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When Moral Concerns Become a Psychological Disorder:

The Case of Obsessive Compulsive Disorder

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John, a 28-year-old man, steps into my office and describes his problem: “I find it very difficult to leave my apartment. I have thoughts that I might hit someone. I just can’t stop thinking about it…it drives me crazy. I try to tell myself ‘you never hit someone…. except in high school 15 years ago’ and ask my parents whether they think I am that kind of a person…they always say no. I also worry all the time that bad things will happen to my parents. That is why I have to do things in a certain way before I go to sleep or leave the house. I have to check the stove 33 times and make sure that I locked the doors and windows…three times each. I can’t fall asleep if something goes wrong with my night routine, because something bad might happen.”

John suffers from obsessive compulsive disorder (OCD), an anxiety disorder that has been rated as a leading cause of disability by the World Health Organization (1996). His symptoms, like those of many others suffering from this disorder, include morality-related worries, feelings, and cognitions, such as perceived violation of moral standards, guilt, and inflated responsibility (Salkovskis, 1985; Shafran, Watkins, & Charman, 1996). However, sensitivity to moral issues, by itself, is unlikely to lead to an emotional disorder. Many of us experience events or thoughts challenging our moral standards but are not flooded by negative self-evaluations, dysfunctional beliefs, and pathological preoccupations. In fact, for most people,
such experiences would result in the activation of distress-regulation strategies that dissipate unwanted thoughts, reaffirm the challenged self, and restore emotional equanimity. In this chapter, we propose that dysfunctions of the attachment system, as manifested in heightened attachment anxiety, can disrupt the process of coping with morality-related concerns and therefore contribute to OCD. For people with high attachment anxiety, experiences challenging an important self-domain, such as morality, can increase the accessibility of “feared self” cognitions (e.g., I’m bad, I’m immoral) and activate dysfunctional cognitive processes (e.g., an inflated sense of responsibility) that result in the development of obsessional preoccupations.

We begin this chapter with a brief description of OCD and current cognitive models of the disorder. We then describe the role of dysfunctional self-perceptions and sensitive self-domains – domains of the self that are extremely important for maintaining self-worth (Doron & Kyrios, 2005) – in OCD. Next, we review empirical findings linking attachment insecurities and obsessive compulsive phenomena and propose a diathesis-stress model whereby experiences challenging sensitive self-domains, such as morality, and attachment insecurities interact to increase vulnerability to OCD. We then focus on morality as a particularly important self-domain in OCD and present new, previously unpublished findings showing that experiences in the morality domain can lead to OCD symptoms and that this effect is moderated by attachment anxiety.

**Obsessive Compulsive Disorder**

According to the Statistical Manual of Mental Disorders (DSM IV-R; American Psychiatric Association, 2000), a diagnosis of OCD is appropriate when either, or both, obsessions or compulsions (1) are experienced at least at some stage as excessive, unreasonable, and inappropriate; (2) cause significant distress; and (3) are very time consuming or interfere
with daily functions. Obsessions are unwanted and disturbing intrusive thoughts, images, or impulses. Obsessional themes include contamination fears, pathological doubt, a need for symmetry or order, body-related worries, and sexual or aggressive obsessions. Compulsions are deliberate, repetitive, and rigid behaviors or mental acts that people perform in response to their obsessions as a means of reducing distress or preventing some feared outcome from occurring. Common compulsive behaviors include repeated checking, washing, counting, reassurance seeking, ordering behaviors, and hoarding.

Although a wide range of etiological models have been proposed for OCD, cognitive-behavioral theories have been supported by a large body of empirical evidence and have led to the development of effective treatments (see Frost & Steketee, 2002, for review). According to these theories, most of us experience a range of intrusive phenomena that are similar in form and content to clinical obsessions (Rachman & de Silva, 1978), but individuals with OCD misinterpret such intrusions based on dysfunctional beliefs (e.g., inflated responsibility, perfectionism, threat overestimation; Obsessive Compulsive Cognitions Working Group [OCCWG], 1997). Moreover, individuals with OCD tend to rely on ineffective strategies for managing intrusive thoughts and reducing anxiety (e.g., thought suppression, compulsive behavior) which paradoxically exacerbate the frequency and impact of intrusions and result in OCD (Salkovskis, 1985). For instance, John believed people should control their thoughts and was highly distressed by his inability to prevent the occurrence of intrusions inconsistent with his values and moral standards (e.g., hitting others). John also exhibited an inflated sense of responsibility and believed that by acting in a certain way (i.e., checking and counting) he could prevent bad things from occurring to close others. According to cognitive theories, these
cognitive processes increase the re-occurrence of intrusive thoughts and exacerbate compulsive behaviors.

Whereas cognitive models have improved the understanding and treatment of OCD, recent findings suggest that a substantial proportion of individuals with OCD do not exhibit higher levels of dysfunctional beliefs than recorded in community samples (e.g., Taylor et al., 2006). Moreover, findings regarding the specificity of the dysfunctional beliefs related to OCD are equivocal (e.g., OCCWG, 2005; Tolin, Worhunsky, & Maltby, 2006). Cognitive theories have also been criticized for not sufficiently addressing the developmental and motivational bases of the disorder (Guidano & Liotti, 1983; O’Kearney, 2001). Moreover, a substantial proportion of patients do not respond to cognitive behavioral therapy (Abramowitz, 2006; Fisher & Wells, 2005).

**Self-Sensitivity and OCD**

In response to these criticisms, Doron and colleagues (Doron & Kyrios, 2005; Doron, Kyrios, & Moulding, 2007; Doron, Kyrios, Moulding, Nedeljkovic, & Bhar, 2007; Doron, Moulding, Kyrios, & Nedeljkovic, 2008) incorporated theories of the self within existing cognitive models of OCD. Specifically, they proposed that the transformation of intrusive thoughts into obsessions is moderated by the extent to which intrusive thoughts challenge core perceptions of the self. Indeed, Bhar and Kyrios (2007), Clark and Purdon (1993), and Rachman (1997) had already argued that the appraisal of an intrusive thought as inconsistent with one’s sense of self (i.e., as ego-dystonic) contributes to the formation of obsessions. Along this line of thinking, Clark (2004) wrote that “obsession-prone individuals have a preexisting ambivalent or fragile self-view, then unwanted intrusive thoughts that are completely contrary to this self-view are more likely to be interpreted as highly significant or threatening” (p. 141).
According to Doron and Kyrios (2005), due to socio-cultural and developmental factors (e.g., ambivalent parenting characterized by rejection but camouflaged concurrently by an outward appearance of devotion; Guidano & Liotti, 1983), specific self-domains become extremely important for defining one’s sense of self-worth (Doron and Kyrios, 2005, called these “sensitive self-domains”). As a result, perceived competence in these self-domains becomes crucial for maintaining self-worth (Harter, 1998), and people tend to be preoccupied with events that bear on their perceived competence in sensitive self-domains (e.g., Wolfe & Crocker, 2003). In OCD, sensitive self-domains include the areas of morality, social acceptance, and job/school performance (Doron et al., 2008).

Doron and Kyrios (2005) also proposed that thoughts or events that challenge sensitive self-domains (e.g., immoral thoughts or behaviors) damage a person’s self-worth and activate attempts at repairing the damage and compensating for the perceived deficits. In the case of individuals with OCD, these coping responses may paradoxically further increase the occurrence of unwanted intrusions and the accessibility of “feared self” cognitions (e.g., I’m bad, I’m immoral, I’m unworthy). In this way, for such individuals, common aversive experiences may activate overwhelmingly negative evaluations in sensitive self-domains (Doron et al., 2008). These processes, together with the activation of other dysfunctional thoughts (e.g., an inflated sense of responsibility, threat overestimation), are self-perpetuating and can result in the development of obsessions and compulsions.

*The Moderating Role of Attachment Insecurities*

Although sensitive self-domains have been implicated in OCD (Doron et al., 2008), it is unlikely that every person experiencing an aversive event that challenges such self-domains will be flooded by negative self-evaluations, dysfunctional beliefs, and obsessions. Some individuals
whose sensitive self-domains are challenged by failures and setbacks adaptively protect their self-images from unwanted intrusions and restore emotional equanimity. In fact, for most people, experiences challenging sensitive self-domains would result in the activation of distress-regulation strategies that can dissipate unwanted intrusions, reaffirm the challenged self, and restore emotional composure. The main question here concerns the psychological mechanisms that interfere with this adaptive regulatory process and foster the activation of “feared self” cognitions and the cascade of dysfunctional beliefs that result in OCD symptoms.

In an attempt to respond to this question, Doron, Moulding, Kyrios, Nedeljkovic, and Mikulincer (2009) proposed that attachment insecurities can disrupt the process of coping with experiences that challenge sensitive self-domains and thereby contribute to OCD. According to attachment theory (Bowlby, 1973, 1982; Mikulincer & Shaver, 2007a; Shaver & Mikulincer, this volume), interpersonal interactions with protective others (called “attachment figures” in the theory) are internalized in the form of mental representations of self and others (“internal working models”), which have an impact on close relationships, self-esteem, emotion regulation, and mental health throughout life. Interactions with attachment figures who are available and supportive in times of need foster the development of both a sense of attachment security and positive internal working models of the self and others. When attachment figures are rejecting or unavailable in times of need, attachment security is undermined, negative models of self and others are formed, and the likelihood of self-related doubts and emotional problems increases (Mikulincer & Shaver, 2003).

When testing this theory in studies of adolescents and adults, most researchers have focused on a person’s attachment orientations – the systematic pattern of relational expectations, emotions, and behaviors that results from a particular attachment history (Mikulincer & Shaver,
2007a). Research, beginning with Ainsworth, Blehar, Waters, and Wall (1978) and continuing through recent studies by social and personality psychologists (reviewed by Mikulincer & Shaver, 2003, 2007a), indicates that attachment orientations are organized around two orthogonal dimensions, attachment-related anxiety and avoidance (Brennan, Clark, & Shaver, 1998). The first dimension, attachment anxiety, reflects the degree to which a person worries that a partner will not be available or adequately responsive in times of need. The second dimension, avoidance, reflects the extent to which he or she distrusts relationship partners’ goodwill and strives to maintain autonomy and emotional distance from them. People who score low on both dimensions are said to hold a stable sense of attachment security.

According to attachment theory, a sense of attachment security facilitates the process of coping with, and adjustment to, life’s adversities, and the restoration of emotional equanimity following aversive events (Mikulincer & Shaver, 2007a). Indeed, secure attachment (indicated by relatively low scores on attachment anxiety or avoidance) has been found to buffer the adverse emotional effects of stressful and traumatic events (see Florian, Mikulincer, & Hirschberger, 2002; Mikulincer, Shaver, & Horesh, 2006, for reviews). Moreover, attachment security is associated with heightened perceptions of self-efficacy, constructive distress-regulation strategies, and maintenance of a stable sense of self-worth (e.g., Collins & Read, 1990; Mikulincer, 1998; Mikulincer & Florian, 1998). During aversive events, securely attached individuals mobilize internal representations of supportive others or actual sources of support, which in turn sustain optimistic beliefs, constructive strategies of distress regulation, and mental health (Mikulincer & Shaver, 2003, 2005). Laboratory studies also indicate that experimental manipulations aimed at contextually heightening access to security-enhancing representations
(i.e., security priming) restore emotional equanimity after distress-eliciting events and buffer post-traumatic dysfunctional cognitions (see Mikulincer & Shaver, 2007b, for a review).

According to Doron et al. (2009), the sense of attachment security may act, at least to some extent, as a protective shield against OCD-related processes, such as the activation of feared-self cognitions and dysfunctional beliefs following events that challenge sensitive self domains. For people who have chronic or contextually heightened mental access to the sense of attachment security, these aversive experiences and the intrusion of unwanted thoughts will result in the activation of effective distress-regulation strategies that dissipate the thoughts, reaffirm the challenged self, and restore well-being.

Conversely, attachment insecurities can impair the process of coping with experiences challenging sensitive self domains and thereby increase the chances of OCD symptoms. Following these experiences, insecurely attached individuals may fail to find inner representations of security or external sources of support, and so may experience a cascade of distress-exacerbating mental processes that can culminate in emotional disorders. For example, anxiously attached individuals tend to react to such failure with catastrophizing, exaggerating the negative consequences of the aversive experience, ruminating on these negative events, and hyper-activating attachment-relevant fears and worries, such as the fear of being abandoned because of one’s “bad” self (Mikulincer & Shaver, 2003). Avoidant people tend to react to such aversive events by attempting to suppress distress-eliciting thoughts and negative self-representations. However, these defenses tend to collapse under an emotional or cognitive load (Mikulincer, Dolev, & Shaver, 2004), leaving the avoidant person flooded with unwanted thoughts, negative self-representations, and self-criticism. These kinds of thoughts and feelings tend to perpetuate threat overestimation, lead to overwhelming, uncontrollable distress,
exacerbate unwanted thought intrusions and negative self-views, and thereby contribute to the development of obsessions (see Figure 1).

**Self-Sensitivity, Attachment Anxiety, and OCD: Empirical Evidence**

There is growing evidence for the role of self-structures in the transformation of intrusive thoughts into OCD symptoms. For example, Rowa, Purdon, Summerfeldt, and Antony (2005) found that individuals with OCD rated more upsetting obsessions as more meaningful and contradictory of valued aspects of the self than less upsetting obsessions. Bhar and Kyrios (2007) found that individuals with OCD exhibited higher levels of self-ambivalence (i.e., worry and uncertainty about one’s self-concept) than non-clinical controls, although they did not differ from individuals suffering from other anxiety disorders. Doron, Moulding, and Kyrios (2007) found that young adults who reported higher sensitivity to morality-related self-domains, social acceptability, and job/school competence (overvaluing a domain while feeling incompetent in that domain) were more likely to report OCD-related cognitions and symptoms. In another study, Doron, Moulding, Kyrios, and Nedeljkovic (2008) found that individuals with OCD reported higher levels of self-sensitivity in the domains of morality, social acceptability, and job competence than individuals with other anxiety disorders.

There is also evidence supporting the involvement of attachment insecurities in vulnerability to OCD. First of all, both attachment anxiety and avoidance are associated with dysfunctional cognitive processes similar to those included in current cognitive models of OCD (OCCWG, 2005). For instance, attachment anxiety is associated with exaggerated threat appraisals (e.g., Mikulincer & Florian, 1998), perfectionism (e.g., Wei, Mallinckrodt, Russell, & Abraham, 2004), difficulties in suppressing unwanted thoughts (e.g., Mikulincer et al., 2004), rumination on these thoughts (e.g., Mikulincer & Florian, 1998), and self-devaluation in aversive
situations (Mikulincer, 1998). Similarly, avoidant attachment is associated with setting high, unrealistic, and rigid personal standards of excellence (Mikulincer & Shaver, 2003, 2007a), self-criticism, maladaptive perfectionism, and intolerance of uncertainty, ambiguity, and personal weaknesses (Mikulincer & Shaver, 2007a). Moreover, avoidant people tend to overemphasize the importance of maintaining control over undesirable thoughts and suppressing thoughts of personal inadequacies and negative personal qualities (Mikulincer et al., 2004).

Recently, Doron et al. (2009) provided direct evidence for a link between attachment insecurities and OCD symptoms. Australian University students (N = 467) completed questionnaires assessing attachment orientations (with the Experiences in Close Relationships scales, or ECR; Brennan et al., 1998), OCD- symptoms (PI–R; Burns et al., 1996), OCD-dysfunctional beliefs (OBQ; OCCWG, 2005), and depression symptoms (BDI-II; Beck, Steer, & Brown, 1996). As expected, attachment insecurities, both anxiety and avoidance, predicted dysfunctional OCD-related beliefs and OCD symptoms. Moreover, the contribution of attachment anxiety and avoidance to OCD symptoms was fully mediated by OCD-related beliefs, and remained significant even after statistically controlling for depression symptoms.

In two additional unpublished studies, we (Doron, Mikulincer, & Sar-El, 2010) examined the extent to which experimentally induced access to security representations (security priming) weakens the link between dispositional attachment insecurities and OCD-related behavioral tendencies. As is common in OCD research, analogue non-clinical samples (Israeli university students) were used in these two studies. Previous studies have shown that non-clinical samples also report intrusive thoughts, like clinical samples, but with lesser frequency and less associated distress (Rachman & de Silva, 1978). Like individuals clinically diagnosed with OCD, non-clinical individuals also report engaging in compulsive behaviors in order to remove distress or
prevent feared outcomes (e.g., Muris, Harald, & Clavan, 1997). Recently, two taxometric studies (Haslam, Williams, Kyrios, McKay, & Taylor, 2005; Olatunji, Williams, Haslam, Abramowitz, & Tolin, 2008) found that OCD symptoms and cognitions are best conceptualized in terms of dimensions rather than categories. These results support the appropriateness of studying OCD in non-clinical subjects.

In the first study ($N = 87$), we examined the effects of subliminal priming (for 22 ms) with names of people whom participants nominated as sources of security (a procedure known as “security priming”) on OCD-related behavioral tendencies (as compared to subliminal priming with names of mere acquaintances). OCD-related tendencies were measured by asking participants to rate distress, urge to act, and likelihood of acting in response to 10 hypothetical scenarios related to washing and checking (Menzies, Harris, Cumming, & Einstein, 2000; Moulding, Kyrios, & Doron, 2007). In the second study ($N = 90$), attachment security was supraliminally primed by asking participants to recall a security-enhancing experience (in the experimental group) or a shopping experience (in the control group). All participants then completed the OCD-relevant scenarios questionnaire. In both studies, participants also completed the ECR, which measures attachment orientations along the anxiety and avoidance dimensions.

Findings from the first study indicated that subliminal priming with security representations (as compared to neutral priming) reduced distress and urge to act in response to OCD-related washing scenarios. However, this effect was mainly significant for participants who scored relatively high on attachment anxiety or avoidance. In other words, security priming weakened the link between attachment insecurities and OCD-related washing tendencies. This effect remained significant even after controlling for depression, general anxiety, and stress symptoms. Findings from the second study, however, revealed that supraliminal priming of
attachment security was not significantly associated with participants’ responses to the OCD-related scenarios and did not change the responses of insecure participants. Thus, it seems that only the bypassing of deliberate, controlled processes, as happened with the subliminal priming of attachment security, can counteract the cascade of mental processes related to OCD symptoms.

*Moral Sensitivity and OCD*

Morality is one of the sensitive self-domains most frequently involved in the development and maintenance of OCD. The idea that moral preoccupation is related to OCD has been a part of the psychiatric literature since the beginning of the 20th century. For example, Freud (1909/1987) suggested that persistent unwanted aggressive, horrific, or sexual thoughts accompanied by ritualistic behaviors are the result of unsuccessful defense mechanisms (characteristic of the anal-sadistic psychosexual developmental stage) against potential violations of moral standards. Individuals with OCD tend to suffer from unconscious conflicts between unacceptable, immoral sexual or aggressive impulses and the demands of the superego (moral conscience). They attempt to resolve this conflict by relying on undoing (i.e., defensively neutralizing unacceptable ideas by compulsive acts) and reaction formation (i.e., unconsciously developing attitudes and behaviors opposite to the unacceptable repressed impulses).

More recently, cognitive theories of OCD have also implicated morality concerns in the maintenance of OCD. For instance, Rachman and Hodgson (1980) argued that individuals with OCD are of “tender conscience,” and Salkovskis, Shafran, Rachman, and Freeston (1999) suggested that individuals suffering from OCD exhibit “dedication to work and an acute sense of social obligation” (p. 1060). Salkovskis (1985, 1999) argued that an over-inflated sense of personal responsibility, defined as the tendency to believe that one may be pivotally responsible
for causing or failing to prevent harm to oneself or others, is one of the core beliefs leading to the transformation of common intrusive thoughts into obsessions. Beliefs about the importance of thoughts have also been suggested to have an important moral element, such as the belief that having a negative thought is as bad as performing a negative act (moral thought-action fusion; Shafran, Thordarson, & Rachman, 1996).

Research has provided evidence of the association between OCD and sensitivity in the morality self-domain (e.g., Doron et al., 2008). For example, Ferrier and Brewin (2005) reported that, compared to individuals with clinical anxiety disorders as well as normal controls, individuals with OCD were more likely to draw negative moral inferences about themselves from their intrusive thoughts (e.g., perception of self as dangerous by virtue of being bad, immoral, or insane). However, Franklin, McNally, and Riemann (2009) failed to find an association between moral reasoning and OCD. Specifically, OCD patients and controls responded to a series of hypothetical moral dilemmas requiring them to choose one of two undesirable courses of action, both involving loss of life. No group difference was found in the choice of options and latencies to resolve the moral dilemmas. Hence, it is possible that the relationship between OCD symptoms and morality is not extended to moral reasoning but is limited to the emotional and self-relevant aspects of moral concerns. In an unpublished study, Ahern (2006) examined associations between OCD symptom severity, self-ambivalence, and the extent to which self-worth was contingent on morality in a non-clinical student cohort. Morality-contingent self-worth was positively related to OCD symptoms only when self-ambivalence, a marker of attachment insecurities, was high. Interestingly, contingent moral self-worth was negatively related to the severity of OCD symptoms when self-ambivalence was low. It is possible that when individuals are certain about themselves (e.g., when they have an explanation
for their thought intrusions), they may be less sensitive to judgments about being immoral and, thus, less prone to OCD symptoms.

In a laboratory experiment, we (Doron & Sar-El, 2010) recently examined whether challenging self-perceptions of morality would lead to an increase in obsessive-like symptoms (checking, perfectionist behavior). Forty-five Israeli university students were invited to participate in a study examining the link between personality factors and performance on a computer graphics task. Before coming to the laboratory, all participants completed measures of OCD symptom severity (OCI-R; Foa et al., 2002), depression, anxiety and stress (DASS; Lovibond & Lovibond, 1995) and 10 items tapping contingency of self-worth in the domains of morality and sports. Upon arrival at the laboratory, participants were randomly assigned to one of three conditions (morality, sports, neutral). In all conditions, participants were asked to re-position 6 objects (5 textboxes and an arrow) such that their location and properties (i.e., thickness, width, and length) would be identical to a graph presented on the top half of the screen (see Figure 2). That is, the objects on the bottom half of the screen were identical to the objects on the top half of the screen, but they had different properties and were all positioned at the bottom-left of the graph.

In the morality and sports conditions, the top graph consisted of a normal curve indicating a below average score (also marked as the 17th percentile) and 3 colored textboxes with the words “low level,” “high level,” and “You are here.” These textboxes were positioned such that the participant’s low score was emphasized (see Figure 2). In the morality condition, the words “morality level” below the graph suggested that the graph described the participant’s morality level. In a textbox on the right side of the graph, a comment indicated that “This graph shows your morality level.” In the sports conditions, the word “morality” was replaced with the
word “sports.” In the neutral condition, all textboxes included a combination of Xs and Ys. The main dependent variable was the time taken by participants to complete the task, which was interpreted as an indicator of perfectionistic checking behavior.

Participants in the morality condition took significantly longer to complete the task than the other two groups (sports and neutral). This difference was still significant after controlling for depression, stress, and self-reported computer-performance skills. Moreover, the time taken to complete the task in the morality condition was significantly and positively associated with both the severity of OCD symptoms reported before the laboratory session and the extent to which self-worth was contingent on the morality domain. These initial findings imply that an experience challenging one’s self-perception as a moral person (“You have a low level of morality according to the graph”) led to more perfectionistic checking behavior mainly among participants who overvalued the moral self-domain and tended to suffer from OCD symptom.

In a second study, we (Doron & Sar-El, 2010) examined the hypothesized role of attachment insecurities in moderating the link between sensitivity of the morality self-domain and OCD symptoms. A community sample of 68 participants completed self-report measures of attachment anxiety and avoidance, OCD symptoms, depression, stress, and anxiety, and reported on the frequency of morality-related daily hassles (e.g., ignoring a request for aid, violating a promise, acting in contradiction to one’s own moral values). As expected, there was a positive association between morally challenging events and OCD symptoms. However, this association was significant only when participants scored relatively high on attachment anxiety or avoidance, but not when the levels of attachment insecurities were low. These associations were significant even after controlling for depression, anxiety, and stress symptoms. The findings therefore strengthen our confidence concerning the protective shield provided by attachment
security against the adverse effects of challenges in the morality self-domain on possible OCD.

**Concluding Remarks**

According to our model, some individuals perceive themselves as incompetent in domains that they view as extremely important for self-worth (i.e., sensitive self-domains), one of which may be the domain of morality. Experiences challenging such self-domains (e.g., failure to provide help to someone) may lead to an increase in unwanted mental intrusions by negative self-cognitions (e.g., “I’m bad,” “I’m immoral”) and lead to the development of obsessions. Attachment insecurities can exacerbate this cascade of unpleasant mental events by impairing adaptive coping. Conversely, attachment security may protect a person against the adverse effects of these experiences.

In this chapter, we reviewed both correlational and experimental findings that support the hypothesized roles of morality concerns and attachment insecurities in OCD. Taken together, the reviewed findings expand our understanding of the ways in which morality and attachment orientations are involved in the development and maintenance of OCD. Intrusions are more likely to activate dysfunctional beliefs and trigger OCD symptoms in insecurely attached individuals who are sensitive in the self-domain of morality.

Although consistent with our theoretical model, this new body of research has several limitations. First, most of it has been conducted with non-clinical samples. Although non-clinical individuals experience OCD-related beliefs and symptoms, they may differ from clinical patients in the type and severity of symptoms and the resulting degree of impairment. Future research on the links between morality, attachment insecurities, and OCD symptoms should include clinical samples. Examining different clinical groups would facilitate the identification of specific factors associated with particular kinds of OCD symptoms. Second, the associations between sensitive
self-domains and OCD have been found in cross-sectional correlational studies that do not allow conclusions about causal directions. Laboratory studies, conducted with clinical and non-clinical samples, should examine further whether dispositional attachment insecurities intensify the adverse effects of experimental inductions related to the moral domain. Such studies should also examine the extent to which experimentally induced security representations (security priming) buffer the adverse effects of dispositional attachment insecurities and morality-related experiences on OCD-related behavioral tendencies.

Despite these limitations, and pending further replication of the reviewed findings, particularly with clinical samples, our findings may have important implications for the cognitive understanding and treatment of OCD. We believe that OCD-related assessments and interventions focused on the morality self-domain and on attachment insecurities can improve outcomes (Doron & Moulding, in press). When dealing with individuals suffering from OCD, therapists should consider expanding their conceptualization of OCD to include the evaluation of a patient’s sensitivity in the morality self-domain and his or her attachment working models (Doron & Moulding, in press). Patients may, for example, have a rigid and limited perception of morality (e.g., believing they should be free of sexual urges before marriage), such that any urge or thought that challenges their moral standards leads to self-criticism, morbid rumination, and compulsions. When a client has this kind of limiting self-view, special emphasis should be placed on expanding his or her self-concept and conception of morality. This could be done by identifying and bolstering other self-domains, increasing the client’s skills in other domains, or challenging the rigidity and boundaries of the moral domain (e.g., “What does being moral mean to you?”; “What other behaviors/beliefs/attitudes could be included in this domain?”). The contingency of self-worth in the morality domain could be explicitly explored, such that the
client understands the relation between anxiety and perceptions of failure in that self-domain. This would help the clinician with case formulation, particularly understanding why specific mental intrusions lead to heightened emotional reactions or avoidance behavior.

In a similar way, “attachment-based CBT” (Doron & Moulding, in press) addresses issues regarding trust and heightened fear of abandonment, and explores attachment-related internal models within the therapeutic context. It is common for OCD symptoms to be associated with strong attachment-related fears (e.g., horrific images of a partner having an accident followed by repeated checking, for example by making repeated phone calls). In such cases, fear of abandonment can be addressed by challenging dysfunctional perceptions, exploring the relation between relationship fears and OCD, and devising behavioral experiments aimed at increasing tolerance for ordinary separations. This may reduce a client’s tendency to interpret relationship experiences, including the therapeutic relationship, in frightening terms, improve therapeutic efficacy, and possibly reduce drop-out and relapse rates compared to those for traditional cognitive behavioral therapy.
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Figure 1. Proposed diathesis-stress model of OCD symptoms.

- Dispositional attachment insecurities
- Experiences challenging sensitive self-domains
- Heightened awareness of intrusions
  - Negative appraisals/beliefs
  - Devaluation of self
- Dysfunctional responses (e.g., thought suppression, urge to neutralize, compulsions)
Figure 2. Manipulation of self-sensitivity in the morality domain.