust and morality, La Rosa and Mir (2013) concluded findings indicated a bio-directional link between physical disgust-cleanliness and moral cognition. Indeed, inducing disgust appears to increase the severity of moral judgements (David & Olatunji, 2011; Eskine, Kacinik, & Prinz, 2011; Horberg, Oveis, Keltner, & Ab, 2009; Moretti & di Pellegrino, 2010; Schnall, Haidt, Clore, & Jordan, 2008; Wheatley & Haidt, 2005) and the negative evaluations of other social groups (Dasgupta, DeSteno, Williams, & Hunsinger, 2009; Inbar, Pizarro, & Bloom, 2012). Neuroimaging evidence also illustrates visceral and moral disgust share common neural mechanisms (Jones, 2007) and, as discussed, it is well recognised a disgust response can be elicited in relation to immorality, in addition to physical stimuli (Borg et al., 2008). More specifically, activity in the insula

and STG, areas known to be involved in disgust processing, during moral dilemma tasks, has also led theorists to conclude the emotion is closely linked with moral judgement (Chapman & Anderson, 2013; Harrison et al., 2012). Additionally, these links are also illustrated by findings showing cleanliness can reduce the severity of moral judgements (Lee & Schwarz, 2010; Liljenquist, Zhong, & Galinsky, 2010; Ritter & Preston, 2011; Schnall et al., 2008). Conversely, when an individual feels clean, moral self-perception can be enhanced, licensing harsher moral judgements and immoral behaviour (Lobel et al., 2015; Zhong et al., 2010).

Distinguishing between the type of disgust (self or other), the type of moral judgement (whether the person is an actor or observer), and other possible associated emotions, appears important in considering this effect (Russell & Giner-Sorolla, 2013; Tobia, 2015). Ugazio et al. (2012) identified anger, an approach emotion, increased judgements of moral permissibility, whilst disgust, a withdrawal emotion, had the opposite effect, the type of moral scenario appeared to further moderate this.

Guilt. Mancini and Mancini (2015) compared the decision-making of three groups, in which they induced feelings of pride, altruistic guilt (AG), and deontological guilt (DG) respectively, during a task where participants were required to accept or reject economic offers with different levels of fairness. As discussed, DG is thought to result from an appraisal of having violated one's own moral rules, whilst AG is related to appraising one's conduct as not altruistic (Basile et al., 2011). Fairness judgements between groups did not differ however, DG participants were

significantly more likely to accept unfair offers than pride participants. It was therefore hypothesised that DG has the opposite effect to pride, limiting decisional autonomy, and inducing a lack of felt entitlement to take action to restore equity (Mancini & Mancini, 2015).

Reviewing the rise of moral emotions in neuropsychiatry more broadly, Fontenelle et al. (2015) illustrate how specific moral emotions, namely disgust, guilt, anger, and shame, can be clearly implicated in a number of DSM-5 diagnoses. They argue a greater understanding of how these emotions can be conceptualised within disorders would aid both diagnosis and treatment.

Theories of morality: summary. Moral reasoning has dominated the field of moral psychology for many years. More recently alternative perspectives have challenged this so-called *rationalism* and begun exploring the roles of intuitive and emotional processes in moral judgement and moral behaviour. Utilising increasing neuroimaging evidence suggesting the activation of emotional structures during moral dilemma tasks, dual-process theories argue both emotional and cognitive processing is used to make moral judgements (Greene et al., 2001). However, critics have argued conceptualising the two systems as competing with one another oversimplifies the decision-making process and ignores social context (Gray & Schein, 2012; Kahane, 2015).

Other theorists have looked to social and cultural psychology to argue moral reasoning is a post hoc social construction, which follows an intuitive judgement. The MFT (Haidt & Joseph, 2004) outlines innate moral foundations, which are argued

to underpin moral intuitions across cultures, whilst the MMM (Janoff-Bulman & Carnes, 2013) expands the MFT with a more nuanced consideration of the effect of context upon moral behaviours. Aquino and Reed's (2002) theory of the self-importance of moral identity is the most widely used social-cognitive model. It has also increasingly come to acknowledge the influence of situational cues and context upon moral judgement and action (Boegershausen et al., 2015). Moral emotions are increasingly recognised to play an important role in moral judgements, particularly disgust which has been clearly implicated in a wealth of neuroimaging studies.

In addition to the ideas discussed here there are numerous other models, approaches, and hypotheses about the essence of morality, the moral self, moral judgements, and moral action. In a recent special issue of *Current Opinion in Psychology* on morality and ethics, Gino and Shalvi (2015) conclude the richness of the field in terms of theories, methodological approaches, constructs, and observations, comes with both challenges and advantages. Despite no sign of one dominant theoretical framework there is a widespread consensus that morality is a social and interpersonal phenomena and that even maintenance of an internal self-concept happens within a social context (Gino & Shalvi, 2015).

Theories of morality in relation to OCD. A small number of studies have begun examining moral psychology frameworks in relation to OCD. Franklin et al. (2009) compared the moral reasoning of people with OCD and controls. Participants were presented with a series of hypothetical moral dilemmas and asked to choose between a utilitarian option, which would require action, saving the lives of some

whilst causing the death of one, and an omission option, which would not require action but would result in the loss of several lives. The results indicated no differences between groups, however it emerged that a high score on the Responsibility Attitudes Scale (RAS; Salkovskis et al., 2000) did correlate with a lower likelihood of choosing the utilitarian option. In a similar experiment Wroe and Salkovskis (2000) found individuals with OCD were more sensitive to omission compared with anxious or non-clinical controls when faced with scenarios about which they were particularly concerned. As previously discussed, studies which have asked participants to choose between options conceptualised as representing utilitarian and omission choices have assumed they correspond to discrete forms of reasoning, which compete with one another, a supposition which has been widely criticised (Gray & Schein, 2012; Kahane, 2015).

Kang et al. (2016) considered the MFT in relation to OCD symptoms in a large non-clinical sample. They found the strongest association was with the purity/sanctity domain, concluding that this may contribute to an increased vulnerability to appraising unwanted intrusive thoughts as personally significant and therefore distressing. Mapping this finding on to other models of morality this could indicate a particular sensitivity to Shweder's (1990) ethic of divinity, hypothesised to protect the soul and the spirit from degradation through self-control. In the MMM it corresponds with social order and communal solidarity, which incorporates protection from both physical and psychological threats to identity; group cohesion is maximised through group loyalty and conformity behaviours (Janoff-Bulman & Carnes, 2013).

Morality in OCD: summary

Despite a proliferation of research into OCD a comprehensive model able to fully account for the heterogeneity of the disorder is notably lacking. Current cognitive frameworks provide a limited conceptualisation of this complex disorder and have faced criticism for being unable to account for a range of equivocal findings. As a result, treatment innovation has stalled and OCD continues to be one of the most difficult disorders to treat (Clark, 2015).

With an emphasis on finding out why some intrusions are experienced as distressing there has been a renewed interest in the role of self-processes in OCD. Morality has been identified as a sensitive self-domain in OCD (Doron et al., 2008), and empirical evidence indicates threats to moral self-perceptions increase OCD like behaviours and cognitions (Abramovitch et al., 2013; Doron et al., 2012b). Behaviours appear to play a part in reconciling an ambivalence about self-worth by providing objective evidence of adherence to strict moral standards, and as a mechanism through which self-worth can be restored after threats (Ahern et al., 2015; Sachdeva et al., 2009). A moral sensitivity in OCD has also been identified with neuroimaging (Harrison et al., 2012) where areas associated with disgust appear to be significantly more activated during moral dilemma tasks. In addition, whilst there are clear indications of a variety of emotional processing difficulties in OCD (Robinson & Freeston, 2014) what is particularly striking is the growing evidence indicating the prominent role of moral emotions: anger, disgust, guilt, and shame.

The suggestion that morality plays an important role in OCD is not new. Freud (1953) proposed OCD symptoms were unsuccessful defence mechanisms against violations of moral standards, a result of an unconscious conflict between unacceptable, immoral, sexual, or aggressive impulses and the moral conscience (superego). Traditional cognitive theorists have also referred to moral elements of OCD in the form of a tender conscience (Rachman & Hodgson, 1980), an acute sense of obligation, inflated sense of responsibility (Salkovskis et al., 1999), and in terms of moral TAF (Shafran, Thordarson, & Rachman, 1996). Rachman (1997) speculated individuals with OCD strive for moral perfectionism in both thought and action.

The moral psychology literature not only provides a number of different perspectives for understanding and conceptualising morality, moral judgements, and moral action, but it also illustrates how morality, and its corresponding dilemmas, is something relevant to all of us, and not a phenomenon reserved for those experiencing mental health issues. More specifically, it also becomes clear moral emotions, notably disgust and guilt, play a crucial part in our moral judgements and can also influence our behaviour (D'Olimpio & Mancini, 2014).

The moral self-regulation literature demonstrates how susceptible we are to desiring a positive moral self-image and directing our actions accordingly (Sachdeva et al., 2009). Despite the wide-ranging hypotheses put forward for how this happens, it undeniably occurs within a social context, which interacts with emotions, judgements, and actions. Moral judgements can no longer be seen as purely rational decisions and behaviours based on preconceived ideas of good and bad. Indeed the

parallels between moral cleansing behaviours and OCD symptoms are particularly difficult to ignore (West & Zhong, 2015).

Could it be that people experiencing OCD possess a negative, or fragile moral self-image, which results in morality being a particularly sensitive self-domain (Doron et al., 2008) or easily activated moral self-schema (Aquino & Reed, 2002)? A moral code of ethics could provide some certainty in judging this moral self-image, an externally defined benchmark against which you, and others, can judge thoughts and behaviours (Guidano & Liotti, 1983). Ego-dystonic obsessions and emotions could be resolved though external action, or compulsions, in a quest to align parts of the moral self (Jennings et al., 2015). This temporary solution may fail to provide adequate defences against further ambivalence and doubt (Ahern et al., 2015), leading to a continued distressing imbalance, which maintains the difficulties. If this was to be the case, as the condition develops the individual would become increasingly unsure of themselves in complete contradiction of their efforts.

Qualitative studies

Whilst recent studies have been instrumental in contributing to a reconsideration of the central features of OCD and provided a platform for future research, the perspectives of people with OCD are almost entirely absent. In fact a large percentage of OCD studies are conducted with non-clinical samples. A number of qualitative studies in OCD have explored particular treatments including mindfulness CBT (Hertenstein et al., 2012), low intensity interventions (Knopp-Hoffer, Knowles, Bower, Lovell, & Bee, 2016), intensive CBT (Bevan, Oldfield, &

Salkovskis, 2010), and therapeutic context (Murphy & Perera-Delcourt, 2014). More specific features of OCD have also been explored qualitatively; Coughtrey et al. (2012) studied mental contamination finding it was described as primarily coming from a human source and generating a feeling of internal dirtiness. Whilst a study investigating reassurance seeking identified themes which included interrogating feelings to achieve a sense of certainty and interpersonal concern (Kobori, Salkovskis, Read, Lounes, & Wong, 2012).

In the few studies that have explored the lived experience of OCD the experience of the self appears to be a prominent theme. Knapton (2015) found episodes could be grouped into three broad categories; activity, state, and object, with the latter two concerning the self and identity, and the effect of objects on the self. Bhattacharya & Singh (2015) identified themes of connection versus disconnection, the feeling of guilt, and authenticity. Fennell and Liberato (2007) found their participants reported experiencing a crisis of self that led them to use strategies to deal with self-stigma, experienced stigma, and anticipated stigma. Exploring the narratives of adults with OCD Van Schalkwyk et al. (2016) uncovered a dichotomy between those that experienced anxiety versus incompleteness, in addition to those that utilised their behaviours as coping strategies for stress and anxiety and those that denied finding any comfort in their OCD. Interestingly, few studies have qualitatively explored emotions in OCD. Savoie (1996) found guilt was highly idiosyncratic and interpersonal in OCD, and could precede, motivate, and be a consequence of symptoms.

Proposed study

Despite a plethora of theoretical models recent research findings indicate we are far from fully understanding this complex heterogeneous disorder. Advances in OCD research have not translated to treatment outcomes (Clark, 2015) and further exploration of different factors is clearly needed. Morality has been identified as relevant to OCD by numerous researchers, working from a variety of perspectives, using varied methodologies. It therefore provides a potentially promising area for further exploration.

It is striking no known study has explored the experience of morality for individuals with OCD using a qualitative approach. Qualitative methodologies allow for a full understanding of social psychological phenomena by combining a contextualised and dynamic approach focused on social processes, with one concerned with participants' lived experiences (Willig, 2013). The contribution culture and social context play in morality (Baumeister & Vonasch, 2012) further indicates an appropriate approach is crucial in order to facilitate a better understanding of how it is perceived by this group of people. The intention of this study was to address this gap in the literature.

Study aims. The overarching aim of the study was to use qualitative grounded theory methodology to explore the perception of morality for people with experience of OCD. The specific aims were to:

- Explore what morality means from the perspective of people with experience of OCD and how it is experienced in their lives

- Generate a theoretical understanding of morality for people with experience of OCD
- Consider an emergent model in relation to existing theoretical frameworks of OCD and conceptualisations of morality in order to identify novel factors which could be be used to inform our understanding of OCD and contribute to treatment innovation

Chapter 2: Method

Research design

A qualitative research design was used to explore the study aims. Constructivist grounded theory (CGT; Charmaz, 2014) was used to inform the analysis and presentation of findings from 12 semi-structured interviews with adults with experience of OCD.

Qualitative methodology. Qualitative methodology is particularly suited for exploring particular phenomena from the perspectives of the interviewees as it employs an inductive approach, exploring the subject matter in as much detail as possible whilst preserving the subtlety and ambiguity of the issue (Elliott, Fischer, & Rennie, 1999; Hodgetts & Wright, 2007). Qualitative approaches are therefore recommended for areas where there is a significant gap in the knowledge base as it is able to define phenomena in terms of experienced meanings, using fieldwork to contribute to a process of revision and enrichment of understanding (Elliott et al., 1999). In terms of the current study, the use of qualitative methodology was justified as the study aimed to explore the experience of morality, a concept with multiple and varied conceptualisations, from the perspectives of participants.

The epistemological position of qualitative research differs from the positivist, objective position subscribed to by quantitative studies. It challenges the objectivity of the researcher and the universality of the research objects, instead emphasising the role of human experience, social context, history, and language.

This position of relativism attempts to ground findings in the individuals and situations being studied, as well as those studying them (Elliott et al., 1999). Qualitative researchers recognise that their existing knowledge of theories, values, and beliefs must be clearly acknowledged in to order represent and explore participants' experiences more transparently. This process is termed 'bracketing' and is not an attempt to set aside the researcher's perspective; rather it is recognition that it is part of the research itself (Elliott et al., 1999).

Grounded theory. Grounded theory (GT; Glaser & Strauss, 1967) is an inductive, indeterminate, and open-ended, emergent method, well suited for studying uncharted, contingent, or dynamic phenomena (Charmaz, 2008). GT methodology can be seen to have four identifiable features: minimising preconceived ideas about the research problem or data, simultaneous data collection and analysis, remaining open to multiple understandings of the data, and a focus on the construction of middle-range theories in data analysis (Charmaz, 2008). Early analytical thinking is encouraged, prompting researchers to interact with the data and emerging theories at every stage of analysis, differentiating GT from other qualitative methodologies (Charmaz, 2014). GT researchers are required to identify their own ontological and epistemological position before choosing a version of GT that is congruent with their own beliefs (Mills, Bonner, & Francis, 2006).

Versions of grounded theory. Since GT's initial conception by Glaser and Strauss (1967) a number of different versions have evolved reflecting differing epistemological underpinnings and definitions of the relationship between the

researcher and participants (Mills et al., 2006). Glaser's (1978) version is most commonly referred to as traditional GT. Data is considered to be representative of a 'real' reality and the researcher is considered a tabula rasa, entering the research with as few preconceived ideas as possible. In evolved or structured GT (Strauss & Corbin, 1994) there is a greater reflection upon the contexts in which participants are situated, and the importance of a multiplicity of truths and perspectives is acknowledged. In CGT (Charmaz, 2014), the most recent version of GT, 'the method does not stand outside the research process; it resides within it' (Charmaz, 2008, p. 160), the conditions and relations of the research are seen to form part of the knowledge gained.

Constructivist grounded theory. Used across a variety of fields Charmaz (2014) is the leading proponent of CGT; she argues 'data do not provide a window on reality. Rather, the 'discovered' reality arises from the interactive process and it's temporal, cultural, and structural contexts' (Charmaz, 2000, p. 524). CGT is therefore ontologically relativist and epistemologically subjectivist, asserting that there are multiple individual realities influenced by contexts (Guba & Lincoln, 1989; Mills et al., 2006). Charmaz (2014) originally chose the term constructivist to align with other social constructivists who also stressed social context, interaction, and interpretative understandings, however she acknowledges her position is consistent with the modern form of social constructionism.

In CGT researchers are positioned as co-producers of meaning; after examining their own epistemological position they are required to go beyond the

surface of the data to search for and question meanings about values and beliefs, whilst staying close to participants' accounts by keeping their words intact throughout analysis (Pidgeon & Henwood, 1997). Key analytic strategies offer both flexibility and structure to CGT: coding, memo writing, theoretical sampling, and theoretical saturation (Charmaz, 2008). Whilst the researcher is able to fit these strategies to the study in hand, they must learn to tolerate the ambiguity of doing so in order to be receptive to emerging categories and developing strategies, as a more procedural approach supresses the emergent elements of GT and stifles creativity (Charmaz, 2008). In presenting the analysis the researcher is further required to use a style which is evocative of the participants' experiences, enabling the reader to make connections between the analytical findings and the data from which they were constructed (Fossey, Harvey, McDermott, & Davidson, 2002).

Rationale for using constructivist grounded theory. The core aim of the study was to develop an explanatory account of how morality, a complex social process, is experienced and incorporated into participants' lives. Other qualitative approaches such as interpretative phenomenological analysis, narrative psychology, and discourse analysis, with their respective focus on the idiographic process, sense-making, and enactment, may all have offered interesting perspectives from which to approach this research. However, a core aim of the study was to develop a theoretical understanding of morality in OCD that would be clinically relevant, and therefore GT was seen as the most appropriate methodological approach to achieve the study's aims (Larkin, 2015). Charmaz's (2014) CGT was subsequently chosen as it occupies a epistemological position congruent with the researcher's own and is a

methodology able to acknowledge the social and cultural context of concepts. In addition, the flexibility of CGT strategies and transparent data collection and analysis (Charmaz, 2014) allowed for sensitive exploration of morality with participants, whilst also ensuring the study was feasible within the confines of a clinical psychology doctorate.

Position of the researcher. Researcher reflexivity is a crucial part of CGT as any theoretical generation is seen as an interpretative portrayal of the world by the researcher, and not an objective truth. The researcher should acknowledge their own philosophical and conceptual stance and be aware of how this interacts with the data and colours the development of theory generation.

Reflexivity. The researcher adopted a critical realist social constructionist position (Harper & Thompson, 2011). She is a 30-year-old white British female trainee clinical psychologist from a middle class background. Whilst the research was being carried out she was working in an adult mental health service delivering psychodynamic psychotherapy and cognitive analytical therapy. Previous to this she has worked in adult mental health for a number of years. She has experience of working clinically with individuals with OCD delivering psychological therapy using a variety of approaches including CBT and psychodynamic psychotherapy. Whilst this experience will have impacted upon the analysis, it is hoped this allowed for improved data collection and theoretical development. Unlike the participants she has no personal experience of significant distress as a result of obsessions or compulsions.

The researcher began the study with an assumption that the concept of morality was somewhat universal, whilst believing the content of moral values and beliefs, and the importance placed upon them, differ between individuals, groups, and cultures. The researcher was curious about how people with experience of OCD conceptualise morality and the importance they place upon it. She is interested in the work of authors viewing OCD symptoms as normally occurring phenomena lying on a continuum.

Theoretical sensitivity. A researcher's level of knowledge in the research area, their attention to the nuances and complexity in the participants' experiences, their ability to reconstruct meaning from data, and their aptitude in identifying pertinent data are all seen to be part of the multidimensional concept of theoretical sensitivity (Mills et al., 2006; Strauss & Corbin, 1994). Traditional GT argues reviewing literature in the field ahead of data collection risks contaminating emerging codes, however later versions of GT engage proactively with the literature, interweaving it as an additional voice in theoretical construction by the researcher (Mills et al., 2006; Strauss & Corbin, 1998). In order to meet the requirements of the clinical psychology doctorate a literature review of the area of interest was completed by the researcher ahead of data collection and analysis. It is important to acknowledge how together with the researcher's clinical experience, this will have influenced data collection and analysis. A reflective journal (Appendix 1), memo writing (Appendix 2), and supervision were used throughout the research process to increase transparency, encourage active reflection, and recognise biases in analysis.

Procedure

Public involvement and engagement. Public involvement in research is defined as research being carried out *wit*h or *by* members of the public where the term public includes patients, potential patients, and people from organisations representing people who use services (INVOVE, 2015). In the current study consultation was sought with representatives from the UK charity OCD Action who supported development of the initial interview schedule (Appendix 3) and participant information sheet (PIS; Appendix 4).

Ethical approval. The London Camden and Kings Cross Research Ethics Committee granted ethical approval for the study in August 2016 (Appendix 5); subsequently Heath Research Authority approval was given (Appendix 6) and the study was registered with the Royal Holloway University of London Ethics Committee (Appendix 7). Research and development (R&D) approval was gained from five National Health Service (NHS) trusts. Two trusts were not subsequently used to recruit participants as recruitment had ceased before any potential participants had been identified.

Supporting services. A number of NHS Improving Access to Psychological Therapy (IAPT) primary care mental health services across London supported recruitment for the study. Services were identified predominantly based on their location to ensure participants would be able to attend a face-to-face interview with the researcher in central London. These services provide evidence-based psychological treatments, including CBT, to adults (over 18) with depression, anxiety,

and other common mental health problems. Patients typically self-refer to IAPT services or access them via a referral from their general practitioner (GP).

Recruitment. The study employed three recruitment strategies:

1. Clinicians in supporting services were asked to identify eligible potential participants and gain their agreement to be contacted by the researcher
2. Eligible potential participants that had previously consented to be contacted for research purposes were identified from a supporting service's database
3. Advertisements were displayed in supporting services and on the internet inviting eligible participants to contact the researcher if they were interested in participating

The recruitment and data collection procedure process is outlined in *Figure 1*.

Inclusion and exclusion criteria. The following inclusion criteria were applied to potential participants:

- Personal experience of OCD
- Capacity to give informed consent
- Aged 18 or over
- Fluent in English to ensure ability to understand the information sheet, and provide informed consent, understand the interview questions, and provide detailed verbal responses

The following exclusion criterion was applied:

- Currently suicidal, psychotic, or dependent on illicit drugs or alcohol

Measure. An OCD symptom measure was used to locate the sample. For participants that had not been recruited through NHS IAPT services, the Obsessive-Compulsive Inventory-Revised (OCI-R; Foa et al., 2002) was used to verify their experience of OCD ahead of their participation.

Obsessive-Compulsive Inventory-Revised. The OCI-R (Foa et al., 2002; Appendix 8) is an 18 item self-report measure of OCD symptoms. Participants are asked to rate each item on a scale from zero to four based on how much each symptom has distressed or bothered them in the last month. There is a maximum score of 72; a score of over 21 is generally considered to indicate OCD (Foa et al., 2002). The OCI-R has been shown to have good internal consistency with alphas ranging between 0.81 and 0.93 and test-retest reliability ranging between 0.74 and 0.91 in individuals with OCD (Abramowitz & Deacon, 2006; Foa et al., 2002; Hajcak, Huppert, Simons, & Foa, 2004). Originally developed from the longer Obsessive-Compulsive Inventory (OCI; Foa, Kozak, Salkovskis, Coles, & Amir, 1998), the OCI-R correlates well with other established measures of OCD (Foa et al., 2002), over which it offers a number of practical advantages such as ease of completion and scoring, and a full assessment of the breadth of OCD symptoms (Abramowitz & Deacon, 2006).

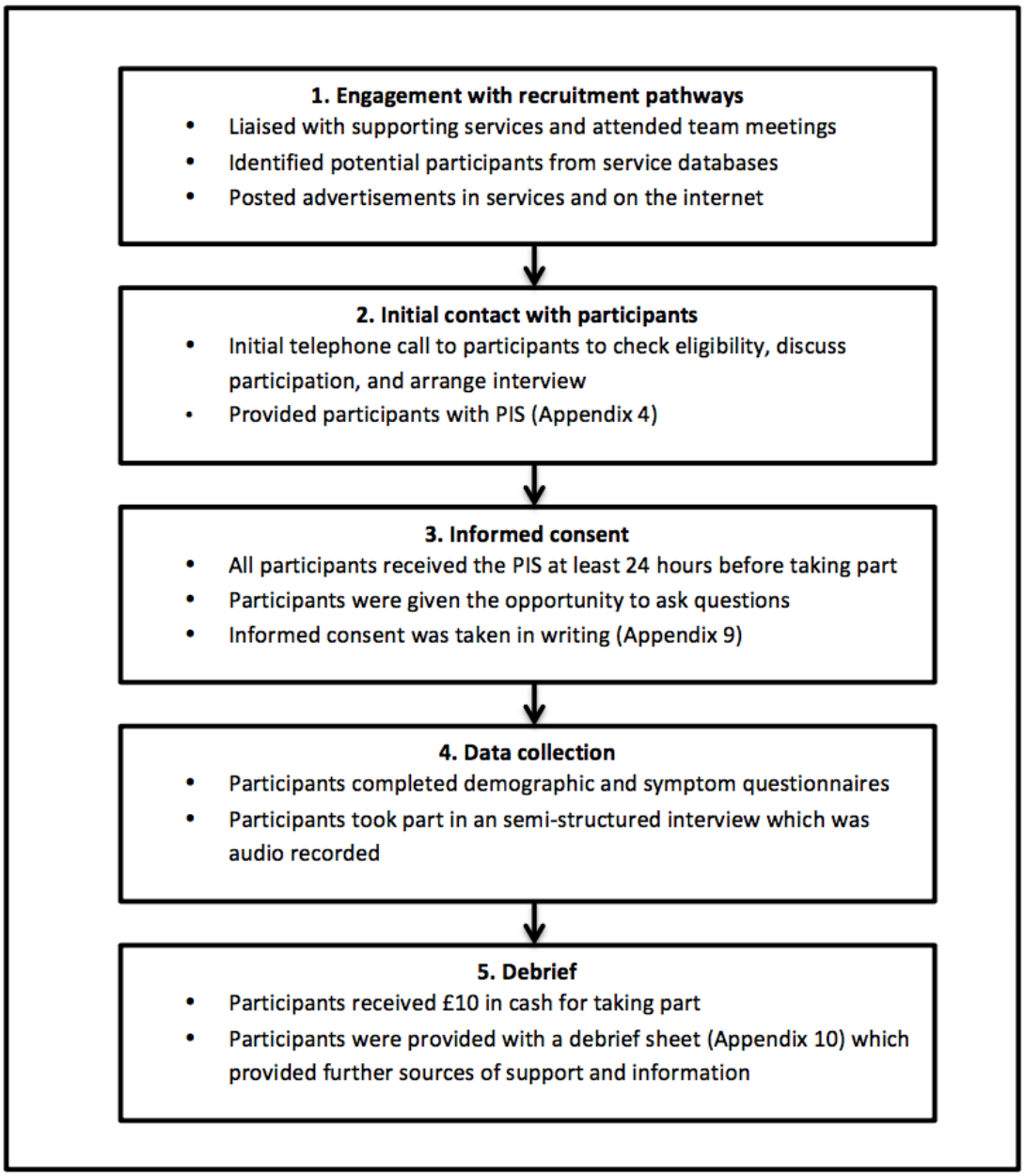

Figure 1. Recruitment and data collection procedure

Participant recruitment. A total of 32 potential participants were either identified by services or contacted the researcher expressing an interest in taking part. A recruitment flow diagram can be seen in *Figure 2*. Of the 17 people who responded to advertisements five did not respond to the researcher's initial request

for a telephone call and four were unable or unwilling to attend a face-to-face interview appointment due to work commitments or travel difficulties. Two did not score 21 or over on the OCI-R during telephone screening with the researcher and were therefore excluded as their experience of OCD could not be verified.

All of the 16 individuals identified through supporting services had been recognised as experiencing OCD at the time of their assessment with a clinician in the service. The researcher was unable to contact six of these people and one person declined to take part after speaking with the researcher citing a lack of time.

Of the total interviews booked, two people cancelled saying they did not have time, and one participant did not attend an arranged interview and no reason was given. It is not possible to know how many potential participants were approached by clinicians in supporting services but declined being contacted by the researcher, equally participants responding to advertisements were self-selecting. In total 12 participants took part in the study.

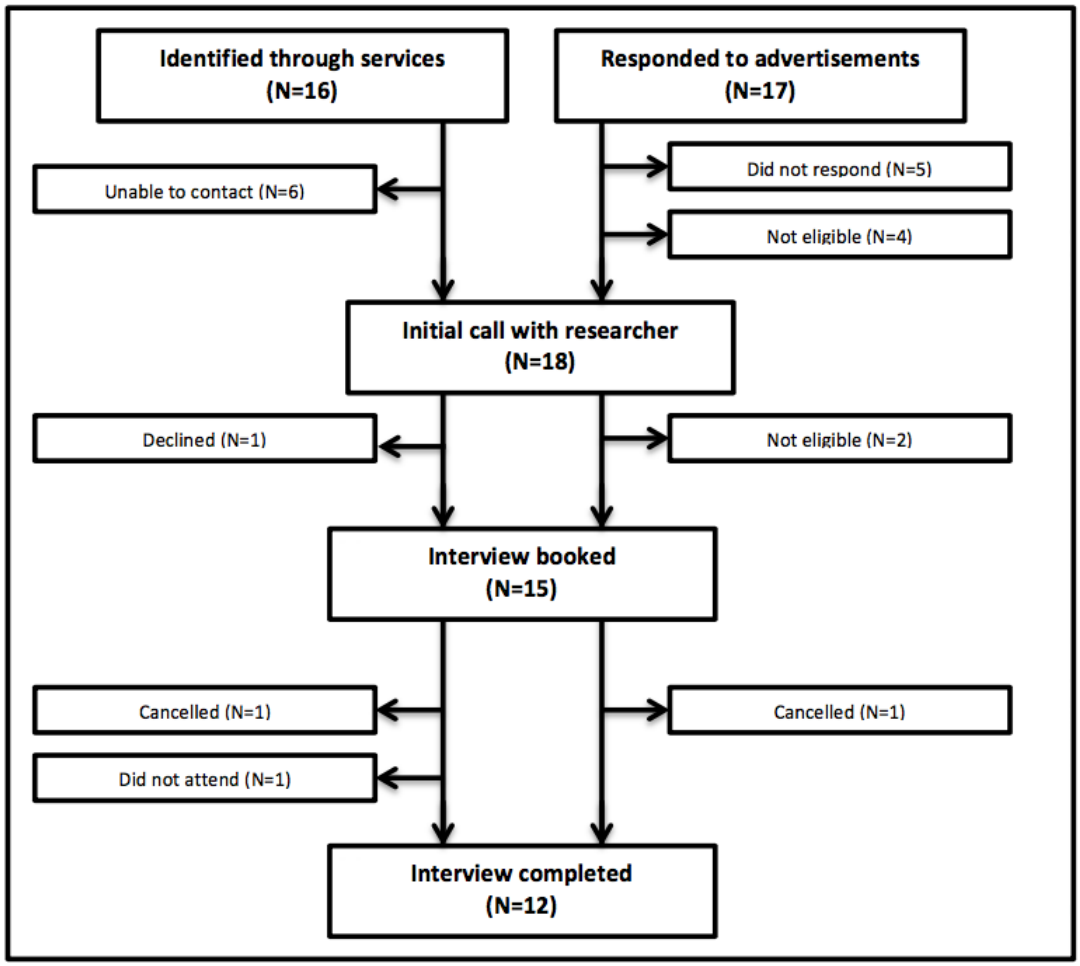

Figure 2. Participant recruitment flow diagram

Data collection

The data collection procedure is outlined in *Figure 1*. Full details of participation are included in the PIS (Appendix 4). Key ethical considerations were addressed as follows:

- **Informed consent**

  Participants were provided with the PIS sheet a minimum of 24 hours before consenting to participate, and given opportunities to ask questions (Appendix

9). It was made clear their participation was voluntary, they had the right to withdraw at any time without giving a reason, and this would have no impact on any treatment they may be receive.

- **Confidentiality**

  Participant information was kept strictly confidential unless significant risk was disclosed. Participants were allocated a study identification number in order to ensure anonymity and interviews were fully anonymised following transcription.

- **Risk and disclosure**

  Participants were made aware that if they disclosed significant risk to themselves or others during data collection this information would be shared with relevant health professionals.

- **Distress during interview**

  If participants became distressed during the interview the researcher was sensitive in asking if they wished to continue. Following the interview all participants were given a debrief sheet (Appendix 10) providing sources of additional support and information.

Participant characteristics. Details of the 12 participants can be seen in Tables 1 and 2. This information was gathered from participants before the interview took place and helps to situate the sample and provide a context for the research. Due to the size of the sample demographic information is shown as totals in Table 1 to preserve participant confidentiality.

Table 1.

Demographic Summary of Participants

	Demographic information	Number of participants (N = 12)
Gender	Female	9
	Male	3
Age	20 – 25	2
	26 – 30	4
	31 - 35	5
	45-50	1
Ethnicity	White British	7
	White Other	1
	Black or Black British African	1
	Mixed White and Black Caribbean	1
	Chinese	2
Marital status	Single	7
	Married	1
	With partner	4
Employment	Employed	7
	Unemployed	2
	Student	2
	Other	1
Highest educational level	GCSE	2
	Bachelor's degree	8
	Master's	1
	PhD	1
Religion	No religion	8
	Christian	1
	Prefer not to say	2
Psychological therapy for OCD	Currently accessing	4
	Accessed previously	5
	Never accessed	1
	Prefer not to say	2

Table 2.

Participant OCD Symptom Information

Participant number	Recruitment pathway	OCI-R
1	NHS service	2
2	**Other**	**44**
3	**Other**	**33**
4	**NHS service**	**45**
5	NHS service	5
6	NHS service	17
7	NHS service	20
8	**Other**	**38**
9	NHS service	18
10	**NHS service**	**32**
11	**Other**	**56**
12	**Other**	**32**

Bold denotes participants experiencing elevated symptoms of OCD at the time of participation

The recruitment strategies, research design, and topic may have influenced the sample. Some participants talked about feeling daunted by being asked to speak about abstract concepts and others shared that they had felt apprehensive about taking part. It was not possible to know how many other potential participants had not felt able to take part due to these factors.

A number of participants spoke about feeling that their experiences of OCD were closely related to morality, however this was not true for all participants. The size of the study and the heterogeneity of the condition always meant that the sample would represent the experiences of only a selection of people however those who felt morality was a more central part of their difficulties may have been more inclined to take part.

The study's recruitment pathways also inevitably influenced the sample in terms of the number of participants that had accessed psychological therapy. It is important to recognise that although five participants had a score of below 21 on the OCI-R (Table 2) all these participants self-reported that they had a current diagnosis of OCD at the time of the interview. Their engagement with a mental health service to access psychological support for their OCD is strongly suggested to account for their lower symptom level at the time of interview, whilst the endorsement of an OCD diagnosis despite low current symptoms was seen to be an important finding. Further, a number of participants commented that they felt more inclined to take part since accessing therapy as it had enabled them to become more familiar with articulating their experiences. These issues are discussed in more detail in subsequent sections.

Interview schedule. An initial interview guide was constructed in collaboration with the research supervisor and UK charity OCD Action (Appendix 3). The developed guide set out open-ended, non-judgemental initial, intermediate, and ending questions with the aim of encouraging unanticipated statements and stories to emerge (Charmaz, 2014). Deliberate overlap allowed the researcher to return to topics to gain rich information by exploring them from different angles.

Interviews. An intensive interviewing method was used as it offered an 'open-ended yet directive, shaped yet emergent, and paced yet unrestricted' approach (Charmaz, 2014, p. 85). This flexible technique creates interactional space for ideas and issues to arise and be explored, allows for immediate follow up of

participants' responses, and results in a co-construction by both researcher and participant (Charmaz, 2014). Charmaz's (2014, p. 70) 'Do's and Don'ts of Intensive Interviewing' were further used to guide etiquette during interviews.

All interviews all took place in private rooms on Royal Holloway University of London sites between October 2016 and February 2017. They varied in length from 38 to 99 minutes, with a mean interview time of 57 minutes. This variation was seen to be influenced by a number of factors: the researcher's confidence in interviewing style, flexible use of the interview schedule, theoretical sampling through extending the interview schedule in later interviews, and different participants wanting to provide extensive detail and elaborate examples. The interviews were audio recorded allowing the researcher to give their full attention and maintain eye contact with participants. Observations and thoughts were recorded in a reflective journal following each interview in order to capture additional knowledge (Appendix 1). Participants were encouraged to set the tone of the interview and the researcher aimed to recognise multiple cues from participants to allow for adapting questions, exploring points further, or moving on.

Charmaz (2014) notes interviewers must remain attuned to how participants perceive them, and how participants' identities influence the character and content of the interaction. A number of participants positioned the researcher as an expert by discrediting their own statements saying *'I'm not remotely qualified to talk about OCD'* or by making certain assumptions about the researcher's own mental health status, for example saying '*you must have to be slightly more in control of your*

mental state'. Further, some participants seemed concerned that the researcher would know more about them than they did themselves, or reveal things that they did not know, for example participant 6 said *'I might find out something about myself that I wouldn't like'.* As the researcher also occupied a health professional role participants may actually have felt more open describing their experiences. Indeed, many participants did disclose significant personal information without being directly asked by the researcher.

It was striking how frightening many participants perceived their experiences of OCD to be and therefore the researcher was mindful of creating a space in which participants felt comfortable talking (Charmaz, 2014). The researcher aimed to do this through emphasising that there were no incorrect answers and by conveying empathy and understanding in their verbal and non-verbal responses to participants. In CGT interview data is seen as a construction of participants' experiences, and as a performance given by participants for a particular purpose within a larger social, cultural, and historical context (Charmaz, 2014). Reflexive progression refers to the notion that participants' views may arise throughout conversation, co-constructed with encouragement from the researcher, rather than preceding the interview starting (Hiller & Diluzio, 2004). This seemed particular pertinent to many participants who expressed how novel the interview questions were saying '*the sessions that you get don't really go this far*'.

Adapting the interview. The interviewing approach changed as the study grew; the researcher's familiarity with the technique developed, and new directions

were indicated by the data, both of which are expected occurrences in CGT studies (Charmaz, 2014). As it was not possible to return to participants as part of the iterative process of GT, theoretical sampling was conducted through continually developing the interview schedule (Charmaz, 2014; Appendix 3). New lines of inquiry were added to later interviews through discussion with the research supervisor to reflect developing analyses. Questions were used to test out and expand the parameters of particular themes by asking participants for their opinions. At times this lead to more directive questioning than in earlier interviews and therefore it was important to be attentive to how this could create a different interactional space. This was addressed through building rapport and context before asking these questions.

As the study's aim was theory construction four theoretical concerns were considered: plausibility, direction, centrality, and adequacy (Charmaz, 2014)**.** Plausibility refers to making patterns in the data visible and understandable rather than relying on socially constructed definitions of accuracy. The iterative process of CGT indicates the range and type of variation in the data, and may indicate inaccurate, embellished, or deceptive accounts. Charmaz (2014) argues these provide important data and may represent a process that is a reoccurring pattern, which cannot be articulated. Coding and memo writing (Appendix 2) throughout data collection allowed for transparent theoretical direction as emerging relationships were tracked, changing directions were recorded, and reflections on the adequacy of the research questions were acknowledged (Willig, 2013). This led to theoretical centrality as certain ideas and areas were pursued. Finally, theoretical

adequacy refers to the robustness of theoretical categories and was aimed for through theoretical sampling.

Memos. Memos form a fundamental part of CGT as they provide an opportunity to learn about the data rather than just summarising it, a chance to track the development of a category, capturing both the process and the progress (Charmaz, 2008). Memos were used to comment upon raw data, describe the conditions in which codes and categories emerged and changed, and to note gaps in the data. The researcher aimed to write memos whenever she had an idea and memos took a variety of forms from short notes to diagrams (Appendix 2), providing something to work with, ponder, and explore as the study progressed (Glaser, 1978).

Theoretical sampling. Theoretical sampling involves returning to the field, once data collection and analysis has commenced, to check, develop, and define emerging categories in order to explore all conceivable theoretical explanations for the data (Charmaz, 2006). As time and resource constraints prevented the researcher from leaving the confines of the original data set to broaden and refine the analysis (Willig, 2013), theoretical sampling was aimed for through adapting the interview schedule (Charmaz, 2014), as discussed.

Theoretical saturation. The aim of theoretical sampling is to attain theoretical saturation, which is when gathering more data provides no further knowledge of the theoretical categories. Charmaz (2008) notes that theoretical saturation does not mean the repetition of themes in the data, it refers to establishing the parameters of a category. It is important to acknowledge that due to

the small sample size in the current study the theoretical codes may well have not reached saturation, however theoretical sufficiency was achieved in terms of having sufficient data to construct a coherent theory (Dey, 1999).

Data analysis

Transcription. The researcher transcribed all interviews verbatim, providing an opportunity for immersion in the data and increased in-depth understanding (Charmaz, 2014). A denaturalised approach to transcription was taken preserving as many verbatim features, such as 'um' and 'you know' of speech as possible, in an attempt to capture the subtlety and complexity of participants' intentions and actions (Davidson, 2009).

Initial coding. Initial coding involved closely studying fragments of data for analytical emphasis, moving the researcher into an interactive analytic space. Sensitising concepts relating to symbolic interactionism such as action, agency, process, meaning, identity, and self provided a starting point for analysis without determining content (Charmaz, 2014). Words, lines, sentences, and stories were actively labelled with constructed codes that simultaneously categorised, summarised, and accounted for them (Appendix 11). During this early stage of coding the aim was to remain open to all possible theoretical directions by sticking close to the data whilst also asking questions of it.

Focused coding. Focused coding refers to using significant and frequently occurring initial codes to 'sift, sort, synthesize, and analyse' larger portions of data

(Charmaz, 2014, p. 138). They condensed and sharpened what had been constructed in the initial codes, highlighting what was emerging from the analysis. An interesting development at this stage was the construction of processes and phenomena that participants were describing experiencing but had not yet conceptualised or found ways of succinctly articulating, a direction outlined by (Charmaz, 2014).

Theoretical coding. Theoretical coding helped build theory from the data by specifying possible relationships between focused codes. Making comparisons and looking for opposites moved the analysis from a descriptive to an analytical level, modifying the original constructs with theoretical sensitivity. Glaser (1978, p. 72) describes how this process weaves 'the fractured story back together' making it coherent and comprehensible (Charmaz, 2014). The emergent theory consisted of overarching theoretical codes with focused codes used to illustrate nuances represented by initial codes and raw data.

Diagramming. Diagramming, a central part of the coding and theoretical construction process, initially consisted of flow diagrams and logic diagrams, whilst more integrative diagramming was used to illustrate the complex interplay between different levels of codes and the emerging theory (*Figure 3*; Charmaz, 2014; Strauss & Corbin, 1998).

Research quality

In the present study the use of CGT acknowledges there is an inherent subjectivity to knowledge production (Madill, Jordan, & Shirley, 2000), and therefore

the straightforward transference of criteria such as objectivity and reliability to assess research quality is not appropriate. Elliott et al.'s (1999) quality guidelines for conducting qualitative research were used instead to inform the research design, analysis, and presentation of results.

Owning one's perspective. Participant understanding, researcher interpretation, cultural meaning systems, and acts of judging particular interpretations as valid by scientific communities, are all seen as influencing knowledge production (Pidgeon & Henwood, 1997). The researcher articulated their own perspective, acknowledging factors such as age, gender, and race to inform the reader of the position from which they analysed the data (Wilkinson, 1998). This technique was not used to put aside biases, but to acknowledge how personal and cultural assumptions affect interaction with data. A reflective journal (Appendix 1) was also used throughout the research process to capture beliefs and anticipations emerging as the study developed.

Situating the sample. Demographic and symptom information for participants are presented in order to situate the sample (Table 1, 2). A number of further characteristics of the sample are also discussed, in addition to the researcher reflecting upon the context of recruitment strategies and research design. This aids the reader in judging the applicability of the findings (Elliott et al., 1999).

Grounding in examples. The analytic procedures are outlined and examples are provided in order to illustrate the analysis process in the form of excerpts of coding (Appendix 11) and memos (Appendix 2) illustrating the development of

knowledge and understanding. Direct participant quotations have also been used to present the results in order to illustrate how findings are grounded in the data (Tindall, 1994).

Providing credibility checks. Comparative coding with other researchers, as recommended by Yardley (2015), was used to triangulate perspectives and ensure the findings made sense to other people. Secondly, initial findings were checked with a participant who felt the developed model accurately captured their experience. This provided testimonial validity (Stiles, 1993).

Coherence. The findings are presented as both a narrative framework and a visual map (*Figure 3*) to provide coherence between different levels of theoretical codes and themes. The developed model depicts both developmental and sequential relationships and feedback loops.

Accomplishing general versus specific research tasks. The research consists of 12 interviews with a range of male and female participants of different ages and backgrounds, with different experiences of OCD. The heterogeneity of OCD, along with the small sample size means it is important not to generalise the findings, the conclusions provide insight into the specific group studied. The emergence of the overarching themes across different participant narratives (Appendix 12) strengthens the findings.

Resonating with readers. Throughout the study the aim was to stimulate resonance in readers by expanding appreciation and understanding of the subject of morality and how it is conceptualised by people with experience of OCD. In addition,

the goal was to accurately represent participants' accounts, capturing experiences through language that previously may have been difficult to articulate and conceptualise.

Chapter 3: Results

This section presents a grounded theory of the experience of morality in OCD. The model incorporates seven overarching theoretical codes that emerged from analysis of the data. These comprised of focused codes, each of which contained specific properties identified during the initial coding stage of analysis. The composition of the analysis is presented in Table 3. A diagrammatic model illustrating the interrelationships between the theoretical codes and prominent focused codes is presented in *Figure 3*.

Following an overview of the developed model, the results for each of the theoretical codes are presented. Theoretical codes emerged throughout interviews rather than in response to specific questions, and participant presentation, style, and engagement were seen to wield additional knowledge. All aspects of interviews were therefore used to aid data analysis. Participant quotes[1] are used to ground findings in the data and illuminate the analysis to the reader. In order to protect participant confidentiality all identifiable information has been removed and participants are referred to using numbers P1 to P12 (see Table 2). The presence of the theoretical codes across all 12 participants can be seen in Appendix 12.

[1] Participant quotes are represented in italics. Interviewer quotes are represented in bold italic. The participant number is reported in brackets following the quote. A string of dots denote text has been removed, and square brackets within quotes denote information added by the researcher, to increase clarity for the reader.

Table 3.

Theoretical Codes, Focused Codes, and Properties of Codes

Theoretical codes	Focused codes	Properties of codes (initial coding examples)
1. CONCEPTUALISING MORALITY	**1.1 Early experiences influencing moral development**	Parents having strong moral values Strict parenting Parental mental health issues Family values
	1.2 Different levels of morality	Contextual use of morals Personal morals Describing morality as a social attitude
	1.3 Black and white moral rules	Abiding by the law Defining morals as a set of rules Defining actions as moral and immoral
	1.4 Possessing a moral compass	Referring to a moral compass Digesting a situation
2. HOLDING RIGID MORAL VALUES AS PART OF IDENTITY	**2.1 Moral rules providing a sense of self**	Strict adherence to moral rules Morals making you feel human
	2.2 Valuing a positive moral identity	Associating morality with positive characteristics Desiring a positive moral image
3. EXPERIENCING MORAL UNCERTAINTY	**3.1 Feeling uncertain about self**	Divided self Fragile self False self Doubting self
	3.2 Struggling to understand internal experiences	Not knowing where thoughts are coming from Not understanding emotions
	3.3 Feeling ambivalent about others	Displaying moral superiority Martyrdom
	3.4 Interpersonal uncertainty	Social anxiety Feeling misunderstood

4.	**SEEING THE WORLD IN BLACK AND WHITE**	**4.1** **Creating opposites**	Good –bad Moral – immoral Right – wrong Normal – psychopath Caring – selfish
		4.2 **Quantifying experiences**	Using mathematical language Describing an OCD equation Bringing things back to an equilibrium
5.	**FEAR FACTOR**	**5.1** **Fearing being a bad person**	Fearing own agency Fearing being a bad person
		5.2 **Fearing others**	Fearing punishment Being a social pariah Fearing a world without morals
		5.3 **Avoidance**	Avoiding own mind Avoiding others Avoiding emotions
6.	**SEEKING CERTAINTY**	**6.1** **Using rules to create certainty**	Rules creating a sense of self Moral rules Interpersonal rules Sticking to the rules
		6.2 **Taking action**	Checking Neutralising Using internal mechanisms
		6.3 **Looking for explanations**	Using external sources for verification of self Attributing meanings to intrusions
7.	**FEELING AMBIVALENT ABOUT OCD**	**7.1** **Separating OCD from self**	OCD part of mind OCD as a fungus
		7.2 **OCD personality**	Identifying with OCD traits Being supersensitive
		7.3 **Valuing OCD**	Describing positive features of OCD Crediting OCD with bringing good fortune OCD helping to maintain positive view of self
		7.4 **Lacking agency against OCD**	Being trapped in a cycle Being a prisoner

Model of morality in OCD

A central aim of the study was to develop a model of the experience of morality in OCD. In *Figure 3*, a model is presented showing how the seven theoretical codes and prominent focused codes were seen to interrelate. A sequential, developmental pathway is used in conjunction with cyclical structures; arrows are used to illustrate feedback loops and processes seen in the data. The model begins with participants' upbringing, which was seen to influence participants' conceptualisation of morality. Although not specifically explored during interviews the emergence of particular themes from participant narratives about their early experiences warranted inclusion in the model. The theoretical codes beneath the dotted line indicate those explicitly explored by the study.

Morality was conceptualised as a set of black and white rules that must be adhered to, and although applicable at different contextual levels, it was seen as inherently interpersonal. A moral compass was described as being instilled in you as a child and represented how participants had incorporated moral values into their sense of identity, leading to the second theoretical code: holding moral values as part of identity, a positive moral identity was valued and hoped for. Morals were seen as providing a sense of self, which was important in the context of the third theoretical code, experiencing moral uncertainty. Uncertainty was centred on a divided, fragile, and false sense of self, which also led to ambivalence and uncertainty about others. The fourth theoretical code, seeing the world in black and white, was seen to act as both a confounding factor and an attempt at making sense

of uncertainty by dividing the world into binary categories: good and bad, right and wrong. Fear factor represents the consequence of conceptualising the self, others, and the world in this way; participants were seen to believe they could only occupy one of two positions, creating an overwhelming fear, due to enduring uncertainty, that they could occupy the unfavourable position.

Propelled by this fear, participants were desperate to seek certainty as to which position they occupied. The theoretical code seeking certainty incorporates how participants used rules and took action to generate valuable feedback for themselves, in addition to looking for explanations, in order to create predictable, stable, and neutral environments internally and externally. A two-way feedback loop is modelled between early experiences and the seeking certainty theoretical code as participants were seen to draw on the values of their families to inform their moral rules and actions, as well as using their early experiences to provide explanations for their OCD.

These strategies, or compulsions, were seen as necessary, helpful, and inherent in protecting a fragile positive moral self and managing an overwhelming fear of who or what they could be otherwise. In this way strategies were seen as preferable to the alternative: the potential unleashing of a feared dangerous self. This is captured in the final theoretical code, feeling ambivalent towards OCD, from which feedback arrows represent how the importance of holding rigid moral values as part of identity was strengthened whilst simultaneously increasing participants' uncertainty about who they really were, as participants continued feeling fearful of what would happen if these restraints were not in place.

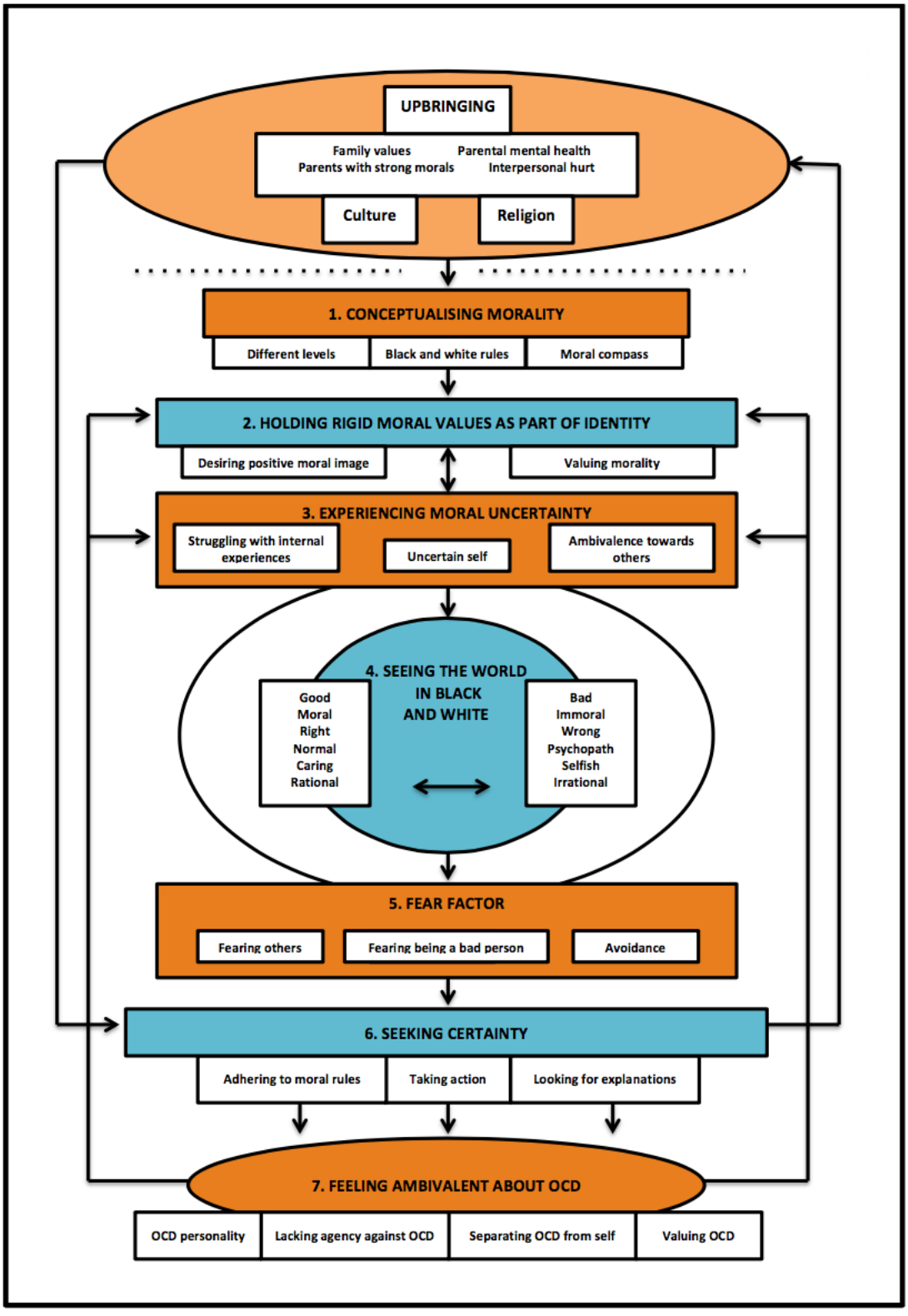

Figure 3. Model of the experience of morality in OCD

1. Conceptualising morality

The first theoretical code captured participants' conceptualisation of morality and how they felt they had come to develop their moral values. Morality was understood and valued by all participants who described the concept as having different levels and contextual application, being comprised of black and white rules, and internalised within them in the form of a moral compass. Many participants felt their upbringing had had a significant impact on shaping their morality. All participants understood and placed value upon morality, recognising that it was an inherent part of their lives, however the quote below illustrates the uncertainty some participants described when asked about their views.

> *I'm not quite like sure almost how you would define morality because it is such an important thing yet is it such an abstract thing in a way, I feel like it permeates sections of everybody's life and all of your life but you can't quite think of how to give an example* (P12)

Early experiences influencing moral development. Participants spoke about how they felt their upbringing, and the environment in which they had grown up, had strongly influenced their moral development. The research did not set out to explore participants' early experiences, however many participants provided extensive information about their childhoods. Notably, participants described how their parents had experienced adversity, including some experiencing their own mental health issues. This experience was often framed as having taught participants to be kind and considerate towards others, as they had felt protective over their

parents. A number of participants also reflected on how their parents had also displayed possible symptoms of OCD, for example through excessive cleaning (P2; P8), or by creating arbitrary rules (P12).

> *My family was very clean like in terms of OCD, my dad would mop and hoover the floor like 3 times a day um my mum liked to keep clean house we were always like trained to do the cleaning* (P8)

Family values were considered to be fundamental in informing participants about moral rules. These ranged from highly valuing possessions, cleanliness, or academic achievement, to integrity, honesty, or a particular political position. A thread within participant narratives was how their family values were often reflected in their individual experiences of OCD. A further theme here was how participants described being very aware of their parents' morals; how their parents had been very vocal about their own moral beliefs and had strictly enforced them within the family.

> *My mum was always very vocal about, you know, what they were saying wasn't right* (P5)

Participants also saw the wider cultural context as having influenced their conceptualisation of morality. For example, despite few participants identifying as religious many spoke about how growing up with Christian ideas such as the Ten Commandments had influenced their perceptions of right and wrong. Some participants also felt their family's position within wider society had contributed to their current morals; describing how they had grown up not feeling entitled to things

(P1), how they felt their family had been discriminated against in wider society (P5), had been part of a minority group (P10), or had had to work very hard (P8).

Participants recollected inconsistencies between parental moral values and those displayed by others in different contexts such as at school, with peers, or in wider society, when they were children. They spoke about being confused or scared by the behaviours or views of others when they did not reflect the values they had been taught at home. For example, participant 7 described how learning about religion at school, whilst not having religious parents, created a confusing conflict which caused them to question who was right and who was wrong. Understandably, these issues caused anxieties and almost all participants described experiencing difficult feelings when they were growing up. There was a sense that participants had not felt well supported in managing, or making sense of these experiences as children.

> *I would sometimes sort of get like really angry without a way of sort of calming myself down* (P5)

Interpersonal experiences were also referenced by participants as a mechanism through which they had learnt what was right and wrong. Many participants provided examples of how experiences with peers at school, accidently upsetting others, or being upset themselves, had informed their current moral position. They described how drawing on how they had felt at the time was a strategy they used as adults to think about how they should act towards others.

If you've been bullied or in the past or have been mistreated then you'd know that, how it feels, and for you not, not to behave like that in the future towards other people (P11)

Different levels of morality. Morality was conceptualised by participants as having different levels of definition and articulation. Firstly, morality was described as important personally, informing participants' self-image and directing their actions accordingly. It was also seen to be important in regards to interpersonal interactions and relationships, where participants spoke about an emphasis on being kind and avoiding causing harm to others. At a societal level, participants referenced how laws reflected what was right and wrong, and spoke of the importance of citizens abiding by these rules in order for society to function. These different contextual levels were also demonstrated through participants providing examples of moral behaviours, which ranged from describing the actions they took as individuals such as giving money to homeless people or donating to charities, to referencing the actions of politicians and the morality of wider global issues such as the refugee crisis, climate change, or health epidemics in Africa.

When you think of morals you're thinking about mainly how it affects other people um but there are also morals in a sort of wider context (P7)

Black and white moral rules. Participants described morals as a set of rules defined by others that determined right and wrong. Their conceptualisation of morals in concrete, black and white language linked closely with the observation that participants often constructed their worlds in binary terms, which is discussed in

more detail in relation to the theoretical code seeing the world in black and white. Moral rules were seen to offer little flexibility and participants spoke about categorising themselves, others, characteristics, actions, thoughts, and ideas as good or bad, moral or immoral. Adhering to this moral code was seen to be imperative because it defined who you were, a good or a bad person.

> *I mean there is some sense of morality that is coming from above or outside or from other people or from this idea that there is a prescribed set of rules and you can't really break them and if you do you become sort of bad and if you stay within them you are kind of good* (P12)

Possessing a moral compass. Participants described how possessing a moral compass aided their adherence to moral rules. This term alluded to an idea about having a practical tool within you that created a concrete, fixed, and stable reference point to help manage an abstract concept. Interestingly, participants often used mechanistic and technical language to describe how their moral compass had been constructed, describing how morals had been instilled or drilled into them as a child. Participants described how their moral compasses guided their decision-making and assessment of behaviour.

> *I always refer to my having a moral compass that I, when a situation comes to me I'll sort of digest it and put it on my moral compass so to speak and decide if I feel like that's the right thing to do* (P1)

Summary. Morality was conceptualised by participants as something that developed through childhood, predominantly influenced by social context. It was

seen to have different contextual levels, and provide a set of black and white rules, adherence to which indicated an individual's integrity. A moral compass encapsulated participants' internalisation of these moral rules, aiding their adherence to them.

2. Holding rigid moral values as part of identity

The second theoretical code captured the personal significance of morality for participants' sense of identity. The value placed on morals by their families, the construction of morals as black and white, and the belief they indicated who you were as a person, were all seen to contribute to the emphasis participants placed on their own strict rules for sticking to the rules. In the quote below participant 4 described the strictness of their moral compass and how they felt this was different to other peoples.

> *I suppose everyone picks their moral north don't they and then the compass is trying to find that, but for most people you know that's, like a compass does, it sort of gravitates around that and that's ok as long as they are heading broadly in that direction, but for me it's almost like I'm expecting a, you know like a GPS north not like one of those ship's compasses* (P4)

Moral rules providing a sense of self. More than simply indicating that you were a good person, possessing and adhering to moral rules was seen by participants to constitute a fundamental part of their identity. Moral rules provided a sense of who they were, and were described as making you feel human, providing direction in life, and influencing aims and goals. Additionally, there was a sense that

without morals participants were uncertain about who they would be, how they would define themselves, or what they might do. This was seen to link closely with a fragile sense of self presented in the following section.

> *I think it would be pointless to live on this planet [without morals] because you don't have any values … it seems like that person is actually an empty bottle* (P2)

Valuing a positive moral identity. A positive moral identity was highly valued by participants and associated with a wide range of positive characteristics such as empathy, honesty, kindness, integrity, compassion, and selflessness. Participants spoke about hoping they were moral, often saying it was more important that they felt moral within themselves, than others thought of them as moral, although this was also seen as desirable. Moral characteristics were also valued in others, and those that did not display them were described negatively, as lacking something, or likely to commit crime.

> *It is important for me to be moral because I would just feel, well I think on a personal level I would feel very bad* (P12)

Summary. Morals were seen to provide a sense of self, and an identity for participants who valued and desired a positive moral identity. The relevance of this is illustrated further in the following section where the enduring moral uncertainty participants described in terms of who they were is presented.

3. Experiencing moral uncertainty

The strongest theoretical code across all participants' narratives was one of enduring uncertainty. Most notably participants spoke about a distressing and confusing uncertainty about themselves and whether they were a good person or not. Uncertainty towards others was also described; feelings of resentment and contempt towards others was interwoven with describing other's needs as more important than their own, creating a perplexing sense of ambivalence. As with many themes, opposites were continually constructed; participant's descriptions indicated it was only possible for themselves and others to occupy one of two polar positions: good or bad, tyrant or martyr. This theme is discussed in more detail in the seeing the world in black and white section.

Uncertainty also emerged through participants' presentation during interviews. Participants often gave a number of different answers to the same question, sometimes directly contradicting what they had said previously. Participants also often sought to devalue their answers, claiming that they may well be incorrect even when providing information regarding their own experiences.

Feeling uncertain about self. Participants overwhelmingly described being concerned about not knowing for sure whether they were a good or a bad person. This code encompassed three notable themes: having a fragile sense of self, distress at presenting as false, and a fragmented self-perception divided into different parts.

> *I have this weird conflicting idea that part of me thinks that you're not a bad person … but then there is another part that is like you're a bad person* (P7)

Fragile self. Feeling uncertain about themselves seemed to make participants particularly vulnerable to thoughts, emotions, and actions influencing their self-view; there was a sense it was very fragile and could be completely changed from a single incident. Participants spoke about giving credence to these sources of information as accurate ways of inferring who they were. For example, this meant that unwanted thoughts were interpreted as meaning something about who they were (P9), accidents were seen to reveal their true intentions (P4), and experiencing unwanted emotions such as guilt resulted in a fundamental change to their self-image (P12). Many participants described analysing past actions and querying what they meant about them as a person. This constant questioning and doubting was also evident throughout the interviews.

> *Now I've come back to it and thought shit what does that mean now? How does that reflect on me as a person now? … Has it shaped who I am now? Should I really be…. you know, am I as I think I am?* (P9)

It was also clear was that this worked only in one direction, towards a negative self-perception, as positive information was disregarded or seemed to influence self-perception only temporarily. Therefore, instead of questioning serving to reassure or confirm their motivations or intentions it seemed to only increase participants' uncertainty and distress. In the quote below participant 11 described how taking part in the interview had made them question themselves more, indicating both an uncertain and absent sense of self.

It's almost like eroding my foundations, like well why do you do that, why do you think that, it's actually made me question … actually why did I do that and really kind of getting to the bottom of it and at the bottom there is not much (P11)

This fragility was also seen to result in reliance upon external sources of information, including others, to provide self-verification. This is discussed in more detail in the seeking certainty section.

False self. Uncertainty also seemed to feed a particular concern in regards to not being a genuine person and presenting as false or fraudulent. Participants seemed anxious to present as their true self yet unsure how they would know if they had achieved this. This appeared to put them in a predicament where they were destined to feel that they were presenting as false. It was interesting to consider how this fitted with the desire for a positive moral image, discussed earlier, and the value placed on honesty as a positive moral characteristic.

I think like well that one thing means that I'm actually a horrible person and then I feel like … any sort of attempt at morality now is presenting as sort of false self and I'm lying to everybody because like they, um, they might think I'm a nice person at the moment but they don't know (P4)

Divided self. Another way in which participants conceptualised themselves was as being divided into different parts with a significant lack of gestalt. This theme was seen to link closely with a number of others including creating opposites and separating OCD from self, discussed in later sections. A divided self appeared to

create, maintain, and in some ways provide a solution to uncertainty, as participants were able to attribute different features to different parts, seemingly as a way of making sense of what was happening to them, whilst retaining a sense of insight and perspective. However, this strategy also left them unsure as to which part was really them.

> *The rational mind has a more realistic view of responsibility and how much I can actually do and change and things and the OCD mind would probably see me as um responsible for all of the bad stuff in the world really* (P4)

Struggling to understand internal experiences. A further indication of participants' uncertainty was a prevailing sense that they found understanding and articulating their internal experiences really difficult. Participants described not knowing where thoughts came from, not always being able to clearly identify what emotions they were experiencing, or having difficulties distinguishing what had caused a particular emotion. This was illustrated by participants using vague and ambiguous language to describe how they were feeling, for example describing feeling uneasy, not right, or referring to a gut instinct. Alternatively participants changed the subject or simply said they didn't know when asked by the interviewer.

> *It [experiencing intrusive thoughts] would make me feel extremely uncomfortable and all like, all the negative words* (P1)

Another aspect of interviews was the striking absence of talking about emotions all together, with participants referring to physical reactions or actions they took, rather than how they felt, in this way participants appeared to lack

knowledge and skills about how to do this. There was also a sense of being at the mercy of thoughts and feelings; participants described being surprised by emotions, or taken over by them unexpectedly. These experiences seemed to fuel a perpetual feeling of confusion and unease.

> *It [anger] just comes over me and sometimes I just can't help but feel it and I don't know why* (P8)

Feeling ambivalent to towards others. This theme encapsulates the variety of ways in which participants positioned themselves in relation to others. Participants often moved between positions within a few sentences, portraying a sense of confusion and uncertainty about other people. As discussed, all participants valued moral characteristics, and whilst descriptions of moral others were largely positive some participants simultaneously conveyed a sense of derision at those presenting themselves as moral. This almost conveyed a sense of jealousy. Participant 10 spoke about how they didn't feel it was possible to be completely moral all the time and therefore anyone presenting like this was false.

> *Sort of like a desperate housewife then aren't they? Like a doll face, you know you come out in society and you are just one thing and you go back home and you are another, maybe like a double* (P10)

Participants also questioned the intentions of people claiming to be moral. It was interesting to consider whether this acted as a self-defence from their own declarations of morality by acknowledging that some people use it disingenuously.

There is almost two types isn't there, there's the moral person and then there is the self-professed moral person and I don't think they're the same (P5)

Participants overwhelmingly described morality as being inherently interpersonal and the importance of helping others and not being selfish. In some answers however participants went further and conveyed a sense of almost martyrdom in prioritising other's needs at the detriment to their own wellbeing. Participant 4 spoke about having an underlying belief that they were less worthwhile and therefore their only purpose was to make others happy. In the quote below participant 8 described how they always put others first despite the adverse consequences for them.

I have always wanted to help others more than I want to help me so I always prioritise others … and I hate myself for it sometimes because I think why have I not chosen something that works for me? Why have I not put myself first? But um you when you reflect and look back I think you take note of all this and realise it's the person that you are (P8)

Through prioritising others, participants also implied a sense of moral superiority, that they were more moral and selfless than others. This also emerged through participants describing how they held themselves to higher or different moral standards than other people, and that others could not always be trusted to act as morally as they did. At the same time, participants were equally quick to deny judging others on moral transgressions, claiming they were unqualified to make judgements about other people. Additionally, participants described others as being

much more capable than them in dealing with the things they struggled with, however there was some confusion about how others managed to do this.

Interpersonal uncertainty. A sense of not knowing or understanding others was also evident through anxieties about interpersonal interactions. Some participants spoke about their assumptions that others would view them negatively and their worries about this. In the quote below participant 6 describes their initial assumptions about taking part in the study.

> *I was immediately on guard, like I felt threatened, like this is someone who wants to judge me or find my morality was maybe bad or something so I was on defence really* (P6)

Concerns included what they might find themselves doing in interactions, upsetting others, or coming across in a way they had not intended to. Being misunderstood by others was a further worry, which also played out during interviews. Participants often asked if they were making sense, provided excessive detail, or were keen to give multiple examples to illustrate what they were trying to say. Many participants also spoke animatedly about how they felt OCD was commonly misunderstood in the public domain and how they felt this had partly contributed to their initial distress in not understanding what was happening to them, and subsequent distress in anticipation of being stigmatised by others.

Summary. A fragile, false, and divided sense of self, and a difficulty understanding internal experiences, was seen to lead to an enduring uncertainty about their own morality. This uncertainty also extended to others; participants

were ambivalent about the morality of others and their own position in relation to them. These difficulties were seen to be confounded by participants conceptualising the world as either good or bad, which is presented in the following section.

4. Seeing the world in black and white

The fourth theoretical code captures how participants sought to define the world in concrete, binary terms, often by creating two polar opposites. This became increasingly apparent when considering participant narratives as a whole as it was a strategy used by participants when describing a wide variety of concepts. Two particular themes emerged illustrating the devices participants employed to do this during their interviews: creating opposites and quantifying their experiences.

Creating opposites. Virtually all participants were seen to continually construct opposites and extremes as they were talking. This can be clearly seen in a number of themes discussed previously: black and white moral rules, and uncertainty about the self and others, where participants seemingly divided the world and themselves into two discrete categories, right or wrong, good or bad, all or nothing, with little space to occupy a position between the two. There was an implication that it was only possible to occupy one of the two distinct positions, if you were not one then you must be the other. For example, participant 12 described how if they weren't perfect academically and good, then they would be failing and bad.

> *[Being] perfect academically … became an important part of my identity that became an important part of you know what made me good and you know*

and then losing that and being bad at things or like failing at things was very scary (P12)

Despite the clear overlap with other codes in the data, it felt important to highlight this theme in its own right due to the pervasiveness of participants using this strategy to conceptualise their worlds across all manner of subjects. The most prominent way in which this was observed was through the differentiation between good and bad, which was applied to thoughts and actions, self and others. Participants also constructed normal and not normal, to refer to others and themselves respectively, as there was an assumption that others either didn't experience difficulties or were better able to cope with them.

A particular theme was the construction of a bad person without morals being a psychopath who was dangerous, uncontrollable, and capable of causing extreme harm to others. The fear of becoming this person is presented in more detail in the following section. OCD was consequently described as the opposite of this with participants describing it as a form of extreme over-caring (P6), and a super sensitivity towards others (P1; P7). Describing other positive characteristics associated with morality, participants talked fervently about having empathy, and helping others. Putting your own needs first was automatically associated as selfish behaviour, and the opposite of being moral, again evoking an idea of selfless martyrdom.

I feel that selfishness is probably putting your happiness, and what you want and you being right, before what other people might want or need, it's the opposite of having respect for other people (P4)

Quantifying experiences. A further theme was the precise, concrete, and mathematical language participants used when describing abstract concepts such as morality or emotion. As discussed, participants used technical language to describe their development and use of a moral compass, however participants also used it to describe how they managed unwanted thoughts and emotions. Many participants evoked a set of scales, describing how they would try and bring things back into equilibrium by neutralising negative thoughts, images, or emotions, or cancelling them out with positive equivalents. In a similar way, many participants also spoke about thinking about an OCD equation in order to work out how they could make sure everything balanced. There was also a sense of trying to quantify their own identity; here participant 11 described how they saw themselves.

I don't think I am 100% but I would say I was 50, 50% moral and 50% not (P11)

Summary. The tendency to try to quantify the world, and themselves within it seemed like an attempt by participants to structure and make sense of it, making it more predictable and less uncertain. However, conceptualising the world in binary categories also left little space for moral deviation, and in some ways confounded their difficulties in amplifying the fear of occupying the undesirable position.

5. Fear factor

The theoretical code fear factor emerged from all participant narratives. It incorporated participants' fears of being a bad person, and what they might be capable of, their fear of others and what interpersonal difficulties they may face, as well as a fear about the wider world, the future, and society. The sheer terror that many participants described feeling was particularly striking, with participants describing how it could result in a helpless paralysis, intense physical symptoms, and avoidance. Unlike with other themes, participants displayed no uncertainty in describing the central role fear played in their OCD, with many participants stating that if they were able to overcome, or get rid of, their fears then OCD would not be a problem for them at all.

> *It's the fears the people need to get rid of not the OCD, because the OCD is only there because of the fears* (P10)

Fearing being a bad person. Having divided their worlds into binary categories, and extreme opposites, a central issue for participants was a preoccupation with the possibility of being a bad person, as opposed to a good person. Several participants described their OCD as antagonistic in that they felt it had chosen to manifest itself as the thing they feared becoming the most. In this way participants made a direct link to their individual values, and those of their upbringing.

A bad person would be someone who hurts other people intentionally … which is funny because, I mean, I don't think I ever do that but in a sense that is what I fear becoming, or doing, being a bad person (P12)

OCD was probing for the worst thing. … and the one that it landed on that really stuck … I was like this is literally the worst thing that could happen to me as far as I was concerned (P5)

Participants provided vivid accounts of the intensity of the fear they experienced if they felt that there was a possibility that they were a bad person, describing powerful physical symptoms and emotions. As discussed, this fear was seen to be partly driven by a belief that they could only occupy one of two extreme positions, good or bad, making participants particularly vulnerable to a fear of being bad in the event of any instance where they were not perfectly good. OCD was depicted as a direct response to these fears, helping participants to push away fear and reduce the possibility of them becoming true. These themes, along with the helplessness participants showed in response to their fears, are presented in more detail in the seeking certainty and feeling ambivalent about OCD sections.

Fearing own agency. Participants displayed a fear of their own agency, what they may have done in the past, or would be capable of doing in the future, and were particularly concerned about their effect on other people. Participants also spoke about feeling that they needed to be restrained or controlled by an external entity because they could not be sure what damage they could do otherwise. Many participants spoke about the importance of abiding by the law and rigidly adhering

to moral rules in the context of being afraid of what might happen if they did not. Participants described concerns about being sectioned (P1) and taken away by the police (P1; P5), in response to their fears that they were a threat to others.

> *Awareness of the potential to be a bad person, that keeps me on the moral track* (P4)

Participants also revealed their concerns about fitting into society without their moral values, describing how they might become a nuisance (P2), trouble to society (P11), a social pariah (P9), or a criminal (P8; P3).

> *It would just mean you were a trouble to society I think with no moral values or not the right moral values um you could end up doing something quite harmful like taking someone's life* (P8)

Fearing others. Uncertainty about others and interpersonal interactions also saw participants being afraid of the interpersonal hurt, punishment, and negative judgement that could be inflicted by others. Two particular themes were seen in relation to concerns about being seen to be acting immorally by others: a fear of concrete punishment such as law enforcement, and a fear of social punishment by being shamed or embarrassed in front of others.

> *There's that fear you know if you do something that is, that is, that is immoral you know there is, there are consequences, there are repercussions so that, kind of, there is a bit of fear of getting in trouble* (P3)

I'm putting myself in a bad light if it ever came out … I feel guilty about it or I just would worry that somehow err it would come out (P9)

A further theme was a wariness towards others acting immorally, as they were seen as unpredictable and could not be relied upon to have the high moral standards of participants, it was therefore important to '*watch out for people*' (P6).

Fearing a world without morals. Participants also spoke about their fears about a world without morals. Closely resembling the extremes constructed in other themes, as discussed, participants described a messy world of terror (P7) and chaos (P3) where people would be arguing and hurting one another (P12).

It will just be chaos there would just be complete chaos like there'll be like riots every single day there'd probably be like wars and no I mean I can't even imagine (P3)

Avoidance. One of the ways participants described responding to fear was through avoidance. This included wanting to avoid their own minds, avoiding engaging with others, and withdrawing from the world. Participant 1 spoke about how they worked on strategies to '*keep myself out of myself*' as a way of avoiding their own thoughts. Several participants spoke about avoiding disclosing their experience to others as they felt afraid of what might happen if they told people, potentially perpetuating their fears and preventing them from seeking support. Additionally, participants spoke about avoiding the world feeling that either they were not safe to be in it or did not deserve to enjoy it.

Depending on how strict your moral code is it can really severely enhance your OCD to the point where you just kind of restrict yourself to doing very little because you are too afraid of challenging that code [P9]

Summary. Fear was a prominent theme for all participants; a black and white conceptualisation of the world where it was only possible to occupy extremes fuelled participants' fears of being a bad person, others being bad, and the world being messy and chaotic. These fears appeared to impart a frantic urgency upon participants to seek certainty to ensure that these fears were not true, and do everything they could to ensure that they never would be.

6. Seeking certainty

The theoretical code seeking certainty includes the use of rules to create personal and interpersonal certainty, taking action to gain control over fear and uncertainty, and the recruitment of other sources in a quest for explanations, guidance, and understanding. As with many of the other themes, participants' tendency to see the world in binary terms, and to categorise the world into opposing extremes, meant that strategies that initially provided certainty, and a sense of knowing oneself, became extreme, unrealistic, and all or nothing. Participants spoke about aiming for perfection and allowing themselves little flexibility or forgiveness when goals inevitably became unachievable.

Using rules to create certainty. The creation of rules by participants, and the importance they placed on adhering to them, was present throughout narratives. Black and white moral rules were used to create a sense of certainty about the

morality of the self, as discussed in earlier sections, as adherence provided valuable feedback to inform a fragile self-view. In this sense they were seen to provide a way of measuring and verifying one's existence and integrity, linking with the rigid moral values participants held as part of their identities. Sticking to the rules was not seen as something that was optional or negotiable in any way.

> *There is a prescribed set of [moral] rules and you can't really break them and if you do you become sort of bad and if you stay within them you are kind of good* (P12)

> *No matter how easy it is, you just don't break the rules* (P11)

Rules also seemed to provide a way of gaining control over fears and uncertainties for participants by reducing unpredictability and increasing control. They were described as a *'box that you keep your actions within'* (P12), offering both prescriptive and proscriptive guidelines. As presented in relation to the fear of agency theme, moral rules were often also described as a necessary form of protection or restraint against a potential immoral self.

Participants also spoke about how following rules increased certainty about their internal experiences; participants were seen to reassure themselves that as long as they followed the rules they could avoid experiencing unwanted emotions.

> *I know that if I follow what I believe is right and wrong I can go through my life not hurting anybody … and get to the end of it and not have to feel anxious that I've done anything wrong* (P1)

Participants' interpersonal uncertainties and fears were also addressed through creating rules for interactions. Overwhelmingly, participants described how it was of upmost importance to always help others and not to be selfish. The need to avoid confrontations, and others' negative judgements, was also deemed to be imperative, with an emphasis on making others like you.

> *I mean I'm almost taking the utilitarianism approach to make everyone happy … I guess, to me it's just being true to oneself and then in turn that affects how you, your relationships with others* (P9)

Here participant 9 creates a rule that is almost impossible to achieve if you feel uncertain about yourself. Interestingly, participants were reflective about how they understood rules and feeling in control to be part of their OCD, however they were predominantly seen as helpful and positive strategies in making them feel less uncertain.

> *OCD is essentially a set of arbitrary rules that you kind of invent for yourself and then you kind of work out ways to satisfy them, um, to kind of keep yourself, like sane is totally the wrong word, but to keep yourself sort of feeling ok and feeling happy um or feeling like in control a little bit* (P12)

Taking action. Participants described how feeling uncomfortable, uncertain, and fearful, would propel them towards taking action. Often participants described how the action itself could be quite arbitrary and unrelated to the specific concern but that it was just important to do something. Taking action appeared to provide a

sense of containment through being able to control the external environment despite feeling they could not control their internal environments.

> *I'm just trying to be perfect in my head, it's like I can't control my thoughts in my head so I can control the things around me. So because I can control the things around me it kinds of substitutes for not controlling what goes on in my head and fearing* (P10)

Participants also described taking action in order to control their emotions as both positive and negative emotions were described as bringing as sense of uncertainty. For example, participant 10 spoke about how it was preferable to stay '*neutra*l' and participant 11 described how they did not feel comfortable going above their '*happiness quota*' as it indicated something bad was around the corner.

> *I always try to kind of neutralise it [guilt], you know by doing another caveat, for example … I'll donate something … so it's like a bargaining thing really* (P11)

Internal actions or neutralising strategies were also described by participants as a way of gaining control over thoughts and emotions. Strategies included filling their head with other noise and distractions (P7), rewinding thoughts (P10), or holding good images in their mind (P12). Whilst participants predominantly described taking action in response to negative experiences, actions were also used protect a positive state, with some participants describing how it was too risky to stop actions if things were going well. In this way participants were seen to have a

distorted sense of their own agency bestowing an exaggerated amount of power upon it, which can be linked with the theme fearing own agency, presented earlier.

Looking for explanations. A particularly evident theme was participants seeking explanations for their experiences. Throughout their narratives participants put forward multiple ideas and theories about their OCD ranging from linking it to their upbringing, past experiences, their immune system, personality, drugs, accidents, god, and karma. The sheer number of possible theories put forward seemed to confound participants' difficulties in that they became increasingly uncertain about which, if any, were correct. In their quest to find reasons for their experiences, coupled with a fragile self-view, participants attributed significant importance to their internal experiences or intrusive thoughts, believing that they must hold some meaning about who they really were.

> *[I thought] I am thinking about this stuff so much that I must really care about it and it must mean something, that was the key really, it must mean something* (P9)

Participants also used feedback from their own actions and emotions to retrospectively ascertain their true intentions. As discussed, the fragility of their self-view meant that seeking explanations for difficult emotions could result in increased distress and result in an obsessive analysis of past actions.

> *If I do anything that I enjoy … then it will mean I don't care about the um the bad thing I did (P4)*

The more I question it [feeling guilty] or try and find answers, the more guilty I get … I'm trying to find a reason for why I feel that way (P9)

Participants also relied on interpersonal feedback. Indirect feedback, such as seeing someone upset was used to infer that they must have intended to do something wrong or upset others. This was seen to link with themes such as interpersonal uncertainty, fear of others, and the adherence of rules in social situations to avoid this happening. Direct interpersonal feedback, through seeking reassurance, was also a way participants described seeking certainty, as others were positioned as more qualified to judge actions. Aside from asking others for help with decisions or for assurances, participants also described feeling a need to confess wrongdoings. This was something participants were also seen to do during the interviews sharing numerous detailed examples of what seemed like minor transgressions, participant 5 saying '*I'm trying to think what else I have done*'.

Participants, in pursuit of concrete guidelines about how to act, were also seen to rely on other external sources of information for moral guidance. However, as participant 11 described one of the difficulties they faced with morality was '*it's hard for people to kind of say where it is written*' (P11). Many participants spoke about how they used religion (P7; P8), literature (P4), films (P12), and political ideologies (P4; P5), as well as their family's values, to provide them with moral guidance. This further emphasised how participants were seen to appropriate externally defined moral values in an attempt to create an internal moral identity for themselves.

Summary. Uncertainty and fear were seen to propel participants to seek certainty as to which position they and others really occupied. Rules created safe boundaries within which things were more predictable, adherence to rules provided valuable feedback about the self, and taking action provided a sense of control, keeping fears at bay. Multiple sources were recruited to offer explanations and provide moral guidance. Participants appeared incredibly pro-active in their certainty seeking, which was described as helpful and necessary in the face of their fears.

7. Feeling ambivalent about OCD

The theoretical code feeling ambivalent about OCD relates to participants' narratives about their experiences of OCD. The researcher was particularly mindful of the language and phrases participants used to position OCD in relation to themselves. The themes can be seen to represent OCD as being outside of, within, and above (caring and controlling) the self. Whilst at first the themes within this theoretical code seem to contradict one another this reflects how participants fluctuated between perspectives as they were talking in their seeming quest to make sense of their experiences and attribute meaning to them.

Separating OCD from self. Throughout many of the participants' narratives OCD was positioned as an active subject to which they were the objects. OCD was described as making things important, telling you to do things, and punishing you. In this way many participants actively personified OCD as a completely separate entity to themselves, for example participant 11 described OCD as '*like my father'*. Describing OCD as a mental disorder and likening it to a physical illness, which came

out of the blue, uninvited, and was nothing to do with them as they had no control over it, were other ways in which participants were seen to separate OCD from themselves. In the following quote participant 10 gave a particularly vivid description of how unrelated they felt OCD was from them.

> *I don't think anyone asks to have OCD um it's so annoying, it's like a fungus that keeps coming back, and you think it has gone and then bam it comes back* (P10)

Participants were also concerned about separating themselves from OCD during interviews, as participants seemed keen to differentiate themselves from OCD yet also unsure how to disentangle themselves. Participant 12 spoke about being uncertain whether to talk about their OCD or '*about what I believe personally apart from OCD*' (P12). A further strategy some participants seemed to use to achieve this separation was to talk about OCD in an abstract or theoretical way. Participant 4 spoke about how having '*that slight academic distance*' and being '*an object of study*' felt safer than talking directly about their experiences, and participant 3 described how they felt '*more comfortable talking theoretically*'.

Participants appeared to be more comfortable incorporating some aspects of OCD into their identities than others. The quote below highlights the dilemma many participants appeared to be grappling with throughout the interviews in terms of their ownership of OCD.

> *I sort of see a distinction between yourself and the OCD that you don't necessarily see it as part of yourself … I see the personality traits that are*

associated or that make you more susceptible to OCD … maybe I see that as part of myself but I don't necessarily see the OCD that comes out of it as part of myself (P7)

OCD personality. The majority of participants subscribed to the idea of having a current diagnosis of OCD despite not all reporting elevated symptoms at the time of the interview (see Table 2). In this sense OCD was seen to provide a sense of identity, with participants displaying a level of acceptance that OCD was now part of who they were. This was seen to relate closely to the following two themes; valuing OCD and lacking agency against OCD, in addition to the theoretical code holding rigid moral values as part of identity, discussed earlier.

I'm so used to it it's just a part of who I am … like a lot of time if don't really see it as a disorder I kind of just feel it's part of my character (P3)

Many participants also spoke about how positive personality traits such as being very empathic (P1; P4), supersensitive (P1; P7), and over-caring (P6) were what had got them '*into trouble with OCD*' (P1). In this way personality traits and a vulnerability to OCD were often interwoven in participant narratives. Many participants also gave lengthy descriptions of how they felt the context and values of their upbringing had contributed to their personality in addition to influencing the type of OCD they had developed.

I think it's because of those aspects of my personality which have very much come from my environment growing up that led me to develop OCD in the way that I did (P1)

Valuing OCD. In addition to describing OCD as being necessary, protective, and helpful for controlling a potentially bad, immoral self, and protecting a fragile positive moral self, participants also spoke about OCD being a preferable option given the alternative, living with an overwhelming sense of fear. Not only was OCD seen as a helpful solution to this problem by '*pushing the fear away*' (P12), participants also spoke about OCD bringing good fortune into their lives, helping them to maintain a positive view of themselves (P12), be a kinder person and a better friend (P4), and achieve things (P11).

> *There are good elements … it does you know like help make me a kinder person* (P4)

> *I'm going to give credit where it's due and I will credit OCD for helping me to achieve the things that I do* (P11)

Lacking agency against OCD. Something that stood out in many participants' narratives was their awareness and insight into their OCD and their rejection of it making any sense. They described it as irrational, silly, crazy, and weird. However, this knowledge only seemed to accentuate their passivity and helplessness in relation to it as they described feeling that they were trapped, stuck in a cycle, and had no control over OCD, which was described as having more power and authority.

> *I know it's mental, and that's the really annoying thing about OCD because you know that everything you are saying or, no, everything that you are thinking in your mind is completely like untrue and really out there but you can't kind of get away from it* (P12)

Being trapped in a cycle. Many participants described being trapped in cycles, stuck in circles, or pulled into spirals with their OCD symptoms, creating a sense of their felt powerlessness. Participants spoke about how they were wary of triggers pulling them into a spiral of panic or a time-consuming series of rituals. Participants also talked about being aware that often the things they did to help manage their symptoms were ineffective, provided only temporary solutions, maintained the problem, or even made things worse, but again there was a sense that they were somewhat helpless and had no other options.

> *I feel like this is my way of controlling the situation when really it's not controlling anything, it's not doing anything for me but it's just my mechanism* (P10)

A further interesting example of how participants seemed resigned to this was through their descriptions of setting unrealistic and unachievable goals for themselves, which they were aware that they would inevitably fail to achieve. Although this would lead to distress and a renewed effort to meet their goals, it was seen as preferable to having nothing in place to measure oneself against.

Being a 'prisoner'. A notable feature of participants' lack of agency in the face of OCD was their accounts of having no control over it. Participants recounted how it took over their lives in a vivid all-encompassing manner and held them prisoner. Similarly, emotions were also described as being uncontrollable and taking over the mind and body.

> *The rational brain is … sort of prisoner of the OCD* (P4)

I struggle with it [anger] sometimes, sometimes it just takes over me and I can't supress it (P8)

As discussed earlier, one way in which some participants attempted to understand their experiences was by attributing meaning to them, concluding that they indicated they were a bad person or had done something wrong. As a result, some participants described how they felt they deserved to be punished and should suffer for the all the things that they had done wrong.

Participants' descriptions of OCD coming and going without feeling they played an active part in either triggering it or making it go away also evoked a sense of helplessness. This also fed into participants' perceptions of recovery in that they felt either incapable of making OCD go away, or attributed little credit to themselves if they had recovered. For example, participant 10 described recovering from OCD as '*a waiting game'*. In this sense participants were seen to be held hostage by OCD in that they could not be sure when it would come back. The strength of powerlessness participants felt in relation to OCD was illustrated through many talking about how they had considered suicide as a way of escaping, believing that they had no other way out.

I was pushed to definitely wanting to commit suicide and not too frightened about the idea just happy that I wouldn't have to dealing with whatever is in your head, it's not voices, not demons, but you know the intrusive thoughts because they are all encompassing (P1)

Summary. Participants described a complex relationship with OCD, reflecting to some extent the moral uncertainty they felt towards themselves. At times OCD was separated from the self with participants incorporating the perceived positive features into their self-view whilst rejecting less favourable aspects. Simultaneously, participants also described having an OCD personality, positioning OCD as a fundamental as part of who they were, in the absence of an alternative stable sense of self. OCD was therefore valued and used proactively to protect a fragile moral self, and positioned as a powerful and useful strategy to do so. However, OCD also became a dominant feature in participants' lives and a force they felt they could not escape from captured by their descriptions of lacking agency against the condition and being held prisoner by it. These themes linked back to maintaining the experience of moral uncertainty, and the importance of creating an identity through holding rigid moral values, as participants used OCD to create an identity for themselves at times by incorporating it into their self-view, or by actively rejecting it.

Chapter 4: Discussion

This study explored how morality is experienced by people with OCD using a qualitative methodology. Twelve adults with experience of OCD took part in semi-structured interviews and data were analysed using a CGT approach (Charmaz, 2014). The aims were to explore morality from the perspective of people with experience of OCD and to generate a theoretical understanding in the form of a grounded theory. Additional aims were to consider this emergent model in relation to existing theoretical frameworks of OCD and conceptualisations of morality. Seven overarching theoretical codes emerged from the data and were mapped on to a model outlining the sequential and cyclical processes indicated by the data (*Figure 3*).

Overview of findings

The findings suggest an enduring moral self uncertainty and a fear of being a bad person are important aspects of OCD. These features appear accentuated by a tendency to see the world as divided into black and white binary categories. In the absence of a strong and certain sense of self participants used moral values as a way of constructing an identity. Feedback from adhering to rigid moral rules was used by participants to ascertain whether they were good or bad, and essentially to define who they were. An overwhelming fear of being bad is suggested to have driven participants to seek certainty that they were in fact good. These strategies, or compulsions, whilst inconvenient were seen as essential in protecting a fragile positive moral self-view and were therefore valued by participants. Their use is

suggested to reinforce their need as participants continued to fear who they would become without them, in the absence of an alternative sense of self. Participants subsequently developed an ambivalent relationship with OCD where it became both valued, due to its identity-giving features, and maligned, as a result of the control it wielded over their lives.

1. Conceptualising morality

Participants conceptualised morality as something they had learnt as children through their social interactions with others, their parents, teachers, and peers. In this way it was seen as an inherently interpersonal concept that defined how you should act towards others and as a member of society. It was also seen to have personal significance, and participants emphasised the importance they placed on being seen as moral by both themselves and others. In these respects, participants' constructions of morality reflected the more recent conceptualisations of morality in the literature as something predominantly formed within a social context (Carnes et al., 2015; Haidt, 2003), as opposed to the individually focused models presented in earlier work by Kohlberg (1969) and Turiel (1983).

Participants also spoke about the influence wider sociocultural factors, such as religion, culture, and political ideologies, had had on their moral development. These findings are consistent with the moral philosophy literature where the MFT has been used to explore how morality may be constructed differently across political affiliations (Haidt & Graham, 2007), ethnic groups, and religions (Davis et al., 2016, 2017). In conjunction with the other theoretical codes, this also reflects the

increasingly well-established finding that sociocultural factors influence the content and presentation of OCD symptoms (Clark & Inozu, 2014; Radomsky et al., 2014).

Participants' descriptions of the different contextual levels at which morality could be articulated and applied, in addition to the perception that morality provides a set of prescribed and proscribed rules for these differing contexts, strongly echoed the taxonomy of morality put forward in the MMM (Janoff-Bulman & Carnes, 2013). The MMM proposes morality has self, other, and group based motives, regulating behaviour through approach and avoidance mechanisms so as to promote social cohesion and group living (Janoff-Bulman & Carnes, 2013). The rigidness with which participants defined moral rules can interpreted as their attempt at rationalising an abstract concept; this not only accurately reflected the challenge faced by philosophers and scientists for centuries, but also revealed a tendency to classify the world into binary categories as a way of managing uncertainty. This is discussed further in subsequent sections.

Many participants described possessing an internal tool, which they could use to make moral decisions: a moral compass. Multiple perspectives endorse the idea that appraisals or decisions are made based on pre-existing values. For example, cognitive theories conceptualise this as possessing core beliefs or schemas (Beck, 1979). Wisnewski (2007) argues it is our relationships with ourselves and others which provide frameworks for us to consider what is the right thing to do, in this way although our decisions are considered in light of pre-existing values, our context as an agent is also pertinent.

Herman (1993) describes morality as what we count as good, as moral agents morality becomes constitutive of our moral identity and the essence of ourselves. This is in line with the current findings as participants strongly endorsed the perception that acting morally provided valuable feedback on whether they were a good person or not. Wisnewski (2007) also argues that morality provides an identity-giving feature of agency, a disposition to act in a certain way, the value of which provides a definitive characteristic of the agent's identity.

2. Holding rigid moral values as part of identity

Participants, potentially as a result of possessing a fragile sense of self, were seen to construct their identities around rigid moral values. They described how they valued and desired a positive moral image, and aimed to be perceived in this way by themselves and others. Moral behaviour was subsequently seen to be indicative of a positive moral identity by participants. Rachman and Hodgson (1980) discussed how in OCD a 'tender conscience' defined as possessing high standards of conduct and morality could make individuals more susceptible to interpreting unwanted intrusions as unacceptable, and therefore distressing. This was certainty reflected in how participants described the rigidity of their moral rules, and the subsequent distress they experienced at their inevitable failure to uphold such high standards, whether it was through thoughts or behaviours.

Incorporating moral values into their identity can be seen to reflect the *having* side of the moral self outlined in moral self theories (Blasi, 1983; Jennings et al., 2015), and the *internalization* dimension of Aquino and Reed's (2002) social

cognitive theory of moral identity. This suggests participants' moral self-schemas were particularly accessible and they placed importance on their subjective experience of a moral identity (Aquino & Reed, 2002). The *doing* or s*ymbolisation* dimension of participants' moral selves was also strongly indicated through the importance participants placed on presenting as moral as a way of affirming their moral identity to both themselves and others (Boegershausen et al., 2015). Within participant narratives this was illustrated through the credence they gave to retrospective behavioural feedback as a way of ascertaining their moral intentionality; for example, participants were keen to give examples of helping others or giving money to homeless people to illustrate their morality.

Holding moral rigid values as part of their identity was seen to relate closely to the moral uncertainty participants experienced, appearing as an attempt to construct a sense of self in the absence of one. This was articulated through participant 2's description of someone without moral values as '*an empty bottle'* and participant 11 describing their experience of examining their rigid moral values as '*eroding my foundations'* and finding '*at the bottom there is not much*'. Moral self-theories (Jennings et al., 2015) could conceptualise this as the *doing* side of the moral self being used to compensate for deficiencies in the *having* side which participants experienced as fragile, false, and divided.

In accordance with social cognitive theory, participants were found to seek consistency between their *having* and *doing* moral self-concepts though aligning their behaviours with their moral values (Aquino & Reed, 2002; Jennings et al., 2015). However, their uncertain self-perception and the subsequent rigid moral

standards that they relied upon for a sense of identity made this virtually impossible, leading to a distressing discrepancy. Stets and Carter (2012) also found moral self inconsistencies to result in negative emotions, including guilt and shame. The findings also provide support for the work of Doron and colleagues (2008) who postulated morality was a sensitive and vulnerable self-domain in OCD, resulting in perceived failures negatively impacting upon self-worth.

Although, participants could be seen to have integrated morality into their identities it appeared to remain something that was experienced as externally imposed, rather than a felt sense. This came across through participants' anxieties about getting it right and seeking sources of information that could offer concrete guidelines.

3. Experiencing moral uncertainty

Experiencing uncertainty about self. The theory of self-ambivalence in OCD outlines three core features: holding contradictory self-views, an uncertainty about self-worth, and a preoccupation in verifying self-worth (Bhar & Kyrios, 2007; Guidano & Liotti, 1983). The current findings are seen to provide substantial support for this theory as these features were strongly reflected in participants' narratives. The theoretical code experiencing moral uncertainty captured how participants experienced a fragile, false, and divided sense of self, which they aimed to reconcile through seeking confirmation of a positive moral self-view through external actions, in the absence of internal moral certainty. The temporary nature of the strategies

they used to do this, widely reported by participants, reflects the findings of Ahern et al. (2015).

In line with previous research (Rachman, 1997; Rowa & Purdon, 2003; Rowa et al., 2005) participants described experiencing distress in response to ego-dystonic intrusions. An fragile self-view seemed to leave participants particularly susceptible to making negative inferences about themselves following intrusions, or unwanted emotions, and labelling themselves as bad, immoral, or insane, reflecting well-established research findings (Ferrier & Brewin, 2005). The individuality of what participants considered ego-dystonic was particularly apparent and was seen to reference the specific moral values they held as part of their identity, which in turn were heavily influenced by their reported family values and social context. As discussed, this reflects the growing recognition that sociocultural factors influence the content of unwanted intrusions (Radomsky et al., 2014), but also importantly that culturally incongruent intrusions and obsessions can cause significant distress (Clark & Inozu, 2014).

Participants' perceptions of themselves as being divided into different parts can be seen to reflect the findings of Makhlouf-Norris and Norris (1973) who found the actual-self concepts of participants with OCD were alienated from their ideal-self concept and isolated from their concepts of others, whereas controls were observed to have neither isolated nor alienated self-concepts. They concluded obsessions and compulsions represented devices to reduce uncertainty about the self, which is further supported by the current findings (Makhlouf-Norris & Norris, 1973).

Intolerance of uncertainty (IU) has been defined as an unwillingness to tolerate the possibility of negative events in the future, regardless of low probabilities (Freeston, Rhéaume, Letarte, Dugas, & Ladouceur, 1994) and is well documented in the cognitive OCD literature. However, it has been found to have poor specificity to OCD compared with other anxiety disorders (Bottesi, Ghisi, Sica, & Freeston, 2017; Gentes & Ruscio, 2011; Holaway, Heimberg, & Coles, 2006; Laposa, Collimore, Hawley, & Rector, 2015), and research often fails to differentiate between pathological and normative contexts (Cougle & Lee, 2014). The current findings suggest it is a specific uncertainty about the moral self, which is intolerable in OCD, as opposed to a general concern about negative outcomes. Further, the probability of a negative outcome, essentially being a bad person, is not experienced as low for an individual with an uncertain sense of self.

Lopatka and Rachman (1995) found distress was reduced for those with OCD when responsibility for a gas explosion was attributed elsewhere, regardless of the final outcome. Mancini and Gangemi (2004) have argued this represents a fear of being asked to account for one's actions, as opposed to a general IU. Interestingly, Gangemi, Mancini and van den Hout (2007) also found experiencing guilt was used as a source of information about threat and performance by OCD patients. When considered alongside participants' reports that, in the absence of self-certainty, they used retrospective behavioural and emotional feedback to provide information about their self-integrity, it follows that they would experience situations, in which there is a possibility of them being held responsible for negative outcomes, as intolerable. In this context, actions or assurances to confirm blame will not be

attributed to them appear warranted, as blame from others, and feelings of guilt, would have a catastrophically negative effect on their sense of self. This is further illustrated by the finding that participants wanted to confess wrongdoings, as a way of seeking reassurance and confirmation from others that they were not to going to be held responsible, thereby abating their fear of having to retrospectively infer what their (immoral) intentions may have been. These findings also provide support for studies indicating specific self-relevant, negative information can increase OCD-like cognitions and behaviours (Abramovitch et al., 2013; Doron et al., 2012b).

Tolin et al. (2003) suggested pathological doubt could be related to an individual's knowledge structures as well as their emotional reactions to feeling uncertain. Doubt has since been strongly associated with OCD symptoms, global impairment, and a poor response to CBT treatment in a large clinical sample (Samuels et al., 2017). In the current study participants were observed to actively doubt themselves throughout interviews, which also appeared linked to difficulties understanding internal experiences. As with actions, participants appeared particularly vulnerable to using emotions to retrospectively infer their intentions.

Struggling to understand internal experiences. The difficulties participants demonstrated in understanding and articulating their internal experiences is in line with evidence suggesting both interoceptive awareness (Vicario, 2013), and emotional appraisal and processing difficulties in OCD, including alexithymia (Robinson & Freeston, 2014). More specifically, an experiential deficit with attenuated access to internally experienced emotions, rather than a lack of theoretical understanding has been proposed (Dar, Lazarov, & Liberman, 2016).

Chiang et al. (2016) suggests this potentially prevents development of regulatory strategies for feelings in OCD, rendering the experience of emotion confusing, overwhelming, and something to be feared. Participants' wariness of both positive and negative emotions reflects this hypothesis, as well as providing support for Stern et al. (2014) who identified elevated levels of perceived threat from emotions in OCD. The notable absence of emotion in much of participant narratives, together with reports of wanting to actively avoid or get rid of emotions such as guilt, are in line with Clark and Purdon's (1993) conclusion that emotional processing difficulties result in an emphasis on thoughts or descriptions of actions over affect by people with OCD.

Participants' understanding of their own psychological experiences was found to be uncertain and confused, as was their perception and understanding of others; this can be seen to closely mirror difficulties with reflective function (Fonagy & Target, 1997). Reflective function is defined as the ability to respond to and understand other's behaviours, beliefs, and feelings, thereby making them meaningful and predictable. Development of reflective function is thought to act as a precursor for a child to begin to understand and find meaning in their own psychological experiences, which is seen to be the foundation of affect regulation, self-agency, self-monitoring, and essentially the organisation of the self (Fonagy & Target, 1997). Considerable research evidence suggests an early understanding of emotions predicts positive perceptions of social relations, complex emotional understanding, and mature moral sensitivity (Dunn, 1996), characteristics that notably emerged as difficult for participants or were absent from narratives. Kullgard

et al. (2013) concluded there was a complicated relationship between reflective functioning and OCD, which was certainly reflected in the current findings.

Interpersonal ambivalence and uncertainty. Cognitive theories have traditionally focused on pro-social attitudes in OCD, such as inflated responsibility and worry about causing harm to others, whereas psychodynamic theories have emphasised anti-social attitudes such as latent aggression and hostility (Moritz, Niemeyer, Hottenrott, Schilling, & Spitzer, 2013). Both perspectives were endorsed in the current study; participants were seen to feel ambivalent about others, describing how they felt they had higher standards, implying a sense of moral superiority, whilst also emphasising that other's needs should always be prioritised, implying a sense of martyrdom. Additionally, participants described being wary of others, and fearful of other's negative judgements. Mortiz et al. (2013) also found high interpersonal ambivalence in OCD, with OCD patients displaying both high pro-social and anti-social interpersonal attitudes compared with controls. Research has also found higher levels of interpersonal distrust (Moritz, Kempke, Luyten, Randjbar, & Jelinek, 2011), hostility, and suspicious thoughts (Tellawi, Williams, & Chasson, 2016) in OCD, and to some extent increased elevated levels of latent aggression and calculating behaviour (Moritz et al., 2008; Moritz et al., 2011).

Solem et al. (2015) found patients with OCD had more interpersonal problems, such as submissiveness, compared with healthy controls, but not with other psychiatric outpatients, whilst Fatfouta and Merkl (2014) found individuals with OCD had more positive attitudes to revenge, higher trait revenge, and increased revenge motivation. Evidence also suggests individuals with OCD experience

interpersonal transgressions more frequently in their daily lives compared with non-clinical participants, and this positively relates to OCD symptoms (Fatfouta & Merkl, 2014).

Knox (2007) explored the consequences of inhibited development of a mature and reflective sense of self-agency arguing the infant develops a fear of relationships being destructive to their own subjectivity and a sense that their own individuation process threatens their objects. She postulates the subsequent fear, of allowing one's self to exist as a subject rather than an object, which is created contributes to a range of clinical problems, including perceiving all relationships to be coercive, and a belief that one party is always controlling or dominating another (Knox, 2007). Participants' perceptions of relationships as coercive was identified on multiple levels: in terms of their relationship with themselves in which they were suspicious and doubtful of their own true intentions, their interpersonal uncertainty and fear of others, and through an ambivalent relationship with OCD where they became both a prisoner and devotee. This is discussed in more detail in the following sections.

4. Seeing the world in black and white

Dichotomous thinking is defined as an individual's propensity to think in terms of binary opposition, good and bad, and all or nothing (Oshio, 2012a). The theoretical code seeing the world in black and white strongly reflects participants' tendency to think in this way, and this was seen to represent a compound of their distress as well as a response to it.

Whilst previous research has linked dichotomous thinking with eating disorders (Byrne, Cooper, & Fairburn, 2004), personality disorders (Oshio, 2012a), and suicidality (Neuringer, 1961; Williams & Pollock, 2000), there is a lack of research exploring links with OCD. However, OCD has been increasingly linked with suicidality (Angelakis, Gooding, Tarrier, & Panagioti, 2015), which suggests dichotomous thinking may play an important role. Cognitive inflexibility has also been linked with both OCD (Gruner & Pittenger, 2017) and suicidality (Williams & Pollock, 2000). Reflecting these findings, participants were not only seen to favour a dichotomous way of thinking but many spoke about how they had considered suicide in response to their distress.

Namatame, Ueda and Sawamiya (2015) considered whether a tendency towards dichotomous thinking contributes to maladaptive coping mechanisms in response to stressful experiences, consequently inhibiting the development of emotional intelligence. Emotional intelligence is defined as the knowledge of one's own and other's feelings and emotions, and the use of this information to guide thinking and actions, and can be hindered by unsuccessful handling of one's emotions (Salovey & Mayer, 1990). Holding dichotomous beliefs, which refers to thinking the world can only be divided into two categories, was found to have a significant positive effect on avoidance, and was suggested to relate to maladaptive parts of perfectionism, seeking immediate answers, avoidance of complicated situations, and negative appraisals towards self and others (Namatame et al., 2015). Strikingly these difficulties were all well reflected in the current findings. The indication this coping style serves to inhibit the development of increased emotional

intelligence is also indicated by how participants struggled to understand their internal experiences, and how others managed to cope, in addition to reflecting well-established findings indicating emotional processing difficulties in OCD (Robinson & Freeston, 2014).

Participants' black and white adherence to moral rules, and subsequent distress when this was not possible, is supported by evidence indicating dichotomous thinking is related to negative perfectionism and high emotional distress (Egan, Piek, Dyck, & Rees, 2007). It has also been suggested that people who think dichotomously are more likely to undervalue an individual when they perceive negative attributes, and tend to see human abilities as innate (Oshio, 2012b). This seems relevant to the current findings as participants not only displayed ambivalent attitudes towards others but also towards their own OCD, potentially illustrating their beliefs about it being somewhat innate within them.

What appears to be a somewhat unique finding in this study is the potential mediating effect of dichotomous thinking upon the experience of moral uncertainty. Dichotomous thinking appeared to considerably enhance the distress participants experienced by constructing an extreme opposite which evoked overwhelming fear.

5. Fear factor

Fear of self. The intensity with which participants spoke about their fears of being a bad person was a particularly strong theme in the data; whilst a bad person meant different things for participants, a fear of being someone they did not want to be was relevant for all. This finding is consistent with a rapidly emerging area of

research into the fear of self in OCD (Aardema et al., 2013; Melli et al., 2016; Nikodijevic et al., 2015). The current study's findings support the conclusions made by concurrent research that a fear of self could be an important part of explaining why some intrusions cause significant distress, and develop into obsessions, whilst others do not, something traditional cognitive models have so far been unable to fully account for.

It was notable how many participants emphasised that their OCD had manifested itself as the thing they feared most, echoing research suggesting negative-self themes in areas an individual doubts of fears themselves guide intrusions (O'Connor et al., 2005) which, combined with a distrust of self, causes intrusions to be significantly emotionally charged (Aardema & O'Connor, 2007). Melli et al. (2016) have suggested feared-self beliefs can be incorporated into both an inference-based model (O'Connor et al., 2005) where fear of the self is seen to influence the content and emotional charge of intrusions, and cognitive-appraisal models (OCCWG, 2005) where a feared self could be seen as representing appraisals such as the importance of thoughts.

The significant correlations found between fear of self and other self-constructs such as self-trust, self-ambivalence, and inferential confusion (Aardema et al., 2013) are also in line with the current findings. Further, despite overlap the conclusion these constructs all uniquely contribute to a model predicting OCD symptoms (Aardema et al., 2013) provides substantial support for the differentiation of these theoretical codes within the current study's developed model.

Evidence suggests emotional states may contribute to determining the type of intrusion experienced (Clark & Inozu, 2014), it therefore follows that being continually fearful may have made participants more vulnerable to experiencing unwanted intrusions. Research has also found intrusive images increase during stress (de Silva, 1986). Fear of self has also been closely linked with doubt in OCD, which is hypothesised to interfere with reasoning processes (Nikodijevic et al., 2015). As discussed, participants displayed high levels of uncertainty through both the content and process of their interviews, actively doubting and questioning themselves.

Fear of agency. A further theme participants described was a fear of their own agency, what they may have done, or what they could be capable of. This fear, together with participants feeling that they needed to be controlled and restrained, links to findings suggesting a fear of being out of control and causing harm is particularly relevant in OCD compared with other anxiety disorders (Lipton, Brewin, Linke, & Halperin, 2010). Further, Moretto et al. (2011), investigating the relation between the experience of action and responsibility of action, found enhanced binding of effects in moral scenarios in comparison to non-moral scenarios, implying a sense of agency has strong implications for moral responsibility.

As discussed, self-agency is seen as being dependent upon the quality of one's reflective function (Fonagy & Target, 1997). A caregiver making sense of a child's wishes and translating them into actions enables the child to make links between mental states and action sequences. Interaction, which links emotions, thoughts, and perceptions to causes and consequences of action without fear constitutes self-agency (Fonagy & Target, 1997). This theoretical perspective

suggests the anxieties participants described in relation to their own agency could indicate early experiences of care in which a disproportionate, or inaccurate, amount of effect was attributed to their actions by caregivers, resulting in distorted links between their mental states and actions. This perspective is also endorsed by Chiang et al. (2016). Knox (2007) proposes that a child whose agency is met with a negative response may subsequently develop self-blame, shame, or fear in response to their own intentionality believing that it causes distress, disgust, or fear in others. Participants' descriptions of their sensitivities to interpersonal feedback and fears of hurting or upsetting others, due to an expectation this will result negative judgements, provides tentative support for these arguments.

Objecting to Salkovskis and Forrester's (2002) definition of inflated responsibility, Mancini and Gangemi (2004) argued it is fear of being asked to answer for one's own conduct, and not a particular outcome, that causes distress in OCD. This fear of not acting in accordance to your moral standards has been conceptualised as a fear of guilt for acting irresponsibly, where the concern is for the quality of their own performance rather than towards preventing harm (Mancini & Gangemi, 2004). The current study provides support for these arguments; participants described fearing their own agency in anticipation of the negative intrapersonal and interpersonal consequences, with some directly referring to the avoidance of guilt. Furthermore, the recently developed Fear of Guilt Scale (FOGS; Chiang et al., 2016), shown to significantly predict OCD symptoms, has been found to have two factors: punishing self for feeling guilt, and harm prevention to proactively prevent guilt. Reflecting this, participants firstly described feeling distressed when

using their emotions to infer their original intentions, particularly in relation to guilt, as there was an assumption this indicated they had done something wrong and should be punished. Secondly, participants spoke about the moral rules they aimed to abide by in order to attain predictability and stability in their internal and external environments, so as to avoid unwanted affect, in particular guilt.

6. Seeking certainty

As discussed, IU and the desire to seek certainty is well recognised in OCD (Morein-Zamir et al., 2016; Tolin et al., 2003), however growing evidence suggests these concepts remain underspecified and currently fail to recognise the full complexities of these processes in OCD (Cougle & Lee, 2014). For example, participants' construction of a good person, and the strategies they used to seek certainty of a positive moral image, was often seen to be directly drawn from their family's cultural values. As a result there was enormous variation in the strategies participants used, however they appeared to have a common function. Equally, in their quest to seek explanations for their OCD participants were also keen to consider their early experiences as a possible explanation. These feedback loops are illustrated in the developed model.

Using rules to create certainty. The inability to experience conviction, or certainty, was postulated as a central feature of OCD by early theorists (Reed, 1985; Shapiro, 1965), who proposed individuals were able to cope quite well despite this due to their adoption of objective rules to guide their behaviour (Dar, 2004). Many participants endorsed using rules, describing how they created '*a box to keep your*

actions within' (P12), increasing predictability and decreasing uncertainty. Rachman (1997) speculated individuals with OCD strive for moral perfectionism in both thought and action, lending support to the rigidity with which participants aimed to adhere to their rules.

Using structural equation modelling IU has previously been found to fully mediate the relationship between perfectionism and OCD symptom severity in a non-clinical sample (Reuther et al., 2013). Conversely, in the current study's developed model the interrelated theoretical codes experiencing moral uncertainty, seeing the world in black and white, and fear factor, were seen to promote the seeking of certainty through the creation and adherence to strict perfectionistic rules. The utilisation of OCD was therefore valued by participants as it kept fears at bay and reduced uncertainty; rules created an externally defined yardstick against which participants could measure their moral self-worth in the absence of a certain internal self-view.

Taking action. In what perhaps at first seems contradictory to having a fear of agency, in other ways, participants were seen to believe themselves to be particularly effective agents. Action was utilised as a way of protecting against fears and providing valuable feedback information about themselves in their attempts to positively influence their fragile moral self-view.

Participants described how their actions, internally in the form of neutralisations, or externally in the form of rituals or behaviours, would often be in response to a fear of being a bad person, imperfect, or impure in some way. A

particularly interesting finding was that participants were incredibly reflective about how these arbitrary actions were often unrelated to their particular concern. Action taken following a threat to the moral self in order to restore self-worth, rather than to amend a situation or influence an outcome has been conceptualised as moral cleansing (West & Zhong, 2015). A further acknowledgement by participants was not only the temporary nature of this effect, but also how their strategies most likely confounded their difficulties, which reflects previous findings in the literature (Ahern et al., 2015). Participants' striking insight into their condition and logical rationale for their actions and behaviours is in stark contrast to the recent reclassification of OCD in DSM-5 (APA, 2013) as a condition defined by impulsive behaviour.

Looking for explanations. Reassurance seeking, well recognised to play a part in OCD (Salkovskis, 1985), was also a way in which participants were seen to seek certainty about their moral selves, with the temporary or ineffective results also well recognised by participants (van den Hout & Kindt, 2004). Dar (2004) found individuals with OCD were more likely to experience doubt and reduced confidence when repeatedly faced with the same question compared with controls. As a result Dar (2004) concluded it was possible the well-established confirmation bias was applicable to controls but not to individuals with OCD who appeared to generate evidence contradicting the chosen alternative. The multiple theories put forward by participants reflected this hypothesis well as this served to increase their uncertainty rather than resolve it. Dar (2004) draws on the work of Lakatos (1976) to argue individuals with OCD follow both an impossible and irrational approach of strict refutation of their theories though constant questioning. Whilst a refutation of

theories has been seen by some as the only rational way of progressing science, Lakatos (1976) argued research programmes must contain both positive and negative heuristics, the former directing future research, and the latter forbidding doubting the core theory. In this way it is suggested by Dar (2004) that ability to discount doubt is essential to both scientific and personal progress; potentially causing difficulties for people with OCD given their vulnerability to doubt (Tolin et al., 2003). In the current study participant's doubt could be seen to be inhibiting their personal progress in moving towards a certain sense of self, as a result of their fragile core theory (of themselves).

7. Feeling ambivalent about OCD

Writing about the literary and linguistic construction of OCD, Friedrich (2015) comments on the problem of identity stemming from the desire to legitimise the experience of OCD whilst simultaneously wanting to escape the identity of an OCD sufferer. The themes separating OCD from self and OCD personality can be seen to reflect participants grappling with this dilemma; many endorsed both perspectives, simultaneously externalising and separating OCD from themselves whilst also describing how it was a fundamental part of who they were. Externalising problems linguistically is a fundamental part of narrative therapy practice (White & Epston, 2004), aimed at helping clients to see themselves as separate from their problems. However, participants' use of this strategy appeared to increase their uncertainty; if they were not OCD then they were uncertain about who they were. Separating OCD from themselves also appeared to reduce their agency in relation to it as it was

subsequently constructed as something outside of themselves, over which they had no control.

In a similar way to rigid moral values, OCD also was seen to provide an identity for participants in the absence of one. Endorsing OCD as part of their personality and character positioned it as something embedded within them and therefore potentially more difficult to eradicate without a detrimental effect on the individual's sense of self. Interestingly, research aimed at identifying personality variables related to OCD have found only weak and inconsistent effects (Clark & Inozu, 2014), suggesting participant's endorsement of this theory was a further strategy aimed at making sense of their confusing experiences.

In their meta-synthesis of qualitative studies exploring the experiences of mental illness, Kaite et al. (2015) identified an on-going struggle for reconciliation between the illness and the self to be a core theme, in addition to a loss of identity, and a pain at having your life stolen. These features were certainly reflected in the current findings, emerging through participants' descriptions of their complex relationship with OCD, both in terms of the way in which it increased their uncertainty about their identity, and the sense that it was holding them hostage.

The lacking agency against OCD theme incorporated participants' awareness of the temporary or counterproductive effect of their strategies to manage distress and fear as well as a sense that they deserved punishment for their potential immorality. This reflects cognitive-appraisal models of OCD in which ineffective strategies are seen to maintain difficulties, exacerbating the impact of intrusions

(Clark & Beck, 2010; Salkovskis, 1985) in addition to findings showing individuals with OCD are likely to have lower self-worth compared with controls, specifically linked with other people and relationships (Ehntholt, Salkovskis, & Rimes, 1999).

Participants' helplessness in the face of OCD was strikingly illustrated through many describing how they had considered suicide as their only option. As discussed, recently the increased risk of suicide in OCD has begun to be more widely recognised (Angelakis et al., 2015), and dichotomous thinking has also been linked to suicidality (Neuringer, 1961; Williams & Pollock, 2000). The current study's developed model therefore contributes to our understanding of the interrelationships between uncertainty, fear, and dichotomous thinking in OCD.

Holmgren (1998) suggests that whilst retaining negative attitudes towards oneself in response to an offence, might well promote compliance to future moral obligations, or motivate avoidance of the transgression in the future, it does not constitute true respect for morality, as no clear purpose can be served. Here lies the unfortunate predicament participants appeared to find themselves in; without forgiveness participants continued to feel they deserved punishment, viewing themselves with self-contempt, as opposed to true self-respect. Character defects are more quickly eradicated from a perspective of love, respect, and compassion for oneself and others, than from maintaining an attitude of guilt and self-hatred (Holmgren, 1998). In the current study's developed model participants' continued difficulties with this are represented through the feedback loop from feeling ambivalent about OCD, back to experiencing moral uncertainty. A situation whereby moral transgressions, internal and external, are forgiven would potentially prevent

the intense fear of being all bad, once one has not been all good, and the subsequent attempts to manage this. A sense of forgiveness for moral transgressions was notably absent from narratives and participants' fragile moral self-views were further captured through their concerns about how acting immorally may fundamentally change who they were as there would be no way of going back. Participant 12 notably described how a moral transgression would be like *'some sort of Rubicon'*, impossible to come back from.

Strengths and limitations

Strengths. A strength of this study was the use of qualitative methodology to explore the role of morality in OCD, which no other known study has done. This is significant for a number of reasons; firstly, the study was able explore the qualitative accounts of people whose experiences have caused them significant distress, providing unique insights into contributing factors. This differs from the majority of OCD research in which analogue samples are used. Secondly, qualitative methodology, and more specifically CGT, enabled the research to explore morality, as defined by participants, rather than using pre-existing conceptualisations. This was important as not only is there a huge variation in how morality is defined in the literature, but participants' individual accounts of morality emerged as being closely interwoven with their individual experiences of OCD.

The use of a variety of credibility checks and triangulation methods to increase the quality of the analysis (Madill, Jordan & Shirley, 2000; Elliot et al., 1999) is a further study strength. Service-user feedback on the interview schedule and

other study materials was sought ahead of data collection promoting public and patient involvement (INVOVE, 2015). The researcher also utilised supervision and participation in a grounded theory peer-support group to validate different stages of coding and model development, promoting researcher reflexivity and ensuring emerging codes and themes were grounded in the data. Further methodological adherence, which enhanced reflexivity and coherence, included using the interview schedule flexibly to explore emerging themes, the use of a reflective diary throughout the study (Appendix 1), and the writing of memos in a variety of forms (Appendix 2; Charmaz, 2014). Moreover, the developed model was found to resonate with a participant who provided feedback indicating it captured their experience well, in particular their black and white conceptualisation of morality.

Additionally, participants were not only asked about their experiences of being interviewed (Kvale & Brinkmann, 2009) but also invited to contribute additional information they felt was important for the researcher to know in order to understand morality and OCD, both of which provided additional insights into their experiences. Anxieties about how they had come across during the interview were also voiced, however all participants reported a positive experience of taking part in the research.

Limitations. In terms of study recruitment and sampling, it is not possible to know how many other potential participants were approached by clinicians or viewed study advertisements and chose not to participate. From the potential participants approached by the researcher only one person actively declined participation however a further three did not attend arranged interviews (*Figure 2*).

With these factors in mind it is possible the sample was comprised of people that felt morality was especially relevant to their personal experience of OCD. A countenance to this however is the varied presentation of OCD symptoms within the sample.

The demographic profile and size of the sample considerably limit the generalisability of the findings. The majority of participants were female (9 out of 12), and had a relatively high level of education; all were recruited from a large city in the UK and were either in contact with mental health services, or actively seeking research opportunities. The model may therefore not be applicable to those that are more socially isolated, have received less formal education, or who live in different geographical locations.

A further potential limitation of the study is that not all participants were experiencing elevated symptoms of OCD at the time of the interview. The same argument is also relevant to how some participants had sought psychological therapy for their OCD, or were currently doing so, whilst others had not. However, it was felt that including participants at different stages of experiencing OCD enriched the data as a number of additional themes become evident: participants using OCD to form part of their identity despite few current symptoms, and the lack of agency participants attributed to themselves in facilitating or maintaining recovery. Further, those participants reflecting upon their experiences retrospectively provided remarkably similar information to those with current symptoms; all spoke with striking insight into their difficulties and distress.

A number of participants spoke about how engaging in psychological therapy had enabled them to learn how to talk about their fears, aiding their participation in the study. However, it was impossible to ascertain to what extent the type of therapy they had accessed may have coloured their conceptualisation of their experiences. Research has suggested that constructs can remain elevated in individuals that have recovered from disorders, compared with controls, when the issue has not been a direct focus of psychological treatment (Blatt, Quinlan, Pilkonis, & Tracie, 1995; Blatt, Zuroff, Bondi, Sanislow III, & Pilkonis, 1998; Srinivasagam et al., 1995). Not only did participants talk about how they had not explored morality during their therapy sessions, but the core themes were seen to emerge from the majority of participant narratives irrespective of current symptom level or therapy engagement (Appendix 12).

Adapting the interview schedule as data collection progressed embodied the spirit of theoretical sampling by enabling further exploration of tentative categories and advancing the analysis through testing out emerging theory (Charmaz, 2014). However, it is unlikely themes in the data reached saturation; a larger sample and more comprehensive theoretical sampling may well have extended the findings to some extent. Instead, the study sought theoretical sufficiency as proposed by Dey (1999) who highlighted how categories and themes are *suggested* by qualitative data, and coding is rarely exhaustive. Arguably, theoretical sufficiency is indicated through the representation of identified themes across the majority of participant narratives (Appendix 12).

A further study limitation concerns the potential for social desirability in the data, something actively voiced by participants during their interviews. The results indicated the issues being discussed were particularly challenging for participants and, together with the enduring uncertainty participants displayed, this could have resulted in data being heavily influenced by the context of the interview and the researcher. The ability of participants to verbalise their experiences, for example in the form of alexithymia (Robinson & Freeston, 2014), may also have had a bearing on the data collected. The researcher attempted to reduce these potential biases through emphasising confidentiality and making participants feel comfortable, as well as using supervision, a reflective journal, and memos, as discussed. Notes about participant presentation were recorded following each interview to aid data analysis; the absence of topics, such as emotion, in participant narratives was also acknowledged. Further, seemingly inaccurate or contradictory accounts were seen to provide important data and represent unarticulated processes such as enduring uncertainty and ambivalence (Charmaz, 2014).

Although all participants were e-mailed the developed model and invited to comment upon it, only one participant responded. This limits the testimonial validity of the findings and raises the possibility that other participants may not have felt able to engage in this process. It is therefore not possible to know if some participants felt that the developed model did not accurately reflect their experiences. Presenting the model in an alternative format, adapting the technical language, and providing a more comprehensive summary of the main findings, may have resulted in more participants providing feedback. Additionally, using an

alternative form of communication, such as a telephone call or face-to-face meeting, in order to gather participants' valuable feedback, may have been more appropriate and thoughtful. This has further highlighted that dissemination of the findings to services and charities must be presented in an accessible format, aimed at a wide range of individuals in order for the research to be useful, thought provoking, and ultimately understood.

The researcher's prior knowledge of the field through completion of a literature review ahead of data analysis due to academic and ethical requirements, in conjunction with the researcher's clinical experience, may also have influenced findings. This was addressed through acknowledging prior assumptions in the reflective journal and grounding findings in participants' quotes. It is also argued the researcher's clinical experience enhanced data collection and contributed to a fuller analysis of the data.

Whilst the generalisability of the findings is clearly limited, the study did not aim to represent the experiences of all individuals with OCD. Instead the intention was to represent the qualitative accounts, and develop a corresponding grounded theory, of the experience of morality for a sample of individuals with experience of OCD. The tentative theoretical understandings constructed in grounded theory are always situated in time, position, and interaction (Charmaz, 2014); the participant and researcher's contexts will have influenced the findings, as it arguably does in all research. The acknowledgement of the researcher's position and presentation of participant demographic data increases the transparency of this process and helps to situating the findings to the reader.

Further research

The current findings highlight numerous potential directions for further research. Prospective trans-cultural research is needed to determine the influence of cultural, as well as more specific sociocultural characteristics, on the conceptualisation of morality in OCD. Further, the impact this has on the construction of what it means to be a good moral person, and how this relates to the strategies individuals with OCD use to seek certainty of this for themselves, has the potential to provide additional insight into the heterogeneity of OCD.

The current findings also raise questions about how morality is operationalised in quantitative research; both the FSQ (Aardema et al., 2013) and SAM (Bhar & Kyrios, 2007) include items asking about morality, however the current findings suggest these items potentially capture very different things for different people due to idiosyncratic conceptualisations of morality. Further, if individuals are asked to differentiate morality from other domains such as social acceptance, or scholastic competence, as in previous studies (Doron et al., 2008), for some individuals this could result in an amalgamation of several constructs into item, whilst for others this could result in the repeated measure of the same concept across several items.

Early experiences, and more specifically parenting style (Lennertz et al., 2010; Timpano, Keough, Mahaffey, Schmidt, & Abramowitz, 2010), have been found to provide important information about OCD vulnerability. The current findings suggest research examining the impact of early experiences in OCD would benefit from

looking at the nuances of reflective function, and the development of the self. Moral uncertainty about the self and others emerged as a central component of the developed model; it therefore seems crucial further research continues to investigate these constructs in OCD, and especially across subtypes, to discover if they can be considered unilateral features of the condition. Similarly, the study supports the recent substantial findings indicating a fear of self plays a central in OCD (Aardema et al., 2013; Melli et al., 2016) suggesting this is a promising area of research, and an important factor to consider when developing psychological treatments. Interpersonal style, both in terms of pro-social and anti-social attitudes, also appears worthwhile to explore given the impact this could have on treatment engagement.

Dichotomous thinking also emerged as a potentially crucial mediator between uncertainty and fear in participants' experiences, indicating further examination of the interrelationships between self-uncertainty, fear of self, dichotomous thinking in OCD is an important avenue for further research. This appears particularly pertinent given the links with suicidality. Path modelling using data from recently developed quantitative measures aiming to capture these factors (FSQ; Aardema et al., 2013; SAM; Bhar & Kyrios, 2007; Dichotomous Thinking Inventory; Oshio, 2009), would provide further information about their unique and combined contributions to OCD symptom severity.

Overall the findings clearly indicate further studies would benefit from prioritising focussing on sociocultural factors and self-processes in OCD, rather than behavioural presentations, as it appears these factors are potentially identifiable

across subtypes and play a significant role in an individual's distress. The subsequent challenge for research is to incorporate findings into both theoretical frameworks and psychological interventions. The current study lends support for a cognitive-appraisal theory of OCD in multiple ways however indicates that traditional models are woefully underspecified in their current form.

Clinical implications

The findings of the current study indicate, along with other research in the field, that our current understanding of OCD, and corresponding treatment approaches, including those recommended in NICE guidelines (2005), fail to acknowledge a number of key aspects of the condition. Firstly, the findings lend support for a wider understanding of the nuances and complexity in OCD experiences. Many participants spoke about how they felt OCD had been trivialised in the media and wider society, with others misunderstanding the complexity and severity of the condition, reflecting previous findings (Pavelko & Myrick, 2015). Greater public awareness would not only contribute towards decreasing stigma but may also facilitate the seeking of support from individuals experiencing distress from OCD symptoms. Many participants spoke about how a lack of knowledge about OCD had significantly contributed to their suffering when first experiencing the condition, particularly in relation to intrusive thoughts. Findings have also shown professionals to have a poor understanding of the condition (Glazier, Calixte, Rothschild, & Pinto, 2013). Greater awareness of self-themes and the fundamental role of fear, in addition to the ambivalence participants feel towards OCD, may be particularly

helpful for clinicians in terms of aiding their understanding of individual experiences. Chiang et al. (2016) suggest a thoughtful exploration of moral self-concept may be particularly informative, and this is strongly indicated by the current findings.

Attempts at developing specific treatments for sub-types of OCD (Mataix-Cols, Marks, Greist, Kobak, & Baer, 2002; Rachman, 2006) have had limited success due to the co-occurrence of many symptoms (Starcevic & Brakoulias, 2008), indicating a renewed focus on interventions targeting unifying concepts may be more beneficial for individuals. The current study suggests a focus on moral self-uncertainty, fear, and dichotomous thinking would potentially be helpful. Bhar et al. (2015) found resolving self-ambivalence predicted positive treatment outcomes in CBT for OCD whilst others have suggested increasing tolerance of uncertainty could be further incorporated into CBT (Tolin et al., 2003). Resolving ambivalence may therefore be an important issue to address in order for treatment to be effective.

The current findings indicate psychological interventions able to explore an individual's relationship with themselves would potentially be the most beneficial in exploring and resolving the enduring uncertainty and fragility of the self participants so clearly demonstrated. There is a growing convergence between cognitive behavioural and psychodynamic approaches to OCD (Doron, Mikulincer, Sar-El, & Kyrios, 2015; Kempke & Luyten, 2007), particularly through the mental representation of the self and others.

Three intersubjective tasks for psychotherapy have been proposed by psychodynamic theorists: affect regulation, mentalization or reflective function, and

self-agency (Knox, 2013). The links that can be drawn between these three intersubjective tasks and the difficulties expressed by participants: emotional difficulties, interpersonal uncertainty, and a distorted sense of agency, suggest that it may be helpful to explore these areas clinically as a way of facilitating a coherent and certain sense of themselves. Despite inconsistent findings on the effectiveness of psychodynamic approaches for treating OCD (Maina, Rosso, Rigardetto, Piat, & Bogetto, 2010; Ponniah, Magiati, & Hollon, 2013) many authors have argued that a psychodynamic perspective can be particularly helpful for certain OCD presentations (Chlebowski & Gregory, 2009), and that further investigation into psychodynamic treatments is a promising approach (Leichsenring & Steinert, 2016). In particular, treatment approaches that strengthen the capacity for reflection and the emotional significance of symptoms have been put forward (Allen & Barlow, 2009; Kullgard et al., 2013).

Cognitive analytical therapy (CAT; Ryle, Leighton, & Pollock, 1997) draws upon both psychoanalytic models and cognitive theory and is based upon a 'clearly defined and radically social concept of the self' (Ryle & Kerr, 2003, p. 34). Infants are hypothesised to develop a sense of self through internalising the *voices* and relationships patterns of their caregivers as well as wider culture. Furthermore, CAT recognises the role of the *false self* (Ryle & Kerr, 2003) as a term to describe a sense of self too dependent upon the responses of others and out of touch with *authentic* feelings. In light of the current findings it is argued CAT provides a promising approach to working with individuals with OCD. Reflecting on the therapeutic relationship, and the therapist's use of self, are central features of the CAT model

(Johnstone & Dallos, 2013). The process issues identified during participant interviews, from which central themes emerged, in addition to the feelings elicited in the researcher during the interviews and throughout data analysis, provide further indications it would be helpful to take these aspects into account during psychological therapy.

Personal reflections

Burnham's (1993) social graces provided a foundation from which to consider my own position whilst collecting and analysing data. In addition to these factors which were discussed earlier, I was also aware of being associated with a university and inviting participants to take part in interviews in prestigious buildings in central London and how this context may have impacted upon the experience for individuals (Burnham, Alvis Palma, & Whitehouse, 2008).

Participants often positioned me as being very knowledgeable about OCD, which I had not anticipated. I viewed participants as being experts of their own experiences, however they often gave the impression that they thought I might know more about them they did themselves. Consequently, some indicated concerns that I would say their answers were incorrect and because of this I felt particularly mindful of using the interview schedule flexibility so as to make participants feel that they were able to talk freely about the aspects of their experiences that felt relevant to them in the context of the research. As a novice to grounded theory my development as an interviewer, able to balance following up on participants' answers whilst also focussing on the interview schedule, took place

alongside data collection. Despite this, I found I enjoyed interviewing participants, and was completely surprised at their openness and the wealth of personal information they volunteered. I reflected on participants positioning me as a professional and wondered if this had facilitated the frankness with which they spoke to me.

Many participants asked me questions about my own perceptions of people with OCD, or my own mental health experiences, which again I was not expecting. I hoped this indicated they felt comfortable with me, but was also aware of their anxieties that I would be judging them negatively, and how this may have coloured their responses. As interviews progressed I found that process issues became increasingly evident, participants often provided extensive examples and excessive detail. In addition to participants displaying enduring uncertainty, I noticed I became increasingly confused, frustrated, and uncertain of the research at times. At times during the data analysis I was overwhelmed by the excessive detail and extensive examples participants had provided. I felt very much as though I was mirroring participants' experiences, and reflecting on my own reactions to the data was helpful in recognising some of the themes that had not been explicitly articulated.

Conducting the research has fundamentally changed how I approach working clinically with individuals with OCD, dramatically increasing my knowledge and awareness of OCD as a psychological difficulty. This is in large part due to the openness participants displayed during interviews, which I felt allowed us to explore together aspects of their experiences that a number of them said they had not done during therapy. As a clinician this highlighted how much of an individual's experience

can be ignored when we are wedded to a particular understanding of a condition, and unable to provide a space to explore other factors. Additionally, as discussed, I was struck by how many of the themes were not explicitly verbalised by participants and instead emerged through the interaction itself. As an active participant in that process I was not always able to recognise when this was happening in the moment, it was therefore enlightening to see these themes emerge as I moved through different stages of analysis.

Conclusion

This study aimed to explore morality from the perspectives of people with experience of OCD and develop a theoretical model. A CGT approach allowed for in depth exploration of an abstract concept providing unique and novel insights into an area of OCD that, despite continued interest, has been poorly specified in current theoretical frameworks. The study contributes to the evidence base in this field by providing support for a number of recent research findings particularly in relation to the role of self-processes and a feared self in OCD. Additionally, the study adds to current knowledge by proposing the conceptualisation of morality, and an individual's corresponding moral rules, play an important role in constructing an identity for people with OCD, who are suggested to have an uncertain and fragile sense of themselves. The findings also highlight the possible mediating effect of dichotomous thinking upon this process. Further, sociocultural influences were found to influence participant's conceptualisations of morality as well as the behaviours they used to seek certainty of a positive moral self. The ambivalence

participants felt towards OCD was seen as a result of the perception that it provided a useful strategy for protecting against fear, and provided a sense of identity, and valuable behavioural feedback which was used to inform a positive moral self-view. In conclusion, the findings lend support for the arguments that current theoretical models of OCD may benefit from better incorporating moral self-concepts if they are to contribute to innovative treatment approaches for this complex heterogeneous disorder.

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Appendix 1: Extracts from reflective journal

7/11/16 – Reflections on interview with P1

P1 was really chatty and had lots to say about morals and their '*moral compass'*, as they described it. I was surprised at how open P1 was to talking about their moral values and OCD and how strongly they seemed to endorse the idea of the two being linked, although this seemed to come out as we were talking rather than P1 previously having thought about this. Hiller and Diluzio (2004) refer to 'reflective progression' and Charmaz (2014) talks about an 'identifying moment' to describe the co-construction of knowledge during an interview and it was really interesting to see this happening as we were talking.

I was quite struck by the number of other theories that P1 put forward during the interview as to why they might have developed OCD, and at times they seemed to almost contradict themselves. Lots of the questions seemed to have been covered by previous answers and sometimes it felt as though the questions were going over things that had already been mentioned. Although, approaching topics from different directions did also seem to wield additional information, so I think it will be helpful to keep this in mind for future interviews.

P1 spoke a lot about being more sensitive, empathic, and concerned for others than other people, which they feel may have made them more vulnerable to OCD in the first place. P1 also talked about not holding other people to the same standards that she holds herself to. It was interesting to hear P1 talking about the experience of having what they perceived to be an 'immoral' thought and how it made them feel about themselves (wanting to commit suicide – to get rid of themselves) and both the physical and emotional reactions that they noticed.

Interestingly P1 mentioned assessing situations to make sure that the right decision has been made and that it is important that others understand why this decision has been made and that everyone feels ok about it. This reminded me of the arguments by Haidt (2001) that moral reasoning is completed as a social task, in case we have to justify our actions and/or decisions. It also made me think of the debates around inflated responsibility, and how some authors have argued it is more accurate to conceptualise this as concerns about being held accountable rather than actual outcomes (Lopakta & Rachman, 199; Mancini & Mancini, 2004).

P1 said that at times they had been unsure what I was getting at, or what I wanted them to say, despite my reassurances that there were no wrong answers. They seemed keen to say the correct answers. I think that it will be important to keep in mind social desirability in the data and how this impacts participant's responses. P1 asked afterwards about my views about people with OCD and shared concerns about telling people they have OCD as they might then see them differently, but that they felt ok talking to me as they knew I was a health professional. Demographically, P1 seemed quite similar to me and I wonder if this impacted the interview both in terms of facilitating our conversation but also adding to concerns about my judgement as a

peer. Also P1 said that they were not sure whether they would have wanted to take part in the study before they had accessed psychological treatment and received more information about what OCD is, as it would have been difficult to find the words to describe what they was going through and verbalise their experiences, if they had not done so previously. I am pleased and optimistic about how many interesting themes have emerged from the first interview, many of which I did not expect to be so clearly evident. I also feel a little apprehensive about the number of things that have emerged and the all the different directions the data.

8/11/16 – Reflections following supervision

Today we talked about interview techniques and developing my style of interviewing. I thought about how I had been nervous about doing a research interview and was conscious of not turning the interview into a therapy session, which had perhaps held me back from fully engaging in the conversation. My supervisor pointed out that this had meant that I potentially missed opportunities to follow things up and gain rich information. I did not direct the interview that much and instead just let the participant speak. For example, when P1 was answering the first question I failed to explore exactly what they meant. I also thought about how I had been unsure about how much to summarise and paraphrase answers as I was concerned about leading the conversation too much but this meant further missed opportunities to clarify things with P1. In the next interview I need to ensure that I achieve a better balance between interview intensity, curiosity, and exploration, whilst also listening to what the participant is saying and not leading the conversation with my own assumptions and views.

15/11/16 – Reflections on interview with P4

Today I was really moved by the hatred P4 talked about feeling towards themselves, describing how they felt less worthwhile as a human than others, and that they needed to control themselves as they were essentially a bad person. It made me think about the intensity of distress experienced by participants and how incapacitating this can be. Although I had considered this previously, hearing the way in which P4 spoke about this in a very matter of fact way, in addition to the way it seemed incomprehensible for them to consider any possibility of causing harm to anyone, and that if they did the only option would be suicide, was really powerful. This reminded me of P1 also talking about suicide being the only option and made me reflect on how inescapable participants feel their distress is.

9/2/17 – Reflections on context of interviews

Reading Mills et al. (2006) I am thinking about the context of the interviews and the construction of meaning between myself as the researcher, and the participants in their interaction with me. I noticed several participants assumed my expert status, questioned what training I was doing, were keen to argue that OCD is so commonly misunderstood, apologised for rambling or not making sense, were worried about giving good, correct, helpful answers, felt concerned that they didn't know what I wanted them to say or how to answer my questions. I hadn’t expected participants to show as much concern about whether their own experiences were ‘correct’ or

not, and I think I was a bit taken aback by their interest in me, perhaps because as a clinician you do not generally invite patients to ask you questions about yourself. I wondered again about the balance between research and therapy, in terms of these interviews, and having to be quite conscious myself of not being in a clinical role whilst talking to participants.

26/2/17 – Reflections on morality
Dictionary definitions of morality:
'Morality may also be specifically synonymous with "goodness" or "rightness".
'Manner, character, proper behaviour'

Participants all speak about placing importance upon acting in a 'good' way however they differ on their endorsement of morality being linked with their OCD when asked about this directly. I wonder what is evoked for people with the word 'morality' in a semantic way. I've been reflecting on my own conceptualisation of morality whilst noticing how participant have answered this question. I was hesitant about how people would find answering this question and many have said that it is a tricky question. I wondered whether using 'goodness' or 'rightness' would have evoked different responses, and explanations. I considered the use of the word morality early in the research process and was conscious of defining morality for participants, as that in itself would have been putting my own construction of the term to them. On reflection, whilst morality may be difficult to define, I feel the terms 'goodness' or 'rightness' are both somewhat restrictive in their meanings, and are more heavily loaded with a construction of their opposites 'badness' and 'wrongness' something that I wanted to remain conscious of evoking whilst exploring morality with people. I have noticed that many people have volunteered images, descriptions, feelings, and actions that they define as good and bad, but that these have varied in their content and identification has been really contextual.

Interestingly a couple of participants almost appear to think through and consider how different conceptualisations of morality could be interweaved with different conceptualisations/types of OCD and have been really open to developing (co-constructing) ideas during the interviews. I wonder if it is a new idea for people, but that some feel more able to consider this, whilst others feel threatened by a new hypothesis or conceptualisation and defend against it or interpret the idea as implying that the content of their morals is 'wrong'.

13/3/17 – Reflections on data analysis
I feel well and truly immersed in the data. Today I had supervision and it was helpful to have the opportunity to discuss feeling really overwhelmed by the volume of data and initial codes, and how anxiety-provoking this is, and seemingly endless! It feels as though there are some really strong themes in the data, but so many of them have emerged from so many of the narratives that it feels difficult to 'sift, sort and synthesis' these large chunks of data as Charmaz (2014) describes.

Appendix 2: Examples of memos

20/11/2016 – Memo (4 interviews completed)
There is a theme about the importance of upholding morality for your own perception of yourself. Participants have spoken about desperately wanting to be perceived as moral by themselves but almost feeling that this is not entirely within your control. Interestingly, participants seemed to have articulated that they place value on caring and helping others and making sure they are ok, whilst simultaneously denying their moral actions are because they want others to see them as really moral. It seems as though the primary concern is not actually others wellbeing, but their perception of themselves in these circumstances.

Another theme which has emerged from the interviews so far is the idea of policing. Participants so far have spoken about laws (in many cases spoken about as representing morals) as being policed and this being important. There is an emphasis on restraint, punishment, and control and that perhaps without these barriers in place individuals would be immoral, and societies would be out of control. Also, P4 spoke about how being really sensitive to others needs and worrying obsessively about hurting or offending others was some kind of 'penance' implying a sense of deserving punishment.

1/12/17 – Process in interviews
I'm noticing how there are some themes in the process of the interviews. There is a sense that answers need to be justified/qualified in some way by providing examples or explanations for everything. Perhaps there is a sense that I won't understand otherwise. Participants often say '*probably*' or '*I'm guessing'*, it seems as a way of lessening the certainty of answers to the interviewer, perhaps to protect against the possibility of being told they are incorrect. This is also done with bracketing answers all the time *'it's probably irrelevant', 'I can't speak for everyone' I'm probably wrong'*; they seem to devalue their answers.

There is an assumption that the interviewer is more expert, and a fear of answering questions (even relating to own experience) wrong, and being told so by others (interviewer). There is also something about the language that is used to describe OCD and intrusive thoughts; that they happen to you, are inflicted on upon you, and come from outside. Also when OCD goes away it is seen to leave of its own accord. '*I woke up one day and it was gone'*.

I've noticed that people talk about normal versus not normal a lot.

7/2/2017 – Notes on emerging themes
Thinking back to the interviews with P11 and P12, they both describe a tally or checklist, and objective measure of good or bad, a scorecard of some kind, very black and white, objective, and seeming inescapable from, as well as externally defined.

I was struck by how both of them cushioned their OCD as something that was protective, part of them and a positive feature in lots of ways whilst also being struck by how insightful they were to how inconvenient, annoying, frustrating etc. OCD could be, but there was very little talk of recovering or giving up their OCD.

Throughout all interviews I have noticed a significant lack of emotion. When asked questions about emotion people seem to either be unsure how to answer, refer to physical symptoms or begin describing a series of events or actions.

I have also noticed a tendency to confess things, I wondered if this was a form of reassurance seeking. I've also been surprised at how open people have been about their backgrounds how many have offered very personal information without being asked for it, especially about their early lives. Almost everyone has mentioned their parents and many have spoken about school. People constantly seem concerned about providing good answers for me.

12/2/17 - '*box that you keep your actions within*'
There is something about OCD being about sticking to rules. Morality seems to provide an additional set of rules to adhere to, which is containing and reassuring, yet difficult because morality is hard to define and it is not *written* anywhere. Sticking to the rules seems to provide information about the self and a sense of control or management of the self-image to self and others.

Moral people are described as '*priest-like'* (P11), but also held in contempt a little and described as '*boring*' (P9). It comes across as jealousy.

22/2/17 – Developing themes: Fragile self, Fear
Fragile self: Participants have described how you learn morals though what you get punished for (or made to feel bad about) therefore if you are made to feel bad and there is no explanation for why then you conclude that you must have done something wrong somewhere along the way? Combined with a fragile self, i.e. using this information to inform sense of self seems to increase vulnerability to distress.

Fear: There seems to be an assumption that without morals everyone would be hurting each other and the world would be dangerous and chaotic. Do morals keep people in check? Do they offer some form of restraint mechanism over what people would do otherwise? There is a fear of what this might be, what people could do if morals were not there.

'Err well I guess they stop me from doing things that I might otherwise have done….um….. I mean do you want examples?' (P9)

2/3/17 – Processes
Coding other colleagues' transcripts I am struck by the differing presentation of people during interviews, the amount of information given in response to questions, and examples given. In comparison my interviews appear incredibly rich, yet

confusing, contradictory, and filled with examples, including seemingly off-topic or irrelevant information. My participants seem anxious, uncertain, confused, they seem to work incredibly hard during the interview providing numerous detailed examples, yet despite this their meaning, or message is often jumbled, unclear or ambiguous. I wonder if this reflects their state of mind.

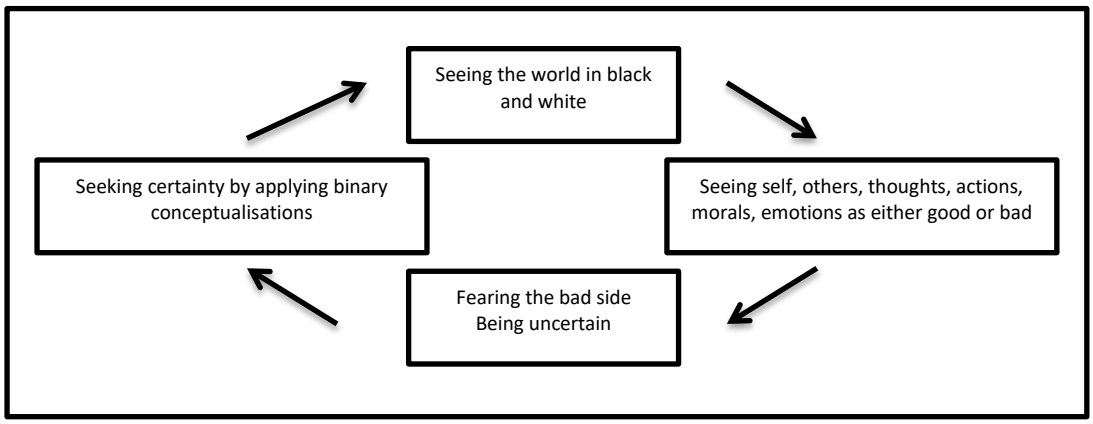
4/3/17 – Developing theme: lacking agency, feeling powerless towards OD
'I know its mental, and that's the really annoying things about OCD because you know that everything you are saying or, no, everything that you are thinking in your mind is completely like untrue and really out there but you can't kind of get away from it in a sense' (P12)

Something that is really striking about what participants have said is how they know that what they are doing isn't solving their problems and how they know their OCD is irrational:

'Know thoughts are silly' (P10)
'Fucking ridiculous' (P12)
'I know it sounds really bizarre' (P11)
'I know this sounds a bit psychotic' (P11)
'My rational mind thinks…' (P4)
'Doesn't do anything for me' (P10)
'Arbitrary actions' (P7)

It's like they are resigned to doing something even though they know it doesn't make any sense and isn't helpful. This must also make them feel quite powerless and foolish in a way, which in the long term must impact on their self-esteem.

7/3/17 – Developing theme: seeing the world in black and white
There is a tendency for participants to describe things as being very black and white, good-bad, moral-immoral, normal-not normal. It seems as though this works both ways though, it causes problems because they see everything as only good or bad, but then it also helps structure the world and reduce their uncertainty in way by making sense of abstract things (such as morality).



20/3/17 – Developing theme: Morals providing identity

'It's almost like eroding my foundations …and at the bottom there is not much' (P11)
'empty bottle' (P2)

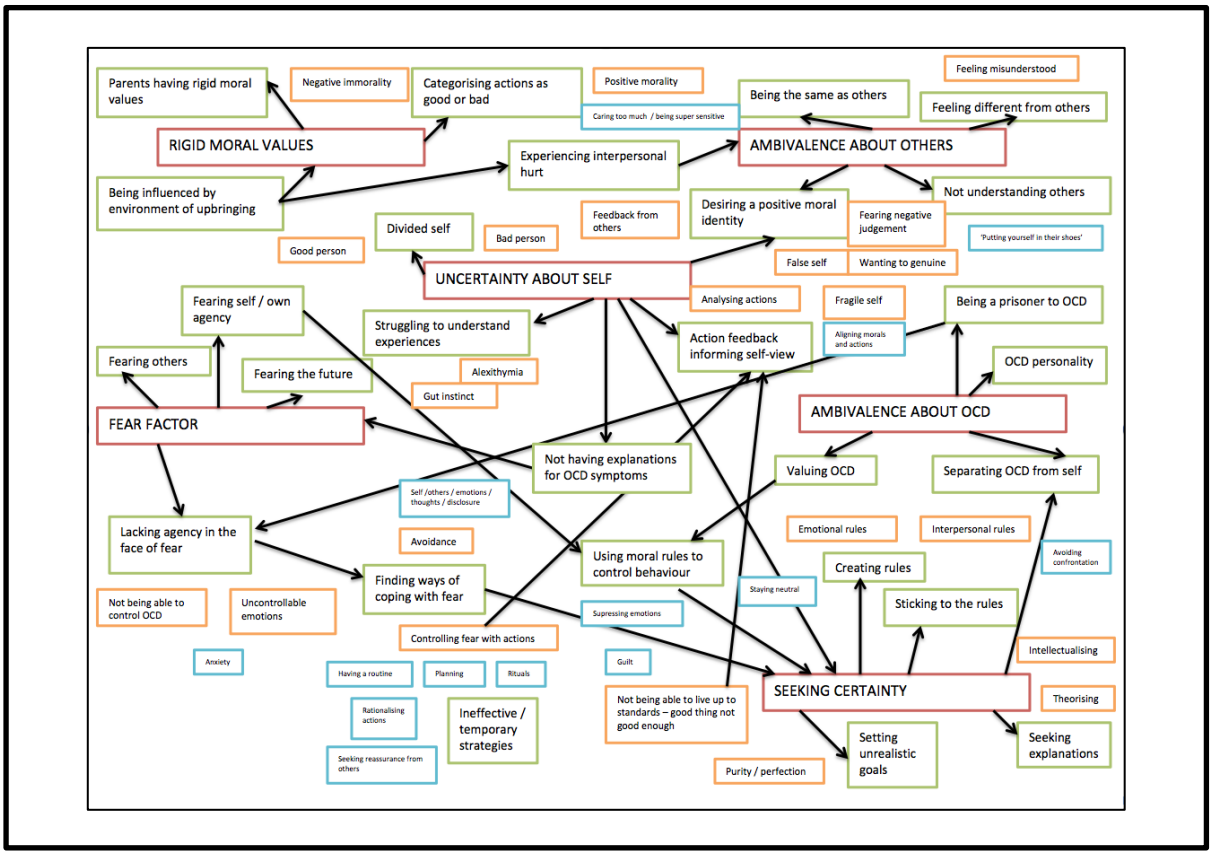
When asking people about what it would be like not to have morals they are either quite defiant about how they would be a criminal, a psychopath, or inhuman in some way or they are almost unable to answer the question.

Developing theme: fragile self

It makes you change how you feel about yourself?
Oh yeah absolutely (P9)

There is a really fragility about participants' beliefs in themselves, so much so that really minor actions, emotional changes, or thoughts seem to be able to radically change who they think they are as though they are entirely dependent upon something else telling them who they are.

22/3/17 – Developing the model



Appendix 3: Interview schedule

The interview schedule was used flexibly; the researcher encouraged participants to set the tone of the interview and pertinent themes were followed up. The interview schedule was continually revised during data collection to incorporate the essence of theoretical sampling. Questions that were added to later versions of the interview to explore emerging themes and lines of inquiry are indicated in italic.

Introduction

- Introduce myself
- Explain purpose of meeting and interview
- Explain the nature of the questions and that there are no right or wrong answers
- Reiterate that the interview will be recorded and transcribed
- Reiterate confidentiality and the right to stop the interview and/or withdraw from the research at any time without giving a reason
- Explain I am interested in their individual experience
- Explain I would like to get as much detail as possible
- Ask if they have any questions before we begin

1. Could you tell me about how you would define morality, morals or moral values?
    a. What does that mean to you?
    b. Some people have spoken about different types, or levels, of morals, what do you think about this?

2. Can you describe what characteristics you would associate with morals?
    a. In what ways, if at all, do these features relate to how you see yourself?

3. How would you describe someone who was very moral / had good morals?

4. Could you tell me about what you feel has contributed to your morals/moral values?
    a. How have these things influenced you?
    b. What was important about these things?

5. In what ways, if at all, is it important for you to be moral?
    a. How do you know you are moral?
    b. To what extent is it important for you to see yourself as moral?

6. How would you describe yourself in relation to having moral values?

7. In what ways, if at all, are morals helpful to you?

8. What does being a person with/ or without morals mean to you?

9. In what ways, if at all is it important for others to see you as a moral person?
    a. Tell me more about what it would mean if someone saw you as a moral person / an immoral person

10. What do you think about other people's morals?

11. It what ways do you see your own morals as the same or different from other peoples?

12. In what ways, if at all, do you feel morals influence what you do (or don't do)?
    a. Could you tell me about any examples of this / when this has happened?
    b. In what ways, if at all, does acting morally change how you see yourself?

13. In what way, if at all is it important to act in line with your moral values?
    a. To what extent do you feel your behaviour reflects your moral values?
    b. Some people have said acting morally makes them feel better about themselves, what do you think about this?

14. Could you tell me about your experience when you've feel you've acted in a moral way?
    a. Tell me more about your thoughts and feelings
    b. How did this influence your perception of yourself, if at all?

15. Could you tell me about any experiences of acting in an immoral way
    a. Tell me more about your thoughts and feeling
    b. How did this change your perception of yourself, if at all?

16. In what way, if at all, do your moral values relate to your experience of OCD?
    a. Could you tell me more about how you developed these ideas

17. Some people describe how OCD can be helpful in some ways, what do you think about this?

18. How do you make sense of your experience of OCD?

19. What do you think other people understand about these things?

a. Morals
b. OCD
c. Morals and OCD

20. How do you feel about [any emotion mentioned]?

Ending

21. What do you think are the most important things about moral values?

22. Is there anything else you think I should know to understand your experience better?

23. Is there anything that you might not have thought about before that occurred to you during this interview?

24. Is there anything you would like to ask me?

- Thank participant for their answers
- Explain how the recording and transcriptions will be used
- Explain how the findings will be disseminated

Appendix 4: Participant information sheet

Morality in OCD: Participant Information Sheet

My name is Cleo McIntosh and I am a clinical psychology trainee at Royal Holloway, University of London. I am carrying out a study exploring the experiences of morality for people with obsessive-compulsive disorder (OCD). You have received this information sheet because you have experienced OCD, and either your clinician has spoken to you about participating in this study and you have agreed to be contacted, or you have contacted us to say you would be interested in finding out more about taking part.

Before you decide whether you would like to be involved you need to understand why the research is being done and what it would involve for you. Please take the time to read the following information carefully and decide whether or not you wish to take part. Feel free to talk to others about the study and please ask if there is anything that is not clear.

What is the purpose of the study?

The aim is to explore how people with OCD think about morality by asking about their experiences. There are no incorrect answers; we are interested in finding out about your individual views and experiences.

Who can take part in this study?

You will be eligible to take part if you:
- have experience of OCD
- are aged 18 or over
- are fluent in English
- are NOT currently suicidal, psychotic or dependent on drugs or alcohol

Do I have to take part?

You do not have to take part and it is up to you to decide. If you do take part, you do not need to answer any questions that you do not want to and you are free to withdraw from the study at any time, without giving a reason. This will not affect any treatment you are receiving or may need in the future.

What will happen if I do take part?

If you decide to take part, we will ask you to complete some questionnaires and take part in an interview asking questions about morality. This will be audio recorded to help us better understand your answers and ensure we capture exactly your responses. It is anticipated this will take between 60 to 90 minutes. You will receive £10 for taking part in the study. A number will indicate your identity on the information you provide rather than your name, so your answers will remain anonymous. The audio recordings will be transcribed and then deleted. All data will be stored securely and only the research team will have access to it.

What are the possible benefits of taking part?

Your involvement in this study will help researchers to further understand morality in OCD. The more we find out about OCD the better we are able to continue developing effective treatments.

What will happen if I don't want to carry on with this study?

You can change your mind at any time and want to withdraw from the study; you can leave at any time without explaining why. Any information collected before this may still be used, unless you request that it is destroyed.

Will my information be kept confidential?

Yes. Only the research team will have access to your answers. Confidentiality will only be broken if significant risk to yourself or others is indicated in which case your GP or other health professionals would be informed. The information from the study will be securely stored for 5 years in accordance with the UK Data Protection Act (1998). Responsible individuals from regulatory authorities may also look at anonymised data collected during the study for quality control and audit purposes.

What will happen to the results of this study?

The preliminary results of the study will be provided to you, unless you decide that you do not want to receive them, so that you can provide feedback on what has been found. When the study has finished it is intended the findings will be published in a journal article. Some direct quotations may be used in this article to illustrate the findings, however these will be anonymous and no individual participants will be identified.

Who has reviewed this study?

The research has been approved by a NHS Research Ethics Committee (16/LO/1028), an independent group of people who are there to protect your safety, rights, well-being and dignity. This study has been also been registered with Royal Holloway Research Ethics Committee.

What if I have concerns about this study or want to make a complaint?

If you have any concerns about the procedure of this study or want to make a complaint please contact the Department of Clinical Psychology, Royal Holloway University of London (dclinpsy@rhul.ac.uk / 01784 443851).

Who else is taking part in this study?

I am hoping to recruit approximately 15 people to take part in the study.

Further information and contact details

If you would like to discuss any aspect of the study please email, call or text me or my supervisors using the details below:

Cleo McIntosh: cleo.mcintosh.2014@rhul.live.ac.uk
01784 414 012 (call only)
07XXXXXXXXX (call or text)

Dr Olga Luzon olga.luzon@rhul.ac.uk

Dr John Fox john.fox@rhul.ac.uk

Appendix 5: London Camden and Kings Cross Research Ethics Committee approval

NHS
Health Research Authority
London - Camden & Kings Cross Research Ethics Committee
Jarrow Business Centre
Rolling Mill Road
Jarrow
NE32 3DT

Telephone: 0207 104 8086

Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

02 August 2016

Miss Cleo McIntosh
Trainee Clinical Psychologist
Camden and Islington NHS Foundation Trust
Doctorate in Clinical Psychology
Royal Holloway University of London
Egham, Surrey
TW20 0EX

Dear Miss McIntosh

Study title:	**Exploring morality in obsessive compulsive disorder using a grounded theory approach**
REC reference:	**16/LO/1028**
IRAS project ID:	**202323**

Thank you for your letter of 29th July, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact the REC Manager, Miss Christie Ord, nrescommittee.london-camdenandkingscross@nhs.net.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Appendix 6: Health Research Authority approval

NHS
Health Research Authority

Miss Cleo McIntosh
Trainee Clinical Psychologist
Camden and Islington NHS Foundation Trust
Doctorate in Clinical Psychology
Royal Holloway University of London
Egham, Surrey
TW20 0EX

Email: hra.approval@nhs.net

04 August 2016

Dear Miss McIntosh,

Letter of HRA Approval

Study title:	**Exploring morality in obsessive compulsive disorder using a grounded theory approach**
IRAS project ID:	**202323**
REC reference:	**16/LO/1028**
Sponsor	**Royal Holloway University of London**

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

Appendix 7: Royal Holloway University of London Ethics Committee research registration

Ethics Review Details

You have chosen to self certify your project.	
Name:	McIntosh, Cleo (2014)
Email:	PBVA061@live.rhul.ac.uk
Title of research project or grant:	Morality in OCD
Project type:	Royal Holloway postgraduate research project/grant
Department:	Psychology
Academic supervisor:	Olga Luzon
Email address of Academic Supervisor:	olga.luon@rhul.ac.uk
Funding Body Category:	No external funder
Funding Body:	
Start date:	01/07/2016
End date:	01/07/2017

Research question summary:

Initial research questions in grounded theory are required in order to focus attention on a particular phenomenon, however it is important that the question serves to identify, but not make assumptions about, the phenomenon. The research questions will become more focussed as the research progresses (Willig, 2013).

The principle research objective is to explore the role morality plays in OCD which encompasses:

- How people with OCD view morality?

- How do people with OCD experience moral judgements and decision making?

- How do ideas about morality influence how people with OCD see themselves?

Research method summary:

The study is a qualitative design. Data will be collected in the form of semi-structured verbal interviews which will be audio recorded, transcribed and analysed using a grounded theory approach.

Grounded theory methodology has been chosen to meet the study objectives as it was principally designed to open up a space for the development of new contextualised theories (Willing, 2013). It is able to move from data to theory, ensuring that subsequent theories are grounded in the data from which they have emerged rather than being reliant upon constructs from pre-exiting theories. The flexibility of grounded theory will allow for the research questions to become more focussed as the research progresses. Grounded theory allows for a full understanding of social psychological phenomena by combining a contextualised and dynamic approach focussed on social processes, with one concerned with the structure of the internal world of participants (Willig, 2013), essential to explore in the domain of morality.

Potential participants will be provided with the participant information sheet a minimum of 24 hours before taking part in the study. After providing informed consent, participants will be asked to complete a demographic questionnaire and a self-report OCD symptom questionnaire (OCI-R). Participants will then be asked some open-ended questions about their experience of OCD, morality, moral judgements and moral decision-making. Their answers will be audio recorded. The interview will be semi-structured meaning that participants' answers may be followed up with further questions by the researcher. Data collection will only take place on one occasion for each participant and is estimated Participants will be reimbursed £10 in cash to compensate them for their time and travel expenses.

Risks to participants

Does your research involve any of the below?

Children (under the age of 16),

No

Participants with cognitive or physical impairment that may render them unable to give informed consent,

No

Participants who may be vulnerable for personal, emotional, psychological or other reasons,

Yes

Participants who may become vulnerable as a result of the conduct of the study (e.g. because it raises sensitive issues) or as a result of

Appendix 8: Obsessive-Compulsive Inventory-Revised (Foa et al., 2002)

Not included due to copyright restrictions

Appendix 9: Participant consent form

Morality in OCD: Consent Form

	Please initial to confirm the statements are true
I have read the Participant Information Sheet	…….
I have had the opportunity to ask any questions about the study and my questions have be answered	…….
I understand I am free to withdraw from the study at any time without giving a reason, and this won't affect any treatment I am currently receiving or may receive in the future	…….
I agree for my interview to be audio recorded and I understand that this recording will be destroyed following transcription	…….
I agree for my direct anonymised responses to be included in the final results of the study	…….
I understand that if I disclose information indicating significant risk to myself or others this will be shared with my GP or other relevant health professionals	…….
I understand anonymised data, collected during the study may be looked at by responsible individuals from regulatory authorities for quality control and audit purposes. I give permission for these individuals to have access to my records	…….
I agree to participate in the study	…….

Name: _____

Signature: _____ **Date:** _____

One copy to be retained by the researchers, one copy given to the participants and one copy placed in participants medical records (for those recruited through NHS services)

Appendix 10: Participant debrief sheet

Morality in OCD

Thank you for your participation in this research study.

The purpose of this research is to investigate the experience of morality in obsessive-compulsive disorder (OCD).

We hope that by investigating and understanding more about the things we have talked about today we will be able to learn more about OCD. The research may also help us to think about different things that might be helpful in psychological therapy for people experiencing OCD.

Your participation in this study is greatly appreciated and any contribution you have made will be treated in the strictest confidence. However, if you wish to withdraw any data you may do so and you will not be asked to give a reason.

Sometimes people might experience some level of discomfort after talking or thinking about the type of questions I have asked you today. I will be happy to discuss this with you. This sheet also provides some additional sources of information that you may find helpful. If you continue to feel you would like additional support please speak to your clinician or your GP.

Who can I contact if I have any questions or need some support?
If you have any questions regarding this research please feel free to ask them now. If you have additional questions at a later date please contact the researcher, Cleo McIntosh, cleo.mcintosh.2014@live.rhul.ac.uk or the study supervisors, Dr Olga Luzon olga.luzon@rhul.ac.uk and Dr John Fox john.fox@rhul.ac.uk

What if I have concerns about this study or want to make a complaint?

If you have any concerns about the procedure of this study or want to make a complaint please contact the Department of Clinical Psychology, Royal Holloway University of London (dclinpsy@rhul.ac.uk / 01784 443851).

Other contacts you may find helpful are listed on the next page.

Useful contacts:
You can always contact your clinician or GP for additional help and support

OCD Action
OCD Action is the national charity focusing on Obsessive Compulsive Disorder (OCD). They provide support and information to anybody affected by OCD.

OCD Action helpline line is open Monday to Friday, 9.30am to 5.00pm.
Telephone: 0845 390 6232
Email: support@ocdaction.org.uk
Website: www.ocdction.org.uk

OCD-UK
OCD-UK is a UK registered charity that provides impartial information, advice and support to both adults and children affected by OCD. This service is confidential.

OCD-UK Advice line is open Monday to Friday, 9.00am to 5.00pm.
Telephone: 0845 120 3778
Email: support@ocduk.org
Website: www.ocduk.org

MIND
Mind is a mental health charity that provides information and support to people experiencing mental health difficulties.

Mind helplines are open Monday to Friday, 9.00am to 5.00pm.
Telephone: 0845 766 0163
Email: info@mind.org.uk
Website: www.mind.org.uk

Samaritans
The Samaritans can help people who are in crisis. They provide confidential, non-judgmental, emotional support to people who are experiencing feelings of distress or despair, including feelings which could lead to harm or suicide.

They are open 24 hours a day.
Telephone: 08457 90 90 90
Email: jo@samaritans.org
Website: www.samaritans.org

What shall I do if I am in crisis and I am worried that I might harm myself or another person?
Call 999 and ask for help.
Alternatively you can go to your nearest Accident & Emergency department (A&E).

Appendix 11: Extract of initial coding

Comments / Memos	Initial codes	Can you say a bit more about what they [morals] mean to you?
Individual application of morality and what it means *Describing what you are afraid of becoming?* *Interpreting the question as content rather than meaning – what things are unfaithful rather than what it means to them* *Being uncertain about on morals?* *There is a fear about being found out and what that would mean about themselves, or how others would see them* *Obsessing – thinking out loud – rationalising moral rules* *Being uncertain in answers*	Being unfaithful Being a complete bastard Broad morals Far-reaching moral definitions Going too wide with moral rules Differentiating self from others Others being more rational Honesty thing Describing different application of morals in different contexts Proving moral credentials Fearing putting self in a bad light Feeling guilty about lying Worrying about being found out Ridiculing worries Describing thinking process Obsessing Predicting the future Being uncertain about the future	Yeah sure, sure I mean um so being unfaithful I guess I don't know I just feel you are a complete bastard if you do something like that but I mean it's such a wide, such a broad you know there could be so many things under that definition of being unfaithful that um err I would probably go a bit too wide in that whilst some people are a bit more um rational about it and able to see, you know some things that I consider to be bad I wouldn't um and then I guess the whole honestly thing, I mean I don't know its weird some things I probably wouldn't bat an eye lid in lying about but others, like sick days for example, I've not had a sick day where I've pretended to be ill off work just because I feel like A, I'm being, I'm not, I'm not, I'm putting myself in a bad light if it ever came out in the company you know if the company expect me to be there to work and I'm not really ill so I just feel like that lie is not really cricket and um you know I feel guilty about it or I just would worry that somehow err it would come out that I had a duvet day when I wasn't actually ill you know which is ridiculous because even if it did come out they would probably just chide me and then just …or maybe they wouldn't maybe they wouldn't give a shit…so I just start thinking about it like that so um….
		You mentioned guilt there, how do you feel about guilt?

Difficulty describing how guilt feels? *The experience of guilt having an on-going negative effect on self*	Hesitation Guilt playing a big part in OCD Being brought down by guilt Beating self up	Err, I don't, I don't really, err I feel I think guilt is one of the big things about my OCD I feel, I think that's the thing that really erm brings me down in the guilt because, when feel guilty I just start beating myself up about it and um
		When you say beating yourself up…
Using guilt to retrospectively work out potential previous wrongdoings	Talking to self Searching for reasons for feelings Analysing self	Yeah I'll just say oh this is really bad, you feel bad, you feel really guilty, there is a reason why you feel guilty erm let's explore that, lets really analyse that to the 'enth degree…
		So quite critical thoughts to yourself?
Questioning self *Being without an explanation for feelings leading to search for one*	Criticising self Questioning self Trying to find answers Engaging with guilt Trying to find a reason for feelings Worrying about adverse effect of self on others Worrying about being a social pariah	Yeah very critical, um you know and just, and the more I question it or try and find answers, the more guilty I get because I guess I'm engaging with that guilt and trying to find erm, I'm trying to find a reason for why I feel that way or you know how that effects my relationships how I've affected that person my outlook does it make me a social pariah blah blah blah um…
		Can you say a bit more about that how it makes you feel about yourself?
Inconsistency between internal and external self *Evoking a sense of being helpless in the face of it all – being ill-equipped for it*	Feeling like a bad person Being untrue Acknowledging discrepancy between outside and inside Feeling terrible Searching for reasons for feelings Describing a range of feelings Feeling worthless Being helpless Not knowing how to deal with it	Yeah I mean it just, well its very draining erm I just feel like a bad person, you know I'm not being true to, while on the outside it might look like everything is hunky dory really on the inside I feel terrible and you know, the reasons behind me feelings guilty you just think about all over again and yeah I guess that's the obsessive nature of and so yeah all in all it can range from just kind of feeling worthless to you know helpless because you don't really know how to deal with it

		Ok, thank you, can you describe what characteristics, or personality traits you would associated with someone who was moral?
Interesting contempt shown for someone 'moral'	Describing moral person Really boring moral person	Erm boring, I guess, um fairly, I don't know I mean if I think about someone who is completely moral I just think of like my aunty in a cardigan doing nothing, you know really boring people
		Can you say more about boring, what…
Linking morals with laws	Describing moral person Not doing anything controversial Abiding by laws Speeding Not feeling guilty for speeding Breaking a law Morality as a scale with extremes Grey person Living life by every moral code Judging moral others	Well just not, not doing anything that would be controversial in the slightest, not um, like abiding by every single law that there is, not saying that you shouldn't abide by a law but you know people will often speed for example and not feel guilty about it even though they have broken a law, um yeah I guess there is the one very extreme end of the scale where they are just really boring, grey person who just lives their life by every single moral code there is available, err
		So that would be like a negative thing?
Uncertainty about own answers – contradicting self	Acknowledging own contradiction Considering morals to be important Stressing out about morals Displaying uncertainty	I guess so yeah even though I'm sitting here saying you know err I consider morals to be important otherwise I wouldn't stress myself out about them so much, yeah, weird, ok
		Ok, well how about someone doesn't who have morals, what kind of characteristics might they have?

Appendix 12: Table showing the presence of theoretical and focused codes across participants

Theoretical codes	Focused codes	Participant number (shading indicates presence of theme)											
		1	2	3	4	5	6	7	8	9	10	11	12
1. CONCEPTUALISING MORALITY	1.1 Early experiences influencing moral development	■	■	■		■	■	■	■	■	■	■	■
	1.2 Different levels of morality	■	■		■	■	■	■	■	■		■	■
	1.3 Black and white moral rules	■	■	■	■	■	■	■	■	■	■	■	■
	1.4 Possessing a moral compass	■			■	■			■	■	■	■	■
2. HOLDING RIGID MORAL VALUES AS PART OF IDENTITY	2.1 Moral rules providing a sense of self	■	■		■	■	■	■	■	■	■	■	■
	2.2 Valuing a positive moral identity	■	■	■	■	■	■	■	■	■	■	■	■
3. EXPERIENCING MORAL UNCERTAINTY	3.1 Feeling uncertain about self	■	■	■	■	■	■	■	■	■	■	■	■
	3.2 Struggling to understand internal experiences	■	■	■	■	■	■	■	■	■	■	■	
	3.3 Feeling ambivalent about others	■	■		■	■	■		■	■	■	■	■
	3.4 Interpersonal uncertainty	■	■	■	■	■	■	■	■	■	■	■	■
4. SEEING THE WORLD IN BLACK AND WHITE	4.1 Creating opposites	■		■	■	■	■	■		■		■	■
	4.2 Quantifying experiences		■		■			■		■		■	■
5. FEAR FACTOR	5.1 Fearing being a bad person	■	■	■	■	■	■	■		■	■	■	■
	5.2 Fearing others	■	■	■	■	■	■	■	■		■	■	
	5.3 Avoidance	■			■	■			■	■	■	■	■
6. SEEKING CERTAINTY	6.1 Using rules to create certainty	■	■		■				■	■	■	■	■
	6.2 Controlling fear with actions	■	■	■			■	■	■		■	■	■
	6.3 Looking for explanations	■			■	■	■		■	■		■	■
7. FEELING AMBIVALENT ABOUT OCD	7.1 Separating OCD from self	■		■	■	■	■	■		■	■	■	■
	7.2 OCD personality	■	■	■	■			■	■		■	■	■
	7.3 Valuing OCD		■		■		■	■	■	■		■	■
	7.4 Lacking agency	■		■	■	■	■	■	■	■	■	■	■