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The relationship between obsessions and the self: Feared and actual self-descriptions in a clinical obsessive–compulsive disorder sample

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Abstract

Cognitive models of obsessive–compulsive disorder (OCD) posit the relevance of the self in OCD, although the nature of this association is still unclear. We aimed to explore actual and feared selves and its association with obsessions and intrusions in a group of OCD patients. A group of 58 patients with OCD identified their most upsetting obsession and intrusion (non-clinical obsession) experienced in the past 3 months. These cognitions were classified as either moral-based or autogenous (obsessions $n = 32$; intrusions $n = 26$) or non-moral-based or reactive, depending on their content. Next, patients described their actual self and their feared self, that is, the person they feared being or becoming, and whether they believed these descriptions were associated with their obsessions/intrusions. Results indicate that individuals with OCD described themselves as insecure, anxious and fearful, but also as good and nice. They particularly feared a selfish, aggressive, bad, liar, coward, insecure and arrogant self. Two-thirds of the patients believed that their obsessions said something about their actual self (65.52%) and that their obsessions brought them closer to the person they do not want to be (62.06%). A third of patients believed their intrusions said something about their actual self (actual self: 30.35%; feared self: 25%), which was a significantly lower percentage than for obsessions. These associations existed independent from the content of the obsession and/or intrusion, although patients with obsessions with moral-based contents more often tended to believe that their obsessions brought them closer to the person they do not want to be. Results suggest the relevance of the real and feared selves in the maintenance of obsessions.

KEYWORDS
actual self, feared self, intrusions, obsessions, obsessive–compulsive disorder

1 | INTRODUCTION

Cognitive models of obsessive–compulsive disorder (OCD) propose that the dysfunctional appraisal or misinterpretation of a non-clinical intrusive thought facilitates its conversion into an obsession (e.g., Rachman, 1997; Salkovskis, 1985). Moreover, some authors have suggested that this conversion is also influenced by the personal significance or meaning of the intrusion's content (Purdon & Clark, 1999; Rachman, 1998; Salkovskis, 1985). The reference to 'personal significance' acknowledges that the self-view is a key element in the way intrusive thoughts are evaluated. Thus, OCD individuals may be more likely to appraise intrusions that are contrary to or threaten their self-view as meaningful (García-Soriano et al., 2012). In this regard, Rachman and de Silva (1978) reported that most patients with OCD (six out of eight participants) felt that the content of their main obsession was alien to or quite unlike their normal self. Regarding the other two patients, one thought his obsession was consistent with his nature, that is, prone to worrying and being anxious about everything, and the other patient thought her obsession was not entirely alien to her.

Obsessions have frequently been described as ego-dystonic, that is, '… having little or no context within one's own sense of self or personality' (Purdon et al., 2007, p. 200). In this regard, OCD patients have been found to rate their most upsetting obsession as contradicting important aspects of the self to a greater degree than their least upsetting obsession (Rowa et al., 2005). Some authors have proposed that intrusive thoughts that become obsessions are related to self-evaluative domains where the person perceives a failure to maintain standards (e.g., avoiding aggression, being orderly and clean) (García-Soriano et al., 2012; García-Soriano & Belloch, 2012), or that obsessions are more likely to arise in self-domains where the individual feels incompetent (Doron & Kyrios, 2005). Other authors have proposed that individuals with OCD misinterpret intrusions that contradict valued aspects of their self-concept because they are highly ambivalent about their personal characteristics. In this vein, Bhar and Kyrios (2007), extending the proposal of Guidano and Liotti (1983), reported that OCD patients show high self-ambivalence or ambivalence about their own self-worth and moral qualities. Finally, it has also been reported that patients with OCD show overall lower self-esteem than a non-clinical comparison group (Ehntholt et al., 1999). Likewise, OCD patients have shown a low self-image reflected by lower self-esteem, compared to undergraduate students, and less entitlement (tendency to believe that they deserve special consideration or that they are better than other people), compared to undergraduate students and psychiatric outpatients, measured with a self-report assessing personality trait dimensions (Wu et al., 2006).

According to Rachman (1997), intrusive contents, especially those related to moral systems, such as aggression, sex and blasphemy, are often interpreted by patients 'as revealing important but usually hidden elements in their character' (p. 794)—an observation that is strongly reminiscent of the notion of a feared possible self, stemming from the social literature (Carver et al., 1999; Markus & Nurius, 1986). The feared possible self is defined as '… a set of qualities that the person fears or worries might be part of oneself or might become part of oneself at some point in the future' (Aardema & Wong, 2020, p. 2). This fear of who one might be or become has subsequently been proposed as a characteristic of obsessional narratives creating confusion between the person's feared and actual self (Aardema & O'Connor, 2003, 2007), and it has led to initial empirical investigations of the role of the feared and actual selves in OCD (Ferrier & Brewin, 2005; Sauvageau et al., 2020). Ferrier and Brewin (2005) performed a content analysis of feared self-descriptions in a sample of OCD patients, anxious patients and non-clinical participants. The feared self-descriptions were organized into four general themes: 'flawed' ('involving traits that are perceived as undesirable but not inherently dangerous to the self or others (e.g., selfish, proud)'); 'depressed/anxious' ('reflecting symptom-related self-perceptions (e.g., fearful or hopeless traits)'); 'rejected' ('involving self-perceptions of being lonely or unlovable'); and 'dangerous' ('involving the possibility of harm coming to others or being out-of-control') (p. 1368). Results suggested that participants more frequently endorsed adjectives related to a flawed self than any other category. Moreover, comparisons of the three groups of participants showed that people with OCD more frequently reported a feared self that is dangerous to themselves or others (being bad, dangerous, immoral or insane), validating the notion that people with OCD are more likely to draw these types of negative inferences about themselves, as initially proposed by Rachman (1997), whereas feared-self perceptions in other samples were more related to general feared flaws and self-related qualities.

More recently, Aardema and Wong (2020) proposed that the unsuccessful resolution of one's identity during some critical life periods (e.g., parenthood) results in a vulnerable self-identity, which, combined with erroneous inferential reasoning (i.e., mistrust of one's own senses, relying more on the imagination than on reality), leads to believing more in a feared self, that is, *the sort of person I am afraid of becoming* (e.g., I could become a dangerous person, I could become an ill person and I could become immoral) than in the actual self, that is, *the sort of person I am*. Hence, according to these authors, a clinical

KEY PRACTITIONER MESSAGE

- Individuals with OCD describe themselves as insecure, anxious and fearful, but also as good and nice.
- Individuals with OCD fear being selfish, aggressive, bad, liar, cowardly, insecure and arrogant.
- Most OCD patients believe their obsessions (especially aggressive, sexual, religious and immoral obsessions) bring them closer to the person they do not want to be.
- Most individuals with OCD believe their obsessions say something about their actual and feared selves.
- Individuals with OCD more frequently fear a 'dangerous/immoral' or 'corrupted' self as compared to other feared-self themes.

population would prioritize their feared self over their real self, which influences the development of obsessions prior to the occurrence of dysfunctional appraisals, making the misinterpretation of obsessions more likely to occur because they are believed to reflect the reality of the feared self that led to the obsession to begin with (Aardema & O'Connor, 2003, 2007).

The association between the construct of the feared self and OCD was further developed by Aardema et al. (2013) in the development of the Fear of Self questionnaire (FSQ). Results based on the FSQ showed that the fear of self in OCD patients predicts obsessions, even when controlling negative mood states, related self-themes and obsessive belief domains (Melli et al., 2016), and they confirm that fear of self is especially related to blasphemous, sexual and aggressive obsessions (Aardema et al., 2013; Aardema et al., 2017; Llorens-Aguilar et al., 2019; Melli et al., 2016). Recently, Aardema et al. (2021) presented a new self-report questionnaire that assesses three separate feared-self dimensions: a corrupted self, a culpable self and a malformed self (Aardema et al., 2021). Results showed significant associations with OCD symptoms in clinical and non-clinical samples, with the corrupted feared self uniquely predicting obsessions, and the culpable feared self uniquely predicting indecisiveness, in a clinical OCD sample.

In sum, theoretical and empirical proposals have emphasized the relevance of the actual (real) and/or possible feared self, either in the conversion of intrusions into obsessions through appraisal (e.g., Rachman, 1997) or in the emergence of obsessions even before appraisal has occurred (e.g., Aardema & O'Connor, 2007; Aardema & Wong, 2020). Moreover, some authors have proposed that these feared-self perceptions are related to specific obsessional contents, particularly those reflecting moral sensitivity or a preoccupation with maintaining 'purity', in line with more recent notions of a 'feared corrupted self' (Aardema & O'Connor, 2003; Aardema et al., 2021). However, no studies have analysed how OCD patients idiosyncratically describe themselves and whether this self-description is differentially related to obsessions and non-clinical intrusions. Only two studies explore the fear of self in a sample of 24 OCD patients (Ferrier & Brewin, 2005) and 16 patients (Sauvageau et al., 2020), but without analysing its association with obsessions or intrusions. According to different theoretical proposals, the relevance of the self is expected to be linked to obsessions, but not to non-clinical intrusions. Because OCD patients experience both obsessions and intrusions, the relevance of the self should be found in association with obsessions. Previous research focused on the self has analysed obsessions in OCD samples (e.g., García-Soriano & Belloch, 2012; Rowa et al., 2005) and/or non-clinical intrusions in non-clinical samples (e.g., García-Soriano et al., 2012). However, no studies have investigated non-clinical intrusions experienced by OCD patients as a control. Hence, the current study asked patients with OCD to describe in their own words the person they feared being or becoming (the feared possible self) and how they actually perceived themselves (actual self), and it explored how these self-descriptions were associated with the occurrence of both intrusions and obsessions. In doing so, we aimed to compare clinically relevant obsessions with non-clinical intrusive thoughts in a sample of OCD patients. Thus, these non-clinical intrusive thoughts (called intrusions) serve as a comparison control for obsessions. Other studies have used a similar procedure when comparing the most upsetting obsessions with the least upsetting obsessions (i.e., Rowa et al., 2005). Specifically, the present study aimed to the following: (1) explore and describe the actual self of OCD patients, (2) explore and describe the feared self of OCD patients, (3) explore and compare patients' perceived relationship between their actual self and the content of their most upsetting obsession and intrusive thought that has not become an obsession and (4) analyse and compare the perceived relationship between the fear of self and the content of the most upsetting obsession and intrusive thought that has not become an obsession. Based on the literature and previous findings, we hypothesized that patients with OCD would (1) describe their actual self in terms of a general negative actual self, given that previous research has shown low self-reported self-esteem in OCD patients (Ehntholt et al., 1999; Wu et al., 2006) and (2) describe their feared self as being flawed and dangerous, as previously shown in Ferrier and Brewin's (2005) study. Furthermore, because intrusions and obsessions have been proposed to exist on a continuum, we hypothesize that patients' intrusions that did not become obsessions are less likely to be perceived as reflecting self-ascribed qualities, compared to obsessions. In this regard, it is possible that these intrusions that finally become obsessions have contents that are more relevant to the individual's self. Specifically, we hypothesize that patients with OCD (3) perceive their obsessions (vs. intrusive thoughts that have not become obsessions) as significant or as reflecting their actual self, as suggested by Rachman (1997) and (4) perceive that the content of their obsessions (vs. intrusive thoughts that have not become obsessions) brings them closer to the self they fear being or becoming. We also expect that these perceived explicit relationships will be more relevant for aggressive, sexual, religious and immoral obsessions than for other obsessional contents, as previously suggested (e.g., Aardema & O'Connor, 2003; Rachman, 1997).

2 | METHOD

2.1 | Participants

The sample consisted of 58 patients with a primary Axis I DSM-IV OCD diagnosis. The mean age was 35.07 ($SD = 10.05$) years, and there was a nearly equal gender representation (48.3% women). The majority of the participants were middle-class (70.2%), following the parameters of the Spanish National Institute of Statistics, and had university education (80%). Seventeen patients (29.31%) had a secondary Axis I (DSM-IV) comorbid disorder: major depression (four patients), panic disorder (two patients), generalized anxiety disorder (four patients), social phobia (three patients), specific phobia (one patient) and hypochondriasis (three patients). Patients showed moderate levels of anxiety and depression, according to the Depression Anxiety Stress Scale – Short version (DASS-21;

Lovibond & Lovibond, 1995; score range: 0–21) [*M* (*SD*): depression = 16.50 (7.47); anxiety = 14.05 (5.91)].

2.2 | Measures

Obsessional Intrusive Thoughts Inventory (Spanish original version: 'Inventario de Pensamientos Intrusos Obsesivos', INPIOS; García-Soriano, 2008)—*1st part* consists of 48 items that measure the frequency of unwanted intrusive thoughts, images and impulses with content similar to clinical obsessions, experienced in the past 3 months. Items are grouped in six first-order factors depending on the intrusion's content: aggressive, sexual/religious/immoral, contamination, doubts/mistakes/necessity to check, symmetry/order and superstition intrusions. These factors are nested in a second-order structure composed of two dimensions: (1) type I moral-based intrusions/obsessions, which include aggressive, sexual, religious and immoral themes; and (2) type II non moral-based intrusions/obsessions, which include contents that do not refer to moral issues (i.e., contamination; doubts, mistakes and necessity to check; symmetry/order; and superstition) (García-Soriano et al., 2011). The two subtypes closely resemble the differentiation between autogenous and reactive obsessions proposed by Lee and Kwon (2003). Respondents rate each statement from 0 ('I have never had this intrusion') to 6 ('I have this intrusion frequently during the day'). In this study, patients completed the INPIOS—1st part as a self-report. These data were used by the interviewer to help patients choose their main obsession/intrusion for the interview described below.

Semi-structured interview of obsessions and intrusive thoughts in OCD (Llorens-Aguilar, 2020) is a semi-structured interview designed to explore obsessions and intrusions in the same OCD patient. During the interview, the same questions are asked about the main (most upsetting) obsession or intrusion in a counterbalanced order. After a description of what an intrusive thought is, patients are asked to describe their most upsetting intrusion that constitutes an obsession and then an upsetting intrusion that has never become an obsession, from those experienced in the past 3 months. Following the description offered in the INPIOS, the interviewer reminds them about what an intrusive thought is in the following terms: 'Mental intrusions are upsetting or unpleasant thoughts, feelings, images, or impulses that most people experience from time to time. These thoughts are called "intrusions" because they suddenly intrude into our minds against our will and interrupt what we are doing or what we are already thinking. It is often difficult to control these unwanted intrusive thoughts. No matter how hard we try, it can be difficult to get them out of our mind or stop them from re-appearing. Unwanted intrusive thoughts are usually uncomfortable, unpleasant, and sometimes unacceptable, because they refer to things we do not like to think about, or they simply seem quite strange or bizarre. These unwanted intrusive thoughts occur in one of the following forms: as images, that is, as pictures that suddenly appear in our heads; as a strong urge to do or say something; as a thought about something or a feeling. We are not talking about worries, but rather about "intrusive thoughts, images, sensations, or impulses" that suddenly appear in our minds as a kind of brief and annoying "flash". An example would be the typical summer song that gets into your head, and even if you do not like it, you cannot stop singing it mentally or humming it.' Then, the interviewer asks the patient: 'We are interested in knowing if you have also experienced mental intrusions, and how often. Some examples are the ones you mentioned in the questionnaire called INPIOS. Do you understand what an intrusion is? Do you have any questions? Based on the description of an intrusion I read to you earlier, do you think you have had an intrusion in the past three months or that you are having one at this moment?' If the patient says 'yes', the interviewer asks: 'Can you describe your most upsetting intrusion?' Here, the interviewed patient is expected to describe an actual obsession. If this is the case, the interviewer posits: 'This intrusion has become very frequent and upsetting; we usually call them obsessions. Now, I would like you to describe an intrusion that you have had in the past three months but that has never become an obsession (interviewer can use the INPIOs—1st part list to help the patient)'. Patients' open answers are checked against their INPIOS—1st part answers and the clinical interview to ensure that they chose an actual upsetting obsession and an intrusion that has never been clinically significant (i.e., the intrusions selected have never been obsessions in the past) but would be a proxy for an obsessional intrusive thought. If this is not the case, the interviewer discusses the incongruence with the patient to ensure that he/she chooses an actual obsession and an actual intrusion that has never been an obsession. Then, the main obsession and the main intrusion that has never become an obsession were explored (e.g., discomfort or frequency). That is, we followed the same methodology used in other studies that analyse the role of obsessional intrusive thoughts in clinical (e.g., Llorens-Aguilar et al., 2021) and non-clinical (e.g., García-Soriano et al., 2011; Radomsky et al., 2014) samples. In this study, the semi-structured interview was only used to identify patients' most upsetting obsession and intrusion.

Self-description questionnaire (Llorens-Aguilar, 2020) is an idiographic self-report based on previous self-discrepancy measures (Carver et al., 1999; Ferrier & Brewin, 2005; Francis et al., 2006; Higgins et al., 1986; Kinderman & Bentall, 1996). It asks participants to generate five attributes they would use to describe the person they actually are (actual self: *describe in five words how you see yourself*), would ideally like to be (ideal-self: *describe in five words how you would like to be*), should be or ought to be (ought-self to be: *describe in five words how you should be*), fear being or worry about becoming (feared self: *describe in five words the sort of person you would be afraid to become*), and believe other people would use to describe them (actual self according to others: *describe in five words how you think others see you*). Next, they are asked to answer some questions about their obsession and their intrusion that has never become an obsession, previously identified and transcribed using their own words. Regarding the actual self, the question asked is: *Taking into account how you define yourself, do you think this thought* (patient's obsession/intrusion is written here) *says something about how you are?* (Answer options: yes, no, I do not know/not sure). Regarding the feared self, the question is asked: *Taking into account the sort of person you would be afraid*

to become, do you think this thought (patient's obsession/intrusion is written here) *brings you closer to that sort of person?* (Answer options: yes, no, I do not know). For both the actual and feared self, if the participant answers 'yes', they are asked to explain in what way. In this study, we will focus on the questions about the actual and feared self and their relationship with the obsessive and intrusive contents.

2.3 | Procedure

The present study received the approval of the Ethical Committee of the University (H1458129873255). Participants were recruited from private clinical practice, announcements in blogs, and an OCD patients' association. The evaluation process was divided into three sessions. In the first session, participants received information about the purpose of the research and signed the written consent form. Next, participants were individually screened by the first author to determine their eligibility for participation using the ADIS-IV-L diagnostic interview (Di Nardo et al., 1994). In the second session, participants completed a set of questionnaires at home (e.g., INPIOS and DASS-21). In the third session, participants were interviewed using the *Semi-structured interview of obsessions and intrusive thoughts in OCD* (average time 60–90 min). Next, they were asked to complete the *Self-description questionnaire*, which included the identified intrusion/obsession, at home.

2.4 | Data analysis

Statistical analyses were conducted using the Statistics Package for Social Sciences (SPSS for Windows, 22.0, 2013). Variables were compared using Student's t test for quantitative variables and the χ^2 or Fisher's test for qualitative variables. Effect sizes (Cohen's d and Cramer's V) were also calculated. Following Cohen (1988), $d = 0.2$ was considered a small effect size, 0.5 a medium effect size, and 0.8 a large effect size. Cramer's V values bigger than 0.25 indicate a very strong relationship (Akoglu, 2018).

The adjectives used by patients to describe their actual and feared selves on the *Self-description questionnaire* (Llorens-Aguilar, 2020) were compiled by one of the authors using the synonyms from the Office Word Thesaurus to group adjectives with the same meaning. Only adjectives reported by participants three or more times were taken into account in the analyses because they were considered more representative of the sample.

Then, due to the categorical characteristics of the data, two PhD level psychologists with a strong background in cognitive-behavioural models of OCD independently classified the information extracted from the interview on two variables of interest for both the obsessions and intrusions reported by the patients, namely, (1) feared self-theme and (2) type of intrusion/obsession (i.e., autogenous/moral-based vs. reactive/non-moral-based). Neither of the raters was aware of the study hypotheses or had evaluated the patients. Interrater reliability was measured using the kappa statistic. Based on Cohen (1988), data were interpreted in the following way: values ≤ 0 indicate no agreement, 0.01–0.20 none to slight, 0.21–0.40 fair, 0.41–0.60 moderate, 0.61–0.80 substantial and 0.81–1.00 almost perfect agreement. In both cases, agreement was reached after discussion between the raters.

Regarding the feared-self theme, the raters grouped the adjectives used in four different themes following the same description used by the raters in Ferrier and Brewin's (2005) study. Adjectives were categorized as a 'dangerousness/moralistic theme' if they involved the possibility of harm coming to others, being out-of-control, or revealing important and often hidden elements of the character (e.g., traits such as unkind which have an element of active intent); as a 'depressive/anxiety theme' if the adjectives reflected 'symptom-related self-perceptions (e.g., fearful or hopeless traits)'; as a 'rejection theme' if the adjectives involved 'self-perceptions of being lonely or unlovable'; and as a 'flawed/negative personality theme' if the adjectives involved traits perceived as undesirable but not concerned with violating moral codes (e.g., selfish and proud). Almost perfect interrater agreement was found in the categorization of the feared-self adjectives in the four categories (0.82).

Likewise, obsessions and intrusions were classified, based on the type of intrusion or obsession, as either autogenous or reactive (García-Soriano et al., 2011; Lee & Kwon, 2003). Obsessions/intrusions were classified as autogenous if they were about aggressive, sexual, blasphemous, or immoral thoughts, images, or impulses. Obsessions/intrusions about doubts about mistakes and necessity to check, symmetry/order, contamination or superstitious/magical thinking contents were classified as reactive. Agreement between raters was at the moderate to substantial threshold in the categorization of obsessions and intrusions as autogenous and reactive (obsessions = 0.62; intrusions = 0.78).

3 | RESULTS

3.1 | Preliminary analysis

All the patients ($n = 58$) reported having experienced an upsetting obsession, and 56 identified an upsetting intrusion in the past 3 months. Results showed that patients experienced obsessions [$M = 5.41$ ($SD = 0.817$)] with a higher frequency than intrusions [$M = 2.82$ [$SD = 1.130$)] (t_{55}) = 14.291; $p < .001$, $d = 1.554$). Regarding the type of obsession, approximately half of the obsessions and intrusions were categorized as autogenous [55.2% ($n = 32$) obsessions & 48.3% ($n = 26$) intrusions] and half as reactive [44.8% ($n = 26$) obsessions & 51.7% ($n = 30$) intrusions]. Fisher's exact test revealed that there were no significant differences between the two types of obsessions and intrusions, $p = .375$.

Regarding the number of adjectives reported, most of the patients (65.51%, $n = 38$) described their actual and feared self (*Self-description questionnaire*) using five adjectives, although eight patients gave a description of their actual self that contained between 2 and 4 adjectives (i.e., 2 adjectives, $n = 2$; 4 adjectives, $n = 6$), and

12 patients gave a description of their feared self that contained between 1 and 4 adjectives (i.e., 1 adjective, $n = 1$; 2 adjectives, $n = 2$; 3 adjectives, $n = 4$; 4 adjectives, $n = 5$). Of the reported adjectives, analyses were conducted only for self-descriptions that were reported three times or more, yielding a total of 154 adjectives to describe the actual self and 156 adjectives to describe the feared self.

TABLE 1 Adjectives used by the obsessive–compulsive disorder (OCD) patients ($n = 58$) to describe their actual and feared self

Adjectives	% (*n*) of patients used this adjective to describe their actual/feared self
Actual self	
Caring/warm/attentive/tender/nice/well educated/good person/sociable	53.44% (31)
Insecure/weak/volatile/fragile	46.55% (27)
Anxious/impatient/worried	46.55% (27)
Fearful	22.41% (13)
Honest/loyal/fair	13.79% (8)
Obsessive	13.79% (8)
Empathetic	13.79% (8)
Hard-worker	13.79% (8)
Joyful/dreamer/happy	12.07% (7)
Doubtful/indecisive	8.62% (5)
Perfectionist	5.17% (3)
Sincere	5.17% (3)
Intelligent	5.17% (3)
Sad/depressed	5.17% (3)
Feared self	
Selfish/materialist	37.93% (22)
Heartless/cruel/violent/aggressive	29.31% (17)
A liar	24.14% (14)
Fearful/coward/afraid	20.69% (12)
A bad person	20.69% (12)
Insecure	17.24% (10)
Proud/arrogant	17.24% (10)
Depressed/sad/pessimistic	15.52% (9)
Nervous/anxious	12.07% (7)
Lazy	10.34% (6)
Disloyal/unfaithful	10.34% (6)
Insensitive/indifferent/cold	8.62% (5)
Self-centred	8.62% (5)
Repugnant/despicable/disgusting	8.62% (5)
Crazy/out of control/irrational	8.62% (5)
Manipulative	6.90% (4)
Introverted	6.90% (4)
Not empathetic	5.17% (3)

Note: Data offered as percentage (*n*).

3.2 | Actual and feared self descriptions

The adjectives used by patients to describe their actual and feared selves are reported in Table 1.

When the adjectives reported by OCD patients to describe their feared selves were assigned to the four categories proposed by Ferrier and Brewin (2005), results showed that patients more frequently feared having a dangerous/immoral feared self ($n = 63$), followed by a flawed self or negative personality ($n = 50$), a depressed/anxious feared self ($n = 38$) self and a rejected feared self ($n = 5$). See a more detailed description in Table 2.

3.3 | Descriptions of the actual self and its association with the most upsetting obsession and intrusion

Most of the patients (65.52%, $n = 38$) found an association between their obsession and their actual self (i.e., perceived the obsession as saying something about who they are). Results are summarized in Table 3. Of the 38 patients who believed their obsessions were associated with their actual self, 20 had obsessions with autogenous content, and 18 had obsessions with reactive content, and so no significant differences were found based on the type of content [χ^2 $(1, N = 38) = 0.105$, $p = .746$].

For intrusions, only one-third of the patients (30.35%, $n = 17$) associated the content of the intrusion with their actual self. Of these 17 patients, seven patients reported an autogenous intrusive thought, whereas 10 reported reactive thoughts, and no significant differences were found based on the intrusive content [χ^2 $(1, N = 17) = 0.529$, $p = .467$]. Overall, more patients (65.52%) reported that their obsession (vs. intrusion, 30.35%) was associated with (i.e., said something about) their actual self [χ^2 $(4, N = 56) = 13.077$, $p = .011$, Cramer's $V = 0.342$].

3.4 | Feared self and its association with the most upsetting obsession and intrusion

Most patients (62.06%, $n = 36$) believed that the content of their most upsetting obsession brought them closer to their feared self (i.e., perceived that the obsession brought them closer to the sort of person they would be afraid to become) (Table 3). Some patients ($n = 9$) described an association directly related to their reported adjectives (e.g., 'yes, it means that I am a bad person' or 'yes, it means that that I am aggressive'), whereas other patients used different adjectives (not previously reported by them), or they described general or abstract answers, such as 'yes, I become closer to the kind of person I would not like to be' or 'yes, it is contrary to my values'.

TABLE 2 Adjectives used by the obsessive–compulsive disorder (OCD) patients ($n = 58$) to describe their feared self, grouped according to Ferrier and Brewin's (2005) proposal

Flawed/negative personality theme ($n = 50$)	Dangerousness/moralistic theme ($n = 63$)	Depressive/anxiety theme ($n = 38$)	Rejection theme ($n = 5$)
Proud/arrogant (10)	Heartless/cruel/violent/aggressive (17)	Insecure (10)	Repugnant/despicable/ disgusting (5)
Lazy (6)	Liar (14)	Nervous/anxious (7)	
Self-centred (5)	Crazy/out of control/irrational (5)	Depressed/sad/pessimistic (9)	
Introvert (4)	Manipulative (4)	Fearful/coward (12)	
Not empathetic (3)	Bad person (12)		
Selfish/materialist (22)	Disloyal/unfaithful (6)		
	Insensitive/indifferent/cold (5)		

Note: Adjectives (number of patients reporting the adjective).

TABLE 3 Patients' reported associations between their intrusion/obsession and their description of their actual and feared selves

	Obsession ($n = 58$)			Intrusion ($n = 56$)		
The thought says something about my …	Yes	No	Not sure/not know	Yes	No	Not sure/not know
Actual self	65.52% (38)	25.86% (15)	8.62% (5)	30.35% (17)	44.64% (25)	25% (14)
Feared self	62.06% (36)	27.59% (16)	10.34% (6)	25% (14)	50% (28)	25% (14)

Note: Data offered as percentage (*n*).

Of the 36 patients who believed their obsession brought them closer to their feared self, most had autogenous content (61.11%, $n = 22$), although no significant differences were found with the number of reactive obsessions [χ^2 (1, $N = 36$) = 1.778, $p = .182$]. Of the 16 patients who did not think the obsession brought them closer to their feared self, most of them (78.57%, $n = 11$) experienced a reactive obsession (autogenous, $n = 5$), but with no significant difference [χ^2 (1, $N = 16$) = 2.250, $p = .134$].

Regarding patients who perceived a link between the feared self and the intrusive thought, only one-quarter believed the intrusion brought them closer to their feared self (25%, $n = 14$). In terms of the content of their intrusive thoughts, six were autogenous, and eight were reactive, and so no significant differences were found [χ^2 (1, $N = 14$) = 0.286, $p = .593$]. In general, more patients (62.06%) reported that their obsession versus their intrusion (25%) was associated with their feared self (i.e., brought them closer to the sort of person they would be afraid to become) [χ^2 (4, $N = 56$) = 27.728, $p = <.0001$, Cramer's $V = 0.498$].

4 | DISCUSSION

The aim of the present study was to explore OCD patients' perceptions of their intrusions and obsessions in relation to self-descriptors of their actual and feared possible self, using a within-subjects design. To our knowledge, this study is the first to explore the relationship between self-perceptions and intrusive thoughts and obsessions in the same patient, with intrusive thoughts that have never become an obsession as a control comparison. This is of special interest because the role of the self has been implicated in the initial occurrence of obsessions and the conversion of intrusive cognitions into obsessions through appraisal. Consequently, building on previous research that has shown differences between intrusions and obsessions in the same individual with OCD (Llorens-Aguilar et al., 2021), we expected that intrusions would not be perceived by patients as linked to their self (actual or feared self) to the same extent in comparison to obsessions,

Results showed that OCD patients frequently describe their actual self as insecure/volatile, doubtful, anxious, fearful and obsessive, but also as empathetic, good, honest, joyful and hard-working. In contrast with our hypothesis, OCD patients do not simply seem to have a general negative self-concept or view of themselves. Instead, when negative descriptors are used, they characterize themselves mainly as insecure and volatile, self-descriptions that appear to reflect low confidence and perhaps a sense of ambivalence towards the self, as described by Guidano and Liotti (1983). Indeed, although not specific to OCD, self-ambivalence is associated with symptoms of OCD (e.g., Bhar & Kyrios, 2007) and related to the construct of the feared self (Godwin et al., 2020). Patients also seem to identify with the disorder when they describe themselves as anxious, fearful and 'obsessive'.

Regarding the feared self, as expected, patients used more negative attributes, especially those related to a fear of being materialistic, selfish, cruel, aggressive, bad, dishonest/liar, fearful or cowardly. It is worth mentioning that being 'selfish/materialistic' ($n = 22$) was the most frequently reported feared adjective grouping, followed by being 'heartless/cruel/violent/aggressive' ($n = 17$), 'a liar' ($n = 14$) and 'bad' ($n = 12$). This result supports previous descriptions of OCD individuals' fear of having a dangerous or immoral self (Ferrier & Brewin, 2005) and the recent notion of a feared corrupted possible self as a central construct in OCD (Aardema et al., 2021). It is also

consistent with Rachman's (1997) observation that people with OCD fear that their obsessions might reveal hidden elements of their character, such as being evil, dangerous, unreliable, uncontrollable, sinful, immoral or insane (Rachman, 1997).

In particular, patients might interpret that being obsessed with something forces them to dedicate most of their attention and energy to these thoughts, which can lead them to perceive themselves as selfish. A large number of patients feared having a 'liar identity', which could be due to the credibility patients assign to their obsessions and their efforts to hide them from the rest of the world to avoid possible rejection. It is also consistent with the notion of a distrust of the self (Aardema & O'Connor, 2007), where those with OCD feel they cannot trust themselves. This mistrust not only represents a general lack of self-confidence, but also suspicion and paranoia directed towards their inner self (Aardema & O'Connor, 2007), giving rise to feelings of being a liar and committing wrongdoings, even when none have occurred. This type of thinking is also related to intense feelings of shame that might explain OCD patients' long delay in asking for professional help (García-Soriano et al., 2014).

Some patients also reported that they feared being cowardly, anxious, fearful and/or depressive (feared self), whereas other patients actually described themselves as insecure, anxious, fearful or depressed (actual self). This is consistent with one of the main 'consequences' of the disorder: anxiety and depressive mood (Brakoulias et al., 2017). Most of our sample had suffered from their obsessions for a long period of time; thus, it is not surprising that they are afraid of OCD affecting their mood or that they feel that it actually affects it. In fact, the present sample showed moderate levels of anxiety and depressive mood, as measured by the DASS-21, and some of them also presented comorbidity with depression and anxiety disorders.

When categorizing adjectives into Ferrier and Brewin's (2005) four categories, patients more frequently reported that they feared a dangerous/immoral self, followed by an imperfect or flawed self. In Ferrier and Brewin's (2005) study, OCD individuals scored higher on fearing a 'flawed self', but only the dangerous/immoral feared self distinguished OCD patients from anxious and non-clinical controls. Future research will have to determine and replicate whether this feared-self theme is the most relevant to those with OCD, although it is consistent with recent findings that emphasize the role of the corrupted feared self in OCD, in comparison with more general concerns about one's character (Aardema et al., 2021).

Most of the individuals with OCD interviewed believed that their obsessions said something about their actual self. The most frequently reported self-descriptor was 'being insecure'. Moreover, as expected, the percentage of patients who believed their obsessions were significant to who they are was significantly higher than for intrusions, regardless of the content of the obsessions and intrusions (i.e., autogenous vs. reactive). Likewise, with regard to the feared self, most patients believed their obsession brought them closer to the person they do not want to be (e.g., violent, manipulative, out of control or a bad person). This was especially true for patients with autogenous obsessions, but also for those with reactive obsessions, without significant differences between the two, perhaps partly due to the relatively small sample size in the current study. However, the higher frequency in those with autogenous obsessions is consistent with empirical studies using the FSQ that have consistently found associations with autogenous contents (e.g., Aardema et al., 2013; Aardema et al., 2017; Llorens-Aguilar et al., 2019; Melli et al., 2016). Finally, as expected, significantly more patients believed their obsession brought them closer to their feared self, compared to intrusions. These results are consistent with cognitive-behavioural formulations of OCD that propose a continuum between intrusions and obsessions that occurs through appraisal (e.g., Rachman, 1997; Rowa et al., 2005). Intrusions that are believed to reflect aspects of one's actual or feared self may be more likely to develop into obsessions, whereas those that do not would remain 'mere' intrusions without escalating into obsessions. However, this finding may also suggest that intrusions and obsessions are not entirely similar phenomena in the context of a feared self. Recent extended cognitive-behavioural formulations have proposed that a person's feared self may not only affect the appraisal of obsessions, but it may also be responsible for the occurrence of obsessional intrusions before specific appraisals of personal significance occur (Aardema & Wong, 2020). Indeed, Aardema et al. (2021) found that a fear of being or becoming corrupted interacts strongly with the importance and significance a person attributes to thoughts, but it also makes unique and independent contributions to the prediction of obsessions.

This study has some limitations. First, the cross-sectional nature of the study did not allow us to establish causal relations among the constructs measured. We cannot rule out the possibility that the described selves, actual and feared, could be the consequence of the disorder and that obsessions are related to the self due to living with OCD. Second, the sample size was not large, resulting in low statistical power for some analysis that could be limiting the reliable detection of differences. Longitudinal research with larger samples would be required. Moreover, this study departs from a cognitive appraisal-based model by asking about the real and feared self as differentiated constructs. According to other proposals (Aardema & Wong, 2020), OCD patients prioritize the feared self and may not be able to distinguish between them. Nonetheless, our results suggest that individuals with OCD identify themselves as insecure and anxious, and they fear being selfish and aggressive. Moreover, results show that about two-thirds of the patients found that their obsession was associated with their actual self and brought them closer to their feared self, whereas a significantly lower number of participants believed this to be case for their intrusions. No differences in this association were found between autogenous and reactive obsessions, but there was a trend for patients with autogenous obsessions to more frequently report that their obsessions brought them closer to their feared self.

In general, the results are consistent with the notion that the self may play a defining role in the emergence or maintenance of obsessions. There is a need to complement the current psychological treatments for OCD with strategies focused on the self because it seems that the clinical population often relates their negative attributes to clinical obsessions. Furthermore, it is necessary to identify the feared

self and modify it in order to lower the patient's vulnerability to suffering from obsessions and, hence, reduce the possibility of relapse. Future research should replicate this study with larger samples in order to reach more general conclusions about the role of the actual and feared self in OCD patients. If future studies confirm the relevance of the actual and feared self in OCD, clinicians will be able to add vulnerable self-themes to existing cognitive-behavioural protocols for OCD. The proposal of the inference-based model (O'Connor & Aardema, 2012; O'Connor et al., 2005) explicitly addresses the feared self in OCD. It helps patients to develop greater self-trust by utilizing more reality-based criteria in defining their sense of self and, more importantly, showing them that their feared possible self is solely based on an imaginary narrative that stands in sharp opposition to who they really are (Aardema & O'Connor, 2007; Moulding et al., 2014). Once patients realize that obsessions come from an imaginary feared self, intrusions become easier to understand and process.

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CONFLICT OF INTEREST

All authors declare that they have no known conflict of interest to disclose.

ETHICS STATEMENT

All procedures were in accordance with the ethical standards of the institutional research committee and with the 1964 Helsinki declaration.

DATA AVAILABILITY STATEMENT

Data available on request from the authors: The data that support the findings of this study are available from the corresponding author upon request.

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