

Post-secondary students with obsessive-compulsive disorder:
An interpretative phenomenological approach linking
persistence and quality of life insights

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For students with OCD and
those who care about them

For my daughter Ling
I hope my thesis fosters
your scholarly pursuits :)

Abstract

The purpose of this qualitative, exploratory study was to develop a deeper understanding of educational and other social experiences and relationships of post-secondary students who were clinically diagnosed with primary obsessive-compulsive disorder (OCD). The researcher also investigated their strengths, weaknesses, coping strategies, and quality of life through mental and physical health. The majority of people with OCD have obsessions and compulsions that last greater than an hour each day or severely impact daily life. Obsessions are irritating feelings or mental pictures that individuals try to block or mitigate with irrational physical or mental compulsions, often appearing as excessive hand washing in reaction to a contamination obsession. Participants comprised seven university students who completed three self-report questionnaires and two semi-structured interviews with the researcher. Five participants submitted self-report journals. These data were examined using interpretative phenomenological analysis (IPA). The present study advanced previous research as it documented extensive lifelong characteristics, experiences, and relationships from these students. It yielded salient findings related to their OCD functional impairment and quality of life. Further, it showed that as students, their intellectual integration seemed to play a greater role in academic persistence than did their social integration. In addition, participants' university policy and practice recommendations were congruent with a similar study from about a decade ago indicating that perhaps few or none of the past recommendations were implemented for the benefit of such students. Present recommendations should be implemented accordingly.

Table of Contents

List of Tables, Figures, and Appendices.....	xi
Abbreviation Guide.....	xii
1. Chapter I: Description of the Thesis and its Significance.....	1
1.1 Research Context.....	2
1.1.1 Historical Perspectives and Development of OCD.....	2
1.1.2 Behaviour Therapy, Cognitive Therapy, and Cognitive-Behaviour Therapy.....	5
1.2 Research Topic, Problem, and Purpose.....	6
1.3 Research Questions.....	7
1.4 Methodology.....	8
1.5 Salient Findings.....	9
2. Chapter II: Literature Review and Conceptual Framework.....	11
2.1 Literature Review.....	11
2.1.1 Description of OCD.....	11
2.1.2 Etiology.....	15
2.1.3 Comorbid Disorders.....	17
2.1.4 Diagnosis.....	18
2.1.5 Treatments.....	18
2.1.6 Post-secondary Students with Primary OCD.....	23
2.1.6.1 Addressing Gaps in the Research.....	32

2.2	Conceptual Framework.....	34
2.2.1	Tinto's Longitudinal Model of Institutional Departure:Components and Persistence	34
2.2.2	OCD and Quality of Life (QoL) Measurement Constructs.....	39
2.3	Chapter Summary.....	42
3.	Chapter III: Methodology.....	43
3.1	Research Design.....	43
3.1.1	Phenomenological Research and Interpretative Phenomenological Analysis (IPA)...	44
3.1.1.1	What is IPA?.....	45
3.1.2	Seidman's Interviewing.....	47
3.2	Participants.....	47
3.2.1	Sample Size and Saturation Addressed.....	51
3.3	Data Collection.....	55
3.3.1	Primary Data Collection.....	56
3.3.1.1	Self-report Journal.....	56
3.3.1.2	Three Self-report Questionnaires.....	57
3.3.1.3	Interviews.....	59
3.3.2	Secondary Data Collection.....	61
3.4	Data Analysis Path.....	62
3.4.1	Transcriptions of Interviews and Case Development with Self-report Data.....	63
3.4.2	Analysis of the Primary Data Collected.....	65
3.4.2.1	Analysis of the Self-report Journals.....	65
3.4.2.2	Analysis of the OCI-R and the SF-36v2.....	66
3.4.2.3	Analysis of the Interview Data.....	67

3.4.3	Analysis of the Secondary Data Collected.....	68
3.5	Researcher's Perspectives and Pilot Study.....	69
3.6	Addressing the Quality of IPA Research, Trustworthiness, and Related Checklists.....	72
3.7	Participant Vignettes.....	82
3.7.1	Robin.....	82
3.7.2	Anne.....	83
3.7.3	Mary.....	84
3.7.4	Oliver.....	84
3.7.5	Nick.....	85
3.7.6	Elaine.....	86
3.7.7	Steve.....	87
3.8	Chapter Summary.....	88
4.	Chapter IV: Findings.....	89
4.1	Robin.....	89
4.1.1	OCD Diagnosis, Recommendations, Treatment.....	89
4.1.2	Experiences, Beliefs, Feelings, Relationships.....	90
4.1.3	Goals, Challenges, Changes, Persistence.....	95
4.1.4	Strengths, Weaknesses, and Coping Strategies.....	96
4.1.5	The Three Questionnaires and Journal: Comments and Clarifications.....	98
4.1.6	A Typical Day.....	99
4.1.7	Others with OCD and Those who Encounter Them.....	100
4.1.8	Final Comments.....	101

4.2	Anne.....	102
4.2.1	OCD Diagnosis, Recommendations, Treatment.....	102
4.2.2	Experiences, Beliefs, Feelings, Relationships.....	104
4.2.3	Goals, Challenges, Changes, Persistence.....	108
4.2.4	Strengths, Weaknesses, and Coping Strategies.....	109
4.2.5	The Three Questionnaires and Journal: Comments and Clarifications.....	110
4.2.6	A Typical Day.....	112
4.2.7	Others with OCD and Those who Encounter Them.....	113
4.2.8	Final Comments.....	115
4.3	Mary.....	115
4.3.1	OCD Diagnosis, Recommendations, Treatment.....	115
4.3.2	Experiences, Beliefs, Feelings, Relationships.....	116
4.3.3	Goals, Challenges, Changes, Persistence.....	119
4.3.4	Strengths, Weaknesses, and Coping Strategies.....	121
4.3.5	The Three Questionnaires and Journal: Comments and Clarifications.....	122
4.3.6	A Typical Day.....	124
4.3.7	Others with OCD and Those who Encounter Them.....	124
4.3.8	Final Comments.....	125
4.4	Oliver.....	125
4.4.1	OCD Diagnosis, Recommendations, Treatment.....	126
4.4.2	Experiences, Beliefs, Feelings, Relationships.....	127
4.4.3	Goals, Challenges, Changes, Persistence.....	131
4.4.4	Strengths, Weaknesses, and Coping Strategies.....	133

4.4.5	The Three Questionnaires and Journal: Comments and Clarifications.....	134
4.4.6	A Typical Day.....	137
4.4.7	Others with OCD and Those who Encounter Them.....	140
4.4.8	Final Comments.....	142
4.5	Nick.....	142
4.5.1	OCD Diagnosis, Recommendations, Treatment.....	143
4.5.2	Experiences, Beliefs, Feelings, Relationships.....	143
4.5.3	Goals, Challenges, Changes, Persistence.....	148
4.5.4	Strengths, Weaknesses, and Coping Strategies.....	150
4.5.5	The Three Questionnaires and Journal: Comments and Clarifications.....	151
4.5.6	A Typical Day.....	153
4.5.7	Others with OCD and Those who Encounter Them.....	155
4.5.8	Final Comments.....	158
4.6	Elaine.....	158
4.6.1	OCD Diagnosis, Recommendations, Treatment.....	159
4.6.2	Experiences, Beliefs, Feelings, Relationships.....	160
4.6.3	Goals, Challenges, Changes, Persistence.....	164
4.6.4	Strengths, Weaknesses, and Coping Strategies.....	166
4.6.5	The Three Questionnaires and Journal: Comments and Clarifications.....	167
4.6.6	A Typical Day.....	170
4.6.7	Others with OCD and Those who Encounter Them.....	171
4.6.8	Final Comments.....	172

4.7	Steve.....	173
4.7.1	OCD Diagnosis, Recommendations, Treatment.....	173
4.7.2	Experiences, Beliefs, Feelings, Relationships.....	174
4.7.3	Goals, Challenges, Changes, Persistence.....	177
4.7.4	Strengths, Weaknesses, and Coping Strategies.....	179
4.7.5	The Three Questionnaires and Journal: Comments and Clarifications.....	180
4.7.6	A Typical Day.....	182
4.7.7	Others with OCD and Those who Encounter Them.....	184
4.7.8	Final Comments.....	185
4.8	Chapter Summary.....	185
5.	Chapter V: Inter-case Analysis.....	186
5.1	OCD Symptom Distress (OCI-R) / Comments and Clarifications.....	186
5.2	QoL and SF-36v2 Mental and Physical Health / Comments and Clarifications.....	187
5.3	Experiences, Beliefs, Feelings, Relationships.....	190
5.4	Goals, Challenges, Changes, Persistence.....	193
5.5	Strengths, Weaknesses, and Coping Strategies.....	196
5.6	A Typical Day.....	198
5.7	Others with OCD and Those who Encounter Them.....	199
5.8	IPA and Participants' Comments and Clarifications Case Heading.....	200
5.8.1	Initial Comments.....	200
5.8.2	Demographic Form.....	201
5.8.3	Participant Journals.....	203

5.8.4	Additional OCD Functions of Participants.....	204
5.8.5	Final Comments.....	206
5.8.6	Secondary Data.....	207
5.9	Chapter Summary.....	210
6.	Chapter VI: Discussion and Conclusions.....	211
6.1	Review of the Present Study.....	211
6.2	Addressing the Research Questions.....	212
6.2.1	Research Question One.....	214
6.2.2	Research Question Two.....	219
6.2.3	Research Question Three.....	224
6.3	IPA, Participants' Comments and Clarifications Case Heading, Secondary Data.....	235
6.4	Contributions of the Thesis to Knowledge, Theory, Method, Policy and Practice.....	239
6.5	Study Limitations.....	248
6.6	Paths for Future Research.....	250
6.7	Concluding Remarks.....	252
	References.....	255

List of Tables, Figures, and Appendices

Table 1:	Descriptions of the eight studies that included post-secondary students (PSS) diagnosed with (primary) OCD.....	25
Figure 1:	Adaptation of Tinto's Longitudinal Model of Institutional Departure.....	38
Appendix A:	Study Recruitment Ad.....	276
Appendix B:	Formulaire de Consentement du/de la Participant(e)	277
Appendix C:	Participant Consent Form.....	280
Appendix D:	Interview Schedules for Session 1 and 2.....	283
Appendix E:	Participant demographic form.....	288
Appendix F:	Obsessive-Compulsive Inventory--Revised (OCI-R) and results summary.....	290
Appendix G:	Summary of SF-36v2® Health Survey Items / Participant Health States.....	292
Appendix H:	Self-report Journaling from Anne, Oliver, Nick, Elaine, and Steve.....	295
Appendix I:	Summary of Participant Data.....	315
Appendix J:	Researcher's Fieldwork Journal.....	317
Appendix K:	Study Concept Map.....	322
Appendix L:	Additional OCD functions of Participants.....	324
Appendix M:	An Overview of Pediatric and Geriatric OCD.....	334
Appendix N:	Additional OCD-Related Insights.....	341
Appendix O:	Approval for use of SF-36v2® Health Survey.....	344

Abbreviation Guide

ACT - Acceptance and Commitment Therapy

BDD - Body Dismorphic Disorder

BT - Behavio(u)r(al) Therapy

CBT - Cognitive-Behavio(u)r(al) Therapy

CT - Cognitive Therapy

DSM-IV-TR - Diagnostic and Statistical Manual of Mental Disorders TM, 4th Ed., Text Revision

DSM-5 - Diagnostic and Statistical Manual of Mental Disorders TM, 5th Ed.

ERP - Exposure and Response Prevention or Exposure and Ritual Prevention

GAD - Generalized Anxiety Disorder

GTS - Gilles de la Tourette Syndrome or Tourette's Syndrome

HRQOL - Health-related Quality of Life

IPA - Interpretative Phenomenological Analysis

OCD - Obsessive-Compulsive Disorder

OCI-R - Obsessive-Compulsive Inventory--Revised

OCRDs - Obsessive-Compulsive Related Disorders

OCSDs - Obsessive-Compulsive Spectrum Disorders

PANDAS - Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infection

QoL - Quality of Life

SF-36v2® - Health Survey, Version 2

SSRIs - Selective Serotonin Reuptake Inhibitors

TTM - Trichotillomania

Y-BOCS - Yale-Brown Obsessive-Compulsive Scale

Post-secondary students with obsessive-compulsive disorder:**An interpretative phenomenological approach linking persistence and quality of life insights****Chapter I: Description of the Thesis and its Significance**

The researcher of the present study investigated post-secondary students who were clinically diagnosed with primary obsessive-compulsive disorder (OCD). To clarify, post-secondary students refers to adult students enrolled in what the literature has termed as a college, community college, or university. A clinical diagnosis of primary OCD refers to a diagnosis made by a qualified clinician that has indicated OCD as the patient's most severe disorder. Primary OCD is one of the most problematic medical disorders in developed countries (Eisen et al., 2006). More specifically, the six thesis chapters evolved from the qualitative approach used to develop and analyse the cases of seven post-secondary students from an urban area of Ontario, Canada. Chapter II: Literature Review and Conceptual Framework includes an overview of OCD, focusing on its etiology, comorbid disorders, diagnosis, and treatment. Descriptions of post-secondary students with OCD then follow. The three primary lenses used in the conceptual framework to collect and present participant data were Seidman's interviewing as qualitative research (2006, 2013), an adaptation of Tinto's Longitudinal Model of Institutional Departure (Tinto, 1993), and interpretative phenomenological analysis (IPA) (Smith, Flowers, & Larkin, 2009; Smith, Jarman, & Osborn 1999; Smith & Osborn, 2003). IPA's "two important theoretical touchstones" (Smith, 1996, p. 263) of phenomenology and symbolic interactionism were influential. Primary data collection included two interviews, self-report journals, and three self-report questionnaires. Secondary data collection included the researcher's interview notes and fieldwork journal. Chapter III: Methodology describes the data collection methods and analyses, and presents seven participant vignettes. Chapter IV: Findings features cases of the seven study participants who were assigned

the pseudonyms of Robin, Anne, Mary, Oliver, Nick, Elaine, and Steve. Chapter V: Inter-case Analysis highlights these seven cases in relation to one another. Chapter VI: Discussion and Conclusions addresses the three research questions and summarizes the study contributions to knowledge, theory, method, and policy and practice. Next, limitations, paths for future research, and concluding remarks are conveyed. References and 15 appendices complete the thesis. In order to assist readers and to maintain coherence and flow of the text, technical and other key terms from respective sources are italicized throughout the present study. Quotation marks are used for somewhat longer segments of important text and these segments are accompanied by the corresponding citation with page number(s). The remainder of chapter I comprises the research context in terms of the historical perspectives and development of OCD, and provides more detail about the research topic, problem and purpose, research questions, methodology, and findings.

Research context

Historical perspectives and development of OCD.

OCD, formerly termed obsessive-compulsive neurosis, is evident through history and it does not seem to have been confined to particular populations, but noticeable across many cultures and social strata (OCD-UK, n.d.). In his 1666 book, for instance, John Bunyan (1628-1688) described fears related to blasphemous, intrusive thoughts; the famous lexicographer Dr. Samuel Johnson (1709-1784) reportedly exhibited intricate rituals when going through doorways and walking along sidewalks; and Charles Darwin (1809-1882) documented his many unwanted, obsessional thoughts (OCD-UK) (see also Brown & Broeske, 2004; Newman, 2005 on Howard Hughes in Appendix N: Additional OCD-Related Insights). Hundreds of years in the past, those with obsessive thoughts related to sex or blasphemy were viewed as *possessed* and thus *exorcism* and *torture* were implemented to treat this condition, but such beliefs and practices of religion were gradually

overtaken by medical perspectives, notably the first account of OCD by Esquirol in 1838 (Jenike, 2001). Similarly, Goodman (2010) viewed that OCD-like behaviour has been acknowledged for over 300 years and each step that has led up to the current understanding of this disorder has been subject to the respective zeitgeist. He noted that English writers from the late 1600s and into the 1700s implicated the devil when describing those who experienced visions of blasphemy. Later in France, the clinician Esquirol described *folie de doute* to indicate symptoms related to this madness of doubt (Goodman). He believed that this *monomania* or *partial insanity* was caused by either faulty *intellect* or faulty *will* (Stanford School of Medicine, 2012). This perception of OCD did not endure because of five main criticisms, such as its lack of precision and inability to account for individual presentations, and it was unable to explain changing symptomology (Berrios, 1989). From about the 1850s, obsessions and compulsions were then frequently viewed by French clinicians in terms of *panic disorder*, *phobias*, and even *sexual perversions* (Stanford School of Medicine). Berrios noted that Morel viewed OCD as an emotional disease, or neurosis, that he termed *délire emotif*. This term involved insight and no cognitive problems within several disorders, such as phobias and dysphoria. Morel's term was greatly valued due to his reputation, its German counterpart that saw OCD as a form of paranoia, and its applicability for anxiety disorders. Its weakness, however, is that it failed to account for the diversity of symptoms within OCD.

These volitional and emotive perspectives were fervently supported in France, but the German focus of OCD relating to paranoia and intellect was also respectively supported (Stanford School of Medicine, 2012). In 1877, Wiestphal attributed obsessions to disordered *intellectual function* (*Zwangsvorstellung*) (compelled presentation or idea) that led to the English term *presentation*, as it comprised *mental experiences and actions* (Stanford School of Medicine). In the UK, the translation of this German term was *obsession*, while the American translation

was *compulsion*, with the resultant compromise of *obsessive-compulsive disorder* (Stanford School of Medicine).

During the later half of the 19th century, the origins of OCD were explained by the use of the volitional and emotive theories from French psychiatry, with the emotive theory gradually taking hold, and the intellectual theory supported by German psychiatry (Berrios, 1989).

At the beginning of the 20th century, Pierre Janet, among other colleagues, emphasized that OCD symptoms were underpinned by *loss of will and low mental energy* (Goodman, 2010). He and Sigmund Freud differentiated OCD from other disorders, or the then popular term of *neurasthenia* (Stanford School of Medicine, 2012). In his very well received research entitled *Obsessions and Psychoasthenia*, Janet asserted that both obsessions and compulsions derived from the deepest level of psychoasthenia, noting that due to a deficiency of *psychological tension* or *nervous energy*, the person is unable to perform higher-level cognitive tasks, such as those that related to *will* and *directed attention* thereby channeling this nervous energy into more basic actions that also involved obsessions and compulsions (Stanford School of Medicine).

Freud's perspective on OCD comprised the three factors of *mental structure*, *mental energies*, and *defense mechanisms*, whereby the individual's mind reacted *maladaptively* between stresses that were categorized as *unacceptable*, *unconscious sexual*, or *aggressive* impulses and the *demands of conscience and reality* (Stanford School of Medicine, 2012). Struggles with control and ways of thinking led to the triggering of *superstitious compulsive acts* that the individual attempted to manage using the three strategies of intellectualization and isolation, undoing, and reaction formation (Stanford School of Medicine). These three strategies concerned repelling unwanted impulses and ideas, attempting to neutralize these through compulsions, and forming *character traits* that directly opposed these feared impulses respectively. Being unable to

successfully cope with these struggles caused the individual to exhibit OCD characteristics, such as aversions to dirt and irrational fears (Stanford School of Medicine).

For about the next three quarters of the 20th century, OCD was viewed with respect to *psychoanalytic theories* that focused on early, unconscious developmental problems that were deemed to be undesirable in a conscious state (Goodman, 2010). These psychoanalytic theories did offer insight into the *content* of obsessions, but they have failed in terms of elucidating the key underpinnings and they have not led to useful OCD treatments (Goodman). In a more definitive manner, the National Institute for Health and Clinical Excellence asserted that for the treatment of OCD, psychoanalysis offers *no evidence of efficacy* (as cited in Rachman, 2009). Due to these deficiencies identified, OCD began to be viewed with a focus on models of learning due to success with BT and its use of acting upon improperly learned responses (Goodman).

Behaviour therapy (BT), cognitive therapy (CT), cognitive-behaviour therapy (CBT).

During the 2006 Obsessive-Compulsive Foundation conference, I recall one of the presenters addressing a disputed issue regarding behaviour therapists versus cognitive-behaviour therapists by noting that they basically practice the same therapy. Those who deem themselves to be strictly behaviour therapists add cognitive tasks, making their actual therapy into CBT (see also Tolin, 2009 in chapter II). Rachman (2009) conducted a review of BT, CT, and CBT and found that they emerged chronologically, with BT appearing around the 1950s, CT in the 1960s, and these two therapies were then combined to form CBT in the 1980s. BT arose from research conducted in the UK and US between 1950-1970, while CT research was conducted in the US from about the middle of the 1960s. From around the end of the 1980s, CBT has been developed, approved, and implemented and this is now a major therapy throughout Western countries and the world. Rachman further examined strengths and weaknesses of these therapies, with BT triggering a

positive, significant shift from *introspectionism* to the search for improved treatments, but also lacking as it explained anxiety only in terms of flawed learning or conditioning, thus it could not effectively explain and treat the diversity of symptoms. Whereas patient cognitions were considered to be *distractions* in BT, CT allowed therapists (originally Beck and Ellis) to focus on *corrected appraisals and corrective actions*. CBT formed from the research of Clark and then Barlow, whose work was separate, but integral to the formation of this therapy that is often used around the world. Again, however, CBT is not without its weaknesses, as Rachman noted that this has not always been the most effective therapy, for example, when compared to BT and therapy that only focused on exposures, referred to as exposure and response prevention (ERP). CBT can also be difficult to implement, as salient cognitive changes may only occur over long periods of time. Further, ERP has been criticized for its excessive demands, attrition, and induced distress on patients. In addition, as he noted from Seligman (1988), CBT fails to mitigate the *tenacity* with which, for instance, panic disorder patients continue to defend their beliefs in catastrophic occurrences even after having experienced numerous counter examples. Similarly, with OCD, “the extraordinarily inflated feelings of responsibility encountered...can be despairingly tenacious” (p.114). A broader discussion of OCD etiology and treatments is presented in the next chapter.

Research topic, problem, and purpose

Although many studies over past decades have focused on OCD symptomology among university students and other adults, the present study seems to be the first to have qualitatively developed an extensive number of lifelong characteristics, experiences, and relationships from a variety of university students diagnosed with primary OCD. Studies that have examined the lives of this specific group of adults have largely been cursory despite findings that have highlighted a significant need for such research. Hartley (2013) noted, for example, that students

with mental health problems have a *high risk for college dropout*, and Karno et al., (1988) (as cited in Mathews, Jang, Hami, & Stein, 2004, p. 78) observed "college students are an appropriate group for studying obsessions and compulsions because they represent the age of highest risk (18-25 years old) for developing OCD." This disorder has a prevalence of about 2% within the general population, but its effects are particularly significant among young adults because of its great impact on work and social life, including the propensity of such adults to keep their symptoms hidden, even from clinicians (Rodriguez-Salgado et al., 2006). In a more recent study, Yoldascan, Ozenli, Kutlu, Topal, and Bozkurt (2009) acknowledged the dearth of research into university students diagnosed with OCD and the lack of methodological investigations of OCD epidemiology involving these students. Thus, little is known about the lives of post-secondary students with this serious mental health disorder.

The purpose of this study was to develop a deeper understanding of these students' characteristics and educational and other social experiences and relationships and thus potentially contribute new knowledge with implications for institutional practice, policy, and OCD awareness and treatment. Because of the salient gaps in the related literature, specifically with the participant recruitment, data collection, and findings, a qualitative approach seemed warranted to study these students who often experience severe educational and social problems while coping with OCD.

Research questions

The researcher's three primary lenses were instrumental in forming the three research questions of the present study. More specifically, research question one derived from the first and second interviews described in Seidman (2006), the fostering of related participant responses in Widdifield (2004), elements in an adaptation of Tinto's Longitudinal Model of Institutional Departure (Figure 1), and IPA with its focus on developing a rich source of data through

elicitation of a wide range of experiences and interests. Research question two derived from the third interview described in Seidman and developing an understanding of the meaning participants have in terms of experiences, events, and states from IPA. The third and final research question derived from IPA with its focus on obtaining an *insider perspective* in terms of a person's experiences (Fade, 2004), the importance of researching underrepresented post-secondary students (Tinto & Pusser, 2006), and the OCD and quality of life questionnaires described below.

The data collection was conducted solely by the researcher. Greater detail is provided below.

Research question one: With respect to past, present, and future contexts, what are the characteristics of participants' educational and social experiences and relationships?

Research question two: With respect to these temporal contexts, what meanings, if any, do participants attribute to these experiences and relationships?

Research question three: In general, and with respect to OCD, what are the characteristics of participants' quality of life?

Methodology

Qualitative research is particularly useful for understanding human experiences and shows "what a phenomenon or situation is like, how it evolves, and how that matters for individuals in that situation" (Fischer, 2006, p. 411). More specifically, Merriam (2001) viewed qualitative research as being *richly descriptive* because of its concern with "process, meaning, and understanding" (p. 8). As Fade (2004) noted, however, the complexities of qualitative research usually require lengthy explanations to adequately inform the reader, thus the researcher decided to employ the concise, well-established approach of interpretative phenomenological analysis (IPA) (Smith & Osborn, 2003) to serve both the researcher and reader more effectively. Another feature of qualitative research is that it employs purposive sampling (Smith & Osborn), to recruit

specific participants from places that are most advantageous to gaining a deep understanding of a specific phenomenon.

The methodology chapter comprises more detailed explanations of the seven participants, the sampling process, and the primary and secondary data collection. The primary data collection included two interviews with each participant over a period of about one week, self-report journals developed over a period of about a month, and self-report questionnaires. Secondary data collection comprised the researcher's interview notes and the fieldwork journal. The interview notes highlighted interview rapport, such as emotional discomfort and verbal diversity, while the fieldwork journal noted, for example, recruitment and ethics experiences.

The present study is unique as all its participants were post-secondary students with (primary) OCD. Similar studies have also employed methodologies that included IPA, Tinto's model, and quality of life measurements, but they did not focus on this specific group of adults. These similar studies are further explained in the following chapter.

Salient findings

Although many studies over the decades have focused on OCD symptomology among university students and other adults, the present study seems to be the first to have qualitatively presented an extensive number of lifelong characteristics, experiences, and relationships from a variety of university students diagnosed with primary OCD. It yielded salient findings related to participants' OCD functional impairment and quality of life. Further, it showed that as students, their intellectual integration seemed to play a greater role in academic persistence than did their social integration. In addition, participants' university policy and practice recommendations were congruent with a similar study from about a decade ago indicating that perhaps few or none of the past recommendations were implemented for the benefit of such students. Present

recommendations should be implemented accordingly.

Chapter II: Literature Review and Conceptual Framework

The literature review initially focuses on OCD description, etiology, comorbid disorders, diagnosis, and treatments. A more detailed discussion then follows, specifically related to post-secondary students with OCD (within adults ages 18-64). Appendix M provides readers with an overview of pediatric OCD (below age 18) and geriatric OCD (about age 65 and above). This approach was adopted because OCD research has covered a broad spectrum of ages and OCD can present itself throughout many periods of life (Antony, Purdon, & Summerfeldt, 2007). In addition, participants in the present study frequently recalled OCD-related experiences from their childhoods and they often noted the chronicity of their disorder. Thus, they did not expect to overcome OCD as adults; they have tried to manage its effects and they will likely continue their efforts throughout their lives. This review is intended to be both descriptive and critical in its presentation of the selected literature and its apparent gaps. The conceptual framework highlights the operationalization of three primary lenses implemented in the present study, as well as measurement constructs related to OCD and quality of life. Primary and secondary data collection are addressed more thoroughly in the methodology chapter.

Literature review

Description of OCD.

This brief description addresses the commonly cited OCD definition from the *Diagnostic and statistical manual of mental disorders* (DSM) (American Psychiatric Association, 2000, 2013) related criticisms, OCD onset, genetics, neuroimaging, and quality of life issues. People with OCD have obsessions or compulsions or both that last greater than an hour each day or severely impact daily life. Obsessions are irritating feelings or mental pictures that individuals try to block or mitigate with irrational physical or mental compulsions, often appearing as excessive hand

washing in reaction to a contamination obsession (American Psychiatric Association, 2013).

More concisely, Schwartz and Begley (2003) described OCD as a neuropsychiatric disease characterized by distressing and intrusive obsessions that trigger strong urges to perform ritualistic compulsions. Further, they noted that these obsessions still elude researchers in terms of their causes and the biological reasons for the diverse symptoms of OCD patients. One criticism of the DSM (American Psychiatric Association, 2000) has been that most patients have both obsessions and compulsions rather than just one or the other (Foa & Kozak (as cited Markarian et al., 2010)). The DSM definition from 2013 still includes *or*, but later emphasizes that “the characteristic symptoms of OCD are the presence of obsessions and compulsions” (p. 238) and “most individuals with OCD have both...” (p. 238). Abramowitz (2006) noted another criticism of the DSM from 2000, arguing that its diagnostic aspects focus on the form, but not on the functional qualities of obsessions and compulsions. He strongly advocated for a greater focus on “functional aspects of these phenomena” (p. 16). The DSM from 2013, however, explains a number of OCD “functional consequences” (p. 240), for instance, delays in submitting school projects due to the feeling of them not being *just right*, and reluctance to develop relationships because of harm-related obsessions.

OCD studies have used a variety of definitions for age of onset, causing problems for determination of comorbid disorders and response to treatment (Grant et al., 2007). Such definitions have included, for example, the age of initial symptoms, the age when one began exhibiting extreme distress, and the age when one met the description of OCD as indicated in the DSM from 2000. Lomax, Oldfield, and Salkovskis (2009) described another troublesome issue associated with onset. They noted the poor reliability of self-reported OCD symptoms and they advised that such reporting should be confirmed by others, for instance, clinicians and family

members. OCD symptoms often progress slowly with a quarter of individuals beginning at age 14 and a mean of 19.5 years (American Psychiatric Association, 2013),

Regarding OCD and genetics, Nicolini, Arnold, Nestadt, Lanzagorta, and Kennedy (2009) examined a diversity of research including findings that showed an increased prevalence of OCD found among immediate family members, a strong genetic association found in twin studies, a gender study that revealed genetic links among males within families, a dearth of research in genetic and drug response studies, and inconclusive environmental factor studies. The researchers acknowledged the difficulty in this area due to this diversity of influences and the variability of the disorder throughout the lifetime of a patient. They asserted that the modest advances in OCD and genetics could be used to develop programs that could assist children who are highly OCD susceptible by identifying this disorder early and thus identifying potentially related environmental influences.

Neuroimaging, or *non-invasive mapping*, has provided many functional and structural insights to both pediatric and adult OCD research, specifically in terms of identifying abnormal structures and measuring blood flow and biochemical activities (Huyser, Veltman, de Haan, & Boer, 2009). After reviewing the related pediatric OCD literature from about the past quarter century, these authors found "dysfunction of several cortical-subcortical circuits in particular at the level of the thalamus and basal ganglia" (p. 828), resulting in abnormal processing of emotions and information. Further, they acknowledged that pediatric OCD may not necessarily be a *precursor* to adult OCD. Despite these contributions, however, Huyser et al. acknowledged that many limitations need to be considered, such as the relatively small number of participants (n=462), their comorbidities and diversities in age, medications, symptom severity, and illness duration, and also the variety of the neuroimaging hardware manufacturers.

In terms of quality of life, people with OCD are often described as having difficulties in a variety of areas, such as with personal relationships, employment, and education. Earlier studies found, for example, that most OCD patients keep their symptoms hidden for years probably due to the shamefulness of their OCD symptoms (McGinn & Sanderson, 1999), and because people with OCD are often ashamed of their abnormal thoughts and behaviors, they tend to go to great lengths to hide these symptoms from people close to them, thus educational, occupational, and social functioning are often severely impaired (Abramowitz, Brigidi, & Roche, 2001). Further, Pallanti et al. (2002), explained that while SRI drug studies have been effective in OCD, "up to 40-60% of patients do not have a satisfactory outcome. Non-response to treatment in OCD is associated with serious social disability" (p. 181). These authors found no practical definition for *non-response*, and concluded that they should "encourage the participation of those with expertise from other backgrounds...to improve agreement between different points of view on quality-of-life issues" (p. 187). More recently, Tolin and Steketee (2007) described the significant effects of OCD upon finances, education, and social lives. They noted several studies that indicated many with OCD are unable to work, thus triggering the need for financial help and hindering their financial stability and career prospects. Further, many adults often drop out of post-secondary education, leading to a limited earning potential. Moreover, their social lives are frequently affected, such as encountering problems within their families and also being unable to continue relationships. In addition, Penzel (2000) noted that OCD symptoms are often exacerbated by stress from a variety of stimuli, for instance, having financial difficulties, changes in premenstrual hormones, and being hungry or tired. Both pediatric and adult OCD are often very debilitating and difficult to treat (Huyser et al., 2009). To improve treatment efficacy, Speisman (2012) argued that it is imperative to include QoL when treating OCD patients so that symptoms and QoL can improve.

Etiology.

Over the years, numerous clinicians (e.g., Abramowitz, 2006; Davison, Neale, Blankstein, & Flett, 2005; Penzel, 2000; Taylor, Abramowitz, & McKay, 2007) have acknowledged the uncertainty regarding OCD etiologies. Penzel noted that OCD was believed to have only a psychological origin, derived from one's early childhood experiences. This perspective effected captivating reading, but it did not improve the understanding of OCD and further, it placed blame upon families. Penzel acknowledged the growth of genetic studies since about 1970, and more recently of those related to environmental aspects, such as being raised in perfectionist or chaotic families, brain illness from rheumatic fever, and also brain injury. He argued, however, that the most likely cause of OCD is associated with serotonin. The serotonergic theory was derived from prescribing the antidepressant clomipramine (Anafranil) as it affected norepinephrine and serotonin neurotransmitters. As seldom encountered in the literature, Penzel precisely explained how this theory is envisioned and why:

serotonin is stored in chambers known as vesicles near the endings of certain neurons.

When the neuron is stimulated by an electrical impulse, the vesicles release their serotonin into the gap...between neuronal fibers....known as the synaptic cleft. The serotonin then travels across the synaptic cleft and fits into receptors on the others side...much like keys being inserted into their locks. This next allows the electrical nerve impulse to cross the synaptic cleft and continue on its travels through the brain to its final destination. When the impulse has jumped the gap, the serotonin is then taken back into the vesicles to await the next impulse....This last activity is known as "reuptake." Theory hold that in OCD, the serotonin is released into the synaptic cleft, but before the nerve impulse can properly jump this gap, reuptake happens prematurely and a proper electrical transmission...does

not take place. When this takes place simultaneously at multiple nerve cell junctions, we have a brain dysfunction. (p. 312)

Only a few years later, however, Abramowitz, (2006) reported that results from studies of serotonin and its positive treatment effects upon OCD symptoms have been mixed, and thus one cannot strongly attribute such a neurochemical theory to OCD etiology. Further, he noted that neuroanatomical OCD theories, implicating certain abnormal regions in the brain, are also inconclusive. Psychological theories related to learning and cognitive deficit also have limitations, such as not accounting for the development of fear and not explaining why there exists such a diversity of symptoms. Abramowitz favoured a cognitive-behavioural model as this is closely related to intrusive thoughts that are greatly exacerbated compared to the general population and cause extreme distress and loss of time, but he also acknowledged the strong likelihood of the interplay among the factors involved with the environment, genetics, and biology.

Similarly, Davison, Neale, Blankstein, and Flett (2005) described a varied OCD etiology, based on psychoanalytic, behavioural and cognitive, and biological perspectives. Regarding psychoanalytic theory, obsessions and compulsions are resultant from excessive toilet training and can be exemplified by one who has become extremely concerned with cleanliness and symmetry. Adler (1931) espoused the view that low self-esteem in children, caused by very strict parents, could instill a desire for them to focus on mastering even the most simplest of tasks. Behavioural and cognitive theories have also linked OCD behaviours, such as excessive hand washing to mitigate anxiety, checking due to faulty memory, thinking about how insignificant events could very easily become extremely significant ones from a preoccupation with reflection, and attempting to ignore other such distressing thoughts. These researchers noted potential merits of these viewpoints, but they asserted that these still did not account for the entire OCD story as

biological factors, such as familial genetic associations, neurochemical aspects, and brain trauma and tumors involving the basal ganglia and frontal lobes as documented in brain scan studies, are also associated with OCD.

More recently, Markarian et al. (2010) described OCD as a "complex neurobiological illness that likely has multiple etiological determinants" (p. 79), such as psychological, neuroanatomical and chemical, and genetic. Maia and McClelland (2012) also noted this complexity and they asserted that taking a neurocomputational approach to OCD is becoming increasingly beneficial to psychiatry because it allows for understanding at several levels, such as from synaptic abnormalities to presentation of OCD behaviours. They acknowledged, however, that the main area for OCD brain abnormality is still unknown and may also be different among patients. In a recent example from neuroimaging research, Milad and Rauch (2012) asserted that models from the past decades have concentrated on the OCD brain's cortico-striatal circuitry, but this focus should now be expanded to include "the lateral and medial orbito-frontal cortices, the dorsal anterior cingulate cortex and amygdalo-cortical circuitry" (p. 43). They argued that an expanded focus is needed because these additional regions "may be related to deficient fear inhibitions, severity of symptoms and predictors of treatment response." (p. 49).

Comorbid disorders.

The variety of OCD comorbid disorders has been discussed by numerous clinicians in many publications. Penzel (2000), for example, referred to them as obsessive-compulsive spectrum disorders (OCSDs), and included body dysmorphic disorder (BDD), trichotillomania (TTM), onychophagia (nail biting), and Tourette's syndrome (GTS) due to their similar characterizations, such as comorbidity, intrusion, repetition, causing anxiety, and their severe impact on quality of life. Also, Abramowitz (2006) has used the term comorbidities, and Pallanti and Hollander (2008)

identified these as "the putative cluster of OCD-related disorders (OCRDs)" (p. 6), which is a perspective used to examine dysfunction of the basal ganglia. They noted that OCRDs are still being developed and debated, despite their commonalities, such as chronicity, potential inheritability, and brain dysfunction. More recently, American Psychiatric Association (2013) has included OCD, BDD, excoriation disorder, hoarding disorder, and TTM within the classification of obsessive-compulsive and related disorders.

Diagnosis.

Self-diagnosis or mental health queries by a family member or friends usually occurs prior to a formal, clinical diagnosis as OCD sufferers are frequently so embarrassed by their symptoms. They commonly deny their behaviours and try to avoid being caught in the act. Acknowledging that they have these symptoms and then eventually seeking and receiving help are steps that often take years. Probably the most widely used clinical OCD diagnostic tool is the Yale-Brown Obsessive- Compulsive Scale (Y-BOCS), comprised of its thorough checklist of obsessions and compulsions rated from subclinical to extreme and its clinical interview to probe the functional aspects of the disorder, rather than its form (Abramowitz, 2006). In place of a formal, clinical diagnosis, there are, however, a number of self-report instruments that have demonstrated their usefulness (Overduin & Furnham, 2012), for instance, the Florida Obsessive-Compulsive Inventory (FOCI), the Clark-Beck obsessive-compulsive inventory, (CBOCI), and the Obsessive-Compulsive Inventory-Revised (OCI-R).

Treatments.

Schruers, Koning, Luermans, Haach, and Griez (2005) described OCD as being a chronic and very disabling disorder and noted that 30% of OCD patients are deemed to be treatment refractory with respect to current treatment protocols. More recently, however, Boschen,

Drummond, Pillay, and Morton (2010) researched the outcome of treatment for severe, treatment resistant OCD in inpatient and community settings. Key findings included that their study was only the second study to explore outcome predictors in severe OCD, and that elevated symptom severity and being married led to more favourable treatment outcomes, thus there may be some hope for those affected.

Treatments for OCD can range from rather mild to very invasive interventions, such as from breathing exercises and yoga to psychotherapy and medication and then on to neurosurgical options for extreme cases. Tolin and Steketee (2007) identified exposure and response prevention (ERP), also referred to as exposure and ritual prevention, as the psychological treatment that has been the most broadly tested. Despite this notoriety, Tolin (2009) more recently described OCD psychological treatments as *Alphabet Soup* as their abbreviations are in need of clarification and the various types of cognitive-behavioural therapy (CBT) do not seem to differ much from other types of OCD psychotherapy. He noted that ERP, CT, and acceptance and commitment therapy (ACT) all include self-monitoring, psychoeducation, and proactive internal and/or external anxiety-reducing practices, such as confronting the common fear of becoming contaminated while shaking hands. Although ERP, CT, and ACT have different recommended durations for patients to spend on confronting fears, Tolin observed that the effectiveness of such differences in time spent are still being debated and these differences do not really qualify as being markedly different treatment procedures. In terms of the effectiveness of these treatments upon patients' symptoms, there also appear to be no marked differences. Considering the advantages and popularity of treating OCD with CBT, Antony et al. (2007) asserted that this type of treatment "can be extremely challenging and full of pitfalls." (p. 5). Further, seeing the broad scope of treatment approaches, many have acknowledged that OCD patients still experience ineffective treatment regimes and

remain treatment refractory (Scarff, 2010). In addition, Davison, Neale, Blankstein, and Flett (2005) found that patients with OCD are rarely cured, even when considering all forms of treatment. Still, new treatment variations are being developed and tested, such as mindfulness-based cognitive therapy (MBCT) for OCD (Hertenstein, et al., 2012). This treatment differs from ERP because it does not induce anxiety-producing thoughts or behaviours, but focuses on patients categorizing occurrences that cause discomfort and then refraining from judgements and compulsions. In their qualitative study of 12 OCD patients, they found that treatment was reported to be effective in some cases, for example, in reducing OCD symptoms and ameliorating the quality of sleep and daily mood. As noted above, however, treatment was not effective for all, as four people did not notice any benefits from MBCT.

Regarding medication for OCD, selective serotonin reuptake inhibitors (SSRIs) are commonly prescribed due to the theory described by Penzel (2000) above. He noted that the SSRIs Prozac, Zoloft, Paxil, Luvox, and Celexa, among other drugs, are prescribed alone or in combinations depending upon the response of the patient. Although taking medication alone or in combination may seem straightforward and relatively safe, Turner, Matthews, Linardatos, Tell, and Rosenthal (2008) found that the inconsistencies in reporting antidepressant research could have had negative effects upon stakeholders. Their data ranged from 1987 to 2004 and comprised 12,564 patients and 12 antidepressants in 74 studies. The SSRIs above were included in almost half of these 74 studies. They concluded that studies that agreed with the Food and Drug Administration (FDA) were much more likely to be published than studies that were contrary to the FDA. Further, studies with negative outcomes were more likely to be published in a manner that was positive. Thus, the ability to weigh positive and negative effects of antidepressants has been undermined by such inconsistencies.

In terms of the general efficacy of medication, Markarian et al. (2010) cited pharmacotherapy studies using SSRIs as being effective for about half the patients, with drawbacks such as patients having to wait many weeks for maximum effect, side effects of insomnia and elevated anxiety, and continuous use of medication to prevent symptom relapse. Further, Markarian et al. noted the valuable contribution that functional impairment and quality of life research can play in terms of expanding the dearth of related research, and thus, potentially leading to improvements in treatment approaches. They also strongly supported research that considered OCD from a variety of academic fields. This exploratory study contributed verbatim, contextualized data related to both functional impairment and quality of life among the rarely studied population of university students with OCD, and it also informed post-secondary student education by eliciting participants' recommendations surrounding OCD.

Similar to areas of OCD research mentioned in this chapter, there is also a dearth of surgical studies on OCD (Bear, Fitzgerald, Rosenfeld, & Bittar, 2010). Neurosurgical treatment is viewed as a last option due to its invasive nature and the potential complications involved. Currently, there are a diversity of views regarding the appropriateness of surgical interventions for OCD (Bear et al.; Lapidus et al., 2013). Perhaps, the foremost result of this diversity of views stems from horrendous surgical procedures of the past. The use of an ice pick and hammer for brain surgery on patients with obsessions and compulsions, depression and schizophrenia, for instance, was developed by Moniz in the mid-1930s and earned him a Nobel prize and a following that lasted about 30 years (Bear et al.). Contemporary surgical procedures can be classified as lesioning, or destroying specific brain regions, and neuromodulation that involves deep brain stimulation (DBS) (Bear et al.). In a significant earlier study, for example, Dougherty et al. (2002) described lesioning areas of the corticostriatal circuitry, with surgical interventions such as subcaudate

tractotomy, limbic leukotomy, capsulotomy, and cingulotomy. Their study involved 44 patients who received one or more cingulotomies for treatment-refractory OCD. Functional improvement in several areas for 20 patients was reported with minimal side effects overall. The authors concluded that after patients had exhausted psychotherapy, medication, and all other non-surgical procedures, cingulotomy seemed to be of benefit to many of their patients. For psychiatric disorders in Canada and the USA, cingulotomy is the most common type of neurosurgery (Lapidus et al.). In the neuromodulation procedure, a DBS lead and electrode are implanted and a very specific brain region can then be electrically stimulated and regulated by the patient and physician, which is much more advantageous than the destructive nature of lesioning because DBS can be modified according to symptom changes and it is reversible (Bear et al.; Lapidus et al.). A major drawback with DBS, however, is that it has an initial cost of about AUD\$35,000 and an annual cost of about AUD\$15,000, with patients required to live near an urban area in case of emergency (Bear et al.). Another drawback with DBS is referred to as the “paradox of psychiatric surgery” (Lapidus et al., p. 12) because alterations in a variety of neural circuits cannot be fully effective with the stimulation of only a very specific brain region. Seeing that lesioning and DBS are effective for roughly half of the patients, these procedures seem to hold some hope for those with intractable OCD (Bear et al.; Lapidus et al.).

An additional treatment can be added from Scarff (2010), who acknowledged the many limitations that still persist in terms of OCD treatments, for instance, that as many as half the pharmacotherapy patients do not completely benefit from SSRIs, and the exorbitant cost of ERP therapy. These limitations triggered this surprisingly different perspective on the relationship between obsessions and compulsions, markedly different from the ubiquitous example of trying to reduce compulsive hand washing by focusing on a patient's contamination obsession. Scarff

advocated for a "self-talk technique" (p. 217) that introduces a focus on an additional obsession to treat the primary obsession and its related compulsion. Using the hand washing example, a patient would be encouraged to mitigate his or her time spent on hand washing by noting that another obsession, such as financial worries, would activate after a pre-determined amount of time. It is the intention of this technique that a patient would only have to spend a few minutes, rather than hours, washing repetitively or up to a certain time, as another obsession would be ready and waiting to activate, thus producing even greater distress if the hand washing did not end after this self-imposed time limit. He noted that therapists choosing to implement this technique should carefully inform and monitor their patients as this technique has still not been tested, and could result in exacerbating the degree and frequency of certain obsessions. Despite these drawback, Scarff asserted that this technique could be used supplement current treatments and patients could gradually diminish their OCD symptoms, thereby becoming more able to control their lives with OCD. Further potential benefits of this technique, he noted, are that this could be implemented at any moment and be used for many compulsions, without having to pay for expensive treatment visits each time.

Post-secondary students with primary OCD.

Only a small number of studies have examined psychiatric disorders in university students (Verger, Guagliardo, Gilbert, Rouillon, & Kovess-Masfety, 2010), consequently, it was not surprising that only eight studies could be compiled that included a population similar to the present study. This review describes these eight studies identified and the apparent gaps in researching the lives of this student group. To provide some background, researchers have investigated OCD among post-secondary students for decades, but the majority of theses studies have focused on OCD symptomology among university students unlikely to have been clinically

diagnosed with OCD (e.g., Dorfan, 2008; Huppert, 1999; McBride, 2006; Nelson, 2005; Peacher, 1980). In a more recent study, for example, Gelfand (2013) noted that in OCD research, using nonclinical participants has become an *established practice* because it is much easier to collect data. Other studies have included students diagnosed with (primary) OCD, along with other adults, but they either did not describe the student status or indicate a primary OCD diagnosis, or both (e.g., Akpinar et al., 2013; Ehntholt, Salkovskis, & Rimes, 1999; Grenier, O’Conner, & Bélanger, 2010; Hertenstein et al., 2013; Thordarson, 2001). Research somewhat closer to the present study has included university students diagnosed with OCD, but diagnoses were either not specified as primary, or verified by the researchers, or both (e.g., Brockelman, 2009; Haase, 2003; Verger et al.; Yoldascan et al., 2009). From searches ending in February 2015 through dozens of databases such as APA PsycNET and ProQuest Dissertations & Theses Global (also the UK and Ireland), five quantitative and three qualitative studies were found to be closest to the present study as participants were predominantly post-secondary students diagnosed with primary OCD (see Table 1 below for detailed descriptions). An addition study (Bond, 2011) is also described as it seemed to bridge the five quantitative and three qualitative studies reviewed.

Table 1: Descriptions of the eight studies that included post-secondary students (PSS) diagnosed with (primary) OCD

Five quantitative studies					
	Rh��aume (1998)	Thordarson (2001)	Mendhekar & Andrade (2009)	Yu & Li (2010)	Ferris, Mills, & Hanstock (2012)
Recruited subjects	Five adults clinically diagnosed with primary OCD	Eighty-eight adults in clinically diagnosed OCD group, three non-OCD control groups	Case study of a 22-year old male	Case study of a male and female in early 20s with OCD	Case study of a 28-year old female
Number of PSS	Two PSS with primary OCD	Nine or ten PSS with OCD About nine with primary OCD	One with OCD	Female with mainly moderate symptoms, male with weaker symptoms	One with OCD
Description of PSS' Institution	College, in Quebec, Canada	Unspecified, in British Columbia and/or Arkansas	College, probably in India	University, in southern China	Community College, in NSW, Australia
Focus of Study	"individual relationships between variations in negative mood states, symptoms and beliefs during (CBT) of OCD"	Investigated validity of 55-item Vancouver Obsessional Compulsive Inventory (VOCI)	"preoccupation with cell phone ring tones" "running repeatedly through his mind"	Investigated efficacy of physical therapy on OCD symptoms	Investigated efficacy of ERP on "repugnant thoughts and images"
Data Collection/Treatment	Used several quantitative measures before and after 16 weekly CBTs, e.g., related to thoughts, symptoms, beliefs	Distributed VOCI to OCD and non-OCD groups	Prescribed fluvoxamine (SSRI) and clomipramine (antidepressant) taken daily	Used Y-BOCS and SCL-90 before and after eight weeks of mainly physical therapy, with some cognitive therapy	Used several quantitative measures before, during, and after 11 ERP sessions

	Rh��aume (1998)	Thordarson (2001)	Mendhekar & Andrade (2009)	Yu & Li (2010)	Ferris, Mills, & Hanstock (2012)
Results	Found great diversity in these relationships, suggesting the manner and time in which "individuals may change their obsessions, distorted beliefs and mood states may be highly idiosyncratic"	Supported six main factors (symptoms) for those with OCD, i.e., just right, contamination, obsessions, hoarding checking, indecisiveness	He found the medication helped 90% with "no residual functional impairment" after 3 months	Physical and mental health improved, more so with severe and moderate symptoms than with milder symptoms	After 11 ERP treatment sessions, she found great improvement in mental health, e.g., better control over thoughts and able to reduce distress
Contri- bution	Individual case perspectives, rather than typical group analyses, and showed idiosyncratic variations that could improve clinical treatment for OCD	Additional tool to understand OCD symptoms in adults clinically diagnosed with (primary) OCD	Only case associating musical obsession with ring tones	Physical therapy may be an additional tool useful in OCD treatment	ERP is an effective treatment for OCD when client is fully briefed about each session

Three qualitative studies			
	Savoie (1995)	Weiner (1997)	Haase (2003)
Recruited subjects	Nine adults with a “formal diagnosis of OCD”	Eight university students clinically diagnosed with a chronic mental illness	Fourteen adults ‘who have had the experience of OCD”
Number of PSS	One PSS with primary OCD	Two PSS with OCD, both possibly with primary OCD	Two PSS (possibly more) who have had the experience of OCD
Description of PSS’ Institution	University, in Saskatchewan, Canada	University, in Ontario, Canada	University and unspecified Alberta, Canada
Focus of Study	Investigated meaning of guilt for adults with OCD Used phenomenological interviews to increase understanding of links between guilt and OCD	Investigated “meaning of education for students living with a serious mental illness”	Investigated the lived experience of OCD using phenomenological interviewing
Data Collection	Used unstructured interview surrounding guilt, but based on ten questions related to origin, feelings changes, reflections, effects One interview of ~ 2 hours	Used semi-structured interviews that addressed six questions related to meaning and goals of their education, barriers, support, administration, and advice Between 2-4 interviews each, initial interviews 1-2 hours	Interviewed most participants only once for about an hour, but with no interview schedule
Results	Documented 15 themes related to guilt and OCD, such as forbidden thoughts, rituals, fear, coping, and reparation	Led to a model integrating shifts and variations of university and illness experiences	Found eight themes, e.g., OCD and contexts of time and corporeality, were compared to researcher’s own “ordinary” experiences

	Savoie (1995)	Weiner (1997)	Haase (2003)
Contri- bution	Contributed to the literature and clinical practice by showing the importance of harm, propensity of guilt, and the cyclical, rather than linear, relationship of guilt and symptoms	Contributed recommendations, such as the need for mentoring, and greater flexibility and understanding on campus	Contributed lived experiences of OCD to provide a greater understanding to participants, readers, and her fellow nurses and healthcare colleagues, and to provide a new “sense of hope”

Of the five quantitative studies, three of them involved the efficacy of psychological treatments: CBT (Rhéaume, 1998), CT (Yu & Li, 2010), and ERP (Ferris et al., 2012). Rhéaume employed several quantitative measures, including the Y-BOCS, to investigate the efficacy of CBT upon variations of negative mood states, symptoms, and beliefs. Her study comprised five participants with primary OCD, two being college students. According to the post-treatment Y-BOCS results, three of the five participants, including the two college students, achieved a nonclinical status and remained at this level after a six-month post-test, while the remaining two participants showed no significant improvement after treatment. A brief paragraph introduced each participant, while qualitative descriptions of case variations following treatment were presented on a limited scope. Based on the findings, she advocated for the investigation of these variables *without* the influence of treatment in order to further the understanding of OCD symptoms. In Yu and Li, a male and female undergraduate were treated with eight weeks of both physical and some cognitive therapy in order to mitigate their OCD symptoms. Results from a pre- and post-Y-BOCS and a multidimensional psychological symptom checklist (SCI-90) showed that mental and physical health improved more for severe to moderate OCD symptoms than for milder OCD symptoms. Ferris et al. investigated the efficacy of ERP upon an Australian community college student with OCD. Her main symptoms were related to disgusting thoughts and images. With a variety of quantitative measures, including the Y-BOCS, used before, during, and after 11 sessions, the researchers found she had greater thought control and reduced distress if fully informed about each ERP session. The fourth study involved the efficacy of an SSRI combined with an antidepressant (Mendhekar & Andrade, 2009). At age 19, its participant was diagnosed with OCD and symptoms of checking, counting, and cleaning. By age 22, he had experienced a five-year period of frequently using new mobile phone ring tones, but his enjoyment developed into an obsession that disrupted his academic and social life and lasted six to eight hours

per day for the month prior to treatment. Consequently, he wore earplugs, grinded his teeth, and he also became depressed. After a three-month period of taking an SSRI and antidepressant combination, the patient noted a 90% efficacy. In the fifth study, Thordarson (2001) sought to validate the 55-item Vancouver Obsessional Compulsive Inventory (VOCI) by distributing it to four groups of adults. The OCD group had 88 adults clinically diagnosed with OCD (91% with primary OCD), including about nine PSS with primary OCD. The three control groups comprised psychology undergraduates, adults from the immediate community, and adults clinically diagnosed with mood or non-OCD anxiety disorders. His results shown in Table 1 supported six main OCD factors that were also represented within participants' symptomology of the present study.

Although these five quantitative studies had their merits, their results were mainly quantitative and thus they did not contribute broad descriptions about PSS living with OCD. From general OCD treatment studies mentioned above, and the quantitative treatment studies herein, it is evident that psychological and pharmaceutical treatments have been useful, but not entirely effective. Perhaps, as Rhéaume noted, studying OCD symptoms without the influence of treatment may advance understanding, such as physical aspects of OCD addressed in Yu and Li.

It is interesting that a quantitative study (Bond, 2011) seems to bridge the five quantitative and three qualitative studies being reviewed as it had several similarities to the present study. It included, for example, adults with primary OCD who completed the OCI-R, and it required participants to record daily OCD experiences including family reactions. In addition, some of the participants were described as *undergraduate student volunteers*, but it was neither possible to discern how many of these students participated nor what data could be attributed to them. The Bond study required participants to record their experiences over a week with a book that comprised *activity descriptors* within a prepared coding list, whereas the present study included

a self-report journal intended to provide less restrictive data over a month. Bond's participants were not asked to elaborate upon their experiences in qualitative interviews, but they were asked to describe their experiences within the context of the OCD diagnostic interviews and coding list. He noted the uniqueness of his study as it yielded data related to the specific activities during each day, times of occurrence and durations, family reactions, and their opinions about these family reactions. He found, for example, that family reactions did not have a strong effect upon OCD symptoms or rituals. One limitation was described as the focus on *overt compulsive behaviors*, rather than also including important *mental rituals and obsessions*. The present study included many lengthy, verbatim quotes related to both obsessions and compulsions. For future research, Bond stressed the need to increase the "understanding of the dynamics of OCD" (p. 109).

Of the three qualitative studies, two had very specific focuses, namely the meaning of guilt (Savoie, 1995) and the meaning of education (Weiner, 1997). The third study (Haase, 2003) was rather unfocused and replete with her own personal questions and anecdotes mixed with quotes from her participants' experiences with OCD. Savoie investigated the relationship of guilt and OCD in nine formally diagnosed adults, one being a PSS diagnosed with primary OCD. Similar to the present study, she used phenomenological interviews, but these were based upon 10 questions within a single interview. Her findings yielded 15 related themes, whereas the results from the present study yielded both broader and more detailed phenomenological data, such as in Weiner and Haase who conveyed similar life experiences. Weiner recruited two university students with clinically diagnosed OCD, both possibly with primary OCD, while Haase's recruitment was open to those "who have had the experience of OCD" (p. 69), thus it was unreliable in terms of recruitment of clinically diagnosed participants. Haase's study also included two PSS, but possibly more. For data collection, Weiner used semi-structured interviews based on six questions that

focused on educational issues. Haase interviewed most participants only once for about an hour and she had no interview schedule. Further, the data were collected while she told her participants about others with similar OCD experiences in order to make them feel more normal. In relation to findings, Weiner's model incorporated experiences of eight university students, two with OCD, but her other participants were diagnosed with schizophrenia and other disorders. Haase's findings mainly described OCD experiences by comparing them with her own *ordinary* human experiences.

Addressing gaps in the research.

Considering these eight studies in terms of understanding life as a post-secondary student with lifelong primary OCD, three apparent gaps are evident, namely, participant recruitment, data collection, and findings. In the present study, the researcher addressed the gaps of participant recruitment, data collection, and findings as identified above. Seven PSS were recruited, while in each study above, only about two such participants were included. Further, recruitment was more rigorous, being restricted to only those PSS who were clinically diagnosed with (primary) OCD. In addition, the approach to data collection was much broader, using three self-report questionnaires, two face-to-face interviews, and self-report journals when available. Also, the researcher tried to be more objective than Haase by not discussing his knowledge of OCD with participants. Findings were similar to those of Weiner, but they were much more extensive, for instance, including self-report journal and quality of life data. Further, unlike Haase, the researcher mainly relied upon verbatim interview data from participants and their respective questionnaires, rather than comparing his own personal experiences. It is important to note that potentially informative aspects of studies above were reflected in the interview schedules developed for this present study herein, such as from Weiner, who asked her participants about school administration and advice for fellow students (see also Data Analysis Path). Salient findings related to

participants' OCD functional impairment and quality of life aspects. Further, they showed that as students, their intellectual integration seemed to play a greater role in academic persistence than did their social integration. In addition, participants' university policy and practice recommendations were congruent with a similar study from about a decade ago indicating that perhaps few or none of the past recommendations were implemented for the benefit of such students. Present recommendations should be implemented accordingly. Lastly, through its variety of verbatim accounts, it is hoped that the dynamics of OCD noted in Bond (2011) from these seven perspectives have contributed to an increased understanding.

Conceptual framework

To operationalize a study that considered the researcher's curiosity surrounding the lives of post-secondary students with primary OCD as well as the gaps in OCD academic literature noted above, the present study included an adaptation of Tinto's Longitudinal Model of Institutional Departure (see Figure 1), interpretative phenomenological analysis (IPA) (Smith et al., 2009; Smith et al., 1999; Smith & Osborn, 2003), and Seidman's interviewing as qualitative research (2006, 2013) as its primary lenses with which to collect and present the participant data (for visual representation see Appendix K: Study Concept Map). Descriptions of Figure 1 and related justifications are explained below in addition to measurement constructs related to OCD and quality of life. IPA, Seidman's interviewing, and the primary and secondary data collection and analyses are explained more thoroughly in the subsequent chapter.

Tinto's Longitudinal Model of Institutional Departure: Components and persistence.

Tinto (1993) described this model as relating to the longitudinal process of students interacting within the tertiary institution and community beyond, while also considering persistence and retention. In one of the numerous posits of his 11-page description that elucidated this model, Tinto argued that "interactive experiences which further one's social and intellectual integration are seen to enhance the likelihood that the individual will persist within the institution until degree completion, because of the...continued reformulation of individual goals and commitments" (p. 116). The present study focused on this particular posit and adapted model components in its methodology (see Figure 1 below for visual representation). Adapted model components used to develop the interview schedules included pre-entry factors of family and education background, abilities, and related goals, formal and informal academic and social experiences, academic and social integration, and departure decision. Tinto explained that

departure outcomes include leaving a satisfactory post-secondary education before graduation in order to pursue other goals, taking a leave of absence, transferring to a different educational institution, and completing one's degree. All participants considered transfer and withdrawal at least once during their tertiary education and thus these aspects were addressed in the interview questions. Also, since the participants in the present study were all university students during the data collection period, persistence related to life *within the institution*, or *university* in this case.

It is important to note that Figure 1 was a primary lens used to develop interview questions intended to yield participant data, and also hopefully glean some data related to their persistence (see also appendix K). The researcher's aim, however, was not to persist in obtaining enough data to plug into each and every model component so that the entire model could be wholly analysed in terms of a completed data set for each of the seven participants. He did not dwell upon model components that were not addressed or fully addressed by iterating related questions later on in the same interview or in the subsequent interview as there were other potential data to explore and thus he did not want to confine or discourage participants from speaking. Similarly, Hartley (2013) noted that in Tinto's 1993 theory "academic persistence depends on the complex interplay between the student and his or her ability to integrate academically, referring to attending class and studying, and socially, referring to fitting in the university over time" (p. 241). Perhaps due to this *complex interplay*, however, he used Tinto only to provide a basis for two *outcome variables* (GPA and credits completed) related to "concepts of academic and social integration" (p. 242).

Metz (2004-2005) emphasized Tinto's assertion that one can develop more effective and relevant policy initiatives when research is conducted on specific individuals within specific institutions, as opposed to more general, national studies. He also noted, however, a criticism by Pascarella, who strongly argued for the inclusion of community college students, thus broadening

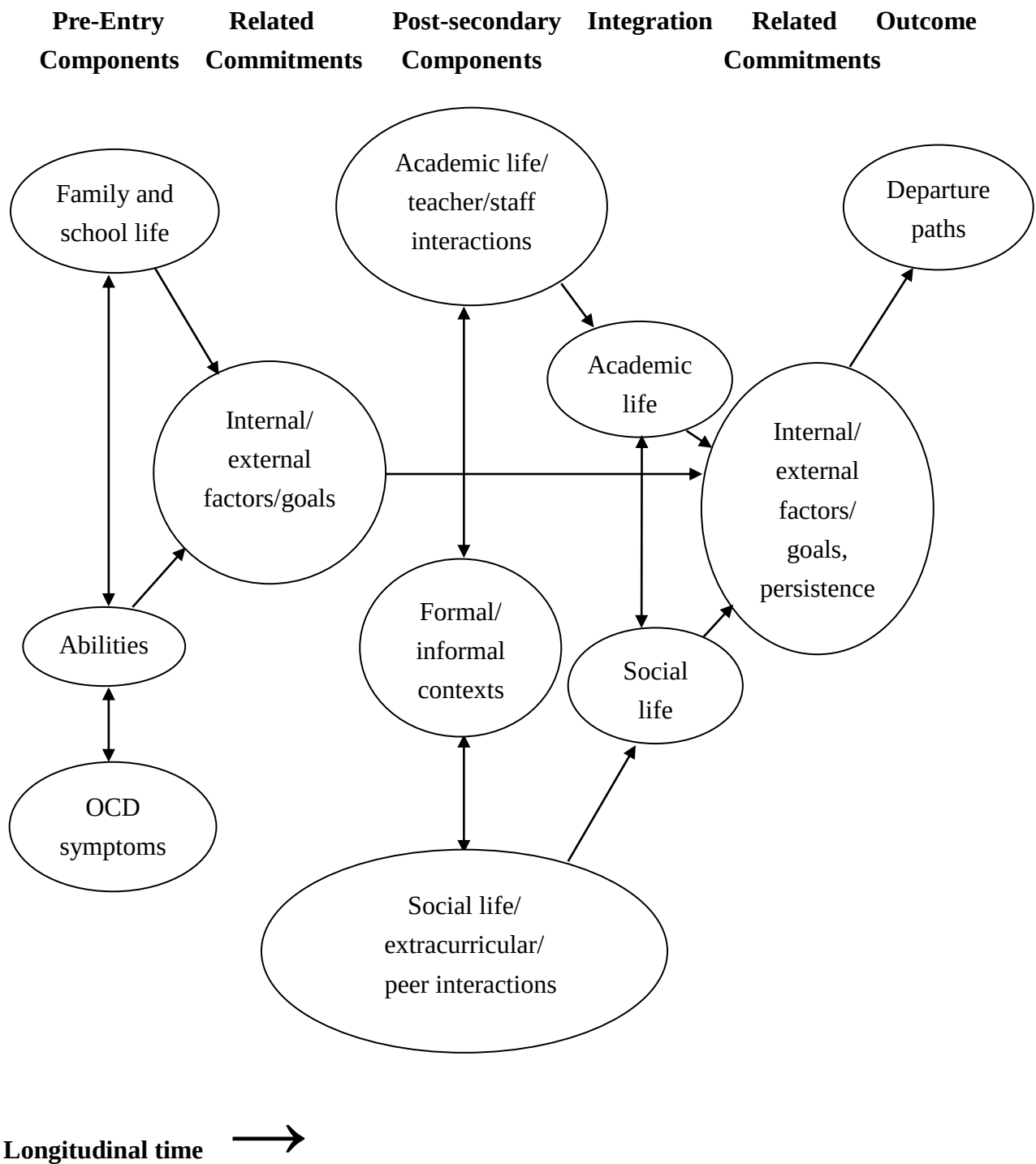
Tinto's research beyond its focus on university students. In Tinto (2006-2007), however, he acknowledged the importance of including such students. In another criticism, Cabrera, Nora, and Castaneda (1993) argued that Tinto's theory has a significant gap in that the role of external factors, such as financial commitments, and parental support. Recognizing both the significance of Tinto's assertion (above) and these criticisms, the researcher strove to collect and incorporate data from both university and college students, and to examine such external factors. After reading many related articles and books, it became frustrating to see Tinto's model almost exclusively discussed in terms of *student retention* and/or *student persistence*. After many searches, the researcher discovered that Tinto explained "retention and persistence are interwoven. Institutional actions on behalf of the former promote student behaviours that engender the latter" (Tinto, 2005, p. 94).

More recently, Tinto (2006-2007) identified several areas that warrant further research, including an increased focus of institutions and states to improve the persistence and graduation rates of students from two- and four-year colleges and universities, the important influences on post-secondary persistence of student high school and related family experiences, and especially the effects of classroom practice on learning and persistence. Considering these aspects, this study also included questions that related to high school and family experiences and relationships and their connections to post-secondary persistence. Also, the subject of classroom dynamics was explored in terms of individual experiences and relationships. Tinto and Pusser (2006) noted the copious research on student attrition and persistence, which has also been enlightened by research on underrepresented and low-income post-secondary students. Data collected in the present study related to experiences from the underrepresented population of post-secondary students with OCD to further enlighten this research.

To recapitulate, Figure 1 has guided this research in terms of the development of its research questions, specifically related to temporal periods in students' lives and their persistence while being university students. Respective data were collected considering interview rapport and participant interest. Analysis and presentation of these data are addressed in the subsequent chapter under the Data analysis path heading.

Figure 1: Adaptation of Tinto's Longitudinal Model of Institutional Departure

Adaptation based on

A longitudinal model of institutional departure (Tinto, 1993, p. 114)

OCD and quality of life measurement constructs.

To more effectively examine participants' OCD symptomology, quality of life, and to provide them with the opportunity to view and comment on these related dimensions, the Obsessive-Compulsive Inventory-Revised (OCI-R) (see Foa et al., 2002 in Appendix F) and the SF-36® Health Survey, version 2.0 (SF-36v2) (see Ware, Kosinski, & Dewey, 2000 in Appendix G) were implemented in the present study. These aspects are explained below.

OCD symptomology.

Researchers (e.g., Abramowitz, Tolin, & Diefenbach, 2005; Hajcak, Huppert, Simons, & Foa, 2004; Watson & Wu, 2005) have acknowledged OCD symptomology to be operationalized within the six main symptoms of washing, obsessing, hoarding, ordering, checking, and neutralizing. In a more recent study, Laposa and Rector (2009) suggested different subtypes comprising "contamination/ cleaning, symmetry/order, pure obsessions, harming/doubting/ checking, and hoarding" (p. 599), and they also noted in other research (Calamari et al., 2004) the potential of an additional subtype that involves being afraid of harming other people by contaminating them. Briefly, excessive washing can be triggered after having touched people or things deemed to be contaminated and this can also result merely from the need to feel clean or *just right*. Obsessing involves thoughts that are distressing and cannot easily be controlled. Hoarding can involve keeping receipts, personal notes, and computer files well beyond their useful functions, such as for income tax filing purposes. Excessive ordering can be apparent, for example, when items of clothes must be specifically arranged in a closet or books placed in a bookshelf according to date of purchase or size. Distress can occur when such ordering is disturbed by someone or cannot be carried out. Checking often involves light switches, door locks, and alarms that must be repeatedly checked to verify that all is well, for instance, an alarm set to ensure that one wakes up in time for

a morning exam. Neutralizing frequently involves numbers that serve to guide one's behaviours to avoid harm to oneself or to others, such as with the use of lucky and unlucky numbers. If the number 5 is lucky for a student, for example, five pens may be brought to an exam to potentially have a better result and thus mitigate some exam-related anxiety.

In a study that used the OCI-R with 178 nonclinical university students, Hajcak et al. (2004) found it to be an accurate measure of obsessive-compulsive symptoms. Other studies, such as Watson and Wu (2005), had similar findings. Further, Huppert et al. (2006) found the OCI-R to be not only a concise, psychometrically sound tool that addresses many of the primary OCD symptoms, but also suitable for research purposes involving both clinical and non-clinical participants. Similarly, Abramowitz, Tolin, and Diefenbach (2005) studied 77 primary OCD adults and found the OCI-R to be psychometrically sound with the ability to gauge the impact of OCD obsessions and compulsions even with the presence of poor insight. Further, Abramowitz and Deacon (2006) recommended the OCI-R "as an empirically validated instrument that can be used in a range of clinical and research settings for research on OCD" (p. 1016). More recently, Overduin and Furnham (2012) thoroughly assessed the OCI-R along with nine other self-report OCD measures. They concluded the OCI-R is "a reliable and valid measure of OCD symptoms" (p. 316), but they also noted the limitations of having a small number of items in each subscale that could cause unstable measures, and there are more compulsion subscales than obsession subscales.

OCD and quality of life.

OCD can often significantly impact quality of life (QoL), but the concept of QoL in OCD has not been well researched despite its recognition as the 10th-most significant medical disability throughout developed countries (Eisen et al., 2006). Greatly reduced QoL in OCD is often associated, for example, with washing, hoarding, and ordering (Speisman, 2012). Research has

shown OCD to strongly interfere with socializing, studying, working, and other important aspects of one's life, but many studies have either acknowledged the difficulty in defining QoL, or completely avoided the issue (Lochner et al., 2003). Reflecting upon the ongoing debates regarding individual and population-level definitions and measurements and objective and subjective perspectives of the construct of QoL, Rapley (2003) advised researchers to make an informed choice when employing this construct. After providing an extensive review of the QoL research, Rapley recognized the prominence of the SF-36 Health Survey in measuring health-related quality of life (HRQOL). Even a decade after this review, Herenstein et al. (2013) acknowledged that the use of various QoL instruments to study OCD is problematic because of the variety of domains. Because of the strong impact of OCD on QoL, the dearth of related research, the need to develop a deeper understanding of post-secondary students with OCD, and the prominence of the SF-36 Health Survey, this study employed the latest SF-36® Health Survey, version 2.0 (SF-36v2), with its 36 items related to physical and mental aspects of health. The broad concept of physical health is reflected here to include physical functioning, role- physical, bodily pain, and general health. The broad concept of mental health is reflected here to include vitality, social functioning, role-emotional, and mental health as it refers to degrees of calmness, depression, happiness, nervousness, and peacefulness. Many studies have found the survey to be quite informative, for example, Rodriguez-Salgado et al. (2006) found that QoL was linked to several factors including OCD severity and employment status. Further, Moritz et al. (2005) studied the QoL of 79 OCD patients before and after treatment. The authors were surprised to find that these patients were not only impaired emotionally and socially, but also physically, thus revealing the usefulness of this measure to develop a deeper understanding of QoL among people with OCD. In addition, Verger et al. (2010) implemented a part of the SF-36 to study university students and

their psychiatric disorders. Of particular relevance to researching post-secondary students, who must attend many lectures, and take notes and tests for several years, is the finding that some people with severe OCD symptoms are able to view themselves as continuing to meet obligations and to have healthy lives (Stein et al., 2000). With the SF-36v2, however, Cleary and Howell (2006) acknowledged that a main concern is that it may fail to provide a broad view of respondents' health-related quality of life (HRQOL) and this may not recognize meanings, relationships, and environmental factors that could influence quality of life. Thus, they suggested that researchers conduct supplemental interviews or discussions with open-ended questions to potentially develop a broader picture of respondents' HRQOL. Similarly, Fontenelle et al. (2010) noted that their use of the SF-36 with OCD patients may not “fully capture the particularities and daily difficulties of our patients” (p, 202). The present study addressed these issues by striving to collect such participant data.

Chapter summary

The literature review highlighted a variety of articles selected for their similarity with the present study and their relevance to historical and contemporary OCD issues. Three apparent gaps were identified from the related literature, while the conceptual framework addressed these gaps by emphasizing the operationalization of three primary lenses and OCD and quality of life measurement constructs.

Chapter III: Methodology

This chapter includes the research design, IPA, Seidman's interviewing, and the study recruitment in terms of participants, sample size, and saturation. Next, primary and secondary data collection, the data analysis path, the researcher's perspectives and pilot study, and the quality of IPA research, trustworthiness, with related checklists are addressed. Lastly, vignettes are presented to introduce participants and familiarize readers with some of their relationships and symptoms.

Research design

The researcher of the present study investigated lifelong educational and other social experiences and relationships of post-secondary students who were clinically diagnosed with OCD. A qualitative approach was adopted because few studies have considered lifelong characteristics within this population. Most similar studies have used quantitative methods to research OCD symptomology among university students unlikely to have been diagnosed with OCD. The researcher addressed the main research gaps of participant recruitment, data collection, and findings as identified above. As noted, three lenses were used to collect and present participant data due to their suitability in researching this group of adults. Face-to-face interviews, three self-report questionnaires, and participant journals comprised the primary data collection that addressed the study's three research questions. These questions involved the past, present, and future of participants' characteristics in education, other social contexts, and quality of life. Although many studies over the decades have focused on OCD symptomology among university students and other adults, the present study seems to be the first to have qualitatively presented an extensive number of lifelong characteristics, experiences, and relationships from a variety of university students diagnosed with primary OCD. It yielded salient findings related to participants' OCD functional impairment and quality of life.

Further, it showed that as students, their intellectual integration seemed to play a greater role in academic persistence than did their social integration. In addition, participants' university policy and practice recommendations were congruent with a similar study from about a decade ago indicating that perhaps few or none of the past recommendations were implemented for the benefit of such students. Present recommendations should be implemented accordingly.

Phenomenological research and interpretative phenomenological analysis (IPA).

Fade (2004) described phenomenology as beginning with the thoughts of Husserl and a focus on human understanding. Willig (2001) and Patton (2002) acknowledged that there are a variety of research methodologies in phenomenology and they advised that one should be clear about the approach being discussed. The researcher considered the methodologies of many prominent phenomenological researchers, such as those of Moustakas (1994), Giorgi (1983), Giorgi and Giorgi (2003), Spinelli (2005), and van Manen (1997). After considering their approaches, the views of Fade, and many books and journal articles related to phenomenological research, those studies from the field of health psychology seemed to be most compatible with this OCD study, and such articles have acknowledged and demonstrated the usefulness of IPA (e.g., Chapman, 2002; Chapman & Smith, 2002; Fade; Hepper, Weaver, & Rose, 2005; Kay & Kingston, 2002; MacLeod, Craufurd, & Booth, 2002; Robson, 2002; Scior & Grierson, 2004; Senior, Smith, Michie, & Marteau, 2002; Shaw, 2001; Smith, Michie, Stephenson, & Quarrell, 2002). Kay and Kingston, for example, found IPA to be valuable because intimate issues could be elicited and examined. Further, in their study of 18 psychiatric patients (Hepper et al.), there were two, secondary school aged students diagnosed with OCD, making this study one of the few found that used IPA to analyse participants diagnosed with OCD.

Another salient reason for employing IPA in the present study is that, contrary to the prominent phenomenological researchers mentioned above, Smith et al. (1999) asserted that in order to gain a perspective from the participant's viewpoint, "access depends on....the researcher's own conceptions and indeed these are required in order to make sense of that other personal world through a process of interpretative activity" (pp. 218-219), and the IPA case-study approach (Smith & Osborn, 2003) is bound to assiduous case analyses instead of striving for generalization among cases.

What is IPA?

For the purposes of generalizing and interpreting, traditional methods of analyzing qualitative interview data usually break apart long accounts into very small parts and then describe these parts out of context without considering that a long account could be viewed as “a unit of discourse” (Reissman, 2002, p. 239). This traditional pattern is contrary to IPA, where analysis is dependant upon lengthy verbatim quotes used in context and it is “committed to the examination of how people make sense of their major life experiences” (Smith et al., 2009, p. 1). This approach often makes use of flexible, semi-structured interviews to collect data from participants who have a significant *stake* in their interviews. Analysis is explained as an “iterative process of fluid description and engagement with the transcript...(with) flexible thinking, processes of reduction, expansion, revision, creativity and innovation” (p. 81). Further, they noted that innovation in researcher analyses is encouraged, but this can be based on their six-step analysis process. Earlier work by Smith and others is then used to explicate this rather complex analysis process. The present study also used such earlier work in its IPA description and analysis process. Notably, Fade (2004) described how IPA is phenomenological because it aims for *insider perspective* in terms of a person’s experiences, and IPA is interpretative as it recognizes the researcher's background and

beliefs and their importance in understanding and interpretation. More specifically, Smith (1996) described phenomenology and symbolic interactionism as being IPA's key theoretical factors. The main purposes of the IPA case-study approach (Smith & Osborn, 2003) are to explore how participants make sense of their personal and social world, and to develop an understanding of the meaning participants have in terms of experiences, events, and states. Further, IPA employs a double hermeneutic process that combines empathic and questioning hermeneutics. This process attempts to understand the viewpoint of a participant, but also enables the researcher to critically examine and question the interview text of a participant. In the IPA approach, participant recruitment is conducted using purposive sampling and then semi-structured interviews are employed as a main source of data collection, but the authors also acknowledged that other forms of data collection, such as personal accounts, could also be informative. The data analysis basically comprises the four, main cyclical processes of looking for commonalities in the first case from the interview transcripts, looking for connections within this case, producing a master list of headings, and writing the remaining cases as a recursive process (Smith et al., 1999). More detail is provided later in the Data Analysis Path.

In terms of symbolic interactionism, Smith and Osborn (2003) related its "concern for how meanings are constructed by individuals within both a social and a personal world" (p. 52), and more specifically that IPA "shares with the social-cognitive paradigm a belief in and concern with, the chain of connection between account, cognition and physical state" (Smith, 1996, p. 265). Smith described, for example, that when a researcher interprets a questionnaire item, it is assumed that the data collected reflect the participant's cognitive activity. Smith and Osborn referred to Denzin (1995) for a more detailed description. He stated symbolic interactionism "offers a generic theory of action, meaning, motives, emotion, gender, the person and social structure" (p. 57).

Similar to the present study, Murphy and Perera-Delcourt (2014) used IPA to understand the relationships and experiences of those with OCD. The researchers, however, chose not to delve into participants' clinical diagnoses or ask them to complete any OCD-related questionnaires. They focused on participants' lives while undergoing CBT. Another study (Spragg, 2013) used IPA to study adult participants with OCD who were in group CBT, but they were not identified as students. Kellett, Greenhalgh, Beail, and Ridgway (2010) also implemented IPA to study adult OCD, but their focus was on compulsive hoarding and no participants were identified as students.

Seidman's interviewing

The qualitative interviews in the present study were guided by Seidman's interviewing as qualitative research (2006, 2013) and their success from the researcher's prior pilot study. He described using a series of three phenomenological interviews that lasted a maximum of about ninety minutes each and were spaced approximately three to seven days apart. The first interview focuses on students' previous life experiences up to the present. The second interview focuses on detailing present experiences, such as with the reconstruction of a day from awakening to falling asleep. The third interview focuses on eliciting *intellectual and emotional* relationships, including future paths. In the pilot study, a two-interview structure was implemented due to the strong possibility of increasing attrition using three interviews, and thus the present study retained this two-interview structure. Seidman (2006) noted that acceptable results have been obtained using variations on his three-interview series.

Participants

In terms of participant recruitment, Smith and Osborn (2003) described the IPA approach as non-representative and non-random sampling, or *purposive sampling*. They added that the practicality of recruitment is influenced "by who is prepared to be included in it!" (p. 54).

A later interpretation of sampling (Morgan, 2008), however, asserted that purposive sampling is associated with the manner of specifying the population, but not the manner of recruiting participants from that population. Morgan noted that nearly all qualitative studies use *nonprobability* sampling, such as *convenience sampling*, because of the *difficulty* in recruiting admissible participants. Thus, convenience sampling seems to more aptly characterize the participant recruitment in the present study because all interested students were recruited if they were enrolled at a post-secondary institution and they had also been clinically diagnosed with (primary) OCD. Participants were assigned the pseudonyms of Robin, Anne, Mary, Oliver, Nick, Elaine, and Steve. Participant recruitment began at the end of August 2007. As ethics approvals for study recruitment were granted, more post-secondary institutions were added to the recruitment process. At its maximum, from October 15, 2007, recruitment took place at four post-secondary institutions in the province of Ontario, Canada comprising five campuses in total. Usually, the researcher posted his one-page recruitment ad (see Appendix A) on walls and other areas designated by the respective institutional administrators, but in some instances, the researcher handed his ad copies to institutional administrators who agreed to post them as long as needed. In one case, this posting was on the front door of a help centre for students with health problems and related issues. At three of the campuses, administrators had to stamp each ad copy with an expiry date and the respective institutional name before the researcher could post them. Ad copies were reposted, for example, if they had expired, been covered by other ads, or been removed. The first participant contacted the researcher about one week after the first set of recruitment ad copies were posted. All initial contact between the participants and the researcher was through email, although some participants did offer their telephone numbers as an additional means of contact. The researcher replied to each initial contact email by thanking each potential participant for his

or her interest, sending a copy of the recruitment ad, and requesting confirmation of his or her clinical diagnosis of primary OCD and availability for the interviews. In all of the researcher's initial contacts, he also included his mobile telephone number. To the best of his knowledge throughout the study, the researcher did not receive any telephone calls from participants. Further, he did not need to make any telephone calls to participants. Before participants were accepted into the study, they had to confirm their post-secondary student status and respond affirmatively to the questions, "Were you diagnosed with primary OCD? (primary refers to your most significant disorder)", and "Did the clinician who diagnosed you have many years of experience treating OCD patients?" The only exceptions to this process were Nick and Steve. Nick confirmed before and during the first interview that he had been diagnosed with generalized anxiety disorder (GAD) and OCD, and with symptoms of depression. Nick's diagnoses were documented in a psychiatrist's letter, but these had not been weighted in terms of their severity. The researcher asked Nick to consider if he experienced OCD, GAD, and depression about equally or if one disorder was most prominent. Nick considered OCD to be his most significant diagnosed disorder throughout his life and therefore the researcher admitted him into the study. Similarly, Steve considered OCD, rather than his diagnosed depression, to be more prominent throughout his life. Subsequent to these verifications, participants were required to complete the study consent form prior to inclusion. Each time, the researcher first offered the form in French (see Appendix B) and then the form in English (see Appendix C). All participants chose the English consent form and at no time did they ask to communicate using French. In total, eight students contacted the researcher with the intention of participating in his study. Only one out of the eight students was not admitted into the study because she had not been clinically diagnosed with OCD. At the end of our email exchange in December 2007, the researcher thanked this student for her interest in the study and he asked her

to contact him “if her status changes as I will continue recruitment into early next year.” The researcher received no subsequent contact from this student.

More specifically in terms of participant contact and recruitment, the researcher had never met his seven participants prior to recruitment, quite unlike Weiner (1997) who already knew her participants prior to recruitment. Weiner saw this familiarity as an advantage as she claimed that she was able to judge participant attrition and her participants already trusted her. After almost seven months, recruitment ended near the end of March 2008 with seven participants. At no time did any of the seven participants communicate to the researcher a desire to terminate his or her participation in the study or withdraw a portion of the collected data, despite this option provided in the consent form. All initial and subsequent emails from participants were in English.

It is important to note that recruitment was conducted at four post-secondary institutions in Ontario, with five campuses in total, but only university students were participants in the present study. It was the intention of the researcher to try to include both university students enrolled in a degree program and students from accredited colleges enrolled in a program of about a year or two in length. The researcher tried his best to recruit college students in order to gain a broader picture of post-secondary student lives. It is surprising that community college students did not contact the researcher considering that Katz (2012) recently found they are “significantly more likely” (p. 106) to acknowledge their diagnoses or treatment of OCD and related disorders when compared to university students. Moreover, it is unfortunate they did not contact the researcher as Katz also found community college students seemed to be more in need of mental health guidance at school where there was also comparatively less information available.

Sample size and saturation addressed

Shortly after the final interview with the seventh participant, study recruitment was terminated. Primarily, this decision was made by considering not only the study's principal influences of Smith and Osborn (2003) who explained that an appropriate sample size depends on different factors, for instance, the operating constraints, the level of analysis, and the "richness of the individual cases" (p. 54), but also seven main and approved reasons for termination, such as participants conveyed a wide range of educational and social experiences and relationships...spread throughout their lives, and these data were in keeping with the purpose, research questions, and the dissertation title. Also, recruitment encompassed five, post-secondary campuses and yielded the 5-10 participants that corresponded to the number prior to study approval. Further, the three self-report questionnaires fostered the collection of a wide variety of data. Secondly, after interviewing the seventh participant, the researcher wondered what recruiting for another seven months could yield, for instance, would a greater diversity of students representing more academic programs, age ranges, or individual OCD symptom severity lead to a better study? Perhaps recruitment during finals exams and summer holidays would add the established average of about four students, or one student a month to the study, or perhaps no students would express interest due to the time of year? To address the ubiquitous term *saturation* and further address sample size, a number of related sources are cited below.

O'Reilly and Parker (2012) emphasized that saturation was initially associated with generating a theory within grounded theory, and thus it is not suitable for all types of qualitative studies. Further, they noted that saturation has not been clearly defined as it has a variety of meanings, commonly that new data are not being collected. They also acknowledged that individual cases are *unique* and therefore new data can always be elicited; saturation is *never*

attained and serves to *undermine* important research. Findings from studies not claiming saturation can therefore still be valid, with the recognition that more data could be collected to further advance the knowledge already gained. Seeing that OCD is widely heterogeneous and students can come from a variety of backgrounds, academic disciplines, and post-secondary institutions, it does not seem worthwhile to argue for saturation. The authors noted, however, the importance of clearly explaining recruitment and its termination.

Similarly, earlier research from Guest, Bunce, and Johnson (2006) asserted saturation "provides little practical guidance for estimating sample sizes..." (p. 59). They also noted that saturation has reached the status of "gold standard by which purposive sample sizes are determined in health science research" (p. 60), yet their extensive literature review yielded "no practical guidelines for estimating sample sizes for purposively sampled interviews" (p. 60). They stressed that probabilistic sampling should be implemented where possible, but acknowledged that it is nearly impossible to accomplish when recruiting "hard-to-reach, stigmatized, or hidden populations" (p. 61). They further emphasized that "anyone can find, literally, an infinite number of ways to parse up and interpret even the smallest of qualitative data sets. At the other extreme, an analyst could gloss over a large data set and find nothing of interest" (p. 77). A notable problem using saturation is exemplified in Mooney (2007) who used verbatim interview transcripts to study 12, newly qualified nurses. She found data saturation had been reached after her tenth participant, but she noted that her eleventh participant was quite different from the previous ten. She cited a "limited time frame" (p. 76) as being the reason for not being able to recruit more than 12 nurses.

In three similar and recent studies, sample size was identical to, or just above, that of the present study. Heck-Sorter (2012) investigated persistence and academic and social experiences of seven university students with autism spectrum disorder, but her sample size was noted as a

limitation without mentioning recruitment termination or saturation. Further, in a qualitative study using recorded, face-to-face interviews (Birrell, 2013), recruitment and sample size were comparable to those of the present study. She used a flyer on a clinic door to recruit her seven participants who were required to have already been diagnosed with a primary anxiety disorder. She conducted the study as “there seems to be little research that adequately describes the personal experiences of people who have been diagnosed with anxiety disorders” (p. 5). Similarly, Gammon (2014) acknowledged the acute dearth of qualitative studies that have sought to identify and examine the needs and experiences of university students with mental illness. Her study, however, recruited at only one campus using fliers and an online announcement, and her participants were required only to have *self-identified* with a mental illness. Gammon expected as many as 10 participants, but she found that due to “scheduling difficulty and low response rate to study advertisements” (p. 50) eight participants were recruited for recorded, focus-group interviews. Neither of these three recent studies, however, included students with OCD.

For additional perspectives, the researcher of the present study consulted Baker and Edwards (2012) who collected 14 *expert voices* on the subject of saturation in qualitative research. They were surprised to discover that this number was in itself a questionable termination point for collecting sources of opinions. In terms of the present study, four of these sources were particularly relevant. Adler and Adler suggested that a small sample size can be quite *valuable* and justifiable when recruiting participants who are difficult to access. Also, recruitment of only a small number of participants could be directly related to their prevalence. Further, Back asserted that transcriptions from interview data are overrated and should be supplemented by other means. Bryman noted that due to their focus on detailed analyses, studies related to IPA use very small sample sizes compared to other qualitative research. In addition, Charmaz pointed out that

obtaining a great amount of data does not necessarily indicate that an *original contribution* has been made to the existing research. In the present study, data were collected and analysed from students who were likely much more difficult to recruit than other students, for instance, musicians or sports fans. Further, a modest sample size was possibly due to the availability of participants who were clinically diagnosed with OCD. Also, to potentially obtain a greater understanding of these students beyond interviews, other data collection tools were implemented. In addition, a variety of research was cited in order to support the contributions gained from the present study.

Even if one were to satisfactorily demonstrate that participant recruitment was terminated because saturation had been reached, i.e., additional data collection yielded no new informative data, there still seems to be significant problems using the term saturation in qualitative research, especially with doctoral dissertations. By analysing 560 *PhD studies* that used qualitative, one-on-one interviews to collect data, Mason (2010) found that participant numbers were typically *multiples of ten*, with 20 and 30 being dominant. He concluded that those working toward a Ph.D. and/or their related supervisors did not understand the concept of saturation, or perhaps sample sizes that ended in zero were deemed to be much easier to defend. Reaching pre-determined sample sizes may have also been a factor. More specifically related to the present study, Mason found that there was a minimum recruitment of six participants among the total of 57 phenomenological studies located and for the 25 studies that solely used interviews, the lowest number of participants was seven. Thus, the recruitment of seven participants in the present study can be considered reasonable as this figure falls within both of these phenomenological dissertation categories.

To summarize, the researcher of the present study has attempted to clearly explain recruitment and its termination with the understanding that the concept of saturation in the context

of qualitative interviewing is problematic for a number of reasons. Further, recruitment and sample size were quite similar to recent qualitative studies that employed interviews to collect data.

Data collection

The researcher sought to collect a wide range of data in order to develop a broad understanding of participants' experiences and relationships. Thus, the present study comprised the three primary data collection methods of interviews (see Appendix D for interview schedules session 1 and session 2), participant self-report journals (see Appendix H), and three self-report questionnaires (see Appendix E, F, G). The secondary data collection methods were the researcher's interview notes, and fieldwork journal (see Appendix J). At the time of their interviews, Robin, Anne, Mary, Elaine, and Steve were pursuing undergraduate qualifications, while Oliver and Nick were pursuing their second, post-secondary qualification. All of the students completed both face-to-face interviews with the researcher, as well as the three, self-report questionnaires. Participant journals were submitted by Anne, Oliver, Nick, Elaine, and Steve. Anne, Nick, and Steve were available to verify their cases developed from their respective interviews with the researcher. It is important to note that data collection began only after participants completed the consent form and the researcher addressed all participant concerns when applicable. After Anne, Nick, and Steve verified that their cases were accurate representations of their interviews, I sent them a follow-up email informing them that I may need to make some revisions according to suggestions I receive, and that the self-report journals and questionnaire data still needed to be added to their descriptions. Further, I explained that the ethics board(s) needed to be informed when I no longer needed to contact participants and for them to let me know if this point in our relationships had been reached. After their acknowledgement, the researcher received no further contact from these participants.

Primary data collection.

Most of the primary data were collected during the face-to-face interviews, followed by the self-report journals, and then the questionnaires. In keeping with the presentation of the findings and analyses, however, these data are subsequently ordered beginning with the journals, followed by the questionnaires, and then the interviews.

Self-report journal.

Just prior to the start of the first interview, the researcher described the self-report journal and asked each student if he or she would like to participate in this task during the one-month period that encompassed their respective interviews. All participants agreed to complete the one-month journal using the notebook and pen provided by the researcher. This journal involved monitoring and taking notes about OCD-related experiences and relationships, such as coping with OCD symptoms while alone and at school with classmates. From the pilot study, the researcher found that using a notebook and pen respected participants' privacy and perhaps yielded more personal and private journal entries, thus creating richer data, for example, as Hiemstra (2001) asserted, journaling "often evokes conversations with self, another person, or even an imagined other person" (p. 19). Further, it was considered that self-report journals may provide additional insights, and may lead to a more comprehensive understanding of each participant. In support of this task, Spengler and Jacobi (1998) found that a great deal of obsessions and compulsions are triggered in particular environments, and thus OCD clients may be able to provide better descriptions of their symptoms while monitoring themselves throughout a usual day. Similarly, Feske and Chambless (2000) noted that constant monitoring increases the accuracy of information, while interviews and questionnaires rely on potentially faulty recollections. These journals also adopted an aspect of Duncan and Grazzani-Gavazzi (2004), who used synchronous emotion

diaries to study the phenomenon of university students' positive experiences. Each experience was recorded in terms of the respective situation, such as being within a group or alone, related emotions, and if the student told other people about an experience. Duncan and Grazzani-Gavazzi acknowledged, however, that students may not record every positive experience. In view of this possibility, participants were asked to record journal entries for a period of one month, which is double the amount of time requested in the emotion diary study.

In terms of the benefits of journal writing, Hiemstra (2001) described personal growth and development, improved self-discovery, problem solving, stress reduction and health benefits, and reflection and critical thinking. He observed, however, that journaling is still an underused tool in terms of teaching and learning tool. All participants agreed to complete this journal and the researcher immediately gave them a notebook, a pen, and \$50. Two participants did not submit a journal.

Three self-report questionnaires.

These questionnaires were described and handed to each participant in the order of the self-report demographic form (see Appendix E), the OCI-R, and then the SF-36v2. Regarding the description of the second and third questionnaires, the researcher stressed to each participant that the OCI-R is related to behaviours in the past month and the SF-36v2 is mostly related to the past four weeks or month. In the demographic form, participants were asked to describe their family history, including cultural/ethnic and religious affiliation(s) and any superstitions, general health and medical history, and educational and employment history. Its main purposes were to encourage dialogue, develop an accurate and informative profile of each participant, and guide the researcher during interview sessions. The researcher acknowledged the "wide range of within- culture variability" (Sica, Novara, Sanavio, Dorz, & Coradeschi, 2002, p. 377), but still preferred that

participants describe their respective cultural/ethnic and religious affiliation(s), and any superstitions because these aspects were found to be a part of OCD phenomenology (Sica et al.).

To potentially elicit a greater number of perspectives, and potentially encourage them to discuss their OCD symptoms and quality of life further, this study employed the well-established self-report measures OCI-R and SF-36v2. The OCI-R, which was revised from Foa, Kozak, Salkovskis, Coles, and Amir (1998), is an 18-item inventory that relates to everyday experiences of OCD symptom distress in the past month, and focuses on washing (items 5, 11, 17), obsessing (items 6, 12, 18), hoarding (items 1, 7, 13), ordering (items 3, 9, 15), checking (items 2, 8, 14), and neutralizing (items 4, 10, 16). Participants rate their discomfort by indicating *Not at all*, *A little*, *Moderately*, *A lot*, or *Extremely*. Foa et al. found the OCI-R to be useful for assessing OCD patients and concluded that this inventory seems to be a psychometrically sound measure of the major concerns of OCD patients, and differentiates well between patients with and without OCD (see also Foa et al. for OCI-R psychometric properties). The authors did note, however, the imbalance of obsessions versus compulsions in the OCI-R, with its two obsessions of obsessing and neutralizing and its four compulsions of washing, hoarding, ordering, and checking. As noted above, Overduin and Furnham (2012) also had similar findings after comparing nine other self-report OCD measures.

The SF-36v2 comprises 36 items related to physical and mental health. The physical health summary measure consists of physical functioning, role-physical, bodily pain, and general health, while the mental health summary consists of vitality, social functioning, role-emotional, and mental health. Participants rated aspects of their physical and mental health, often in the past month, and often by indicating *All of the time*, *Most of the time*, *Some of the time*, *A little of the time*, or *None of the time*. A QualityMetric administrator informed the researcher that there were

27 adult anxiety studies and three OCD-related studies that have used the SF-36 Health Survey (Michelle Koch, personal communication, November 14, 2006). This questionnaire was offered in both French and English, but all participants chose to complete the English version.

Adults with OCD frequently have comorbid disorders (American Psychiatric Association, 2013), but the researcher of the present study focused on recruiting post-secondary students with primary OCD in order to streamline recruitment and data collection and analyses. To acknowledge the potential influences of comorbid disorders, however, participants were asked in the demographic form to describe any clinically diagnosed disorders and related treatments, concerns, and symptoms. These descriptions were included in the findings, but further investigation was deemed to be beyond the scope of this exploratory study as many complications could have arisen, for instance, inaccuracies due to self-report diagnoses from many years in the past, and degrees of past and current symptom severity.

Interviews.

Smith and Osborn (2003) stressed that interviews should be guided rather than dictated by the interview schedule, and they should serve to facilitate participant rapport, encourage flexibility and elicitation of a wide range of experiences and interests, and develop a rich source of data. In addition, the authors asserted that the interview typically lasts an hour or longer. To mitigate the potential of participant attrition, and because of the success of a two-interview process in (Widdifield, 2004) that incorporated open-ended questions regarding OCD symptoms, related behaviours, experiences, and relationships within educational and other social contexts in addition to self-report journals, the present study included similar, semi-structured interviews also informed by Seidman (2006). The first interview focused on students' previous life experiences up to the present, and then focused on reflection and the future in the second interview. Accordingly,

each interview session lasted a maximum of about ninety minutes and were spaced approximately three to seven days apart.

The 23 questions of interview schedule session 1 were developed considering the three questionnaires, Figure 1, Seidman (2006), and Savoie (1995) and Weiner (1997) from the literature review. Question 1 served as a starting point to discuss any salient thoughts, symptoms, and any other matters that may have been of interest to participants immediately after completion of the three questionnaires. All participants chose to complete all three questionnaires immediately before their respective interviews despite being offered the option of completing them at a later date. The time participants took to complete these questionnaires was not added to the respective interview times, that is, all reported interview times were based on the face-to-face interviews. Questions 2 and 3 derived from Seidman's initial interview topics and also pre-entry components in Figure 1. Question 4 was asked to develop greater insight of participants' clinical OCD diagnosis process. Questions 5 and 6 introduced participants to the main time frames in the interviews, namely their elementary, secondary, and post-secondary education. These questions were also influenced by Figure 1, Seidman and living with OCD. Questions 7 and 8 were developed from Savoie's (1995) focus on feelings. Question 9 was asked to further explore participants' perceptions of their abilities (based on Figure 1) and to gauge their abilities coping with OCD. Questions 10 to 14 inclusive derived from Figure 1, changes from Weiner (1997), and living with OCD. Questions 15 and 16 were adapted from Figure 1 and Weiner. Question 17 was included from Seidman's second interview description about experiences from a day and carried over to question 18 with parts of Figure 1. Questions 19 to 22 were developed using Figure 1. Question 23 provided participants with the opportunity to recall the interview contents and ask for or add any related information.

The eight questions of interview schedule session 2 were developed considering the three questionnaires, Figure 1, Seidman (2006), and Weiner (1997). Question 1 combined the three questionnaires, the first interview, and the focus on meaning from Seidman's third interview description and Weiner. Questions 2 and 3 were adapted from Figure 1. Question 4 further developed Seidman's third interview description with the focus on reflection, and also asked participants to focus on life with OCD. Questions 5 to 7 were adapted from Weiner and integrated into participant responses. Question 8 provided participants with the opportunity to recall the interview contents and ask for or add any related information.

These digitally recorded, face-to-face interviews were conducted solely by the researcher of this study. Within about a twenty-four hour period before all second interviews took place, the researcher listened to the respective first interviews twice and reread all respective questionnaires in order to refresh his memory and note participant data that could benefit from more clarification and/or elaboration.

In order to mitigate potential researcher influences during the data collection, the researcher did not offer advice to participants and he did not disclose any details regarding his related experiences or those of other cases or study participants, quite unlike Haase (2003), who told her participants about others with similar OCD experiences in order to make them feel more normal. Also during the data collection, the researcher encouraged his participants to talk freely about their experiences and relationships, while he tried to maintain an appropriate level of neutrality.

Secondary data collection.

The secondary data collection comprised the researcher's interview notes and fieldwork journal. Merriam (2001) acknowledged that some researchers prefer to tape interview session and also write notes at the same time. In the present study, interviews were digitally recorded

and the researcher also took notes that were concealed from the interviewees. Further, Merriam described the researcher's fieldwork journal as "an introspective record.... (that) includes his or her ideas, fears, mistakes, confusion, and reactions to the experience..." (p. 110). This journal covered about a year and a half, from the first day of recruitment to the final day of participant contact.

Data analysis path

Combining the three primary lenses from Appendix K contributed to the interview method, rapport, questions, and data collected. With respect to data analysis, the influences of IPA in Smith et al. and Seidman are addressed below. In terms of Figure 1, it is important to iterate that it was used to develop interview questions intended to yield participant data, and also hopefully glean some data related to their persistence. To mitigate adverse affects, however, the researcher did not dwell upon model components that were not addressed or fully addressed. Consequently, model components were not presented separately, but in combinations often characteristic of the manner expressed by participants. Such an interwoven approach is not unusual, as Tinto (1993, p. 113) acknowledged, "the model seeks to explain how interactions among different individuals within the academic and social systems of the institution and the communities which comprise them lead individuals of different characteristics to withdraw from that institution prior to degree completion." More recently, Hartley (2013) noted similar complexity, citing Tinto's 1993 model, "academic persistence depends on the complex interplay between the student and his or her ability to integrate academically, referring to attending class and studying, and socially, referring to fitting in the university over time" (p. 241). Perhaps due to this *complex interplay*, however, he used Tinto only to provide a basis for two *outcome variables* (GPA and credits completed) related to "concepts of academic and social integration" (p. 242).

Transcriptions of interviews and case development with self-report data.

For the transcriptions of the study interviews using IPA, Smith and Osborn (2003) suggested that they are "generally at the semantic level: one needs to see all the words spoken including false starts; significant pauses, laughs and other features are also worth recording" (p. 64). Similarly, Smith et al. (1999) also noted the importance of each aspect being "...represented in the verbatim transcript..." (p. 223). Moreover, Seidman (2006) asserted that "a transcript...can reflect the interview as fully as possible by being verbatim" and it "can be of great benefit to a researcher who may be studying the transcript months after the interview occurred" (p. 116). Usually, it is recommended that researchers listen to their interview recordings a few times in order to verify the accuracy of the respective transcriptions (Hammersley, 2012). In the present study, all interviews were transcribed using a two-step process. In the initial process, interviews were transcribed without using the voice recorder's playback function. This process allowed the researcher to develop a broad grasp of the data in a relatively short amount of time, note salient aspects, and develop the transcription key. In the second process, interviews were transcribed using the voice recorder's playback function. This often repeated playback process allowed the researcher to complete the transcriptions and the transcription key and ensure their correspondence with the recordings, correct typographical errors, and further develop the cases. Because this development was an iterative process, the final list of headings was not completed until all of the transcriptions had been completed.

Cases were developed in keeping with the IPA approach (Smith et al., 1999; Smith & Osborn, 2003), where accounts employed verbatim excerpts in order to "distinguish clearly between what the respondent said and the analyst's interpretation or account of it" (Smith & Osborn, p. 77). Thus, participants were often quoted verbatim, with the researcher drafting each

account a) with one or more upper case words, for instance, using IF and IT'S NOT FUNNY, in order to indicate emphasis and/or a voice louder than the respective, typical speaking voice, b) to include laughter as haha, i.e., one "ha" represents the length of about one second, and c) using brackets to improve clarity or to indicate that a word or words were replaced to maintain confidentiality. Such examples include participants who sighed [sigh], a participant who categorized a disabilitating [debilitating] disorder, a participant who used exasperates instead of [exacerbates], and replacing a specific academic program name with [program]. Another connotative example is represented by an emphasis on the word *clean*, as Robin humourously described OCD and the relationship with her mother, "we never talked about it, I don't think it ever affected her. I would CLEAN a lot, that like helped her I guess haha" (lines 123-124). As case analyses were completed, the researcher requested participants to verify that their respective cases were accurate representations of their interviews. Anne, Nick, and Steve were available to complete this process.

Smith et al. (1999) also noted "the level of detail and structure of the results or analysis section can also vary" (p. 227), thus these cases were then supplemented with data from the respective self-report journal data, when available, and the respective OCI-R, and the SF-36v2. Based on the case-study approach of IPA (Smith et al., 2009; Smith et al., 1999), the data analysis comprised the four, main cyclical processes of looking for commonalities in the first case from the interview transcripts, looking for connections within this case, producing a master list of headings, and writing respective cases as a recursive process. Similarly, Seidman (2006, p. 125) suggested a "conventional way of presenting and analysing interview data...to organize excerpts from the transcripts into categories. The researcher then searches for connecting threads and patterns among the excerpts within those categories and for connections between the various categories...."

Further, Seidman advised that each excerpt should be labelled in relation to its transcript location. The researcher noted the line number(s) of each and every excerpt contributed by participants. In terms of reporting information from the self-report demographic form, confidentiality had to be maintained and therefore, as mentioned earlier, this form served to encourage dialogue, develop an accurate and informative profile of each participant, and guide the researcher during respective interview sessions. If not covered in the first interview session, demographic information was mentioned by the researcher during respective second interview sessions so that participants could have an additional opportunity to elaborate further, thus a separate section discussing the analysis of the demographic form was deemed to be unwarranted. Anne, the second participant, was the first case to undergo the initial three cyclical data analysis processes because all of her data had been submitted and the researcher was awaiting the self-report journal from Robin who was the first participant. Based on Anne's interview data that also included her demographic form, commonalities in this initial case master list yielded 21 main headings, with four subheadings and also Anne's final reflections upon her participation in the study. This initial case draft was comprehensive, but there was repeated information throughout its 16 pages. After all the remaining participant data were collected, the initial fourth cyclical process was undertaken and explained after the analyses of the remaining primary data are discussed.

Analysis of the primary data collected.

Primary data analyses are described below in the same order as they appear in the Findings chapter, that is, the self-report journals, the OCI-R, the SF-36v2, and the interview data that also included the demographic data (see Appendix K: Study Concept Map for overview).

Analysis of the self-report journals.

All journals were paraphrased from the raw data in order to maintain confidentiality and to

concisely identify specific experiences and their related events. To more effectively contextualize these experiences and events, key journal data were inserted and noted in the “Typical Day” case heading of respective participants (see Analysis of the interview data below).

Analysis of the OCI-R and the SF-36v2.

In terms of the OCI-R, overall distress levels range from *not at all*, *a little*, *moderately*, *a lot*, to *extremely*. Overall distress levels for each participant were determined by averaging their item choices and corresponding item numerical values. A total numerical score of 54, for example, would result in an overall distress level of *A lot* since *A lot* directly corresponds to the numerical value of 3 and all 18 items are equally weighted. Similarly, “it is possible to compare the symptom severity across subscales by adding their item scores.” (p. 494) (see also Appendix F: Obsessive-Compulsive Inventory--Revised (OCI-R) and results summary).

In the SF-36v2, Ware, Kosinski, and Dewey (2000) cautioned that their scoring algorithms, based on population norms in the United States within a 12-week period in 1998, are to be implemented at the user's discretion, as they may not be suitable for application. Considering their disclaimer, and that all participants were Canadians who completed this survey about 10 years after the norms were established, the qualitative OCI-R data analysis, and the qualitative nature of this entire study, the researcher chose to analyse SF-36v2 participant data using its two summary measures and eight scales and the corresponding item choices. This approach was also suggested by a SF-36v2 scientist who explained that I could use participant item choices "to establish whether there are consistent themes or issues that emerge for individuals with OCD" (D. Kopec, personal communication, February 22, 2008). The SF-36v2 item choices were analysed similar to process for the OCI-R. Overall health states could range from *excellent*, *very good*, *good*, *fair*, to *poor*. Overall health states for each participant were determined by averaging their

precoded item choices and corresponding final item numerical values. Final item numerical values sometimes differed from the survey's precoded item numerical values in order to ensure that "a higher score indicates a better health state" (Ware et al., p. 28) (see also Appendix G).

Analysis of the interview data.

From the initial fourth cyclical process of analysis, a master list of headings eventually emerged and yielded about 25 main headings for each case. The number of headings varied because some participants, for example, did not submit journals and some did not respond to all interview questions. After a lengthy process of revising these cases, including reducing repetitive data and combining and expanding related data (Smith et al., 2009), for instance, using summary tables, a master list of eight headings formed. These eight headings are presented below with all the corresponding 23 interview questions from session 1 and 8 interview questions from session 2.

Data under OCD Diagnosis, Recommendations, Treatment directly related to session 1, question 4. Experiences, Beliefs, Feelings, Relationships formed from most of the session 1 interview questions, namely, questions 2, 3, 5, 6, 7, 8, 13, 14, 16, 18, 19, 20, and 22. Goals, Challenges, Changes, Persistence comprised responses from session 1, questions 10, 11, 12, 21 and session 2, questions 2, 3, 4. Strengths, Weaknesses, and Coping Strategies formed from session 1, question 9. The Three Questionnaires and Journal: Comments and Clarifications comprised data from session 1, question 1 and session 2, question 1. A Typical Day arose from session 1, question 17. This heading also includes related self-report journal data. Data from session 1, question 15 and session 2, questions 5, 6, 7 produced Others with OCD and Those who Encounter Them. Final Comments was the heading assigned to data from session 2, question 8. Data from the session 1 final question, question 23, were assigned to the related heading, if available. Robin and Anne, for example, did not have any additional related comments, but Mary discussed a potential

genetic link to mental illness in her family and thus her comments were placed under the heading Experiences, beliefs, feelings, relationships. Data from the final interview question, session 2, question 8, was given its own heading because this question was the researcher's last opportunity to digitally record participants' interview data and sole opportunity to gauge their level of comfort after having nearly completed the interview sessions. Salient advice and other important ideas were also elicited.

To recapitulate, the case study headings employed to encompass participants' respective data are OCD Diagnosis, Recommendations, Treatment; Experiences, Beliefs, Feelings, Relationships; Goals, Challenges, Changes, Persistence; Strengths, Weaknesses, and Coping Strategies; The Three Questionnaires and Journal: Comments and Clarifications; A Typical Day; Others with OCD and Those who Encounter Them; Final Comments. These headings were used to organize and elucidate participants' life experiences, with an emphasis on first person accounts of the form and functional aspects of their disorder. Cases are presented starting with Robin, and then continue with Anne, Mary, Oliver, Nick, Elaine, and Steve. To maintain coherence and cohesion, each of the seven cases employed the same headings. Consequently, some of the data, due to their complex, interwoven nature, could have been discussed under two or more of these headings. As also noted earlier, OCD studies have used a variety of definitions for age of OCD onset (Grant et al., 2007). Therefore, to maintain clarity, each participant overview identified the age of OCD symptom onset as the time when participants first noticed OCD symptoms, and then identified the age when they were clinically diagnosed with OCD.

Analysis of the secondary data collected.

The secondary data collection comprised the researcher's interview notes and fieldwork journal. The researcher's interview notes were useful, for example, when detecting a participant's

discomfort or misunderstanding with a specific question. The researcher noted this discomfort and avoided a similar question in the subsequent interview. For a misunderstanding, such a question was revised and clarified. These notes served to improve the flow of the interviews and clarity of the data elicited. Similar to parts of the self-report demographic form, confidentiality had to be maintained with the researcher's interview notes, thus participants were described as a group and not individually. Within a few hours after each interview, the researcher used his fieldwork journal to record, for example, the degree of eye contact, the mood of the participant, and the flow of the respective interview. Subsequent contact with each participant was also recorded within the journal period that covered the first day of participant recruitment to the end of the data collection. At times, characteristics from specific participants in the fieldwork journal can be found in the researcher's interview notes.

Researcher's perspectives and pilot study

To expand upon the potential researcher influences during the data collection as noted above and to link IPA's inclusion of the researcher's perspectives (Smith et al., 1999) with section that follows, it is important to fully describe the researcher's motivation for conducting an OCD-related study in a post-secondary context. His motivation was triggered after watching a television broadcast of *David's journey* (Zirinsky, 2001). David was a reputedly very intelligent philosophy student who hoped to become a philosophy professor, but the severity of his OCD forced him to drop out of university in 1998 and then keep himself locked in his parents' bathroom for years that followed. About the same time that I viewed *David's journey*, I was working as a university instructor and I became acquainted with hundreds of undergraduates. Considering David's story, the well-being and potential challenges of my students, and my own lifelong struggles with OCD symptoms, I became convinced that an effort should be made to conduct a

study that would attempt to uncover and examine the experiences of students with OCD in a post-secondary context. I believed that such a study could help myself and also these students, for example, if they read about how others have coped, they may adopt similar coping strategies and become encouraged to remain in school and achieve their academic goals. Further, despite Dr. Jenike's cautious and caring treatment approach with David and some of his other patients in the same television broadcast, I could not envision myself undergoing this exposure therapy, such as being coaxed to touch railings, public phones, and scatter money on my bed. I knew immediately that the research route would be much more preferable. This research was also inspired by the fascinating clinical tales from Sacks (1990; 1995). In order to determine the value and viability of investigating post-secondary students with OCD using such a framework, a pilot study was conducted and is explained below.

Widdifield (2004) conducted a collective case study that documented and analysed life histories of two male and two female post-secondary students with clinically and/or self-diagnosed OCD. The literature review served as a starting point for familiarization of the related research, gleaming insights for the researcher into four main categories identified as pediatric versus adult studies, educational and social relationships, hiding OCD symptoms, and related interventions. Hiding symptoms, for instance, was found to be common, with many not seeking treatment or being clinically diagnosed until many years after experiencing initial symptoms. The related treatments available were identified as education, psychotherapy, and medication. Psychotherapy, for example, was commonly identified, especially with the use of exposure-response therapy. Following this review, the collective case study was conducted. Each participant was interviewed twice during a period of about one week. Each interview lasted about one hour and mainly consisted of open-ended questions regarding OCD symptoms, related behaviours, experiences,

and relationships within educational and other social contexts. Three participants completed self-report journals during the month that encompassed their respective interviews. Despite the small number of students, many similarities and differences were uncovered, such as all participants became aware of their OCD-related behaviours during childhood, they usually kept these behaviours hidden, and they all felt that being forthcoming in their interviews had a positive effect on them. In contrast, educational and social experiences varied from being quite positive to being very negative. Although this pilot study had its merits, such as its literature review, its demonstration that such students could be recruited in a timely manner and then interviewed by the researcher, and no negative short-term or long-term effects were reported by participants, this study did have many shortcomings. These comprised its inclusion of non-clinically diagnosed participants and its lack of a conceptual framework. The results of this pilot study also encouraged me to pursue another, related study within a doctoral program.

My decision to conduct a doctoral OCD study rather than seek medical advice and treatment options for myself was later reinforced while briefly attending an OCD contamination workshop led by Dr. Jonathan Grayson (Erwin, Grayson, & Kirby, 2006), and also while reading *The Mind & The Brain: Neuroplasticity and the Power of Mental Force* (Schwartz & Begley, 2003). The workshop outline stated that "sufferers...will...learn how to motivate themselves to do exposures." Dr. Grayson persuaded some participants with fears of contamination to chew a piece of gum and then pass it to another participant to chew. People were crying and some became very emotional. I certainly did not want to see how this workshop progressed so I exited quickly to attend another conference presentation. Similarly, Schwartz categorized this kind of evocative treatment as being "cruel and distasteful in the extreme--but it also seemed unnecessary" (p. 3). He emphasized that such treatment for contamination fears should not cause distress to those in need of such help and

it should definitely not involve actions that an ordinary individual would refrain from doing, leading him to conclude that "behavior therapy was missing the boat" (p. 4).

Addressing the quality of IPA research, trustworthiness, and related checklists

Mertens (2005) stressed the importance of employing a variety of strategies to establish the credibility of qualitative research. Accordingly, the researcher of the present study used a variety of sources selected to consolidate key terms, to contextualize the present study, and to demonstrate its credibility. In this section, Smith et al. (2009) was used to assess the quality of IPA research, Heck-Sorter (2012) was used to contextualize trustworthiness, and Miles, Huberman, and Saldaña (2014) was used because of its comprehensiveness and its recognition of salient qualitative research terms such as *quality*, *trustworthiness*, and *authenticity*. Quality is a key term in Smith et al., trustworthiness is a key term in Heck-Sorter, and trustworthiness and authenticity are two of many key terms used in the three comprehensive checklists in Miles et al..

Smith et al. (2009) illustrated four aspects related to the quality of IPA research based on Yardley (2000). These aspects are *sensitivity to context*, *commitment and rigour*, *transparency and coherence*, and *impact and importance*. Sensitivity to context involves, for example, overcoming recruiting difficulties and enabling participants to feel comfortable during interviews so that they can provide appropriate data that lead to developing accurate analyses. Also, a substantial number of verbatim quotes should be included to support the interpretations made. In addition, related literature should be cited to contextualize the study and findings. In the present study, recruitment took place at five locations at its maximum and included both university and college campuses. Interview rapport seemed to be unproblematic throughout the data collection and a substantial number of quotes were presented and analysed. It is notable that all participants agreed to submit self-report journals and accepted the necessary materials, but only five journals were submitted.

No participants requested to have their data removed from the study and no participants expressed distress from their participation. To contextualize the present study and its findings, many related sources were cited (e.g., Bond, 2011; Haase, 2003; Heck-Sorter, 2012; Weiner, 1997).

Regarding commitment and rigour, commitment refers to the quality of the interview rapport and how well the researcher has captured and presented participants' data. In the present study, interview rapport seemed to be unproblematic and the researcher spent a considerable amount of time engaged with participants' data. Rigour relates to the appropriateness of the participants recruited, as they should be relatively *homogeneous* and also suitable in terms of providing data for the study research questions. Further, illustrations from participants should be selective, balanced, and appropriately used to support the research. In the present study, the researcher took reasonable care to ensure that all participants had been diagnosed with OCD by an experienced clinician familiar with OCD, and that they were post-secondary students. Participant data were organized by interactions between the researcher and the feedback provided from four professors.

In terms of transparency and coherence, the researcher needs to clearly explain the participant recruitment process, the development of the interview schedules and respective interviews, and the data analyses. Further, it is important to present all of these aspects in a coherent and cohesive manner, often aided by multiple revisions. In the present study, these aspects were carefully addressed using multiple and very time-consuming revisions in conjunction with feedback from three participants and four academic advisors. For impact and importance, it is necessary for the researcher to convey the importance of the study to the reader and to note interesting or useful contributions. In the present study, a variety of such contributions were conveyed in the discussion and contributions sections.

Heck-Sorter (2012) is perhaps a suitable bridge between the IPA criteria, especially to contextualize the present study, and the more comprehensive strategy in Miles et al. (2014). She sought to *increase the validity* of her study by discussing *trustworthiness* in terms of triangulation, member checking, peer review and debriefing, and researcher journaling. Triangulation included analyses of participant interview and respective email data, and data from related university sources. Member checking involved giving participants the opportunity to verify their respective interview data. She did not state how many participants took advantage of this opportunity. For peer review and debriefing, both peers and her doctoral committee members reviewed her research during the drafting process. In terms of researcher journaling, Heck-Sorter made notes to record her personal experiences for reflection during her study. In the present study, these aspects of trustworthiness were very similar, but peer review was not included due to confidentiality and member checking was more explicit, with verifications from three participants. Her qualitative research was very similar to that of the present study as she investigated the persistence and academic and social experiences of seven university students with autism spectrum disorder. Participants were also interviewed twice by the researcher, but used 24 interview questions. Her sample size of seven was noted as a limitation without mentioning recruitment termination or saturation. To expand upon these quality and trustworthiness issues, three checklists from Miles et al. were examined in relation to the present study.

The use of IPA has already been well established in health-related research, but three checklists from Miles et al. (2014) were consulted to provide an additional level of rigour to the analyses and conclusions within the present study. Although these authors acknowledged that “many interpretivist researchers” (p. 311) view qualitative study standards to be inappropriate, for instance, because of the personal nature of qualitative research, terms such as *trustworthiness*,

quality, and *authenticity* still prevail. Thus, their checklists with 13 tools of analysis, 13 strategies for testing findings, and 5 standards for checking conclusions were consulted to address these *battles*. It is important to note that some of the checklist items related to collecting data that supported or opposed prior hypotheses, and reaching generalizations. The present study was not conducted for such purposes; it was conducted with a small sample size for the purpose of advancing the understanding of the lives of post-secondary students with primary OCD.

With respect to the 13 analysis tools, the researcher addressed 12 tools during his study. 1) Noting Patterns/Themes was used, for example, to organize goals, challenges, and coping strategies. 2) Seeing Plausibility was used, for instance, to conclude that students' intellectual integration seemed to play a greater role in academic persistence than did their social integration. 3) Clustering is defined as "our best attempt to categorize what seems to belong together" (p. 280), but the authors noted that "clusters are not always mutually exclusive and may overlap" (p. 279). Similarly, as noted in the present study, "to maintain coherence and cohesion, each of the seven cases employed the same headings. Consequently, some of the data, due to their complex, interwoven nature, could have been discussed under two or more of these headings. As also noted earlier, OCD studies have used a variety of definitions for age of OCD onset (Grant et al., 2007). Therefore, to maintain clarity, each participant overview identified the age of OCD symptom onset as the time when participants first noticed OCD symptoms, and then identified the age when they were clinically diagnosed with OCD." 4) Making Metaphors, such as referring to a learning room as an *oasis*, was not implemented in the present study. 5) Counting, or "doing qualitative analysis with the occasional aid of numbers is a good way of testing for possible bias and seeing how robust are insights are" (p. 284). In the present study counting was useful to justify its recruitment and compare participants' OCI-R scores with other studies. Comparing the OCI-R scores of the

present study to those from Foa et al. (2002) showed that participants measured much higher than the cutscore of 21, or just above *A little*, determined by separating those with OCD from the non-anxious control group. The lowest score was from Robin with slightly less than *Moderately*. In addition, Huppert et al. (2006) studied the validity of the OCI-R with 186 OCD patients. Findings included a mean OCI-R score of 26.3, or just below the middle of *A little* and *moderately*, which is still below the lowest score from Robin. More recently, Bond (2011) used the OCI-R with 17 primary OCD participants who had a mean score of 21.1, or just over the cutscore above. All 17 were adults, but some were described as *undergraduate student volunteers*. Of interest, Holland (2012) found that contrary to past research, obtaining high scores on self-report OCD questionnaires does not necessarily indicate a level high enough to meet a clinical diagnosis of OCD. Thus, this recent finding provides support for the stipulation of a clinical diagnosis of OCD for participant recruitment in the present study. The drawback, however, as Holland acknowledged is that recruiting such participants “can be a monumental task” (p. 37) and may pose greater difficulty when recruiting in a post-secondary context due to the small number of potential participants. In addition, Gelfand (2013) also acknowledged the difficulty in recruiting participants who have been clinically diagnosed with OCD.

6) Making Contrasts/Comparisons were useful during analyses, but many varying degrees of differences and similarities were apparent in the present study. Miles et al. also acknowledged this variation as “cases showing different degrees” (p. 151).

7) Partitioning Variables “should be in the service of finding coherent, integrated descriptions and explanations.” (p. 285). In the present study, for example, “Reflections” was an initial category, but it was determined in later analyses to be too general and it contained many identical data that already appeared under other categories. Thus, the Reflections category was abandoned to promote data integration and coherence.

8) Subsuming Particulars Into

the General was carried out, for instance, using the “Typical Day” category, as there were a variety of experiences and relationships elicited during each typical day, but if separated, the reader would likely have great difficulty compiling all of the separated data into a coherent, typical day for each participant. This category from the Findings also related directly to session 1, question 17 and self-report journal data, and further, served to respond to research question three. 9) Factoring is referred to creating “categories of categories” (p. 286) or a *Pattern Code*. With multiple cases, for example, pattern coding “lays the groundwork for cross-case analysis by surfacing common themes and directional processes” (p. 86) and its purpose is “to contribute to our understanding of the case” (p. 287). In the present study, “a master list of eight headings formed”. 10) Noting the Relations Between Variables was conveyed, for example, with Nick as he had exhausted all possible treatment options, he attempted to take his own life, and he had years of substance abuse, yet ironically he was still successfully pursuing a second degree in a highly-competitive program. 11) Finding Intervening Variables refers to variables that should be connected, but do not seem to be, or variables that are connected, but their relationship is unclear. With Oliver, for instance, his extreme shyness and his personal relationships were connected, but their relationships were unclear. He stated that he always had many people around him, he was good at getting and maintaining many friendships, and all of his jobs had been in customer service where he felt no apprehension when approaching groups of about 30. Yet ironically, Oliver lived alone, he did not have any visitors, he was very secretive about his OCD, and after graduation, he was looking forward to getting away from the people around him. 12) Building a Logical Chain of Evidence related to the finding, for instance, that students’ intellectual integration seemed to play a greater role in academic persistence than did their social integration. 13) Making Conceptual/Theoretical Coherence was demonstrated by providing evidence that advanced the understanding of this

specific population using the three lenses of lenses of Seidman's interviewing as qualitative research, an adaptation of Tinto's Longitudinal Model of Institutional Departure, and IPA.

Within the present study, the researcher addressed 10 of the 13 strategies for testing findings. The purpose of these 13 strategies is to address “*validity or trustworthiness*” (p. 293). 1) Checking for Representativeness was not applicable as generalizing was not an objective in the present study with its sample size of seven participants. 2) Checking for Researcher Effects is related to researchers who observe groups of people while at the same time try to avoid influencing the behaviour and language used among group members. In the context of the present study, many of these items were applicable. Those include, for example, informing participants about the purposes of the study, the forms of data collection and the use of these data; using a variety of data collection methods; following-up on participant data that was misleading or perhaps unclear; the researcher refraining from discussing his knowledge of the topic with participants; obtaining colleague feedback on field notes; and maintaining focus on the research questions. 3) Triangulating is intended to glean data that have a variety of strengths and forms. It then serves to strengthen the trustworthiness of the study by allowing a variety of data to be compared and contrasted resulting in the study findings. In the present study, triangulation comprised face-to-face interviews with each participant, self-report questionnaires and journals, and the researcher's interview notes and fieldwork journal. 4) Weighting the Evidence seems to apply more to data from participants who are closer or more distant to the research topic, for example, stakeholders in a study for school improvement. In the present study, most data were in the form of self-report and secondary data collection played a minimal role. 5) Checking the Meaning of Outliers was not part of the present study as individual differences and experiences varied a great deal and thus it was not the intention before, during, or after data collection to eventually describe a *typical* student

with OCD. One student, for example, attempted to take his own life, one student resorted to self-mutilation, one student made use of breathing techniques and yoga, and another student continued to take a helpful medication. 6) Using Extreme Cases was noted in the present study with Robin, Oliver, and Nick who seemed to have had the most difficulty in dealing with OCD and its impact on their QoL, as experiences of very extreme despair were revealed. Further, Mary was the only participant who had no interest whatsoever in communicating with others who had OCD. 7) An example of Following Up Surprises is related to IPA and the researcher's emotional response in an initial interview, "From the fieldwork journal, two main IPA aspects were surprisingly exemplified at the same time, namely, the importance of encompassing backgrounds of both participant and researcher and their interactions." I recorded that my first interview with Oliver was the most emotional interview considering all 22 interviews, including the eight interviews from my pilot study. While he expressed his feelings and experiences, his eyes began to water a little and I felt mine do the same, perhaps because I recognized very similar OCD-related experiences that we had in common. The researcher was quite surprised to experience IPA in this manner. 8) Looking for Negative Evidence relates to finding data that disprove hypotheses or theories, but the present study was not conducted for hypothesis or theory generation. 9) Making If-Then Tests, 10) Ruling Out Spurious Relations, and 11) Replicating a Finding were similarly inapplicable to the present study. 12) Checking Out Rival Explanations refers to the consideration of alternative reasons for conclusions proposed. In the present study, both positive and negative influences of OCD were elicited from participants, yet as Speisman (2012) acknowledged, people with reduced QoL might be more susceptible to developing OCD and therefore having OCD cannot necessarily account for a poorer QoL. This issue was noted in the study limitations. 13) In terms of Getting Feedback From Participants, the researcher emailed all seven participants

for the purpose of receiving feedback. Anne, Nick, and Steve were the only participants who responded and who also verified that their cases were accurate representations of their interviews.

In terms of 5 standards for checking conclusions, 1) Objectivity/Confirmability relate to how explicit the researcher has been in terms of methods used and data collection, analyses, and conclusions. Through comparisons with similar studies and feedback from academic advisors, the researcher has sought to comply with this standard. 2) Reliability/ Dependability/ Auditability relate to the appropriateness of research questions to study design, and suitability of data management. In the present study, one research question was reframed due to the interview rapport, and data management was guided by three participants who provide feedback on their respective interview data and four faculty professors provided verbal and/or written feedback. 3) Internal Validity/Credibility/Authenticity relate to the appropriateness of the findings. The present study included Seidman (2006, 2013) who noted that interviews enhance data validation because participants express how they comprehend their experiences considering themselves and also the interviewer. Both people share in this comprehension process where interviewers can test *internal consistency*. Further, Smith et al. (2009) acknowledged that due to the substantial number of verbatim quotes used in IPA, readers can check the claims made by the researcher, thus elevating their credibility. 4) External Validity/ Transferability/Fittingness is related to the *generalizability* of the study, but as already noted, this aim was not intended in the present study. 5) Utilization/ Application/Action Orientation relate to the idea that “we still need to know what the study does for its participants—both the researchers and researched—and for its consumers” (p. 314). In the present study, data from the final interview question, session 2, question 8, was given its own heading *Final Comments* because this question was the researcher's last opportunity to digitally record participants' interview data and his sole opportunity to gauge their level of comfort after

having nearly completed the interview sessions. Salient advice and other important ideas were also elicited. Looking beyond Final Comments, the researcher mentioned the effects of the present study upon himself under the heading *Concluding remarks*. Further, participants offered a variety of advice intended for university administrators, teachers, and fellow students. In addition, the present study may benefit its *consumers* by giving them a greater understanding of such students within post-secondary institutions and within society in general.

To recapitulate, the researcher endeavoured to demonstrate the quality of his research through the use of sources selected to consolidate key terms and to contextualize the present study. As exemplified, these sources made use of similar key terms such as credibility, trustworthiness, and validity. Though somewhat dated, Mertens (2005) offers other notable aspects. She adopted similar key terms as described above for the purpose of assessing qualitative research. To judge the *quality* of studies, she described six key terms comprised of *credibility*, *transferability*, *dependability*, *confirmability*, *authenticity*, and *emancipatory*. Within credibility, member checks and triangulation were most relevant to the present study and these two criterion were addressed above. For transferability, however, *thick description and multiple cases* were emphasized as key factors. In the present study, thick description was endeavoured by including a significant number of salient, verbatim extracts intended to reveal to readers important aspects of participants' lives, such as demographic information, time frames, contexts, and symptomology. Further, data from seven participants were presented and analysed using a number of salient categories that were consistent for each case. Dependability refers to the degree of openness and specificity throughout the research process. In the present study, this methodology chapter was written and revised in conjunction with multiple readers in order to address this issue. For confirmability, interpretations should be clearly justifiable based on the raw interview data and the researcher's own influence

should be mitigated. Formal peer audits were not conducted for dependability or credibility due to confidentiality. For these aspects, the researcher relied upon participant feedback, the inclusion of a significant number of verbatim quotes and self-report questionnaire data, and multiple readers. An important aspect of authenticity was described as *ontological authenticity*, which refers to participants' experiences of becoming *more informed*. Robin, for instance, noted that life events she discussed in the interviews may have had a more significant impact upon her than she realized previously. For emancipatory, it is important for the researcher to accept that study is incomplete and it represents what was collected at a particular time and place. With the present study, its limitations and further paths for research were addressed.

Participant vignettes

The following vignettes serve to familiarize readers by briefly describing participants' respective family and school relationships and their main OCD symptoms according to the OCI-R and their respective self-report journals.

Robin.

She acknowledged that her relationship with her mother has always been very positive and open, whereas her father's inability to cope with children and bad temper have resulted in a more distant relationship. Robin has close relationships with her siblings, but she becomes quite uncomfortable in some situations with them due to a traumatic childhood experience. Regarding on-campus friendships, she noted having about five friends and preferring this number, as she has been with her current boyfriend for a few years and does not really need additional relationships. Living with her boyfriend has kept her motivated and more focused on her social science undergraduate program. Ordering and neutralizing were Robin's most salient OCD symptoms as gauged by the OCI-R. The self-report journal was not submitted to the researcher for additional

symptomology data.

Anne.

Prior to her clinical diagnosis, Anne's initial OCD symptoms were odd and troubling to her because she could not explain them and these affected relationships, especially with her family. Around the time she was in grade 6, Anne needed to repeatedly retype a sentence on a friend's computer. This friend became frustrated with this lengthy process and Anne was also troubled as she could not understand this behaviour. Her sister also pointed out and questioned her behaviours, such as when seeing her walk backwards. Despite Anne's extreme discomfort, she emphasized the lack of parental support. Later in grade 7, she read an OCD article that led to her self-diagnosis of OCD. This revelation, however, could not bring her to inform her parents as she was too embarrassed and reluctant to disrupt her father's portrayal of his family being normal. She saw herself as being very abnormal and gradually noticed that her symptoms were becoming worse, and her parents' lack of understanding continued to be quite troubling. Eventually, a family discussion in grade 11 led to Anne getting some help. Nearing the completion of her social science undergraduate program, her OCD became quite debilitating and this brought her to the point of seriously considering a break from school. After carefully considering that her parents would strongly disapprove of this break, she decided to remain in school, with a new roommate helping to reduce her anxiety. She exemplified her anxiety by noting her extreme shyness at university, especially with voicing her opinions and merely sitting in class, which resulted in poor grades. She reflected that OCD worsens in class due to nervousness about drawing attention to herself, causing unhappiness and great discomfort. Checking, washing, and obsessing were Anne's most salient OCD symptoms as gauged by the OCI-R. In terms of the self-report journal, her main symptoms were regret, worry, contamination, ordering, doubt, panic, and frustration.

Mary.

At about age 10, she was diagnosed with depression by her family doctor as a result of the death of a sibling. Later came a different diagnosis of an anxiety disorder, and then later with the eating disorder bulimia. At the age of about 16, in conjunction with two or three psychologists, she was diagnosed with OCD due to what she believed as being her obsession with eating in 2s. For her family and others, Mary explained that her parents find her OCD to be rather strange, with her mother being a little more accepting due to her occupation as a health care provider. Other family members have a history of mental health problems, thus they do not blame Mary for her OCD. Still, they find this disorder to be rather strange. Her roommates do not fully understand Mary, but they assist her, for instance, after she buys groceries by eating a second head of lettuce that would spoil. She stated that they think she is *crazy* and one believes that Mary merely needs to consume more vitamins and salad to rid herself of OCD. Other friends are aware of Mary's OCD, but they still think she is strange or showing off due to her need to complete actions in multiples of two, such as consuming two alcoholic drinks. Despite qualifying for extensions, such as for exams, she has not requested them during her undergraduate social science program because she views her OCD as being more annoying than debilitating. Neutralizing and hoarding were Mary's most salient OCD symptoms as gauged by the OCI-R. The self-report journal was not submitted to the researcher for additional symptomology data.

Oliver.

Oliver noted very positive feelings growing up from childhood to his undergraduate years, leading a happy family life with his parents and siblings in a good community. He had many friends and played many sports with them. It was not until his clinical diagnosis of OCD that Oliver had a revelation about the significance of these undergraduate studies and his inability to

recognize that he had OCD. With the support of his parents, Oliver was directed to seek additional help at a clinic and his formal diagnosis of OCD was determined very shortly thereafter. He added that this time was likely the most distressful period of his life. With certainty, he noted that his OCD stems from his mother obsession with germs. In terms of current social relationships, he admitted to having many friends, but these are not people with whom he really enjoys spending time. Dating and letting friends become close have always been difficult, as Oliver has never invited them to his home where he lives alone. He expressed the high degree of insecurity for himself and his classmates while working on his second degree in a professional program, with being heavily in debt, working long hours, incessant demands, and the uncertainty about where to apprentice. Washing, obsessing, and checking were Oliver's most salient OCD symptoms as gauged by the OCI-R. In terms of the self-report journal, his main symptoms were contamination, reflection, regret, high anxiety/stress, worry, and uncertainty.

Nick.

Nick first noted that his parents held unrealistically high expectations for him with respect to social, physical, and extra-curricular activities, and especially in terms of school grades. He was always expected to perform beyond his best efforts. These expectations arose in elementary school and they have not abated since. He recalled being quite controlling when interacting with his younger siblings, and regrettably, this may have involved some verbal and physical abuse. Nick had very fond memories of classmate friendships from elementary to his second year of high school, when he identified a peak in his OCD-related behaviours. At around the age of 15 or 16, he experienced excessive washing, fear of contaminating food, and increasing difficulty interacting with classmates leading up to this event. This peak involved a possible encounter with a family member and it was accompanied by excessive worrying, which then triggered his first

breakdown and the intervention of his concerned mother who took him to a doctor. Nick was prescribed an antidepressant and shortly thereafter he attempted to take his own life. Despite these problems, he has consistently had good relationships with his teachers, but he did develop a fear of raising his hand and asking questions in class. More recently, however, he has had serious doubts both academically and socially, for example, his answers to in-class questions lead him to approach professors so that they can think for him. He also has had difficulty collaborating with classmates as he needs to employ his own way of thinking to ensure suitable outcomes. He saw that he persists in his professional program, his second degree, while being quite ill internally and living alone. Obsessing and ordering were Nick's most salient OCD symptoms as gauged by the OCI-R. In terms of the self-report journal, his main symptoms were checking, repetition, discomfort, and uncertainty.

Elaine.

Prior to her diagnosis, Elaine experienced only moderate symptoms and these just slightly affected her personal relationships. Symptoms involved becoming bothered by threes and fives, for instance, being at parties and needing to eat three or five chips or candies at one time, switching lights and the television on and off, and needing to complete these patterns to feel *just right*. Coping with these symptoms was a matter she kept to herself. Gradually, such behaviours led Elaine and her parents to seek help from a psychiatrist when she was about 10 years old. Subsequent to her clinical diagnoses and treatment recommendations, Elaine has found counselling to be helpful, along with her additional coping methods of breathing exercises, yoga, and meditation that she has taken up over the years. These additional coping methods have been very beneficial to her in terms of staying balanced, calm, and focused, especially through the academic and social pressures of late high school and into university. She identified pressures such as being

secretive about, and coping with, her fear and nervousness of reactions to being judged by friends and teachers. Socially, Elaine perceived her public life as being very different from her private life, and noted that many others have also had this perception of her. In her public life, she tends to avoid people who have negative energy and who negatively influence her. Further, she asserted that she has become more able to hide her troubles, and she then deals with these and OCD while alone, with her roommate, or with others close to her. Last year, for example, she noted anxiety attacks that occurred almost daily, nearly preventing her from getting up in the morning to attend her undergraduate social science classes. Checking and neutralizing were Elaine's most salient OCD symptoms as gauged by the OCI-R. In terms of the self-report journal, her main symptoms were repeated actions and just right.

Steve.

Growing up, Steve was closer to his mother than his father and other siblings as he spent a great deal more time with her. Also, he was much younger than his siblings thus he was not able to spend much time with them after they left home after high school. Within about the past year, he viewed that the relationship with his brother has become more normalized. Steve lived with his sister during a year of his post-secondary education, but that was several years in the past and he noted that they have not talked much since that time. Similarly, he has not been close with his parents since telling them of his homosexuality the previous year. Currently, he has many friends from employment and school in addition to having several roommates. He seldom converses with professors in his undergraduate social science program. Steve viewed that as he has been such a perfectionist, retaining creative control during high school and into university has influenced his aversion to teamwork and pair work. Over the past year and a half to two years, he became somewhat less motivated and focused due to depression, OCD, and issues related to being

a homosexual. His gradual acceptance about being gay was arrived at following difficulties, such as unwillingly having to date girls and trying to hide and deny these feelings. He added that having a functional relationship is still a significant challenge. Currently, Steve noted that OCD is the most prominent in the morning, evening, and when he is alone. Neutralizing and checking were Steve's most salient OCD symptoms as gauged by the OCI-R. In terms of the self-report journal, his main symptoms were luck, just right, regret, discomfort, repetition, and depression.

Chapter summary

The purpose of this chapter was to identify and describe the data collection and analyses with a focus on the participants and their recruitment, the primary and secondary data, and addressing the quality of IPA research, trustworthiness, and related terms. The researcher's perspectives were also included in order to explicitly address his personal connections to the present study. Participant vignettes served to familiarize readers, specifically in terms of participants' early life and OCD symptomology. The present study comprised three conceptual lenses, IPA from Smith et al., Seidman's qualitative interviewing, and Tinto's adapted model (Figure 1).

Chapter IV: Findings

Findings are presented as individual cases, starting with Robin, and then continuing with Anne, Mary, Oliver, Nick, Elaine, and Steve. Oliver and Nick were working toward their second university degree, while the others were undergraduates. These students ranged in age from early to late 20s. Each of their cases begins with a salient quote and an overview. Each overview contains key findings from the self-report journal, if available, and the OCI-R and SF-36v2. As noted earlier, the remaining case headings were developed from the interview data that also included the demographic data (see Data Analysis Path). All of the self-report journals were paraphrased from the raw data in order to maintain confidentiality, and to concisely identify specific experiences and their related events. In addition, related journal data were inserted and noted in A typical day case heading of respective participants. To iterate, data related to Figure 1 and other categories are sometimes interwoven because of the nature of the data elicited. Salient case findings are summarized in Appendix I. Due to space limitations per case, additional verbatim OCD functions of participants were relocated to Appendix L.

Robin "one of the biggest parts of OCD is control"

Robin's interviews with the researcher lasted 63.5 and 31.5 minutes respectively for a total of 95 minutes. Her age of onset was at about age 12 and the clinical diagnosis of OCD was about age 16. She completed all self-report questionnaires. An overall distress level of slightly less than Moderately was determined by her OCI-R. In terms of the SF-36v2, her overall health state was Good and Robin indicated that her health in general is much better now than one year ago.

OCD diagnosis, recommendations, treatment.

With respect to her earliest memories of having OCD symptoms, Robin recalled having to assign specific numbers to certain actions, such as the volume on the television and being out of

the room according to what was on at the time. When she and her siblings began to notice these behaviours, they teased her about them, but she was not able to defend herself.

Considering her parents, Robin did not approach them with her problem, but she figured that her mother knew from the beginning as a result of needing a note for school. She chuckled, "we never talked about it, I don't think it ever affected her. I would CLEAN a lot, that like helped her I guess haha, but, I keep it pretty like, pretty low key" (lines 123-126).

As for her clinical diagnosis of OCD and treatment, Robin was admitted to hospital under in-patient care that involved 3 to 4 weeks of assessment, followed by about 2 months of primarily group treatment. Her hospital admission was due to a serious incident that occurred. During her hospital stay, she was diagnosed with OCD and other disorders, possibly impulse control disorder, anorexia, and dissociative disorder. This last disorder she figured was probably a result of another serious incident that occurred, but with a sibling. She recalled being the only patient in the ward that was not taking medication and she added that she still wants to maintain control of her life without the help of drugs, stating, "I wanna just rely on myself" (line 137).

Experiences, beliefs, feelings, relationships.

Regarding her earliest memories, Robin began by emphasizing that the relationship with her mother has always been very positive and open, probably due to the incident with a sibling early in her life. Her relationship with her siblings and father has not been as close, due to this incident and her father's very bad temper and his inability to relate to children. As for other early relationships, she recalled having an alcoholic neighbour that she was very afraid of when she was about 7 or 8 years old.

In terms of school and family relationships, Robin recalled having two quite close friends around grade 2, but they moved away and thus she mainly had friends just at school as her home

was far from other local children her age. In middle school, Robin recalled that many children came from wealthy families and she could not live up to their standards, but this was not really problematic for her. She was an excellent student during this time and she was quite close to her family. Later on in junior high school, Robin developed a closer group of friends, but this situation changed drastically in high school, where she developed an extremely loyal group of friends who she felt she could manipulate as she pleased. Robin looked back on this behaviour with extreme regret and disgust and she still does not know why she acted in such a manner. She noted that these kids smoked and fought and did other things that she had never been exposed to before, and she began to emulate their behaviours. Before long, Robin:

started realizing that if I talked a certain way people would be like afraid of me,
PHYSICALLY I mean like...um that's when I started to have a pretty bad relationship
with my mom because she obviously saw that I started to rebel and I wouldn't like,
I would take it out on her A LOT. Uh, we didn't get along a lot. Everyone, when I was
younger, would tell me that THEY hoped when I, like grow up, that I have a daughter
like MYSELF, and I never understood what that meant, but now I do, like I was a pretty,
I was, I was hell, I don't know how she dealt with me. (lines 185-195)

She added that these high school kids were not genuine friends, but merely wanted Robin for protection, thus she showed that she could frequently shoplift and manipulate people. She stressed that they are no longer a part of her life. Currently, she admitted to having a few close friends and her boyfriend, and her relationship with her parents and siblings has never been better.

In terms of teachers, Robin spent her final 6 months of junior high school [grade 8] studying in the principal's office during lunch because she did not get along with her teachers and this was the only way they would allow her to pass. Frequently suspensions also occurred, with her parents

and teachers, and principal meeting often. Robin recalled hearing how the principal emphasized her great potential in many areas, and this made her understand how he sincerely cared about her wellbeing, and that he had never hated her as she believed. Still, in front of others, Robin admitted that she never showed kindness toward them, but when alone with them, she felt these relationships were positive.

As for her post-secondary school experiences and relationships, Robin affirmed that she never raises her hand, but just listens and does not communicate with her professors. She only met a professor one time during her office hours, and found her to be very kind. Regarding on-campus friendships, she noted having about five friends and preferring this number, as she has been with her current boyfriend for a few years and does not really need additional relationships. Another possible cause of limiting her relationships is the negative experience she had from joining a student organization about two years before. She made about 5 or 10 friends and about 50 enemies after she left.

As for her beliefs, Robin mentioned being raised in a religious family, but she saw that this did not influence her as she does not consider herself to be a religious person. When asked to view her beliefs from other perspectives, she replied:

I guess I ALWAYS, ALWAYS knew that education was important, it was never an option for me...to NOT go to school, I guess to go to class was a different story haha, but as long as I was IN school. (lines 297-299).

She added that having a job and being able to support herself was also quite important.

After some thought, Robin explained her feelings by describing her disinterest in developing close relationships and her great difficulty in being empathetic. She believed these feelings were probably triggered by the separation of her parents and by the incident with her

sibling. In grade 7 or 8, she often felt angry, possibly because she felt her teachers were treating her unfairly and she experienced, for the first time, feeling very betrayed by her group of close friends. Thus, her disinterest in developing close relationships and her anger toward people grew. Considering her teachers, Robin acknowledged, "looking back I know I deserved it, I was a little shit" (lines 350-351). In high school, she felt about the same way, emphasizing the dominant feeling of anger throughout her life, up until the past few years. She noted, "it's the only feeling that was REALLY easy for me to feel...especially in high school, that's where I guess where it all kind of blew up" (lines 357-359). When asked to elaborate about this dramatic change, Robin explained that her involvement in a student organization made her realize the importance of nurturing her true friendships, instead of being angry and treating everyone badly. She also recognized her need to end relationships that were insincere, therefore she left the student organization knowing that her departure would create for her dozens of enemies.

Looking back on influential positive experiences, Robin discussed her deep appreciation for her mother, despite the problems they have had. Further, her longest relationship with a boyfriend was very significant, as she described its importance:

he was a REAL prick at first, he would, he didn't know I had anything wrong with me, so he would, he would make fun of little things about me and he didn't know how serious it affected me and once we started dating, I remember ['I was like 18, 19', (line 1012)], we were talking all the sudden and I said, what are you doing? And he said, oh, I'm looking up OCD online and I was like, why, so you can make fun of me? And he's like no, 'cause I wanna, I wanna understand it, and to this day like, I still it's one of the most, the NICEST things anyone's ever done for me. (lines 575-588).

With academic areas, Robin recalled meeting individual teachers to discuss her academic progress

and her inappropriate behaviour in class. From these meetings, she came to realize that her teachers really did care about her and her grades, and they were not just focused on reprimanding her. She characterized these meetings as being very helpful and making her much more interested in school. Regarding negative influential experiences, Robin explained that she thinks about a few people that she cared for deeply, but they betrayed her and this feeling still causes discomfort.

Considering her most memorable emotional experiences, Robin described:

the most ANXIOUS I've ever felt in my life was when I was in the hospital and there was all the, the uh, the LEGAL stuff going on that I didn't really hear about...I had no idea what was happening...I knew that when I left the hospital, I was going to be arrested and that was it. I didn't even know what being arrested meant. I didn't know, what anything meant, so that was definitely the most stressful time in my life, and uh, probably also combined with like, the most, the happiest was when it was all over. (lines 670-680)

Further, Robin was astonished by the strong support shown to her by her siblings, as they often visited her during her hospital stay. She added that she still finds it easy to express anger, but she has learned to control this from her experience with the police.

In a more revealing emotional anecdote, Robin explained that she used to cut herself over a period of about 2 months just before becoming an in-patient, noting:

when everything was just REALLY bad just my life and everything was shittier, seemed shitty, I started to cut myself, and I remember the FIRST time I did it, the reason I did it is because I didn't want to write...a geography test and...so I'm like if I have a big gash in my hand, I can't write the test, well I wasn't smart enough to do it in my writing hand, I did it on this hand, so RIDICULOUSLY STUPID, and, I remember going to school, people would be, what happened to your hand? And I seriously said NOTHING, like...

I've never been like trying to get attention, and then I just realized, like, for some reason obviously it made, it felt better, like it felt like a release. (lines 1126-1135)

Considering current friendships, Robin estimated that she sends about 100 text messages per day and she maintains constant contact with her close friends and boyfriend, and added that she sent 8000 text messages in a month from the previous summer. Further, she admitted to having very little or no contact with her classmates and professors. Robin stressed that she has not been unfriendly, but now she just prefers to interact with people who she already knows and cares about, having wasted so much time with insincere friendships in the past.

When asked if her academic and social life influenced each other, Robin replied, "definitely, my social life when I was busy with the [student organization] or with friends, or going out, my academics suffered SIGNIFICANTLY. Um, I was never able to balance both" (lines 796-799). Currently, she noted that she has managed to balance her work, and academic and social life.

Goals, challenges, changes, persistence.

With respect to her goals, Robin explained that in junior high school and high school, she did not have life goals, only those related to her immediate social life. Unlike her peers, she always thought she would gain admission to a university without much effort. Near the end of high school, however, she tended to put more effort into her grades related to a class for children with special needs. Especially in the past year, Robin has been highly motivated to pursue employment related to this field. Another significant motivating factor for her strong academic persistence has been her boyfriend, who had to struggle much more than she to get through university. Robin saw herself being handed everything and showing little appreciation, while her boyfriend was raised only by his mother and encountered many more financial hardships. An additional factor in her strong persistence has been her OCD. This has helped her set and

meet goals, such as saving money on a weekly basis.

In terms of challenges and changes, Robin mentioned, "OCD I deal with like daily and I've kinda just come to, I guess I cope with it rather than have overcome it. Um, when I used to have impulses that I couldn't control, sometimes they would be violent, like hitting someone or like stabbing someone with something" (lines 543-546). When asked if she meant physically, or only mentally, acting out these impulses, she chuckled, "no, doing it haha" (line 548). Robin explained that she now refrains from acting upon these impulses and talks them out instead. She has received advice advocating a positive outlook on life to change the effects of her OCD and meet her goals. She has realized that some occupations would still be too troublesome to pursue, for instance, if she became a lawyer, frequently repeating words in a courtroom would be unavoidable. Missing parts of lectures due to her retyping of laptop notes also remains problematic.

As for her recent goals and the future, Robin mentioned that she was committed to pursuing her goal of becoming a lawyer, but she eventually realized that her word repetition would be troublesome and her grades would be insufficient for law school admission. Regarding her outlook for the near future, she explained that her goal is to complete school and she is doing her best to reach graduation. She added that she really misses working in the area of special needs. Therefore, after university, she will probably return to this field depending upon available options. Considering her academic persistence, Robin took a break of about nine months from her university studies, with her boyfriend being her main motivation for resuming school.

Strengths, weaknesses, and coping strategies.

During elementary school, Robin excelled at her school work, while she considered her social relationships to be of little importance. In junior high school, social relationships became more important and a real strength, as she began to pay more attention to her status. Her school

work and her relationships with her family suffered due to this shift. In high school, Robin was an average student in terms of grades and she put in little effort. A key coping strategy for her was her social skills, as she noted:

it was like everything I, I wanted I could have and people would do whatever I told them to, and so that's what my focus was. So that, I don't know what my strength would be...it was a COPING strategy FOR SURE, because if anything ever upset me, I could have it taken care of, but, I mean strength in I guess being able to manipulate people, which isn't really a strength looking back, but at that time it was very important to me.

(lines 395-400)

As for current coping strategies, she no longer tries to cope on her own, but confides in her mother, boyfriend, or best friend who are of enormous help. Robin reflected:

I think I've become really good at, talking things out, realizing what I need to do and actually doing it instead of, saying well that's too hard, I'll do what's easier. Um, my strength is DEFINITELY, well exactly that, like how strong I am and my like determination, my resolve, and, um, I think my weakness still is though that I can't, I don't, it's not that I don't CARE what I do to people, but, even if, like, if someone's put in a couple, like a couple years with me or months or whatever and regardless of how close we are, it'll take one thing for me to say, all right, like you're done, goodbye, and I think that is, I do see it as a strength in a lot of ways 'cause it gets those people out of my life and it is a weakness because, I'm, I'm sure I'm losing something good when I tell them to screw off. (lines 407-414)

In terms of OCD and her academic life, she explained that symptoms are exacerbated by stress, such as during exams. A positive aspect, perhaps a strength, of her OCD is while reading

she must complete what she has started, despite her need to sleep. It was quite difficult for her to write lecture notes as a mistake or poor penmanship caused her to rewrite her notes. Occasionally, she needed to rewrite notes from a previous class while attending another class and she characterized this as being "really distracting" (line 420). A very helpful solution to this problem was the purchase of a laptop computer, but she still encounters troubles, noting, "I have little things that I have to do on the laptop every now and then, but it doesn't take up too much time" (lines 435-436). These things include underlining and adding bullets.

Further, she noted:

well a coping strategy I guess is that I'm more open about it [OCD] now than I ever have been. My friends know, my boyfriend knows, my parents know, and I'm much more able to talk about it, so if I'm HAVING a problem, I'll say it, you know, I'll say, sorry, I can't write with that pen, or, like, you know, people are, I guess a little more understanding now we're older, so that definitely helps that I'm able to be so honest about it.

(lines 451-455)

The three questionnaires and journal: Comments and clarifications.

With the OCI-R, Robin noted her counting and fear of contamination are "just so NORMAL NOW" (lines 858-861). She described avoiding doorknobs and elevator buttons, and waiting for others to touch them for her. When alone, she uses her clothes to protect herself, but she has touched these herself when in a hurry, and then just wiped off her hand on her clothes. She noted that there were so many items that did not apply to her OCD, causing her to realize she is unique. Robin also recalled being curious about others with extreme OCD symptoms unlike hers and that others may perceive her to be odd for having extreme symptoms that they do not have. With the SF-36v2, Robin associated *tired* with the need to sleep, but *worn out* with a lack of time to relax.

In the demographic form, she noted that both her compulsive counting and fear of germs have been present for about the past 10 years. With her impulsive speaking over the past four years, Robin recounted, "no haha it's not, it's just annoying, um. I do it A LOT and people get like annoyed because they want me to just like shut up but they don't understand that I can't" (lines 902-905). Correcting herself and restarting thoughts is part of this speaking process. She added that such a process, usually in a conversation, involves very insignificant matters. She guessed that her feeling of discomfort is related to an issue of the degree of truth in the utterance, rather than outright lies that she has no trouble telling. Speaking to herself or in a whisper is also an option.

A typical day.

Robin explained that her typical days are about the same, with school, lunch with her boyfriend, and then return to school or go to work. At school, she usually reads and does not socialize much. Evenings are spent at home having dinner with her boyfriend and then watching television and talking. When considering OCD and a typical day, Robin recalled:

it definitely affects me every day, but sometimes it's more, I guess I've done things for so long that I'm used to them, and I think, well this is how I'm going to do them, but I don't think this is how I HAVE to do them. Now I do them and I know if I don't it will upset me, but I don't spend a lot time worry about them being done because I know they will be. (lines 727-733)

She related a pertinent example of her morning ritual of washing her face, brushing her teeth, and then applying moisturizer, which occasionally cannot be completed in this order, thus causing some anxiety. At work, she described her need for order and symmetry, for example, "if I'm setting the table, like the napkins being RIGHT on the edge, with the fork and the knife IN the middle like [sigh]" (lines 741-745).

Others with OCD and those who encounter them.

Robin recalled a high school classmate with OCD. Those around her treated her OCD as being as *cute*, but not troubling. Thus, Robin did not approach this classmate about the issue. She added that even when she was an in-patient, her fellow patients were more concerned about how mentally ill they were perceived to be, thus again contact was not made. As for indirect contact, Robin has read about people with OCD and noted the similarities with her own behaviours:

I guess what PISSES me off is when, and obviously I'm only sensitive to this 'cause I have it, I'm sure I do it with other things, but people are like, oh, I always have to do this, I have OCD, and I'm like, well if you HAD IT, you would realize that it's not a) funny or b) something to be proud of, it's TERRIBLE, you DON'T want it, but these people, like, you know, it's kind of a JOKE, so that's why I never, a lot of the times I DON'T tell people because I know that, you know, they're like oh I have that too, and a lot of people don't understand. I'm really open about it, but when people are talking about it, it's like a joke. (lines 645-650)

With respect to offering advice to fellow students with OCD, Robin explained:

I guess like the only advice I have, because I want to say like, 'cause the way I deal with it is by understanding it and realizing I can't change it, so just go on with it, but I also understand that one of the biggest parts of OCD is control, so I can't tell people oh, just let go, it's NOT that easy. (lines 1148-1153)

She also advised students who hide their disorder to be more open about it because people are really more accepting of OCD behaviours than one would expect. Once this is realized, the thought and actual act of letting others see your behaviours will not seem as disturbing or significant. Letting others see and hear about your behaviours will make you feel much better

than keeping everything inside and dealing with OCD alone.

As for offering advice to people who encounter those with OCD, Robin advised them to become informed if not already. Further, they should definitely not instantly assume that this person is imagining they have these symptoms or this person is embellishing his or her symptoms. Robin also stressed that this disorder is real and others should not make fun of those who have it.

She was not able to offer any advice for university teachers or administrators, but she did remark upon the potential need for changes to services, policies, or both at her current post-secondary school. She noted that this OCD study recruitment ad was the very first information she had seen about OCD on campus, and probably many other students like herself would be interested in joining a small support group via a similar ad or email from administration so that she could be heard and understood.

Final comments.

After some thought, Robin reflected upon the times her OCD had a negative, or very negative effect upon her life, causing her to consider taking some action. She then usually acknowledges that others are more adversely affected by OCD. From another perspective, she noted:

it's frustrating because you look at it and like someone who's...anorexic let's say, you can look at an anorexic and say, what's wrong with you, just eat! And you think logically, you're right, I should just eat, and it's like this with this thing, but it's like, it's worse 'cause it's ALL in your head, and you just think like why can't I get over it? (lines 1200-1207)

She expressed even greater frustration about not being able to rid herself of these OCD thoughts.

In terms of her opinion of this study, she explained:

I'm interested to see how it all comes together, because talking about it has sort of made me realize like, there were definitely certain events in my life that maybe have more significance than I really gave them 'cause just talking about them makes me realize...so ya, I'm really interested to see how it comes together...how it's all tied in.

(lines 1218-1223)

Anne "sometimes I wonder if people can see what I'm doing"

Anne's interviews with the researcher lasted 95.5 and 33.5 minutes respectively for a total of 129 minutes. She had gaps in her journal writing, with three entries between September 30 and November 7 inclusive for a total of 1493 journaled words. Anne noted main symptoms of regret, worry, contamination, ordering, doubt, panic and frustration. As she recalled, her self-diagnosis of OCD and age of onset were at about age 12 and the clinical diagnosis of OCD was at age 17. She completed all self-report questionnaires. An overall distress level of slightly more than Moderately was determined by her OCI-R. In terms of the SF-36v2, her overall health state was Good and Anne indicated that her health in general now is about the same as one year ago.

OCD diagnosis, recommendations, treatment.

With respect to OCD symptoms and her earliest memories, Anne described an incident that occurred around grade 6. Her friend was very frustrated with her because she repeatedly typed and then deleted a sentence. Anne had no understanding of why she needed to repeat this sentence and her friend was unable to understand why Anne could not just continue typing. Not only were Anne's friendships troublesome at this early age, but her family relationships also "took like a nosedive" (line 146). Anne's sibling, for example, remarked upon her unusual behaviours, such as her need to walk backwards. Anne would try to deny these behaviours and laugh about them,

but her sibling would constantly ask her what she was doing and why. Concerning her parents, Anne asserted they were "COMPLETELY...unsupportive" (line 164) and they ignored her behaviours and said nothing despite her "REALLY STRUGGLING with this" (line 166).

Later in grade 7, Anne read an article about OCD that finally explained her unusual behaviours. She realized she had OCD, but she was reluctant to tell her parents due to her great embarrassment. Further, she noted her father's insistence that he had a normal family, while at the same time she thought of herself as being "flamingly abnormal" (lines 175-176). One example she cited was of believing that "like something bad is gonna happen" (line 250) unless she acts in a certain way.

Just prior to becoming a teenager, Anne believed that she had OCD and subsequently, she conducted some OCD research that unequivocally confirmed her belief. During the years that followed, she noticed that her symptoms were becoming worse. She was also bothered by her parents' lack of understanding.

About 3 years later, around grade 10, Anne finally approached her parents, suggesting she see someone for help, but again no action was taken. In grade 11, Anne told her sibling that her parents had failed her and this prompted a family discussion where she expressed her anger and frustration about their inaction. She noted, "I told my dad how I felt...I wasn't expecting that to come out of my mouth" (lines 1459-1461). Her parents then agreed to send her to a psychologist, but Anne still holds a "huge grudge" (line 201) against her parents, especially against her father.

At 17, she ended up seeing a family doctor who Anne labeled as "HORRIBLE" (line 264) because she was uncaring and just prescribed medication. A short time later, she went to a much kinder doctor, a psychologist, who asked her to write a journal about her daily experiences and who eventually diagnosed her OCD. Such daily experiences included her problem getting dressed,

one that still persists. As Anne explained:

getting dressed in the morning is like, you know, like choices between certain things, like I hate choices, they're good, but they're also like, mess with my brain...so like I'll be picking out socks and I'll be like, I REALLY WANNA pick out those like, REALLY WANNA wear those socks, be like YES, THOSE ONES, but then, you know OCD comes along and it's like, no if you pick those socks, not like that, but something like well your family will get cancer or something, and then I'll be like DAMN IT and I'll be like ok what about I'll pick I guess, I guess I can wear these socks and then, it'll be like yes, but if you wear those socks blah, blah, blah, and then like DAMN IT and then so, for example, it was like really bad when I was 17 because I'd go through like ALL my socks and it would be like well, what about this one? NO, this one? NO, this one? NO hahaha...and then it would be 20 socks later and I'd still have I'd be like ok I don't have anymore socks hahaha I NEED to pick a pair of socks and so she told me to like, when that happens, to just like try on all the socks and then, you know, obviously you have to pick one, so it's like you need to see the correlation between like that happening and that happening so just do it and then realize it makes no sense and then just like pick a pair and wear them and that's ok. (lines 299-317)

Anne admitted to not having seen a psychologist for quite some time, thus she tries to rely upon what she believes she should be doing to cope with her OCD.

Experiences, beliefs, feelings, relationships.

Anne's earliest family-related memory was the passing of her grandparent when she was about 6 years old. Many family members were present at the time, and this recollection led her to discuss the genuine closeness of her family. She chuckled as she described her mother's recent

comment that Anne was "the quietest kid ever...I would never like cry when I wanted to be fed, she'd like have to wake me up to feed me haha and...what is wrong with this child haha kind of thing" (lines 122-126). Further, she admitted to not being talkative and mainly communicating with her immediate family during her early years. As she got older, she did develop friends in her neighbourhood, such as with a neighbour who Anne described as being "one of my best friends" (line 133).

Anne surmised that OCD may play a part in the lives of her siblings. She explained that her sister may have an eating disorder and other problems relating to food and also a strong need to maintain control over her life. Her other sibling has a strong need to keep his clothing arranged symmetrically and becomes angry if anyone disturbs this order.

Despite being "really shy and quiet" (line 358), Anne recalled that in grade 1 and 2, she "really liked that school and my teacher really liked me I think and I had a lot of friends in the class" (lines 356-357). Similarly, at a new school from grades 3 to 6, she described these as being "really, really good years...I liked my teacher, I liked my classmates, I liked pretty much everything" (lines 367-369). In one notable example, she described how an elementary teacher encouraged her and he was so proud of her for overcoming her extreme nervousness by successfully reading her poem in front of many classmates. For grades 7 and 8, Anne attended another new school, but she detested it mainly due to the snobbish students and their cruel remarks, and her teacher who just ignored their terrible behaviour. Due to this persistent bullying, she believed that a few of her close classmates developed eating disorders and even led one to suicide, causing more distress for her small group of friends.

For high school, Anne switched schools again, but she found grade 9 to be difficult despite attending with some classmates she met in previous school years. She recalled that her siblings

were very popular and outgoing, but she was just the opposite, even with encouragement from her siblings' friends. She noted this pattern of extreme shyness as early as grade 6, with her teachers disliking her because she was unwilling to talk. Later on, she managed to adjust to high school and Anne especially enjoyed art class which included many of her friends.

Currently, Anne considered her relationship with her family to be much closer than previously, mostly because of improved communication, openness, and support, for example, her admission to her family about participating in this OCD study. Anne's mother, however, was shocked about Anne's participation, leading her to feel that she had perhaps become too open with her family about her disorder. She noted that this shock may have been due to her mother not witnessing many of these OCD symptoms. Anne admitted to her mother, "just 'cause I don't do it in front of you because that would be really awkward" (lines 463-464). Anne mentioned her aversion to sharing drinks and fruit, even with family members, but this is more pronounced with those outside immediate family.

Anne figured that most of these behaviours occur "when I'm by myself I guess" (line 466) and she "definitely" (line 468) tries to hide or mask them despite the difficulty in a post-secondary environment. Also at school, Anne recounted her reluctance to touch door handles and railings, especially in bathrooms. She frequently uses her shirt to open doors and such awareness about contamination has heightened since returning from the summer away from school. Having too much caffeine and also being in front of many people further exacerbates Anne's anxiety. Compounding the anxiety related to writing exams is writing multiple choice exams. Anne noted:

multiple choice exams I HATE because I'll do, like, I'll think about the question, or I'll think about the answers, EACH, and then I'll be like well OK it's obvious what the answer is B and then my OCD brain is like, OH NO, if you choose B, blah blah blah is

going to happen, just like, you know, a list of bad things that are like my top like, things that I think about kind of thing...what I worry about the most, uh, so like stuff like that or like you're gonna go blind 'cause I really worry about my eyes, so stuff like that and so I'll like choose like C instead of B even though I know it's wrong, so like usually that doesn't happen TOO often throughout the exam because I'm like ok, you can't fail this exam even if I know all the answers, so like, probably like three or four times throughout like a 100-question exam like that'll happen and um it's bad because, like I KNOW that I'm putting down the wrong answer, and it's just like, I think that's like kind of the MAIN, like problem with OCD I guess I have is exam writing 'cause just it's so stressful.

(lines 530-551)

Very recently, a friend of Anne who has ADD told her that she writes her exams in a room that is separate from her classmates. Anne found this to be very encouraging and she planned to find out about her eligibility.

Considering her beliefs, Anne considered her personal system of beliefs, including treating others as you would like to be treated and her experiences with Christianity. She figured that both she and her family were uncommitted to a religion. With respect to her feelings, Anne recalled being quite happy in her mostly positive school environments prior to high school. After adjusting to high school over grades 9 and 10, grades 11 and 12 were much better for Anne academically and emotionally as she received help from a psychologist for her OCD. For university, Anne described different feelings associated with her living situations, for instance, living with others for years and living alone for one year. She identified the benefit of making and maintaining strong friendships, while also enjoying life alone, but becoming very lonely too. She reasoned that her academic and social life have greatly influenced each other, for example, meeting other

students with similar academic interests through campus organizations.

Goals, challenges, changes, persistence.

Anne explained that she worked hard throughout school to accomplish her goals, trying to please both her father and her teacher, despite also having to cope with her anxiety. Near the end of grade 12, Anne took a world issues class. This class influenced her to enter a similar university program, which she has nearly completed. She noted, however, her great fear about what she will do regarding the program requirement of gaining experience abroad. Her OCD and worries about different customs and cleanliness of food may not be easily managed in such a new setting.

Regarding challenges, Anne reasoned that telling her parents about her symptoms and trying to gain their acceptance was quite challenging, as her father still has not come to terms with his daughter's OCD. Telling friends about her OCD has also been challenging. Further, understanding why OCD behaviours have changed significantly has also been challenging for Anne. She discussed, for example, paying relatively little attention to the cleanliness of her hands over the past 5 years. For about 5 years before this period, however, Anne washed her hands excessively to the point that they would have cracks due to her obsession with contamination. In addition, her need to keep her bed free of contamination has subsided, as she can now let her mother sleep there. In the past, all other people and all objects could not even touch a part of her bed, such as her knapsack or clothes that had come into contact with public transportation.

In terms of persistence, Anne recalled wanting to leave university, especially just after she entered. During her first year, she came to accept her new life and her second and third years have been similar. At the beginning of her final year, her OCD was quite severe and she just wanted to take a break for a semester to work or do something else. Anne did not consider dropping out due

the potentially serious consequences from her parents. She asserted:

I was just really stressed out, like couldn't do anything 'cause I was like paralyzed with OCD pretty much, but like um, then, I don't know how I got out of that, I think it's, my roommate wasn't there to begin with and then when she moved in it made it a lot less stressful. (lines 1152-1160)

Strengths, weaknesses, and coping strategies.

When asked to comment on these factors, Anne began discussing her weaknesses at university, as she emphasized:

I'm RIDICULOUSLY shy and that I DON'T like talking in class and therefore like whenever I participate, like for example I have a class right now, that's like 15% participation mark and like I don't even know what I'm gonna do, 'cause all the other, like 85% is a class presentation, so I'm just baffled...." (lines 679-682)

She believed that her grades have been very negatively affected as a result. Drawing attention to herself is a significant issue, as she is constantly anxious about classmates noticing if she makes a noise or does something that is not socially acceptable within classes of about a dozen students to hundreds. Anne mentioned another weakness related to her participation with a friend involved in reusing trash. She admitted that she should be environmentally responsible, but engaging in such an activity strongly conflicted with her obsession about contamination and her relationships with such friends.

For Anne, coping with OCD has been a part of life. From her therapy, she has become more effective at suppressing urges to carry out OCD-related behaviours. She noted:

if I feel I have to do something, then I'll just go NO, you're not doing it and I'll walk away, but um, like if it's possible...it depends on the situation I guess, because sometimes

it just makes it worse in the end, so like if I keep like suppressing like the um urges to like do whatever, like anything that my brain like...you have to repeat this or, usually it's repeating stuff, um, uh, so ya you have to do this or whatever will happen and then usually I can just be like, I don't have time for this and then I'll walk away, and I'll like leave the room and I'll just do whatever, but if I'm in class, then usually I have to just like sit there and deal with it haha. (lines 1388-1394)

Over many years, Anne has learned to accept that she cannot engage in some activities that pose no problems for others. She sees that this situation with her OCD will probably remain unchanged.

The three questionnaires and journal: Comments and clarifications.

After completing the questionnaires, Anne found that some of the items to be quite vague causing her to be uncertain about responding. In the demographic form, she affirmed that her health has been good for most of her life, but she later detailed her experience with Paxil that influenced her for the 3 to 4 years that she took it, starting in grade 12. She chuckled:

I can't believe that I was on it that long though. Ya, I hate Paxil haha and um pretty much because, it's uh, it didn't really do much I find, um, it made me like slightly less anxious which was good, but um not really much for OCD and um it made my body addicted to it, so when I tried to, like when I forgot to take it, which would happen a lot, like I'd feel really sick and I'd have a headache and like um, like stomachache and stuff like that, so I didn't like that at all. (lines 1227-1233)

In terms of her dosage, she mentioned an increase, followed by a decrease, and then finally taking herself off of the drug without any salient differences. With respect to employment, Anne briefly had a service-oriented job that to her surprise, suited her well, as she explained that she generally finds it difficult to work in social settings.

For the OCI-R, Anne confessed that her checking compulsion has improved a great deal since living alone the previous year. While living alone, she frequently checked and rechecked her stove, radiator, door and bicycle lock. In terms of the SF-36v2, Anne chuckled, "this one makes me laugh, when it says do you, have you felt calm and peaceful during the past 4 weeks and I said none of the time haha...I thought that was kind of funny haha" (lines 1403-1406). Regarding humour, Anne noted, "being able to laugh at yourself, and you're like yep, I'm a little bit weird, but that's ok" (line 1410). For item 9, she added:

I usually feel tired um, like on a regular basis I guess, but um I haven't been sleeping well lately, and 'cause I usually attribute to being tired and uh I'm always nervous so that's just like 100% of the time, it's like it'd be an anomaly for me NOT to be nervous, so um, what was the other one? Happy, I feel ok, so I'm not like joyously happy every day, but I'm happy enough to like continue to go on with my daily business. (lines 1313-1317)

From the OCI-R, checking, items 2, 8, 14, was Anne's most distressful experience, as she responded *extremely, a lot*, and *extremely* respectively. Further, washing and obsessing were all deemed to be *a lot*. Neutralizing, items 4, 10, 16, was the most diverse, with responses of *moderately, not at all*, and *a lot* respectively. Hoarding and ordering responses were all *a little*. In the SF-36v2, Anne's mental health item responses were mainly *some of the time*, such as being full of energy, worn out, and depressed. Anne also responded that she was both very nervous and happy *most of the time*. In terms of physical health item responses, she showed only one slight limitation of physical functioning and some slight degrees of limitation for role-physical and bodily pain, with her general health expressed as *good*.

A typical day.

Anne emphasized that she is the most anxious at the beginning of each day as she considers all the things that must be done and this is accompanied by slight stomach pain. After getting out of bed and realizing that her worries are unfounded, this anxiety lessens. Anne then eats breakfast, cleans her teeth, and often rides her bicycle to school after ensuring that it has not been vandalized and it is in working order. On her way to school, her anxiety increases as she fears riding into a pedestrian. After arriving, she locks up her bicycle and then proceeds to her class, feeling quite nervous. While in class, her discomfort continues if she cannot follow the lecture and if the class takes a break, as she cannot decide what to do and she is reluctant to stand up in front of all her classmates. After the lecture, Anne returns home or goes to the library to study. More specifically in terms of OCD, Anne noted that just after waking up, she must consider not only what things she must accomplish, but also the ways in which she could accomplish them. After getting up, for instance, Anne takes about 10 minutes to decide upon what socks to wear. She also needs time to consider appropriate footwear, as she really enjoys the freedom of biking but her sandals are unsuitable for this. In her journal, Anne wrote that her psychologist advised her to try everything on when choosing clothes in the morning and following this advice has helped me, though the problem still exists. She can now wear the first items of clothing that she picks rather than waiting for item choices to be *just right*. Also while at home, Anne noted regrets and distress, for instance, adding to clutter in her already untidy room, and while preparing dinner, choosing to use the least convenient piece of cutlery and not returning things to their proper place.

Anne still experiences difficulty and discomfort at school due to her OCD, such as her difficulty writing complete words in exams and worrying about markers' reactions. Further, she regretted sitting at the front of a lecture room and also regretted not having the required note to

write exams in a separate room, but multiple choice exams are admittedly less troublesome.

In her journal, Anne also described being quite anxious in class from a discussion that involved death, fate, risk, and why negative events occur. She associated this with her odd OCD behaviours and fate, noting that her obsessions need to be followed by respective compulsions to avoid bad things from happening. When compulsions are suppressed, she blames herself when bad things occur as a result. Recently in class, she began to worry about becoming schizophrenic because of OCD's connection with irrational behaviour, such as compulsively highlighting entire sentences and/or page sections creating incoherence in the reading, and while typing, compulsively omitting or leaving words incomplete. In other social contexts at school, such as a gathering with food and drinks, Anne is reluctant to partake if others have contaminated them or if her hands are not clean. Anne experiences frustration due to her feelings of being abnormal and her family and friends disbelieving and not understanding her behaviours, or telling her that things are clean enough to suit her. Still, she is comforted by knowing that she is unique and help is available outside her current social network.

Others with OCD and those who encounter them.

Anne noted that an online forum at www.healthyplace.com has been very helpful to her because of the variety of disorder information and the diversity of posts from people who can express their feelings, explore their interests, and obtain advice. In her late teens, Anne recalled posting a message and receiving a reply that encouraged her to be strong:

it really helped me because and I remember like I printed it out and like I put it in a box I had and I still have and stuff, so it was like really, really positive um like feedback, like don't worry, there's other people like you, you can do this, like, you know, you're not like a crazy person. (lines 907-909)

Also from high school, Anne remembered quite a popular classmate who had OCD, but he was well liked despite the general perception of people thinking that he was a little strange. From her perspective, Anne saw that he just accepted his disorder and she considered him to be a positive influence. She wrote him a confidential message confessing that she also had OCD, but Anne noted that this experience was somewhat stressful because he did not destroy or return her message to her as requested. She feared that someone could have found this message and discovered her secret.

With respect to other related contacts, Anne commented that around the time of becoming a teenager, she purchased a book about OCD, but she remarked that she doesn't like such books because of the way people are described in them. Finally, Anne emphasized the importance of online forums as they helped her when she had no one to talk to. She still does not talk to others about her OCD, except for a valued friend who has another disorder and shares her peculiar behaviours. She has told many other friends about her OCD, but they did not believe Anne and this caused her great distress due to their lack of support. Regarding advice for fellow students with OCD, Anne suggested that especially for first-year students, they should find out about the available campus support services so that their lives during university will be more manageable and they will not feel isolated.

For those who encounter people with OCD, Anne recommended self education before asking innumerable questions that will probably only lead to discomfort. For family members, she stressed the importance of being supportive and avoiding comments related to OCD behaviour observations. Considering teachers and other educators, they should be approachable and make students aware of the support options available for those with physical and mental disabilities, including flexibility with deadlines and writing examinations. Anne could not recall a teacher at

any previous school telling her this. In terms of her current school, she emphasized increasing awareness through campaigns, posters, and talks so that those with OCD will feel less stigmatized. The school administrators, Anne advised, should be familiar with a broad range of diseases and disorders and they should create anxiety support groups, such as for OCD, to prevent students from feeling isolated and to encourage them to talk openly about their problems and receive help.

Final comments.

As for Anne's reflections upon this study, she stressed, "I really wanna know...I wanna read the final thing" (lines 1559-1560) and she wondered, "why would somebody wanna write a paper on this?" (lines 1567-1568).

Mary "I've had other jobs where they think I'm TOTALLY weird"

Mary's interviews with the researcher lasted 34 and 24 minutes respectively for a total of 58 minutes. Her age of onset was at about age 13 and the clinical diagnosis of OCD was at about age 16. She completed all self-report questionnaires. An overall distress level of Moderately was determined by her OCI-R. In terms of the SF-36v2, her overall health state was Good and Mary indicated that her health in general is somewhat better now than one year ago.

OCD diagnosis, recommendations, treatment.

Mary recalled being told that her OCD was not that serious, but this eventual diagnosis came after many clinical consultations between about age 10 and 16. At around age 10, she was diagnosed with depression by her family doctor as a result of the death of a sibling. Later came a different diagnosis of an anxiety disorder, and then later with the eating disorder bulimia. At the age of about 16, in conjunction with two or three psychologists, she was diagnosed with OCD due to what she believed as being her obsession with eating in 2s.

As for recommendations, Mary explained that her doctors recommended both medication and therapy. She saw one psychologist for about a month, but her disapproval led to a second psychologist who she saw for about a year and a half. This therapy involved Mary communicating with her internal voice and assuring herself that performing something once was enough. In December 2006, Mary discontinued seeing a psychologist as she felt she could deal with this by herself with the aid of her antidepressant medication. Still, however, this issue is still problematic, for example, while at work handling money, but she noted, "it doesn't really BOTHER me as much" (lines 85-86). As for her medication, Mary explained that she still performs counting rituals and makes lists, but this has diminished considerably from before. Now she can now buy just one item instead of two, but she noted that this was, "kind of weird for awhile haha" (lines 94-95).

Experiences, beliefs, feelings, relationships.

Considering her earliest memories of experiences and relationships, Mary recalled these as being predominantly positive until she reached about age 10 or 12. Around this time, a sibling died and her doctors really struggled to diagnose her OCD. Since her diagnosis, she has responded very favourably to her medication and this has enabled her to lead a relatively normal life.

In terms of her OCD symptoms, she remarked upon her obsession with multiples of 2, for example, when listening to the ending of a song, it would not feel complete until she heard the second note of the final beat. Further, she recalled her affinity to making lists and being organized, while still purchasing, for instance, two heads of lettuce. She felt that these behaviours contributed to her lengthy diagnosis process because she did not have typical symptoms of hand washing or being excessively clean.

Considering her relationship with family and others, Mary explained that her parents find her OCD to be rather strange, with her mother being a little more accepting due to her occupation

as a health care provider. As for other family members, she noted that there is a history of mental health problems therefore they do not blame her for her OCD. Still, they find this disorder to be rather strange. Mary explained, "'cause when you think about it, it IS kind of weird...my [grandparent] had manic depression, my aunt had an eating disorder, my [parent's] an alcoholic and has depression, my (parent) has anxiety...people understand" (lines 109-112). She and her family acknowledged there may be some genetic link to mental illness thus her parents expected Mary to be vulnerable, but not to be the first in the family with OCD. Further, her roommates do not fully understand Mary, but they help her after she buys groceries, for example, eating a second head of lettuce that would spoil.

In terms of her beliefs, Mary described how her parents forced her to attend church for a long period of time, up until only a few years ago. She noted that they finally understood her disliking church. Mary asserted:

I do believe in, karma, higher power, be nice to others, that sort of thing...education should be a right, everyone should be educated, um if you don't go to university, then that's your own thing. Some people don't like doing that. (lines 117-123)

As for her feelings, Mary recalled that she was probably the ideal child until about age 6 or 7, but her demeanor apparently changed from then on after being with other children. Her feeling of not being like her peers started around the time of the death of her sibling, possibly related to becoming more mature than them. She noted that she was slightly depressed and "I used to do things to channel my emotions, but then I realized that I wasn't channeling my emotions, that it was actually the OCD that was sorta kickin' in there" (lines 129-133). Her doctors told her that it was this traumatic event that was responsible for triggering her OCD.

Regarding her positive influential experiences, Mary discussed her parents taking her to school when she was younger and their near completion of masters' degrees that influenced her to attend university. The volunteer work of her family and especially the work of an elderly relative have been quite influential, motivating Mary to follow in their direction. Her friends' social activism has also been influential. With respect to OCD, she noted that performing things twice has been beneficial, for instance, catching errors while proofreading an essay for a second time. She permits herself to proofread twice as this is perhaps the only positive attribute of her OCD.

With respect to negative influential experiences, the death of her sibling and the remark from her father that he would have rather had a son instead of Mary have caused tension in their relationship. Concerning her roommates, Mary stated that they think she is *crazy* and one believes that Mary merely needs to consume more vitamins and salad to rid herself of OCD. Mistakenly, this same roommate threw out Mary's medication, which caused her some inconvenience and discomfort. Other friends are aware of Mary's OCD, but they still think she is strange or showing off due to her need to complete actions in multiples of two, such as consuming two alcoholic drinks. In terms of working, her current employer is quite understanding and accepting due to the nature of this business, but Mary noted, "I've had other jobs where they think I'm TOTALLY weird and sort of just like OOOH stay away from her" (lines 270-272).

Considering her most memorable emotional experiences, Mary recounted very enjoyable family summer trips to a European country during her childhood. The death of her sibling and the pregnancy of her mother when Mary was about 9 or 10 disrupted her family life as she did not want another sibling. The prolonged diagnostic process also was quite memorable because of Mary's confusion and her doctors' struggles for about 5 years to arrive at a final diagnosis of OCD.

In terms of academic and social life, Mary noted failing high school math 3 times and just missing a university scholarship due to her problem with numbers from OCD. Also from high school, she related her social learning experiences:

seeing through the eyes of different people I've got sent to um, the college for the diverse school, I guess I'll put it like that, whereas I was the minority...so I was able to look at life through the eyes of others. (lines 379-382)

Regarding her current social life, she replied:

well I usually go to class during the day, I work at night, I usually chill with my friends after work, which is about 3 a.m. haha and then I usually sleep, and that's pretty much it, it's like a set routine pretty much 'cause I like routine. (lines 362-364)

As for participation in campus organizations, she chuckled about being far too busy for these due to her job, school, and other things like trying to get adequate sleep. Further, she expected to have much more frequent contact with her friends, because her life in the past has been so busy, with periods of going a month up to a year without seeing close friends.

When asked to consider if academics and social life influenced each other, Mary agreed and offered the example of being able to study developing nations, thus fostering her social activities and goals, such as donating food and planning a career based upon helping others. In contrast, she asserted, "I really hated the administration here haha, considering every year, somehow I disappear, I don't exist, that sort of thing, so it's frustrating as well" (lines 629-630).

Goals, challenges, changes, persistence.

Regarding goals, Mary explained that she was unlike her peers when she was much younger because they all knew what they wanted to become, but Mary only knew that she did not want to become a nurse. As a result of a visit from a relative when Mary was about 10 or 12, Mary visited

a foreign country a few years later where this relative lived and worked helping people. From this visit, she recently decided to fervently continue with her current area of study.

In terms of her persistence, she acknowledged that not completing her degree will leave her trapped in a low-paying job, hence earning a degree was a priority not only for eventual financial gain, but also for the higher social status. Further study may include a master's degree and becoming officially bilingual. Her desire to continue helping people through a cooperative school program was significantly hindered due to her failure to obtain a second reference letter. Mary saw that she was unable to obtain a second reference letter probably due to her absence from school for an academic year, when she tried to take a medical leave. She explained:

like my um G.P. said that if you drop the year, you'll get your money back, you know,
like you know oh maybe I'll think about that and then of course I'd see two other shrinks
AND I actually saw the people here and I sent my thing in and they said oh ya, ya, ya,
you can get your money back, so I'm like fine, I'm just going to quit, focus on myself for
a bit, and then getting a letter saying we've decided that YOUR NOT CRAZY ENOUGH
or something, or too crazy, something like this, so we're not giving you your money back,
and I'm just like [sigh]. THAT was one thing, and another thing the university apparently
says that they care about other people and then saying that they have you know a Mental
Health Unit at the [hospital], that's sort of um ironic compared to what they sorta did
to me, I don't think that was too cool. That's what I think they can work on here haha.
(lines 692-704)

When asked about a possible appeal, she replied, "they consider this matter closed. That's what it said on the letter..." (lines 706-708). Mary added that she has never asked for extra time to complete essays or exams, despite being eligible.

About the issue of facing challenges, Mary remarked upon the weakness of her immune system and having to miss a great deal of school when she was younger. Despite this problem, she was still able to keep up with her peers academically and maintain social ties. Regarding OCD, Mary has learned to cope, but she emphasized:

it's VERY time consuming I find to count, and before it used to be with money and coins and I wouldn't spend my coins, 'cause I'd count them. And then if I had like 38 pennies, I'd want 40, you know that sort of thing. Um, now it's sort of evolved a bit more into points [cards]. (lines 205-210)

Recently, this problem has improved, but she was unsure of the reason or reasons, "it may be the medication really kicking in or it may be just me learning to accept or maybe I just do it so repetitively it's kind of boring now" (lines 216-218).

Strengths, weaknesses, and coping strategies.

Concerning strengths and weaknesses, Mary iterated her dislike of math due to the counting and use of numbers, but noted her strengths in her other subjects, for instance, languages and writing. In terms of coping strategies, she stressed the importance of keeping busy, with listening to music, going to concerts and gym. During her first year at university, OCD made her really focus on multiples of two therefore she needed a great deal more time to complete tasks. This focus diminished with her strategy of keeping busy, and her realizing that she would not have enough time anyway to complete an action twice. Regarding her medication or just thinking through her actions, Mary explained the importance of both, "I still don't feel really RIGHT, but I think I sort of deal with it now 'cause before it really sucked" (lines 342-343).

The three questionnaires and journal: Comments and clarifications.

Mary found the three questionnaires to be somewhat vague, but thorough. For the OCI-R, Mary elaborated upon her responses to hoarding:

most things I do have two of, which is kind of stupid I think, but I just feel sort of compelled, like I have two of the same books and two of the same CDs and it's not like they're irreplaceable or something anyway, but I still have two, like I have two [computers] ha. That's kind of weird I know...'cause I don't know, I have this sort of irrational fear that some day one of them might break.... (lines 496-505)

As for the neutralizing, she added, "multiples of two. I just feel WRONG if I don't do it in 2s, 4s, whatever, multiples of 2, for example, 2, 4, 6, 8, or whatever" (lines 513-515). When asked for an example, such as when she brushes her teeth, she confirmed that brushing must follow this multiple rule too, as well as chewing. Further, she explained that she does things in two without even realizing this, once causing frustration for her professor. She wrote two similar responses for a question on an exam. For Mary, odd numbers are negative, with zero being slightly positive. In terms of ordering, she commented that her possessions need to be in groups that feel *right*, such as books and CDs. If others change the manner that things are arranged, she noted that upset is not really the right word, but bothered or annoyed would be better descriptors. As for a particular order, Mary gave the examples of her need to stack paper from the largest piece at the bottom up to the smallest, and her grouping her books according to size and when they were acquired. She asserted that everyone needs to group their possessions in some way, or her behaviours may not necessarily be related to OCD.

Considering the SF-36v2, she responded to the expectation of her health becoming worse by choosing mostly true, but in the first interview, she stated that her medication had helped her a lot. When asked about this possible contradiction, she replied:

well, according to my family history, like my grandparents are getting up there now, and their mental state isn't getting too well, like I mean they're gettin' more depressed, more alcoholic whatever, so I'm assuming, according to that pattern, mine's probably going to get worse, in like 50 years, in the short term I'm pretty sure it's going to be fine.

(lines 591-596)

From the OCI-R, neutralizing was Mary's most distressful experience, as she responded *extremely* to all items, while washing and obsessing were her least distressful experiences, as she indicated *a little* for every item. Checking was the most diverse, with responses of *a lot*, *a little*, and *not at all*. In the SF-36v2, her mental health item responses were mainly *some of the time*, such as being full of life, calm, and depressed. She reported being worn out and tired *most of the time*. As for Mary's physical health item responses, she showed only one slight limitation of physical functioning and some slight degrees of limitation for role-physical and bodily pain, with her general health expressed as *good*.

When asked about the progress of her journal, she commented:

good, I wrote every day except for there was one day where I slept the ENTIRE day...but it did help me sort of examine what more I do on a day-to-day basis. There were a few things that I already knew, like I sort of, which is kind of obvious, but there was a couple things that sort of, didn't really, you don't really think about it unless you actually THINK about it. (lines 479-487)

A typical day.

Mary usually gets up at about noon, goes to school for a few hours, and she then goes to work at a part-time job that lasts about 5 or 8 hours. More specifically, she noted, "usually, I can't sleep at night, so I usually work late, and then I usually do my readings at night, watch some TV until I fall asleep at about 6, and start the day again" (lines 322-324). Regarding OCD, she described her annoying behaviours that she must perform before going to bed and when she awakes, such as counting her money for fear of having lost some while sleeping, and counting points earned from using credit cards.

Others with OCD and those who encounter them.

When asked about contact with others with OCD, Mary did not recall having such contact. Further, she expressed no interest in reading related articles, asserting, "I'll be honest, I REALLY DON'T CARE haha. I've seen the negative stereotypes on TV but I really don't care, mind you it's not exactly that I go around broadcasting what I have, but I don't care" (lines 309-312).

Concerning advice for other students with OCD, Mary emphasized the importance of taking medication as prescribed, as she had a bad experience when she failed to do so. Despite this advice, Mary noted that her medication does not allow her to sleep throughout the night, but for only about four hours at a time. To counter this side effect, Mary must take naps during the day. In addition, she noted the importance of having a schedule planner:

invest in a good planner...'cause I find that I have to list things, and if I lose it, 'cause I lost my planner once 'cause my bag was stolen, THAT and the fact that my medication was in my bag was not a good week for me, so, other than that, 'cause I found I sort of had a little bit of a breakdown when that happened, 'cause I didn't have my lists, I didn't have my medication, sort of felt in a world of chaos.... (lines 738-753)

As for those who encounter people with OCD, Mary emphasized the importance of tolerance, and not drawing attention to her very odd, repeated behaviours because she is not usually aware of these, possibly as a result of her medication. She noted an unpleasant experience with a professor who pointed out that she had written two identical answers for the same question. Mary, however, was unaware that she had done so.

Final comments.

I don't think a lot of things have significant meaning...I've never really done that many studies, so I really wouldn't know, but the timing seems fine and I don't really mind telling you 'cause it's probably helping you somehow, so the study seems fine. The personal information part doesn't really bother me anyways 'cause I really don't...care if people KNOW, as long as you don't look at me and think I'm totally nuts.

(lines 794-804)

Oliver "for some reason that has to stay separate in my head"

Oliver's interviews with the researcher lasted 59 and 35 minutes respectively for a total of 94 minutes. In his journal, he wrote almost every day, but he had gaps in writing due to serious OCD relapses, with the longest gap of about a month. He conveyed experiences related to contamination, reflection, regret, high anxiety/stress, worry, and uncertainty and noted that at the end of each day and he wrote about 5 significant OCD-related experiences, although he may have had about 50 OCD-related experiences throughout each day. Oliver recorded a total of 3330 journalled words. OCD onset occurred at about age 13 and a clinical diagnosis of OCD was made in his late 20s. He completed all self-report questionnaires. An overall distress level of between Moderately and A lot was determined by his OCI-R. In terms of the SF-36v2, his overall health state was Good. Oliver indicated that his health in general is somewhat better now than a year ago.

OCD diagnosis, recommendations, treatment.

A few months prior to his clinical diagnosis of OCD, Oliver experienced an extremely difficult period in his life. At this time, he described:

it started to spiral like crazy and I just found myself doing all kinds of stuff that I'd never done, I mean my phobias, especially as an adult, have always circled around germs, but never to the degree, it got ridiculous that I was washing dimes and nickels and I remember thinking that's nuts, like even as I was doing it, I was like this is crazy you know.

(lines 113-120)

Along with support from his parents, Oliver visited a mental health centre where he was diagnosed in a very short amount of time compared to what he experienced with some previous psychologists. These psychologists he met previously used what Oliver termed as “Freudian talking theory” (line 150) that amounted to him talking for hours and generating a costly bill without yielding much help other than feeling better for a short time afterwards. This diagnosis occurred during what he described as a time when OCD took over his life and this was “probably like the lowest I'd ever been, especially as an adult” (lines 128-131). When asked about this brief diagnosis, Oliver noted that some take-home tests and his explanations of being afraid to touch everything and obsessively washing things led to a diagnosis of OCD. Based on his undergraduate psychology studies, Oliver was puzzled as to how he could have missed such an obvious diagnosis. When asked about a slight potential of being self-diagnosed while studying psychology, Oliver noted that he was generally happy during this time without any abnormal phobias.

Considering recommendations for his OCD, Oliver described his exposure therapy tasks related to repetition and consistency that he discussed with the psychologist in appointments every few weeks. Oliver noted, “it's worked, a 100 times better than anything I've done before...but if

you had caught me last, like March [about 6 months before this interview] and done this study, I would have, like it would have been a totally different story" (lines 180-184). At first, he was quite apprehensive about engaging in these tasks, as he noted "I wouldn't touch ANYTHING" (line 190). Noting and assigning numerical values to specific anxieties enabled him to mitigate their effects. He first noted 16 salient anxieties, but he admitted that he could have recorded 60 with more thought. Further, focusing on only one specific action for about a week, such as touching certain door handles, helped him to gradually move on to the other anxieties on his list.

When asked to elaborate upon the progress of his therapy, Oliver asserted that his symptoms and his reactions to them had been greatly reduced, with still some *core* anxiety-provoking issues remaining, such as becoming nervous during [atmospheric phenomenon]. Despite some talk about also taking medication, Oliver decided that he did not want to pursue such a course of treatment.

Experiences, beliefs, feelings, relationships.

Oliver recalled having a happy family life with his parents and siblings, and living in a good community. He had many friends and played many sports with them. In terms of anxiety, he noted having difficulty from about the age of 12 or 13. He recalled:

my first experience was, looking back on it, I became petrified of [atmospheric phenomenon], like irrationally afraid of when I was about 12, um, and uh, I guess at the time nobody really picked up that the problem was this, they just thought it was a general phobia, but it kind of materialized more than that. (lines 54-59)

His family was quite supportive at the beginning, but after a few months, they became increasingly frustrated because he could not overcome this fear. He was able to understand their frustration, however, as he saw his behaviour as abnormal. After a year or two of tolerating this behaviour, Oliver's family told him that he must put an end to this fear. Regarding contamination and his

family members, Oliver noted that this obsession has impacted his life for a long time and this is probably chronic in his case. He noted with certainty that his OCD stems from his mother who he characterized as a “big germophobe” (line 235), as she wore gloves to cook chicken and cleaned the family home excessively. Other family members have not exhibited such behaviours.

Prior to high school, Oliver remembered always being strong academically, but not caring much about education or communicating with his teachers. This attitude has not served him well as he still is unable to obtain reference letters. He did, however, enjoy the social interactions of school, such as participating in a variety of sports.

In high school, Oliver was part of a stream of 60 advanced students. He noted that he could get to know them quite well and he still keeps in contact with some, but a much larger, mainstream class would have been better socially. Still, he participated in a wide variety of sports, but he did not communicate with his teachers unless necessary.

In terms of OCD, Oliver appreciated the support and understanding from his family, but he also noted their frustrations before his clinical diagnosis. Prior to the diagnosis, family members could not come to terms with his behaviours and they could not understand why Oliver could not just let things go. After his OCD was identified, family support became much greater. He noted, “NOW they've been super supportive of it. Um, I've NEVER told my friends, uh, or classmates, or anything” (lines 312-315). When asked about telling teachers or administrators or anyone else, he confirmed, “nobody” (line 317). He clarified that he may have casually mentioned his OCD to a friend or two, but this was not something that he emphasized. Oliver observed that many of his classmates identify themselves as having OCD due to the program’s high academic demands for organization and precision. He remarked:

I usually sit there and laugh because I know they DON'T, you know what I mean? Like they just, they understand oh geez, I need to do this, I need to do that, god I must have OCD and they always talk about it. Anytime I've, you know, had like 2 hours of procedural stuff [rituals] I did that morning then I just kind of look at them like you guys don't have a clue, but so I've probably mentioned it to them, with the, under the impression that they never really grasped, like the extent to what it does. I would never, I don't think anybody, I can't imagine telling anybody. (lines 329-337)

When asked to elaborate on the most serious OCD episodes, with contamination possibly being the biggest problem, he explained:

the entire world became like this phobic thing...everything around you is a potential contaminant or something like that... you couldn't turn it off and you couldn't get away from it and there was no safe spot, you know even if you cleaned your entire house, you know, eventually you'd have to get groceries, you'd have to do this, you had to do that, I mean there was no way to avoid it so, uh this was probably the worst one and I kind of allowed it just to fester and grow on its own. (lines 161-167)

When asked if this behaviour impeded his social and academic life, he responded, “ya, I mean, I used to wake up, I only live a block from school, and it would take me two hours to get ready” (lines 169-170).

He admitted to having few, if any, political and religious beliefs, but superstitions have played an increasing important role in his life. He described, for example, his aversion to black cats crossing his path and street lights going out as he walks past being bad omens:

every light bulb in the city burns it seems 'cause every time I walk by one, it seems like it goes out. I don't know why, it's not like I've ever read somewhere that it's a bad omen, but

I just, I always feel that there's something ominous about it. (lines 350-354)

Oliver noted very positive feelings growing up from childhood to his undergraduate years, with looking forward to weekday and weekend plans, and days passing slowly without being boring. He characterized his feelings toward his current program as each day being:

exhausting and I've hated it and you wake up every day kinda like, I don't wanna do this anymore, but I've sort of put like \$40,000 into this and I'm broke and I guess I sort of have to. Uh it's depressing, and uh you wake up every day kind of like wishin' there was a solution to this problem. (lines 391-395)

After some consideration, Oliver noted the positive experiences of moving to a new city for his current program of studies, and always having many friends. In the city that he lived in previously, Oliver was quite unhappy due to the unfavourable paths his high school friends were taking. His relocation facilitated his desire to avoid a future similar to that of these friends. Despite the many problems encountered in his program, this relocation has been quite positive. Regarding friendships, he remarked upon his good fortune to have had many friends throughout his life, despite some that have been basically good with some negative character flaws. He clarified this description, stressing that he has never really been lonely, but he is neither constantly surrounded by friends, nor is his telephone constantly ringing.

Oliver has always found school to be very easy up until his current program. Studying for tests only amounted to a few days of preparation at most. In his current program, however, he noted the strong emphasis on the importance of considering the opinions of many in the academic discipline, as opposed to his own independent learning that served him quite well previously and was much better suited to his learning style. Socially, he explained, "I've sort of learned that I come across very kind of like stand-offish, and I didn't really know that" (lines 803-804).

When asked if his academic and social life influenced each other, Oliver noted that his program is somewhat confining because his classmates are the same as the people in his social life outside of school. During his first degree, he had a different set of friends inside and outside of school. In this current situation, he feels more scrutinized and he also sees that there is a great deal of gossiping. Despite having many friends in his program, Oliver admitted that they are not people that he sincerely enjoys being with and this may be his own fault as he is frequently yearns to move. He would like to move nearly anywhere else to apprentice. As for dating, Oliver noted his persistent difficulty and resistance related to becoming close, as others may discover his flaws. He has never invited friends to his home, but he clarified “it's NOT because I don't wanna have friends over, or maybe it is partly because somewhat I don't want to have friends over, but I just, I, I, I've never gotten into the habit of it” (lines 871-874).

Goals, challenges, changes, persistence.

Since he was young, Oliver has played a variety of sports and starting at about age 10, he has been interested in a career in forensic psychology. He realized, however, that entering this specific field became very popular and therefore quite competitive. Though his grades were strong enough, Oliver could not obtain any reference letters, thus he entered his current program. He still often considers pursuing this long-held goal, but he noted that despite his disdain for many aspects of his current program and the related profession, “it's the first time I've ever had an opportunity to get a real job, like that I've studied for, so I probably will at least [apprentice], and then figure out, maybe go back to school” (lines 500-502). Oliver emphasized, “I definitely have to graduate and move on, like I wouldn't even think about not doing it, but I'm not looking forward to it” (lines 508-509).

Considering his current program, Oliver noted its inherent challenges, but then he questioned whether or not he avoids challenges due the absence of significant accomplishments on his resume, such as having organized events or having strong commitments to important issues. When asked to comment on a transfer, leave of absence, or dropping out, Oliver chuckled that he tried to drop out of his program after the first week, but a senior administrator advised him to remain and he promised Oliver that care would be taken with his situation. Oliver also recalled wanting to drop out of school several other times in the more distant past. He figured that he was not well suited to being a student, but also that life as a student was not that bad either. When asked why he still pursues higher education, he was unsure, but he continues to believe "there's something better out there, but every time I get there it doesn't look that good" (lines 837-838).

Despite his pending program completion and his realization that he has become too old for school, he saw his goals had become very uncertain, with no decision about relocating to even a country in which to [apprentice]. He noted the common insecurity among students in his program, especially related to debt, always having no money, working 12 hours per day, and having everybody around you "barking at you constantly" (line 1191), but that life would eventually normalize. He summarized, "I always kind of get the impression I'll stop when I feel like it's the right time to stop, so then you just keep movin', so I don't know where that is yet" (lines 1160-1163).

When asked about general challenges and changes, Oliver first discussed his OCD, and explained that "this is probably the biggest challenge I've overcome" (line 514). From March, Oliver noted that there was only slight improvement during the first month, as the doctor had not yet decided to implement CBT tasks as part of their weekly meetings. Around the fifth meeting, specific tasks were added to the treatment, based upon his explanations of his life and family, and

results from some diagnostic tests. Oliver remarked that his early fear of a specific atmospheric phenomenon has, for example, been controlled as he has developed the ability to recognize the anxiety this triggers and then focus on mitigation. When this fear began, he used to sit in a place in his basement and close all the blinds in order to cope, but he noted that this fear has not been troublesome lately and he has perhaps grown out of it. He added that OCD is not like *a prison* as many seem to perceive it to be and relying upon medication to cope with OCD throughout life is also an inappropriate perspective. For Oliver, exposure therapy has been effective, and this has brought him to understand that “you don't HAVE TO live like this, so, you can do whatever you want” (lines 1175-1177).

In his first interview, Oliver affirmed that he provided complete answers and that he tends to focus on negative thoughts, with the possibility of something bad going to happen despite the low probability. He identified the precursor of each extended, negative period in his life as being “an instigating moment” (line 1207) and “like this epiphany moment at the start that you know this is NOT going to let go...this recognition that I'm screwed...that I know when I'm kinda like really, really, really in big trouble” (lines 1212-1218). He added that he clearly remembers all of these moments that began about age 11 and he is unable to forget them.

Strengths, weaknesses, and coping strategies.

Oliver asserted:

I've always been good at, at, I'm not good at meeting people let's say, but I've always been good at getting a lot of friends, like I'm very, very shy and I don't really open up very often, but for some reason I always have a lot of people around me and it's not for any reason that I'm like really, really great with people, but usually good at keeping friends.
(lines 416-420)

With weaknesses, Oliver iterated his acute shyness:

super shy like to the point where, like, you might, you might get a negative impression of people sometimes because you're so, like if you don't, I don't know, people always say this, sometimes you come across snobbish or if you're OVERLY shy, and I usually get that kind of...unintentionally kind of like, ya, pull back from people um, and nervous, like and I think they probably go hand-in-hand, like I bet a lot of the shy people are just nervous people and that's what leads to the behaviour, so those are definitely the big drawbacks.

(lines 430-434)

He observed that ironically, all of his jobs have been in customer service, where he has not become nervous or scared, even when he needed to approach a group of about 30. Expressing himself during a lecture in front of his classmates and professor, however, makes Oliver extremely nervous. Regarding coping strategies, he explained that in his childhood, he would become so anxious with activities such as piano lessons and gifts like a woodcarving set that he would simply give them up. Lately, he judged that he focuses on and controls aspects of his life to ensure no problems follow.

The three questionnaires and journal: Comments and clarifications.

In terms of Oliver's initial comments after completing the questionnaires, he noted that his responses to item 11 in the SF-36v2 may be quite surprising as he chose *mostly true* for all responses, but he really feels that he is more likely than others to become sick. He realizes that he is in very good physical health and there is no justification in thinking that he will become ill, but the propensity to become ill is always present in his mind. Near the end of the second interview, Oliver added:

I, I don't genuinely get sick, I just have this habit of getting, anticipating getting sick or spending my whole life worried about getting sick, so I always FEEL sick, but if I went

to a doctor, they'd tell me to go home...so I don't really have anything to complain about, but I have like all these like concerns about them. (lines 1142-1147)

When asked to elaborate upon his choice of *Very good* for his general health on item 1 from the SF-36v2, despite his belief that he will get sick later on, Oliver explained that he seems to anticipate catastrophe in life due to his experiences with compounding problems.

Regarding his response of *Most of the time* for item 5c that asked if work or other activities were done less carefully due to emotional problems, Oliver stated that his OCD-related thoughts have distracted his concentration while at work and during lectures. Occasionally, he had missed lectures due to the intensity of these thoughts. Similarly, with item 6 and his response of *Quite a bit* regarding the extent physical or emotional problems interfered with regular social activities, Oliver characterized himself as “a big gym rat” (line 1105), but he also noted his extreme aversion to germs and the towels for cleaning sweaty equipment. With the help of his exposure therapy, he asserted that he has learned to gradually deal with these aversions by building confidence and creating new, positive images that diverge from past negative perceptions of becoming ill. He added that clearly his emotional problems are salient and no physical problems are at issue.

From the OCI-R, Oliver stated that some of his OCD symptoms were more prominent than others, but he could understand why all questionnaire items were related. Further, he acknowledged how others could perceive their specific symptoms as being more problematic and realistic than his “REAL-WORLD” (line 936) OCD symptoms. When asked to elaborate, if not too stressful, upon his choice of *Extremely* for item 6 involving difficulty in controlling one's thoughts, he responded:

no, it's fine. If I get fixated on a particular issue...like you can't be afraid of certain things at certain times 'cause they're just not present, but germs are kind of omnipresent, you

really CAN'T escape...germs are one of those things that you CAN'T GET RID OF. So um, when I start getting into one of these fixation POINTS...as much as everybody just kind of tells you like drop it, it's fine, uh, I can't, like you're anxiety's so high that you have to react to it or, you're, I don't know what would happen, but, I, you just, you kind of become like a victim of your own [thoughts]. (lines 957-972)

Oliver affirmed that his obsession with germs relates to how he may become contaminated rather than how he may contaminate others.

Elaborating upon his response of *A lot* to item 13's avoidance of throwing things away as they might be needed later, Oliver explained that this item did not adequately characterize his related behaviour. He explained that he refuses to touch objects for periods of time “‘cause I'm waiting for like the contamination issue to dissipate...if I sneezed on something or whatever it would be, like I'll probably give it a couple of days, even if it's in the middle of the floor sometimes, wait it out and then pick it up or feel better about picking it up” (lines 1112-1015).

With his response of *A lot* to item 9's getting upset if others change how things are arranged, Oliver explained that such objects are kind of *quarantined* for a few days. If someone disrupts this process by putting them away, or even moving them slightly, then his anxiety escalates. He emphasized that he is not overly concerned with keeping things in order or even being neat, but lately this quarantine issue has been present. Oliver described:

it's gotten to the point now I don't recognize I've done it, and it'll be like a week go by and I'll FIND something...that I've just avoided touching, and I don't do it CONSCIOUSLY. It's just kinda become this thing where you just step around it and you forget it's THERE, so it could be anything from a day to a week to a month. (lines 1043-1049)

Regarding his response of *Extremely* to item 2's checking things more often than necessary, Oliver explained how he frequently checks that his stove is off despite knowing that he has already turned it off. He expressed his frustration about not being able to convince himself that his stove has not been left on. He must physically check both the dials and the burners to verify they are off even though he has never mistakenly left these on. This "absolutely INSANE" (line 1064) obsession began in his first year of university when he found a roommate had left the stove on.

From the OCI-R, washing was Oliver's most distressful experience, as he responded *extremely* to all items, while neutralizing was his least distressful experience, as he indicated *a little* and *not at all* twice. All three items in obsessing, hoarding, ordering, and checking differed. In the SF-36v2, mental health item responses mainly ranged from *some of the time* to *most of the time*, such as being down in the dumps *some of the time* and worn out, very nervous, and depressed *most of the time*. In terms of physical health item responses, Oliver had no physical functioning limitation, but some slight degrees of limitation for role-physical and bodily pain, with his general health expressed as *very good*.

A typical day.

Oliver figured that his morning preparation for the day takes him about an hour. This involves getting up, eating breakfast in the kitchen, showering that he characterized as probably lasting longer than necessary at about 20 minutes, followed by shaving and dressing. At school, he attends lectures or spends time in the library with emails and reading, but he admitted that reading has not been done as diligently as the year before. He goes home for dinner at about 8:30 and then works out at a gym, returns home to watch television and he then goes to bed.

In terms of functional OCD, Oliver detailed:

I'll take a shower, um, I won't touch the bathmat, don't know why, I just won't touch it, um, and I take a shower, uh, wash my face and all that, get out, I have one towel for my hands, one towel for my face and one towel for my body, because, so then I'll dry myself, although I've been, there's still kind of this procedure, but not to be like overly hopeful, but it's been quieting down lately, but just can describe like a couple of weeks ago this is what was still going on, um so then I'll put like uh, you're supposed to put moisturizer on your face, so you put the cream on your face, wash my hands again, um, and then I had an eye infection, so I had to put drops in my eyes, so wash my hands again, um, and then. So that would be kind of like, that would take up most of that ritual like, but those are kind of related to like, there is again an illness issue there, like you have to put this stuff on your face and you have to put drops in your eyes, so, like I wasn't just doing them for the sake of doing them, but, there was a lot of hand washing, like you **SHOULDN'T HAVE TO** rub cream on your face and **THEN** you wash your hands and put it in your eye, uh there's no need for all of that, washing your hands constantly like that. (lines 717-733)

When asked if hand washing involved a certain number of times or minutes, Oliver responded that this was never the case, but he did need to *feel* adequately clean, thus repeated hand washing was occasionally necessary. In his journal, he added that he could not stand on his bathmat even though he was the only one who used the bathroom. He noted this behaviour on seven days, and later saw that this worry diminished after recovering from a serious relapse.

Further, Oliver explained the daily influences of OCD in his kitchen:

I'm very careful about TAPS and you know, if you have dirty hands and touch the tap and turn it on, you have to make sure, or what I'll do is I'll hit it with my elbow to turn it

on so you DON'T touch it with whatever it is that you haven't washed off with your hands, you know. Things like that, 'cause then I can turn it off, 'cause if I turn it on, and then turn it off with my bare hand, I'd be putting back wherever it was the dirt that I put on the handle, so things like that or I'll wash that handle more often than I should or I won't take soap from the kitchen and use it in the bathroom, I, I, for some reason that has to stay separate in my head, but, ya, so I guess those are the regular ones. (lines 773-784)

In his journal, he also mentioned instances of hand washing in his kitchen, for example, when his hand touched near the window that had potential raw meat contamination from about a week earlier, and when he came into contact with kitchen objects. He recorded fears of touching the cutlery drawer knob, and the microwave and tap, despite having already washed them. Further, he expressed strong regret about rewashing dishes for 30 minutes due to his unrealistic worry over cross-contamination from raw meat. Oliver also reported that he experienced extreme discomfort in his kitchen, fearing contamination from everything, including the light switch. Every night, he must thoroughly disinfect the counter. Regarding other aspects of life at home, Oliver noted his fear about the contaminated garbage chute handle that triggered him to wash his hands and apartment entry doorknob, and a suitcase in the middle of his floor with contaminated clothes inside. He also recorded many other incidents related to contamination, such as leaving his shorts on the floor for a week and being frustrated about not knowing why, and hesitation about touching his household garbage for disposal and his dirty laundry basket.

Another recurrent journal topic surrounded worry about infection on his face and hands. He often washed his face and hands and applied antibiotic cream. He also put band-aids on finger cuts or areas that were not cut but could become infected or merely caused worry. Excessive washing then led to additional worry as his skin became increasingly irritated to the point that he was

unable to bend his hand. Other OCD incidents included declining a ride home due to a contamination fear about the inside of the car. This led to a frustrating walk home in the rain and strong regret about the time wasted. Fear of contamination also negatively impacted other social contexts, such as not being able to fully participate in a pot luck dinner, and feeling extreme discomfort due to a requirement to wear clothes that others had already worn for their formal class photo. He also needed to wash all his clothes after visiting a clinic and after sitting on a public sofa. Using public bathrooms also causes discomfort. In addition, his aversion to lice and similar transmittable contaminants increases his anxiety. He described that while engaging in a part-time job that involves close proximity to homeless people, he may need to wash all of his clothes, including his shoes, in order to counter the contamination. This reaction, Oliver noted, was much more extreme months before his OCD symptoms improved.

Reflecting on daily journal writing, Oliver saw OCD as being problematic because dozens of compulsions are very common every hour. Thus, these are not easily recognized as compulsions, but considered to be quite normal and under control. He also expressed worry and regret about the diligence with which he wrote, his penmanship, and the usefulness of these data for the study. Some positive incidents were noted, for instance, when he forced himself to touch elevator buttons with a finger without becoming scared, and more significantly, when he became stronger and much less influenced by OCD after a severe relapse that he documented.

Others with OCD and those who encounter them.

Oliver converses with a classmate who he thinks also has OCD or at least is a germophobe. He is obsessively clean and organized at home, and especially his kitchen table is absurdly clean. Oliver has not revealed his OCD to this classmate, but he noted:

it's the only time I ever talk to somebody and I can TELL that I know he's on the same page as me. And I know what I'm saying is not going to come across as like extreme, it'll come across kind of like he'll agree and be like ya, ya, and then he'll go, probably he'd take it a step further, like I would hold back say, he WILL say. (lines 619-624)

Considering advice for fellow students with OCD, Oliver was unsure about where he may be in terms of being a typical OCD sufferer, but he advised such students to not see their OCD as so confining and negative. They should seek help with a clinician who assigns CBT homework rather than focuses on chatting with Freudian talking theory that Oliver found to be generally unhelpful.

In terms of general advice for such students, Oliver pointed out the importance of looking at the positive aspects, for instance, not being able to let things go and being meticulously clean, detailed, and organized beyond normal. The drawback being that "it just takes them DAYS to do it you know and make you waste a lot of time" (lines 1341-1343). Further, students should not expect to understand their disorder, despite others without OCD affirming that they are able to understand. Oliver noted a personal example while his parents stared at him in his room. He was unable to touch anything, but his parents could not comprehend his situation despite being aware of his OCD.

As for university teachers and administrators, Oliver perceived that drug addiction and alcoholism are given much more weight in society because they are more tangible and special treatment for such students is easily granted, whereas OCD is not easily characterized and "it's sort of seen as like fluffy and you know kinda like one of those psychological things that nobody can identify" (lines 1379-1381). Oliver was reluctant to ask permission for such special consideration, but he asserted that such help would have been very welcome the year before. He added that his program offers no such flexibility, despite the pronounced offers of help for students in such need.

As for his university experiences and related policies and services, Oliver asserted that his school's student health clinicians did not cater to very complex mental health concerns, but were merely able to deal with problems such as insomnia and anorexia. Further, the clinician that eventually treated him offered a student rate, but that was still quite expensive. Oliver saw a great need to offer such clinical services to students, where clinicians could volunteer their time and possibly detect OCD and other complex disorders that may continue for decades without an accurate diagnosis or even some advice about how the student should proceed. If his parents did not pay for his treatment, Oliver argued that he would have never been able to undergo a clinical assessment and eventually receive a formal diagnosis of OCD.

Final comments.

Oliver stressed that people with OCD can learn to cope and this disorder should not be considered as a *prison*. Symptoms can become less pronounced over time, however, one still must understand that they can also become much worse unexpectedly. Regarding his participation in the study, he noted that he thought the interviews would be much more invasive, and not as broad or as at ease as they were.

Nick "I am a stranger to myself"

Nick's interviews with the researcher lasted 77 and 71.5 minutes respectively for a total of 148.5 minutes. In his journal, Nick wrote almost every day for about 2 weeks for a total of 1495 journaled words. He reported main symptoms of checking, repetition, discomfort, and uncertainty and he confirmed that he recorded the most salient, daily experiences that he could recall. OCD onset occurred at age 13 or 14 and a clinical diagnosis of OCD was made at age 15 or 16. He completed all self-report questionnaires. An overall distress level of between Moderately and A lot was determined by his OCI-R. In terms of the SF-36v2, his overall health state was between

Fair and Good and Nick indicated that his health in general now is about the same as one year ago.

OCD diagnosis, recommendations, treatment.

Several years after initial OCD-related experiences, Nick explained "this all came to a kind of peak" (lines 150-151) at about the age of 15 or 16, when he would wash his hands excessively and fear that he would contaminate food he was preparing for others. Interacting with his classmates also became increasingly more difficult. Notably, he described, "something really drove me crazy, and I think it's what, you know, led to the whole, breakdown, for my first breakdown...I don't know if this really happened, is I feel I had, some sort of an encounter..." (lines 681-685). His possible encounter was with a family member and for a long period of time, this event caused him to expend a great deal of mental effort worrying tremendously about his orientation and also preventing him from sleeping. These symptoms led to him confiding in his mother who took him to the family doctor. Nick then began taking an antidepressant. Shortly thereafter, he attempted to take his own life and this event led to hospitalization as an in-patient. As therapy sessions progressed, his initial diagnosis of OCD and depression was made. Subsequently, Nick was also diagnosed with Generalized Anxiety Disorder. His treatment consisted of medication, cognitive-behavioural therapy sessions, and recording troubling thoughts in a journal. Thoughts were discussed during the sessions in terms such as reasoning, decision making, and rationalization. Despite these efforts, Nick has found that "since the age of 15...I don't think I've had a treatment that I felt was helpful at all" (lines 196-197). He noted that his OCD has not permitted him to have adequate *time*, *strength*, or *courage* to work through the problems in his life.

Experiences, beliefs, feelings, relationships.

Nick first noted that his parents held unrealistically high expectations for him with respect to social, physical, and extra-curricular activities, and especially in terms of school grades. He was

always expected to perform beyond his best efforts. These expectations arose in elementary school and they have not abated since. Despite these pressures, and similar pressure put upon himself coupled with his persistent doubts, Nick did well academically in elementary school. He recalled being quite controlling when interacting with his younger siblings, and regrettably, this may have involved some verbal and physical abuse. Nick had very fond memories of classmate friendships from elementary to his second year of high school.

Among his earliest OCD-related memories, Nick focused on getting things right, noting:

I can remember a feeling...when I was in grade 6...junior high...I wanna be a doctor so everything's gotta be arranged RIGHT. I gotta have these certain marks, I gotta have the top of the class in the sciences, um, I used to be very meticulous with my notes in that I'd spend exorbitant amounts of time getting them RIGHT. (lines 1295-1299)

He needed to spend days writing and excessively formatting his notes onto his computer, being careful not to miss even a single word for fear of jeopardizing these notes intended for exam preparation. Nick figured that he still continues in this manner, but his current program is more stressful than his undergraduate studies and thus its impact on his life has become greater.

In his early teens, Nick explained that he worried a great deal about how he affected others. He frequently tried hard to deny these persistent thoughts that interfered with his ability to sleep. Nick noted that his relationship with his mother became slightly closer after asking her about her enjoyment of life. She thought, perhaps, that her son was quite caring or somewhat worrisome. In contrast, he did not confide in his siblings about such thoughts, therefore their relationships were minimally affected. Because he often internalized such thoughts, he saw that this adversely affected his interactions and activities with his family. In one example, he was so worried about his hair and appearance being "right" (line 101) while looking in a mirror that a family day at

the beach was spent in the family car as OCD "just took control of me"(line 105). OCD either prevented him from fully enjoying such activities or caused him to stop such activities altogether.

While trying to sleep, and also during the day, he has often spent "several hours" (line 143) performing "certain rituals to kind of dispel those thoughts from my head" (line 120), such as, while trying to get to sleep, he would count quietly and nod his head to try to rid himself of the thought. He specified that "three used to be the magic number" (line 133) in terms of nodding his head. Despite his efforts, these thoughts did not dissipate, but the rituals enabled him to carry out what needed to be done. Later, he added:

ya and at the same time I would do a walking motion with my head, the magic number was really three, so it was like one, two, and a third time would be a major, kind of a major movement...it would express the thought flying out of my head. (lines 1244-1246)

Nick has consistently had good relationships with his teachers, but he did develop a fear of raising his hand and asking questions in class. More recently, he has had serious doubts both academically and socially, for example, his answers to in-class questions lead him to approach professors "to get someone else to do the thinking process for me" (line 234). Socially, he has had difficulty working with his classmates, "maybe I can't collaborate with people because I have to do things the certain way that my mind tells me I have to do them in order to feel comfortable with the outcome...I have my own completely different thinking process that I find" (lines 237-241). Further, Nick described his need to entertain minute details that may be of little or no importance, which led to even pair work becoming uncomfortable for him. He related a pertinent example that has been going on since high school:

it's a whole process...when I get an assignment, it becomes, until it's, until it's done, it become, it consumes me. And I keep thinking about it, I keep thinking about it, as I'm

doing it I keeping thinking about it, of course, and afterwards, like I could have done it this way, I shoulda done that, I shoulda done this, and then, so it, even when it's done and over with, I can't put it to rest, that same thinking process continues afterwards.

(lines 290-294)

Similarly, in terms of high school and university administration, frequent visits to guidance counsellors or the assistant dean involved and still involve discussing course selections and possible alternatives that may be of more benefit or not. His second guessing is continuous as he affirmed:

ya, think a little bit more, can I drop it? The drop dates coming, even after the drop date comes, oh, um can I go back? They know, they know I have, like they know I've, you know I filed medical things with them to get help with things, um, and then I say, ok, just go ask them, maybe they'll make a special exception? And just, it never ends.

(lines 318-321)

Considering his beliefs and feelings, Nick recounted that he was very open and he knew himself quite well as a young child, for instance, his likes and dislikes. He led a very happy and optimistic life until about the age of 15. Since then, he confessed:

I feel very LOST, as if I don't have a place, um, as if I don't know where I'm going and I'm generally not, I'm not happy, I, I would say that I'm miserable every day from the point I wake up to the point that I go to bed, so I'm not that SAME person that I was...very open, very friendly, very sociable, um thinking that, KNOWING myself, being confident...I've...become the opposite haha of what I was. (lines 326-336)

Recently, because nothing has been helpful, Nick has relied much more on god who comforts him when he is lonely, and who has decided that Nick "SHOULD be going through this" (line 350). Along similar beliefs, he admitted to having strong curiosities about the supernatural, up until about high school, but he stated that since he has been "so busy fighting with myself I don't have time to read up on those things" (lines 359-360). With respect to the medical profession, Nick still has faith in it generally, but he can no longer believe in psychology and psychiatry due to their failure to help him, leading him to believe that "maybe I'm not supposed to get better" (line 370). Even his weekly visits to a psychiatrist have been of no help and they have not led to answers. Since the OCD peak, he described that on a day-to-day basis:

I am not at all content or satisfied with anything...I'm not able to deal with the disappointments in life because there's not enough good there, it seems like everything's a disappointment and, I'm much, much more uptight, all the time, than I used to be, I'm not able to ever relax.... (lines 383-390)

Considering his learning experiences, Nick recalled that reading and completing assignments would not involve worrying. More recently, however, his worrying has caused him to make certain that he has understood each sentence before he can proceed to the next. He noted, "academics is a very painstaking activity" (line 830).

When asked if his academic and social life influenced each other, Nick figured that these did influence each other and he explained, "I don't think there's any sphere in my life that is not impacted by my condition" (lines 860-861). He cited the example of feeling below the academic level of his classmates, and this contributed to his difficulty with classmate relationships. Despite his efforts to function academically and socially, he chuckled, "I feel inadequate, in either sphere... it's as if I've failed in one sphere, and I try to redeem myself in another, but the actual fact is I

know that, my thinking is telling me that in both spheres hahaha" (lines 880-886). Nick noted in the demographic form that this fear of failure, coupled with his perfectionism, has been part of his life for about the past nine years. In terms of significant positive experiences in general or related to OCD, Nick could only describe the time when he won a computer for his academic work prior to high school. More recently, he affirmed that he has had no positive experiences.

Goals, challenges, changes, persistence.

Nick recalled having goals in elementary school, such as being very determined to achieve a shutout in a school sport. This determination continued in junior high school, such as working "REALLY hard on my sciences" (line 462) in order to enter a medical profession. He emphasized that prior to his OCD, he was working toward many life goals. Recently, however, he has had great difficulty, as he summarized, "so I think in a sense, my compulsions have affected my career goals because, I question it so much that I don't, I don't have the answer for it anymore" (lines 1377-1378). Further, he saw that he has asked so many meticulous questions that "I don't have the big picture of it anymore, and I've confused myself, so I don't know what my goals are anymore" (lines 1387-1388).

Regarding challenges in junior high school, Nick admitted to having a slight fear of public speaking, but he encouraged himself to be *strong* and *successful* in front of everyone, despite feeling very nervous. In terms of his undergraduate degree, Nick admitted, "I don't feel it's an achievement. I felt I just got through it and got no sense of satisfaction out of it" (lines 533-554).

With OCD, Nick noted:

I guess the main challenge I've faced is...it feels as if it's not me saying it, it's my mind saying you have to do this, you have to do that. And there are times where I can...suppress it, and not make myself...look like a fool by...giving into my thoughts. (lines 537-541)

The few times, though, when he does not give in to his thoughts, he is bothered later by failing to, for example, check parts of an assignment. He summarized, "either way it's disappointing, either I play into it and I regret it...or, I'd, I suppress it and then later on I think, oh man, I should have done that, I should have done that" (lines 562-566). For more recent challenges, Nick noted with a chuckle, "the one thing I would say is, to remain in school...I'm actually, on the inside, I'm very ill, but I'm able to persevere somehow. I don't know how I do it haha" (lines 520-522). Nick later added that when comparing his compulsions from 10 years ago and now, his compulsions changed, in that before, excessive hand washing and fear of contamination were salient, but have now been replaced with worries and "meticulousness with my...school work...money matters" (lines 1346-1347).

Nick described his situation as often being "detrimental" (line 477), because as job opportunities arose, he would question his intentions, such as submitting the applications, the suitability of the jobs, and his reactions to offers of employment. He chuckled about his situation as he explained, "I always think, ok, it's either I keep going, or I completely switch...drop out" (lines 493-500), but both of these paths are filled with doubt.

With respect to taking a leave of absence or dropping out, Nick has given these a great deal of thought, as he explained:

what do I really want to do? I've always, it's always about the ESCAPE. I wanna drop out, I wanna drop out and I just, I've come very close to doing it, for instance at the beginning of the semester, I was just SO, feeling SO BAD that I went to my assistant dean and I said, can I take a year, a leave of absence? And then always, something always seems to like, I feel like I always stick to it for some reason. (lines 896-904)

He reasoned that due to the influences of his assistant dean, family, and friends, he continues along the same route. If he were able to take a break, Nick envisioned going:

somewhere to figure myself out because I feel as if I don't know myself anymore...I don't even know what I like...like to eat...what subjects I like...what activities I like 'cause I DOUBT everything either before those things I doubt them or during, while I'm doing them I'm doubting them or in retrospect, so it's like I've, I've, I am a stranger to myself. I think, my great escape fantasy is...dropping everything, and quitting this....for awhile.
(lines 912-926)

Strengths, weaknesses, and coping strategies.

Nick related that he has the intellectual capability to handle academic work, but "every single academic task, even extra-curricular task has become very painstaking in a sense that there's so much from the thought process and so much worrying that goes into it, that, that it consumes me, my whole life becomes that, becomes that assignment or whatever and I'm, it's just very stressful" (lines 423-427). To cope, he explained, "the only coping mechanism I have now is to give up. I say oh well, what can you do?" (lines 437-438). This option has provided some relief for Nick, but thought processes promptly return to "I HAVE TO get out of this, like, it's not like this is where I'm supposed to be...I don't care if this is how it's supposed to be, I don't wanna be here" (lines 451-453). He explained his coping situation as a *mechanism* or *device* that has the *phases* or *stages* of suppression or aggression that come and go every few days. With suppression, Nick described:

it just becomes a practice of getting rid of whatever uncomfortableness I have, suppress it, suppress it, so it feels as if suppression has become, one of the key devices that I use, the key mechanisms to deal, to deal with it...to suppress it and to deny what I feel.
(lines 1423-1432)

With aggression, this is spontaneous, as he exemplified in a time when he purchased a suit, "I spent SO MUCH TIME in that store thinking and I worked myself up over it, I couldn't make a decision anymore, I was paralyzed. So I'm like, ok, pick a suit, purchase it, without thinking about..." (lines 1466-1468).

The three questionnaires and journal: Comments and clarifications.

In terms of the demographic form, Nick clarified that he was first admitted to hospital for psychiatric treatment in 1998, and then 3 years later, he was treated by a different psychiatrist. Due to these troubling times, however, he was unsure about the dates and types of medication prescribed. He listed the names of several medications, including three SSRIs and one antipsychotic drug. He also recalled a period of alcohol abuse from about 2003 to 2005.

From the OCI-R, Nick described a nasty thought as "just thoughts that are perhaps, irrational and I can't get rid of" (lines 1069-1070). In terms of the 3 items related to hoarding, Nick explained that because he fears he will "forget things" (line 1090), he tends to "develop these stacks of papers" (line 1092) and on his computer, save an "innumerable number of documents" (line 1093) as even if he makes "the slightest change to a document" (lines 1096-1097), he may have made an error and then will need to refer back to the original document at a later date, leading him to store as many as 10 versions of a document. In addition, he also must save credit card and other receipts for a period of about a few months in order to check that overcharges and any other errors were not committed. After this period of time, he noted, "I say to myself, this is getting ridiculous, just throw it away..." (lines 1133-1134).

As for the ordering items, Nick explained that visitors need to respect his possessions, thus if someone picks up something of his, "like the whole time, my concentration is on that thing, like, you know, you moved it, don't touch my stuff" (lines 1145-1146). With respect to checking, he

cited the example of leaving his apartment and having to check at least three times that his door is locked. Even after this process, however, while waiting for the elevator, he can have feelings of doubt about the door lock and he then must return to check the door again. Similarly, he explained that he has to get up out of bed to check that he locked his door, and admitted that "I can't get to sleep until...I ensure that I've checked it" (lines 1186-1187). This checking includes both visual checking and then physical checking to verify the state of the door lock. Such repeated checking is also performed in terms of the red light on his stove and the functions connected to enabling his cell phone alarm clock to wake up in the morning. Setting the time is another related issue, where the time to wake up must be on the half-hour, as "it's just a feeling of comfort" (lines 1227-1228). Setting at 3 minutes past the hour would not be problematic, but he said, "it's something that I'd never do" (line 1233).

On the OCI-R, obsessing was Nick's most distressful experience, as he responded *extremely* twice and *a lot* to the third item. Washing was his least distressful experience, as he indicated *not at all* and *a little* twice. On the SF-36v2, mental health item responses were mainly *all of the time*, such as being worn out, very nervous, and depressed. With respect to physical health item responses, Nick had no limitations in physical functioning, but he showed some slight degrees of limitation for role-physical and bodily pain, with his general health expressed as *poor*. For items 6 and 10, both Nick's physical and emotional problems interfere with his social activities, but he commented that the emotional component is stronger.

At the beginning of the second interview, Nick responded to his journal writing progress:

I record the most significant daily occurrences that I can remember...for instance, yesterday I was talking to my academic advisor, and I felt the need to ask her to clarify things several times because I often feel that they're not registering in my, in my head,

as if I need to ask them a number of times in order to understand it...in order to completely, completely understand what they're saying despite the fact that, maybe I, maybe I do understand what they're saying the initial time, but I feel unsatisfied and I feel very uncomfortable afterwards, if I don't ask several times and make sure what was said I understood. (lines 972-979)

His feeling of misunderstanding, he commented, stems from the reactions of both interlocutors, but Nick added that another person listening to the conversation could perceive that her first response was understandable and needed no further clarification. Such instances of repeated checking occur with respect to "critical subjects" (line 993) including academic and money matters, deadlines, and reading textbook pages both consecutively and thoroughly. He chuckled, "I find sometimes I can usually waste a lot of time doing that, like, I mean one set of readings I could spend 5 minutes or more, just making sure hahaha of the pages" (lines 1008-1010).

A typical day.

Nick awakens with anxiety and worry as he thinks about specific tasks for the day. He resists getting out of bed and he tries to return to a peaceful sleep. Eventually, Nick showers and then eats breakfast while at the same time, he noted, "the anxiety's just building up, I'm dreading the day, I'm dreading going out there and living" (lines 754-755). He experiences intense anxiety during the day caused by the need to make decisions and the accompanying doubts, such as even choosing what to eat, and what and how to study. In his journal, for example, Nick recorded instances of repeatedly checking lecture readings for correct page numbers, references, and rechecking the accuracy of multiple versions of his documents throughout the semester, but still feeling regret and uncertainty. Sometimes, page numbers are not rechecked for accuracy. They are only rechecked for his own satisfaction, as he visualizes them or repeats them in his mind. He also

rechecks the area where he sits, both before and after lectures, in order to ensure that he leaves with all his belongings. In addition, it is important for him to recheck the diagrams in his notes and classmates' notes to ensure accuracy and that details have not been missed. This process, however, is accompanied by great discomfort because these doubts and related rechecks may cause him to lose focus and miss parts of the ongoing lecture. Similarly, such discomfort is also triggered by starting a course after missing a few classes, as his knowledge of the entire course may be deficient and his enjoyment may be reduced. He viewed that his iterative checks are caused by OCD, thus, they are not preventable and they trigger discomfort if not carried out.

During counselling sessions, Nick needs to recheck that his questions were phrased accurately, therefore counsellors must repeatedly restate their responses after Nick's repetitive questions. This process also occurs when he asks for clarifications. He recorded that he often asks questions regarding details that he should know, or that he already knows, for instance, asking a senior administrator the meaning of *audit* after he had already audited a course. Nick experiences discomfort when trying to avoid asking such questions, and also when he is perceived as being unprepared for such sessions. He has become physically ill due to the career decision process and he expressed fear of total disaster if the right decision is not made, but he also admitted that these extremely distressful searches for appropriate decisions may be pointless as he is never fully satisfied with the decisions made.

When communicating with others, such repeated requests often involve school work, money, and deadlines, and these are also accompanied by extreme discomfort and uncertainty because he again feels that he has missed details expressed in the repeated responses. Dwelling on options, decisions, and outcomes has caused Nick to become extremely fatigued and irritable, and this has also led him to yawn incessantly despite having had enough sleep. Further, while standing in a line

talking with someone, Nick has needed to carefully check the surrounding area and his pockets to ensure that nothing has been dropped.

Sometimes, Nick turns to his "only coping mechanism, which is to say [sigh] oh forget it, let it go, just don't do the work, I don't care about it anymore" (lines 766-768). As this is unhelpful, he returns to his repetitive doubts and worries that last until he falls asleep at night. Even if no important tasks await him on certain days, he feels compelled to worry about something that must be done or some choice that must be made later. He added in his journal that he becomes so frustrated from incessant obsessions that he can act spontaneously without considering consequences.

Others with OCD and those who encounter them.

Nick stated that he had not really had contact with others with OCD, but occasionally, he has noted others who also have problems making decisions, ask irrelevant and/or very annoying questions, and who may have similar "mental health issues" (line 621). With respect to contact through the internet, he admitted that sometimes, when he feels very depressed, he reads articles about those with related health issues. He explained, "I guess it's just some kind of identification that, you know...others have been through it as well....it doesn't provide any help, it just provides a sense of comfort" (lines 659-663).

Regarding advice for fellow students with OCD, Nick described himself as "an outcast" (line 1652) who is even unable to advise himself. He viewed his academic and workplace environments as being unwilling to accept people such as him. He advised, "give up or keep pushing, do what you can" (lines 1652-1654). But reflecting upon this thought, he added that settling upon only what you can do may lead to regret years later as more effort should have been expended in a particular situation, but hindered by personal limitations.

In terms of advice for those who encounter people with OCD, Nick emphasized the need for understanding, tolerance for the diversity among students, and continuity with encouragement and empathy. He characterized his experiences with academic administrators as having “a disconnect” (line 1696), as they have listened very attentively while he has discussed his “deep secrets” (line 1698) and struggles at counselling sessions, yet in subsequent sessions and other settings, these administrators have acted as if they had only cursory knowledge of his secrets and problems. Nick believes that perhaps such a disconnect is necessary as administrators need to keep their distance in order to avoid the perception of favouritism. His family and friends also behave in such a fashion. He also suggested that students need to be aided to find “alternate arrangements” (line 1714) or “canvass options” (line 1732) in order to cope better and succeed within their particular situations. More specifically, he advised that there should be an administrator available to assist students with their transition from the academic to the workplace environment, while they are still coping with OCD and trying to maintain “a level of sanity” (line 1748).

Looking back at university life, Nick has felt dissatisfied with the services as people there have failed to understand his situation, for example, denying him a longer extension for exam writing due to their cap on time extensions for students with anxiety disorders. Additional time required a doctor's note. He was told by an administrator that more time would not be helpful, but only cause him to agonize more over the questions. He argued that he must read each question “three times over in order to even first approach it. So I feel as if, I don't know how to suggest change, but I think, get some sort of person maybe trained in these things” (lines 1530-1534). He affirmed that more leeway and understanding about specific circumstances would be helpful, but he also acknowledged the administrative benefit of setting pre-determined limits.

He realized that although he has encountered kind, well-intentioned people, students like himself are very alone and they face policies that seem inappropriate and inflexible. There seems to be only a certain amount of counselling time and understanding allocated for each student, therefore much more training should be mandated, along with a greater understanding and flexibility in counselling and policy approaches. Similarly, he expressed his frustration in terms of getting help with his goals, with simply being advised to pursue what he might like, rather than being provided with specific, informed answers related to potential career paths.

For teachers, Nick advised that they should consider student learning styles to improve understanding during office appointments and lectures, such as implementing visual aids for visual learners such as himself. Further, he recommended that education specialists be required to inform teachers about the needs of such students. Nick stressed the importance of having "consistent support there" (line 1840), as he urged, "I think people need to understand that it's chronic, and family and friends need to have that consistent support there...I know it's hard when people are wrapped up in their own lives" (lines 1839-1842). Such support has helped Nick, especially when he has been "at a breakdown point" (line 1845), for instance, hearing "something nice again...that'll last [encourage me] for another couple of weeks" (lines 1845-1847). He noted that because many of the people he encounters are not aware of his OCD, he cannot expect them to empathize with him and therefore this issue may be one of the reasons he feels a lack of empathy. He hoped that if people do know about his OCD, that they do not treat "such people as such weirdos and a burden because you ask too many questions" (lines 1855-1856).

Nick recounted a recent example of when he counselled a fellow student for about an hour in order to discuss an assignment and a strategy for the remainder of the semester. His classmate was quiet upset and Nick spent time to help. He admitted that he cannot counsel himself in such

a manner, but he wished that others would take a similar approach with him much more often.

Final comments.

In terms of Nick's participation in this study, he confirmed after the first interview, "I think I've really said everything that relates to it, I really tried to dig deep" (lines 960-962). At the end of the second interview, he noted:

I'm kind of hopeful that...it'll get incorporated in some way, that educational institutions... will use this kind of study and the feedback they're getting from students, in this environment, 'cause often this doesn't come across...to address that and I feel that I hope someone pays attention to it and realizes that there's a significant need, 'cause myself... throughout all spheres of my life...I'm absolutely miserable and anxious day-to-day, and I feel, in a way, I wish someone would help to make me feel better, it shouldn't be that way. And have them see the light, so in that sense I feel, I hope, I hope that, you know, academic people, you know, schools, they really take this seriously. (lines 1889-1905)

Elaine "I started to block out what other people thought, kind of just have tunnel vision"

Elaine's interviews with the researcher lasted 35 and 46.5 minutes respectively for a total of 81.5 minutes. In her journal, she wrote almost every other day for about 3 weeks for a total of 458 journaled words. Salient symptoms reported were repeated actions and *just right*. Her onset and clinical diagnosis of OCD were at about age 10. She completed all self-report questionnaires. An overall distress level of *A lot* was determined by her OCI-R. In terms of the SF-36v2, her overall health state was between *Fair* and *Good* and Elaine indicated that her health in general now is about the same as one year ago.

OCD diagnosis, recommendations, treatment.

Elaine described her initial symptoms as moderate and not having much effect upon her relationships. More specifically, she noted:

well I remember when I was younger I would get very upset because um I have a problem with, specifically with numbers, in threes and fives, for example, if we're, if I'm at a party and we're eating chips or candies, I have to have three or five at a time, the same with switching lights on and off and turning the TV off and on AND, that consumes a lot of your time, and as a child if I'm consumed with that, and my parents say OK, we have to go here or we have to go to this family event, I would get really upset because I HAD to complete this otherwise it just didn't feel right to me, so um, from that we, I went to my doctor and I started seeing a psychiatrist. I think it was around age 10.

(lines 68-78)

At about age 12 or 13, she recalled being diagnosed with anxiety, and she also experienced eating disorders and depression, which she believed developed to help her cope with the anxiety.

With respect to treatment recommendations, Elaine noted her parents' strong resistance to her taking medication, and Elaine was also quite apprehensive, thus they have followed the "counselling route" (line 92). Her father has only been somewhat supportive, but her mother has been very helpful and constantly supportive. She talks her daughter through problems and cautions her to not give in as control over her life will diminish. Elaine considered her mother's similar experiences and the benefit this brings to their relationship.

As for the effectiveness of her counselling, she stressed:

IT HELPED, I found new ways of coping with it. Um, as I got older, I discovered breathing exercises like yoga and meditation and I find that helps extremely, in general it helps with everything, I find it helps keep me calm, it helps me to keep focused and balanced. (lines 95-99)

Elaine found high school, however, to be too difficult to handle. In the eleventh grade, for instance, she withdrew from many people and she had many problems and pressures to deal with, especially related to university preparation. Because of her strong involvement in yoga and meditation, she figured that the twelfth grade was slightly easier and relationships were not as adversely affected. But at the beginning of university, Elaine became very withdrawn as she lived alone and the increased pressure was more difficult to manage. When she started university about a year ago, Elaine was able to work with a cognitive-behavioural therapist, and her appointments occurred weekly, but after 3 months, she noted, "I moved it up to two, twice a week, so I still go twice a week" (lines 886-887).

Experiences, beliefs, feelings, relationships.

Elaine first remarked that she has always been emotionally close to some, but her symptoms have always caused her to "put up a WALL between the two of us" (line 22). She added that she has been secretive with friends because of the difficulty they have had in understanding her OCD. Further, her anxiety attacks in public have made her less willing to interact with others, wanting to avoid questions about her behaviour and always being nervous in public. Consequently, friendships that she has made have been "very selective" (line 39) in order to maintain a certain level of comfort and *familiarity*. When asked to elaborate about this familiarity, she commented:

sometimes there's slight forms of OCD, maybe not as severe as mine, but um, they suffer from a variety of things, either anxiety or depression, or like eating disorders, something that kind of goes hand-in-hand when you experience those other things, so there's more comfort there, in the relationship. (lines 46-49)

In terms of OCD and her family, she described herself as being *lucky* because the experience her mother has had with anxiety and her father's experience with OCD. This situation has promoted understanding. Elaine noted, "they never made me feel alienated or made me kind of ashamed of maybe the things I was experiencing, so in that retrospect I was lucky" (lines 58-60).

Regarding her beliefs, she explained that was raised in a specific religion and she attended a related religious elementary school, but she then moved on to a public high school and does not view herself as being very religious. She considers herself, however, to be spiritual, and influenced by meditation and Buddhism. In terms of her beliefs in the educational system, she expressed her dislike of the elementary school system, where students are "penalized a lot for sharing ideas" (line 129) and children are not really permitted to grow. Elaine surmised that this lack of freedom could have been due to this religious school, where only some ideas were accepted and OCD and anxiety were certainly not issues to be discussed.

As for her feelings and her earliest memories, Elaine recalled that around the end of primary school and the beginning of high school, she lacked confidence and she also had many doubts and felt quite lost. With the help of therapy, Elaine discovered new methods of coping with her problems and she continued to make steady progress, noting, for example, "I started to block out what other people thought, kind of just have tunnel vision" (lines 143-145). She explained that her therapist always asked open-ended questions similar to those from this study. They would then discuss how to she can cope with problems more effectively, rather than just avoid them.

With respect to positive influential experiences, Elaine iterated her need to be quite careful when choosing friends, but this has been positive as she now has “a GOOD group of friends...very good, supportive friends” (line 271-272). Such achievements have made her more confident and proud as she is “able to do certain things, just like everybody else” (line 274). Considering positive, academic support, she noted her relationships with her high school teachers as being closer, more motivational, and supportive than at university due to the great difference in class size.

For negative influential experiences, Elaine described her continued discomfort and distancing herself from people due to “bad experiences...where people are nervous to say the wrong thing, or make the wrong action towards you just in case it triggers something. It's almost like uh, you're treated like a piece of glass [delicately], and I guess that's why I've resorted to putting up walls” (lines 1051-1053). She recalled that in the eleventh grade, for example, this was a significant problem, thus she did not attend many birthday parties and family events. Regarding negative experiences in post-secondary education, she noted her disappointment with her academic performance the past year due to her problem with motivation. Her current academic year, though, has been more successful because of her desire to achieve better results.

Considering her most memorable emotional experiences, Elaine noted her nervousness and anxiety attacks just prior to presentations in elementary school, and especially just before exams in high school. These situations were so uncomfortable due to all the people surrounding her that Elaine would frequently phone her mother and then return home. Currently, however, her new breathing, relaxation, and self-assurance techniques have helped her to mitigate this discomfort and she has come to realize that these situations will only become worse if such techniques are not followed. When asked to elaborate on her anxiety attacks, she explained that they vary from frequent feelings of her throat closing and inability to breathe, to her hands shaking

and her body feeling *like jelly* with little control. Elaine added that such symptoms occur in a variety of social situations, including classrooms and while alone, and they can also be accompanied by an increase in body temperature.

Looking at her present academic and social experiences, Elaine stated that she is overly-conscious of gossip at work, therefore whispering and talking often triggers extreme nervousness and causes her to withdraw as she worries about being judged and continued gossip. When asked if she was referring to something like checking her pulse and someone noticing, she replied, "ya, I try to be very private about it" (line 376). She continued:

I think it's mostly just school, I was in some clubs last year, but uh, I always get withdrawn after awhile, I'm not su, I never really, uh realize why I, in the beginning I give myself 100%, but I guess I really run myself down to the point where I have no more motivation left, or no more energy to contribute. (lines 380-383)

When asked to describe an experience when she withdrew, she noted the great frequency in high school, but also in first-year university, when she would expend so much effort to go to every class well prepared, but then lose all motivation after receiving even one grade lower than she expected, such as a B or C. She would not attend class or just "do mediocre work" (line 390). She explained that sometimes this would cause her to drop a class too. Elaine has experienced discomfort being around others who were really outperforming her academically, and she has had difficulty when trying to relate with these classmates on subjects other than academics. She figured that when she is experiencing problems socially, this also negatively influences her school work, and vice versa.

Further, Elaine noted her skillfulness at separating her life into public and private sides. With her public side, she has become more able to hide her problems, and with her private side, Elaine has become able to cope with many more problems. She asserted that many people who

have come to know her have noticed great differences between these opposing sides of her personality. She explained, for instance, when with a close friend, she can be slightly less secretive about her OCD and anxiety, but at a social event in public, "you would never know ha" (line 478). Elaine added that she hopes to become a public, government figure and she is also interested in law school, with both being dependent upon successful personal relationships.

Goals, challenges, changes, persistence.

With respect to life goals and persistence, Elaine mentioned her desire to attend university since the seventh or eighth grade. This goal, however, was at times, quite difficult to stay focused upon due to her inability to remain motivated. To aid her with her motivation, Elaine explained that she developed a goal board so that she could actually see her individual goals. This has helped her during high school and it has also helped during university. Currently, her goal board features a great deal of travelling, and completing a master's degree in a country from which she recently returned. Accomplishing her goal of travelling to this country gave Elaine a sense of achievement. After each goal has been accomplished, Elaine noted that it is checked, but it still remains there as a reminder and as 'proof that I'm able to do more in the future" (line 191). Other goals include becoming bilingual, getting creative writing published, and working for the government.

Later, she further elaborated upon her variety of interests, and noted art being her *first love* because of the freedom it allows, such as expressed in her painting, acting, drawing, and writing. Despite their strong calling, these interests and thoughts of travelling or just working have not pulled Elaine away from her university studies as she remains fearful of not completing school.

In terms of challenges and changes, Elaine admitted that during the past year especially, she had anxiety attacks nearly every day which almost prevented her from getting out of bed to attend class. Currently, however, with her meditation and strong help from yoga, Elaine has been able to

see a bigger picture and become stronger, with bad events not affecting her as much. Further, she noted her ongoing aversion to negative people and energy.

Specifically in terms of OCD, she discussed a significant challenge:

I think one of the biggest things I find really difficult, um, it's kind of like a challenge for the therapist, when I have an occurrence, especially with the numbers, or with the lights, like test yourself, talk yourself through it, you know, say ok, today I'll just do it once, and I used to find that really difficult, I used to cry and like break down, but um I find I'm able to talk myself through it more, 'cause I find now that once I took that jump, I found that, if I didn't give in to the occurrences, like nothing happened. I guess in my mind I was always fearful of if I didn't complete this, something would happen, but testing myself like that I realize it's, it's mind over matter, even though it feels bigger than that, but in retrospect, that's what it is. (lines 214-223)

She clarified, "either or, so for example if I'm at a party, and I don't know if we're eating like candy or chips, if I have had three, in my mind I'm ok, but if I go for the fourth, I HAVE TO have the fifth" (lines 227-229). This also relates to other objects and actions, such as "light switches, TV, the tap, um also with closing my [laptop] computer" (lines 233-235). In terms of time, she chuckled, "I used to have this thing when I was doing homework, I always had to start an assignment or like homework on like the start of the hour, and if it was like 3 or 5 minutes after the hour, I'd wait 'till like the next hour to occur haha" (lines 239-243). When asked if setting an alarm clock at 7:03 or 7:05 would be possible, she replied, "no, it would have to be on the hour" (line 246).

As for new changes in her life now, she explained that it is still occasionally difficult to adapt, but she has learned how to deal with these better than, for example, during the eleventh grade and her first year of university when the pressure was overwhelming. Elaine figured that she has maintained her relationships satisfactorily. Further, she noted that she just began working, unlike in her first year at university, and her new job presented difficulties, but she has managed to deal with these due to her strict adherence to her schedule book.

Concerning her life goals and persistence, Elaine asserted that she must constantly motivate herself, as she is extremely critical of herself and thus, her motivation often dwindles. She has learned to view life from a broader perspective and give herself an extra boost when needed, having learned from the past and dealt with being very disappointed from failed goals. Completing homework, for instance, is an ongoing problem due to the great deal of time that is wasted and the regret related to not being able to accomplish more. She figured that “it's never really gotten in the way of my goals, I've always found some way to get stuff done” (lines 1077-1079).

Strengths, weaknesses, and coping strategies.

Elaine admitted having a primary weakness with motivation and a related strength:

I know a big weakness of mine is, uh I lose motivation very quickly, I'm very hard on myself, um, I guess one way I cope with that is um, I've really learned, tapped into positive thinking, I try not to give into pressure too much. I know a big thing for me is when I get a syllabus for a course, I try not to look at how much a test or a mid-term, or an essay is worth, 'cause in my mind, that will only increase the pressure or the anxiety I place on myself. I just try to do the best on anything I do no matter how much the weight of the assignment is...a strength of mine that I've just recently acquired is uh, talking myself through things, analysing the situation and um just keeping calm. (lines 155-162)

Considering the past, she chuckled, "I think I had more weaknesses haha, in the past, um, uh, I gave into depression really quickly and I freaked out more, a very tiny thing would seem like a bomb in my life, but uh, with time I learned to deal with that" (lines 165-168).

The three questionnaires and journal: Comments and clarifications.

Just after completing the questionnaires, Elaine reacted positively to being asked about her experiences within the past month, as she recalled from past OCD studies that most of these only requested details regarding her initial symptoms and diagnosis. Regarding the demographic questionnaire, Elaine mentioned her confusion surrounding the time she was diagnosed at about age 10. She was very worried about how her diagnosis would be dealt with and how she would be perceived by others, but this discomfort was somewhat offset by knowing that the label of OCD had been attached to her problems. Coping with her disorder alone could now be left behind as other options came to light. When asked about her response of being clinically diagnosed with OCD at age 10 and then clinically diagnosed with an anxiety disorder at age 12, she associated OCD with triggering, for example, her superstitions with numbers and lights. With anxiety, she explained, "I feel almost completely out of control, like I can't breathe, um, almost if my throat is closing...I guess one kind of affects another sometimes" (lines 855-857). After being shown, however, and read definitions of several anxiety disorders from a substantive Canadian publication on abnormal psychology (Davison, Neale, Blankstein, & Flett, 2005), disorders including phobia, panic disorder, generalized anxiety disorder, and OCD, and being asked if her definition of anxiety may be close to panic disorder or phobia, she stated, "ya, I think um, that's what I meant, I started like experiencing the panic attacks, like by age 12...YA, I would definitely say that...I'd more say panic disorder" (lines 867-878). She added that by around age 12 or 13, she "started feeling the

PHYSICAL anxiety of it, the physical like panic [panic disorder as described in the abnormal psychology book]" (lines 1000-1006). In addition, she later acknowledged that her description of her throat closing, hands shaking, and pulse increasing is panic disorder. Elaine further associated OCD and anxiety and genetic links, with her father and OCD and her mother and the maternal side of her family with panic disorder respectively.

In terms of her current living situation, Elaine reemphasized the strength her roommate gives her and the great importance of their mutual support. Regarding superstition with numbers, she noted that with increased stress from relationship conflicts or work, her repetitive behaviours with threes and fives proportionally increase in frequency, such as turning lights on and off and eating in small portions. With respect to academic success lately, Elaine admitted to having more control over her OCD, as she has strongly considered the potential damage caused by failing courses and not attending classes. With work, she noted that OCD can have a greater impact depending upon any problems that may arise. Her use of alcohol and a recreational drug has lessened compared to the year before.

For the OCI-R, she first commented on hoarding and the questionnaire in general:

it's funny, I actually noticed I have here um, it asks like if you save up a lot of things that gets in the way, and when I originally did this, I put...moderately, but I've actually noticed lately that um, I have a lot of stuff that I've kept for awhile. I guess after I did this survey, I took kind of notice of a few things like that. I've heard a few responses like that, people say maybe I DO do this? and they look back...you actually don't even notice it's a habit I guess 'till someone points it out. (lines 592-600)

With checking, Elaine figured that this is excessive and it interferes with her time management, for instance, being so bothered while in her building elevator that she must return to

her apartment to recheck. Checking lights and doors and repeating numbers are daily behaviours, as well as washing her hands or cleaning herself in order to mitigate stress. A significant issue that bothers Elaine is the untidy and disorderly habits of her roommate, for example, leaving the sink full of dirty dishes and leaving empty boxes in their cupboard. Occasionally, her thoughts are difficult to control when she has relationship conflicts, as she noted, "I find the smallest thing will set me off..." (line 625). In terms of the neutralizing, Elaine emphasized her affinity with the odd numbers three and five, and fifteen minutes past the hour. Her homework is normally begun on the hour, but she occasionally starts on the half hour. If the time is 7:05, for example, Elaine would write in her journal or listen to music until 8:00, causing much frustration and wasted time that could be spent catching up on sleep. Her difficulties sleeping and eating regularly have adversely affected her health and made her less socially active, but she noted that she is much healthier now when compared to the previous year and her life is also much more stable now. Considering washing and its items 5, 11, and 17, Elaine feels the need to wash compulsively after coming into contact with someone's hand, but not with inanimate objects.

Regarding the SF-36v2, and her response of *not limited* to item 3g walking more than a kilometre, but walking several hundred metres and one hundred metres for items 3h and 3i are limited a little, she related this issue to flying time. Shorter flights are more difficult to handle because she expects them to end faster, whereas long flights are associated with more delays and waiting longer is expected. When asked if this meant that she could relax more and she could have more time to plan, Elaine confirmed, "ya, exactly" (line 718). When reminded of her day-planner that she kept to organize her time, she noted, "I try to stick...to that as much as possible...especially this semester and it's really helped me" (lines 736-737). With respect to item 7 and bodily pain, when Elaine becomes exhausted, mostly from stress, she always experiences back

pain and tension in her shoulders. Further, if she also drinks alcohol, she noted her quite unusual experiences of very sharp pain in her joints. With item 9 that involved how things have been going during the past four weeks, Elaine added that she always needs both daily and larger goals, such as obtaining a degree, in order to maintain her focus toward the future. These motivate her with school work and her job. In addition, she clarified that item 6 related more to emotional rather than physical health, and 9g and 9i concerning the meanings of worn out versus tired, she related worn out with emotional health and tired with physical health. Similarly for her, item 10 related to emotional rather than physical health.

From the OCI-R, checking and neutralizing were Elaine's most distressful experiences, as she responded *extremely* twice, and *a lot* to the third item in each. Ordering was slightly less distressful, and the remaining symptoms mostly comprised diverse item responses. In the SF-36v2, her mental health item responses mainly ranged from *a little of the time* to *most of the time*, such as having a lot of energy *a little of the time* and being worn out and depressed between *some of the time* and *most of the time*. Her physical health item responses mainly showed some slight degrees of limitation and bodily pain, with her general health expressed as *fair*.

A typical day.

Elaine often begins her day at about 7:00 with some meditation, as this keeps her “very calm and it's a good way to start off the day” (line 345). In her journal, however, she repeatedly checked her alarm prior to taking a test to be held the following morning, thus she was unable to sleep the entire night. Further, she was late for class as she needed to wash her hair three times and brush her teeth twice. She frequently attends school from around 8:30 to the early afternoon, but this is always accompanied by some nervousness, especially in classes of 200 or 300 students. Seeing so many students together causes Elaine's breathing and heart rate to increase, and she

often monitors her own pulse when this occurs. After school, Elaine returns home and does her homework until about 5:00 or 5:30, followed by dinner. Several times in her journal, she noted homework being problematic because of her need to start on the hour. She recorded taking from two to seven hours just to start, for example, a final assignment. She works at a part-time job on weekends from about 7:00 p.m. to 1:00 a.m. Repeated actions, generally in threes and fives, were also a salient part of Elaine's journal. These related to turning lights on and off, changing television channels, cleaning, eating, drinking, and washing and drying her hands.

Others with OCD and those who encounter them.

Elaine first recalled both discouraging and encouraging relationships. Her good friend from high school, for example, has OCD and Elaine found their relationship to be a "downward spiral" (line 310). The relationship with her current roommate, however, has been one of tremendous support and striving to maintain daily routines despite setbacks.

Concerning advice for others with OCD, Elaine highly recommended meditation and yoga due to enormous benefits that they have given her. She noted the learning aspects of controlling her breathing, focusing, and relaxing, thus effecting more control over her life. Also from her personal experience, she stressed the difficulty and pain in keeping OCD to oneself, therefore one should frankly discuss these issues. She advised such students to "seek support, I mean it's very difficult to just rely on yourself, and keep it private. I find it's very painful and um it's more of a burden to carry on" (lines 1125-1126).

With respect to her current post-secondary institution, Elaine found that her initial visit with the counselling services staff was very positive, but they lacked training and understanding. There should be a broader range of people available to treat students with depression and related problems. She spoke of knowing about many universities, such as where a friend attends, that

welcome students who have OCD and depression, and openly downplay the embarrassment of seeking such help.

In terms of advice for those who encounter such students, Elaine mentioned having an open mind and treating them just like other people. She noted her discomfort when others considered her feelings too much, leading her to feel isolated and abnormal. She cited, however, a positive example from a language course she took where she was open about her OCD and her teacher was fortunately quite accommodating and encouraging. Elaine did not keep her OCD hidden and she greatly appreciated the teacher and the final mark she received.

Final comments.

Elaine viewed her progress by stressing the importance of seeing OCD experiences in terms of positives and how she has benefitted, even in the slightest ways, rather than viewing them as being quite negative, such as having regrets. She noted, “if I can, get up in the morning and not check the lights AS MUCH, as like, say I did last week or last year. I feel like...my progress is getting better, so that makes me feel better as a person, just keeps you more motivated to keep working harder” (lines 1172-1175). Further, after being fearful of trusting others in high school, Elaine has gradually learned to overcome her fear by expressing herself without hesitation to non-family members. This openness, she revealed, is necessary for a genuine relationship. Further, she explained that she has learned to pace herself academically, by accepting that straight As are not possible for her and she must try different ways of approaching assignments and focus more on positive experiences rather than on negative ones.

Regarding her participation in this study and potential influences from other similar studies in which she has participated, Elaine noted some questions that were common, but she stressed that they did not influence her responses or change the views of her experiences. Elaine found that

many topics were raised and questions were “very open minded” (line 1184). She noted, “I feel like your interview approach is...really gentle too, I don't feel intimidated....I've done some of these before where...you feel nervous, you don't even want to make eye contact, so I think it's been an enjoyable experience, like I'm glad I took it up” (lines 1185-1189).

Steve "I was always able to adapt very well to different situations"

Steve's interviews with the researcher lasted 65 and 36.5 minutes respectively for a total of 101.5 minutes. In his journal, he wrote almost every day for about a month, but missed a few days due to depression. He reported main symptoms involving luck, *just right*, regret, discomfort, repetition, and depression for a total of 1771 journaled words. OCD onset occurred during early elementary school and a clinical diagnosis of OCD was made in his early 20s. He completed all self-report questionnaires. An overall distress level of slightly less than A lot was determined by his OCI-R. In terms of the SF-36v2, his overall health state was Good and Steve indicated that his health in general now is about the same as one year ago.

OCD diagnosis, recommendations, treatment.

During a class that highlighted OCD symptoms, Steve and some of his friends recognized that he had been exhibiting such symptoms and this was the first time in his life, then at age 17, that Steve had this awareness. In the past year, Steve described that both his OCD and depression have adversely affected many aspects of his life, for instance, his school work, his part-time employment somewhat, and socializing. He noted that when he has been quite depressed and lost hope, such as in the last few weeks, his OCD has helped in that it became more intense and thus caused him to take his focus off depression. Recently, he was clinically diagnosed with OCD and depression and he was asked about his thoughts regarding treatment. Steve did not want to proceed with treatment for OCD because he was told that the therapy would last a long period of

time and he “was nervous to change those behaviours...worrying about bad luck if I would have changed the behaviours...it would be deliberately going against them” (lines 99-103). The description of therapy for OCD included acting against his regular compulsions, such as not checking and setting his clock alarm to a certain time. This therapy, Steve remarked, “I wouldn't have done” (line 114). He was not presented with an option to take medication. Steve noted, however, that prior to his clinical diagnosis, he took depression medication for a brief time, but ended this as it was not beneficial.

Experiences, beliefs, feelings, relationships.

Considering earliest memories, Steve explained that his relationship with his mother was probably closer than with his father, and in terms of his siblings, he tried to emulate them as they were much older. Steve noted that he was the youngest in the family and his older siblings did not get along well, and he often fought with his brother. Eventually, his siblings moved out of the family home, with his brother becoming a drug addict and his sister continuing with her education. At a young age, friendships with his peers were “fairly normal” (line 16), but he was “usually the more dominant personality...and...I was always trying to be the best” (lines 19-21). This need to excel was apparent inside and outside the classroom, for example, during extra-curricular activities like sports. The motivation to be “top of the class” (line 23) at a very young age came from himself, and also from his parents, more so from his mother.

In terms of earliest memories and OCD, Steve recalled that in grade 3 or 4, mistakes he made writing a letter or word in pen would need to be repeatedly retraced to look just right. These letters or words would become so large from his retracing that teachers would occasionally comment on them. They also commented on his need to recheck everything when writing tests or with other class work. Further, around grade 6, Steve experienced common OCD behaviours, such

as checking that doors were locked and setting and repeatedly checking that his clock alarm was on a lucky number. A time, for example, of 3:04 would have been lucky because 3 added to 4 is 7. He noted that due to a traumatic experience, though, the number 9 changed to being an unlucky number. In addition to numbers and checking, Steve also experienced great worry about baby-sitting at around grade 7, as some terrible event might happen, for instance a house fire or going to the hospital because a child stabbed himself with a knife that he forgot to put away.

While in high school, Steve and his mother were quite close as she was his teacher. He got along with his father, but their relationship was distant. In his first year at university, Steve told his parents that he was homosexual and since then, his relationship with them has been strained as they were unwilling to fully accept his sexual orientation. When he lived with his sister, she observed his many rituals including checking doors and lights. Like Steve, his brother also has an anxiety disorder as well as some similar OCD symptoms. He still communicates with his siblings, but their relationships are not very close.

He found that his high school classmates generally did not notice his OCD behaviours, but some did point out that he always needed to sit in a specific type of chair prior to exams. Currently, Steve has many friends from both work and school, as well as the people he lives with and a roommate from the previous year. He has found that they have not noticed his OCD behaviours that much, but they have watched him repeatedly check door locks, light switches, and stove, both visually and physically. Further, he chuckled, "if I iron clothes, I have to check the iron over and over again to make sure it hasn't fallen OVER, or if it hasn't, like the cord's not gonna be like set on fire haha or something haha, if it's still plugged in or something" (lines 341-342).

Steve explained that he had good grades overall coming out of high school, thus he could have entered any university program. He was influenced by his sister and father to pursue social

sciences at university, but he admitted, "I probably would have chosen liberal arts now if I could have went back, which would have been more like philosophy and stuff like that" (lines 217-218). For teachers, he noted, "for the most part teachers liked me, um, in [school], I started to talk less and less, and then um in university, teachers wouldn't even know me too much right now" (lines 202-203).

In terms of his beliefs, Steve recounted his active participation in church activities and his desire to eventually become a church leader, noting "religious values and beliefs definitely shaped what I believed" (lines 352-353). After he entered high school, he rejected much of these experiences to explore other religions, such as Buddhism and Paganism. Currently, he sees himself as non religious, but he admits being influenced by the religious values from his past. Further, he detests capitalism, greed, and the educational system that he is a part of, therefore he sees that change is needed with respect to governments, laws, and prisoner rights.

With respect to positive influential experiences, Steve mentioned the impacts of superstitions in his life, for instance, becoming more confident in grade 8 from winning a speech competition with his speech about superstitions. He found that while researching his speech, he may have become even more superstitious, but he recalled the pleasure he experienced while repeatedly checking every aspect of his speech so that it was just right. In addition, attending leadership conferences was very positive in that he broadened his understanding of people. Playing tennis also gave him great satisfaction, as he strove to play just right, following his superstitions.

His most memorable emotional experiences have come from the praise that he has received, such as from teachers and his parents, and he acknowledged that he did not seek this and he has never wanted to "make too big of a deal of it" (line 663). Further at school, he expressed a great

deal of happiness regarding plays in which he acted, wrote, and also directed. He also recalled many happy times from around grades 8 to 11, including bush parties and plenty of beer. In particular, Steve related a significant, emotional relationship that he had with a girl, who eventually moved away and triggered a great deal of anxiety for him. He also remarked upon the confusion he has experienced surrounding his place in society, his employment, and his sexuality.

Steve iterated his need to be at the top of his class throughout elementary and high school. Just prior to university, he realized that learning from experiences outside school rather than in class were of much greater importance. Further, he noted his dislike of learning in groups, unless it involved familiar classmates. He expressed his boredom with university for about the past year and a half caused by a great deal of recreational drug use with his roommate, and his willingness to miss lectures, especially if attendance is not taken.

When asked to consider his academic and social life, he explained that his academic life had been more important than his social life, probably due to his prolonged focus on being the best student in class. Recently, however, his social life has taken priority, as he has missed lectures due to late-night parties and other events. Steve figured that perhaps maintaining such high academic results for such a long time has led to his recent need to enjoy his social life much more.

Goals, challenges, changes, persistence.

As for goals in elementary school, there were awards for achievement, behaviour, and effort, but Steve always strove to be recognized for achievement. Further, he worked towards having an overall average about 80% from grades 1 to 6. In terms of high school, he recalled trying to “win the most awards possible” (line 500), such as awards for the highest marks in specific subjects, the citizenship award for volunteerism, and also being voted class valedictorian.

Prior to university, Steve wanted to be a lawyer. As he became more acquainted with this field at university, however, he changed his mind due to its shortcomings, and also his struggles with motivation, depression, OCD, and being a homosexual. Currently, he admitted to having few goals, but he was keeping in mind a master's degree. And with his two part-time jobs, going to school on a full-time basis, and maintaining a busy social life, he has had no time for volunteering. He retained his jobs while at school because he strove to be "self-sufficient and not rely on my parents too much" (lines 533-534). In the very near future, he expected to graduate and then work or travel, and then perhaps start a master's degree a year or two later, dependant upon maintaining close contact with specific friends.

With respect to facing and overcoming challenges, Steve recalled from his earliest memories trying to be the best student in the class while still trying to make and maintain friendships. Eventually, he found a balance. He attributed this *push*, of always trying to exceed his classmates, to his parents, mostly to his mother, who made him "more of a perfectionist" (line 1225) and who possibly influenced his OCD. In addition, he also faced a significant challenge as he had to date girls to maintain school and family expectations, while knowing well that he was only interested in dating boys. Steve noted, "the biggest challenge was dealing with being gay" (line 547), "so you're always trying to maybe get rid of the feelings or, um, you're always trying to do things to, to um, not be gay, um, until you come to acceptance with it anyways" (lines 1155-1158). He still struggles with dating relationships. In the past year or so, he has been less motivated and he has been looking forward to changes in his life after completing school, such as pursuing activism.

Specifically in terms of his OCD, Steve explained:

probably, like my best way to describe...OCD it's kind of like, like that feeling...when you're a kid and it's Christmas Eve and the next day you know it's Christmas and you want to go to sleep 'cause you know that's going to make Christmas come, but the only thing you can think about is Christmas the next day, so you can't go to sleep. So that's kind of what I feel like with OCD, so I feel like, like it's not, like a BIG, um like there was a big incident where I was like, oh I was or able to overcome a challenge or an obstacle or something, but it feels like all the time with OCD, it's like little challenges, so I FINALLY went to bed, so I FINALLY stopped checking the alarm clock.

(lines 564-572)

He added that he has not had any traumatic events to trigger OCD, such as a death in the family, but during stressful periods like exam time, his OCD becomes much more challenging to manage. Before an exam, for example, he must find a pen that is just right, and the importance of setting his alarm on an auspicious time increases about tenfold. He has never dropped out or transferred “‘cause it's kind of a sign of a failure, and I'd always be worried about what my parents thought...it would be a reflection on me as well” (lines 826-830).

Strengths, weaknesses, and coping strategies.

Steve emphasized his academic strengths from early on to his third year of university, with depression and recreational drug use probably having adverse affects since this third year. He noted a weakness of being *bossy*, *selfish*, and socially *dominant* in elementary school, but this changed to introversion and extreme shyness during late elementary school and early high school. In early high school, he lacked confidence and he was overly concerned about behaving appropriately. In the latter part of high school, though, he found that he became more able to deal

with this behaviour issue by being more cautious with his actions and words. Steve perceived that from his perfectionism, he "was always able to adapt very well to different situations, and adapt well to high levels of stress in terms of academically...it almost seems like...more I had on the plate...the better I was able to get things done and be more efficient about it" (lines 455-460). In addition, his perfectionism has pushed him to check essays more than typical students, thus helping him to be much more careful and thorough in his school work. He noted perfectionism and OCD have prevented him from participating fully in some social situations. During high school and university, Steve has tried to maintain control over any work related to groups, and even pairs, as he has needed to dominate. The opportunities have been less prevalent in university, but Steve has consistently asserted this need to be in control.

The three questionnaires and journal: Comments and clarifications.

In terms of the demographic questionnaire, Steve noted that he is generally in good health, but that he is also often influenced by reports of illness and pain. He obsesses over such related symptoms and checks online to assess his health. More succinctly, he described, "if I hear about something...externally...then I'll internalize it to be for myself" (lines 892-894). He explained that he is unsure of how his obsession with luck and lucky numbers began, but he has experienced this since he was young and throughout high school. He figured that this relates to having control over his day, for instance, if his day went poorly, then he would reflect upon actions he could have taken to improve his luck. He could then make necessary changes to possibly improve his luck in the future, such as considering that 13 is an unlucky number, making sure not to step on sidewalk cracks, and not to use doors that are intended only for those who are handicapped.

Steve further elaborated upon his living situations in the demographic questionnaire by explaining that he lived with both his parents until age 17, and partly with siblings, but he then lived with his sister the following year and his OCD symptoms were not that extreme. Afterwards, he lived alone for 2 years and this situation greatly influenced his OCD, "it was a lot stronger...by far...my OCD tendencies I remember like, uh, mostly like just even getting ready to go to bed at night was like where it was THE strongest" (lines 968-974). Such tendencies included turning off all lights in a specific order, door checking, listening to a set number of songs, and frequent alarm setting and checking. Subsequent to living alone, he had roommates that Steve figured served to distract him and thus lessen the effects of his OCD. In addition, he noted his weekly treatment for depression basically involved recording emotions and talking about alternative ways of thinking. For OCD this was much more difficult, as the therapist explained how OCD thoughts functioned and how he needed to act against what seemed to be normal behaviour for him. He summarized his 17-weeks of treatment by stating that he "felt good when I was done in the sense that like the depression is pretty much gone. Um. I don't have the same kind of the depression that I did before, and the OCD is still the same, so that didn't really change at all" (lines 1027-1031).

From the OCI-R, Steve was asked to provide examples of unpleasant thoughts and nasty thoughts. He described how he often thinks about the:

WORST POSSIBLE outcome of a situation, especially when I'm very nervous, and then I'll imagine it happening...like thinking, I'm going to fail an exam...and then I would just imagine it in the worst possible way, or even more so, like often it comes with social things, like I'll imagine like, if there's a secret or something...that I don't want somebody to know, I'll imagine them find out and then I'm going crazy...I just keep...going back to that. (lines 1037-1044)

Regarding the three items about hoarding, Steve noted the absurdity about living in such a small room with so many clothes that he never wears. Further, he keeps papers that he no longer needs as well as notes that he has written to people. Steve admitted that his counting and superstitions related to the neutralizing items 4, 10, and 16 are his strongest "OCD tendencies" (line 1071), as even around the time when he was in kindergarten, he recalled being at a shopping centre and trying to avoid stepping on cracks.

From the OCI-R, neutralizing was Steve's most distressful experience, as he responded *extremely* to all items, closely followed by checking, while washing was his least distressful experience, as he indicated *a little* twice and *not at all* to the third item. Item responses for hoarding and ordering were all *a lot*, while obsessing items were *moderately*, *a lot*, and *moderately* respectively. In the SF-36v2, Steve's mental health item responses were mainly *some of the time*, such as being down in the dumps, depressed, and happy, while physical health item responses were mostly *not limited at all*, and with only *very mild* bodily pain. Steve expressed his general health as *good*. Considering the SF-36v2, Steve clarified that his emotional problems affected his health more so than any physical problems in the past 4 weeks. He interpreted worn out as not being able to focus and concentrate on such things as lectures, whereas being tired meant that he would have no trouble sleeping for a long time.

A typical day.

Steve noted his usual reluctance to wake up and get out of bed, thus he often sets his alarm quite early allowing him the opportunity to reset and avoid getting up immediately. He emphasized his need for resetting his alarm to a "good time to wake up" (line 740) and sleeping in a bed that is also in a good place, but which is neither symmetrically aligned, nor space efficient. He asserted that his OCD affects him most often during this time, at night, and while alone,

but that his recreational drug use mitigates or eliminates these effects. Getting ready to start his day involves a routine that includes a shower and wearing the most appropriate clothes, as this “would really be a big thing to decide” (line 720). This process can be very time consuming, especially if Steve is required to dress more formally in addition to wearing clothes that feel *lucky*. He noted that this time, of about 30 minutes, is not directly related to looking attractive and it could also vary depending upon the availability of his shared washroom that he uses in his morning routine. In his journal, he wrote that even finding appropriate socks took about 15 minutes. Further, cleaning his room and exam preparation can also take him a great deal of time.

Steve then proceeds to one of the places he works part time or to a university class. He admitted that his attitude toward school is drastically different from his second year and before, as he now often lacks interest in class, or does not listen, or falls asleep, or he just avoids attending. When he leaves for school, he must recheck that his door is locked. Walking to school involves not deviating much from his usual route and not stepping on lines and cracks as these may negatively affect his luck. From his journal, he stepped on too many cracks while walking, thus he had to go back a block and rewalk it for better luck. Further, while ascending steps, symmetry is important, for example, both feet must touch the same step. In addition, if he kicked a step with his right foot, then he would also need to kick the same step with his left foot, even if people were watching him. Steve noted that if such compulsions are not followed, then this can negatively affect his mood. Travelling by public transportation is similar, with Steve needing to lift his feet while passing over bridges and train tracks, and duck his head while passing under overpasses. He also needs to find seats that are just right on public transportation, and other situations, such as in restaurants, at friends’ homes, and at work. In the evenings, he frequently goes drinking, or works at a part-time job, and he then returns home and spends time with friends.

With greater insight from his journal, he noted additional actions that must be performed during each day, i.e., making sure his hair is just right, closing his curtains just right, and listening to a lucky number of songs before going to bed. He also has difficulty going to sleep due to worries about arguments or fights with friends that he could, but would probably not, encounter.

Others with OCD and those who encounter them.

Steve acknowledged that he is really not in a position to offer advice on how to overcome OCD, as his struggles continue, but he emphasized that it was somewhat helpful for him to find out that the source of his OCD is from being pushed to be a perfectionist. He added the importance of trying to understand one's OCD, for example, by writing a journal and by talking about one's obsessions and compulsions. In terms of others with OCD that he has met, Steve argued that it is common for many people to believe they have OCD simply because they avoid behaviours like stepping on cracks:

it's too broad a term like now that, I think they might have tendencies or actually things they might do that's OCD...they may have little superstitions or something, but it's not to the point where it's, like they actually get emotionally upset over it if they don't do it...everybody likes to think they're special...." (lines 1242-1249)

The only salient OCD-related relationship Steve has had was with a guy he dated. They used to influence each other, for instance, Steve began checking taps when he saw his friend checking. They also had many similar traits, such as striving to be the best in class and in complete control, but also acting wild at parties and binge drinking.

As for services and polices at his current school, Steve commented that from his experience both as a student and working within the system, there is some help available for those with depression, but the awareness is not widespread. More often, people understand that help is

available for physical health problems rather than those related to mental health. There needs to be greater awareness on campus about mental health services, such as accommodation for special needs related to the stress of taking exams. When encountering people with OCD, Steve advised ignoring or downplaying what is observed, as drawing attention to abnormal behaviours will not be helpful. If a teacher sees a student who seems to be in great difficulty, possibly due to OCD, the teacher should approach the student and address the issue.

Final comments.

In terms of this study, he noted, "I think it's a valuable study...the end results would be interesting I think" (line 1427).

Chapter Summary

In keeping with IPA (Smith et al., 2009), the findings included a substantial number of verbatim quotes intended to provide readers with both a broad and detailed view of participants' lives. The headings served to organize the respective data collected, emphasizing the functions of OCD (see also Appendix L: Additional OCD Functions of Participants). Data related to Figure 1 and other categories were sometimes interwoven because of the nature of the data elicited.

Chapter V: Inter-case Analysis

This analysis highlights the seven cases in relation to each other. Chapter headings arose from the processes outlined earlier in the Data analysis path. These headings usually follow the same presentation order of the Findings chapter. It is important to note that because some data were very closely related, they were combined under one heading. First, data from the OCI-R and participants' respective comments and clarifications were analysed in the Analysis of OCD symptom distress (OCI-R)/Comments and clarifications section below. Second, data from the SF-36v2 and participants' respective comments and clarifications were analysed in the Analysis of QoL and SF-36v2 mental and physical health/Comments and clarifications section. This section also includes the data from the case heading OCD Diagnosis, Recommendations, Treatment. Third, the remaining data from the case heading The Three Questionnaires and Journal: Comments and Clarifications were discussed in the section IPA and participants' comments and clarifications case heading. A final exception in the heading presentation order is that recommendations from participants were relocated to chapter VI in order to examine their relationships to similar studies.

OCD symptom distress (OCI-R)/Comments and clarifications

Participant symptom severity levels ranged from *A lot* for Elaine to slightly less than *Moderately* for Robin. Steve rated slightly less than *A lot*, while Oliver and Nick rated between *Moderately* and *A lot*. Anne rated slightly more than *Moderately*, while Mary rated *Moderately*. Regarding most distressful experiences, Elaine's results showed checking and neutralizing, while Anne's results showed checking and Steve and Mary's results showed neutralizing. The remaining participants had different results, as Oliver indicated washing, Nick indicated obsessing, and Robin indicated ordering. Notable comments and clarifications came from Elaine, Steve, Oliver, and Robin. Elaine realized that she saves things up much more than she ever realized and

noted that such a habit goes unrecognized until it is brought to light, such as in the present study. Also, she clarified that her compulsion to wash occurs after making contact with someone's hand, but not after making contact with objects. Further, Steve recalled that he avoided stepping on cracks from perhaps around the time when he was in kindergarten. In addition, Oliver took an alternate interpretation to the hoarding item of not throwing things away by explaining that he needed to leave things on his floor for a couple of days before he could pick them up again, for example, after sneezing on them. Someone moving these would also increase his anxiety. He added that these *quarantined* things have become so natural that he sometimes does not even realize that the things have been on his floor for a day to a month. Robin considered the normality of her symptoms, thus making it difficult to indicate any one being the most significant.

It was interesting to discover that no participants reported a fear of contaminating others, even when asked directly by the researcher. In Zirinsky (2001), however, David had a pronounced fear of contaminating others, such that his food had to be delivered under the door of the bathroom he had been living in for years, and he strongly urged those who merely touched this bathroom door to shower and change into clean clothes.

QoL and SF-36v2 mental and physical health/Comments and clarifications

Robin, Oliver, and Nick seem to have had the most difficulty in dealing with OCD and its impact on their QoL, as experiences of very extreme despair were revealed. Robin explained that from all aspects, her QoL was so terrible that she resorted to self mutilation for a period of about two months. Cutting herself made her feel better as it served as a form of release. In his journal, Oliver wrote while he experienced a panic attack. He described that everything around him was crumbling, extreme fear was becoming real, and wanting to cry and return to a time when his life was worth living. A few sentences later, he clarified that this time was better than death,

but nowhere close to the general perception of living a life. Oliver added that he then had to turn to the next problem that would be much more serious and likely destroy his life. Nick attempted to take his own life shortly after taking an antidepressant, and explained that since his OCD peaked at about age 15 or 16, he has been unable to relax and everything in his life has been disappointing.

In terms of OCD diagnosis, all participants first noticed OCD symptoms around their early teens, or between about age 10 and 13 or 14. Clinical diagnoses occurred within a much wider range, with Elaine at about age 10, Robin, Anne, Mary, and Nick around ages 15 to 17, Steve in his early 20s, and Oliver in his late 20s. Notable OCD diagnoses include those of Robin, Nick, and Anne. Robin was admitted to hospital under in-patient care that involved 3 to 4 weeks of assessment, followed by about 2 months of primarily group treatment, and she recalled being the only patient in the ward that was not taking medication and she still tries to maintain control of her life without the help of drugs. Similarly, Nick's attempted suicide led him to become an in-patient at a hospital, where he underwent therapy and was diagnosed with OCD, depression, and Generalized Anxiety Disorder (GAD). From her onset and for about the five years that followed, Anne's family failed to support and understand her. A breakthrough eventually resulted in Anne being diagnosed by a family doctor that Anne found to be very unpleasant.

Recommendations and treatment for Nick and others included, for example, medication, cognitive-behavioural therapy sessions, and recording troubling thoughts in a journal. Anne and Nick took medication for the first few years after the clinical OCD diagnosis, while Mary still takes an antidepressant medication. The remaining participants have not taken related medication (see Appendix I for additional details). Currently, Oliver's treatment involves helpful meetings with his doctor about twice a month for exposure therapy and related homework discussions. In addition, Elaine has found counselling to be helpful, along with her additional coping methods

of breathing exercises, yoga, and meditation that she has taken up over the years. Further, Mary explained that her doctors recommended both medication and therapy. She saw one psychologist for about a month, but her disapproval led to a second psychologist who she saw for about a year and a half. At the end of 2006, Mary discontinued seeing a psychologist as she felt she could deal with this by herself with the aid of her antidepressant medication. Similarly, Anne admitted to not having seen a psychologist for quite some time, thus she tries to rely upon what she believes she should be doing to cope with her OCD. Nick's weekly visits to a psychiatrist have been of no help. Robin and Steve seemed to favour self-reliance, as Robin mainly relies upon herself for support and Steve did not want to be treated for OCD due to its lengthy treatment process and his nervousness and worry about forcing changes that might also negatively affect his luck.

Mental and physical health.

Results from the SF-36v2 showed that physical health (physical functioning, role physical, and bodily pain) was limited minimally or not at all, but the other measures of general health, and mental health (vitality, social functioning, role-emotional, and general mental health) showed greater variation. General health ranged from poor to very good, but getting sick somewhat easier than others was *mostly true* to *definitely true* for five participants, with Robin and Nick responding *definitely false*. Nick perhaps misread the item as he was the only one to indicate his general health as *poor*. Further, as for health being excellent, four participants indicated *don't know*, with Elaine indicating *mostly false* and Nick indicating *definitely false*. Oliver was the only participant who indicate *mostly true*. For mental health results, general mental health item responses were often quite negative, as five participants responded to being very nervous *most* or *all of the time* and four participants being calm and peaceful none of the time. Similar negative results characterized vitality, social functioning, and role-emotional. Regarding impairment of social functioning,

responses were often *moderately* and *some of the time*, but Elaine indicated *extremely* and *all of the time* respectively. Notable comments and clarifications came from Elaine, Steve, Oliver, and Anne. Elaine added that travelling short distances, such as with short flights, caused more anticipation, but longer flights involved expected delays and enabled her to relax more. In addition, similar to Elaine, Steve interpreted *tired* as relating to sleep, but *worn out* relating to lack of energy and ability to concentrate. Further, when asked to elaborate upon his choice of *Very good* for his general health, despite his belief that he will get sick later on, Oliver remarked upon his anticipation of a *catastrophic* event and being unable to control his surroundings. Also, Anne laughed about the calm and peaceful item, as she responded *none of the time*.

Experiences, beliefs, feelings, relationships

There was a diversity of characteristics among participants, notably, related to degrees of familial and outside closeness and support, and OCD influences in the past, degrees of prominence and/or positiveness and negativeness in the present, and degrees of motivation and direction toward new and specific experiences in the future.

In the past.

Oliver seemed to have the greatest familial and outside closeness and support in the past, with him recalling a happy family life with his parents and siblings, living in a good community with many friends, and very positive feelings as a child growing up right up to his undergraduate years. Before his clinical OCD diagnosis, he and his family members could not come to terms with his behaviours, but the diagnosis led to much greater support and understanding. He admitted to having few, if any, political and religious beliefs, but superstitions played an increasingly important role in his life. Next, Steve had positive familial experiences and a closeness to his mother until his admission of homosexuality in his first year at university. He had academic and

social success despite the influences of OCD, for instance, with checking and neutralizing.

Robin was closest to her mother although their relationship was somewhat strained due to the separation and divorce of her parents. She had different groups of friends before university, but they were not always positive. Her junior high school principal was a notably positive figure. For OCD influences, Robin had a boyfriend in her late teens who sincerely wanted to understand her OCD better and she found his interest to be one of the nicest things anyone has ever done for her. Anne mainly communicated with her immediate family during her early years, but she later developed good relationships with her teachers and classmates. With high school, her siblings encouraged her to overcome her extreme shyness and she eventually adjusted along with help from a psychologist for her OCD. Mary had positive familial relationships as mental health problems were common along with empathy, and mostly positive outside relationships. The death of her sibling, however, resulted in her feeling different from her peers and about a five-year process that ended in an OCD diagnosis and a helpful medication. In terms of academic and social life, she noted failing high school math 3 times and just missing a university scholarship due to her problem with numbers from OCD. Similarly, Elaine's family also had mental health problems and empathy, but her OCD always caused her to be secretive with her friends because of the difficulty they had in understanding. With the help of her therapy, Elaine discovered new methods of coping with her problems and she continued to make steady progress. Her relationships with her teachers at high school was closer and more motivational and supportive than with those at university due to class size. Nick had strained familial relationships, with pressure from his parents and himself to perform beyond his best efforts, and abusive acts toward his younger siblings. He had good relationships with his teachers, but less so with others. OCD was very influential from about 15.

In the present.

Experiences, beliefs, feelings, and relationships were very diverse, but these characteristics could be grouped according to degrees of prominence and/or positiveness and negativeness. Steve stood out as all four characteristics seem to have been quite prominent and/or positive in his current life, with active experiences and relationships at work, school, his home, and with his family, and being influenced by his religious values and strong views about government and the educational system in which he is a part. His social life and a great deal of recreational drug use have taken priority over his former studious disposition. Similarly, Oliver noted the positive experiences of moving to a new city for his current program of studies and always having many friends. He expressed, however, his persistent difficulty and resistance related to becoming close, as others may discover his flaws thus he has never invited friends to his home. Elaine, Robin, Mary, Anne, and Nick had less prominent and positive characteristics respectively, from Elaine having better academic success and anxiety management, but still often withdrawing from present academic, employment, and other social situations due to her excessive anxiety symptoms and sensitivity to Nick who has serious doubts and struggles both academically and socially. He has difficulty working with his classmates because of his need to feel comfortable in implementing his own ways of thinking and he has developed a greater reliance on god for comfort as his psychiatrist has been of no help. Robin, Mary, and Anne's characteristics could be considered relatively moderate in prominence as they have some close friends, and moderate success with experiences and relationships along with some related negative factors, such as those from OCD.

In the future.

Robin, Mary, Elaine, and Steve seemed to be quite motivated and looking forward to the completion of their studies and then moving on to new and specific experiences. With Anne,

Oliver, and Nick, however, the future seemed to be less certain and associated with worries from OCD for Anne, a yearning to get away from his friends and resident city for Oliver, and waiting for direction and enjoyment for Nick.

Goals, challenges, changes, persistence

All participants were working toward the common goal of graduation, but they all had a variety of differences regarding persistence and challenges and changes in their lives with OCD. All participants considered transfer and withdrawal at least once during their university education, but Nick seemed to have the most difficulty moving through each day as he just continued along his current path despite his lack of enjoyment in life and no treatment approaches that have helped. He persists due to the influences from his family and friends and a glimmer of hope while noting that he is quite ill internally. Similarly, Oliver persists as he believes a better opportunity awaits, but such an opportunity has yet to present itself. Robin and Mary were the only participants to have taken leaves of absence. For Robin, this leave was beneficial, but the outcome for Mary was quite negative. After returning from a leave of absence of about nine months from her university studies, Robin's persistence derived mainly from her boyfriend, as he has encouraged her to graduate and then pursue employment in her chosen field. An additional factor in her strong persistence has been her OCD that has helped her set and meet goals. Mary took a leave of absence for most of an academic year with the understanding that it was considered as a medical leave. Despite seeing four doctors, her school refused to refund her tuition and her leave prevented her from getting a second recommendation needed to volunteer abroad. Elaine and Steve have persisted in their programs due to fear of failure. Anne experienced the most difficulty with persistence at the beginning and end of her program. She considered dropping out while in her first year due to her university experience being beyond her expectations. Nearing the completion

of her studies, however, her greatly debilitating OCD brought her again to the point of strongly considering a break from school with her parents and new roommate being influential in continuing. Oliver, Nick, and Robin seem to have experienced the most extreme challenges, with Robin resorting to self mutilation for a period of about 2 months, Oliver journaling that everything surrounding him was crumbling, and Nick attempting to take his own life and experiencing no enjoyment out of life due to OCD. It is important to note that data from the Findings above included comments about student persistence prior to university, but these comments were often comparatively limited and similar to the comments related to student persistence as a university student and beyond, such as influences from family. Thus, persistence was analysed in relation to being a university student, which is also congruent with the posit adopted from Tinto that specified *within the institution*.

Considering goals, challenges, and changes, and OCD, talking to oneself and others, and treatment seem to be points of significance, with talking for Robin, Anne, Nick, Elaine, and Steve, and treatment for Mary and Oliver. Robin has learned to control her once very physically violent impulses by talking instead of taking physical action. She has received advice advocating a positive outlook on life to change the effects of her OCD and meet her goals. Despite her challenges, especially related to explaining OCD to her parents and friends, Anne noted that she has worked toward her goals by aiming to do well throughout school. The changes in her contamination obsession have been puzzling, as grades 7 to 11 involved frequent and lengthy hand washing along with skin irritation, but for about the past 5 years, she has not needed to focus on this obsession and she does not understand this significant change. Sometimes Nick has been able to suppress his OCD thoughts, but usually, they have caused distress and disappointment, with suppression resulting in doubts, for example that an assignment was not thoroughly checked,

and with acting on thoughts, such as asking repetitive questions, resulting in regret about giving in to the disorder. Elaine's goal board that has served as a visual motivation aid during high school and university. She has become more able to hide her troubles, and she then deals with these and OCD while alone or talking with those close to her in her private life. Adapting to new events in her life, such as recently starting a new job, has also been problematic, but she acknowledged that her initial difficulty with feeling lost and disorganized was managed by strictly adhering to her work schedule detailed in a book. Steve aimed to become a lawyer, but he gradually became less motivated and focused due to depression, OCD, and issues related to being a homosexual. His gradual acceptance about being gay was arrived at following difficulties, such as unwillingly having to date girls and trying to hide and deny such feelings. Despite his very active social life, he added that having a functional relationship is still a significant challenge. Delaying his goal of pursuing a master's degree is the closest issue he saw as failure and changing goals. He noted small challenges and changes being significant, such as finally going to bed without alarm clock checks, rather than having one enormous challenge to manage.

Mary's goals may lead to include a master's degree and becoming officially bilingual, but OCD has continued to be challenging and quite time consuming, moving from counting money to maximizing points on consumer point cards and meeting related point deadlines. Such challenges, she noticed, have lessened over the years possibly due to her medication, her acceptance, or the monotonous repetition. Despite his pending program completion and his realization that he has become too old for school, Oliver saw his goals had become very uncertain, with no decision about relocating to even a country in which to (apprentice). Dating and letting friends become close have always been difficult, as he has never invited them to his home. He believes he can pursue his goals with the help of exposure therapy, thus life does not need to be thought of as a

prison. Oliver has noticed an enormous change in his OCD from the beginning of his treatment in March to the present, with quality of life having improved a hundredfold due to the gradual implementation of exposure tasks.

Strengths, weaknesses, and coping strategies

Participants revealed a variety of perspectives in terms of their academic and social lives, as well as their lives coping with OCD. Oliver and Steve seemed to be the strongest both academically and socially throughout their lives coping with OCD. Similar to Oliver, Nick is also enrolled in a highly-competitive professional program, and he figured that he has the intellectual capability to handle academic work, but he still struggles a great deal both academically and socially. Oliver perceived that his extreme shyness and general nervousness have not impeded his ability to make and retain many friendships. He also described his additional strengths of academic work and athletics. He viewed that ironically, all of his jobs have been in customer service, where he has not become nervous or scared, even when he needed to approach a group of about 30. Expressing himself during a lecture in front of his classmates and professor, however, makes Oliver extremely nervous. Regarding coping strategies, he judged that he focuses upon and controls aspects of his life to ensure that no problems follow. Steve noted his academic strengths from elementary school to about his third year of university. Subsequent to this time, depression and recreational drug use had negative influences academically. Socially, he figured that he had always been dominant and somewhat bossy or selfish. He explained that his adaptability has always been strong in a variety of situations, for instance, becoming more effective and efficient in highly stressful academic situations. In addition, his perfectionism has pushed him to check essays more than typical students, thus helping him to be much more careful and thorough. He noted, however, that perfectionism and OCD have prevented him from participating fully in some

social situations. For Nick, the processes of thinking about both academic and extra-curricular tasks have caused extreme stress and worry, but his academic capability has been adequate. He identified his only coping mechanism as giving up, but noted that this option has offered only some relief as the same thought processes return. He elaborated that his coping situation is a *mechanism* or *device* that has the *phases* or *stages* of suppression or aggression that come and go every few days.

Robin, Anne, Mary, and Elaine have been less successful academically and socially relative to the three others above, but their coping strategies have been progressive. In high school, Robin put little effort into her academic work and she was about average, while her social status remained important. She expressed regret when admitting that a high priority was manipulating classmates, but noted this was a key coping strategy. Further, she perceived that she now approaches others for help, such as her mother, boyfriend, or best friend rather than coping with problems alone and this has been very helpful, and it has also strengthened her ability to identify and accomplish what needs to be done. Socially, Robin regretted that such decisions could be too hurried, as friendships have ended instantly following a single incident. Anne first mentioned her extreme shyness at university, especially with voicing her opinions and merely sitting in class, resulting in poor grades. She perceived that OCD worsens in class due to nervousness about drawing attention to herself, resulting in unhappiness and great discomfort. She noted that a positive outcome from her therapy has been that she has become more effective at suppressing urges to carry out OCD-related behaviours. Mary has coped by keeping busy with activities such as listening to music, going to concerts, and the gym, but she acknowledged that OCD, especially during her first year at university, has caused her to do things in twos, thus taking up more of her time than usual. She added that both her medication and thinking through her behaviours have

helped her to cope. Elaine remarked upon her motivation, noting that being excessively hard on herself has led to her losing motivation quite quickly, such as putting great effort into an assignment, but not achieving the desired mark. She has adopted positive thinking, and she has tried to mitigate pressure and anxiety by trying her best and, recently, by talking herself through situations and remaining calm. She added that in the past, depression, anxiety, and placing great significance on insignificant problems were among other weaknesses, but she acknowledged that she has come to deal with these over the passage of time.

A typical day

Participants revealed a variety of similar characteristics, for example, Mary, Elaine, Anne, Oliver, and Steve spend excessive amounts of time performing morning rituals, but Mary, Elaine, and Steve also experience difficulties sleeping. Because she is unable to sleep at night, Mary often works at her job until late evening, and then completes school work and watches TV until falling asleep at about 6:00 a.m. From her journal, Elaine he repeatedly checked her alarm prior to taking a test to be held the following morning, therefore she was unable to sleep the entire night. In addition, several times in her journal she noted homework being problematic because of her need to start on the hour, taking from two to seven hours just to start, for example, a final assignment. Steve also has difficulty going to sleep due to worries about arguments or fights with friends that he could, but would probably not, encounter. For Nick and Robin, their daily lives are rather monotonous comparatively, with Nick experiencing continuous worry and Robin admitting that her days are about the same while working and going to school. Nick awakens and he immediately feels stressed and burdened by each day and his anxiety and reluctance to go out increase. He experiences great anxiety every day from incessant worrying about making decisions, and about decisions that he has already made. Robin emphasized that OCD affected her daily life, but she

has grown accustomed to dealing with her symptoms and daily routines. Diurnal patterns of OCD symptoms are addressed more thoroughly in the subsequent chapter.

Others with OCD and those who encounter them

Participants provided a variety of responses in terms of contact that ranged from one extreme to another. Mary had absolutely no interest in direct or indirect contact, while Robin, Anne, and Nick had some contact and read related articles. Elaine, Oliver, and Steve have or have had close relationships with people with OCD or OCD symptoms. Notably, Mary could not recall having had contact with others with OCD and she conveyed her strong disinterest in having such direct contact, or even indirect contact from related articles. This viewpoint may have been influenced by seeing negative portrayals on television. Further, Anne found the online forum at www.healthyplace.com to be particularly comforting and encouraging, as it allowed her to communicate with others when she had no one to talk with. Also, Steve dated a guy with OCD who influenced him in terms of compulsions, for example, he suddenly developed a similar need to check taps. Additionally, Robin, Oliver, and Steve expressed their displeasure about people who claim to have OCD, but have a poor understanding of the disorder.

IPA and participants' comments and clarifications case heading

Considering IPA with its emphasis on the importance of encompassing backgrounds of both participant and researcher, their interactions, and allowing the researcher to critically examine and question the participant interview text, comments and clarifications from the interviews and participant journal data case heading, and final comments are presented in this section as they seem to include all of these salient IPA factors. Questionnaires and interview schedules were developed and/or chosen by the researcher to elicit participants' background information and reflections. He then had the opportunity to examine their responses and elicit further comments and clarifications. Additional comments regarding the questionnaires and journal progress were usually elicited near the beginning of each second interview session. This time provided the researcher with opportunities to further delve into participant responses, and it also provided participants with added opportunities to comment upon the questionnaires and/or elaborate upon their responses. This section analyses participants' responses in terms of initial comments after completing the questionnaires, comments and clarifications from the demographic form, participant journals, additional OCD functions of participants, and participants' final comments.

Initial comments.

Initial comments about the questionnaires ranged from items being vague to straightforward, but also inapplicable. Anne found some items to be quite vague, thus she was unsure about how to respond. Mary saw that a few items were somewhat vague, but they were thorough overall. Elaine asserted that many of the items were straightforward, and she was pleased with the questions relating to the past month, rather than in previous studies where she was only asked about past experiences, such as when OCD symptoms began. Oliver noted that his responses in the SF-36v2 relating to his general health and becoming sick easier than others may be quite shocking as he

knows he is physically in good health, but he has always felt quite susceptible to sickness despite there being no justification for this feeling. Later, he elaborated that he has a habit of spending his life anticipating and worrying about becoming sick and he always feels sick despite having no complaints physically. In terms of the OCI-R, Oliver acknowledged the relationships of the symptoms, and he identified with some more than others. Robin strongly identified with the ordering items from the OCI-R, but she noted that the hoarding items were inapplicable.

Demographic form.

Elaine and Steve provided the most additional insights, while Robin, Anne, and Nick offered fewer, and Mary and Oliver did not have further data to contribute. Elaine remarked upon the uncertainty, concern, worry, and relief related to her formal OCD diagnosis and that she and her roommate share similar experiences as they support and encourage each other. Regarding superstition with numbers, she noted that with increased stress from relationship conflicts or work, her repetitive behaviours increase in frequency. Further, her use of alcohol and a recreational drug has lessened compared to the year before. Steve explained the obsession related to his health as although he feels in good health, he may hear about or think about pain and then research this pain online. He noted these external triggers cause him to internalize them to believe that he is sick and this process then interacts with his OCD. As for depression and OCD, he added that after a bout of depression, OCD returns with much greater strength. He found his CBT for depression to be much easier than for OCD because it just involved talking, whereas he was expected to talk and really *go against* his typical OCD behaviours. After 17 weeks, his depression became insignificant, but his OCD remained the same. He was unsure about why he values good luck, perhaps related to an earlier interest in numerology, but he figured that it serves to provide some control over having good days and bad days. He recalled good luck being important for as long as he can remember,

and even all throughout high school, with his avoidance of stepping on sidewalk cracks and using handicapped doors for instance. Regarding social relationships, Steve lived with his parents during his adolescence, and siblings for part of this time. Subsequently, he lived alone for 2 years and noticed that his OCD was much stronger, especially before going to bed, such as turning off lights in a specific order, listening to a certain number of songs, and setting and checking his morning alarm. Living with roommates, however, has since distracted him slightly from these compulsions.

Robin noted that both her compulsive counting and fear of germs have been present for about the past 10 years. Further, she expanded upon her repeating and impulsive speaking that she reported doing over the previous 4 years. She saw these as being annoying, rather than being stressful, and consuming a great deal of time and occurring frequently. Others also became annoyed with her as they felt she would not stop talking, but they failed to realize that she could not stop until feeling *just right*. She added that such a process, usually in a conversation, involves very insignificant matters, but this information must be corrected and/or repeated at least in a whisper for her to eventually arrive at feeling of *just right*. She guessed that her feeling of discomfort is related to an issue of the degree of truth in the utterance, rather than outright lies that she has no trouble telling. Anne estimated that her self-diagnosis took place at about age 12 and it was later confirmed by her psychologist at age 17. Her family doctor later prescribed medication. Anne expressed her great dissatisfaction being on Paxil for about 3 or 4 years, as there were no significant improvements and several negative side effects. She added that caffeine also has affected her, but only from around the middle of her university studies. In terms of social relationships and experiences, she confirmed that she has lived with her family for most of her life, but she has also lived alone, with other students, and with a roommate while attending university. Further, her brief experience in a service-oriented job surprised her because she seemed to be

well-suited to this job despite her usual difficulty coping in social settings. Nick clarified that he was first admitted to hospital for psychiatric treatment in 1998, and then 3 years later, he was treated by a different psychiatrist. Due to these troubling times, however, he was unsure about the dates and types of medication prescribed. He listed the names of several medications, including three SSRIs and one antipsychotic drug. He also recalled a period of alcohol abuse from about 2003 to 2005.

Participant journals.

It is important to stress that journal entries were subject to the awareness of respective participants, thus as Mary, Oliver, and Nick noted, OCD symptoms may have occurred, but they may not have been recognized or recalled and therefore not recorded. Similarly, as Steve emphasized, the number of times experiences occurred in his journal would not necessarily relate to their actual frequency, but merely represent times they were recorded. Gaps in journal writing and recorded periods of time varied in all journals. Oliver wrote almost every day, but he had gaps in writing due to serious OCD relapses, with the longest gap of about a month. Anne also had gaps in her journal writing, with three entries between September 30 and November 7 inclusive. Nick wrote almost every day for about two weeks, while Elaine wrote almost every other day for about three weeks. Steve wrote almost every day for about a month, but he missed a few days due to depression.

Further, a variety of main symptoms were reported. Anne and Oliver had common symptoms of regret, worry, and contamination, while Nick, Elaine, and Steve had repetition in common. Anne noted main symptoms of regret, worry, contamination, ordering, doubt, panic and frustration. Oliver described contamination, reflection, regret, high anxiety/stress, worry, and uncertainty. In addition, when he submitted his journal, he told the researcher that he recorded

journal entries at the end of each day and he wrote about 5 significant OCD-related experiences, although he may have had about 50 OCD-related experiences throughout each day. Also, he recalled that it was difficult to focus on OCD-related experiences because these had become quite natural and therefore they were not always easy to notice and, therefore, express.

Nick reported main symptoms of checking, repetition, discomfort, and uncertainty. He confirmed that he recorded the most salient, daily experiences that he could recall, citing a recent meeting with his academic advisor that involved Nick repeatedly asking her to clarify herself so that he could ensure that he heard her repeated clarifications correctly, eliminating any possibility of misunderstanding her (see also Nick's journal entry of November 15). For Elaine, salient symptoms were repeated actions and *just right*. Steve reported main symptoms involving luck, *just right*, regret, discomfort, repetition, and depression.

Additional OCD functions of participants.

These additional functions (see Appendix L) were deemed to be more suitable as supplemental to the individual cases in the chapter V. They comprise quotes from Robin, Anne, Mary, Oliver, and Nick. Regarding OCD diagnosis, recommendations, and treatment, Oliver added that his list of fears from his exposure therapy was rather daunting initially, but they gradually became insignificant as he progressed. In terms of experiences, beliefs, feelings, and relationships, Anne and Nick related their great social discomfort at school, with Anne expressing concern about how others may perceive her while she takes notes in lectures and what may go wrong in front of others as she writes exams. Nick described his extreme mental and physical distress also while taking notes in lectures, with worries about not keeping pace with his classmates, and trying to cope with his need to take accurate notes while at the same time realizing that he is missing parts of the lecture. Oliver conveyed his frustration about needing to spend 2 hours performing rituals in

the morning, but he also acknowledged that these mitigated anxiety and so they must continue. He also described how his fears with contamination were much more pronounced at home than out in society. Contamination from public bathrooms, doorknobs, and feeling less in control from street lights going out were expressed as concerns for the latter context. Further, he noted his surprise that people have never suspected him of having OCD, despite his shy and *stand-offish* demeanor.

Considering goals, challenges, changes, and persistence, Mary, Oliver, and Nick described a variety of goals and challenges. Mary explained that she was unable to obtain a second reference letter probably due to her absence from school for an academic year. After obtaining permission from many doctors, however, she was still unable to recoup her tuition. She spent her absence working at a store, which prompted her to continue working toward a degree and further, to strive to reach her goal of employment that involved helping others. She does not consider her OCD to be severe, but she admitted that intrusive thoughts to perform things twice or even four times continue to be challenging. Oliver figured that his greatest challenge has likely been with his OCD, but he has come to understand how he experiences it, how he has improved with therapy, and how he can cope through his persistence in managing OCD. Nick has recurrent doubts and disappointments, but he continues to persist in his studies toward graduation, with some hope of life eventually improving.

With respect to strengths, weaknesses, and coping strategies, Robin, Anne, and Nick discussed frustrations encountered while coping in their day-to-day lives. Robin commented on typing, writing, and reading. While using her laptop in lectures, she noted specific steps that must be followed, such as when underlining, adding bullets, and back spacing. These also must be carried out until she feels just right about them, which could result in repetitions of up to about three times and missing parts of lectures. When using writing implements, Robin described

frustrations about not being able to always produce clear writing, with pens sometimes not distributing ink evenly, and writing with drafting pencils that are so *ugly* and smear easily. When reading, she described excessive highlighting to improve her concentration and due to doubts concerning her retention of the material. She also noted highlighting parts which may or may not be important to remember. In addition, Anne discussed personal writing, with using cryptic notes of encouragement on her bulletin board that only she could understand. Frustration arose because her encouragement and her own advice to think logically became redundant and lacked originality. As with Robin, Nick also expressed great distress from doubting, for example, from purchasing a suit and regretting that he did not carefully consider the entire process.

For comments and clarifications related to the questionnaires, Robin added that with her impulsive speaking, she attempts to mask her repetitive utterances by feigning distraction and she expressed her frustration about sometimes taking an inordinate amount of time to express herself.

For a typical day, Oliver and Nick expressed additional doubts. Oliver noted that if his hands did not seem to be clean enough, more aggressive washing was undertaken, even when his skin became quite irritated. With Nick, every decision is accompanied by excessive worry and doubt, from simple tasks such as choosing what to eat to conveying thoughts to a psychiatrist. Considering advice for fellow students with OCD, Mary stressed the great importance of vigilance when taking medication, despite all of the side effects.

Final comments.

The purpose of the final interview question was to provide an opportunity for participants to contribute additional thoughts that they deemed to be important. This question was also the researcher's last opportunity to digitally record their interview data and his sole opportunity to gauge their level of comfort after having nearly completed the interview sessions. Their level of

comfort was of particular interest to the researcher as it directly related to the study ethics approval and the often embarrassing and secretive nature of OCD. Robin, Oliver, and Elaine offered salient personal anecdotes from the study. Robin expressed her frustration about OCD being worse than anorexia, as judging from their appearance, anorexics just need to be told to eat, but those with OCD are only impaired cognitively and not visibly. Further, she noted her frustration about having insight that allows her to realize that outcomes will not be bad if she does not act upon her OCD thoughts, and she expressed even greater frustration about not being able to rid herself of these OCD thoughts. Robin saw that life events she discussed in the interviews may have had a more significant impact upon her than she realized previously. Oliver remarked upon his regret for not being able to participate in the study much earlier in the year, as his OCD was profoundly more severe at that time. He stressed that people with OCD can learn to cope and this disorder should not be considered as a *prison*, despite the thought that symptoms can become much worse unexpectedly. Elaine reflected upon negative and positive experiences, noting that regretting less, and appreciating even the smallest accomplishments more, will lead to better progress and greater appreciation and enjoyment in life. As for their participation in this study, Robin, Anne, and Steve expressed interest in the study findings, with Anne also iterating her curiosity about why I would want to conduct this kind of OCD research. Mary, Oliver, and Elaine emphasized that their experience had been positive, while Nick stressed the importance of educational institutions acting upon the participant recommendations in order to help students such as himself.

Secondary data.***Interview notes.***

During the 14 interviews, participants exhibited a wide range of verbal and nonverbal characteristics. These comprised talking very quickly, talking slowly with frequent pauses of about

5 to 15 seconds, and also talking at a regular conversational pace, but with occasional pauses of about 5 to 15 seconds. These characteristics may have occurred, in the former instance, due to the nature of the participant's speech and/or the disclosure of such personal information, whereas the latter instances may have functioned to indicate a request for clarification, or they may have occurred due to the time needed to reflect, recall, and recount information. In addition, there was frequent doodling with little eye contact throughout an interview, frequent hair twirling throughout an interview, and keeping one hand in a jacket pocket for long periods of time throughout both interviews. These characteristics may have been due to feelings of common uneasiness with personal interviews, or more significantly, related to OCD compulsions. Further, during both interviews, occasional facial tics were exhibited that were not meant to be noticed by the researcher. Perhaps these tics were related to the common comorbid disorder GTS, or they were the result of a skin condition. I also noted that due to such very rapid speech or slow speech combined with frequent pauses, interview length did not necessarily reflect the quantity of data conveyed. Moreover, I did not ask some questions due to the apparent emotional discomfort of a few participants, for example, question 14 that asks participants to describe some negative experiences that have been influential and could be related to OCD. It is worth noting that ascribing a specific meaning to nonverbal communication, such as a wink, has been shown to be very difficult as many meanings are possible (Adler, Rolls, Proctor, & Towne, 2009). It is with this ambiguity in mind that the researcher interpreted his interview notes. Similarly, using IPA involves interpretations "presented as possible readings" (Smith et al., 2009, p. 181), thus these data may also be ambiguous at times.

Fieldwork journal.

The researcher's fieldwork journal covered the period from the first day of participant recruitment to the end of the data collection (see Appendix J for complete fieldwork journal). Emotion, and rapport and responses are two themes that could characterize the aggregate interactions recorded. In terms of emotion, my first interview with Oliver was the most emotional interview among all of the participant interviews, including all eight interviews from my pilot study. While he expressed his feelings and experiences, his eyes began to water a little and I felt mine do the same, perhaps because I recognized very similar OCD-related experiences that we had in common. Considering rapport and responses, all participants were quite friendly and open and willing to provide adequate responses to all or most of my questions, with Robin being the only participant to ask me about how much of her life she should disclose. Surprisingly, Anne was quite open despite admitting that she was very uncomfortable in a variety of social situations and "RIDICULOUSLY shy" (line 679). She had the second-longest total interview time, and she also laughed the most out of all the participants, perhaps due to some uneasiness or maybe due to her view that it is fine to laugh and accept the way she is. Several times, Mary and Elaine provided shorter responses when compared to the others, possibly due to secrecy and/or Mary being very busy and not sleeping, and Elaine acknowledging that her public and private lives were quite different. Elaine, however, was the only participant to modify some of her responses, despite the researcher never requesting or even mentioning such a procedure. Nick had the longest aggregate interview time at about 150 minutes, or 20 minutes longer than Anne, possibly due to the influence of his weekly psychiatric appointments. Thus, his responses were unique in that many seemed to have been rehearsed, but some seemed to have been a change of pace.

Chapter summary

Analyses highlighted the seven cases in relation to each other. Primary and secondary data showed a wide variety of characteristics. Notable primary data analyses included OCD and its impact upon QoL, where findings varied greatly. In the past for instance, Robin, Oliver, and Nick seem to have had the most difficulty, while currently, Mary was the only participant taking medication to maintain her QoL and Elaine was the only participant to practice breathing exercises, yoga, and meditation. Nick, however, found his weekly visits with a psychiatrist to have been of no help and Robin and Steve seemed to favour self-reliance. Further, contact with others related to OCD ranged from one extreme to another as Mary had absolutely no interest in direct or indirect contact, Robin, Anne, and Nick had some contact and read related articles, and Elaine, Oliver, and Steve have or have had close relationships with people with OCD or OCD symptoms. Notable secondary data analysis included occasional facial tics exhibited that were not meant to be noticed by the researcher, recorded in the interview notes, and the very emotional interview with Oliver from the fieldwork journal.

It is important to acknowledge that the data elicited from participant interviews are *limited*, as their lives continue, while these data about them are *framed and reified* by the researcher (Seidman, 2006). More positively, Seidman note that in-depth interviewing fosters insights related to individual experiences and “interconnections among people who live and work in a shared context” (p. 130). Analyses within this chapter yielded interconnections among these students who provided a wide range of data, mostly through in-depth interviewing exemplified in the Findings chapter.

Chapter VI: Discussion and Conclusions

This final chapter begins with a review of the present study, focusing on its methodology. It then addresses the three research questions in terms of the findings, conceptual framework, and related literature. A related section on IPA, participants' comments and clarifications case heading, secondary data follows. Next, the study contributions to knowledge, theory, method, policy and practice are presented, including participants' recommendations. The remaining sections are study limitations, paths for future research, and the researcher's concluding remarks.

Review of the present study

The researcher recruited post-secondary students diagnosed with primary OCD in order to explore their educational and other social experiences and relationships in addition to their quality of life. After nearly seven months, the recruiting process yielded seven university students, but no community college students despite the finding that such students tended to be much more open about their OCD diagnosis and treatment and they seemed to be more in need of mental health guidance at school where comparatively less information was available. Three primary lenses were used to collect and present the participant data, namely, Seidman's interviewing as qualitative research, an adaptation of Tinto's Longitudinal Model of Institutional Departure, and IPA. In terms of primary data collection, these seven students participated in two, face-to-face interviews with the researcher and they also completed three, self-report questionnaires related to demographic information, OCD symptoms, and quality of life factors. In addition, five participants submitted self-report journals that documented their respective daily experiences over a period of about one month. Secondary data collection comprised the researcher's interview notes and fieldwork journal. The data analysis path took readers from the interview transcription process through to the analysis of the primary and secondary data. The researcher's perspectives and pilot study were described in

keeping with IPA and to provide insight concerning the extent of the researcher's involvement and interest in OCD. The trustworthiness of the study was then addressed using the guidance of Seidman (2006, 2013), and Smith et al. (2009), and data related to the OCI-R. Participant vignettes served to familiarize readers by briefly describing participants' respective family and school relationships and their main OCD symptoms according to the OCI-R and their self-report journals. With its six chapters, list of references, and 15 appendices, the present study showed a variety of specific OCD functional impairment and quality of life aspects, that social integration seemed to play a lesser role in persistence than did intellectual integration, and similarity with university policy and practice recommendations from about a decade ago. It is important to note that the recruitment of college students may have led to a contrary finding in terms of academic persistence. Social integration may have been stronger than intellectual integration among college students due to the shorter length of their post-secondary programs and the resulting need to establish social contacts for employment earlier than their university counterparts.

Addressing the research questions

As noted in the introduction, the researcher's three primary lenses were instrumental in developing the three research questions that were informed by the primary and secondary data collection in the present study. These data were then presented in findings (chapter IV) and inter-case analysis (chapter V) in order to address the research questions. More specifically, research question one is addressed by the headings Experiences, Beliefs, Feelings, Relationships, and Goals, Challenges, Changes, Persistence with a focus on Figure 1 and OCD onset and symptoms. Research question two initially focused on any meanings participants could attribute to their respective experiences and relationships. When they were asked, however, to consider any general or specific meanings connected to their responses, or anything of related significance,

participant responses consisted of long pauses, repeated requests for clarifications, and very brief replies. Notably, Mary did not believe in significant meaning, and Oliver, who majored in psychology, admitted he could not really respond to meaning. Interview rapport then returned to normal after the researcher asked participants to reflect upon their responses and discuss any thoughts or understanding. As a result, the second research question was reframed with a focus on conveying participants' perspectives using the headings Strengths, weaknesses, and coping strategies and Seeking help: Healthcare professionals and substance abuse/suicide risk/self-mutilation. Research question three was addressed by using data from the headings Analysis of QoL and SF-36v2 mental and physical health/Comments and clarifications, A Typical Day, Analysis of OCD symptom distress (OCI-R)/Comments and clarifications, and Others with OCD and those who encounter them. In addition, seeing that IPA is multifaceted and it was very influential in the present study, a discussion of IPA with participants' comments and clarifications case heading data from chapter V and the secondary data follows the research question responses.

Research question one: With respect to past, present, and future contexts, what are the characteristics of participants' educational and social experiences and relationships?

Participants' characteristics and OCD symptoms in the past.

Considering the past, or mainly pre-entry components and related commitments from Figure 1, it can be seen that OCD onset and symptom progression were often very influential. Mary had positive familial relationships as mental health problems were common along with empathy, and her outside relationships were mostly positive. The death of her sibling, however, made her feel different from her peers and led to about a five-year process that resulted in an OCD diagnosis and a helpful medication. She stressed failing high school math 3 times and just missing a university scholarship due to her problem with numbers from OCD. Similarly, Elaine's family also had mental health problems and empathy, but her OCD always caused her to be secretive with her friends because of the difficulty they had in understanding her disorder. With the help of her therapy, Elaine discovered new methods of coping with her problems and she continued to make steady progress with the aid of the relationships with her high school teachers. For family and school life, Oliver seemed to have enjoyed his life the most, and the time around his clinical diagnosis in his late 20s was much more negatively impacted by OCD. Similarly during her early years, Anne mainly communicated with her immediate family, but she later developed good relationships with her teachers and classmates. With high school, her siblings encouraged her to overcome her extreme shyness and she eventually adjusted along with help from a psychologist for her OCD. Despite her challenges, especially related to explaining OCD to her parents and friends, Anne noted that she has worked toward her goals by aiming to do well throughout school. The changes in her contamination obsession have been puzzling, as grades 7 to 11 involved frequent and lengthy hand washing along with skin irritation, but for about the past five years,

she has not needed to focus on this obsession and she does not understand this significant change. Growing up, Nick had strained familial relationships with pressure from his parents and himself to perform beyond his best efforts, but he had good relationships with his teachers and he enjoyed his life until OCD onset and clinical diagnosis as a young teenager. Similarly, Robin had strained familial and outside relationships, but she did have closeness with her mother and a variety of positive outside relationships in addition to many negative events surrounding her OCD onset and clinical diagnosis also as a young teenager. Steve also had positive familial experiences and a closeness to his mother until his admission of homosexuality in his first year at university. He had academic and social success despite the strong influences of OCD and clinical diagnosis in his early 20s. Such OCD influences, often strongly impacting experiences, beliefs, feelings, and relationships, are congruent with related literature (e.g., American Psychiatric Association, 2013; Karno et al., 1988 (as cited in Mathews, Jang, Hami, & Stein, 2004, p. 78); Rodriguez-Salgado et al., 2006).

Participants' characteristics and OCD symptoms in the present.

Regarding the present, or mainly post-secondary components, integration, and related commitments, the experiences, beliefs, feelings, relationships, and OCD symptoms were diverse. Steve stood out as all characteristics seemed to be very prominent and/or positive, with his OCD symptoms in no need of change. Despite the importance of his social life and recreational drug use, he remains quite involved with experiences and relationships at work, school, his home, and with his family. Similarly, Oliver noted positive experiences and relationships, especially always having many friends, but he did express difficulties in his program, resistance to becoming emotionally close with peers, and recently journaled that everything surrounding him was crumbling. Oliver persists as he believes a better opportunity awaits, but such an opportunity has yet to present itself.

Elaine was experiencing improved academic success and anxiety management, but she still withdrew from present academic, employment, and other social situations due to her excessive symptoms and sensitivity. Robin, Mary, and Anne's characteristics could be considered relatively moderate in prominence as they currently have some close friends, and moderate success with experiences and relationships along with some related negative factors, such as those from OCD.

Participants' goals, challenges, changes, and persistence as university students

All participants were working toward the goal of graduation and they also considered transfer and withdrawal at least once during their university education. After returning from her academic leave of absence, Robin's persistence derived mainly from her boyfriend, as he has encouraged her to graduate and then pursue employment in her chosen field. An additional factor in her strong persistence, however, has been her OCD that has helped her set and meet goals. Now she can control her once very physically violent impulses by talking instead of taking physical action. Mary's academic leave of absence had a negative effect as it prevented her from getting a second recommendation needed to volunteer abroad. She acknowledged that not completing her degree will leave her trapped in a low-paying job, therefore earning a degree was a priority not only for eventual financial gain, but also for the higher social status, such as having a graduate degree like each of her parents. Anne experienced the most difficulty with persistence at the beginning and now at the end of her program. She considered dropping out while in her first year due to her university experience being beyond her expectations. Nearing the completion of her studies, however, her greatly debilitating OCD brought her to the point of strongly considering another break from school. After carefully considering that her parents would fervently disapprove of this break, she decided to remain in school, with a new roommate helping to reduce her stress. Nick continues to have serious doubts and struggles academically and socially. He has difficulty

working with his classmates because of his need to feel comfortable in implementing his own ways of thinking and he has developed a greater reliance on god for comfort as his psychiatrist has been of no help. He seemed to have the most difficulty moving through each day as he just continued along his current path despite his lack of enjoyment in life and no treatment approaches that have helped. He persists due to the influences from his family and friends and a glimmer of hope. In terms of the future, or related commitments and outcome, most participants seemed to be advancing despite their strong and moderate OCD challenges, with Robin, Mary, Elaine, and Steve quite motivated and looking forward to the completion of their degrees and continuing with new experiences, and Oliver still motivated to graduate, but less certain about his future.

Participants' persistence in relation to Figure 1

Considering present and future time periods, it was not surprising that most participants illustrated strong influences of OCD upon persistence, but they also seemed to indicate that social integration played a lesser role in persistence compared to intellectual integration. To iterate the context and function of persistence in the present study, Tinto (1993) argued that “interactive experiences which further one’s social and intellectual integration are seen to enhance the likelihood that the individual will persist within the institution until degree completion, because of the...continued reformulation of individual goals and commitments” (p. 116). Social integration seemed to be rather difficult for Anne and Elaine, and especially for Nick, while Robin relied most upon her boyfriend’s motivation for persistence without a strong need to integrate socially. Oliver admitted that he has many friends in his program, but they were not people that he sincerely enjoyed being with. Mary chuckled about being far too busy to join campus organizations due to her job, school, and other things like trying to get adequate sleep. She added that there have been periods of going a month up to a year without seeing close friends. Steve seemed to be the only

participant who thrived upon social integration. Participants' intellectual goals and commitments seemed to figure more prominently in persistence, as all participants were working toward or near completion of a first or second university degree. Notably, Oliver asserted that he has studied to attain his long-held goal of becoming a member of this highly-competitive profession, and Elaine was determined to complete her degree as she has been highly influenced by her goal board and her fear of failure to graduate.

Perhaps one of the most recent and supportive studies of the experience and relationship data described above comes from Wyatt and Oswalt (2013) who analysed quantitative data from a national assessment survey to study mental health issues among 27,387 undergraduate and graduate/professional students from 55 universities throughout the United States. They emphasized what is "inherent in all quantitative studies-the absence of context for participants' responses" (p. 105) and the great importance that such data would have upon contributing to the understanding of mental health issues and stress within this student population. Based on their research, they advised that mental health services should be widely publicized at universities, with a focus on undergraduates, in order to potentially see improved *retention* and *academic performance*. The present OCD study has addressed this absence of context by contributing contextualized accounts from five undergraduate students and two students near the completion of a professional school program. Although the sample size was modest, it has advanced the understanding of this population through the use of a variety of qualitative data collection tools.

Similarly, Kisely & Kendall (2011) urged psychiatrists to note that qualitative studies can make a significant contribution toward those with mental health disorders. They can "improve our understanding of patient experiences and the process of therapy, facilitate engagement and partnership between researchers and participants, and promote action for change" (p. 367).

With its qualitative approach, an aim of this present study was to improve readers' understanding of student experiences with OCD and inform them through related recommendations.

Research question two (reframed): What were participants' perspectives related to their strengths, weaknesses, and coping strategies?

Strengths.

In terms of strengths related to OCD, Oliver, Robin, Mary, and Steve emphasized positive attributes. Oliver noted that OCD can increase attention to detail and cleanliness, and also the ability to retain information and keep life on track. Robin stressed that once she begins to read something, she must finish reading it even if she becomes sleepy, and OCD has helped her generally by making her complete other tasks that she has started. Further, Mary mentioned that OCD helped her with proofreading, and similarly, Steve acknowledged that his perfectionism has pushed him to check essays more than typical students, thus helping him to be much more careful and thorough. More generally, Oliver and Steve seemed to be the strongest both academically and socially throughout their lives coping with OCD. Oliver noted excelling in his academic work, athletics, and his ability to make and retain many friendships, while Steve noted his academic strengths from elementary school to about his third year of university, broad social ties, and his strong adaptability in a variety of situations. Similar to Oliver, Nick also figured that he has the intellectual capability to handle academic work in his highly-competitive professional program.

Weaknesses.

In terms of weaknesses related to OCD, Nick has struggled a great deal academically and socially and he admitted to being quite ill internally while living alone, but he is able to function adequately in keeping with the study already noted (Stein et al., 2000). Similarly, Anne has struggled a great deal due to her extreme shyness at university, especially with voicing her

opinions and merely sitting in class, resulting in poor grades. She perceived that OCD worsens in class due to nervousness about drawing attention to herself, resulting in unhappiness and severe discomfort. Weaknesses to a lesser extent were found among the other participants, as Robin acknowledged ending friendships too abruptly, Mary noted her weakness with math, Oliver described his extreme shyness and general nervousness, Elaine remarked upon being excessively hard on herself thus leading to rapid loss in motivation, and placing great significance on insignificant problems, and Steve noted that perfectionism and OCD have prevented him from participating fully in some social situations. These weaknesses are characteristic of those with OCD, who often experience extreme impairment in a variety of areas, such as education, employment, and social situations (e.g., Abramowitz, Brigidi, & Roche, 2001; American Psychiatric Association, 2013).

Coping strategies.

A variety of internal and external coping strategies were elicited. With respect to internal factors, Steve explained that his adaptability has always served him well in a variety of stressful situations. Oliver judged that he focuses upon and controls aspects of his life to ensure that no problems follow. Elaine has found counselling to be helpful, along with her additional coping methods of breathing exercises, yoga, and meditation that she has taken up over the years. She has adopted positive thinking, and she has tried to mitigate pressure and anxiety by trying her best and, recently, by talking herself through situations and remaining calm. Similarly, Anne noted that a positive outcome from her therapy has been that she has become more effective at suppressing urges to carry out OCD-related behaviours. She also acknowledged the importance of humour and being able to laugh at oneself. Perhaps Nick has had the most difficulty while coping internally, as he identified his only coping mechanism as giving up, but he noted that this option

has offered only some relief as the same thought processes return. Robin and Mary have focused more on external strategies, with Robin manipulating classmates and approaching others for help, such as her mother, boyfriend, or best friend rather than coping alone. Similarly, Mary has coped by keeping busy with activities such as listening to music, going to concerts, the gym, but also relying on her medication and thinking through her behaviours. Robin and Mary were also the only two participants to take a leave of absence from their university studies. These illness management strategies are congruent with Weiner (1997), such as monitoring stress levels, adhering to medication, communicating with friends and family, yoga, use of humour, and taking an academic leave of absence.

Seeking help: Healthcare professionals and substance abuse/suicide risk/self-mutilation.

All participants sought help for their OCD symptoms, but this process was more difficult for some than others. Further, some participants turned to substance abuse, attempted suicide, or self-mutilation, possibly as coping methods. Among the seven participants, Anne and Nick seemed to be the most distressed in terms of seeking help for their OCD. For about five years before her clinical diagnosis at age 17, Anne struggled a great deal as a result of her unsupportive parents and her worsening symptoms. A very troubling experience with a family doctor finally led to her OCD diagnosis by a much kinder healthcare professional. As a young teenager, Nick struggled with OCD-related experiences for several years before his first mental breakdown and then clinical diagnosis at about age 15 or 16. His mother took him to the family doctor who prescribed an antidepressant that led to a suicide attempt and hospitalization as an in-patient. Therapy sessions led to his initial diagnoses of OCD and depression. Subsequent alcohol abuse from about 2003 to 2005 and a variety of medications and other treatments have left Nick still looking for help as OCD has not permitted him to have adequate *time, strength, or courage* to work through the

problems in his life. Elaine and Steve have also engaged in substance abuse. Elaine's use of alcohol and a recreational drug has lessened compared to the year before her interviews took place, but Steve expressed his boredom with university for about the previous year and a half caused by a great deal of recreational drug use. Robin was the only one who resorted to self-mutilation. She revealed that she cut herself to feel better and to seek a release during a very difficult period.

In terms of related literature, Verger et al. (2010) studied psychiatric diagnoses among university students and they found that just over 30% of 964 first-year university students in France sought help for their psychiatric disorder from a family doctor or mental healthcare professional, or both, in the past year. Their reluctance to seek help was possibly due to, for example, stigma or poor treatment efficiency. Five participants in the present study were clinically diagnosed prior to university, with Oliver and Steve being the only participants to have received their clinical OCD diagnosis while attending university. This result is the inverse of the French study. As for students' substance abuse, Verger et al. also acknowledged increased stress levels associated with students who earn extra money through employment, thus potentially leading to the use of psychoactive substances in order to cope. Robin, Mary, Oliver, Elaine, and Steve maintained employment during their studies, but only Elaine and Steve were also involved in recent and current substance abuse at university. For Elaine, her academic performance has improved compared to the previous year, while Steve has recently been more focused on his social life than academics.

Suicidality in OCD has not been widely studied, as Torres et al. (2011) could find only two studies with a specific focus on suicidality in OCD. Consequently, they investigated six components of suicidal behavior and thoughts with 582 primary OCD outpatients. They found, for example, that "suicidal behaviors are relatively common among OCD patients" (p. 24) and

that 36% experienced suicidal thoughts, while 11% had attempted suicide. They emphasized the need for additional research, such as using qualitative studies to advance the understanding of “the precise reasons, mechanisms, and pathways by which OCD leads to suicidal behaviors” (p. 24). They also emphasized the need for assessing *risk identification* by “direct inquiry concerning suicidal ideation and plans, since most OCD patients may not spontaneously report them” (p. 24). In the present study, Nick, with the possible inclusion of Robin, fell within this 36% which is similar to the finding from Torres et al., and Nick’s attempted suicide is also similar to their finding of 11%. Further, the qualitative data from Nick and Robin in the present study have perhaps served to advance the understanding they advocated. Their assessment recommendation is also comparable to the advice offered by participants. Interestingly, these percentages are much higher in the DSM-5 (American Psychiatric Association, 2013). For the risk of suicide, attempts reportedly occur in about a quarter of those with OCD, while suicidal thoughts are prevalent in about one half. More recently, in their study of risk factors linked to self-injury from over 16,000 undergraduates, Taliaferro and Muehlenkamp (2015) found that students diagnosed and/or treated for disorders, such as OCD, had an elevated risk of self-injury or attempting suicide and such students may try to cope by engaging, for instance, in substance abuse. They advocated for “screenings and dissemination of information...(to)...proactively identify students most in need of mental health services and facilitate access to care, reducing suicide risk” (p. 46). This recommendation is also comparable to the advice offered by participants in the present study.

Research question three: In general, and with respect to OCD, what are the characteristics of participants' quality of life?

The SF-36v2 used to measure participants' general QoL showed that physical health (physical functioning, role physical, and bodily pain) was limited minimally or not at all, but the other measures of general health, and mental health (vitality, social functioning, role-emotional, and general mental health) showed greater variation. General health ranged from poor to very good, but getting sick somewhat easier than others was *mostly true* to *definitely true* for five participants, with Robin and Nick responding *definitely false*. Nick perhaps misread the item as he was the only one to indicate his general health as *poor*. As for health being excellent, four participants indicated *don't know*, with Elaine indicating *mostly false* and Nick indicating *definitely false*. Oliver was the only participant who indicate *mostly true*. For mental health results, general mental health item responses were often quite negative, as five participants responded to being very nervous *most* or *all of the time* and four participants being calm and peaceful *none of the time*. Similar negative results characterized vitality, social functioning, and role-emotional. It was surprising that items may have been interpreted differently. For Elaine and Steve, *tired* was interpreted as relating to sleep, but *worn out* relating to lack of energy and ability to concentrate. Robin associated *tired* with the need to sleep, but *worn out* with a lack of time to relax.

These general QoL results above are congruent with research that has linked QoL and OCD. From an archive sample of 102 adults with primary OCD, Speisman (2012) studied QoL and found OCD to have negatively influenced emotional and general health, and also social functioning, but not physical health. She reported that this result was comparable to past studies. When focusing more closely on the daily lives of adults with OCD, however, results from the present study differed from recent research. In his study of diurnal symptom patterns among 15 adults with

primary OCD, Nota (2013) found that OCD symptoms more often occurred midday, with fluctuations in occurrence possibly due to, for example, physiological rhythms and social environment. In the present study, OCD symptoms more often occurred in the morning with fluctuations due to sleeplessness and social settings. Mary, Elaine, Anne, Oliver, and Steve spent excessive amounts of time performing morning rituals. Merely deciding upon what socks to wear, for instance, took Anne about 10 minutes and Steve about 15 minutes. For Nick and Robin, their daily lives seemed to be rather monotonous comparatively, with Nick experiencing continuous worry and Robin admitting that her days were about the same while working and going to school.

Regarding sleeplessness, Mary, Elaine, and Steve also experienced difficulties. Mary described her inability to sleep at night partly due to annoying behaviours that she must perform before going to bed and when she awakes, such as counting her money for fear of having lost some while sleeping and counting points earned from using credit cards. She also noted that her medication does not allow her to sleep throughout the night, but for only about four hours at a time. From her journal, Elaine repeatedly checked her alarm prior to taking a test to be held the following morning, and therefore she was unable to sleep the entire night. Before going to bed, Steve must listen to a lucky number of songs and he has difficulty going to sleep due to worries about arguments or fights with friends that he could, but would probably not, encounter.

With respect to social settings, all participants experienced OCD symptom fluctuations. Notably, during counselling sessions, Nick needs to recheck that his questions were phrased accurately and counsellors must repeatedly restate their responses after Nick's repetitive questions. Such repeated requests often involve school work, money, and deadlines, and these are also accompanied by extreme discomfort and uncertainty because he again feels that he has missed details expressed in the repeated responses. In addition, when Steve uses public transportation,

he needs to lift his feet while passing over bridges and train tracks, and duck his head while passing under overpasses. He must also find seats that are *just right* in other social settings, such as in restaurants, at friends' homes, and while at work.

Linking OCD symptom distress from the OCI-R and participant journals.

Participant symptom distress levels ranged from *A lot* for Elaine to slightly less than *Moderately* for Robin. Steve rated slightly less than *A lot*, while Oliver and Nick rated between *Moderately* and *A lot*. Anne rated slightly more than *Moderately*, while Mary rated *Moderately*. Regarding most distressful symptoms, Elaine's results showed checking and neutralizing, while Anne's results showed checking and Steve and Mary's results showed neutralizing. The remaining participants had different results, as Oliver indicated washing, Nick indicated obsessing, and Robin indicated ordering. Notable comments and clarifications came from Elaine, Steve, Oliver, and Robin who contributed specific revelations and/or interpretations. With Oliver, for example, some objects needed to be *quarantined* on his floor for a day to a month. It was interesting to find that no participants reported a fear of contaminating others.

Regarding the self-report journals, all participants in the present study agreed to complete this one-month journal that involved monitoring and taking notes about OCD-related experiences and relationships. Such monitoring was advocated by Feske and Chambless (2000) to increase the accuracy of information when compared to interviews and questionnaires that rely on potentially faulty recollections. Similarly, as noted earlier, OCD clients may be able to provide better descriptions of their symptoms while monitoring themselves throughout a usual day since a great deal of obsessions and compulsions are triggered in particular environments (Spengler & Jacobi, 1998). Mary, Oliver, and Nick noted, however, that OCD symptoms may have occurred, but they may not have been recognized or recalled and therefore not recorded. Oliver explained,

for instance, that he recorded journal entries at the end of each day and he wrote about five significant OCD-related experiences, although he may have had about 50 OCD-related experiences throughout each day. Similarly, Steve emphasized that the number of times experiences occurred in his journal would not necessarily relate to their actual frequency, but merely represent times they were recorded. Further, gaps in journal writing and recorded periods of time varied in all journals, but Oliver wrote almost every day when not experiencing serious OCD relapses and Steve wrote almost every day for about a month, but he missed a few days due to depression. In terms of comparing OCD symptomology from the OCI-R and self-report journals, Anne, Oliver, Nick, and Steve had only one main distressful symptom/experience from the OCI-R, but many more were revealed in their journals. Anne's main distressful symptom was checking, but her journal revealed main symptoms of regret, worry, contamination, ordering, doubt, panic and frustration. Washing was Oliver's main distressful symptom, but his journal revealed contamination, reflection, regret, high anxiety/stress, worry, and uncertainty. Obsessing was Nick's main distressful symptom, but his journal revealed main symptoms of checking, repetition, discomfort, and uncertainty. Steve's main distressful symptom was neutralizing, but his journal revealed main symptoms involving luck, just right, regret, discomfort, repetition, and depression. Elaine was the only exception out of the five participants who submitted journals, as she had two most distressful symptoms/experiences, those of checking and neutralizing and these matched the salient symptoms of repeated actions and just right recorded in her journal.

Also of interest is the length of journals, as Elaine had the least amount of words in her journal with 458, followed by Anne with 1493, Nick with 1495, Steve with 1771, and Oliver with a notable 3330 words. Oliver seemed to have the least amount of free time yet he submitted the longest journal. Journal length can be associated with the benefits of journal writing, as

Hiemstra (2001) described personal growth and development, improved self-discovery, problem solving, stress reduction and health benefits, and reflection and critical thinking. In the present study, such benefits were conveyed by participants, notably by Oliver who described about five significant OCD-related experiences each day. Further, Mary explained that her journal was helpful in identifying her OCD-related experiences and she had not realized the extent of these experiences before. In contrast, however, Robin also did not submit a journal, but she expressed difficulty in completing this task. She became so focused on what she was writing that it caused her to dedicate a great deal of attention to her journal.

QoL with OCD: Triggering events, extreme despair/severe symptoms, stigmatization.

Triggering events for OCD onset.

Mary described the death of a sibling occurring around the time her OCD symptoms began and her family having a history of mental health problems. She commented that such an event did not seem to be too probable as a trigger for OCD, but she was advised that this event was the reason for her OCD onset. Oliver noted his germophobic mother as being the cause of his OCD, but he later described vivid memories, since age 11, of instigating moments that were often followed by prolonged bouts of anxiety. At the end of the interviews, however, he considered that the questions posed were at about surface level, thus there seemed to be more key information related to this issue that the researcher was not permitted to access. Nick recalled his OCD-related symptoms beginning in his early teens, but he believed that all of these peaked due to a possible encounter with a family member, resulting in his initial breakdown that included an attempt to take his own life. Robin and Anne did not note a specific triggering event, as they just gradually noticed symptoms. Similarly, Elaine just gradually noticed such symptoms, but she said these led to panic attacks a few years later. As with Mary and Oliver, Elaine also pointed out a related

family history, specifically with parental panic disorder and OCD. Lastly, Steve experienced OCD symptoms as early as grade 3 or 4, but with no specific triggering event. He also noted his brother's anxiety disorders.

Considering a related psychiatric article by Kringlen from 1970 (as cited in Davison, Neale, Blankstein, and Flett, 2005), Davison et al. described OCD onset as frequently occurring after stresses such as problems with family or work, or pregnancy. More recently, Abramowitz (2006) also acknowledged onset as occasionally occurring after pregnancy, but he discounted this conditioning model as stressful or traumatic events seem unlikely to trigger OCD onset. He proposed that OCD likely arises from relationships among environmental, biological, and genetic factors. Having recognized the dearth of such research as it relates to OCD, however, Cromer, Schmidt, and Murphy (2007) studied OCD and hoarding and found a strong link between traumatic life events (TLEs) and the pathogenesis of hoarding from their sample of 180 patients with OCD. This link was strongest with respect to the compulsive hoarding component of *debilitating clutter*, while also considering discarding difficulty and the other component termed *acquisition*. Considering the results from the OCI-R, both Mary and Steve responded *A lot* to all three hoarding items, while Nick responded *A lot*, *Moderately*, and *Extremely*, suggesting that the TLEs of Mary and Nick could be linked to their high distress levels within hoarding.

Extreme despair and severe symptoms.

Robin, Oliver, and Nick seem to have had the most difficulty in dealing with OCD and its impact on their QoL, as experiences of very extreme despair were revealed. Robin explained that from all aspects, her QoL was so terrible that she resorted to self-mutilation for a period of about two months. Cutting herself made her feel better as it served as a form of release. In his journal, Oliver wrote while he experienced a panic attack. He described that everything around

him was crumbling, extreme fear was becoming real, and wanting to cry and return to a time when his life was worth living. A few sentences later, he clarified that this time was better than death, but nowhere close to the general perception of living a life. He added that he then had to turn to the next problem that would be much more serious and likely destroy his life. Nick attempted to take his own life shortly after taking an antidepressant, and he explained that since his OCD peaked at about age 15 or 16, he has been unable to relax and everything in his life has been disappointing.

As noted earlier, however, people with severe OCD symptoms may still be able to lead fulfilling lives (Stein et al., 2000) and the present study showed related examples. Both Oliver and Nick had overall distress levels of between *Moderately* and *A lot* on the OCI-R, yet they were both pursuing their second university degree and both were close to becoming members of a highly-regarded and highly-competitive profession. Steve rated slightly less than *A lot*, yet he also was close to completing a degree with hopes of pursuing a master's degree and remaining ambitious and socially active. Elaine had the highest overall distress level with *A lot*, yet she too had been able to follow her goals in spite of her OCD, with hopes of possibly working for the government, obtaining a master's degree, or going to law school.

Stigmatization.

As editor of his second edition on disability studies, Davis (2006) described this burgeoning field, with newly formed branches such as affective and cognitive disabilities and genetics. He included a number of prominent articles related to stigma from a variety of perspectives, for example, from academic and activist viewpoints. Interestingly, Davis also stressed that this field has become filled with such complexities that its very definition is in question. This situation is quite similar to the heterogeneity of OCD symptoms, where each participant had differing points of view and/or experiences involving OCD. Anne talked about people with OCD being stigmatized

and the need for awareness campaigns, but she was the only individual, including the researcher, to explicitly mention OCD and stigmatization. The remaining participants, however, did discuss aspects of stigma. Goffman (2006) first defined stigma from its Greek origin, where a sign was cut or burned on an individual to denote such aspects as a crime or low moral stature. He later explained that in contemporary society, a stigmatized person is one who is tainted or has shortcomings and who could fall into the three categories of physical disfigurements, flaws of the mind, such as a poor character or mental disorder, and belonging to an undesirable group, for example, a particular religion or a nationality. People who do not fit into these groups Goffman termed as *normals*. Goffman exemplified perspectives of stigmatized people, citing that having a stigma can be used as an excuse for not living up to social expectations. However, once such a person no longer has this stigma, he or she comes to realize that there was really no justification in using it as an excuse. Relatedly, despite the negative effects of OCD upon Mary's life, she refused to think of herself as having a debilitating disorder and she had never requested extensions for essays or tests. This view could have possibly been influenced by her early experiences in school where she considered herself to be a minority and was thus able to heighten her ability "to look at life through the eyes of others" (line 382). Another perspective Goffman cited was that having a stigma can be viewed as a positive in terms of learning. Mary considered that OCD helped her with proofreading and Robin noted that OCD made her read things from beginning to end, even when feeling the need to sleep. Further, Oliver described how OCD positively affected attention to detail, cleanliness, and ability to retain information and keep life on track.

Goffman (2006) also mentioned "mixed contacts" (p. 135), where *normals* and stigmatized meet, causing greater consequences for the latter group. For Anne and Nick, attending university lectures was a particularly uncomfortable mixed setting. Anne reported being unhappy about her

extreme shyness and her inability to understand social norms and talk in class, resulting in poor grades. Nick expressed his frustration about how his thinking is markedly different from others, so he needed to ask his professors to think for him and he was unable to collaborate well with his classmates. He noted that his thinking involves a need to focus on the smallest of details, important or not, and his persistent doubts surrounding assignments, even after they have been completed. These doubts also affect note taking, resulting in great physical distress and ability to understand lecture content. In addition, Goffman described how mixed interactions can lead to the stigmatized displaying opposite behaviours, alternating outgoing and introverted behaviours, thus learning how to manage better than *normals*. This scenario related to Oliver, who admitted to being extremely shy, yet able to keep friendships and be very confident when dealing with people, such as in service jobs where he interacted with groups of about 30 clients at a time without hesitation. Oliver noted that he coped by controlling situations so that problems were averted and he has learned that his perceived stand-offish behaviour has led no one to detect his OCD.

Coleman (2006) emphasized other perspectives of stigma, such as stigma being nearly unavoidable as it is based on differences than may or may not be recognized in a particular culture or at a particular time. Further, she noted that the "dilemma of difference" (p. 143) also pertains to those who are already stigmatized, such as when they recognize those who have even greater degrees of stigma. When she was an in-patient, for example, Robin noted that everybody was worried about being crazier than others. And among her final comments, she explained that in times when OCD became very difficult to manage, she considered others who must be *worse than me*. In addition, Mary acknowledged her differences compared to other such students, as she noted that she qualified for exam and essay extensions, but she had never requested extensions. She asserted that her OCD was more annoying than a (debilitating) disorder. Coleman also emphasized

the role of symbolic interactionism among those who are stigmatized. As discussed earlier, Smith (1996) identified symbolic interactionism as a key component of IPA, with its focus on both the personal and social structures within which participants interact and reflect upon. Coleman argued that those who are stigmatized often play into the stereotype and behave according to what people expect of them, thus ambitions and maturity may not reach full potential. Most notably, Elaine, seemed to fight against those who expected her to act accordingly, as she explained that many people had treated her so delicately for fear of triggering an *anxiety attack or something*. As a result, Elaine withdrew herself from many people and did not participate much in social events, such as parties and family events. She figured that this treatment was the reason for *putting up walls*. Coleman concluded by addressing the issue of how to improve the situation for those who are stigmatized. She advocated for a shift in responsibility, as making those who are stigmatized solely responsible for their stigma will permit those who are nonstigmatized to continue the status quo. It is hoped that, as Nick stated, participant recommendations from the present study will,

get incorporated in some way, that educational institutions will become, will use this kind of study and the feedback they're getting from students, in this environment, 'cause often this doesn't come across...to address that and I feel that I hope someone pays attention to it and realizes that there's a significant need, 'cause myself, I know I like, throughout my, throughout all spheres of my life...I'm absolutely miserable and anxious day-to-day, and I feel, in a way, I wish someone would help to make me feel better, it shouldn't be that way. And have them see the light, so in that sense I feel, I hope, I hope that, you know, academic people, you know, schools, they really take this seriously. (lines 1891-1905)

From an activist viewpoint, Lewis (2006) described Mad Pride (see Appendix N). Its members act toward improving conditions, support, and understanding related to mental health

issues. They focus less on the medical disabilities and more on the pertinent social issues, such as being isolated and excluded from society. This idea was echoed by Elaine, who advised such students to "seek support, I mean it's very difficult to just rely on yourself, and keep it private. I find it's very painful and um it's more of a burden to carry on" (lines 1125-1126), and Nick who noted, "I guess it's just some kind of identification that, you know...others have been through it as well....it doesn't provide any help, it just provides a sense of comfort" (lines 659-663). Mary, being the only exception, chuckled, "I'll be honest, I REALLY DON'T CARE haha" (line 309).

Some participants advocated that authority figures spend more time listening. For Oliver, he spoke with the researcher for more than 90 minutes, yet he admitted only within the final minute that the interviews had been "kind of like surface level" (line 1444), indicating that perhaps with more time spent, more salient symptom data could have been elicited. Further, Nick strongly advocated for more time to be spent with him and others with similar, chronic disorders.

From private to public life: Others with OCD and those who encounter them.

Having focused mainly upon the quality of participants' private lives with OCD, it is also important to address their public lives, for example, in contact with classmates, teachers, and media. Participants provided a variety of responses in terms of contact that ranged from one extreme to another. Mary had absolutely no interest in direct or indirect contact, while Robin, Anne, and Nick had some contact and read related articles. Elaine, Oliver, and Steve have or have had close relationships with people with OCD or OCD symptoms. Further, Anne found the online forum at www.healthyplace.com to be particularly comforting and encouraging, as it allowed her to communicate with others when she had no one to talk with. Also, Steve dated a guy with OCD who influenced him in terms of compulsions, for example, he suddenly developed a similar need to check taps. Additionally, Robin, Oliver, and Steve expressed their displeasure about people who

claim to have OCD, but have a poor understanding of the disorder.

IPA, participants' comments and clarifications case heading, secondary data

Considering IPA with its emphasis on the importance of encompassing the backgrounds of both participant and researcher, their interactions, and allowing the researcher to critically examine and question the participant interview text, participants' responses in terms of initial comments after completing the questionnaires, comments and clarifications from the demographic form, additional OCD functions of participants, their final comments, and secondary data are analysed in this section. These data are discussed in this section as they seem to include the salient IPA factors above and they also explicitly illustrate the usefulness of the IPA process. Questionnaires and interview schedules were developed and/or chosen by the researcher to elicit participants' background information and reflections. He then had the opportunity to examine their responses and elicit further comments and clarifications. Additional comments regarding the questionnaires and journal progress were usually elicited near the beginning of each second interview session.

From these initial comments and interactions between the participants and the researcher, opinions about the three questionnaires ranged from items being vague to straightforward, but also inapplicable. More specifically, Anne was unsure how to answer some items that were vague and Mary also noted the vagueness of some items, but she believed them to be thorough overall. In contrast, Elaine asserted that many of the items were straightforward and gratifying due to their focus on the past month, unlike previous OCD studies in which she had participated. Oliver's responses in the SF-36v2 led to his admission that he has a habit of spending his life anticipating and worrying about becoming sick and he always feels sick despite having no complaints. Both Oliver and Robin acknowledged that some items in the OCI-R were inapplicable, such as those relating to hoarding for Robin. In terms of the demographic form, Elaine and Steve provided

the most additional insights while conversing with the researcher, while Robin, Anne, and Nick offered fewer insights, and Mary and Oliver did not have further data to contribute. Notably, Steve explained the obsession related to his health as although he feels in good health, he may hear about or think about pain and then research this pain online. He asserted that these external triggers cause him to internalize them and believe that he is sick and this process then interacts with his OCD. In addition, Robin elaborated upon her repeating and impulsive speaking that she reported doing over the previous four years. She saw these as being annoying, rather than being stressful, and consuming a great deal of time and occurring frequently. Others also became annoyed with her as they felt she would not stop talking, but they failed to realize that she could not stop until feeling *just right*. She added that such a process, usually in a conversation, involves very insignificant matters, but this information must be corrected and/or repeated at least in a whisper for her to eventually arrive at a feeling of *just right*. Further, Anne conveyed that her brief experience in a service-oriented job surprised her because she seemed to be well-suited to this job despite her usual difficulty coping in social settings.

Regarding the additional OCD functions of participants (see Appendix L), a great deal of informative data were revealed in lengthy responses, deemed to be more suitably placed within the appendices. Including these supplemental OCD functions served to enhance the understanding of the respective participant cases and corresponded with the aspect of IPA that requires a substantial number of verbatim quotes (Smith et al., 2009). Notably, Oliver conveyed his frustration about needing to spend two hours performing rituals in the morning, but he also acknowledged that these mitigated anxiety and so they must continue. Further, he noted his surprise that people have never suspected him of having OCD, despite his shy and *stand-offish* demeanor. Also, Robin commented on typing, writing, and reading. While using her laptop in lectures, she noted specific steps that

must be followed, such as when underlining, adding bullets, and back spacing. These also must be carried out until she feels just right about them, which could result in repetitions of up to about three times and missing parts of lectures. When reading, she described excessive highlighting to improve her concentration and due to doubts concerning her retention of the material.

In terms of final comments, Robin, Oliver, and Elaine offered salient personal anecdotes from their participation. Notably, Robin saw that life events she discussed in the interviews may have had a more significant impact upon her than she realized previously, and Oliver remarked upon his regret for not being able to participate in the study much earlier in the year, as his OCD was profoundly more severe at that time. He stressed that people with OCD can learn to cope and this disorder should not be considered as a *prison*, despite the thought that symptoms can become much worse unexpectedly. In addition, Nick stressed the importance of educational institutions acting upon the participant recommendations in order to help students such as himself.

The collection of secondary data was thought to be potentially useful in the present study. Subsequent to the data collection and analyses, however, these secondary data did not contribute to answering the three research questions. Despite this outcome, secondary data revealed participants' characteristics while being interviewed and they served to strengthen the standard of objectivity/confirmability (Miles et al., 2014). The secondary data also exemplified main aspects of IPA. More specifically, it was evident that all participants were quite friendly and open and willing to provide adequate responses to all or most of my questions, despite the wide range of verbal and non-verbal characteristics exhibited. These findings relate to the aspect of IPA that enables the researcher to critically examine and question the interview text of a participant (Smith & Osborn, 2003). This aspect was successful as exemplified, for instance, by Anne who had the second-longest interview time while admitting to being very uncomfortable in a variety of social

situations and extremely shy. Further, no participants requested the researcher to withdraw any data from the study. In some cases, however, such as with Mary and Elaine, responses were shorter when compared to the other participants, possibly due to secrecy and/or Mary being very busy and not sleeping, and Elaine acknowledging that her public and private lives were very different. Relatedly, the interview notes revealed that due to such very rapid speech or slow speech combined with frequent pauses, interview length did not necessarily reflect the quantity of data conveyed. From the fieldwork journal, two main IPA aspects were surprisingly exemplified at the same time, namely, the importance of encompassing backgrounds of both participant and researcher and their interactions. To iterate, my first interview with Oliver was the most emotional interview considering all 22 interviews, including the eight interviews from my pilot study. While he expressed his feelings and experiences, his eyes began to water a little and I felt mine do the same, perhaps because I recognized very similar OCD-related experiences that we had in common.

Similar to the 11 IPA studies grouped in chapter III, and the more recent studies cited that involved IPA and OCD (Kellett, Greenhalgh, Beail, & Ridgway, 2010; Murphy & Perera-Delcourt, 2014; Spragg, 2013), this discussion has demonstrated the usefulness of implementing IPA as a research tool, even when focusing on OCD. Further, it has exemplified the operationalization of IPA using participants' responses in terms of initial comments after completing the questionnaires, comments and clarifications from the demographic form, additional OCD functions of participants, their final comments, and the secondary data.

Contributions of the thesis to knowledge, theory, method, policy and practice**Knowledge.**

The present study has advanced the understanding of OCD by providing a deeper and broader examination of the lives of post-secondary students with OCD. This knowledge was produced using qualitative methods, permitting readers to access perspectives from seven participants. It showed a variety of data related to their lives as post-secondary students, for instance, coping with OCD symptoms in relation to their academic and social lives. Such a qualitative approach has been advocated by many researchers (e.g., Gammon, 2014; Kisely & Kendall, 2011; Torres et al., 2011). Knowledge produced may be transferred to others with OCD to assist them in understanding facets of their own lives, including the amelioration of coping strategies.

This study also advanced the general finding in Yoldascan et al. (2009) who noted the dearth of studies related to insights about university students with OCD. Notably, as Abramowitz (2006) strongly advocated, it detailed "functional aspects of these phenomena" (p. 16) by examining a diversity of thoughts that produced anxiety, as well as a diversity of strategies that reduced anxiety, for example, with Elaine who used meditation and yoga, and Steve who valued good luck. This importance of addressing such functional aspects was recently included in the DSM-5 (American Psychiatric Association, 2013). Similarly, researchers (e.g., Maia & McClelland, 2012; Markarian et al., 2010) expressed the valuable contribution of studying OCD functional impairment to potentially lead to improvements in OCD treatment approaches. This study contributed verbatim, contextualized data related to both functional impairment and quality of life among the rarely-studied population of university students with primary OCD. It is hoped that through the detailed case data, especially with the experiences of treatment success from Oliver, Elaine,

and Steve to the treatment failures of Nick, a deeper understanding of this group of students has been conveyed and it will help advance OCD awareness and potential OCD treatments. As Speisman (2012) argued, to improve treatment efficacy, it is imperative to include QoL when treating OCD patients so that symptoms and QoL can improve. In addition, Storch et al. (2014) studied functional impairment in 98 adults with primary OCD and found that increased functional impairment was the result of a combined elevation in anxiety sensitivity and OC symptom severity. Anxiety sensitivity was characterized as relating to the manner in which an individual with OCD deals with his or her symptoms and distress. High sensitivity may, for example, lead one to perform a greater number of rituals. These authors noted the importance of considering such OCD factors related to OCD disability as they can allow clinicians to improve treatment and mitigate functional impairment. Data from the present study may be part of such a contribution.

Characteristic of OCD literature, OCD symptom heterogeneity was exhibited among its participants in a variety of educational and other social contexts. In relation to the eight studies in Table 1, only Haase (2003) and Weiner (1997), however, described similar experiences and these were on a more limited scale as noted in the research gaps of participant recruitment, data collection, and findings. Haase's study focused on comparing her own *ordinary* experiences with adults *who have had the experience of OCD*. The present study was more rigorous as it comprised university students who were clinically diagnosed with OCD and whose data were analysed using inter-case analysis. In addition to the interview data, as in Weiner, the present study also included self-report journal, OCD symptom, and quality of life questionnaire data, as well as a focus on the functions with primary OCD. Another difference is that Weiner already knew her participants from a campus program, choosing them based on the established relationship and trust with her and her feeling about their ability to be interviewed intensively. In the present study, recruitment was

impartial as the researcher had no prior contact with or knowledge of his participants. Similar to the present study, however, some of Weiner's findings related to coping strategies, managing university experiences, advice for fellow students, and university policy and practice recommendations and despite the greater diversity of mental illnesses among her eight participants, these findings were comparable in both studies. Unfortunately, the congruency of these policy and practice recommendations seems to indicate that even about a decade after Weiner's study, there have been few or no improvements related to the concerns of such students in urban Ontario. The research of Wyatt and Oswalt (2013) produced a similar finding in relation to university students throughout the United States.

The present study also showed the viability of recruiting post-secondary students who were clinically diagnosed with (primary) OCD. The great difficulty in recruiting such students was outlined with reference to Holland (2012) who characterized this process as a *monumental task*, and Gelfand (2013) who also acknowledged the difficulty in recruiting clinically diagnosed participants for OCD research. OCD diagnoses were further supported by results from the OCI-R, with all participants scoring higher than cut scores of two related OCD studies.

In addition, the present study advanced data collection related to self-report journals and it showed the need to advance knowledge about OCD obsessions and compulsions. Its intended self-report data collection took place over a month, but the Bond study (Bond, 2011) only required participants to record their experiences over a week. Further, Bond's participants were not asked to elaborate upon their experiences in qualitative interviews, but they were asked to describe their experiences within the context of the OCD diagnostic interviews and coding list. One limitation was described as the focus on *overt compulsive behaviors*, rather than also including important *mental rituals and obsessions*. The present study included many lengthy verbatim experiences

related to both obsessions and compulsions. With respect to subsequent research, Bond also stressed the need to increase the “understanding of the dynamics of OCD” (p. 109). Through its variety of verbatim accounts, it is hoped that the dynamics of OCD have improved readers’ understanding.

Regarding quality of life, results from the SF-36v2 showed that physical health was frequently affected minimally or not at all, but other measures were more noticeably affected, namely, emotional and general health, and also social functioning. This finding was consistent with Speisman (2012) who reported that her results were comparable to past studies. Further, as Cleary and Howell (2006) advocated, the present study included interviews with open-ended questions in order to glean a deeper understanding of participants’ HRQOL.

Theory.

The adaption of Tinto’s model (Figure 1) was useful in the present study as it served as a lens to guide the researcher through the post-secondary process, i.e., from its beginnings to departure outcomes, and it fostered participant data from a variety of temporal periods. Although the researcher strove to recruit community college students, as advocated in Metz (2004-2005), and then in Tinto (2006-2007), only university students participated. This limitation, however, was counterbalanced perhaps due to its congruence with Metz’ emphasis of Tinto’s assertion that one can develop more effective and relevant policy initiatives when research is conducted on specific individuals within specific institutions, as opposed to more general, national studies. Policy and practice recommendations, described below, were highly valued by participants as they contributed many specific examples. Further, the present study addressed a need for closer examination of program effectiveness and a greater understanding of the complexities of student retention. Also, most participants illustrated the strong influences of OCD upon persistence, but they also

seemed to indicate that social integration played a lesser role compared to intellectual integration. In addition, the present study addressed the importance of researching underrepresented post-secondary students (Tinto & Pusser, 2006), and it informed the burgeoning *Longitudinal model of doctoral persistence* (Tinto, 1993, p. 240) as it revealed the time frame from the beginning of data collection to its completion. In terms of any criticisms, Tinto's model was intelligible visually, but somewhat to quite unintelligible within its lengthy explication of approximately 11 pages that comprised numerous posits. This complexity was iterated in Hartley (2013), who made use of a much smaller part of Tinto's 1993 model.

Method.

In terms of the usefulness of IPA, the present study showed that IPA could capture many verbatim extracts that were unique to participants and inherent in the process. Similarly, the recursive grouping of data and subsequent analyses and presentations were helpful in conveying students' lives with the emphasis on the importance of encompassing the backgrounds of both participant and researcher, their interactions, and allowing the researcher to critically examine and question the participant interview text. Regarding the usefulness of Seidman's interviewing as qualitative research (2006, 2013), the outcome with the two-interview structure was as favourable as in the pilot study. Participants completed all interview procedures and they did not express any desire to shorten interviews or withdraw related data. Interview questions related to *intellectual and emotional* relationships, including future paths were of interest to the students and yielded many data that also aligned with Figure 1.

Policy and practice.

Participants offered idiosyncratic and contextualized recommendations that encompassed a broad range of society, from university administrators, counsellors, and teachers, to fellow students with OCD, family members and friends, and the general public. Their recommendations, summarized below, were similar to the perspectives advocated in Kessler et al. (2005) who concluded that because of the great impacts of mental disorders upon individuals and the broader population, stronger efforts should be made in terms of population health and mitigating the development of primary and comorbid mental disorders. More recently, Wyatt and Oswalt (2013) advocated for similar action as a result of studying mental health issues among 27,387 undergraduate and graduate/professional students from 55 universities in the United States.

Advice for university administrators and counsellors focused on increased campus awareness, support, and adequate training. Campus posters were considered to be important as they could inform students, for example, about private room for writing exams, or about a small OCD support group that could include a professor or a psychologist. Posters could also inform students with other anxiety disorders. Further, an OCD information booth could be set up in an area frequented by students in order to provide contact information. In addition, campaigns or a talk directed toward supporting students with mental disabilities should be developed, especially aimed at reducing the stigmatization associated with OCD. Encouragement and follow-up counselling/support throughout the semester should be provided, for example, for students who are transitioning from school to the workforce and who require assistance to consider career options and the transfer of academic success strategies to the workplace. Lastly, counselling services should be more readily advertised and available on campus and these should include more staff specifically trained to help students with OCD and other mental disorders.

Training should be provided for those who come in contact with students who have anxiety disorders so that they have empathy and they are better equipped to fulfill their jobs and student requests. Requests, such as more time to write an exam, should be explained in a policy, rather than be approved or denied at the whim of someone who is uninformed about anxiety disorders. Policies and practices must be consistent, for example, do not agree to refund a student's tuition and then renege on this commitment, while at the same time promulgating the idea that the school cares about its students and has a mental health unit available for those in need. It should be emphasized that OCD is a major part of one's life, and may not be as easy to label or understand as, for example, alcoholism or drug addiction. Thus it is vital to be supportive and helpful when such students seek your help, rather than saying help is available, but offering little, inconsistent, or no help in their time of need. Training should also emphasize that one must not make fun of such people or intentionally exacerbate their OCD symptoms, as OCD is not a trivial or amusing disorder. Further, such people should be knowledgeable about disorders that students might have and be able to access related resources, such as a medical dictionary. In terms of education specialists training teachers, it is important to stress the needs of students with OCD, such as being patient and willing to improve understanding through visual representations of lectures. Results from such OCD studies should be considered very seriously and incorporated into institutions, as there is usually inadequate awareness and support for these students who really are in need of help. Mental health clinics should cater to students with complex problems, not just those that are easily remedied. Lastly, qualified, volunteer clinicians should be made available to such students at little or no charge.

Advice for teachers related to campus services, classroom support, and examinations. For assistance outside of the classroom, teachers were advised to inform students about the

available services on campus. Within the classroom, teachers were advised to consider that OCD is a significant problem that may not be easy to label or understand, such as alcoholism. Thus, teachers need to be supportive of such students and offer genuine assistance, rather than just saying help is available followed by little or no concern. They can, for example, consider different learning styles that students may have and visually represent lecture material to improve such students' understanding. With examinations, notification should be given about one week beforehand and alternative accommodations should be offered, for instance, writing in a private room. Further, assistance should be offered during examinations if such students appear to be in great difficulty and teachers should not comment upon duplicated responses.

Seeking support, coping with OCD, and noting a positive outlook characterized the advice for fellow students with OCD. They should not go to great lengths to hide their OCD and they should not permit their symptoms to build up. They need to tell someone about their OCD and believe that people can be more accepting of their symptoms and this disorder. Engaging in OCD behaviours in public or in front of others will not be so conspicuous, thus engaging will make such students feel more accepted and less odd. Further, it is important to recognize that they are not alone and seeking on-campus support very early will make life easier during school. In general, seeking support and being honest about OCD symptoms is much better than coping alone. Despite having a chronic disorder, life does not have to be horrible and it will be much better if you get help, such as from a therapist who does not just talk with you, but gives you helpful exposure homework assignments.

As for coping with OCD, fellow students should accept that OCD is chronic, but also try to prevent OCD from always being in control. Try alternative therapies, such as meditation and yoga, as these may help you to relax and feel more in control. To understand oneself better and to reduce

stress, be aware of and reflect upon your OCD symptoms and record them in a journal and/or talk about them when necessary. In addition, it is important to continue taking OCD medication if it keeps your life relatively normal, despite all the side effects, like nausea and erratic sleeping patterns. Further, keep a planner to organize your life and maintain your medication regimen. Lastly, fellow students should consider their own academic needs and path and take action without a great deal of external advice or assistance. They should acknowledge, for instance, that OCD can be beneficial in that it can prevent you from letting things go and make you focus on neatness and details more than the average student, in spite of a potentially great deal of wasted time.

Regarding family members and friends, participants stressed the importance of them viewing OCD as chronic, and thus consistent, long-term support, encouragement, and acceptance are vital. This group should refrain from remarking upon noticing or not noticing OCD behaviours, and they should be aware that people with OCD may require twice the amount of time usually needed to accomplish something. For the general public, self-education and tolerance were the focus of advice. They should educate themselves about OCD rather than overwhelming such students with numerous questions. Further, they should expect this education process to be frustrating as this disorder will never be fully understood. In terms of tolerance, do not immediately assume that a person with OCD does not really have OCD or is exaggerating his or her symptoms. Unless your initial reaction is supportive, do not react immediately, but consider what this person has said and obtain additional information if necessary. The public should not point out odd behaviours, such as observing someone unnecessarily performing the same behaviour twice, and they should not treat people with OCD as being so abnormal. They should be patient, especially if asked to respond to many questions, some of which may be repetitive.

In terms of current contributions to policy and practice within the Ontario government, these findings could inform the working group's ongoing Accessibility Plans for the Ontario Ministry of Training, Colleges and Universities (Queen's Printer for Ontario, 2014), such as its "Mental Health Innovation Fund to develop additional initiatives for addressing postsecondary mental health issues" (p. 24).

Study limitations

Despite the contributions from the present study, several research limitations became evident. First, although qualitative studies have been appearing more often in psychiatric journals (Kisely & Kendall, 2011), the majority of OCD research still seems to be focused on using quantitative approaches. Thus, considering this pervasive, quantitative approach in OCD research, the present qualitative study may not be readily acknowledged by many clinicians and researchers whose work involves OCD. Second, participant inclusion was restricted to post-secondary students who were clinically diagnosed with primary OCD. Thus, students who were only self-diagnosed with primary OCD were not able to be considered for study inclusion and they could not have the opportunity to discuss living with OCD. Perhaps, such students had not been clinically diagnosed due to the strong tendency to be secretive about their OCD symptoms. It occurred to the researcher that inviting such students to undergo clinical interviews for potential study inclusion could pose a variety of difficulties and therefore diagnostic interviews were not offered. A related third limitation concerns study participants' clinical diagnoses of primary OCD. Although Oliver's recent clinical diagnosis, the letter from Nick's psychiatrist, and results from the OCI-R supported respective OCD diagnoses, the present study may have benefitted from *re-validated* diagnoses, such as in Abramovitch et al. (2013) who recruited 30 adults with primary OCD. Re-validated diagnoses, especially in the cases of Elaine who reported a clinical diagnosis at about age 10,

and Robin and Mary at about age 16, may have contributed to the perception of a more robust recruitment process. A potential drawback, however, is that some interested students may have become more reluctant or even disinterested in becoming involved in a study that required a re-validation clinical interview prior to consideration for study inclusion. Fourth, also due to the secrecy surrounding OCD, including additional and potentially more insightful and widely-recognized questionnaires, such as the Social and Occupational Functioning Assessment Scale (SOFAS) and the Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q) employed in Grant et al. (2007), was not considered in the present study. The researcher believed that such inclusions might have caused participants to become less likely to continue their participation in the lengthy interviews and journal writing. Fifth, each participant provided most of his or her respective data within a period of about one week, thus the total amount of time spent expressing experiences and relationships was rather limited when considering the length of time required to complete a university degree. The data collected could be considered as merely a glimpse of their post-secondary routes. Similarly, Yoldascan et al. (2009) also acknowledged the enormous benefit that longitudinal studies can bring toward understanding psychiatric disorders. Sixth, as noted in Grant et al. and Mancebo et al. (2008), determining the age of OCD symptom onset is based on individuals' early memories and thus these ages should be regarded as approximations. Similarly, as Hartley (2013) addressed, self-report data related to mental health should be viewed with caution as these data may differ from participants' actual mental health. Seventh, the researcher did not have the opportunity to work with someone involved with OCD research and this factor may have restricted his understanding of the subject matter. Eighth, as Speisman (2012) acknowledged, people with reduced QoL might be more susceptible to developing OCD and therefore having OCD cannot necessarily account for a poorer QoL.

This issue could be given more attention in future research. A ninth limitation is that unlike He et al. (2014) who investigated autogenous and reactive obsessions in adults with primary OCD using a 52-item questionnaire, the researcher of the present study neither asked participants to complete such a lengthy questionnaire, nor comment on these two types of obsessions. These researchers found that participants with a mix of both autogenous obsessions, or those not usually triggered by stimuli, and reactive obsessions, or those usually triggered by familiar stimuli, were more likely to have elevated OCD symptom and belief severity than participants who mainly had one type or another. Seeing that the participants in the present study were more willing to complete questionnaires and participate in qualitative interviews than the researcher expected, it may be beneficial in a future study to ask a greater number of questions, including some directly related to these obsession types. Tenth, further considering participants' openness, in a future study the researcher could attempt to ask a greater number of questions related to childhood trauma, such as in Akpinar et al. (2013) who investigated childhood and adolescent trauma including physical and emotional abuse, and incest. These researchers found that those with such histories were much more likely to have sexual obsessions and a corresponding increase in, for instance, hoarding obsessions and compulsions. Eleventh, as noted using related studies and O'Reilly and Parker (2012), a modest sample size was a limitation in that more data could be collected to further advance the knowledge already gained.

Paths for future research

A follow-up study could lead to a greater understanding of these students, but such research may be unfeasible due to the secretiveness of OCD and the availability and/or proximity of participants. Considering a similar population, Doidge (2007) noted that many Ph.D. dissertations have come to a halt due to the writer's worry from OCD and also the writer not feeling just right

about the manuscript. Recruiting such participants, however, could require even more time and patience on the researcher's behalf, as this Ph.D. student population is likely much smaller than the one recruited herein. Another potential path for research could be to further study treatment refractory students, such as Nick, who emphasized that anxiety and unhappiness were prevalent in all aspects of his daily life and he really needed someone to help him improve. He could not find any helpful treatments despite having met so many clinicians and having undergone a variety of treatment approaches. In addition, related to the first study limitation above, the researcher could approach quantitative OCD researchers in order to possibly find common ground for research toward improving the lives of such students.

Related to the eighth limitation above, the researcher should be less apprehensive about potential attrition, and thus a future study could include more lengthy questionnaires and delve deeper into participants' life experiences and relationships. Such a study would yield a broader amount of data that could be used to improve clinical evaluations and treatment, for instance, data related to autogenous and reactive obsessions (He et al., 2014) and childhood and adolescent trauma (Akpinar et al., 2013).

It is important to acknowledge that in many OCD studies, findings were related to potentially improving treatment for those with OCD. However, few have addressed the issue of patients' therapeutic adherence. Although Alosso (2011) found that a decrease in rituals among 148 OCD patients characterized as *severe refractory* was dependent upon their willingness to undergo ERP treatment, Simpson et al. (2011) stressed the need for future research into patient adherence related to CBT assignments, as their results were supportive but not conclusive. They noted that a greater understanding could lead to better individual care. A future qualitative study could explore this issue more deeply, and could benefit students such as Nick who experienced no

improvement from a variety of OCD treatments. This path also links to the finding mentioned earlier that some people with severe OCD symptoms are able to view themselves as continuing to meet obligations and to have healthy lives (Stein et al., 2000). In contrast with cases such as Nick, another research path could document very positive experiences similar to those found in Murphy (2009) (see Appendix N). This book involves Edward Zine who had severe OCD that included rituals based on the number 16,384. He eventually emerged from living in his basement for years, then went on to get married, become a father, and author a book about his life.

Concluding remarks

I was very honoured to have been among the few, or the only person, to have had the opportunity to read about and listen to such secretive experiences through participants' journals and interviews. More specifically, Anne wrote in her journal that she just recently became more comfortable telling very close friends about her OCD, and in her interviews, she admitted to being extremely shy at university and not really being able to discuss her OCD with anyone. Oliver disclosed that he had never mentioned his OCD to classmates, friends, teachers, or administrators. He stressed that he could not even consider telling such people, but he clarified that he may have vaguely identified himself as an OCD sufferer in order to fit in with symptoms that his classmates frequently purported having. His extreme shyness and admission that he rarely opens his personal life to others was another factor that made me feel privileged. Oliver also added that he has been consistently amazed because no one has seemed to have recognized his OCD symptoms. Further, Nick emphasized his strong determination to contribute everything about himself that could assist me in developing his case. It seemed that the aims of this study outweighed any prior need to keep secrets. In addition, Elaine described her secrecy with OCD and her friends, considering the difficulty they may have in comprehending her disorder.

Having read about OCD cases (e.g., Abramowitz, 2006; Antony et al., 2007; Davison et al., 2005; Penzel, 2000; Schwartz & Begley, 2003) was not sufficient enough evidence to satisfy my curiosities surrounding OCD symptoms, as these cases often seemed to be too general or just quasi-factual stories meant to demonstrate what people with OCD have experienced or may experience. Considering all of the data collection and findings from the present study, I now believe that I have a genuine understanding of OCD as "a highly heterogeneous disorder" (Abramowitz, q.v.), and such understanding has provided me with invaluable perspectives in terms of dealing with my own related daily symptoms. Having had the great privilege of learning from seven, first-person accounts of post-secondary students with OCD has heightened my insight and made me feel *just right*. Further, I feel much better equipped to recognize, understand, and manage these symptoms, especially those related to contamination, checking, and potentially catastrophic events. More specifically, for instance, I now pause to consider that my initial understanding and reaction to situations could be reasonable, but these could also be due to OCD as with Oliver who expected situations to result in catastrophic outcomes that never materialized.

In terms of bringing to light perspectives that may help such students to understand and cope better with their OCD, a few examples have become apparent during my research and I sincerely hope that these diverse perspectives serve students in some beneficial ways. First, perhaps those students who have obsessions with contamination and disease, especially Anne and Oliver who chose *A Lot* and *Extremely* respectively for washing items 5, 11, and 17 on the OCI-R, would find this book to be particularly helpful--*Riddled with life: Friendly worms, ladybug sex, and the parasites that make us who we are* by biology professor Dr. Marlene Zuk (2007). Dr. Zuk addressed many diverse and pertinent issues, such as why we as humans need to acknowledge that our body tissues and fluids are filled with parasites and we will never be rid of them despite using

copious amounts of antibacterial products. Further, environments that are too clean may weaken our immune systems and cause other related problems much worse than elements we are trying to fend off. Using regular soap and such products with alcohol are much safer and do not lead to developing resistance as with antibiotics. In addition, these safer products are easily washed off and will thus not kill all harmless bacteria. Another related issue she discussed was the prevalence of geophagy, or soil eating, among many groups of people past and present. This common practice may be enlightening for Anne and Oliver who expressed aversions to dirt. A second perspective derives from the finding that almost half the population of the United States will develop a DSM-IV disorder, with an anxiety disorder being the most common (Kessler et al., 2005). This finding may be of some comfort to those like Anne, Nick, and Elaine who have struggled with the perception that they are so different from others. Third, considering my interviews with the students in the present study and the pilot study, it seems that coping with the odd behaviours surrounding OCD can be made a little easier if one tries to keep a sense of humour about the disorder, exemplified by Anne, Robin, and Oliver. Anne laughed when reading the question about rating how calm and peaceful she had been and acknowledged, "being able to laugh at yourself, and you're like yep, I'm a little bit weird, but that's ok" (line 1410). Robin noted that she never discussed OCD with her mother and it did not seem to affect her, other than, as she chuckled, "I would CLEAN a lot, that like helped her I guess haha" (line 124). Further, Oliver recalled laughing at classmates who believed they had OCD because they had so many things to do, while knowing that they did not even come close to his genuine OCD with "2 hours of procedural stuff I did that morning" (line 331). From a personal example, I also chuckled while reading about the multinational effort of Global Handwashing Day on October 15 (see <http://globalhandwashing.org/global-handwashing-day>)--count me in!

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Appendix A: Study Recruitment Ad

Are you a university or college student who has been diagnosed with primary Obsessive-Compulsive Disorder (OCD) ?

If your response is YES,
then you may want to consider participating in the study described below...

The purpose of this study is to develop an understanding of educational and social experiences and relationships of post-secondary students diagnosed with OCD. Study admission requirements stipulate that participants have been diagnosed by a qualified clinician who specializes in OCD. Participation includes one-to-one interviews that are related to past, present, and future experiences and relationships. Participants will also be asked to complete a one-month self-report journal. Additional information and assistance will be given to those who would like to complete this journal.

Interviews will be conducted in the local area from about September to December 2007. You will be asked to sign a consent form, complete three self-report questionnaires, and participate in two recorded interviews lasting about 60-90 minutes each. Participants will receive \$50 at the beginning of each interview session, and \$50 to complete the self-report journal. If you would like to participate in this study and/or require additional information, please email the researcher of this study:

Researcher: Colin Widdifield Ph.D. candidate Email: (deleted)

Supervisor: Professor Raymond Leblanc Faculty of Education, University of Ottawa
145 Jean-Jacques Lussier Street, Ottawa K1N 6N5 Email: (deleted)

**This study has been approved by the required ethics board(s)
Thank you for your attention and interest !**

Appendix B: Formulaire de Consentement du/de la Participant(e)**Formulaire de consentement du/de la participant(e)**

Titre du projet: Post-secondary students with obsessive-compulsive disorder:

An interpretative phenomenological approach linking persistence,
transformative learning, and quality of life insights

Nom du chercheur: Colin Widdifield, étudiant au Doctorat, Faculté d'éducation, Université d'Ottawa Téléphone: (deleted) Courrier électronique: (deleted)

Nom du superviseur: Professeur Raymond Leblanc

Adresse: Faculté d'éducation, Université d'Ottawa

145 rue Jean-Jacques-Lussier, Ottawa, Ontario K1N 6N5

Téléphone: (deleted) Télécopieur: (deleted)

Courrier électronique: (deleted)

Invitation à participer: Je suis invité(e) à participer à la recherche nommée ci haut qui est menée par Colin Widdifield.

But de l'étude: Le but de cette étude qualitative est d'acquérir une connaissance des expériences et relations éducatives et sociales chez les étudiantes et étudiants au troisième cycle (universitaire ou collège) qui présentent un Trouble Obsessionnel-Compulsif (TOC).

Participation: Ma participation consistera essentiellement à deux séances (entrevues) de 60 à 90 minutes pendant lesquelles je répondrai à des questions ouvertes sur mes expériences et relations éducatives et sociales. Les séances se tiendront dans un emplacement local entre les mois de septembre et de décembre 2007. Je peux donner au chercheur la permission d'enregistrer par audio les deux entrevues. Je serai invité à lire et à commenter les transcriptions et narratives écrites des entrevues. J'accepte que le contenu soit utilisé dans la rédaction du rapport du chercheur et autres publications ou présentations académiques et ce, en respectant la confidentialité des propos. Le chercheur me demandera également de compléter trois questionnaires d'une durée d'environ 30 minutes. Aussi, le chercheur m'invitera à rédiger un journal quotidien sur les occurrences du TOC durant le mois d'entrevues en ce qui a trait à mes expériences et relations éducatives et sociales. Ce journal quotidien consistera à écrire les incidents du TOC quand je suis seul(e) et dans mes interactions avec autrui, c.à.d. avec des administrateurs et/ou administratrices de l'école, d'autres étudiants et/ou étudiantes, et des membre(s) de ma famille. Ce journal constitue une autre source de données sur les perspectives éducatives et sociales des participants et/ou des participantes. La durée de cette tâche variera selon mes expériences.

Risques: Je comprends que ma participation à cette recherche implique que je donne de l'information personnelle, et ce, pouvant créer une possibilité d'inconfort émotionnel. J'ai reçu l'assurance du chercheur que tout sera fait en vue de minimiser ces risques. Je suis libre de me retirer de l'étude en tout temps, soit avant, pendant, ou après une séance et refuser d'y participer ou refuser de répondre à certaines questions. S'il survient des effets négatifs, je peux contacter le Service de counselling et de développement personnel 100, rue Marie-Curie (4e étage), Ottawa, téléphone: 613 562 5200, courrier électronique: couns@uottawa.ca, et/ou La Ligne de Crise en Santé Mentale (24 heures par jour), téléphone 1 866 996 0991, 613 722-6914 (Ottawa et région), 1 866 281 2911 (Leeds, Grenville, et Sud Lanark), et/ou Services d'urgence (24 heures par jour), téléphone: 613 238 3311 (Ottawa et région).

Bienfaits: Ma participation à cette recherche aura pour effet de me donner l'opportunité d'acquérir une connaissance des expériences et relations éducatives et sociales personnelles. En plus, ma participation aura pour effet de contribuer à l'enrichissement du savoir des étudiantes et étudiants souffrant du TOC. De plus, les autres étudiantes et étudiants souffrant du TOC ou de troubles d'angoisse pourront bénéficier de ces expériences de vie.

Confidentialité et anonymat: J'ai l'assurance du chercheur que l'information que je partagerai avec lui restera strictement confidentielle. Je m'attends à ce que le contenu des entrevues ne soit utilisé dans la rédaction du rapport du chercheur et autres publications ou présentations académiques et ce, en respectant la confidentialité des propos. **L'anonymat est garanti de la façon suivante:** Toutes informations personnelles seront modifiées pour protéger mon identité, par exemple, en utilisant des pseudonymes et en effaçant les renseignements qui permettraient d'identifier les participants et/ou les participantes.

Conservation des données: Les données recueillies consisteront de: ce formulaire de consentement du/de la participant(e), trois questionnaires pour chaque participant(e), les enregistrements par audio et leurs transcriptions et narratives correspondantes, et les journaux quotidiens (si applicable). Ces données seront conservées de façon sécuritaire. Quand le chercheur devra utiliser les données de façon fréquente, il conservera ces données dans une filière fermée à clef chez lui. En autre temps, toutes données recueillies seront conservées dans une filière fermée à clef au bureau du superviseur de cette étude. L'accès aux données sera restreint qu'au chercheur et à son superviseur. De plus, toutes données seront détruites cinq ans après la fin de cette étude.

Compensation: Je recevrai \$50 en argent comptant au début de la première séance et \$50 en argent comptant au début de la deuxième séance. Aussi, je recevrai \$50 en argent comptant pour compléter le journal quotidien.

Participation volontaire: Ma participation à la recherche est volontaire et je suis libre de me retirer en tout temps, et/ou refuser de répondre à certaines questions, sans subir de conséquences négatives. Si je choisis de me retirer de l'étude, les données recueillies jusqu'à ce moment seront effacées ou détruites par le chercheur dans les plus bref délais.

Acceptation: Je, _____, accepte de participer à cette recherche menée par Colin Widdifield de la Faculté d'éducation, Université d'Ottawa, laquelle recherche est supervisée par Professeur Raymond Leblanc, Faculté d'éducation, Université d'Ottawa.

Pour tout renseignement additionnel concernant cette étude, je peux communiquer avec le chercheur ou son superviseur.

Pour tout renseignement sur les aspects éthiques de cette recherche, je peux m'adresser au Responsable de l'éthiques en recherche, Université d'Ottawa, Pavillon Tabaret, 550, rue Cumberland, salle 159, Ottawa, ON K1N 6N5
Téléphone: 613 562 5841 Courrier électronique: ethics@uottawa.ca

Il y a deux copies du formulaire de consentement, dont une copie que je peux garder.

Cochez cette boîte si vous souhaitez recevoir un rapport synthèse de l'étude ☐

Signature du/de la participant(e): _____ Date: _____

Signature du chercheur: _____ Date: _____

Appendix C: Participant Consent Form**Participant consent form**

Title of the study: Post-secondary students with obsessive-compulsive disorder:

An interpretative phenomenological approach linking persistence,
transformative learning, and quality of life insights

Name of researcher: Colin Widdifield, Ph.D.candidate, Faculty of Education, University of Ottawa

Telephone: (deleted) Email: (deleted)

Name of supervisor: Professor Raymond Leblanc

Address: Faculty of Education, 145 Jean-Jacques Lussier Street,

P.O. Box 450, Station A, Ottawa, Ontario K1N 6N5

Telephone: (deleted) Fax: (deleted) Email: (deleted)

Invitation to Participate: I am invited to participate in this research study conducted by Colin Widdifield.

Purpose of the Study: The purpose of this qualitative, exploratory study is to gain an understanding of educational and social experiences and relationships of post-secondary students who have been diagnosed with primary obsessive-compulsive disorder (OCD).

Participation: My participation will mainly consist of attending two 60 to 90-minute interviews, during which I will be asked to respond to a variety of open-ended questions concerning my educational and social experiences and relationships. The interview sessions will be held locally and will take place between about September and December 2007. I give the researcher permission to record these interviews with a voice recorder. After these interviews have been transcribed and narratives written, I agree to read through these and make revisions as needed for accuracy. I understand that the contents of the interviews and transcripts will be used as part of the researcher's Ph.D. thesis and may be used for related publications and presentations. I will also be asked to complete a participant demographic form, and an OCD and a quality of life questionnaire. These three forms should take no longer than 30 minutes to complete. Further, I will be asked to contribute a journal in which I will record occurrences of OCD-related experiences throughout the one-month period that encompasses my interviews. Journal writing will consist of writing down daily occurrences of OCD while alone and while interacting with others, such as classmates, and family members. This journal will comprise part of the data collection used to gain an understanding of post-secondary students diagnosed with OCD. The time spent during journal writing is dependent upon the number of OCD-related experiences throughout the month.

Risks: My participation in this study will involve the disclosure of very personal information and this may cause me to feel emotional discomfort. I have received assurance from the researcher that every effort will be made to minimize these risks. If the setting, line of questioning, or any other aspect of the study makes me feel too uncomfortable, then I may refuse to respond to certain questions, or I may even withdraw from the project before, during, or after an interview. If this emotional discomfort persists, the researcher will refer me to the student counselling service located near his or her respective post-secondary institution, such as 100 Marie-Curie Street (4th floor) Ottawa, telephone: 613 562 5200, email: couns@uottawa.ca, and/or the 24-Hour Mental Health Crisis Line, telephone 1 866 996 0991, 613 722-6914 (Ottawa and Region), 1 866 281 2911 (Leeds, Grenville, and South Lanark), and/or the 24-Hour Emergency Services Distress Centre Ottawa and Region, telephone: 613 238 3311.

Benefits: My participation in this study may help me to gain new and helpful insights regarding my OCD behaviours. These could enable me to cope better in educational and social situations. Further, my participation will contribute to the gap in the literature regarding the experiences and relationships of post-secondary students diagnosed with OCD. My contribution will broaden the understanding of those within post-secondary institutions, and will hopefully benefit other students diagnosed with OCD and/or other anxiety disorders by sharing these life experiences.

Confidentiality and anonymity: I have received assurance from the researcher that the information I will share will remain strictly confidential. I understand that this information will be used only for the researcher's Ph.D. thesis, and may be used for related publications and presentations, and that my confidentiality will be protected at all times.

Anonymity will be protected in the following manner: My name, address, and all other personal information that could identify me with respect to others in this study will be modified to ensure anonymity, such as using pseudonyms for personal and institutional names, and erasing information that could identify me as a participant.

Conservation of data: The study data will consist of participant consent forms, three participant questionnaires each, interview recordings and related transcripts and narratives, and participant journals (if applicable), and these will always be kept in a secure manner. As data are produced, the researcher will take these to his home and store them securely in a locked drawer. When the researcher no longer needs these data on a regular basis, they will be stored in a locked container in his supervisor's locked office. Only the researcher and the researcher's supervisor will have access to these data. For five years after the completion of the study, all related data will be kept in a locked container in the supervisor's office. After this period, all data will be destroyed.

Compensation: I will receive \$50 in cash at the beginning of the first interview and \$50 in cash at the beginning of the second interview. Further, I will receive \$50 in cash to complete the one-month, self-report journal that will detail my OCD-related experiences and relationships.

Voluntary Participation: I am under no obligation to participate and if I choose to participate, I can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If I choose to withdraw, all data gathered until the time of withdrawal will be erased or destroyed by the researcher as soon as possible.

Acceptance: I, _____, agree to participate in the above research study conducted by Colin Widdifield of the Faculty of Education, University of Ottawa, whose research is under the supervision of Professor Raymond Leblanc of the Faculty of Education, University of Ottawa.

If I have any questions about the study, I may contact the researcher or his supervisor.

If I have any questions regarding the ethical conduct of this study, I may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 159, Ottawa, ON K1N 6N5 Telephone: 613 562 5841 Email: ethics@uottawa.ca

There are two copies of the consent form, one of which is mine to keep.

Please check this box to receive a summary of the completed study ☐

Participant's signature: _____ Date: _____

Researcher's signature: _____ Date: _____

Appendix D: Interview Schedules for Session 1 and 2**Interview Schedule - Session 1**

Thank you for attending this first interview session. You read about this study in the recruitment ad, where I noted the intent of the study and my affiliation. Do you have any comments or questions about these before I ask you to complete the consent form, demographic form, OCI-R, and SF-36v2? (The researcher can proceed only after all participant comments, concerns, and questions are addressed. After these forms have been completed, the researcher will ask the first interview question. If necessary, these forms may be completed and returned before or at the second interview session).

Participant _____ Date _____

*Questions and question elements may be asked in any order

ES = elementary school

SS = secondary school

PSS = post-secondary school

1. Describe any general and/or specific comments you have about the questionnaires you have just completed. Also, please explain your reasoning where applicable.
2. In terms of your earliest memories, describe your experiences and relationships with your family, friends, and others familiar to you.
3. In terms of your earliest memories of having OCD symptoms, describe your experiences and relationships with your family, friends, and others familiar to you.
4. What event or events led to your diagnosis of (primary) OCD and what recommendations were offered to you at the time of your clinical diagnosis?
5. From the start of ES/SS to just prior to entering SS/your current PSS,
(Since entering your current PSS up until the present), describe your experiences and relationships with your family, friends, classmates, teachers, and others familiar to you.
6. From the start of ES/SS to just prior to entering SS/your current PSS,
(Since entering your current PSS up until the present), describe, specifically in terms of OCD, your experiences and relationships with your family, friends, classmates, teachers, and others familiar to you.
7. From the start of ES/SS to just prior to entering SS/your current PSS,
(Since entering your current PSS up until the present), describe your beliefs.
8. From the start of ES/SS to just prior to entering SS/your current PSS,
(Since entering your current PSS up until the present), describe your feelings.

9. From the start of ES/SS to just prior to entering SS/your current PSS,
(Since entering your current PSS up until the present), describe your strengths, weaknesses,
and coping strategies.
10. From the start of ES/SS to just prior to entering SS/your current PSS,
(Since entering your current PSS up until the present), describe your life goals and persistence
in achieving these goals.
11. From your earliest memories to the present, what changes and/or challenges, if any, have you
faced and/or overcome?
(Where possible, be specific in terms of event(s), severity, and time frame(s))
With respect to these, did your life inside and outside of school improve, stay the same,
or become worse? How and why do you think so?
12. From your earliest memories to the present, what changes and/or challenges, if any, have you
faced and/or overcome with respect to your OCD?
(Where possible, be specific in terms of event(s), severity, and time frame(s))
With respect to these, did your life inside and outside of school improve, stay the same,
or become worse? How and why do you think so?
13. From your earliest memories to the present, describe some positive experiences that
have influenced you (and are related to your OCD), for example, academic and social
support.
14. From your earliest memories to the present, describe some negative experiences that
have influenced you (and are related to your OCD), for example, academic and social
support.
15. Have you had contact with others who have OCD and if so, describe the specific
event(s), time period(s), and any other relevant details.
16. From the start of ES/SS to just prior to entering SS/your current PSS,
(Since entering your current PSS up until the present), describe memorable instances of
happiness, anxiety, confusion, or any other related emotions you can think of, for example,
in terms of classroom experiences or extra-curricular activities.
17. Now that we have covered some of your recent and current PSS life, I would like you
to describe a typical day in your life, from the time you open your eyes in the morning to
the time you fall asleep.
(After the participant has completed this task, the researcher will ask him or her to
elaborate upon salient events, experiences, and relationships elicited during this
"typical day in your life" account. Details related and unrelated to OCD will be included)

18. Now that you have discussed a typical day in your life, I would like you to continue focussing on your current, day-to-day life. I would like you to describe your formal and informal academic and social life in terms of experiences and relationships.
(After the participant has completed this task, the researcher will ask him or her to elaborate upon salient experiences and relationships elicited during this current, day-to-day account, such as extra-curricular activities and employment. Details related and unrelated to OCD will be included)
19. In terms of your past and current academic and social life, describe your learning experiences.
20. Do you think your academic and social life have influenced each other? If so, how and why do you think so?
21. Since entering your current PSS up until the present, describe your life goals and persistence in achieving these goals. Has your persistence ever waned and, if so, have you ever considered transferring, taking a leave of absence, or quitting school to pursue other interests? Please explain using specific examples.
22. Describe how you see your future in terms of your educational and social experiences and relationships.
23. Considering all of your responses and the themes of this first interview, can you think of anything else that would be important to mention or discuss?

Thank you very much for your participation today.
I'd like to confirm the date and time of our second interview session...

Interview Schedule - Session 2

Thank you very much for participating in this second session. Before we continue, do you have any concerns or questions that need to be addressed?

Participant _____ Date _____

*Questions and question elements may be asked in any order

The first interview mainly involved you describing your educational and social experiences and relationships in terms of past, present, and future contexts, and the influences of your OCD. Can you think of anything else to mention or discuss with respect to this first interview?

This second session focuses on reflecting upon your earliest memories up to the present, and then engaging in meaning making based on these memories that you have accumulated throughout your life. This process could involve, for example, reflecting upon what you discussed during the first interview, including the assumptions, beliefs, interpretations, points of view, or understanding that you have developed throughout your life, and perhaps modified over time. (If necessary, the researcher will prompt the participant to describe such reflections with respect to aspects of the first interview, such as specific events, experiences, and relationships within academic, employment, and social contexts)

1. First, reflecting back to the questionnaires that you completed and your related opinions, describe any general and/or specific meanings you can attribute to your responses.
2. Describe your life goals and persistence in achieving these goals throughout your life.
3. How would describe your life goals and persistence in achieving these goals throughout your life, specifically in terms of OCD?
4. Having just described reflections from your earliest memories up to the present, I would like you to please focus specifically on your OCD-related memories. How would you characterize these memories and your reflections, for example, in terms of adapting and developing skills and changing habits, and what meaning(s) do these hold for you?
5. Considering all of your responses and the themes of these interviews, do you see any potential need for changes to services, policies, or both, at your current PSS? If so, please explain using specific examples.

6. Considering all of your responses and the themes of these interviews, what advice would you give to fellow students with OCD and how could they implement your advice?
7. Considering all of your responses and the themes of these interviews, what advice would you give to people who encounter those with OCD, for example, family members, friends, and university and college teachers and administrators?
8. Considering all of your responses and the themes of these interviews, can you think of anything else to mention or discuss in terms of importance or of significant meaning to you?

Thank you very much for participating in these interviews. After I have transcribed our interviews, your self-report journal (if applicable), and drafted the resulting narrative, I will ask you to read the interview transcripts and narrative to verify that they are accurate and complete. Please feel free to contact me if you have any further comments or questions.

Appendix E: Participant Demographic Form (page 1 of 2)

Participant and Immediate Family History (please write au verso if needed)

Participant's name, gender, and age:

Cultural/ethnic affiliation(s):

Religious affiliation(s):

Home address:

Telephone:

Email:

Participant Demographic Form (page 2 of 2)

Prior contact with immediate family in months/years:

Mother:

Father:

Sibling(s):

Other:

Description of current living situation (e.g., alone, with friends, significant other):

General Health/Medical History (please write au verso if needed)

Number of months/years in good health (reasonable enjoyment of life):

Description of personal clinician(s) and diagnosed disorder(s) with respective date(s):

Description of treatment (CBT, SSRI(s)), and respective frequency:

Description of salient behaviour(s), concern(s), problem(s), superstition(s), symptom(s), and/or substance abuse, and respective occurrence in months/years:

Educational History (please write au verso if needed)

Enrollment at secondary school(s) in months/years:

Enrollment at post-secondary school(s) in months/years:

Academic Major(s)/Minor(s)

Favourite subject(s):

Least favourite subject(s):

Reason(s):

Employment History (please write au verso if needed)

Type(s) and length of employment:

Type(s) of responsibility:

I, _____, affirm that all of the information that I have provided here is accurate and complete to the best of my knowledge, unless indicated otherwise / /200

Appendix F: Obsessive-Compulsive Inventory--Revised (OCI-R) and Results Summary

The following statements refer to experiences that many people have in their everyday lives.

Circle the number that best describes **HOW MUCH** that experience has **DISTRESSED or BOTHERED you during the PAST MONTH**. The numbers refer to the following verbal labels:

	0	1	2	3	4
	Not at all	A little	Moderately	A lot	Extremely
1. I have saved up so many things that they get in the way.	0	1	2	3	4
2. I check things more often than necessary.	0	1	2	3	4
3. I get upset if objects are not arranged properly.	0	1	2	3	4
4. I feel compelled to count while I am doing things.	0	1	2	3	4
5. I find it difficult to touch an object when I know it has been touched by strangers or certain people	0	1	2	3	4
6. I find it difficult to control my own thoughts.	0	1	2	3	4
7. I collect things I don't need.	0	1	2	3	4
8. I repeatedly check doors, windows, drawers, etc.	0	1	2	3	4
9. I get upset if others change the way I have arranged things.	0	1	2	3	4
10. I feel I have to repeat certain numbers.	0	1	2	3	4
11. I sometimes have to wash or clean myself simply because I feel contaminated.	0	1	2	3	4
12. I am upset by unpleasant thoughts that come into my mind against my will.	0	1	2	3	4
13. I avoid throwing things away because I am afraid I might need them later.	0	1	2	3	4
14. I repeatedly check gas and water taps and light switches after turning them off.	0	1	2	3	4
15. I need things to be arranged in a particular order.	0	1	2	3	4
16. I feel that there are good and bad numbers.	0	1	2	3	4
17. I wash my hands more often and longer than necessary.	0	1	2	3	4
18. I frequently get nasty thoughts and have difficulty in getting rid of them.	0	1	2	3	4

Obsessive-Compulsive Inventory--Revised © 2002 by Edna B. Foa

Permission to use the OCI-R in this thesis research was granted by Dr. Foa on February 9, 2007.

The OCI-R was adapted from:

Foa, E.B., Huppert, J.D., Leiberg, S., Langner, R., Kichic, R., Hajcak, G., et al. (2002).

The obsessive-compulsive inventory: Development and validation of a short version.

Psychological Assessment, 14(4), 496.

Summary of OCI-R Items and Participant Distress Levels

	Not at all=N	A little=Lit	Moderately=M	A lot=Lot	Extremely=E		
	<u>Robin</u>	<u>Anne</u>	<u>Mary</u>	<u>Oliver</u>	<u>Nick</u>	<u>Elaine</u>	<u>Steve</u>
<u>Washing</u> 5-11-17	Lot-Lit-Lit	All Lot	All Lit	All E	N-Lit-Lit	M-E-N	Lit-Lit-N
<u>Obsessing</u> 6-12-18	All Lit	All Lot	All Lit	E-M-Lot	E-E-Lot	E-Lot-Lot	M-Lot-M
<u>Hoarding</u> 1-7-13	N-N-Lit	All Lit	All Lot	M-M-Lot	Lot-M-E	Lot/E-M-Lit	All Lot
<u>Ordering</u> 3-9-15	All E	All Lit	All M	M-Lot-Lit	Lot-Lot-E	E-E-Lit	All Lot
<u>Checking</u> 2-8-14	M-M-Lit	E-Lot-E	Lot-Lit-N	E-Lot-M	E-Lot-M	Lot-E-E	E-Lot-E
<u>Neutralizing</u> 4-10-16	M-Lit-Lot	M-N-Lot	All E	Lit-N-N	Lit-M-N	Lot-E-E	All E

Overall distress levels
(A lot to slightly less than moderately)

Elaine - A lot
Steve - Slightly less than A lot
Oliver and Nick - Between Moderately and A lot
Anne - Slightly more than Moderately
Mary - Moderately
Robin - Slightly less than Moderately

Appendix G: Summary of SF-36v2® Health Survey Items / Participant Health States**Mental Health (past four weeks)**

None of the time=N A little of the time=L Some of the time=S Most of the time=M

All of the time=A Slightly=SL Moderately=MD Quite a bit=QB Extremely=E

	<u>Robin</u>	<u>Anne</u>	<u>Mary</u>	<u>Oliver</u>	<u>Nick</u>	<u>Elaine</u>	<u>Steve</u>
<u>Vitality</u>							
9a,e,g,i							
Full of life	S	S	S	L	N	L/S	L
Lot of energy	S	L	S	L	N	L	L
Worn out	M	S	M	M	A	S/M	A
Tired	S	M	M	A	A	A	A
<u>Social</u>							
<u>Functioning</u>							
6,10							
Phys.health/ emot.problems							
w/family/friends	MD	MD	SL	QB	E	MD	QB
Phys.health/emot. problems visiting							
friends/relatives	L	S	S	M	A	S/M	S
<u>Role Emotional</u>							
5a,b,c							
Reduce time w/ work/other acts.	S	S	N	S	M	L	S
Accomplished less	S	S	S	S	A	M	S
Less careful	S	S	L	M	M	M	S
<u>Mental Health</u>							
9b,c,d,f,h							
Very nervous	S	M	L	M	A	M/A	M
Down in dumps	L	S	N	S	A	S	S
Calm/peaceful	S	N	S	N	N	L	N
Down/Depressed	S	S	S	M	A	S/M	S
Happy	S	M	L	L	N	S	S

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(SF-36v2® Health Survey Standard, United States (English))

Physical Health

Limited a little=LL Not limited at all=NL None of the time=N A little of the time=L

Some of the time=S Most of the time=M All of the time=A

	<u>Robin</u>	<u>Anne</u>	<u>Mary</u>	<u>Oliver</u>	<u>Nick</u>	<u>Elaine</u>	<u>Steve</u>
<u>Physical functioning</u> (typical day) 3a-j							
Vigorous acts.	LL	LL	LL	NL	LL	LL	NL
Moderate acts.	NL	NL	NL	NL	NL	NL	NL
Lift/carry groceries	NL	NL	NL	NL	NL	NL	NL
Climb several flights of stairs	LL	NL	NL	NL	NL	LL	NL
Climb one flight of stairs	NL	NL	NL	NL	NL	NL	NL
Bend/kneel	NL	NL	NL	NL	NL	NL	NL
Walk >1 km	LL	NL	NL	NL	NL	NL	NL
Walk 100s m	LL	NL	NL	NL	NL	LL	NL
Walk 100 m	LL	NL	NL	NL	NL	LL	NL
Bathe/dress	NL	NL	NL	NL	NL	NL	NL

Role Physical**(past 4 weeks)****4a,b,c,d**

Cut down time							
w/work/other acts.	N	L	N	L	N	S	L
Accomplished less	S	S	S	S	N	S	N
Kind of work/other acts. limited	S	N	L	L	N	L	N
Difficulty w/work/other acts.-extra effort needed	L	S	S	L	N	S	N

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(SF-36v2® Health Survey Standard, United States (English))

Physical Health (continued) and Overall Health States

Very Mild=VM Mild=ML Moderate(ly)=MD Not at all=NA A little bit=LB

Poor=P Fair=F Good=G Very good=VG

Definitely true=DT Mostly true=MT Don't know=DK Mostly false=MF Definitely false=DF

Robin**Anne****Mary****Oliver****Nick****Elaine****Steve****Bodily Pain****(past 4 weeks)****7,8**

Degree of

bodily pain

VM

VM

VM

VM

VM

ML/MD

VM

Pain interfered

with normal

work in/out

of home

LB

NA

LB

NA

NA

MD

NA

General Health**1,11a,b,c,d**

General health

VG

G

G

VG

P

F

G

Get sick little

easier than

others

DF

MT

DT

MT

DF

MT

MT

Healthy as

anybody

MT

DN

MF

MT

MF

DF

DN

Expect health

to get worse

DF

DN

MT

MT

DN

MF/DN

MT

Health is

excellent

DN

DN

DN

MT

DF

MF

DN

Overall Health States

Nick and Elaine - Between Fair and Good

Robin, Anne, Mary, Oliver, Steve - Good

Appendix H: Self-report Journaling from Anne, Oliver, Nick, Elaine, and Steve**Anne's journal***September 25*

Ordering

- Reluctant to return shoes to the shoe rack, but did this anyway

Panic

- Panicked at a social gathering, feelings of being in a very negative environment and being very uncomfortable

Contamination

- Wanted to eat type of food there, but could not due to my dirty hands, and members' dirty hands and practice of dipping food that had already touched their mouths
- Reluctantly shared a drink using the opposite end of a straw, despite it touching dirty hands in the flipping process

September 27

Regret and hoarding

- Regretted very untidy room, but too busy to organize it and must add to the piles of clutter
- Strongly regretted sitting at the front of classroom

Distress and ordering

- Very distressed while making dinner due to reluctance about returning things to their proper place and choosing to use the least convenient piece of cutlery

September 30

Repetition

- Needed to walk away from an OCD moment, rather than spending an indefinite amount of time repeating something

Self-doubt and being in an unavoidable and intolerable situation

- Identified commonality with a song lyric and OCD

October 10

Regret, worry, success, and reflection

- Did not purposely write the wrong answer on a multiple choice exam, but had difficulty writing complete words, such as successfu
- Unsure about how marker will react
- Succeeded in completing the exam despite OCD
- OCD caused incomplete words, the reason being that an incomplete word would mean an incomplete thought and therefore the thought would not come true
- Confessed regret due to lapses in journal writing and not ever being good at journal writing

- Succeeded in completing responses to interview questions (recorded below)
- Reflected upon journey in October, saw that it had not been very good, but not terrible either
- Thought about dropping out a couple of times due to OCD being too prominent and intrusive
- Thought this to be a bad idea for the future, despite all the bad experiences thus far, and the really bad social anxiety
- Regretted not having the required note to write exams in a separate room
- Feeling of success in that next exam is not multiple choice, but worry OCD may still be a factor

November 7 at 6:33 after dinner

Repetition, uncertainty, and success

- Repetition with OCD being ridiculous now as trying to watch a movie and type notes, not sure why OCD is affecting things now.
- Wrote final midterm exam today, and needed to succeed despite OCD strongly affecting a multiple choice question and when trying to write a complete word, and also to make up for a very bad result from a previous exam

Responses to interview questions

(Interview session 1, question 12 regarding changes and/or challenges faced and/or overcome with respect to OCD)

Uncertainty, frustration, being alone, comfort, being down, very anxious in class, compulsions, worry

- Uncertain if still considered to be a normal human being while functioning with OCD symptoms
- this idea may be too harsh
- Before diagnosis, challenging due to uncertainty in terms of explaining symptoms to myself and others
- After diagnosis, uncertain how to explain OCD to others and how to deal with friends' misunderstandings and disbelief
- Very frustrated due to lengthy period of time without parental support, despite my pleas for their help
- Frustrated due to feelings of not being normal and not living up to my parents' expectations
- Frustrated due to sister's strong hostility stemming from her failure to understand why I would not permit her to sit on my bed or use my water bottle
- Frustrated due to feeling of being an outsider within chosen social group, such as being unable to share water bottles, cutlery, but realize it is fine that I am unique
- Frustrated while trying to ignore persistent feelings in head that direct me to do nonsensical things, especially from grade 11 to now
- Frustrated in school due to feeling of being different

- Feeling alone in high school due to inadequate support system
 - In high school and post-secondary school, comforted by talking to people with this problem
 - Comforted by my eventual understanding that friends will continue to misunderstand, disbelieve, and dislike talking about my OCD
 - Comforted that I realized I could seek help elsewhere instead of trying to seek help from such friends, at a time when I was not being treated for OCD and I was desperate for help
 - Very frustrated, feeling of drowning from having to live with very untidy people over a long period of time
 - Frustrated when people indicate to me that things are clean and should not bother me, when I already know
 - Increasingly frustrated and down at school from grades 7 to 11 due to lack of OCD treatment and lack of acceptance
 - Comforted due to greatly improved report cards from grade 11 onwards
 - Very anxious in class due to discussion about risk, fate, death, why bad things happen
 - related this to my thinking about how I strangely leave sentences incomplete and substitute words and how I see the strong relationship between OCD obsessions and fate, i.e., obsessing about bad things going to happen and ignoring related compulsions that could stop them, and then blaming yourself for letting these bad things happen because the compulsions were ignored
 - Recently faced a new change and challenge while studying, mind wanders and start worrying about the future, such as becoming schizophrenic due to OCD's connection with irrationality, like repetition
 - While reading and studying, compulsively highlight entire sentences and/or page sections creating incoherence in the reading
 - While typing, compulsively omit or leave words incomplete
- (Interview session 1, question 21 regarding life goals and persistence)

Persistence and realizing goals

- Psychologist advised me to try everything on when choosing my clothes in the morning and following this advice has helped me, though the problem still exists
- Through persistence, now just pick the first clothes I can rather than waiting for them to be 'right'
- Really wish to see the formation of an OCD group on campus, for those with OCD or those who would like to be better educated about OCD, as just recently became comfortable with telling only my closest friends
- Such a group would also make me feel better as I could talk freely about OCD, perhaps even with friends, family, and counsellors as well, and even discover some practical solutions

Oliver's journal*October 10*

Contamination, frustration, and regret

- Will not stand on bathmat, despite this being own private bathroom
- Suitcase remained in middle of floor due to concern about contaminated clothes inside
- Washed hand that touched near window because of potential raw meat contamination in that area from about one week before
- Declined offer of ride home from a friend due to worry about contaminated car interior
- Such incidents are frustrating and more significantly, time consuming, and resulted in having to walk home in the rain
- Regretted that this journal entry had not been very thorough, but will make up for this tomorrow

October 11

- (Blank)

October 16

Regret, contamination, worry, comfort, stress

- Apologized for not writing for 6 days
- Still will not stand on bathmat
- Put soap on hands after touching tap to ensure they are entirely clean
- Washed hand after touching broom as broom is connected to dirt
- Put bandaid on pink spot on hand due to worry about infection
- Felt good about finally putting suitcase away, but also felt stressed in the process

October 17

Contamination

- Touched elevator button with keys rather than finger due to fear of contamination
- Sweat from running, but feared contamination if wiped or even touched face
- Put bandaid on finger banged on desk due to fear of infection, despite no appearance of blood
- Compelled to put antibiotic on this new pink spot
- Sat on sofas in public place and had to wash all clothes at home due to dirty feeling, despite knowing they were not dirty

October 18

Contamination

- Still will not stand on bathmat
- Still wearing two bandaids from the previous two days
- Feared contamination on my face from being hit with a sports ball and wanted to leave game and take a shower, dislike having face touched

-Forced self to touch elevator buttons with finger, was not scared

October 19

Contamination

- Need to get prescription filled at pharmacy and had to buy hand sanitizer due to potential contamination from pharmacy patrons, clean hands and arms up to elbows
- Could not touch school curtains due to fear of contamination
- Classmate beside me sneezed, so needed to wash hands at break
- Still will not stand on bathmat
- Removed bandaids

October 20

Contamination and reflection

- Attended pot luck dinner, but could not eat chicken, seafood due to fear of them being undercooked, and could not eat finger food as some dipped food they had already bitten
- Had to greet people with kisses, but felt uncomfortable having my face touched
- Still will not stand on bathmat
- Not wearing bandaids
- Face itchy today, but cannot scratch face due to potential skin infections
- No positives today

October 22

Regret, contamination, secrecy

- Apologized for missing journal entry yesterday
- Feared touching microwave and tap, despite having washed them
- Feared touching knob for cutlery drawer
- Face touched couch, so needed to wash face
- Despite feeling very uncomfortable, in class, secretly put on antibiotic cream and bandaid on new cut on hand
- Still will not stand on bathmat
- Feared contamination and infection on my face from being hit with a dirty sports ball

October 23

Reflection and contamination

- Today almost free of OCD due to time mostly spent at home studying and cleaning
- Still must wash hands after touching microwave, cutlery drawer, oven, kitchen tap
- Good day, much better
- Feared contaminated garbage chute handle, so had to wash hands and apartment entry doorknob

October 24

Reflection

- Another good day with no bandaids, very little fear, despite being at school all day, but still discomfort and excessive hand washing caused by kitchen objects

October 25

Contamination and reflection

- Still will not stand on bathmat
- Excessive hand washing throughout day, triggered by cut while shaving and potential infection
- Bought hand sanitizer at pharmacy as a result
- Took taxi and felt dirty enough to want to wash everything
- Excessive washing has caused cracked skin and purchase of hand cream, can hardly bend hand
- Could not touch elevator buttons
- Touched ATM buttons with house keys due to contamination fears
- My sudden strong sneeze resulted in having to wash face twice
- Overall bad day and also due to extreme discomfort in kitchen, fear of contamination from everything, including light switch

November 20

Regret, contamination, reflection, promise

- Acknowledged third attempt to complete one-month journal
- Recovering from serious relapse, but has made me stronger, will describe in a few days
- Few OCD occurrences today, feared contaminated public bathroom door, always use foot to enter or paper towel on handle to leave
- sinus infection, but cannot blow nose for fear of contamination, so infection could worsen
- monitored small cut on thumb
- reopened cut on thumb at gym, closed before arrived home, but at home still put peroxide, antibiotic cream, and bandaid, despite knowing these would be of no benefit
- Once relapses end, notice great improvements (greatly reduced or free from symptoms and behaviours) due to specific energy focus on new problem/fixation, so many prior symptoms and behaviours become less scary or cease without me even recognizing this, such as not fearing, worrying about using bathmat, touching face, bathroom light switch, kitchen objects, sneezing,
- Promised to write journal tomorrow

November 21

Contamination, secrecy, liberation, reflection, frustration, satisfaction

- Ate at restaurant with many friends, but required to touch and cook raw meat and with unclean hands and shocked to see friends' lack of concern

- Ate a lot, but secretly fearful
- Same situation alone would have been impossible
- Felt liberating and world seemed less scary as friends enjoyed this and did not get sick
- With OCD it seems the world is trying to get you
- Had to exit from public bathroom using bare hands due to lack of paper towels, hate doing this, so had to go to another bathroom to wash again and use paper towel on the door handle to exit
- Have left shorts on floor for a week, but cannot move them to put them away and frustrated because cannot remember the reason why
- Felt satisfied due to completing today's entire journal entry

November 22

Frustration, contamination, reflection

- Still not picked up shorts on floor and still cannot remember reason why these cannot be touched
- Usually delay taking out garbage, as do not like to touch garbage
- Uneventful day, just dealing with usual OCD behaviours that seem close to normal
- Hesitated touching door handle and light switch, but managed to push myself to do these
- Describing OCD is problematic because dozens of compulsions are very common every hour, so are not easily recognized as compulsions, they are considered quite normal and under control

November 24

Regret, contamination, panic, return to the past

- Regretted missing journal yesterday, so will include in today's
- Needed to briefly wear formal attire for photo, but many others had already worn these exact things too, so became extremely uncomfortable
- Got cut and had to buy band-aids and put one on, but knew it would be of no benefit
- Went to restaurant where I had to hang up my coat with dozens of others touching it
- Went to clinic for a test and afterwards must always shower and wash all clothes
- Four o'clock in the morning the next day and experiencing a panic attack
- When they occur, feel they are going to be bad, everything around you is crumbling and going to go wrong, with this wrong being a reality, always a certainty
- Can only picture extreme fear becoming real, with no positives beforehand
- Feel helpless, like crying, want to return to a time when life was hopeful and worth living
- (Graphic depicting what happens within a panicking OCD mind -- a 1% covering about half the page and a normal-size 99% to its right)
- 1% represents possibility of worries actually occurring
- 99% represents possibility of phobias not occurring
- I feel the 1% monopolizes nearly all my thoughts, whereas the 99% is hardly noticeable

- Very bad mood and hate feeling of having to cope with this again and again, just need my nerves to return to
- Condition better than death, but certainly not as people perceive living
- Always feeling like a victim, vulnerable, and always waiting for the disaster that never arrives
- When disaster averted, no relief, just focus on another problem that is much worse and really going to ruin my life in a much more horrendous way
- Look back before OCD when life was enjoyable every day, hoping life will return this way

November 25

High anxiety, sluggishness, depression, surprise, extreme fatigue

- Still highly anxious due to extreme attack this morning, hard to be productive, depressed
- Strangely, today experienced minimal problems related to OCD, possibly due to extreme fatigue from this morning's attack
- Too tired to recall minimal problems today

November 26

Contamination, washing

- Small cut on arm from playing sport closed by the time returned home, but still triggered need to put peroxide, antibiotic cream, and bandaid, despite knowing these would be of no benefit
- Cooked chicken, but started with raw meat, so became extremely nervous about contamination and led to excessive hand washing that caused severe irritation and skin to break
- Limited exposure to contamination as spend most of day at home, good day

November 27

Contamination, worry, regret, determination

- Jabbed self with pen by accident, that triggered trip to pharmacy for peroxide, antibiotic cream and bandaids, but this healed by the time these were purchased
- Went to pharmacy near school to get prescription and brought hand sanitizer along, strangely, only very anxious about this specific pharmacy
- Had serious sinus infection for last two weeks and must wash area under nose very thoroughly due to worry of increased infection, excessive washing has caused area to become irritated
- Despite these issues, today was good and had little to no worry
- Occasionally reflect upon 10 months ago when OCD was so bad and this is scary
- Regret having to waste life consumed with worry, when others enjoy their lives, makes self more determined to fight and beat OCD
- Now reflect how enjoyable life once was when things start to become unmanageable

November 28

High anxiety, uncertainty, contamination, tolerance

- Became highly anxious at cafeteria, not sure why, but this triggered me to leave
- Cut self shaving, so minute, but had to put antibiotic cream to calm fears of infection
- Realized today I will tolerate great discomfort for hours just so that I do not touch my face with unwashed hands
- Avoid as much as possible touching my contaminated dirty laundry basket

November 29

Contamination, uncertainty

- Found tiny red spot on face, probably due to shaving, but had to put antibiotic cream on this despite knowing it would be of no benefit
- Still cannot touch dirty laundry basket due to potential contamination from germs
- Gym patron asked to share equipment, but replied I had already finished when I had not, unsure about why became nervous about sharing this, maybe just watching him use same machine
- Left tissue on couch, but do not recall why, and all day feared touching it

November 30

Contamination, regret, being nervous

- Made ground beef from raw meat, so had to clear kitchen counter before taking out meat in order to avoid cross-contamination, but forgot to empty dish drainer full of clean dishes
- Spent 30 minutes rewashing these clean dishes despite meat not even coming close to them, needed to rewash because of contamination worry
- Regretted wasting so much time rewashing clean dishes
- Walked to gym in very frigid weather and nose ran, so had to wash under nose due to potential infection
- Banged hand, but still had to put on a bandaid despite spot never bleeding, become nervous when looking at it

December 2

Apology, contamination

- Apologized for missing journal yesterday
- Spent most of day at home computer, so few OCD triggers
- On walk home from gym, found self behind backpackers, triggering strong fear of becoming contaminated by their potential bacteria and/or lice, eventually ran by them and fear dissipated
- Cooked chicken, so had to excessively wash very small kitchen for about 20 minutes

December 3

Contamination, fatigue, regret

- Ate packaged, pre-cooked seafood, but still required excessive hand washing
- Extremely fatigued today, will write more tomorrow

December 4

Contamination, reflection

- Opened public bathroom door with shirtsleeve due to fear of contamination from everything within
- Despite having no meat in kitchen for past two days, must disinfect kitchen counter thoroughly every night
- Other than this, compulsions were minimal today probably due to exam stress and lack of free time
- Certainly other OCD events today, but so much part of daily life they went unnoticed

December 5

High exam stress, uncertainty, contamination, worry about journal writing

- Highly stressed, as usual, due to exams, causing OCD stress to decrease
- Need to discover way to release stress that doesn't interfere with my night's sleep, becoming so bad that life has no enjoyment
- Written so many exams in past, unsure why cannot manage exam period now
- Reluctant to touch dirty clothes hamper, and pants on floor from about 4 days ago
- Need to relax, as starting to worry that journal has become less and less focused on OCD and will be unhelpful in study, perhaps this journal shows people with OCD have higher stress levels than average person, and also poor penmanship, sorry

Nick's journal

November 13

Checking, repetition, and *just right*

- Checked page numbers and reference names in syllabus many times to ensure reading proper textbook section
- Repeatedly checked textbook page numbers when turning pages to ensure pages have not been skipped by mistake
- Repeatedly asked career counsellor a question to check that I phrased the question correctly and I understood the response absolutely right

November 14

Checking, repetition,

- Checked lecture area where I was sitting 3 or more times to ensure nothing had been left behind, especially notes and books, looked back several times while leaving classroom
- Checking also occurs at beginning of lecture, to ensure everything is placed so that nothing will be forgotten when leaving lecture
- Check pockets to ensure nothing has been dropped, such as standing in a line and removing wallet to pay at cafeteria. Must check floor and entire area from different angles, despite still conversing with someone in line

November 15

Checking, repetition, extreme discomfort and uncertainty

- Repeatedly asked academic advisor to clarify herself so that I could ensure I heard her repeated clarifications correctly, eliminating any possibility of misunderstanding her
- Frequently ask people to clarify themselves and repeat their clarifications because I feel the responses are not registering in my head, or that I feel I must understand them absolutely right
- Such repeated requests often involve school work, money, and deadlines, and extreme discomfort and uncertainty, as I usually still feel I have missed information within the repeated clarifications

November 16

Checking, uncertainty

- Throughout semester, repeatedly checking multiple versions of documents to ensure correctness, but still uncertain about relying upon a specific version

November 19

Checking, discomfort

- To ensure correctness, repeatedly recheck diagrams in notes that were copied from board
- To ensure that nothing has been missed while note taking in lectures, must check classmates' notes

- This checking causes great discomfort due to inability to take complete lecture notes and the accompanying obsessions, thinking about this inability and trying to be very careful not to miss anything, and also the loss of focus and other portions of the remaining lecture

November 20

Ordering, extreme anxiety/discomfort

- Extreme anxiety/discomfort triggered if something in own life is not in proper order, such as starting a course after missing a few classes, knowledge of entire course may be deficient and enjoyment may be reduced, but if take course at another time, professor may not teach as well
- Such thinking about a way to change the situation persists even at exam time, when dropping course is impossible

November 22

Reflection/insight, discomfort, being anxious

- Aware that actions are due to OCD, but cannot prevent them, such as repeatedly checking page numbers and feeling discomfort if I do not check
- Sometimes, repeated checking performed only as a ritual to satisfy own mind, as recognize that page numbers are not even being checked for accuracy. At this point, page numbers are checked by visualizing or repeating them in mind, rather than visually focusing on them for accuracy
- Often ask questions regarding details that I should or already know, such as asking a top administrator the meaning of audit, when previously registered to audit a course and being fully aware of the meaning of audit
- Discomfort due to appearance of looking poorly prepared while asking this administrator
- Tried hard to avoid asking this question
- Became unexpectedly anxious and experienced discomfort in stomach at the thought of not asking this question

November 25

Reflection, dwelling on thoughts, extreme fatigue, incessant yawning

- Dwelling on thoughts often leads to great physical fatigue, irritability, such as agonizing about decisions, variety of options and outcomes
- Takes place at school and while doing school work, accompanied by incessant yawning, despite not being sleepy

November 26

Reflection, dwelling on thoughts, uncertainty, frustration

- Always being so focused on simple decisions causes confusion in terms of what I want, what the answer is, such as choosing a textbook to read, later often regret decision due to confusing thought processes

- Alternately, will become so frustrated from incessant obsessions that I act spontaneously without considering consequences
- Obsessions occur naturally and originate on their own
- Cannot be sure of a decision until I have already acted upon it

November 28

Regret

- Regretted having inefficient study habit of relying upon multiple versions of documents rather than settling upon and studying from the most suitable version

November 30

Panic attack and decision process

- Panic attack triggered by not having fully considered decision process, thus causing wrong or inadequate decisions
- Become physically ill due to decision process and fear total disaster if right decision not made, such as during a significant career decision
- Just realized that search is always for truth or making the right decision, but acknowledge there may be no truth, so such relentless, agonizing searching may be pointless as I never seem to feel that right decisions have been made

Elaine's journal*February 24*

Repeated action

- Turned lights off in sequences of three and ate three oranges

February 26

Just right and repeated action

- Took four hours to start homework because had to start on the hour
- Flipped television channels in a sequence and repeated five times

February 27

Repeated action

- Purchased two items of chocolate, but then regretted leaving the store without purchasing a third item of chocolate, so walked for fifteen minutes back to the store to purchase third item of chocolate

February 28

Secrecy and repeated actions

- Ate chips at social event, but tried to refrain from eating with number pattern due to nervousness about attracting attention and repeatedly picking at chip bowl. Eventually stopped picking, but regretted this and thought about it all night long
- While returning from social event, bought one bag of chips and thought about the two other bags that can be bought

March 1

Repeated actions

- Washing hands at restaurant and pumped hand soap container three times and dried hands with five paper towels
- Repeatedly checked alarm clock for fear of alarm not waking me up for morning test, so stayed up all night long

March 3

Just right and repeated actions

- Took six hours to start homework because had to start on the hour
- Flipped television channels in a sequence and repeated nine times
- Turned lights on and off in sequences of three

March 6

Repeated actions

- Washed hair three times before able to get out of shower
- Ate two remaining apples, but so irritated that had to go to store to buy one more apple

March 8

Repeated actions

- Brushed teeth five times, followed by flipping lights on and off
- Flipped television channels in a sequence

March 11

Repeated actions and just right

- Poured three glasses of milk
- Had five bites from piece of cake
- Brushed teeth three times
- Took six to seven hours to start homework because had to start on the hour

March 12

Just right and repeated actions

- Could not sleep at night as it took so long to start homework, so eventually slept for two hours and tried to complete homework that morning, but needed two hours before able to begin homework
- For breakfast, drank three cups of tea and ate (cereal) divided into five, small portions

March 14

Repeated action

- Late for first class due to washing hair three times and brushing teeth two times
- Turned lights on and off eight times
- Locked and checked door five times

March 16

Just right and repeated action

- Took three hours to start a final assignment
- Flipped television channels in a sequence
- Mopped floor three times

March 18

Repeated action

- Washed hands five times at work and dried hands with three paper towels
- Drank one kind of soft drink three times and then drank another kind of soft drink two times

Steve's journal

Initial Thoughts from the back of the journal front cover

Luck and just right

- Had to perform these actions every day, so pointless to record every day--set alarm and got out of bed on lucky number, curtains completely and properly shut, hair done just right, clothes had to feel lucky each day, avoided stepping on cracks, listened to lucky number of songs before bed

March 9

Just right and luck

- Spent extra 15 minutes trying to find socks that were just right
- Had to place pocket contents in just right pocket
- Before could fall asleep, spent extra 15 minutes waiting to see lucky numbers
- Troublesome writing journal as cannot have only one word on a line

March 10

Worry and luck

- Difficult falling asleep due to worry about potential or very unlikely fights or arguments with friends
- Late for exam, throughout entire exam thought about this as bad luck
- Had to counter this bad luck from waking up late by listening to a lucky number of songs (3 or 7) going to and from school

March 11

Regret

- Regretted having messy room, so had to take great deal of time away from essay writing in order to clean

March 12

Just right and regret

- Played tennis by bouncing ball certain number of times and standing on very specific areas of court
- Regretted long time spent to fall asleep as first needed to listen to 7 different songs

March 13

Luck and discomfort

- On bus, had to lift feet over bridges and train tracks and duck head under overpass
- Entry door held open, but unlucky so entered by another door to avoid discomfort
- Needed to rewalk a block as too many cracks were stepped on

March 14

Just right, luck, regret

- Had to go to bed exactly at midnight
- Felt two lectures unlucky today, so skipped them
- Could not stop cleaning in morning, so late to meet friend

March 15

Luck, checking, ordering, reflection

- Woke up at lucky time and made specific preparations as needed to write test
- Brought 3 pens as 3 is lucky
- Checked date to make sure of this for test
- Rearranged items on desk
- Reflected at night on own, extreme perfectionism

March 16

Sleep and luck

- Slept most of day, so few OCD incidents
- Had to listen to 7 songs before allowing self to fall asleep

March 17

Just right, repetition, checking, regret

- Noticed must use one specific chair and only one of many computers at work
- Repeatedly checked time to ensure not late for anything
- Regretted wasted time checking that should have been for writing essay

March 18

Luck and regret

- Could not get out of bed due to need to reset alarm until lucky and digits did not add up to 13
- Regretted wasting about 20 minutes for this
- Put on lucky clothes due to potential haircut and receiving a mark, thus attempting to ensure day progressed well or was neutral at least

March 19

Ordering, extreme nervousness, regret

- Spend most of day writing essay, but organized this 7-hour schedule into 15-minute increments causing extreme nervousness trying to maintain schedule
- Regretted having to slow down just to maintain schedule

March 20

Just right

- Despite having no logical explanations, needed to sit in the right seats/chairs in a car, restaurant, and at friend's home

March 21

Luck

- Significant day, so did not engage in much activity as experiencing bad luck could have a long-term effect

March 22 (written on 26th)

Depression

- Ill relative reason for depression and lack of journal entry

March 23 (written on 26th)

Depression

- Ill relative reason for depression and lack of journal entry

March 24

Just right

- Started washing dishes with roommate to finish, but felt wrong to stop so had to wash them all

March 25

Extreme nervousness and repetition

- Extreme nervousness caused by large project due and found self pointlessly repeating behaviours, such as erasing information and refolding things

March 26

Mitigated intensity of compulsions and worry

- Used recreational drug that mitigated intensity of OCD compulsions and worry
- If did occur, only to avoid people or situations that could reveal drug use

March 27

Absent obsessions and compulsions

- Used hallucinogenic drug that caused obsessions and compulsions to be absent for hours
- Recognized being in situations that would normally produce OCD compulsions, but drug influenced

me as stated above

March 28

Discomfort and repetition

- Discomfort due to previous night's activities
- Spent long time cleaning room that was already clean, but still did not want friends to see it

March 29

Discomfort, just right, luck

- Took increasingly crowded public transportation that increasingly elevated my discomfort
- Just after getting on, had to change seats three times to feel just right
- Needed to keep eyes closed for a short time due to feelings of discomfort and also had to lift feet while passing over bridges and train tracks and duck while travelling under overpasses

March 30

Compulsion mitigation

- Went on a date, but to mitigate compulsions, refrained from ordering a lot of food during meal

March 31

Luck

- Went on date, drank a lot, refrained from getting too close as would bring bad luck and would repeat earlier pattern that ended badly

April 1

Repetition, luck, discomfort

- Repeated rituals associated with exam preparation, such as going to sleep, waking up, and food consumed
- Also reviewed notes exactly twenty-two times as 22 is very lucky
- In discomfort during entire meal as sitting in chair that was not lucky

April 2

Just right and extreme compulsiveness and anxiety

- While preparing to go out, changed clothes many times as could not find clothes that were just right
- While out, experienced extreme compulsiveness and anxiety, so could not enjoy self and did not want to do much until drunk

April 3

Just right, uncertainty, feeling uneasy

- Could not decide what to wear or even if wanted to go out, so avoided going out, also possibly due to feeling uneasy about enjoying the warmer weather

April 4

OCD discomfort

- Out for dinner with co-workers, but experienced strong discomfort throughout meal due to thinking about sitting at end table
- Did not go out again due to planned location where would have experienced extreme discomfort

April 5

Depression, indifference, pessimism, weaker OCD, just right discomfort, luck

- Depressed, indifferent, pessimistic due to trouble with current dating relationship, so OCD weaker
- Went out for drinks and meal with friends, but experienced strong discomfort throughout due to sitting in seat that was not just right
- Noticed that more than usual, avoided stepping on sidewalk cracks and had to stay within each slab while walking around during the day

April 6

Depression, weaker OCD, just right

- Depressed due to break up of current dating relationship, so OCD weaker
- Left home with certain shoes, but returned to change into shoes that felt just right

April 7

Luck and just right

- Listened to three songs at once
- Tapped desk in class until felt just right
- To ensure last few journal entries were legible, retraced some letters to make them just right

Appendix I: Summary of Participant Data

<u>Gender</u>	<u>Robin</u>	<u>Anne</u>	<u>Mary</u>	<u>Oliver</u>	<u>Nick</u>	<u>Elaine</u>	<u>Steve</u>
	Female	Female	Female	Male	Male	Female	Male
<u>Immediate Family</u>	Parents, siblings	Parents, siblings	Parents	Parents, siblings	Parents, siblings	Parents, sibling	Parents, siblings
<u>Family Mental Health Problems</u>	Did not mention	Possibly	Yes	Yes	Did not mention	Yes	Yes
<u>Living Situation</u>	With boyfriend	With roommate	With roommates	Alone	Alone	With roommate	With roommates
<u>Age of OCD onset (first symptoms)</u>	~12	~12	~13	~13	~13-14	~10	Early elementary school
<u>Age of OCD clinical diagnosis</u>	~16	17	~16	late 20s	~15-16	~10	Early 20s
<u>OCD Medication post-diagnosis</u>	No	SSRI first 3-4 yrs.only	Antidepressant from ~16	No	3 SSRIs & 1 antipsychotic ~first few yrs.only	No	No
<u>Stage of Education</u>	1st degree near comp.	1st degree near comp.	1st degree near comp.	2nd degree near comp.	2nd degree near comp.	~2nd year	1st degree near comp.
<u>Interview Time (total minutes)</u>	~95	~130	~60	~95	~150	~90	~100

	<u>Robin</u>	<u>Anne</u>	<u>Mary</u>	<u>Oliver</u>	<u>Nick</u>	<u>Elaine</u>	<u>Steve</u>
<u>Main</u>	Boyfriend	Parents,	Experiences	Awaiting,	Hoping for	Her goal	Not
<u>University</u>		roommate	abroad, social	and taking improvement	in life, senior	board, fearful	graduating
<u>Persistence</u>			and financial	advantage	administrator	of not	considered
<u>Influence(s)</u>			factors, parent's	of better	family, graduating	graduating	a failure, parents
			graduate degrees	opportunities	friends		
<u>Journal</u>	Did not		Did not				
<u>(# of words)</u>	submit	1493	submit	3330	1495	458	1771
<u>Main</u>		Regret, worry		Contamination,	Checking,	Repeated	Luck,
<u>Journal</u>	-	contamination,	-	reflection, regret,	repetition,	actions, <i>just right</i> ,	
<u>Symptoms</u>		ordering, doubt		high anxiety/stress,	discomfort, <i>just right</i>	regret,	
		panic, frustration		worry, uncertainty	uncertainty	discomfort,	
						repetition,	
						depression	
<u>Main</u>	Ordering	Checking	Neutralizing	Washing	Obsessing	Checking	Neutral-
<u>OCI-R</u>	Neutralizing	Washing	Hoarding	Obsessing	Ordering	Neutral-	izing
<u>symptoms</u>		Obsessing		Checking		izing	Checking
<u>OCI-R</u>	Slightly	Slightly		Between	Between	A lot	Slightly
<u>distress</u>	less than	more than	Moderately	Moderately	Moderately		less than
<u>level</u>	Moderately	Moderately		and A lot	and A lot		A lot
<u>Salient</u>	Worn out	Tired, very	Worn out,	Tired all the	All mental	Tired,	Worn out,
<u>SF-36v2</u>	most of	nervous,	tired most	time, worn out,	health	v.nervous	tired all
<u>Mental/</u>	the time,	happy most	of the time,	emot.problems,	items,	all the time,	the time,
<u>Physical</u>	general	of the time,	get sick	less careful, very	general	accomplished	calm
<u>Responses</u>	health	calm/peaceful	easier than	nervous, down	health	less, less	none of
	very good	none of the	others	most of the time,	poor	careful most	the time,
		time	definitely	calm none of the time,		of the time, very ner.	
			true	gen.health very good	gen.health	fair	most of
						the time	
<u>SF-36v2</u>	Good	Good	Good	Good	Between	Between	Good
<u>Overall Health</u>					Fair-Good	Fair-Good	

Appendix J: Researcher's Fieldwork Journal

I was able to receive feedback from Anne, Nick, and Steve who indicated that their respective reports were accurate representations of their interviews. Subsequently, I sent them a follow-up email informing them that I may need to make some revisions to their reports according to suggestions I receive, and that the self-report journals and questionnaire data still needed to be added. Further, I explained that the ethics board(s) needed to be informed when I no longer needed to contact participants and for them to let me know if this point in our relationships had been reached. After this acknowledgement by each of these participants, the researcher received no further contact from any participants.

Robin

Robin initially informed me that she was diagnosed with OCD in 2000 and then 3 years ago by her family physician. Throughout our interviews, she was calm and very open, for example, she was the only participant to ask me about how much of her life she should disclose. I replied that it was her decision and she quickly responded by letting me know that she would tell me whatever I needed to know. I explained that each participant has his or her own comfort level and she should respond accordingly. I also mentioned that I was not going to judge her and she should feel comfortable throughout the interviews. She confirmed that she felt quite comfortable and we continued the interviews without discussing this issue again. In an email several weeks later, she expressed difficulty in completing the journal by stating that she became so focused on what she was writing and it caused her to dedicate a great deal of her attention to this task. This message ended with an apology and a statement expressing her eagerness about reading my completed study. I replied that I would be grateful to accept anything that she had written and I could arrange to meet her anytime. I acknowledged, though, that she did not have to accept this option and I wished her all the best.

Anne

During our first interview, Anne described many of her behaviours as being strange and I felt she believed that I was strange for researching OCD and wanting to know more about her strange behaviours. She was quite open despite admitting that she was very uncomfortable in a variety of social situations. During the second interview, she made less eye contact and she was not as forthcoming as in the first interview. Her curiosity about why I would conduct such a study persisted. Further, despite her assertion that she is "RIDICULOUSLY shy" (line 679), she had the second-longest total interview time, and she also laughed the most out of all the participants. In terms of drafting the narrative, she advised me to reduce the number of quotations and paraphrase much more throughout. She provided a detailed description of her expectations, and the revision process was completed to her satisfaction shortly thereafter.

Mary

Among her initial emails, Mary confirmed that she had been diagnosed with OCD in April 2005 by her family physician and that this diagnosis was later confirmed by both a psychiatrist and a psychologist. I arrived about 25 minutes before our first interview, but she was already waiting for me. Considering the situation, I asked her if we could begin early. She agreed and we settled into the interview room. At first, her responses to the interview questions were quite brief, but later, she relaxed and opened up more. At the end of this interview, she admitted to being very busy and not sleeping that night and she commented that she does not sleep well. For the second interview, I arrived about 30 minutes early, but curiously she arrived about 5 minutes late. I tried to be friendlier this time because she had the shortest interview of all thus far, but we still had a rather short interview again. She commented that the journal was helpful in identifying her OCD-related experiences and she didn't realize the extent of these before. At the end of the

second interview, she extended her right hand and then we shook hands. I perceived her gesture as a sign that we had developed a good rapport and we had a good interview.

Oliver

Our first interview was the most emotional interview among all of the participant interviews, including all eight interviews from my pilot study. He expressed his feelings and experiences and at one point, his eyes began to water a little and I felt mine do the same, perhaps because I recognized very similar OCD-related experiences that we had in common. This situation was a little embarrassing for me as I had tried to avoid reacting too emotionally throughout ALL the interviews. Despite all the emotions, I thought we had a productive and very informative first interview session. At the second interview, Oliver was also very open, but it was not as emotional as the first one. He mentioned that the interviews were not nearly as intrusive as he expected. As with other participants, I later sent him an email to inquire about his journal writing, such as if there were any additional questions and a convenient time for journal submission. Oliver replied with an apology and stated that a recent OCD episode greatly impaired his day-to-day functioning, causing him to miss some days of journal writing. I assured him that this lapse would not be a problem for me and to please take more time if needed. He promptly replied that he would be happy to continue writing and he hoped that this lapse would not delay my research. I again assured him that this delay would not be a problem and to please take more time if needed. Despite all of the anxiety from his exams, and his admission that this stress overpowered his OCD, we were able to meet for journal submission. At this meeting, he remarked that he recorded journal entries at the end of each day and wrote about five significant OCD-related experiences, although he may have had about 50 OCD-related experiences throughout each day. He also recalled that it was difficult to focus on OCD-related experiences as these had become quite

natural and thus they were not always easy to notice and, therefore, express.

Nick

Although Nick had not seen the interview questions, I felt like many of his responses had been rehearsed, but nevertheless, the first interview went very well. I learned later in the interview that he saw a psychiatrist for an hour each week and therefore I assumed that similar responses may have been given to this doctor. With some of my questions, I felt like he believed that they were not something a psychiatrist would ask and he was put slightly off-balance, which I found to be interesting. At the second interview, he was surprised by question 6 that asked about giving advice to fellow students with OCD. Further, he was very pleased to know that this study addressed post-secondary policies and advice for university service providers, teachers, and administrators. After he read through his narrative, no revisions were requested, as he gave his full approval and also asked if he could be of help in any other manner.

Elaine

In her initial email, Elaine expressed interest in participating in my study and she confirmed her diagnosis of OCD and mentioned that she has been dealing with OCD since childhood. She also wrote that OCD and anxiety are prevalent in both sides of her family. Later, I confirmed with her this diagnosis of primary OCD by a qualified clinician, and we met shortly thereafter for the first interview. At this interview, she smiled and was very personable, and she initiated a hand shake upon meeting and leaving. She had consistent eye contact and admitted that her public and private lives were very different, thus I considered that this difference was perhaps why she hurried through many of the personal questions. At the second interview, Elaine was very receptive to all of my questions and commented on my relaxed interview style and the ability to make eye contact, quite unlike other OCD-related studies in which she had participated.

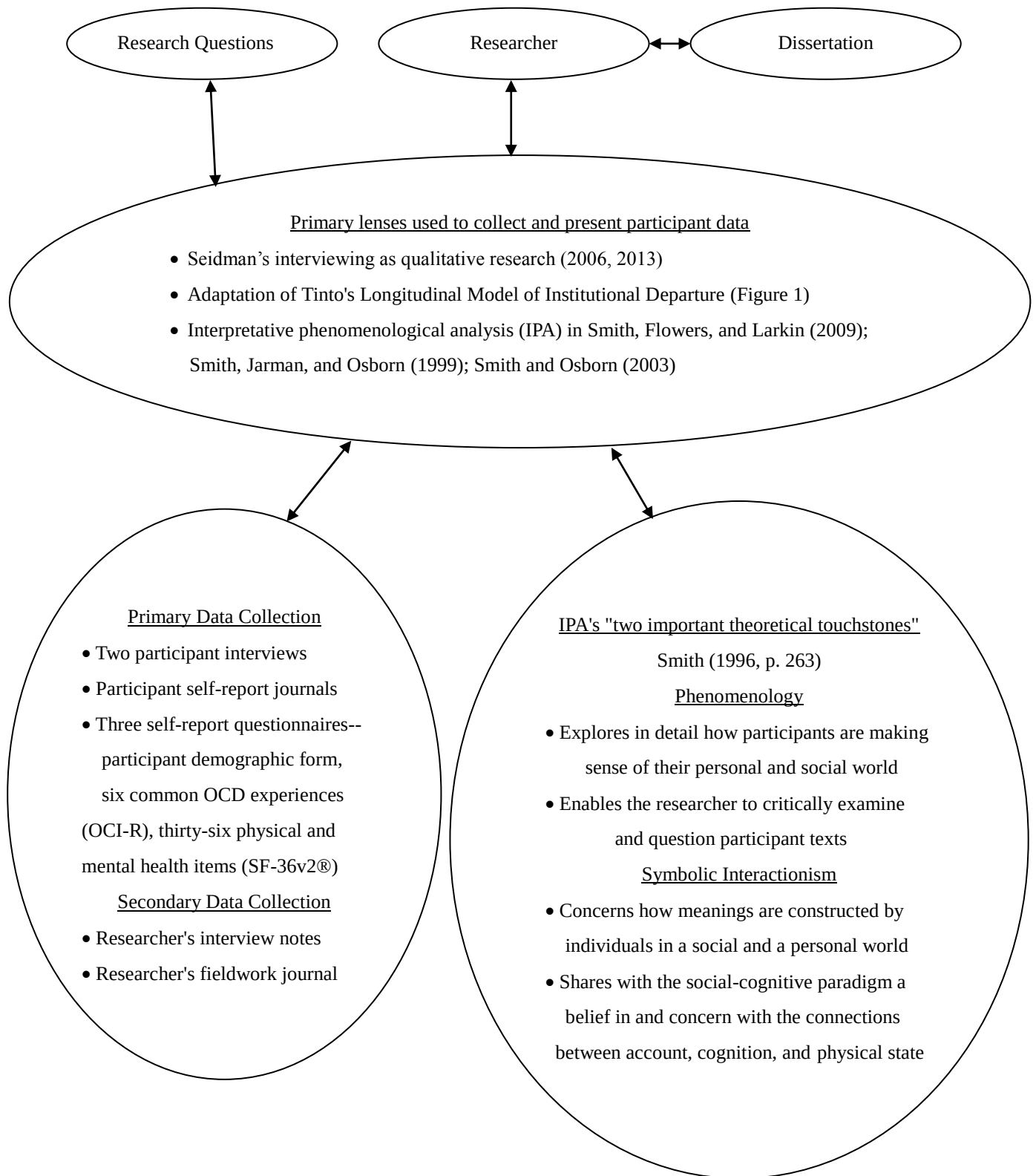
When asked to reflect upon her responses to the questionnaires, she was the only participant to modify some of her responses, despite the researcher never requesting or even mentioning such a procedure.

Steve

In his initial email, Steve expressed interest in participating in my study and he also confirmed a diagnosis of OCD by a psychologist. When I requested more information surrounding his diagnosis, he later explained that throughout his life, OCD had been his most significant diagnosed disorder. At the first interview, Steve was very open about his life and often used hand gestures to express himself. He did not make eye contact often, but this infrequent eye contact did not seem to be an indication of concealing thoughts or responding cautiously to the questions during the interview, rather it seemed like he was just thinking about his responses and trying to recall the information I was asking about. Everything seemed to go very well and he also agreed to write a journal and said he preferred to record his thoughts and experiences in the notebook provided. At the second interview, he seemed relaxed and he made more eye contact throughout. Again, he was very open about his life, but his answers were not as lengthy as at the first interview. I thought perhaps that he had some pressing work to complete. He seemed to be very conscientious about completing the journal every day, as he admitted to missing a couple of days. I assured him that it was no problem as there was no pressure. After reading through his report, no revisions were requested, as he replied that everything was fine, although he joked about his poor grammar.

Appendix K: Study Concept Map

The research questions were developed mainly from the primary lenses used by the researcher. The initial aim of the primary and secondary data collection was to address these questions. The data collection was conducted solely by the researcher himself. These data were analysed and interpreted by the researcher using IPA. Vignettes and participant cases were drafted based on verbatim interview transcripts, and self-report journals (when available). The vignettes and cases were supplemented with data from the respective participant demographic form, participants' everyday OCD experiences of symptom distress and severity in the past month in terms of washing, obsessing, hoarding, ordering, checking, and neutralizing using the OCI-R, and the thirty-six physical and mental health experiences, often in the past month, using the SF-36v2. The secondary data collection comprised the researcher's interview notes and fieldwork journal. Two-directional arrows are used between the bubbles as collection, analyses, and data presentation were ongoing and recursive, including the reframing of research question two. These concepts yielded the final dissertation draft.



Appendix L: Additional OCD Functions of Participants**Robin****Strengths, weaknesses, and coping strategies.**

Regarding her OCD and laptop use, Robin explained:

I have like a specific, like certain things I need to underline and THIS like bullet needs to be used, underline needs to be used and everything, but let's say, like if, you know when you have bullets and you press enter, another bullet shows up? Well, if I don't want that there, I'll have to backspace, backspace, backspace, then press back, go to the letter, like it's hard to describe, but go to the, if the last word was like, NOW, go to the w, go back, go up, go down, go back, go back, and then, do it and so it's difficult to describe, but it's like a set thing in my head that, just to, to get to the next thing. If I don't want it to be, if it's not a continued thought on the next bullet, and I need to make a space for a whole, new thing. I have to go through that process before I do it...it's really annoying 'cause sometimes I do it once and it's fine, and then sometimes I'll have to do it three times until it like, feels right, and then I could go on, so ya, sometimes I've missed like entire like portions of a lecture and it's FRIGGIN' annoying haha. (lines 437-447)

Considering her frustrations with writing implements, Robin described:

this little thing here, where it sort of puts MORE ink in one space than another, like there, that doesn't bother me, 'cause it's not significant, but sometimes you'll get it so it looks like SPLOTCHY. I can't write with pens like that, OR pencils, pencils that you SHARPEN, you know, not automatic pencils, I CAN NOT write with those EVER because they're so FRIGGIN' ugly looking. And when you write, and then if your hand, it smears it, ah, it's SO gross haha so I can't write with those. (lines 466-473)

When reading, she added:

I can't read without a highlighter, so like I can't, I HAVE TO highlight things and when, sometimes I'll read over something and I'll think in my head, ok that was, that was important but I don't need to highlight it. I could go two pages and then it would be like, I can't, I can't concentrate without highlighting that one part regardless of how important it was. And it's also really annoying too when I'm reading if, if it's like a long paragraph and I get three quarters of the way down and I read and I kinda, instead of actually reading it, just kind of like, look over it and don't understand it, I have to start at the TOP of the paragraph and go, and it's SO friggin' annoying, but like, there's that too...it's more for what I feel is important. I feel like I'm going to FORGET it, I have to highlight it and last night like my highlighter ran out and I knew I could keep reading, I had like 20 more pages to read, but I couldn't, I had to go to [store] and buy some more highlighters because I feel like if I don't highlight it, I'm going to forget it all. (lines 477-490)

The three questionnaires and journal: Comments and clarifications.

In terms of her impulsive speaking, Robin described:

so like for example...if I'm telling my boyfriend later that ok well I was in this room, and there was like a big desk and if the minute I say it I feel something inside of me that says, the desk wasn't that big, you shouldn't have said that, so I have to start again and go ok ok, well I was in this room and the desk was like kind of big and they're talking and if I say I THINK, and then I say it after, if I really don't think that, I have to start again, but I try not to make it too obvious that I'm doing that, like I'll act like I got distracted by something and then start again, so it's really like, it's really annoying 'cause sometimes it takes me a LONG time to say things. (lines 906-911)

Anne**Experiences, beliefs, feelings, relationships.**

Anne cited two examples of hiding her behaviours at her current school:

when I'm writing stuff um, I'll wanna like do certain things like...I'll wanna stick a word, instead of sticking it here, sorry, like down a line, I'll wanna stick it like up there just because like I'll be stressed out and I'll just be like...taking notes in class or whatever, so um, I'll try to fit it in, sometimes it won't fit though, it will be too long of a word haha, so I'll just have this like, like writing over into the corner of my page and then I'll have like here, which will be like normal again haha, like this, so like here, I'll just have this word that for some reason I'll have to fit it in or I'll wanna...write a word twice, so like write it up here and then I'll be like AHH I'm going to write it again down here, and...like sometimes I wonder if people can see what I'm doing, um and are like why is she like?, she just wrote that word, she just must be really dumb or something, like to be writing it again, uh, um, or like sometimes, um, I'll like cross out a word I just wrote and then write it again haha and like sometimes it's like OH I FORGOT THAT I WROTE IT, really I'm just like, yep, I hope no one notices that hahaha. (lines 472-491)

She recalled writing exams with hundreds of other students:

there's like 400 OTHER STUDENTS and you're like ALL IN THE SAME ROOM, for me like, um, I don't know, with my anxiety, like, I HATE BEING IN FRONT OF THAT MANY PEOPLE even if I'm not in front of them, like I just think like all the things in my head that could go wrong, like, getting sick...like if I was to throw up in front of all these people, it's just like I get REALLY NERVOUS when I'm around that many people, like even in class, which usually just exasperates [exacerbates] like OCD, like things that I think about. (lines 513-528)

Strengths, weaknesses, and coping strategies.

Regarding coping strategies, Anne recalled:

before I used to like write myself a note on my bulletin board and I'd like, it'd be like really vague so other people wouldn't know what I'm talking about, but it would be like you can do this don't worry, um, just think logically, relax, and that kind of helped me, but, um, there's only like so much times that you can think logically before you're like well I know it's illogical, so I know it's irrational, I'm still gonna do it, so there's only so many times you can tell yourself that it's irrational before you're like WELL I KNOW IT'S IRRATIONAL, give me something else. (lines 763-774)

Mary's Goals, challenges, changes, persistence.

Mary saw that she was unable to obtain a second reference letter probably due to her absence from school for an academic year, when she tried to take a medical leave. She described:

I sorta got overwhelmed and took, attempted to take a medical leave. I saw the three doctors and the doctor here, but I still didn't get my money back. Um, oh well, but what happened during that time I worked full time and I was able to see WOW I hate working [job] so then it sort of spurred me more to like volunteer and wanting to get back in here and getting a degree and actually going out and helping people instead of helping corporations get more profit. (lines 398-401)

Regarding the severity of her OCD, she asserted:

I really, don't think that I have a disibilitating [debilitating] disorder, it's more of an annoyance...'cause mine's, I guess it's pretty mild, 'cause...I'm not like one of those people who has to wash their hands for 3 hours a DAY. It's just more, 30-second thing instead of a 3 hour thing, so it's not really that big of a deal, so it really doesn't affect me that much. (lines 719-724)

In terms of repetitive acts, Mary expressed:

habits are hard to change, I mean doing things once instead of twice, or 4 times is kind of weird. I can DO IT, it just doesn't FEEL RIGHT, it's like a conscience talking to you, saying that like, you COULD kill someone, but you'd have your conscience talking to you telling you not to do it. It's the same thing pretty much with OCD, just not screaming probably like it would if you killed someone, but so you want more of a gentle reminder.
(lines 650-655)

Others with OCD and those who encounter them.

Considering advice for fellow students with OCD, Mary stressed, "take your medication even though it's a BIG PAIN haha and like it makes me sick, like nausea and everything else, but it more or less keeps me, normal. So I guess that's really the defining thing haha" (lines 732-736).

Oliver

OCD diagnosis, recommendations, treatment.

In terms of his exposure therapy tasks, he remarked, "you first look at the list as being kind of like, I can't do this and then as the steps started to fall, it just kind of like crumbled away more than anything" (lines 218-221).

Experiences, beliefs, feelings, relationships.

With respect to taking 2 hours to get ready in the morning, Oliver explained:

I remember being like this is, the most frustrating part was that you consciously knew this was nuts, you're like, you can't do this anymore, you gotta stop, you know, but you couldn't bring the anxiety down, unless you did it, you know, so I was always just like on high on everything I touched until, I finally finished it and you did it all. (lines 170-173)

More specifically, Oliver described:

well, I wouldn't touch a doorknob, I wouldn't touch I wouldn't have touched this seat, I would have washed all my clothes after sitting here uh, just thinking about it makes me like kind of frightened to remember what it was like, but um, if somebody like shaking your hand or somebody like touching your shoulder just like conversationwise that would have flipped me out, you know, but the weirdest thing, the weirdest thing was I was MOST paranoid in my own house, 'cause I lived with three randoms, I subletted a room, those three people didn't really know it when I moved in and uh, I was most paranoid there. When I went out in the world, unless there was a bathroom or something that's like, where you associated normally with things like contaminants and like that, like you'd wash your hands in the bathroom is a normal association with germs, um, I didn't have them, like except doorknobs, for some reason I couldn't touch a doorknob 'cause I always assumed people touched their nose or rubbed themselves, then touch a doorknob, but it really did stay at very, very, specific places, but there were other things that kind of factored in there. (lines 187-200)

When asked to comment on what might happen when he sees a street light go out, Oliver replied, "I don't know, it's just kind of a bad vibe...it kind of, it makes me alert to the situation and kinda like, everything kind of feels a little bit, you kind of feel less in control, you know like you feel someone, something else is kind of watching you, and that's the sign" (lines 356-362).

Regarding his surprise that people consider him to be "stand-offish", Oliver explained:

Um, I thought I came across obvious that I was very shy, but um, I can understand I guess maybe why that would happen. Um, and I've been amazed to find out that nobody can tell I have this problem [OCD], that, that was, 'cause I thought I was a dead, like, you know,

anybody could see that, and nobody seems to know. (lines 804-809)

Goals, challenges, changes, persistence.

Oliver figured that his greatest challenge has likely been with his OCD, as he commented:

I guess having come this far and having seen where I was last March, it started in January, but I only started getting treatment I guess for it in March, um, it's totally night and day and even though...probably qualify me as depressed a little bit, uh my, quality of life in terms of what it takes to go through life and everything has just gone up a hundred times. (lines 515-520)

Regarding the instigating moment he described, Oliver added:

it's always been my experience...like 30 seconds after this has happened, even if it's gonna drag out for 2 years, I remember those 30 seconds, like just that full-body wave of energy and then, if I can just deal with it THEN, instead of letting it fester and, and manifest itself and get into a lot of trouble, then I think you have a chance of beating it. (lines 1221-1223)

A typical day.

In terms of repeated hand washing, Oliver added, "if it just didn't feel clean...or something didn't really add it up, I had to go do it again or do it HARDER or something like that to the point where I'd, like, chafed all the skin off the back of my hand, like I remember being like I should put some cream on that and the cream would act and it turned all red" (lines 740-744).

Nick

Experiences, beliefs, feelings, relationships.

With respect to his most memorable emotional experiences, Nick began by describing his recent emotions within a classroom:

it's always a high-anxiety situation....like being there taking notes, I'm actually missing something, I'm not getting it, look at others, they're getting it, they're, look at what they're typing, compared to what you're typing...it's a very high-stress situation because not only are you thinking about, what the professor's saying, you're also dealing with things in your head. So for instance...when you're sitting there and you're feeling like I'm not getting it, I'm not getting it, imagine like, writing and saying I'm not getting it, I'm not getting it, ok what is she saying? ok, I'm not getting it, I'm not getting it...it's like TWO DIFFERENT...ways in which you're putting mental effort, you're trying to juggle two things at one time, so that can be VERY, it's high anxiety, like I mean there's times in class where I'm just like, and I wanna scream, like, or it even manifests itself physically where my body gets, really like, it gets achy, it gets really tense and I just start yawning, consistent yawning, one after the other and it's, it becomes, it exerts itself physically as well ha so it's very high stress, I mean in terms of, remembering happy moments, I really don't remember ha any happy moments with all honesty, I don't know why.... (lines 702-723)

Goals, challenges, changes, persistence.

Regarding his current life goals, he admitted:

there's no clear sense of anything, I don't know what I want to do, and the majority of the time, what I'm doing, I think, you know what, I'm not even enjoying this, and since I don't enjoy [my program], whatever [program] work I have done, I haven't enjoyed it, so I have no goals, it's like I'm just, my motto is just keep going, what you're doing, just keep going, it's not, it's not about I HAVE this goal, like set everything up so that I can get there. It's just I have no goal, just keep going along this path, just keep going, just keep going, and there's no clear vision of where I'm going. (lines 470-477)

Considering his daily difficulties and life after school, Nick predicted:

I don't see it changing...it's just gonna be the same stress I incurred...while in school. Then there's always this little hope, like just keep going, maybe tomorrow will be better, maybe tomorrow will be better? And tomorrow is NEVER better, but maybe...I will meet someone or have some treatment that will make this all go away and I'll finally be able to enjoy life. So it's all about tomorrow, a little bit of hope, just keep going, that's why, that's why I don't drop it now. (lines 929-950)

Strengths, weaknesses, and coping strategies.

Nick strongly regretted purchasing a suit, as he described:

it is excruciating, because I feel as if I didn't think through it and I didn't, I wasn't methodical with it to the point where I will pick out every little detail, take it home, stare at it for hours....I'll bring it back, talk to the salesman, sometimes even get into a fight over it....so, when I make those spontaneous decisions, I can't live with them afterwards, they cause a lot of stress. (lines 1473-1483)

A typical day.

In terms of making decisions, Nick stressed:

every single decision, HAS a degree of, worrying, DOUBTING, thinking about this is the way I should say it, for instance if I have a meeting with...the psychiatrist, and I'll leave afterwards saying, maybe I didn't tell the story right, was that right what I said? You know, am I, am I, am I really phrasing this right, is she actually getting what I'm saying? So like everything, or even, decision about what I'm gonna eat for lunch. Like, do I really feel like this, am I going to be tired afterwards, or when I'm eating it, do I really like this? I should have chosen something else, what would it have been like to eat something else? I'll

actually VISUALIZE in my mind, or try to FEEL or TASTE the way something else would taste to see if I would like it better than what I'm actually haha. (lines 790-798)

Appendix M: An Overview of Pediatric and Geriatric OCD

Pediatric OCD.

For adolescents and children, anxiety disorders represent the most prevalent mental health problems (Rockhill et al., 2010). Similar to the adult OCD population, those with pediatric OCD also experience many significant problems, such as poor performance at school and poor social integration (Leininger, Dyches, Prater, & Heath, 2010). Despite the variety of educational and social troubles, however, reports concerning QoL for these youth and their families have been quite limited (Lack et al., 2009). In their seminal QoL study, Lack et al. found a substantial decrease in QoL among their 62 participants when compared to controls, but their finding was comparable to similar psychiatric patient populations. They also found that parent and child QoL reports ranged from moderate to strong, showing that parents and children were not consistent in terms of how they interpreted the same, respective OCD symptoms. This disconnect may be related to the observation that the most difficult aspect of pediatric OCD is the acknowledgement of the disorder, followed by an accurate diagnosis by a doctor who could have limited or no knowledge of OCD (Chung & Heyman, 2008). Lack of knowledge has often led to pediatricians and others prescribing inappropriate medication and/or implementing unsuitable psychotherapies (Marien, Storch, Geffken, & Murphy, 2009).

Typical pediatric obsessions include symmetry, contamination fears, and preoccupations with particular numbers and forbidden topics, while compulsions often include repeating, cleaning, checking, and tapping. Insight into these behaviours is often poor when compared to adults, even if physical signs of tics, a decrease in weight, or very chafed hands are noticeable (Rockhill et al., 2010). In spite of these often very distressing presentations, pediatric OCD still exists as a disorder that is frequently hidden and surrounded by embarrassment (Barton & Heyman, 2009).

Regarding the etiology of pediatric OCD, pediatric autoimmune neuropsychiatric disorders associated with streptococcal infection (PANDAS) has triggered a great deal of debate since the term was coined in 1998 by Swedo et al. (as cited in Martino, Defazio, & Giovannoni, 2009). Group A β -hemolytic streptococcal (GABHS) infections are viewed as precursors to PANDAS, with PANDAS comprising childhood OCD and tic disorders, such as GTS. GABHS infections have been found to often occur within the preceding year of a diagnosis of PANDAS. Although there seems to be a linkage between GABHS infections and OCD pediatric patients within the variety of studies conducted, researchers have characterized these patients as a subgroup because not all OCD pediatric patients have had GABHS infections and thus further study is warranted (Martino et al.). Such study includes the role of comorbid disorders, for instance, the prevalence of attention deficit/hyperactivity disorder (ADHD) and their influence on diagnoses and treatment. Comorbid disorders seem to be influential as Lack et al. (2009) found as many as three quarters of pediatric OCD patients also have comorbid disorders, predominantly ADHD.

Diagnosis.

The Y-BOCS, noted earlier, has a pediatric counterpart named the Children's Y-BOCS, as used in Lack et al. (2009). Other related instruments from this study included the self-report Pediatric Quality of Life Inventory, and the self-report Pediatric Quality of Life Parent Proxy Inventory. Chung and Heyman (2008) cited this Y-BOCS as being the *best validated* instrument for diagnosing childhood OCD. Although there are a number of diagnostic instruments available, determining a clear diagnosis is more difficult in pediatric OCD as children have poor insight and it is difficult to ask them to accurately describe their symptoms. For instance, they commonly refer to OCD obsessional thoughts as *voices*, thereby potentially leading to a misdiagnosis of a psychotic symptom (Chung & Heyman). Rockhill et al. (2010) noted that even when asked directly,

children may be unable to effectively describe their distress due to their inadequate communication skills. In contrast, Franklin, March, and Garcia (2007) emphasized that in older children, their personal observations are often given more weight than those of their parents, though parental perspectives are still valued especially in terms of gauging time devoted to performance of rituals.

Treatments.

Contrary to the criticisms directed toward treatment of adult OCD previously noted, Chung and Heyman (2008) characterized child and adolescent OCD as being *very treatable* with CBT and medication, along with the assistance from family. They also acknowledged, however, a dearth of research involving outcomes and longitudinal studies. A further treatment limitation is that CBT therapy is not often available in a majority of areas (Franklin et al., 2007; Marien et al., 2009).

Franklin et al. (2007) emphasized that during the psychoeducational phase of treatment, children should be informed that modifying reactions to obsessions will be stressed, rather than striving to eliminate the obsessions. This modification process also invites challenges, such as the therapist having to *recalibrate* severity of anxiety-provoking behaviours that the child has inconsistently described using numbers. Psychoeducation is often the initial phase of CBT, followed by modifying reactions, determining severity levels, and then gradually exposing patients to anxiety-provoking situations, beginning with the least stressful (Marien et al., 2009).

Leininger et al. (2010) reported the usefulness of both CBT and medication, with medication being a supplemental treatment when CBT is deemed to be ineffective or comorbid disorders are evident. They noted the absence of studies related to CBT for children below age seven. As an integral part of OCD treatment, they asserted that teachers need to carefully monitor and document their students with OCD and those with related behaviours in order to accurately inform parents, clinicians and others who may be involved in the treatment process. Teacher responsibilities

comprise about a dozen classroom strategies to monitor and document such students, for instance, mitigating anxiety during stressful situations and encouraging focus and completion of assignments. In addition to the significant role of teachers monitoring and documenting such students, Leininger et al. emphasized the importance of teachers to be caring, proactive, and providing a great deal of individualized attention. In an ideal world, having such teachers would certainly be beneficial in the pediatric OCD treatment process, but the plethora of teacher qualities and responsibilities described seem quite unreasonable and burdensome for the average teacher with dozens of students who may have other special needs students, such as those with vision or hearing problems, or other physical impairments. Perhaps a more moderate approach should be considered, such as first asking the teacher what he or she could contribute to this treatment process, rather than making such highly time-consuming and unreasonable demands that may only serve to hinder the data collection process.

Marien et al. (2009) noted that CBT effectiveness studies are typically reported based on patients who have received treatment for the first time, while partial or poor treatment-response studies have seldom been reported. To address this disparity, and the serious lack of availability of pediatric CBT treatment providers, Marien et al. developed and conducted an intensive CBT treatment program with an emphasis on family involvement, and the implementation of 90-minute sessions every weekday for between three and four weeks. Although this innovative program was not a part of a randomized study that gauged the degree of treatment efficacy, it showed a decrease of 54% in the severity of symptoms among 30 participants who ranged in age from 7 to 19.

Another innovative study, described as the most comprehensive in pediatric OCD treatment (Rockhill et al., 2010), evaluated three types of treatments in order to judge their effectiveness. Using CBT, sertraline, and combining these treatments, all versus placebo, yielded a superior result

for the combination with a 53.6% remission, while using only CBT yielded 39%, using only sertraline yielded a 21% remission, and placebo yielded a 4% remission. Further, their review of pediatric anxiety disorders led them to conclude that despite recent safety issues related to SSRIs, using medication to treat pediatric OCD has the most favourable outcome when compared to treating all other pediatric anxiety disorders. Barton and Heyman (2009) also noted the hesitation to prescribe medication to children, but they emphasized that not treating OCD with medication could be much more detrimental over the short and long-term care process.

Geriatric OCD.

Geriatric OCD has not seemed to attract a great deal of attention in terms of academic publication considering database searches and also the findings of Carmin and Wiegartz (2000), Grenier, Prévile, Boyer, and O'Conner (2009), and Teachman (2007). Carmin and Wiegartz described a common belief that older adults did not typically have OCD, and thus this population had been understudied. Epidemiological surveys have determined, though, that there was a prevalence of about 1.5% for those who had OCD and who were also above the age of 65. Further, the researchers mentioned the potential inadequacies of ERP among elderly patients versus those who are younger as the elderly may be less likely to show improvement from mere verbal treatment and they may also be physically challenged in terms of carrying out exposure treatment tasks. After about three weeks of ERP with two elderly, male patients considered to have *severe* OCD, the researchers noted that the first participant showed considerable improvement as his symptoms had been greatly reduced, even after a year subsequent to his ERP sessions. This treatment success also involved the assistance of his family, friends, and co-workers. The second participant, however, was much less successful, with promising improvement during his treatment, followed by relapse and failure to comply with follow-up treatment subsequent to his three-week

CBT. This relapse was potentially due to the lack of treatment opportunities available in his area, and also the anxiety associated with returning home to his family who were not eager to continue dealing with his burdensome OCD. Such geriatric treatment, the researchers noted, is further complicated by having to consider the duration of the disorder and multiple health problems.

In more recent geriatric OCD research, Grenier, Prévile, Boyer, and O'Conner (2009) studied 2798 participants who were divided into four groups, with one group of 41 participants designated as "older adults with probable OCD" (p. 863). Despite this diagnostic limitation, the authors acknowledged that their insights contributed to the dearth of data available concerning this particular population. They highlighted data using four categories of social functioning, more specifically, daily mobility and communication, domestic chores and finances, participation in local social events, such as bingo and dancing, and relationships with others. Each category was evaluated with a single question intended to determine the severity of impairment due to participant symptoms. Further, they questioned participants about their social support and perceived mental and physical health. Findings indicated that compared to the other three groups, namely, those with other probable or no disorders, the probable OCD group had significantly higher degrees of relationship difficulties, but they also predominantly reported favourable social support. The researchers also found that those with probable OCD more frequently experienced difficulties within the four social functioning categories than those from the other three groups. In spite of the many difficulties reported, 90% of participants had not sought treatment, possibly due to their lack of symptom insight. The researchers advocated for an awareness campaign to assist such participants in getting the help they deserve.

Another study (Messina, 2009) examined risk factors for obsessive-compulsive symptoms among 165 participants aged 65 to 93. They completed a number of related self-report

questionnaires and they then met with a clinician who obtained additional study data. Despite the limitations of this research, for example, having participants who were mostly Caucasian females that had not been clinically diagnosed with OCD, this study did find evidence for a potentially useful treatment recommendation. It found that increased cognitive self-consciousness (CSC) (thinking about thinking), related to such concerns as mental health impairment, was potentially linked to increased OCD symptoms. Thus, Messina suggested that treatment for this elderly OCD population may be more beneficial if a focus on reducing CSC is considered in conjunction with a focus on reducing OCD symptoms.

Earlier, Teachman (2007) studied OCD symptoms among participants aged 18 to 93. They had sub-clinical, self-report OCD symptoms, and they were mostly healthy Caucasians with no mental health problems. Teachman focused on how subjective cognitive concerns may affect obsessional beliefs and OCD symptoms, for instance, in the elderly, the increased doubt regarding thought processes that may increase checking and may therefore cause other OCD symptoms to worsen. To gauge age differences, participant data were separated by ages 18-64 and 65 and over. The key difference found was that the latter group had greater subjective cognitive concerns than the former group. This finding was thought to likely be from the gradual decrease in cognitive ability as one becomes older, thus making such elderly people more susceptible to worry about cognitive function. Teachman asserted that her key finding may be important when considering treatment for geriatric OCD symptoms, as these subjective cognitive concerns are elevated in this population and should be closely examined. One example she noted was a case of a retired professor who was treated at age 80 for OCD after having worried about his cognitive decline over the previous 15 years. Perhaps, if such cognitive concerns would have been explored in more detail at age 65, he would have been able to benefit from treatment much earlier.

Appendix N: Additional OCD-Related Insights

Not only is there a great diversity of symptoms among individuals with OCD, but there is also a wide range of OCD resources available. In addition to the reference list, the resources below may be of interest to readers.

Internet.

<http://www.cerescan.com>

CereScan provides brain imaging services for those with brain disorders, including Alzheimer's disease, bipolar disorder, and OCD.

<http://www.healthyplace.com>

Anne regarded this site as very helpful. It contains a broad range of mental health information on such topics as disorders and their medications, related tests and recent news.

<http://www.medicalnewstoday.com/articles/123441.php>

Directly related to this exploratory study, this article, *OCD Action calls for universities to support students with obsessive compulsive disorder*, outlines perspectives from London, including those of a senior counsellor at Royal Holloway University of London and a student who had to leave university due to his OCD.

<http://www.mindfreedom.org>

MindFreedom International is a nonprofit organization established to provide support and information to those who have been adversely affected by the mental health system. This site also offers opportunities to become involved in advocacy, such as the Mad Pride 2014 event in Toronto (see <http://www.madprideto.com>).

<http://www.ocdaction.org.uk>

OCD Action is a national charity established to increase awareness about OCD and to provide related support and information. This site includes a variety of resources, such as events, forum discussions, and video stories.

<http://iocdf.org>

The International OCD Foundation is an excellent professional resource for those seeking both broad and specific OCD information.

<http://www.reach.ca>

Reach Canada can assist those with psychological disorders and other disabilities by referring them to an appropriate lawyer who can provide as much as 3 hours of pro bono advice.

<http://www.rebt.ws>

The Albert Ellis site: The official biographical and research site of Dr. Albert Ellis is an excellent resource for those who are interested in knowing more about a key figure in cognitive behavioural therapy. This site features a biography (1913-2007), and also includes videos and related publications.

Movies.

Langan, C. (Producer), & Shergold, A. (Director). (2005). *Dirty Filthy Love: An obsessive compulsive comedy* [Motion picture (DVD)]. United Kingdom: Sundance Channel Home Entertainment. (Manufactured and marketed by Hart Sharp Video, 575 Broadway 6th floor, New York, NY 10012).

Newman, G. (Writer/Producer). (2005). *Howard Hughes: The man & the madness*

(The true story of the aviator) [Motion picture (DVD)]. United States: MPI

Teleproductions. (Available from MPI Media Group, 16101 South 108th Avenue, Orland Park, IL 60467).

(Hughes is probably still the most accomplished and well-known individual to have OCD, but many people would argue that his quality of life was poor as he lived alone for decades and he had few close, personal relationships)

Pancer, M., & Hoffert, D. (Directors). (2001). *OCD: The war inside* [Motion picture

(DVD)]. Canada: National Film Board of Canada. (Available from the National Film Board of Canada, 150 John Street, Toronto, ON M5V 3C3). (see <http://www.nfb.ca>)

(This documentary describes and follows the lives of children and adults with OCD)

Books.

Brown, P.H., & Broeske, P.H. (2004). *Howard Hughes: The untold story*.

Cambridge, MA: Da Capo Press.

Murphy, T.W. (with Zine, E.E. & Jenike, M.A.). (2009). *Life in rewind: The story of a young*

courageous man who persevered over OCD and the Harvard doctor who broke all the rules to help him. New York: HarperCollins. (Edward Zine was also featured in the same television broadcast as David (see Zirinsky, 2001))

Seligman, A.W., & Hilkevich, J.S. (Eds.). (1992). *Don't think about monkeys: Extraordinary*

stories by people with Tourette Syndrome. Duarte, CA: Hope Press.

Appendix O: Approval for Use of SF-36v2® Health Survey

October 14, 2015

REF: Optum CT104221/OP047780/QM032107

This letter agreement is in response to the request from Colin Widdifield, ("Publisher") to include Optum's Smart Measurement System URL's listed below and a summerized age comparison of scores (collectively, the "URL's"), to score and provide interpretation on the SF36v2® Health Survey in his Thesis titled "Post -Secondary Students with obsessive-compulsive disorder : An Interpretative Phenomenological Approach Linking Persistence and Quality of Life Insights " ("Publication") by author, Colin Widdifield, ("Author"). The attached "Sample" watermarked Survey is provided solely for the purpose of reproducing the copyright statement in the footer of the Survey.

Publisher agrees that prior to submitting the Publication to any third party for purposes of publication; Publisher shall first provide Optum with a proof of the Publication for review (the "Proof"). Optum retains the right to decline the permission to publish based on its review of the Proof. Optum shall provide Publisher with a letter approving or declining approval of the Request for Publication. If Optum provides an approval letter, Publisher shall provide Optum with a copy of the final Publication.

In the event Optum provides final written approval of the Request for Publication, the URL address(es) that can be published are as follows:

To log in to the Smart Measurement System.Access www.amihealthy.com.

In the Healthcare Professionals and Administrators section to the right of the screen, enter the login name and password that were provided by Optum as seen below.

A user name and password has been assigned to your Smart Measurement System account.

Please do not change your password.

User Name: QM032107

Password: Password123

In the event Optum provides final written approval of the Request for Publication, the Survey may be published in the Publication along with the Copyright Statement displayed in the footer of the "Sample" watermarked Survey and the following text "No part of the Health Survey may be reproduced or transmitted in any form or by any means – electronic, mechanical; including photocopy, recording or any information storage or retrieval system – without permission of the copyright holder".

Requests for permission to reproduce the SF36v2® Health Survey should be sent to Optum, 24 Albion Rd., Lincoln, RI 02865 or <https://www.optum.com/optum-outcomes.html>.

Licensing and Registration

For permission to reproduce the Survey and/or any associated intellectual property (e.g. trademarks, scoring algorithms, interpretation guidelines and normative data) for any purpose must register or obtain a license at <https://www.optum.com/optum-outcomes.html>.

If you have any additional questions, please feel free to contact Optum at 401-334-8800.

October 26, 2015

Colin Widdifield

REF: QualityMetric CT104221/OP047780/QM032107

Dear Sir

This letter is to confirm that OptumInsight has received proof of the Publication that is the subject of the OptumInsight REF number above, and OptumInsight's prior letter to you dated (the "Preliminary Letter"). OptumInsight is pleased to inform you that your Request for Publication is approved.

Please refer to the Preliminary Letter for information regarding the required ownership statement to be reproduced on all cop(ies) of the figure and/or URL page to be published. Per the terms of the Preliminary Letter, please provide OptumInsight with a copy of the final Publication for its records.

Thank you for your cooperation.

Sincerely,



an OptumInsight company