

‘Life just kind of sparkles’: Clients’ experiences of being in a Cognitive Behavioural Group and its impact on reducing shame in Obsessive Compulsive Disorder (OCD)

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ABSTRACT

This is a qualitative study exploring the personal accounts of service users relating to their experiences of being in Group Cognitive Behavioural Therapy (GCBT) with others who share a similar difficulty associated with Obsessive Compulsive Disorder (OCD). Qualitative process research is lacking in the area of GCBT which has been recently developed for OCD and this study aims to address the gap. Eight participants were purposively selected from two groups. The interviews were transcribed verbatim and analysed using Interpretative Phenomenological Analysis (IPA). Reflexivity sections have been incorporated to highlight my process and reflexive capacity during the research cycle.

Five superordinate themes were generated in the participants' personal accounts relating to the experience of being in group therapy. These were eventually labelled as 'Engagement in the group process', 'Normalising', 'Courage to Fight', 'Being my own Therapist' and 'Restricted by Shame vs. Engaging with Life'. Participants also commented on the helpful aspects of group therapy and made recommendations for change to the content and structure of the group.

The thesis documents my analysis relating to the meaning for participants who shared in a group with others who had a similar difficulty and highlights the significant benefits of the group process as an intervention. Aspects of the group experience that hindered engagement in therapy are also explored. Implications for Cognitive Behavioural Theory are discussed and the relationship of the findings to Social Psychology is explored. The relevance of the findings to Counselling Psychology is highlighted. Recommendations for improvement to the content and structure of ongoing groups are outlined and the role of the group in future clinical practice is explored. A critical appraisal outlining the strengths and limitations of the study is presented and suggestions for future research are highlighted.

Key words: Obsessive Compulsive Disorder, Qualitative research, Group therapy.

Chapter 1: INTRODUCTION

This chapter describes the diagnostic features in Obsessive Compulsive Disorder (OCD) highlighted by descriptions in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-1V; APA 1994). The impact of living with OCD for the sufferer and their families is outlined. Common interventions for OCD currently used are discussed and specific and non-specific factors Cognitive Behavioural Therapy (CBT) aims to target are described. The development of Group Cognitive Behavioural Therapy (GCBT) for OCD is explored and the cognitive behavioural conceptualisation of OCD is highlighted. This is further illuminated through the rich personal account of Laura, one of the research participants. Advantages and disadvantages of group therapy are described and the advantages of individual therapy are contrasted. An overview of the current quantitative research is presented. The advantages and limitations of outcome-based research are discussed and the use of qualitative research with other populations is outlined. The aims of the study and relevance to counselling psychology are highlighted with a view to highlighting gaps in the literature which informed the research questions of this study.

1.1 Diagnostic features in Obsessive Compulsive Disorder (OCD)

OCD is a psychiatric diagnosis given to individuals who are experiencing a number of symptoms outlined in the DSM-1V. OCD has been cited as the fourth most common psychological difficulty, comprising 2-3% of the world's population (Masellis et al, 2003) affecting men and women equally (Rachman & Shafran, 1998). People with OCD experience 'recurrent and persistent thoughts, doubts, images or impulses that are experienced as intrusive and inappropriate and which lead to anxiety and distress' (DSM-1V). The focus of concern often relates to a fear that something awful will happen to self or significant others (Lowe, 2006). In contrast to unwanted thoughts, compulsions are repetitive behaviours which can include hand-washing or mental events such as praying, counting or repeating words silently (DSM-1V). A common factor in the maintenance of OCD that has been overlooked until recently is the 'concealment' of obsessions. This is defined as 'the action of deliberately hiding from other people the content and frequency of obsessions' (Newth & Rachman, 2001 p 457). People with OCD often hide the content of their thoughts due to a fear of revealing an unacceptable side of their personality, sometimes believing that disclosure may lead to a loss of control or even criminal charges (Newth & Rachman, 2001).

A diagnosis of OCD is only made when the individual experiences clinically significant distress which impacts on functioning for more than one hour every day (Bieling et al, 2006).

1.2 Impact on Quality of Life

Recent research has suggested that OCD has a profound impact on the lives of sufferers and their families (Roy, 1993; Gravitz, 1998) because family members and significant others are often involved in the OCD. Families and friends may respond to loved one's persistent demands for reassurance aimed at reducing anxiety and doubt in different ways (Abramowitz, 2009). Stobie (2009) suggests that these responses may include providing reassurance and aiding in the completion of rituals or refusing to participate completely. Both responses are likely to lead to increased conflict within the family system to the extent that individual members' life cycle stages and functioning remain incomplete.

Although very distressing to the individual with OCD, a person can appear to function normally due to the secrecy involved (Schneider & Levenson, 2008). Clinical levels of obsessions and compulsions are associated with poor quality of life. Gururaj et al (2008) demonstrated that severe OCD was associated with high family burden thought to be comparable to the impact of living with people experiencing psychosis and schizophrenia. Although OCD is classified as an anxiety disorder, the emotion of guilt is just as common and it is associated with major depression in 30% of cases (Abramowitz, 2004). For the sufferer, impact on quality of life is disabling because of the amount of time spent completing rituals which can inhibit vocational and academic achievement. One study by Hollander, Kwon, Stein, Broatch, Rowland & Himelein (1996) noted that over 50% of sufferers underachieve academically and as many as 40% are unemployed or underemployed.

1.3 Interventions for OCD

Evidence-based treatments for OCD include pharmacotherapy and psychological therapies such as Behaviour Therapy (BT) and CBT. In very few cases psychosurgery has been used but only when the difficulty is severe and refractory because of the intrusive nature of the procedure (Bieling et al, 2006).

1.3.1 Pharmacotherapy

Studies concerning the effectiveness of medication for OCD have indicated that some people respond well to the use of modern antidepressants such as Selective Serotonin Reuptake Inhibitors

(SSRIs) (Pigott & Saey, 1999) and tri-cyclic antidepressants such as Anafranil, particularly when these are administered at a higher dosage (Hymen & Pedrick, 2010). Studies have demonstrated that both forms of medication are effective in reducing symptoms (Anthony & Swinson, 2001). However, many people with OCD refuse medication and complain about the side-effects. The emergence of psychological therapy for OCD began in 1960 and was informed by behavioural theory (Mowrer, 1939).

1.3.2 Behavioural Therapy

From a behavioural perspective OCD was thought to be an anxiety-based psychological difficulty. Initially it was assumed by theorists that therapy for OCD would be applicable to behavioural theory of 'fear acquisition, persistence and modification' (Clarke, 2005). The focus of therapy was to target external behaviours such as washing or checking and other ritualised behaviour. Research concerning the effectiveness of Behavioural Therapy (BT) was based on interventions using the technique of Exposure and Response Prevention (ERP) (Huppert & Roth, 2003). Behavioural theory was based on a technique rather than an individually tailored case conceptualisation and could only explain ways of overcoming the problem, rather than providing an account of how the problem developed (Fisher & Wells, 2005). Early claims of high success rates using this approach which estimated a 70% success rate for those who completed therapy (Abramowitz, 1997) hindered the development of problem-specific Cognitive Therapy and OCD was viewed and treated like a phobia. However, it has been estimated that 30% of people drop out or refuse BT (Maltby & Tolin, 2005). Salkovskis (1998) suggested that the success rates of BT did not reflect outcome in routine clinical practice and estimated the true success rate to be less than 50%. Behavioural theory could not explain why some people develop compulsions in response to intrusive thoughts and others do not. These phenomenological limitations and the high number of people not engaging in therapy promoted the development of Cognitive Behavioural conceptualisations for OCD.

1.4 Cognitive Behavioural Therapy — Specific and non-specific factors

Cognitive Behavioural Therapy is an empirically validated form of psychotherapy that has been demonstrated to be effective for a range of presenting problems (Bieling et al, 2006). CBT aims to target both specific and non-specific factors. Non-specific factors or 'common' aspects are those that relate to all forms of therapy and include factors such as the quality of the therapeutic alliance. Specific factors are associated with particular therapeutic orientations such as techniques which are commonly viewed as the central facilitator of change (Katzow & Safran, 2007). Research on specific

factors has demonstrated that techniques such as Exposure and Response Prevention are particularly efficacious for people with OCD (Cooper, 2008). The therapist aims to facilitate specific factors through a warm and collaborative relationship aiming to promote rapport, instil hope and trust (Cully & Tetan, 2008).

There is considerable debate in psychotherapy research about the extent to which clients benefit from either specific or common factors. Research on clients' experiences of therapy can usefully contribute to this debate and the questions raised on the nature of change processes (Clarke et al, 2004). This is particularly important since research on therapists' and clients' views of helpful and hindering aspects of therapy are often different. Evidence suggests that only in 30-40% of cases is there agreement between what therapists and clients believe was the most significant event in therapy sessions (Cooper, 2008). Therapists tend to overestimate the importance of specific technical factors compared to common factors (Timulak, 2008a), highlighting the importance of exploring clients' perceptions on therapy.

A study carried out by Elliott & James (1989) reviewed research concerning clients' experience of psychotherapy and noted that clients only described the non-specific or 'common' aspects in therapy as helpful factors. This observation was confirmed in a study by Paulson et al (1999) who explored clients' experiences of counselling. Empirical evidence suggests that the contribution of specific and common factors facilitate change (Feeley et al, 1999). There have only been two studies exploring clients' experience of individual Cognitive Behavioural Therapy for depression. Gershelski et al (1996) explored both common and specific factors in four treatment groups by analysing responses to questionnaire. Clients revealed more responses relating to common aspects of treatment compared to those who had engaged in Interpersonal Therapy. Clarke et al (2004) explored clients' perspectives of change process in Cognitive Therapy concerning the helpful factors in therapy and found that participants valued both specific cognitive interventions and more non-specific facilitative psychotherapy ingredients.

In group work non-specific factors are referred to as process variables. Processes inherent in group therapy such as therapeutic factors highlighted by Yalom (1995) have been highlighted in terms of their value in promoting therapeutic change. Variables such as group cohesion, which has been described as similar to the therapeutic relationship in individual therapy (Bieling et al, 2006), have received less attention in the CBT literature despite the recognition that these processes are important across theoretical orientations (Bieling et al, 2006; Yalom, 2005). The majority of group approaches have been derived from protocols originally devised for therapy delivered in individual

settings (Bieling et al, 2006). Few CBT group approaches consider the meaningful contribution of factors with emanate from the group milieu. However, in group settings clients interact with each other and the therapist, therefore additional factors other than therapist ability or the treatment orientation are likely to influence outcome (Oei & Brown, 2006).

Research into the effectiveness of CBT initially focused on the benefits of individual therapy (Butler et al, 2006). Studies concerning the effectiveness of GCBT began in the 1970s and were primarily driven by concerns about cost effectiveness in healthcare settings (Bieling, et al 2006). Early studies examining group therapy for depression (Hollan & Shaw, 1979) demonstrated that the group approach is equally effective as individual therapy. Since then research protocols for group therapy have been specifically designed for a range of psychological difficulties such as Panic (Evans et al, 1991), Social Phobia (Scholing & Emmelkamp, 1993), Eating Disorders (Bailer et al, 2004), Schizophrenia (Halperin et al, 2000), Substance Abuse (Valasquez et al, 2001) and Bipolar Disorder (Scott, Garland & Moorhead, 2001). Recent studies have begun to evaluate the outcome of CBT group work for OCD (Whittal & McLean, 2002) which will be explored below (1.7).

1.4.1 The development of CBT for OCD

For a long time, despite the prevalence, severity and impact on the lives of sufferers and families, OCD was viewed as a psychological difficulty that was resistant to therapy (Ladouceur et al, 1996). The way in which OCD is viewed by sufferers, mental health professionals and the general public has radically changed during the last decade. OCD is now seen as a common psychological difficulty that is readily helped by psychological interventions suggested by the National Institute of Clinical Excellence (*NICE*) guidelines (2005).

This more optimistic understanding of OCD is due to changed attitudes towards mental health stemming from recent advances in Cognitive Behavioural Theory. Cognitive Behavioural conceptualisations have provided a convincing account of the development and maintenance of OCD that is much more explicit and tangible than previous understandings. CBT for OCD was developed by Salkovskis & Harrison (1984; Salkovskis et al, 1998; Salkovskis, 1999; Salkovskis et al, 1999). It was hoped by Cognitive Therapists that a convincing theory would lead to increased compliance and lower drop-out rates by providing a less anxiety-provoking alternative than earlier behavioural models (Whittal et al, 2005).

1.4.2 Cognitive Behavioural Conceptualisation of OCD

The fundamental premise of the cognitive model is that intrusive thoughts are experienced by everyone although less frequently and intensely than people who develop OCD (Salkovskis, 1998). The main motivator for compulsive behaviours is not the content of the intrusive thoughts but the negative meaning attached, which is often linked with guilt as well as anxiety due to an exaggerated sense of personal responsibility (Salkovskis, 1998). The problem is often fuelled by a range of other behaviours aimed at preventing a feared disaster. So fearful of being responsible for causing harm to self and others or of having failed to prevent a disaster, people engage in a range of 'neutralising' behaviours aimed at reducing the negative feelings associated with the threat (Salkovskis, 1998). Many people with OCD engage in a range of 'protective' behaviours (Bieling et al, 2006) such as carrying wipes to use should the individual come into contact with any substances perceived to be dangerous. People often try to neutralise unwanted thoughts internally by trying to visualise positive images or by trying to suppress thoughts - which has a paradoxical effect of making the thoughts more frequent and intense (Wenzlaff & Wegner, 2000).

In response to the theoretical limitations provided by behavioural theory, Salkovskis et al (1999) speculated how the origins of responsibility may be reflected in the subsequent development of OCD. Patterns of early experience likely to predispose a person to OCD were identified. These include the experience of criticism and blame, overprotective or neglecting parenting styles, exposure to rigid and extreme codes of duty, faulty appraisals and actual experiences of being responsible for harm whilst growing up. As a result of early experiences such as these, children can develop inflated responsibility beliefs (Salkovskis et al, 1999). These previously silent assumptions become activated after a critical incident which can be related to an increased sense of perceived responsibility. A study by Stobie et al (2007) highlighted that the average age of onset was 16 years, which may have been associated with going to college or leaving school highlighting the relevance of responsibility in the development and maintenance of OCD. The activation of beliefs leads the person to become vulnerable to thought intrusions which are often held in opposition to the person's value system. The aim of therapy is to develop a less threatening account of the obsessional experience through the use of behavioural experiments and cognitive interventions (Salkovskis, 1999).

The individualised case conceptualisation approach enables the therapist to explore avenues with the client, leading to the development of a tentative formulation that makes sense to the client. Descriptions of the impact on the sufferer and family outlined earlier highlight the significance of

impairment and restrictions on quality of life. However, what it is like living with OCD and understanding the experience from the person's point of view is more clearly demonstrated by the use of a case example. This is illustrated through the following personal account of Laura, one of the research participants.

1.5 Case Example - Laura

Laura, aged 40, was a married mother with two young children. She worked full time as a Lecturer and a writer. Laura moved to England from South Africa in her early thirties. She had been referred to the Psychological Therapies Service (PTS) for therapy by her GP following the birth of her second child, which had precipitated checking rituals in response to doubts about her handbag being closed. Laura's description of her experience demonstrates some clear theory practice links with the cognitive model (Salkovskis, 1999; Salkovskis et al, 1999; Salkovskis et al, 1998).

1.5.1 Presenting problem

Well, I mean, the main reason I went into it (the group) was because I was having a chronic problem with my bag in the street and my children. I was going through periods of just a minute or so not looking at my children in public areas, and I was very terrified of it, you know, because I was just neglecting them periodically in the worst situation that I could neglect them. I was getting to the point where I wasn't so sure I could take them out at all because I didn't feel that I could look after them properly so that my relationship wasn't crippled by it, but I was very very compromised by it in certain situations, you know, it's horrible to live with that

So fearful of being responsible for causing harm by neglecting her children whilst preoccupied by the OCD, Laura was considering avoiding taking her children out of the house completely.

1.5.2 Early experience and development of beliefs

When I was young, I used to get incredibly distressed by it, incredibly distressed by it, because there was no relief and there seemed to be nothing to be done about it, you know. My mother was extremely hostile about it if I ever mentioned it, you know, so it's a bad thing, it's bad thing that I do, I must be bad, I must be a bad person to do this

During her childhood growing up in South Africa Laura had been concerned about her personal safety due to the war and high crime rate. Laura describes clearly how her core belief developed in

childhood through her mother's hostility and refusal to talk about her difficulties, leading her to believe she was a 'bad' person for carrying out rituals. Since then she had kept her problem secret due to feelings of shame.

1.5.3 Critical incident

There is a sort of critical point when you are not contesting anymore and then you just, you know, it just floods you again and that had happened with the two children and just the stress of managing with kids and working and everything, and I sort of, every time a new little element of behaviours started, I would just umm, bring it on board because I couldn't, I just didn't have the resources not to

Laura had been diagnosed with OCD when she was 18. At that time she had been advised to 'stay calm' by her GP because there was no effective therapy, leaving her feeling hopeless. Laura received some individual therapy after moving to England, giving her some respite, and had presented for therapy again following the birth of her second child. This had constituted a further critical incident activating her responsibility beliefs. She chose to accept her rituals because she no longer felt able to contest the urge to check due to feeling emotionally and physically depleted whilst trying to manage with two small children and working full time.

1.5.4 Maintaining factors

I get so frustrated with myself, I just go and bang my head against the wall, you know, sometimes. I mean when I went for therapy, I was getting in loops with it, just in a loop and out and then in another loop, and out again, only to discover that my whole day was cluttered with it. I was so terrified about setting it off that I was avoiding any behaviour, like any action that I thought might set it off again, which is crazy, you can't live like that

The extent of Laura's frustration was clear as she began her narrative and described the impact of her self-doubt. Laura's OCD was maintained by extensive avoidance behaviour involving any activity or action that might trigger the OCD, resulting in a severely restricted life. Laura's difficulties were further maintained by living in secret with her problems because she felt ashamed about her behaviours. She had tried to share her difficulties with her husband early in their relationship but his aggressive response to her disclosure had led her to hide rituals when he was present. Laura was assessed at the PTS and after hearing what therapeutic options were available to her expressed a

preference for group over individual therapy, wanting to meet others with a similar problem for the first time.

1.6 Advantages and Disadvantages of Group Therapy for OCD

1.6.1 Advantages of Group Therapy for OCD

Although CBT was originally developed for therapy in individual settings it is being used more frequently in groups (Bieling et al, 2006). Group therapy has many advantages over individual therapy far and above the obvious financial benefit of reduced cost. This is due to the generation of therapeutic factors highlighted by Yalom (1995) and Yalom & Leszcz (2005) which are inherent in the group setting. These include a) universality, b) altruism, c) vicarious learning, and d) group cohesiveness. Meeting other people with a similar problem in the group setting, often for the first time, promotes the therapeutic factor of 'universality' (Yalom & Leszcz, 2005) and leaves group members feeling less unique. This is particularly significant for people with OCD due to the secretive nature of their problem.

The social comparison with others who are viewed as 'normal' can increase the risk of disclosure because the person feels less shame through identification with similar others (Bieling et al, 2006). Another advantage of group over individual therapy is that it can promote the therapeutic factor of 'altruism' by providing the opportunity for participants to help one another by giving suggestions, support and feedback which can have the effect of raising self-esteem (Bieling et al, 2006). 'Vicarious learning' refers to motivation to change by observation of other group members working towards a similar goal (Kobak et al, 1995). It has been speculated that the sharing of previously hidden symptoms can facilitate group cohesion which influences motivation to carry out homework, a central component of CBT (Jaurrieta et al, 2008). There are also disadvantages associated to group therapy, some of which apply to groups generally and others that are specific to working with OCD. An individual's motivation to change will also influence the ability to engage in group work.

1.6.2 Disadvantages of Group Therapy

Generally when in a cohesive group, members are united and share therapeutic goals. Groups that are low in cohesion may break down or sub-groups may form. Individual personal roles that may hinder the group process have been highlighted by Basavanthappa (2007). Individuals may act aggressively and express negativism and hostility towards other members. Others may dominate in

an attempt to gain control leaving less time for others to participate in the group. Furthermore, there is an inherent risk in group therapy that members of the group may breach confidentiality, since unlike mental health workers they are not bound by professional obligation to maintain privacy within the group (Lovell, 2010). Concerns about others disclosing may prevent honest participation, particularly by people with OCD, since the secrecy involved relates to an extreme fear of being judged or exposed in some way.

Another aspect on an individual's ability to engage in group work relates to what 'stage of change' clients relate to. Prochaska (1999) suggested a model relating to stages of change. In the pre-contemplation stage the individual has no desire to change and is more likely to drop out of therapy. In the 'contemplation' stage the client may be ambivalent with an intention to change in the future. Individuals with OCD can get stuck in the contemplation stage convinced by the idea that if they continue to ruminate about their fears a solution may be found (Prochaska & Norcross, 2010). When in the 'preparation' stage the individual has a desire to change in the near future. Behavioural changes are more likely to occur when a client is in a later stage. Therapeutic interventions need to be tailored to individual need and more importantly what stage of change people relate to (Cooper, 2008). This individualised attention may be more difficult for the therapist to achieve in group work due to the number of clients in a group. Some clients may feel inhibited about sharing personal issues in front of others. For these reasons there are times when individual therapy is more appropriate for clients. Individual therapy provides an essential context for attending to particular problems. This is due to the privacy and one-to-one attention which can reduce defensiveness and facilitate discussion of feelings about the self and significant others (Feldman & Feldman, 2002). This setting is particularly important for people who feel intense shame or guilt which may stem from having been oppressed or violated in childhood. The one-to-one attention allows an in-depth assessment of all aspects of the client's life which is more difficult in group therapy due to the focus on the group dynamic. Clients may feel more able to disclose secrets in a one-to-one trusting relationship rather than in the group setting (Feldman & Feldman, 2002).

1.6.3 Disadvantages of Group Therapy specific to OCD

Bieling et al (2006) suggests that a major challenge in OCD group work is the differing presentations in terms of psychological content between group members which may lead clients to feel reluctant to discuss certain aspects of the OCD in front of other group members. In the case of violent and sexual concerns for example, clients may minimize the content of other group members' difficulties which are considered less severe such as washing and checking compulsions. Conversely some group

members may be unaware of the universality of violent intrusions and may exhibit a shocked or disapproving response (Bieling et al, 2006). A recent study of group therapy highlighted that cohesion in the group was actually counter therapeutic by virtue of group members holding common beliefs (Schmalisch et al, 2010). This was highlighted when a group member with hoarding difficulties failed to gain insight into the counterproductive nature of acquisition of clutter due to the positive emotion experienced during the course of acquisition. This appeared to weaken the other group members' commitment to non-acquisition of objects and strengthen avoidance behaviour.

Another factor that might prevent an individual wanting to attend group therapy is the common myth that other group members' OCD behaviours can be 'caught' (Bieling et al, 2006). Furthermore, when group members do not comply with homework or exposure exercises this may impact on other group members' motivation. Some may progress at a slower rate than others and feel discouraged and drop out. The group format minimises the individual attention that each client receives. Consequently group members will spend some of the group time listening to discussions that are irrelevant to personal needs (Bieling et al, 2006). On the one hand this may benefit by affording opportunities for altruism between group members. However, altruism may also serve as a form of avoidance with members offering help to others whilst neglecting their own needs, an observation highlighted in the hoarding group (Schmalisch et al, 2010). Bieling et al (2006) highlights a further two issues that can arise in group work. The first relates to the focus of concern which can change rapidly making it more difficult for the therapist and client to select appropriate homework. Secondly, clients may 'transfer responsibility' for the feared catastrophe to the therapist or other group members resulting in less effective behavioural experiments.

1.7 Group Therapy for OCD – Outcome research

Group process is most commonly explored by qualitative approaches and research adopting this paradigm is underdeveloped in the area of CBT generally, despite process factors being recognised as important to the therapeutic experience and being predictive of improvement (Bieling et al, 2006). The emphasis on cause and effect links when demonstrating the effectiveness of therapy has been fuelled by the move towards Evidence-Based Health Care (EBHC) (Baker & Kleijnen, 2000). This advocates the empirical validation of therapies before they are adopted and utilised within the National Health Service (NHS) to ensure that clients are receiving appropriate and effective care. Studies of therapy pertaining to group work for OCD were generated when researchers were exploring questions to empirically validate Cognitive Behavioural approaches and the studies are outcome rather than process related.

The early studies examining effectiveness of GCBT for OCD that adopted generic CBT concepts revealed some limitations with the application of CBT when working with this client group. These studies included strategies such as thought stopping (Epsie, 1986) and the use of positive self-statements and diaries to challenge thoughts (Enright, 1991). Van Oppen et al (1995) also included a cognitive 'self-instructional' training component which was not linked with therapeutic gain. These generic CBT concepts were used before problem-specific models had been developed and are now believed to be unhelpful in the treatment of OCD. For example, the technique of questioning the content of intrusions is counterproductive in OCD, as it can become a mental ritual serving to avoid sitting with uncertainty and providing reassurance (Veale & Wilson, 2005). Contemporary approaches target the meaning attached to intrusive thoughts rather than challenging the content, which is a typical intervention in generic CBT. A number of more recent studies (Anderson & Rees, 2007; Braga et al, 2005; Cordioli et al, 2003; McLean et al, 2001; Jaurrieta et al, 2008) have suggested that contemporary CBT for OCD can be usefully utilised in a group setting.

The 'gold' standard in terms of quantitative outcome research is the Randomised Controlled Trial (RCT) (Ablon & Jones, 2002). This method is considered to be the most rigorous and aims to demonstrate a cause and effect relationship between therapy and outcome (Lowenthal & Winter, 2006). There have been relatively few controlled trials of contemporary GCBT for OCD. McLean et al (2001) carried out an RCT which compared behavioural and cognitive approaches in a group setting. Both treatment conditions were based on 12 sessions comprising six to eight participants in each group. Behavioural therapy was viewed as 'marginally more effective' in terms of symptom reduction measured before and after therapy compared to CBT. However, it was noted that less people dropped out of CBT and more people refused behavioural therapy suggesting the experience of this approach may be more acceptable to clients.

Cordioli et al (2003) also carried out an RCT to compare pre and post therapy results for participants receiving 12 sessions of GCBT with an average of six participants in each group. The study revealed a higher percentage of 'improved' participants (69.6%) measured by the Yale Brown Obsessive Compulsive Scale (YBOCS) compared to the waiting list only showing a 4.2% of improvement. Improvements in quality of life were also demonstrated for participants who had received GCBT compared to those who were allocated to a waiting list. Additional benefits were noted of a further decrease in symptoms at three-month follow-up for those who had received therapy, suggesting that the benefits of CBT persist and result in further benefits over time.

More recently, prompted by the lack of comparison studies regarding the use of group and individual approaches, Anderson & Rees (2007) carried out an RCT to address this gap. Both treatments comprised of 10 sessions with a one-month follow-up. Individual therapy lasted one hour and group therapy lasted for two hours comprising approximately seven participants. Results indicated that individual therapy was associated with a more rapid response; however both therapies had equivalent rates of participants rated as 'recovered' by a brief one-month follow-up. This equivalence was noted due to a greater number of clients who had received individual therapy showing signs of setback at follow-up compared to those who received group therapy. Anderson & Rees (2007) speculated on the possibility that participants in the group programme felt motivated to continue using CBT skills in order to discuss their efforts with the others during the follow-up meeting. It was also observed that the group was associated with a low attrition rate of 13% suggesting that the group setting facilitates attendance, possibly due to the non-specific factors relating to the group milieu. This may be an additional benefit of CBT group work for managing setbacks and preventing relapse.

Jaurrieta et al (2008) carried out an RCT to compare individual and GCBT for OCD to a waiting list control group. Both individual and group therapy comprised of 20 sessions with follow-up at one month, three months and one year. Individual sessions lasted for 45 minutes and group sessions comprising nine participants lasted for 90 minutes. The study demonstrated that both individual and group therapy were effective in reducing the intensity of anxiety, depressive and obsessive compulsive symptoms compared to people on the waiting list who showed no change. In this study those who received individual therapy achieved greater reductions in symptoms. However, those treated individually were twice as likely to drop out of the study compared to those who received group therapy. Jaurrieta et al (2008) speculated that this difference could be due to the cohesion that arises between group members which serves to increase motivation and compliance.

1.7.1 Advantages of outcome research

Until very recently research into group therapy for OCD was in short supply. The results from outcome studies have led to the empirical validation of GCBT and have offered hope to many people who refuse or drop out of exposure-based therapy. The evidence suggests that generic CBT is not appropriate and can be unhelpful in the treatment of OCD. This finding resulted in the generation of a new theory and the development of CBT specifically tailored for people with OCD. Outcome research has informed the National Institute for Clinical Excellence (*NICE 2005*) guidelines which recommended Improved Access to Psychological Therapy (IAPT). CBT therapy has become the

treatment of choice and is recommended as the first line of treatment over medication for some people with OCD in the 'stepped care' model used within the NHS (Gilbody & Bower, 2005).

Controlled trials are vital in evidence-based practice and generate the best answers concerning outcome and efficiency. Most appropriately these studies test the capabilities of therapy after case studies have been carried out (Parry, 2000). RCTs are the most rigorous, aiming to ensure safe, effective, economic therapies are delivered to clients. The RCT has high internal validity which refers to the confidence which the researcher concludes an experiment had demonstrated a causal relationship between treatment and outcome (Parry, 2000). The RCT design provides 'safeguards' to threats to internal validity through three mechanisms 'control, comparison and randomisation' (Bower & King, 2000). Ultimately, the RCT can provide protection to professionals where legal challenges concerning the validity of approaches may arise. Furthermore, the RCT can provide support for the provision of cost-effective therapies which may be under threat (Bower & King, 2000). However, there is a divergence of opinion in terms of what constitutes the most appropriate method for empirically validating treatments (Ablon & Jones, 2002). Researchers adopting alternative epistemological positions have been critical of the RCT arguing that it is inappropriate for use with human beings, can be unethical and lacks relevance to clinical practice.

1.7.2 Limitations of outcome research

1.7.2.1 Appropriateness of research design

RCTs were developed for research in medicine comparing and evaluating the effectiveness of drugs as well as other 'natural' sciences such as physics and chemistry. Some researchers suggest that the experimental method which is borrowed from the 'natural' sciences is an inappropriate design for research in the social sciences for study with human beings and instead advocate qualitative phenomenological research (Landridge, 2007). Others have speculated that the desire for certainty stemming from experimental methods seems 'at odds' with the fluid nature of personal meaning in the therapeutic encounter (Milton, 2006).

1.7.2.2 Ethical considerations in outcome research

Results from RCTs have also been questioned in terms of ethical grounds due to the use of control groups which comprise of people referred to a waiting list, resulting in a delay to therapy. Both Cordioli et al (2003) and Anderson & Rees (2007) used a control group with a view to making findings

more rigorous. The study by Cordioli et al (2003) mentions that the group of participants in the waiting list condition were not given any information which may have resulted in an expectation to improve during the waiting period. However, the length of waiting list and the impact of being assigned to a waiting list have been questioned on ethical grounds in terms of the participants' engagement in subsequent treatment (Cooper, 2008). Allocation to a waiting list may instil hope in some participants or be perceived as a rejection by others. This perception may act as a 'minimal treatment' for some and may negatively impact on engagement with others (McLeod, 2000) who are denied treatment for the duration of the research (Lowenthal & Winter, 2006).

An earlier study exploring the effectiveness of Behavioural Therapy for OCD in a group setting (Fals-Stewart et al, 1993) included a 'placebo' group consisting of people who received relaxation training. Lowenthal & Winter (2006) describe the concept of a placebo as a 'misleading notion' arising from drug trial methods. Unlike research carried out in a medical context, research trials involving human beings are impossible to carry out 'blind' (Wampold & Bhati, 2004). Clinicians will be aware of the 'active' therapy and clients will develop ideas about which treatment group they have been allocated to (Bower & King, 2000). Clinicians are likely to assume that the placebo is less effective - a message which could be communicated to participants (McLeod, 2000).

1.7.2.3 Relevance to clinical practice

Clients enlisted for research studies tend to have mild to moderate problems and are often screened and excluded when co-morbidity is present (Westen et al, 2004). Furthermore when applied in clinical settings the results from clinical trials are disappointing compared to those found in research settings, which questions the external validity or 'clinical effectiveness' of such studies (Roth & Fonagy, 2005). This was evident in the study by Anderson & Rees (2007) which excluded 11 participants due to having a dual diagnosis such as generalised anxiety disorder, major depressive disorder, eating disorder, body dysmorphic disorder, obsessive compulsive personality disorder and anger management problems. A further number of individuals were excluded for unstable medication use three months prior to assessment for the study. In Cordioli's (2003) study participants were excluded where depression, suicide risk, social phobia and a personality disorder were present. McLean et al (2001) compared CBT groups and Behavioural groups and excluded participants with severe depression or the presence of a personality disorder.

Some researchers (Westen et al, 2004; Landridge, 2007) are critical of the experimental approach arguing that this exclusion does not resemble clinical practice. In clinical practice clients are

generally more complex where secondary problems and medication use is common (Cooper, 2008). Rasmussen & Tsang (1986) estimated that 55% of people with OCD also have an obsessive compulsive personality which involves personality traits such as perfectionism, conscientiousness and high ethical standards. OCD can occur in schizophrenia, anorexia nervosa and has been linked to Tourette's syndrome (Gourney et al, 2006). To address issues of clinical effectiveness and generalisability to routine clinical practice, there have been two clinical trials of GCBT for clients with OCD and secondary presenting problems.

Van Noppen et al (1998) carried out a naturalistic trial of time-limited (ten sessions with the group lasting for ninety minutes) GCBT and included participants with depression. Results revealed decreases in symptoms with greater improvements for those taking medication. In order to maximise consistency of the intervention researchers have attempted to standardise therapy by constructing 'treatment manuals', the delivery of which is subsequently assessed by studies of 'adherence and competence' (Lowenthal & Winter, 2006). Braga et al (2005) evaluated manualised GCBT and found that therapy gains were maintained at one year follow-up. Out of 42 participants only eight did not present with secondary problems and many were taking medication. The results from this study indicate that gains from group therapy may persist over time and may generalise to routine clinical practice due to the inclusion of participants with co-morbid problems and medication use.

1.7.2.4 External validity

Despite the inclusion of secondary problems in the naturalistic trials, outcome studies are tightly controlled to increase internal validity. Therapists are usually highly experienced, closely monitored and carry out a manualised approach to therapy so that therapy can be more easily replicated (Cooper, 2008). Outside the research setting strict adherence to a manual is rare because therapists make 'adaptive' choices and use an individually tailored approach to maintain integrity of both the therapy and the therapeutic alliance (Parry, 2000). In clinical practice therapists are minimally monitored and usually use an 'idiosyncratic mixture' of therapeutic strategies (Cooper, 2008). Research generated from the experimental approach provides information about what can be gained in optimal conditions (Lowenthal & Winter, 2006). The key concern however is external validity because when clients, treatments and therapists do not resemble those found in routine clinical practice the implications of the results could be viewed as ambiguous (Bower & King, 2000).

1.8 Future directions – Service user involvement

The success of the CBT group and its value in terms of cost-effectiveness means that its expansion is likely within the NHS. Subsequently the need to refine and develop research methods that lead to new insights into group process has been highlighted (Bieling et al, 2006). Van Noppen et al (1998) noted that the group setting generated curative factors arising from the group dynamic/milieu. Group therapy was observed to facilitate four therapeutic factors highlighted by Yalom, 1995. These were a) universality, b) instillation of hope, c) imitative behaviour and d) altruism. Van Noppen et al (1998) also noticed a sense of growing 'competition' between group members which motivated engagement. Van Oppen (1995) speculated that a sense of competition increased the urge to try harder and observed group members sometimes making contracts with each other to increase the likelihood of reaching a goal. A further study based on therapists' reflections and clients' responses to questionnaire has illustrated the importance of process variables in GCBT therapy with individuals with hoarding difficulties (Schmalisch et al, 2010). Researchers identified four group process factors which were observed through the course of therapy. These were 'universality' which appeared to reduce stigma, 'group cohesion' which motivated change and 'mutual aid' which seemed to instil hope for change - participants also commented on the importance of 'social contact' which reduced isolation, a characteristic of this population.

The Department of Health (1996) recommends researchers to consider using a range of evidence and research methodologies to ensure relevance and appropriateness of therapy. Clinical trials are useful tools for answering questions about outcome and efficacy. However, the design which results in numerical data can prevent understanding concerning therapeutic process. The reliance on quantitative scales used by positivist researchers inhibits participants' responses about effective or ineffective therapeutic interventions (Parry, 2000). Furthermore by relying on constructs imposed by the researcher's choice of questionnaire, investigations are unlikely to unfold new or unexpected findings (Willig, 2008).

Clinical governance relates to the system through which the NHS is accountable for continuously monitoring and improving quality of care (Corrie, 2010). Understanding the impact of counselling and psychotherapy and ascertaining the most effective way of working with clients in specific contexts or specific client groups can provide relevant and valuable information for policy developers, managers, social workers and practitioners (Cooper, 2008). A key component of evaluation relates to clients' experience of the service (Department of Health, 2008). Recent UK government initiatives suggest that service users' perspectives are integral in the formal evaluation

of mental health services. Directions for future research recommended by the American Psychological Association (APA, 2006) have included research involving systematic feedback from clients. Understanding gained from service users who have a unique knowledge concerning what works and doesn't work in therapy can provide a more 'complete conceptual' understanding which can inform both theory and practice (Newton et al, 2007). This exploration is possible by changing research paradigms and adopting a qualitative approach. In contrast to experimental evaluation, qualitative enquiry seeks to capture what the experience of an event or social action means to participants by emphasising the participants' own words (Patton, 2008).

1.9 Qualitative research in CBT group work with other populations

Although quite sparse in the literature, there has been a recent trend to explore the benefits of group therapy from the service user's point of view using qualitative methods. These studies have highlighted changes to the structure and content of group work based on the service user's perspective. A Grounded Theory approach has been utilised to explore experiences of participants in GCBT diagnosed with an eating disorder (Laberg et al, 2001). The findings illustrated that the 'support and friendship' gained from being in the group was valuable and participants gave suggestions relating to the composition of future groups. Participants highlighted a desire for the therapist to be more explicit and to apply more pressure to motivate change and recommended the group should be longer. Bottomly (1998) used thematic analysis to explore views of women with a medical diagnosis of cancer after completion of brief GCBT. Participants found the GCBT programme facilitated an increased capacity to cope and adapt to the illness and also provided information related to improving the group by including more time to talk. This feedback led researchers to recommend including 'spontaneous unstructured' time to facilitate social support. The findings illustrated that participants found the group setting helpful for learning effective ways to manage stress and that the value of particular coping strategies depended on the stage of the illness. Group mindfulness-based cognitive therapy (GMCT) for recurring depression in older people has also been explored using thematic analysis (Smith et al, 2007). The intervention was modified in the light of the analysis resulting in one intervention: 'slow mindful walking', being omitted entirely because participants were in danger of falling over.

O'Connor et al (2008) used Interpretative Phenomenological Analysis (IPA) to explore the views of clients with a diagnosis of 'bipolar disorder' after completing a psychoeducational group using cognitive and behavioural methods. Participants reported an increased acceptance of the illness and found the group powerful for decreasing a sense of being alone. Newton et al (2007) also used IPA

to explore young people's experiences of GCBT as an early intervention for auditory hallucinations. This study demonstrated that service users felt a sense of safety speaking in a group with others who shared a similar difficulty which had a normalising and de-stigmatising effect. Participants benefited by learning from and helping one another. Participants also described that meeting others who were less distressed by the voices triggered feelings of hope and encouragement, indicating the importance of including people with mixed severity of difficulty. The group setting also generated the internalisation of coping strategies and helped participants adopt less distressing explanations concerning the content of voices. More recently IPA has been used to explore GMCT for people with Parkinson's disease (Fitzpatrick et al, 2010). In this study findings indicated that particular coping strategies were more helpful at certain stages of the condition. Finucaine & Mercer (2006) conducted a mixed-methods approach to explore the benefits of time-limited Group Mindfulness Based Cognitive Therapy with participants experiencing depression and anxiety. Participant accounts generated by the thematic analysis indicated that being in the group was a 'normalising and validating experience' and that most participants thought the group should be longer and include a follow-up session.

1.10 Aims of the study and relevance to Counselling Psychology

What remains unclear from the outcome research is an understanding of therapeutic process and how people experience being in a group with others who share a similar difficulty. The specific components of the group approach which make a difference to clients who have completed GCBT remains underdeveloped in the CBT literature. Process research is generally associated with psychodynamic models where process is seen as an intervention in itself, whereas CBT groups have sometimes been viewed as a venue for the delivery of techniques. Bieling et al (2006) argue that despite psychodynamic and cognitive approaches being fundamentally different, group process factors can offer insights that are useful for CBT practitioners because group process can be viewed as 'a theoretical'. Although neglected in the literature, group process factors are recognised and viewed as important by group members (Glass & Arnkoff, 2000). Understanding and working with process in Cognitive Behavioural Therapies can have the advantage of enhancing outcome and significantly enriching clinicians' understanding (Bieling et al, 2006). The individualised approach advocated by CBT (Douglas, 2010) is consistent with the psychological underpinning of Counselling Psychology, emphasising the importance of exploring individual meaning and engagement with subjective experience, values and beliefs (Strawbridge & Woolfe, 2010).

Evaluation and research are fundamental to the practice of Counselling Psychology and empirical investigations concerning process as well as outcome are emphasised (Woolfe & Dryden, 1996). Counselling Psychology aims to draw upon and develop phenomenological approaches in addition to mainstream scientific approaches. Qualitative enquiry lends itself well to the fundamental assumptions of Counselling Psychology which emphasise respect for the individual and the importance of subjective meaning (McLeod, 1996). Professional practice guidelines emphasise research as practice-led and encourage researchers to engage subjectively with people's values and beliefs and to respect first-person accounts as valid in their own terms. Researchers are encouraged to always work in ways that empower rather than control research participants (British Psychological Society, 2005). This study provided the research participants an opportunity to make a valuable contribution which may inform future clinical practice.

This study aims to address the gap in the literature by exploring the process of group therapy from the client's point of view, with a view to complementing the existing outcome research. It is concerned with the lived experience and meaning individuals attribute to being in a group with others who share a similar difficulty. A further focus on the factors participants find helpful and less helpful in group therapy will be explored with a view to improving the group intervention.

1.11 Research questions

How do people experience being in a Cognitive Behavioural Group with others who have Obsessive Compulsive Disorder?

What are the specific components of therapy that participants find helpful and less helpful?

In order to answer the above research questions the researcher is adopting a critical realist epistemological position with a view to exploring in depth eight interviews from service users who had completed therapy comprising 12 sessions of GCBT. Participants were recruited from two consecutive groups carried out in the same trust. The next chapter outlines all the methodological considerations that have been taken into account whilst writing this study.

Chapter 2: METHODOLOGY

The purpose of this chapter is to introduce the critical realist paradigm of the study, the philosophical underpinnings and rationale for the chosen methodological framework of IPA. A reflexivity section is incorporated highlighting my reflexive process during the initial design of the research.

2.1 Positioning of previous research

Researchers adopting a positivist paradigm maintain that a 'real' world exists and attempt to gain knowledge through the use of scientific methods (Landridge, 2007). As a scientist drawing on principles from experimental psychology and other natural sciences the aim of research is to produce objective knowledge. From this perspective the role of the researcher is an objective scientist who is not subjectively involved with the participant and who aims to discover 'truth' about the world to confirm a pre-existing hypothesis (Willig, 2008). GCBT specifically designed for OCD is a relatively new therapeutic approach. Accordingly, researchers adopting a positivist position have attempted to demonstrate the efficacy and effectiveness concerning therapeutic outcome by using methodology consistent with the quantitative paradigm. The results from clinical trials have demonstrated that benefits do exist for clients who receive CBT in a group setting (Anderson & Rees, 2007; Braga et al, 2005; Cordioli et al, 2003; McLean et al, 2001; Jaurietta et al, 2008) therefore it is recognised that there are some benefits of group work for this client group. From a critical realist perspective the author is assuming that OCD exists and that group therapy can be usefully utilised when working with people suffering with OCD.

2.2 Positioning of my research

Within the qualitative paradigm there are differing epistemological and methodological assumptions, including critical realism, which best reflects the philosophy of this study. Critical realism outlined by Bhasker (1975) is a philosophy which aims to provide an alternative to positivism in the social sciences. Bhasker (1975) argues that real structures exist independently of and are often 'out of phase' with the actual pattern of events.

The critical realist perspective of science highlights three domains of reality (real, actual and empirical) in which mechanisms, events and experiences respectively reside (Bhasker, 1975). A

central feature is the preservation of a scientific pragmatic approach when trying to understand what is actually going on in the therapy setting, whilst at the same time recognising the importance of actor's meanings and how to incorporate these into research (Layder, 1993). Critical realists attempt to promote a collaborative relationship with research participants who are actively involved in the process (Robson, 2002). This is consistent with the theoretical underpinnings of Counselling Psychology which emphasise empowerment of research participants (British Psychological Society, 2005).

Landridge (2007) advocates the use of phenomenological methods for research carried out in the social sciences rather than borrowing a method from experimental science. An epistemological focus adopted by the phenomenological paradigm is concerned with experience, narrative and people's 'lived experience' of the world (Landridge, 2007). Phenomenological researchers do not adopt the subject-object dualism that is central to research adopting a positivist position (Smith et al, 2009). Instead it is argued that it makes little sense to view the world separately since the meaning of objects is mediated by perception. The aim of phenomenological enquiry is to study experience as it appears to people. Recognising the same 'object' can have various meanings depending on how it is perceived at different times and in different contexts, the phenomenological approach offers an alternative to what we can know about the world (Landridge, 2007).

2.3 Rationale for choice of method

The aim of this research is to explore participants' experience of group therapy and the meaning individuals attribute to being in a group with others who share a similar difficulty. A further focus on ascertaining helpful and less helpful aspects of group therapy may inform future interventions. The focus on experience and meaning explored in depth through a small number of cases is consistent with the principles of Interpretative Phenomenological Analysis (IPA) which aims to explore how participants make sense of a particular event or experience (Smith, 2008). In contrast to methodology adopted by positivist researchers attempting to identify causal links between treatment packages and therapeutic outcome, IPA is idiographic. This refers to IPA's commitment to focusing on the 'particular rather than the universal'. According to Smith et al (2009) IPA's commitment to ideography and the 'particular' works at two levels. This relates to the sense of detail and depth of analysis which must be thorough and systematic. The analysis must also be committed to understanding the particular experiential phenomena and how it has been understood from the perspective of particular people in a particular context (clients suffering with OCD having completed CBT group therapy).

This approach concerns itself with the unique experience of the individual, maintaining that reality is experiential (Eatough & Smith, 2007). IPA is a qualitative integrative approach informed by both phenomenology and hermeneutics (Smith et al, 2009). Phenomenology - the study of human experience - aims to understand the way in which 'things' are perceived and appear to consciousness (Landridge, 2007). The founder of phenomenology Edmund Husserl argued that researchers should go back to the things 'themselves' by developing a 'phenomenological attitude' which requires a 'reflexive move' directing the researcher's gaze inwards rather than human beings' tendency to fit things into a pre-existing categorisation system (Smith et al, 2009).

The theoretical underpinnings of IPA are also influenced by hermeneutics - the theory of interpretation. A combination of a questioning and empathic stance to interpretation is adopted (Smith et al, 2009). Influenced by the work of Heidegger, who viewed the 'person in context' and emphasised the concept of 'intersubjectivity', IPA endorses the relational nature of human beings' ability to communicate with and make sense of one another (Smith et al, 2009). The researcher aims to generate an analytic interpretation prompted by, and grounded within, the participant's sense-making, albeit understood or interpreted by the researcher.

Unlike research carried out in clinical trials, the researcher is subjectively involved with the participant (McLeod, 2001). Research is viewed as a dynamic process between the researcher and the participant (Eatough & Smith, 2007). The role of the researcher is emphasised in terms of influencing data collection and the interpretation of the participant's experience. From this perspective sense-making is viewed as an activity shared by the researcher and participant resulting in a 'double hermeneutic' in which the researcher engages intensively with the participant's sense-making (Smith, 2008). Less interested in everyday experience, IPA's phenomenological underpinnings allow the researcher to explore experiences which have 'existential significance' for the participant and that have prompted contemplation (Smith et al, 2009).

2.4 Reflexivity – The role of the researcher and participants

The founder of phenomenology, Edmund Husserl maintained that the phenomenological researcher must attempt to set aside a 'natural attitude' - a term used when alluding to obstacles that can get in the way of phenomenological enquiry. A natural attitude is argued to be generated from assumptions relating to the researcher's experience and existing knowledge. This is achieved through the process of 'bracketing' which is sometimes referred to as 'epoche' - the process by which researchers attempt to abstain from influencing the research with preconceived ideas. The

aim is to doubt everyday assumptions or at least reflect and become critically aware of how a natural attitude may be influencing the research process (Landridge, 2007). Adopting a reflexive approach throughout the research cycle will enable the phenomenological researcher to develop this critical awareness.

A number of approaches to reflexivity were considered when designing this research. Functional reflexivity is concerned with the researcher's role and the impact this may have on the research process, with a central consideration of the distribution of power (Finlay & Gough, 2003). My initial idea was to carry out this research with the OCD group I facilitate in the NHS trust. Fundamentally this raised issues concerning my dual role of therapist/researcher and the validity of any findings which may have been influenced by the close relationship I would have developed with participants. When thinking about the legitimacy of findings in qualitative research it is also necessary to consider the needs of the selected group. Many people with OCD have experienced much criticism and blame in childhood and can develop beliefs about the importance of being liked and accepted. I believed that participants might feel less able to disclose criticisms of the therapy to their therapist who was in a helping role. Furthermore, facilitating the therapy group and observing the therapeutic process may have led to assumptions being made about the benefits of particular therapeutic interventions. These assumptions may have influenced the questions I asked or refrained from asking during the interviews which in turn might have influenced the integrity of the data.

I considered processes such as attempting to 'bracket off' my assumptions (McLeod, 2001) and actively seeking criticisms from participants to increase reflexivity as mutual collaboration (Finlay, 2003). Whilst these realist considerations were relevant, adopting a critical realist position demanded reflexivity about my role in the research process. 'Self-reflexivity' (Finlay & Gough, 2003) is a process that involves the researcher exploring the emotional investment in the research relationship. I was responsible for the development of the OCD group within the NHS trust which beforehand only offered individual therapy and therefore was emotionally invested in the development of the group programme. Finlay & Gough (2003) maintain that the credibility of the research can be increased when 'closeness' or personal interest is removed. For these reasons I chose to adopt the role of independent researcher whilst carrying out the research. I renegotiated my role within my NHS trust so that another psychologist could facilitate the group for the duration of the research.

2.5 Participants - Recruitment and involvement

2.5.1 Referral into the group and research

Participants in this study were clients who had completed group therapy at the Psychological Therapies Service (PTS) in an Outer London borough of a NHS Trust. Participants were recruited from two groups; the first started in June 2009 and ended in September 2009. The second group started in November 2009 and ended in March 2010. Participant validation meetings with four of the participants were carried out between April and June 2011 to check the authenticity of the findings following the analysis which took place in January – March 2011.

Referrals from GPs and Psychiatrists within the trust were invited for an initial assessment with the researcher, where a diagnosis of OCD was evident in the referral letter. The researcher had no previous therapeutic involvement with any of the participants involved in the research. Other referrals were assessed by experienced clinicians within the PTS during the initial assessment clinic and then referred for assessment with the researcher regarding suitability for group therapy. Whilst carrying out the assessments potential participants engaged in a conversation with the researcher concerning the content of the OCD. The main intrusions, meaning and emotional responses were explored and the major maintaining factors were identified. The development of participants' difficulties was also explored and where possible predisposing and critical factors were identified. Availability and commitment to attend all sessions was discussed and the importance of completing homework was emphasised. Motivation to engage in the group was also explored and all participants were recommended the book 'Overcoming OCD: A Self-help Guide' (Veale & Wilson, 2005) to read before or alongside therapy. At the time of recruitment this was the standard procedure carried out in the trust in terms of referring for group therapy.

Potential participants were informed during the assessment of the opportunity to be involved in the research on completion of therapy. Participants were then approached at the end of the last group session and a verbal outline of the rationale for the study and the involvement for participants was explained. The participant's information sheet (Appendix a) and consent form (Appendix b) were circulated and questions were clarified. Purposive selection was employed to target the sample. This involved the researcher choosing a particular non-representative subset of a larger population. Participants were chosen on the basis of appropriateness for the study in terms of both relevance and depth (Jupp, 2006).

Eight participants who had completed GCBT for OCD volunteered to take part from two groups. In the first group there were seven clients and one dropped out by session three without giving a reason. In the second group there were eight participants. Four out of six clients in the first group agreed to take part in the research. These consisted of three women and one man. Another member of the group refused at the outset due to time commitments. A second group member expressed fears of saying the wrong thing during the interview and then refused by email after considering the information sheet. In the second group there were eight participants who all completed therapy. Four group members agreed to take part in the research and consisted of one woman and three men. The other four group members expressed an interest at the end of therapy but did not follow this up. The mean age of the participants was 32 with a range from 22-43 years. Participants came from a variety of cultural and ethnic origins. Two were white British, two were white South African, and four originated from India. In terms of employment five were employed, one was in full-time education, and two were unemployed.

2.6 Inclusion and exclusion criteria

Participants were included in the group when available to attend therapy, expressed a willingness to participate in the group and complete homework. Exclusion criteria of active substance abuse, psychosis and current suicidal behaviour was considered but not met. The exclusion of current suicidal behaviour was employed as it is believed that people in crisis situations where suicide is a risk are unsuitable for group therapy. This is because their inclusion can result in the energy of the group being mobilised in solving an external crisis (Gupta, 2005). Yalom (1985) also cautions about the inclusion of individuals with 'impulsive behaviour' due to triggering anxiety in other group members which informed the exclusion criteria of active substance abuse. Burlingame et al (2002) suggests principles that may enhance the development of group cohesion and recommends the exclusion of individuals who are actively psychotic who may negatively impact on the group composition and decrease cohesion. Clients were included in the group when taking medication and where a co-morbid presenting problem such as depression, social anxiety or Obsessive Compulsive Personality Disorder was present to increase external validity and relevance to routine clinical practice. These criteria were generally adopted within the trust when considering suitability for group therapy.

2.7 Ethical considerations

2.7.1 Data Storage

The data (including interview recordings, consent forms and interview transcripts, in which personal data was made anonymous, will be stored for five years in a locked cabinet at the University of East London and on a password-protected computer in line with the BPS (2012) guidelines and Data Protection Act (1998) concerning doctoral level research.

2.7.2 Process involved in gaining ethics approval

Ethical approval for this research was sought and gained from the University of East London in the first instance (Appendix c). Following this an application to the local NHS Trust ethics committee (Appendix d) was submitted which described the steps involved in the study. Copies of the Participant's Information sheet and Interview Guide were included. The researcher was invited to a panel meeting with the ethics board where concerns about approaching the participants for the first time at the end of group therapy were raised. It was agreed that participants would be made aware of the research at the assessment stage to allow further time for consideration of involvement. It was also agreed that the researcher would not contact the participants after the provision of the Participants Information sheet but rather participants would be asked to confirm a desire to participate by contacting the researcher by phone or email. This strategy was considered to promote the ethical principle of 'autonomy' (Beauchamp & Childress, 2001) in case the participants felt under pressure to consent whilst in the group therapy room in the presence of the researcher who worked at the trust. The study was then approved by the NHS Trust ethics committee.

2.7.3 Process of gaining informed consent

Involvement in the research after therapy commenced aimed to ensure that participant's right to receive treatment was not affected. Prior to taking part in the study written informed consent was obtained. It was explained to potential participants that participation was entirely voluntary and did not in any way impact on their right to therapy currently or in the future. Participants were informed that they would be approached in the last group session following completion of therapy and given further details for consideration.

2.8 Group Therapy – The intervention and process

Cognitive Behavioural Group Therapy followed the lines of Salkovskis (1999; Salkovskis et al, 1998; Salkovskis et al, 1999). Therapy consisted of 12 two-hour group sessions. The therapy was carried out by an accredited BABCP therapist experienced in the group approach. The group was co-facilitated by a Clinical Psychologist in the first group and a Trainee Clinical Psychologist in the second group. In the first session ‘group ground rules’ were negotiated to promote a sense of safety relating to sharing in the group. These included confidentiality, respecting difference and participation. The difference between support and reassurance was discussed and the unhelpful nature of reassurance was explored by the therapist’s use of Socratic questioning. The sometimes subtle nature of reassurance was highlighted and participants were encouraged to notice and gently point out reassurance-seeking behaviour in the group. Participants agreed to contact the group facilitator if unable to attend and the importance of completing homework and regular attendance was emphasised.

The early sessions involved normalising and the development of individualised Cognitive Behavioural formulations within the group setting. This included a discussion about relevant early experiences and the identification of the meaning attached to intrusions. During the early sessions some experiments were carried out to reinforce the formulation and to demonstrate the counterproductive nature of strategies such as thought suppression. The concepts of Theory A ‘I am a danger to others and could be responsible for causing or failing to prevent harm’ and Theory B ‘For understandable reasons I worry about being responsible for causing harm’ were emphasised and subsequent experiments were negotiated with a view to reinforcing Theory B rather than disputing Theory A (Salkovskis, 1999). Cognitive challenges concerning the meaning attached to intrusions were also employed. These included the use of continuum work (Veale & Wilson, 2005). Hierarchies were developed to inform behavioural experiments and document progress (Veale & Wilson, 2005). Homework was set each week and reviewed in the following session. As therapy progressed clients were encouraged to design each other’s and their own experiments to increase confidence in acting as their own therapist. Behavioural experiments were carried out during group sessions and *in vivo* for homework.

2.9 Interviews

Those who consented to participate were invited to attend an in-depth semi-structured interview with the researcher. The interview was offered at least six weeks after completion of therapy to

provide an opportunity for consideration of involvement. Where possible the interviews were carried out in the group therapy room to provide a familiar setting and aid recall (Smith & Eatough, 2006). The interview consisted of open-ended questions covering the main areas of investigation outlined in the interview guide (Appendix e). The questions focused on significant moments and participants were encouraged to think about different time points during the group process rather than particular components of therapy. This aimed to ensure that responses were grounded in the participant's reality rather than being imposed by the researcher. The interview guide offered an overall structure but the order of questions did not necessarily follow the order presented, allowing participant's freedom of dialogue and a lead in terms of directing the interview.

At the beginning of the interview participants were thanked for coming and any clarifications concerning the participant's information sheet were discussed. The use of a digital voice recorder was explained and written informed consent was obtained. During the interview participants engaged in a conversation about their experience of group therapy. Interviews lasted for a mean time of 59.22 minutes (range 44 mins – 1 hour 6 minutes) and were ended when the participant felt they had nothing more to say. Interviews were conducted at the time of the participant's choosing. Participants were told that the interview would be transcribed verbatim and that pseudonyms would be used when referring to interview excerpts to preserve confidentiality. It was explained that feedback would help clinicians understand the benefits and less helpful aspects of group therapy from the participant's point of view and that this information may inform how future groups were delivered.

A key issue when representing others relates to speaking for, rather than about, others (Wilkinson & Kitzinger, 1996). Facilitating reflexivity as mutual collaboration (Finlay, 2003) is a significant feature of research emphasised by critical realists. In an attempt to reduce the power imbalance in the research relationship participants were invited to comment on a copy of the verbatim transcripts. Sarah and Anna requested copies of these and confirmed accuracy of content. During the analysis participants were contacted and asked to choose a pseudonym to be used in the write-up. All participants responded and chose a pseudonym. Participants were also provided with a summary of the findings and offered the opportunity to comment in an individual interview whilst the analysis was being carried out. Four participants were involved in a participant validation meeting with the researcher outlined in 2.11.

2.9.1 Reflections on the interview process

In order to develop a critical awareness of how my 'natural' attitude (Landridge, 2007) may be influencing the research process, I engaged reflexively with the interview narrative shortly after the interview had been carried out. This was achieved by listening and reflecting on how my responses impacted on the participant's dialogue in terms of opening or closing it down. I also kept a journal of reflections during the research cycle. Notes from my journal are illustrated below.

2.9.2 Anna

When Anna was discussing significant moments she told me how helpful she had found exploring her early experience in terms of making sense of the development of her problem. Anna believed that this exploration had facilitated a bonding between group members. This explanation fitted with my clinical observations which had developed through the observation of process while previously facilitating groups. These observations had motivated me to carry out the research in the first place. Whilst reflecting on the interview recording, I noticed that I responded by saying 'that's interesting' rather than further exploring the relevance for Anna. Bracketing off my assumptions was harder than I thought even though I had the best intentions and I wondered why I did not explore her narrative in more detail. Here my limiting response was grounded in my 'natural attitude' (Landridge, 2007). Hearing Anna confirm theoretical constructs based on my own existing hypothesis led me to explore her narrative in less detail.

In order to be phenomenological I reflected on the need to disengage from these 'taken-for-granted' assumptions and use probing skills that might elicit further meaning by turning my reflexive gaze back towards the participant's experience (Smith et al, 2009). There were many internal processes to become aware of like being anxious not to put themes on the data by steering the conversation in a particular direction. Maybe being initially so cautious about 'tainting' the data, I was a little inhibited from in-depth exploration. I noticed that although I got the interview copied on the same day due to a fear of losing the tape recorder, I didn't listen to the recording as soon as I could have due to feeling nervous about my skills as a novice qualitative researcher. When I did I was pleased at my voice and tone which was gentle and warm.

2.9.3 Sarah

I felt anxious about this interview, worried that I would become inhibited from exploring in depth again despite reflection on the process. I was predicting that my interviewing skills would result in limited data and felt pressured by my own demands to do it right. I wrote down some questions to help me during the interview. By the time Sarah arrived I had managed to challenge some of my thoughts. We started quite well, on a friendly note, and I felt I had put her at ease. Soon into the interview she started crying and suddenly I was in the middle of an ethical dilemma. On the one hand I was aware of my professional and ethical duty to ensure she was ok and if necessary terminate the interview. On the other hand I was aware that I was in the role of researcher, not therapist and wondered if it was appropriate in this role to explore her emotional response. As all this internal process was going on, I was feeling uncomfortable wondering if my anxiety would come across. I refocused my attention, put my worries on hold and checked if Sarah was ok and asked her if she wanted to stop. On exploring what she was upset about, I discovered her tears were related to a positive memory of feeling accepted by other group members. I felt truly moved for her and pleased that I had explored her emotional response. Listening to the tape was helpful because I realised that even when so much was going on inside of me I sounded calm and empathic.

2.10 Process of data analysis

Interviews were recorded, transcribed verbatim and then analysed to capture meanings and themes in participants' accounts through a step-by-step process (Smith, 2008). The analytic process followed the protocol suggested by Smith et al (2009). Typing the transcription verbatim provided an overall feel of the interview. The transcript was read whilst listening to the recording in the first instance so that the participant's voice could be remembered during subsequent readings.

Each transcript was first subjected to initial descriptive coding and anything of interest was underlined. Idiosyncratic figures of speech, metaphors and emotional responses were noted in the margins. Notes on the transcripts expanded as comments on linguistic and conceptual levels were added to ensure the analysis moved to an interpretative level (see Appendix f). Interview transcripts were re-read many times and themes relating to group therapy process and accounts of change were colour coded with post-it notes. Patterns of commonality and difference in the descriptive coding were drawn together within each transcript then across transcripts with a view to identifying tentative themes. Some themes were collapsed into others where overlaps were observed. The original theme for example 'Impact of Living with OCD' was collapsed into a broader theme

'Restricted by Shame vs. Engaging with Life'. This theme contrasted the participant's experience prior to group therapy with an improved quality of life since completion of the group. Once a set of themes had been identified within the transcripts these were ordered chronologically and some were discarded. Originally, for example, a theme of 'Increased Insight' was discarded as a separate theme with some of the excerpts subsumed into the super ordinate theme 'Being my own Therapist'. Abstraction and subsumption processes were used to identify five superordinate themes within the data set which were eventually labelled as 'Engagement in the group process', 'Normalising', 'Courage to Fight', 'Being my own Therapist' and 'Restricted by Shame vs. Engaging with Life'. Second-order analysis led to the identification of a theme that ran through all the superordinate themes which was generated by the group process. This related to a reduced sense of shame and blame facilitated by social comparison. This level of analysis was influenced by my personal experiences relating to my clinical work as well as my own feelings generated by hearing the participant's rich personal accounts outlined below in 2.12.

Files of interview excerpts were constructed using a word processor and labelled with the theme title. Each excerpt was thought about in great detail and a summary relating to the client's meaning and emotional responses was documented to help build a narrative around the chosen excerpts. A narrative account was subsequently constructed illustrated with verbatim extracts. The resulting themes have been presented in the same order as stages inherent in the development of group process. A reflexive account is documented prior to the presentation of the analysis which highlights my own process during the analysis.

2.11 Participant validation

Paramjit, Sunny and Sarah attended an individual interview and confirmed the accuracy of the interpretation. Paul preferred to give feedback over the phone and gave clarification concerning one aspect of my interpretation which is outlined below. This process, called participant validation (McLeod, 2001), served as a credibility check in the study. Participants were talked through the overview of emergent themes and asked to read through each of the chosen excerpts and the interpretation. Participants were asked to check the accuracy of the interpretation and encouraged to suggest any changes. Paramjit described finding the process of validation 'interesting' and stated 'I think you have captured it really well'. Sunny stated 'yes, I agree that is correct' and described the process of validation as useful and 'a way of understanding and trying to remember what I need to do now to improve'. Sarah stated 'that's all correct' and was pleased and surprised that her account started with the same excerpt she had found most meaningful. She clarified her feeling of guilt

rather than shame in response to hiding her difficulties from family and friends outlined in the analysis (excerpt 2: theme 'Restricted by Shame vs. Engaging with Life': subtheme 'How I am seen'). She described the process as 'interesting' although initially 'daunting' due to being apprehensive about reading her own words. Paul considered his excerpts and related commentary and gave clarification concerning my interpretation in relation to 'blocks to engagement' (excerpt 3) highlighted in the analysis. Paul found the validation process useful for feeling 'grounded again' and a reminder of therapy and 'what to do next'.

Informed by my interpretation of Mia's interview that sharing with others from a similar culture may inhibit disclosure, I explored this issue with Paramjit, Sunny and Paul who originated from India but were resident in the UK. The participants had found being in the group with others from the same and different cultures normalising and had not felt inhibited from sharing in front of others who shared the same or different culture. Paramjit found the cultural diversity helpful for realising 'it can happen to anyone' regardless of the individual's faith and beliefs. Sunny shared that initially he had believed that OCD might only affect people from certain religions and that mixing with a diverse range of cultures had disconfirmed this view. The following section highlights my reflexive process during the analysis.

2.12 Reflexivity – Analysis

The meaning of reflexivity highlighted by Roulsten (2010) relates to the capacity of being 'capable of turning or bending back' (p116). This definition has been further elaborated by Davies (1999) as a process of 'self-reference' which refers to the way in which the 'products of research are affected by the personal and process of doing research' (p4). The account below highlights my process in engaging with reflective introspection and how this developed during the analysis facilitating an understanding of the importance of group therapy for reducing shame, a key theme that ran throughout all the master themes.

My limited experience of research interviewing and the identification that these skills could be improved by further probing questions, led me to initially doubt the quality of my data. I jumped to the conclusion about the data being 'empty' and felt apprehensive about the likelihood of identifying themes. Further engagement with the text by putting myself in the participant's shoes led me to feel a deep sense of pride in what I had achieved and found out. My ability to actively listen had led participants to elaborate well and provide meaningful accounts of their experience of being in the group with others sharing similar issues. Initially I engaged with the data with a pre-

reflexive reflexivity (Smith et al, 2009) which involves engaging with the immediate flow of consciousness before considering what is meaningful or important. This led to an initial focus on content and an emphasis on what words were expressed attending to linguistic narrative.

Listening to the voice of participants whilst I was reflecting on the interview facilitated an understanding of the emotional content expressed by participants and the subsequent analysis of metaphors and meaning. Having identified five master themes and chosen excerpts to illuminate these, I became mentally blocked and pedantic trying to see meaning behind participants' words. My experience was interrupted by asking people what went through their mind in response to particular words, hoping to find some revelation to ensure I had moved from a descriptive to an analytical level. This part of the research process was time- consuming and painful, triggering a preoccupation for detail. I felt I was getting stuck so I decided to disengage from the process for a while and focus on other aspects of my life.

When I returned to the research I decided to develop a diagram to represent the themes which had previously been presented in a table. It was during this stage in the research process that I experienced an unexpected hermeneutic cycle referring to the concept that 'the whole illuminates the part' and 'the part illuminates the whole' (Smith et al, 2009). Reflecting on the interviews I began to understand that participants felt a profound sense of being accepted by others with a similar problem. Being accepted and understood promoted feelings of empathy between group members and made one participant cry when reliving the intensity of this. I felt privileged on hearing this disclosure and was deeply moved for her and pleased that I had explored the meaning behind her emotional response.

2.12.1 Reflexivity leading to second order analysis

Second-order analysis also involves the incorporation of theory prompted by close attention to the participants' personal accounts and is often facilitated by reflection and personal experience. My response to the material presented in the individual cases, particularly Laura's sense of defiance and ability to challenge her critical husband and Sarah's tearfulness relating to being accepted, led to second-order analysis. According to Smith et al (2009) being phenomenological involves a deeper 'deliberate controlled' reflection which involves examining, honing and stretching the data with determination and rigour.

In qualitative research it is important to 'own one's perspective' (Elliott et al, 1999) and acknowledge internal processes that will inevitably influence the research. I reflected on why I had chosen to analyse Laura's interview first. I had thoroughly enjoyed meeting her. She was a writer and had expressed herself so beautifully using metaphors which I ended up using in the title of the project. Like me she was a white middle-class working mother trying to juggle the demands of being a good enough mum with a busy schedule.

I related to her and admired her courage and passion expressed in her defiant response to her critical husband which she had eloquently described. Being able to talk about her OCD without fear of being judged in the group had reduced her sense of shame. This reduction in shame had facilitated her to equalise her relationship by challenging his negative perception of her difficulties which had remained a 'non-discussed' issue at home since they married. I found it helpful to conceptualise her response as 'healthy resistance', a concept used by solution-focused approaches outlined by Renoux & Wade (2008). This approach to therapy informs my clinical work with victims who have been badly treated. Although I did not work therapeutically with Laura it seemed that giving and receiving feedback about her progress in the group had reduced her sense of shame which she had found empowering.

Sarah too had been moved to tears when reliving her experience of meeting others who did not judge her like family and friends. I began to reflect on similarities in the responses of Sarah and Laura and began to see a theme that linked the two narratives relating to the impact of reduced shame. This stage enabled me to transcend the data and connect all five master themes with the impact of the group process. I began to see evidence of the impact of reduced shame stemming from social comparison inherent in the group process running through all five superordinate themes. I began to comprehend how powerful meeting others was for reducing shame and self-blame which had previously led participants to conceal their difficulties from others due to a fear of being judged.

Reflection during the analysis on my own feelings towards the participants and consideration of what surprised me during the interview process facilitated an understanding of the power of group therapy for reducing shame for people with OCD. This reduction in shame stemming from social comparison and the ability to share previously hidden symptoms seemed to be pivotal in promoting the group process and motivating participants to change, a huge benefit of group therapy over individual therapy. The benefits emerging from the process inherent in group therapy are explored in depth in the following chapter (3.0).

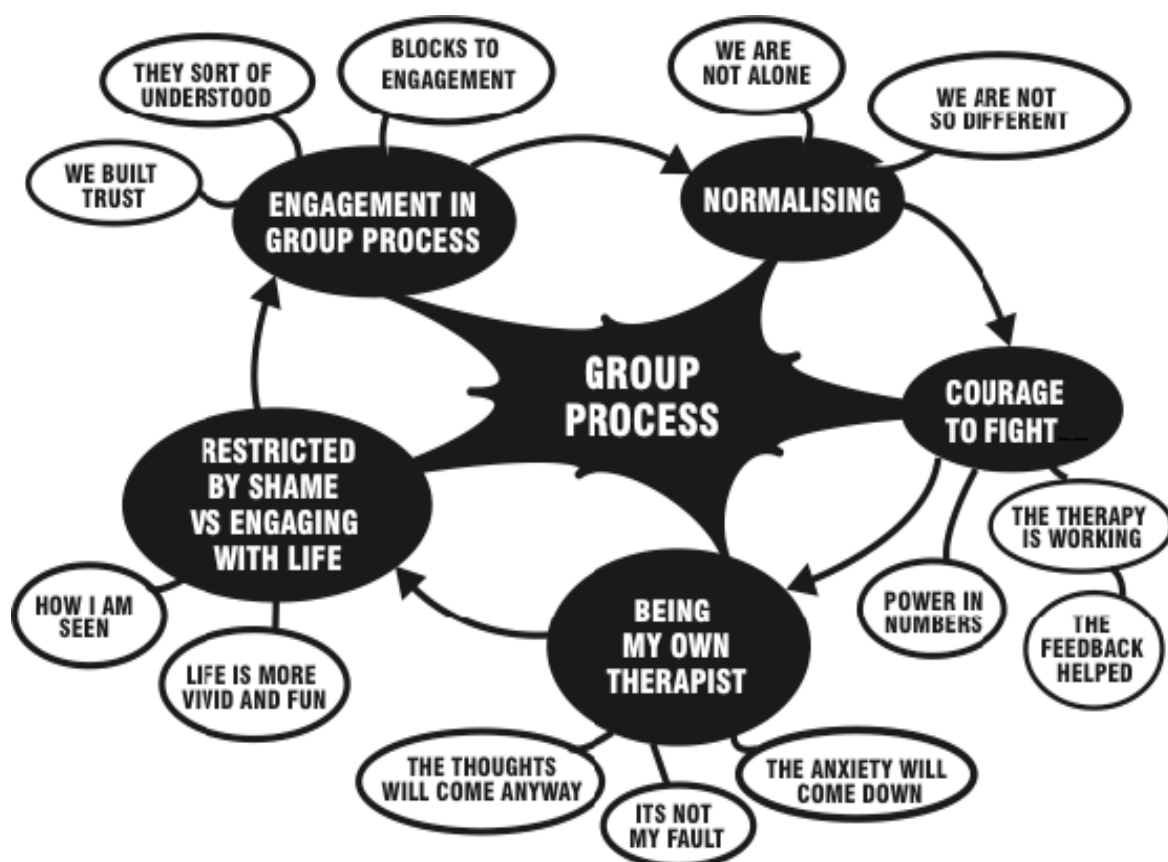
2.12.2 Reflexivity – Acknowledgement of the impact of my own process on the findings

The process of identifying five master themes in relation to the benefits of group therapy was validating in terms of my own clinical observations. In particular the normalising aspect inherent in group therapy was powerful and appeared to have a greater impact than I could have possibly imagined. The sense of cohesion that developed as participants connected with each other and developed empathy for one another after a discussion on early experiences was another aspect of the group programme that I had also noticed as being beneficial. Overall participants appeared to have given a positive impression of the group experience. I reflected on this and wondered why I was not noticing any negative feedback that might inform the development of the group programme. It was possible that my emotional investment in the development of the group was leading me to notice aspects that confirmed my clinical observations, so I began to look at the personal accounts in more depth. This led to the development of a subtheme in which participants had expressed difficulties or reservations about being open in the group which I entitled 'Blocks to engagement'. What emerged from this exploration was that it had been the impact of residual shame that had led participants to conceal certain aspects of the OCD. Aspects of the group experience that were less helpful for participants are explored in the following chapter (3.2.3 'Blocks to engagement').

Chapter 3: ANALYSIS

This study aimed to explore how people experience being in a CBT group with others who share a similar difficulty and to ascertain what participants found helpful and less helpful about group therapy. The first two questions are addressed in the themes below and elaborated in the analysis. Aspects that participants found less helpful are explored in the subtheme 'Blocks to Engagement' (3.2.3).

Figure 1: Interpretative map of group therapy process



3.1 The emergent superordinate themes – an overview

Five superordinate themes were generated from the analysis of the data. The first theme, related to 'Engagement in the group process' was generated as participants developed a sense of trust and felt accepted, having identified with each other. The second theme 'Normalising' related to challenged negative self-perception through social comparison. The third superordinate theme 'Courage to Fight' was generated as participants described feeling motivated to change. The fourth theme related to the development of skills attributed to learning theory in group therapy 'Being my own Therapist'. Participants also generated themes about the impact of living with OCD highlighted in the fifth theme 'Restricted by Shame vs. Engaging with Life', making contrasts with an improved quality of life since having completed group therapy.

3.2 THEME 1: Engagement in the group process

Three subthemes were generated from the qualitative data concerning participants' points of engagement in the group process, which is suggested to occur when group cohesion is high in the group (Yalom & Leszcz, 2005). The first subordinate theme related to a sense of developing trust between group members 'We Built Trust' which occurred at different points in the group for participants. Participants also described feeling accepted by other people with a similar issue represented in the subtheme 'They Sort of Understood' which facilitated engagement in the group process. The third subtheme entitled 'Blocks to Engagement' related to participants feeling inhibited about disclosure of certain issues which occurred when participants felt 'different' and feared being judged by other group members. This inhibited disclosure for some participants and hindered full engagement in therapy. One participant expressed reservations about the rationale for therapy which also hindered engagement.

3.2.1 Subtheme 1: 'We Built Trust'

This theme was generated from the narrative of four participants and was associated with an increased ability to disclose in the group setting. Trust developed for one participant during the group discussion on relevant early experiences. This was explored to understand the development and origins of the responsibility appraisal and inform the case conceptualisation. Other participants were motivated to disclose after hearing and identifying with others' difficulties.

Excerpt 1 - Anna

Anna, aged 26, lived at home with her parents and was studying for an MA. She presented with violent and blasphemous thought intrusions which she interpreted as an indication that she was a 'bad' person. Anna reflected on the relevance of sharing her early experience in the group setting.

*...um definitely it was up until then, obviously one of our, everyone's, concerns was um, confidentiality and, you know, what happens in the group stays very much in the group, but I think from that moment where we had to talk about our childhood stuff, that I mean some people talked about things that were obviously clearly very distressing to them, umm from that moment we really were, had to be bonded, there was no question I think (Transcript 1, p 6, l 149-157).**

Confidentiality was an important consideration for Anna because she had been very concerned about disclosing the content of her thoughts due to fears of being judged by others. Prior to the excerpt Anna had been sharing how group members had been very nervous about disclosing their early experiences within the group. Despite her nerves Anna had been interested in understanding the development of her problem and had wanted to explore where it had originated from. The group space provided the members with a safe environment in which disclosure of personal and potentially upsetting experiences felt possible. For Anna, sharing childhood experiences within the group cemented a bonding with group members, which she was adamant about. (*Transcript No., Page No., Line No.)

Excerpt 2 - Paramjit

Paramjit, aged 22, was the youngest member of the group and had expressed concerns in the initial assessment about talking in front of others. He had also been worried that he would be judged for the length of time he washed his hands. Paramjit reflected on the impact of his decision to share something in the group for the first time.

...so it was more of a listening case for the first and second group, but then after actually hearing everybody, and umm, the sort of friendly atmosphere of the group, that made it easier to sort of contribute and I think I went home after the second session thinking next week I am definitely going to contribute something, and definitely thought in my head, thought about all the things I wanted to say in the next session, and when the session came, umm yeah, I sort of, I got it all off my chest (umm) and was able to tell my story (Transcript 6, p 23, l 557-570).

In response to my question about how he experienced the first few weeks of the group Paramjit shared how he had chosen to remain silent for the first two sessions. Having listened and identified

with others he felt empowered and made an informed choice to share something in the group which he mentally prepared for. He was adamant about his decision, repeating 'definitely' twice when referring to making this choice. He described 'getting it all off' his chest, suggesting the lifting of a weight which had lain heavy on his chest due to shame and 'concealment' (Newth & Rachman, 2001). To maintain his secret Paramjit had stopped socialising with his friends completely. He reflected on all the things he wanted to say in the subsequent week. In the safety of the group setting the following week his decision to 'share something' grew and he felt able to tell his entire story. He sounded relieved when he remembered feeling able to share his story for the first time.

Excerpt 3 - Sunny

Sunny, aged 24, presented with ordering compulsions and a need to have things 'just so'. He reflected on the development of trusting relationships in the group.

...umm I just think that over the weeks that we had sessions, everyone had relationships, we had built trust, and we had managed to fully understand what everyone's OCD problems were. So I think after a couple of weeks or so it did actually allow everyone in the group to be honest about their feelings (Transcript 8, p 18, l 437-445).

Sunny perceived a mutual understanding between group members emphasised by repeating the words 'we had' when referring to the development of trust in the group. A sense of having fully understood everyone's problems facilitated risk-taking and expression of feelings. Sunny described how feeling comfortable in the group after a couple of weeks allowed everyone to be more honest suggesting he and others felt permitted to disclose due to feeling accepted and understood.

Participants' reflections highlighted the importance of allowing time for group members to identify with each other for the development of group cohesion during the early stages of the group process. A sense of trust had been facilitated by the emphasis on confidentiality, elaborated during the setting of group ground rules in the first session. This had enabled Anna to disclose her early experience and the third session seemed pivotal for two participants in terms of risking disclosure of previously hidden symptoms. As participants felt engaged in the group process and relieved by sharing with others a profound sense of being understood and accepted by others with similar issues was facilitated and is outlined in the following theme 'They Sort of Understood'.

3.2.2 Subtheme 2: ‘They Sort of Understood’

Being in the group and sharing with others led participants to feel understood - a theme that was generated in the interviews of four participants. This was often contrasted with narrative concerning feeling judged by family and friends, which had resulted in secrecy and shame.

Excerpt 1 - Sarah

Sarah, aged 33, was a single working mother who presented with checking rituals. She described her moving memory of meeting others in the group who she believed would not judge her like family and friends.

...umm I suppose it's (pause,) it sort of makes you think you are not completely mad for doing it, coz you sort of get, because other people might think, oh why...you try to explain, you know, to friends and family, why do you do that, and you say 'I don't know, I just need to do that' um but in the group it was like

(you look a bit upset are you ok?)

yes its fine, they sort of understood it was like, you, you didn't need to discuss (pause tearful) why... now you are getting me started

(ok take your time)

so you you could just say something to them (tearful) and um they would be like, well I do that as well. You didn't need to explain why or what reason etc. (Transcript 2, p 12, l 295-315).

This was a very emotional moment following a question aimed at exploring how Sarah felt once she realised she had things in common with others. Sarah described previously doubting her sanity when questioned by her family and friends about her reasons for carrying out rituals. Sarah's interpretation that motivated her rituals was that she must 'feel right' before terminating a ritual in contrast to some other group members who carried out rituals to prevent a feared catastrophe. This may have made it more difficult for her to verbalise or pinpoint her motivation for carrying out rituals in response to questions from her family. During participant validation Sarah confirmed this aspect of my interpretation that her need to feel right rather than preventing a specific disaster motivated her compulsions. When I observed Sarah becoming upset I faced an ethical dilemma in terms of my role of ethical researcher/practitioner and Sarah's needs in terms of continuing the interview. I checked my concern with Sarah by noticing her upset and asking her if she was ok which she clarified. I felt very moved and became aware of her motivation to continue, expressed by saying

'it's fine' and that she wanted to tell me how meaningful it was for her to be accepted by a group of people who didn't judge or question her behaviour. I understood that her tears were related to positive memories of being accepted by others and represented the intensity of this for her.

Excerpt 2 - Paramjit

Paramjit reflected on his increased capacity to disclose in the group in the knowledge others would not judge him.

...it was kind of like a big weight being, had been lifted off your shoulders and you could actually sort of just talk to other members of the group, like umm, about any aspect of the OCD, and yeah just like you wouldn't be judged, or just kind of umm, just yeah, just it was like a weight, a big weight, is being lifted off your shoulders (Transcript 5, p 10, l 227-235).

In response to my question about what it was like realising that he was not the only one, Paramjit reflected cognitively on aspects of his experience that were 'embodied'. Embodiment refers to a sense of bodiliness that exceeds physical limits (Smith et al, 2009). This was the second time he referred to his body to describe his emotional response to sharing his difficulties for the first time. He emphasised the 'weight' three times in his narrative, described as 'a big weight' being lifted from his shoulders. His choice of words highlighted the burden he carried by keeping his OCD secret from others due to feelings of shame. Earlier he described 'getting it off his chest' when describing his relief after disclosure in the group. This time he perceived the weight being 'lifted' from his shoulders suggesting it had lightened as he felt understood and accepted by members of the group. He felt able to talk to other group members about 'any aspect' of his OCD without risk of negative evaluation. Paramjit making reference to 'chatting to others' on the way to his car later in the interview highlighted his increased capacity to socialise with others. Paramjit described his experience of relating to others in the group as a 'stepping stone' towards socialising with his friends again.

Excerpt 3 - Mia

Mia, aged 30, engaged in rituals involving touching or repeating actions in response to intrusive doubts. She reflected on her increased ability to talk openly in the group without a fear of being judged.

...just that I could talk more, I could talk openly about my, (umm), particular... like the OCDs. I could talk openly about it (umm) and not think I was going to get

judged on it, because the other people had that same issue, so someone that understood the disorder really (Transcript 5, p 6, l 125-131).

Mia described a reduced sense of shame due to a belief that other group members with similar issues would not judge her. She highlighted how this perception had facilitated her disclosure in the group by emphasising this and repeating how she could 'talk more openly' in the knowledge that others would understand. Mia referred to the OCD as a 'disorder', which suggested she had externalised her problem by internalising the label of OCD. Previously she had viewed her problem as a 'habit she would have to live with', indicating less self-blame by attributing her symptoms to a mental health difficulty rather than herself.

A reduced sense of shame generated by social comparison and feeling accepted by others who had similar difficulties facilitated disclosure in the group. The personal accounts highlighted the importance of creating a safe enough environment for risk-taking to occur. Participants also described times when disclosure in the group was inhibited due to feeling different from others. A fear of being judged by other group members hindered full engagement in the group therapy process for some participants and is outlined in the following subtheme 'Blocks to engagement'

3.2.3 Subtheme 3: Blocks to Engagement

A fear of being judged by others in the group had led three participants to feel inhibited about sharing certain aspects of the OCD. One participant considered dropping out of the group initially and two others concealed content about their OCD due to feelings of shame and concerns related to cultural issues. Another participant expressed reservations about accepting the rationale for therapy which prevented full engagement.

Excerpt 1 - Anna

Prior to this excerpt Anna shared how some people in the group had been 'gobsmacked' after seeing a list of intrusive thoughts found in the general population. She reflected on the impact of this response on her engagement with the group.

*...yes it was very alarming; yes that was quite a **big** deal, it made me think is this right for me? Obviously I didn't want to quit after the first week but it did, I didn't want to feel like a minority within the minority if that makes sense (Transcript 1, p 4, l 75-81).*

Anna interpreted the content of her violent thoughts as indicating she was a 'bad' person who might act on her thoughts and be sent to hell. Anna had not been prepared for this unusual shocked response by some group members. Feeling like a 'minority within the minority' had led her to doubt coming back to the group. She may have been feeling very threatened due to this triggering situation which could have been perceived as exclusion, leaving her feeling doubly marginalised and rejected. It is possible that this process could have paralleled her early experience when she felt different at home and at school due to being highly overprotected by her parents. Early drop-out may have been detrimental and could have possibly confirmed her fears of rejection from others and her negative appraisal about being a 'bad' person due to the content of her thoughts.

Excerpt 2 - Mia

Mia felt unable to share 'certain things' through fear of exposing issues within her culture linked earlier in the interview with wanting to protect her family.

...yeah so, you know, like being Indian, I can't always openly talk about certain things, so and also being gay, I couldn't talk about certain things, and I couldn't say 'oh my partner has noticed me doing certain things', like she has been helping me possibly with the OCD, but I couldn't talk about that aspect of that even though it helped, because I didn't feel comfortable from a cultural point of view like outing myself, (ahh) so that was a bit of, like, I had to hold back on that side of it and how, you know, when people asked me, like it was talked about has your partner noticed or anything, I can't really answer that question (umm) so (Transcript 5, p 22, l 538-553).

Mia was compromised in two ways by 'being Indian and gay'. She made reference to how she 'couldn't and can't talk' about issues relating to her sexuality in front of others who shared her culture. The fear of negative consequences to her family if this information were to leak out worried her. This was emphasised by her choice of words, previously stating 'it's a small world' when referring to her religious community. She may have been very worried about the threat of rejection or being shunned from others in her community who held beliefs about 'same sex' relationships being immoral and a sin to God. Historically homosexuality was viewed as a crime in Indian culture and there is no word in the Indian language for same- sex relationships, a culture which emphasises marriage from an early age (Vanita, 2002).

In 1860 the Indian Penal Code ruled that anyone having a voluntary same sex relationship would be subject to a life sentence exceeding 10 years and a heavy fine (Bhaskaran, 2002). Although homosexuality was recently decriminalised by the High Court in India in 2009, same-sex relationships

are generally viewed as shameful and are rarely discussed openly in Indian civil society. Indian culture is diverse yet many Indian people experience a conflict between the family-defined 'we self' and the attainment of autonomy emphasised by western culture (Puthenpadath & Culbertson, 2000). Due to beliefs about the importance of protecting the family, Mia may have felt conflict between the emphasis of western models of psychotherapy to self-disclose, and a need to protect her family from shame by exposing herself as gay within her culture.

Excerpt 3 - Paul

Paul described feeling unsure whether his religious thought intrusions could be conceptualised as part of his OCD or were related to his religion.

...because sometimes I get these OCDs, I am not sure others could relate to it, to do with prayers and religious stuff, religious thoughts and stuff like that. I felt like, I feel a bit, umm, a bit like whether what I believe, is right or wrong or is it OCD sort of thing, yeah, or is it religion or if it's OCD, (umm) if that makes sense (Transcript 7, p 52, l 280-1287).

Paul's uncertainty and his prediction that others might not be able to relate to his thoughts and behaviour inhibited him from sharing aspects of his OCD related to his religion. His narrative changed from past to present tense suggesting he still felt unsure. However, this particular group was culturally diverse and two other participants shared the same culture and religious beliefs. During the intake interview Mia had described OCD behaviour related to her religion so it seems likely that others may have identified with Paul had he felt able to share his dilemma. Initially I had wondered, if like Mia, this fear of being exposed in the group was due to concerns about disclosing his doubts to people who shared a similar culture, due to feeling exposed within his community for doubting his faith. However, during participant validation Paul informed me that his dilemma had been fuelled by a sense of shame and guilt. These feelings stemmed from his demand 'I shouldn't be thinking or feeling this' and concerns about not 'fitting in' to the group or being viewed as 'not normal', rather than fears of being exposed within his community. As a result of his concerns Paul chose to conceal this information from the group and during the interview recommended the inclusion of some one-to-one sessions alongside group therapy to discuss personal concerns.

Excerpt 4 - Marc

Marc, aged 45, was working full time as a pharmacist. He presented with intrusive doubts about losing his money, which he interpreted as an indication of being a 'careless person'. Marc reflected on his understanding of the nature of his difficulties.

...you know it's that fear, it's a phobia, I would say it's I've got a phobia in me (laughs) because for me I think it's everything to do with money. I do that checking the wallet, everything to do with money, maybe I have got that phobia, you know, because you have phobias about other things as well like small spaces, spiders, fear of, you've got so many fears, all these phobias, different phobias, that you have, so for me I've got that phobia (umm) about about losing my money or the consequence of losing, and just although I haven't, I haven't, lost any money recently in the last couple of years I haven't, I haven't, it's just that I have got this fear, you know, like if I do (umm) so I don't understand it (laughs) I can't explain what is going on (Transcript 2, p 25, l 587-609).

Despite having initially accepted the rationale that he worried about being responsible for harm by being a careless person rather than being actually responsible for causing harm, Marc likened his problem to a more common simple phobia. Perhaps he felt stigmatised by the diagnosis of OCD he had only recently received. Having made limited gains in therapy he may have been searching for another way to explain his difficulties. He seemed to be trying to convince himself by repeating 'I haven't lost' any money, four times in a raised voice. He was animated as he repeated the word 'phobia' six times in his narrative.

Marc appeared to be engaging in reassurance by trying to convince himself that he had not lost any money recently in response to his intrusive doubts. Reassurance is an unhelpful strategy, which could be maintaining his problem by providing short-term relief and increasing preoccupation with doubt in the long term (Veale & Wilson, 2005). He felt unable to explain his problem, suggesting he had not internalised the rationale for therapy. At no point during the interview did Marc discuss his understanding of relevant developmental factors. It is possible that further exploration of factors that made him vulnerable to developing OCD would have helped him make sense of his difficulties by providing clarity and informing the case conceptualisation. Marc later described a difficulty talking about 'personal' problems in the group setting stating a preference for individual therapy. It is possible that he held beliefs about the importance of keeping personal information private from others, which may have prevented full engagement in therapy.

Excerpt 5 - Mia

Mia considered the costs of giving up her OCD and described how she would rather engage in OCD rituals than resort to having a drink.

*...I would rather deal with, have OCDs to deal with the feeling of whatever, or what it is, anxiety, than have a drink (umm). So it's more important to me not to have a drink but I don't want the OCD to get out of hand, so just how other issues interlink with OCD, (right) but then how much can you work on **just OCD**, umm, without touching the other issues, (umm) or do you need to touch on the other issues or do they even overlap in any way (Transcript 5, p 53, l 312-1324).*

During the interview Mia expressed concerns about revealing certain aspects of her OCD, which she believed might be related to her 'addictions' with food and alcohol due to a fear of being judged by group members. Here full engagement in therapy was hindered due to a specific fear of being judged as an 'addict' which she considered to be an unacceptable 'untrustworthy' side to her personal character. She chose to conceal this from the group and doubted being able to work on 'just OCD' without addressing other issues, which she believed, might overlap. It became apparent later in the interview that Mia drank alcohol and ate food in even numbers, which if explored could have been incorporated into the case conceptualisation as maintenance factors.

Participants felt inhibited from disclosing aspects of their difficulties in the group setting due to fear of being judged. Paul and Anna were judging themselves for the content of his thoughts and Mia was judging aspects of herself as 'untrustworthy'. Marc's preference for viewing his problem as a phobia may also indicate he was judging himself or the label of OCD which he was attempting to normalise. Despite these blocks to engagement in the group process, all participants described relating to others with similar issues as beneficial for reducing feelings of shame and facilitating a normalising process.

3.3 THEME 2: – Normalising

This theme dominated the transcripts and was highlighted by all participants. The concept of ‘universality’, a therapeutic factor inherent in group therapy identified by Yalom & Leszcz (2005) was perceived in two ways. This related to participants’ perception that ‘We are not Alone’ and after meeting others, participants viewed themselves as ‘We are not so different’.

3.3.1 Subtheme 1: ‘We Are Not Alone’

Being in the group with others who shared similar issues had a huge impact in terms of challenging the idea that participants were alone or unique, which was experienced as a huge relief.

Excerpt 1 - Laura

Laura, aged 40, was married with two children and working full time. She used a metaphor to describe her experience of meeting others with similar issues for the first time.

...you know I mean, he goes, he’s a chimney sweeper and then he gets transformed into a water baby, and he thinks he’s the only water baby, and then one day he suddenly comes across a whole flock of water babies (laughs) so and they are all unhappy children who had been transformed to water babies, it’s a Victorian (oh right) umm, and it’s that sense, oh no, water babies, whenever I hear about water babies you know other people who need to do just what I am doing (umm hum) and have the same experiences (Transcript 4, p 32, l 784-798).

Prior to the excerpt Laura asked if I had read a story called the ‘Water Babies’. She expressed how transformational the experience of meeting others with similar difficulties was for disconfirming the belief that she was the only one. In this story, a Victorian moral fable, the young chimney sweep had been badly treated and wrongly blamed. Underwater he experienced an extreme transformation from a badly behaved dirty orphan to an angelic water baby who helps others. Laura compared the character before his transformation to her own experience of feeling unhappy during childhood after the onset of her OCD. The chimney sweep’s transformation when he initially believed he was the only one and then goes on to feel accepted by a community of similar others, was compared to her experience of meeting other members of the group. She described ‘suddenly finding a whole flock’ of similar others, indicating a profound sense of feeling less isolated. Her choice of metaphor highlighted that meeting others in the group had begun to challenge her core belief relating to being a ‘bad’ person. This belief had developed in childhood due to her mother’s hostility and refusal to

speak about her problem, leaving Laura to blame herself and believe there must have been 'something very wrong with her'.

Excerpt 2 - Sarah

Sarah experienced meeting others with a similar thinking process, regardless of the different content, as a relief.

*...yeah knowing that somebody else is thinking along the same sort of lines, even though it's about totally different things, but it's, there's the same sort of thinking process as you, so you're not, because sometimes you think well, (pause..tearful) I suppose, why can't I stop thinking this way, and it's quite hard to (umm) **you want to** (yeah) but you can't (sure) and then you think maybe you are the only one, because if you have got friends and family around you and they just do things very quickly, and it's like well **I just do it** and you think, I wish I could just do it, but obviously and in the group finding out other people that can't just do it like everyone else (umm) it was nice that (Transcript 2, p 16, 376-395).*

Sarah described her previous struggle trying to change her behaviour prior to being in the group. She compared herself to family and friends whom she felt criticised by when questioned about her behaviour. She expressed her deep desire to be more like them 'I wish I could just do it' suggesting feelings of sadness and shame. Sarah became tearful and sounded warm when remembering meeting and feeling accepted by others with similar difficulties. She contrasted this to not feeling understood by family and friends. Meeting others for the first time had challenged her view that she was the only one. This perception had developed from her comparison to others without OCD. My use of listening skills and minimal encouragers (Cully & Bond, 2011) whilst Sarah was sharing her story and during emotional moments helped her to elaborate and feel contained.

Excerpt 3 - Marc

Marc also identified strongly with the idea of not being the only one. After getting to know the other group members he was convinced that OCD was a common problem.

...yeah, yeah we see new people, meet people for the first time, who have something in common with you, and once, then you find out what they have, you get to know them err, yeah, so at least I mean, you know, it sends some, some, a message which sends to you that you are not the only one (uh huh). There are other people out there who also have it; it doesn't mean that you err... I mean people have, I mean people are working, one was a student, a student, a student and um, that also have, yeah, you know, so you do find that many people have OCD yeah, yeah (Transcript 3, p 49, 1953-969).

Marc started to question his previous perception that he was alone by making a comparison to other members of the group. In the excerpt he highlighted the fact that some group members were working and repeated three times that one was a 'student'. He sounded surprised and seemed to be trying to convince himself that others who are intelligent, capable of working and studying can also have OCD. This comparison with others he perceived as 'normal' begun to challenge his view that he was 'useless' which he expressed later in the interview.

Excerpt 4 - Sunny

Sunny realised others who do not have OCD experience intrusive thoughts and as a result he described feeling less alone with his difficulties.

...I think it actually made me more aware that it's not just only me who might have the problem, and that other people might have them, especially ordinary people, it may feel that some of these issues might also affect not just OCD people but also might, also affect normal people (Transcript 8, p 10, l 243-249).

Being diagnosed after OCD symptoms were precipitated following his father's death had been useful in terms of prompting Sunny to seek treatment. However, he had internalised the label of OCD as indicating he was 'abnormal' suggesting his self-identity had been influenced by being labelled with the diagnosis. He compared himself to 'ordinary people' and labelled himself and others as 'OCD people' suggesting that meeting others in the group had a normalising effect and challenged his negative stereotype about what others with OCD were like. The similarity he drew between issues that affect 'normal' and 'OCD people' indicated a modified sense of identity and challenged his own sense of being alone with his difficulties. At participant validation Sunny told me he had previously believed OCD only affected people from certain religions and that it had been a relief to realise other 'normal' people could also be affected.

Excerpt 5 - Anna

Anna compared the content of her intrusive thoughts to others found in the general population, provided by the therapist on a list in the first session as psycho-education and a normalising strategy.

*...that in itself was a very positive thing for me, I think, (ok) because it, that, was one of my main concerns I think, being alone in suffering these thoughts, but having it presented on a list of other people experiencing thoughts, which some of which were **massively** sort of worse than, than the thoughts that I experienced, that was **definitely a good thing**, to see initially, you know, from*

*the first session **definitely not alone**, other people even people who don't have OCD have this and they can just put these thoughts to bed (Transcript 1, p 32, l, 798-812).*

Anna expressed her relief after recognising and believing that intrusive thoughts are universal. She emphasised this by raising her voice when repeating the word 'definitely' twice. Her voice was also raised when she described that some of the thoughts presented were 'massively worse' in terms of the content compared to her own and when she expressed 'definitely not alone'. This comparison had enabled her to challenge the meaning she attaches to her own thoughts that she is alone in suffering her unwanted thoughts and about being a 'bad' person. By making this comparison to others who can 'just put thoughts to bed' she had indirectly challenged her self-blame and highlighted a more helpful strategy for managing her thoughts compared to her previous strategy of dwelling on the content. She had fully grasped the treatment rationale that intrusions are universal through the process of normalising.

The normalising process inherent in group therapy was facilitated by social comparison with others perceived as 'normal' and further emphasised by psychoeducation, when the therapist provided group members with a list of thoughts found in the general population (Rachman & Hodgson, 1980). As well as leading participants to feel less alone with their difficulties, social comparison also challenged the meaning attached to the content of intrusive thoughts resulting in a less self-punitive self-concept. Merely by meeting others with a similar difficulty participants modified core beliefs relating to being 'crazy' or 'bad', a central goal of CBT for OCD outlined in the following narrative 'We Are Not So Different'.

3.3.2 Subtheme 2: 'We Are Not So Different'

A second subordinate theme was generated in the narrative of six participants. This was achieved through the normalising process, which enabled participants to view their difficulties as less severe than had been previously believed, resulting in reduced shame. Meeting others perceived as 'normal' also challenged participants' stereotypes about what other people with OCD were like.

Excerpt 1 - Paul

Paul described the impact of a normalising strategy, which had challenged the idea that he was 'different' to other people due to the content of his thoughts.

...especially like knowing that, ok, other people outside the group, they also have certain thoughts as well, which are the same as the OCD thoughts, you think it's OCD thoughts, but it's like yes, you realise it is not such a big deal, in that way you realise that you are not so much different (Transcript 7, p 36, l 877-886).

Realising and believing that intrusive thoughts are universal and not just specific to people with OCD facilitated a reduction in shame for Paul. The recognition that his thoughts were the same as other peoples in the general population had resulted in Paul feeling less 'different'. This realisation enabled him to view his difficulties in a less severe light than previously considered, demonstrated by his reference to 'not such a big deal' indicating increased self-acceptance.

Excerpt 2 - Mia

Mia reflected on her feelings activated by meeting others with OCD for the first time.

*...yeah it was nice, it was a relief, umm, it was **shock** as well sometimes. I think I don't know if I had like an image of people with OCD, I don't know, because that would be like putting myself into a category as well but...*

(tell me more about that what?)

They just came across as normal, I thought it was going to be like, you know, I would walk into this room and there would be like, one person maybe fixing leaflets and like, I don't know, I guess just ticking all the time or doing something and I think I had that bit wrong so that was, you know, me judging really

(so it was different to how you imagined?)

yeah definitely

(in what way?)

People were normal (laughs), I am not saying I am not normal, and people with OCD aren't normal, but yeah I think I had really built up this image yeah, of people doing like, umm, their rituals for something so it was a relief (Transcript 5, p 21, l 505-523).

Having asked Mia what it was like to meet others with OCD she responded by expressing her 'relief and shock' in response to meeting other group members who she perceived as 'normal'. Social comparison had enabled her to relate to her problem in a less critical way and by doing so she refused to judge herself so harshly. This was expressed by her hesitancy about putting herself into a 'category'. Meeting others had challenged her stereotypes and facilitated self-acceptance by

recognising that people with OCD are not abnormal. This revelation achieved through social comparison to others who have OCD for the first time, had also indirectly challenged her own meaning that she was a 'bad' person due to the content of her thoughts.

Excerpt 3 - Marc

Marc reflected on the impact of meeting others and realising that OCD is a common problem.

...umm... yeah well the condition I have, it's it's quite common (umm) it's not like, I don't have to be down, I mean discouraged, just because I have OCD, I am useless or, you know, (ok) you know because people out there have this condition and yet they go on, they are not that useless (umm) not that, like, not that compared to other people, ok it's not a condition whereby it is ok that it's like depression (Transcript 3, p 4, l 976-988).

The recognition that others with OCD are 'out there' enabled Marc to view himself less critically leaving him feeling more optimistic, hopeful and less depressed. This new knowledge and his comparison to others in the group perceived as 'normal' and 'capable' enabled him to liken his difficulties to other more common mental health problems like depression. This changed perception resulting from social comparison challenged his core belief that he was 'useless', a view that may have developed in childhood due to criticism from a significant other.

Excerpt 4 - Mia

Mia compared her difficulties to others in the group who she perceived as more severely affected.

*...yeah ok, another member, and um, he was, just to watch him overcome certain things, was just a really nice feeling and like, you know, I felt kind of **lucky** that, I don't, I don't know, if I can **compare** at all, but if one person's OCD is worse than another's or I guess one person's definition of bad is not another person's definition, maybe I felt I don't have it as bad maybe as some other people, and I am grateful for that, (umm) but it was so nice to see that other person like, overcome or face their fears as well (Transcript 5, p 16, l 391-403).*

Mia used a raised voice and seemed to feel guilty by recognising she was less affected by her OCD than some other members in the group, emphasised by her uncertainty and expression of hesitancy about making this comparison. Her choice of the word 'lucky' indicated she felt that merely by the roll of a dice and different life circumstances she could have been more severely affected. She questioned individual differences in people's definition of what constitutes 'bad'. Mia was comparing herself to another member of the group who she considered to be worse off than herself.

The group member she was referring to had overcome his fear of acting on violent thought intrusions by carrying out a behavioural experiment in the group. It is possible that she viewed the content of his thoughts as more 'bad' than hers, which involved doubts about making mistakes. She felt truly thankful, expressed by her emphasising 'grateful' and empathised with his progress made.

Excerpt 5 - Laura

Meeting and making a comparison to others who were perceived as worse and less affected also led Laura to feel comforted and more motivated to change.

...and then other people in the, you know, there was such a mixed range of people in the group, you know, there was one, umm, and also there was people who were worse than I was, and that's also quite comforting because you think well I have made (umm) because you do something like joining a group initially because you think, oh my god I am cocking up so badly with leading my life, because I have got all these behaviours and it's quite comforting to find people on a continuum, some people are a bit less and a bit more, and it's like, well, and get back in control (umm) so the, the umm, community of it I found very very encouraging (umm) to be with (Transcript 5, p 3, l 60-70).

Comparing herself with others perceived as worse off reduced her sense of shame stemming from her perception that she was failing in her role as a mother and professional. Prior to the group Laura had believed she was 'cocking up so badly'. Comparison with others more severely affected challenged her perception concerning her limited ability to cope with her life before starting group therapy. The speculation of how bad things can get motivated her to take control of her life by fully engaging in therapy. Her use of the term 'comforted' illuminated how reassured she felt by the recognition that she was not 'cocking up' as badly as some of the other group members. Later in the interview she made a contrast with another group member who was refraining from having a third child due to fears of activating her OCD.

Laura had perceived her decision 'not to complete her family' because of her OCD as 'tragic'. This group member had been the only one who dropped out of the group after expressing this decision to Laura during the break, which had saddened Laura. Seeing others on a continuum of severity including others who are a 'bit less' also instilled hope for change (Yalom & Leszcz, 2005). After making this comparison in the group Laura felt empowered to change by wanting to get back in 'control'. She was also motivated by the 'mixed range' of people in the group. The 'community' she was describing stemmed from her perception that the group was a culturally diverse gathering of

people and included people from Africa and Asia as well as from different working classes - all of whom were trying to overcome a similar difficulty.

The normalising process made possible by the group setting is a huge advantage inherent in group compared to individual therapy. Social comparison with others experiencing similar issues challenged group members' beliefs that their symptoms were unique, a perception that had developed due to secrecy and shame. Social comparison also indirectly challenged the negative meaning attached to the content of thoughts, a central aim of CBT for OCD. Once the underlying meaning had been challenged participants began to feel motivated to change and developed risk-taking behaviours, which were facilitated in part by a sense of togetherness. Having achieved a modified sense of identity participants began to engage in the middle stage of group therapy and described being motivated to change, outlined in the following theme 'Courage to Fight'.

3.4 THEME 3: - Courage to Fight

A superordinate theme relating to an increased sense of motivation and strength to overcome the OCD since being in the group was generated. Participants described achieving a sense of 'Power in Numbers' demonstrating the therapeutic factor of 'altruism' as participants wanted to help each other (Yalom, 1995). Some participants also described being motivated by realising 'The Therapy is Working' a subtheme that facilitated the therapeutic factor of instillation of hope (Yalom & Leszcz, 2005). A third subtheme entitled 'The Feedback Helped' related to a motivational factor stemming from a healthy sense of competition between group members which resulted in increased compliance with homework assignments.

3.4.1 Subtheme 1: 'Power in Numbers'

A sense of working together in a team and of being in a shared battle with others was perceived as a motivational factor in the group and was highlighted by seven participants.

Excerpt 1 - Anna

Anna reflected on her motivation to change since being in the group.

I think it helps sort of knowing that there are people out there, not too far away, being their own therapist, as instructed by the therapy, you know, we have really got to be strict on ourselves, and it does help knowing that there are other people experiencing that, and trying to combat it, so just kind of putting that image in our minds of other people being strict with themselves and overcoming certain trials that they may face and stuff (Transcript 1, p 41, l 1025-1038).

Prior to the excerpt Anna's disclosure concerning the email exchange between group members highlighted the significance of group cohesion in the group (Bieling et al, 2006). Just before the excerpt Anna shared how 'we', referring to the group as a whole, felt 'close enough to check in with each other at any moment for support' further elaborating the sense of cohesion in the group. Anna had also internalised the idea of being becoming her own therapist, which is a central goal of CBT in terms of preventing relapse (Abramowitz, 2009). She used 'we' when highlighting the difficulty in overcoming OCD faced by the group and acknowledged that group members must take responsibility for this change. Her recognition that being 'strict' is essential for continued improvement related to her understanding that group members must continue to tolerate anxiety symptoms when triggered rather than gaining instant gratification by carrying out rituals. Her capacity to imagine the others who she perceived were 'close by' struggling to overcome a difficult

problem, was helpful to her in terms of her continuing to feel motivated to change after the group had ended. Her choice of words 'combat' and 'trials' emphasised the impact of her perception of the struggle for the group as a whole who were literally at 'war' when attempting to resist compulsions. She perceived the others as still 'battling' and struggling to fight a distressing ordeal after therapy had ended.

Excerpt 2 - Sarah

Sarah also referred to the sense of knowing and imagining others were trying to overcome difficulties as a motivational factor.

*...we were all there, obviously knowing that someone else was there, they were trying to stop the things they were trying to **stop doing**, it sort of was a little bit of a team, obviously then as the weeks went on, we did homework, we were all trying to stop doing something that annoyed ourselves (Transcript 2, p 15, l 360-368).*

Sarah raised her voice when she emphasised that knowing others were trying to 'stop doing' frustrating rituals was a helpful factor in group therapy. She highlighted her perceived sense of difficulty for the group as a whole in overcoming rituals. She described how her sense of being in a 'team' helped keep her motivated to make further changes on herself outside of the group. Sarah emphasised her sense of togetherness and bonding in the group when she emphasised 'we' three times in one sentence.

Excerpt 3 - Laura

Laura reflected on her decreased ability to contest her symptoms following the birth of her second child and how being in the group had motivated her again.

...because, I mean, what I have realised now, is that I was that uncomfortable contesting, it never stops, that's how it, that's what you do, (umm) you know, and umm being in a group made me have the tenacity to start doing it again which I had lost (Transcript 4, p 5, l 104-109).

Laura lowered her voice and looked down when she described previously having lost her tenacity to fight her OCD, suggesting feelings of guilt or shame for having relapsed after the birth of her second child. She described feeling frightened to object to the urge to check which had resulted in the OCD flooding her by 'never' stopping. Her lowered voice could be linked to the suppression of her voice in the relationship with her husband who was initially aggressive towards her when she risked

disclosing her difficulties early in their relationship. Since then she had kept the problem hidden from her husband. The 'tenacity' she described emphasised her determination to start 'contesting' again. She felt driven by being in the group to start objecting to the OCD, a strength which had also generalised to being more assertive with her husband, discussed in 3.43 (The Feedback Helped excerpt 2). Following the excerpt Laura expanded and shared how her sense of knowing others were 'going nuts' trying to refrain from carrying out rituals promoted a shared sense of discipline which helped motivate her to change.

Excerpt 4 - Mia

Mia shared her experience relating to carrying out behavioural experiments and tolerating her anxiety in the group which served as a motivational factor.

*...and actually **really putting it** into practice, (umm), and I guess like knowing that other people are trying it as well, it's kind of nice, it was like like power in numbers, kind of thing you know (laughs) (Transcript 5, p 12, 291-297).*

Mia emphasised 'really putting it' into practice, outlining the importance of carrying out experiments in the group setting for promoting hope for change. This was contrasted later in the interview with how Mia had told herself for years that she did not have to carry out her rituals but had not managed to resist the urge until being motivated by the group setting. She felt empowered and strengthened by knowing others were trying hard to change by putting new skills into practice which was experienced as a warm feeling and generated a sense of 'power'.

Participants' motivation to change outlined in the above narrative developed from a sense of working together and feeling less alone in struggling to fight similar issues. The therapeutic factor of 'instillation of hope' (Yalom & Leszcz, 2005) had been generated by the group therapy process - an essential goal in any therapy. This was further facilitated as participants began to recognise progress in the group and learned from observation of others' risk-taking outlined in the following subtheme 'The Therapy is Working'.

3.4.2 Subtheme 2: 'The Therapy is Working'

This subordinate theme was generated in the personal accounts of four participants. Group members reflected on how seeing others improve in the group further promoted the therapeutic factor of 'instillation of hope' concerning the effectiveness of therapy (Yalom and Leszcz, 2005). A belief that 'The Therapy is Working' also facilitated empathy and participants described positive

feelings for other group members making gains. By observing others making progress participants also benefited through the process of 'vicarious learning' (Yalom, 1995).

Excerpt 1 - Laura

Laura reflected on her increased sense of hope for change after having observed another group member carry out a behavioural experiment in the group.

...and she did manage to throw one away, and it was like, hey (laughs) it was great to see other people, because it's not just that they are doing it, because you know if they are doing it, the therapy is working, and you are also doing the therapy, (umm) so there is this mutual, like um, it's like you are in a team (umm in a team) yeah the team can do stuff yeah (Transcript 4, p 15, l 359-366).

Laura was animated as she remembered witnessing another triumph by successfully engaging in a behavioural experiment whilst tolerating her anxiety. She laughed, demonstrating her empathy and care for another group member who had made progress. Seeing another who had hoarding rituals manage to throw away a receipt increased her hope in the effectiveness of therapy and the possibility of change for herself. Her sense of belonging and hope was strengthened by her sense of being in a team. She referred to being in a team as a 'mutual' two-way experience indicating the therapeutic factor of altruism (Yalom & Leszcz, 2005) as participants wanted to help each other.

Excerpt 2 - Sunny

Sunny reflected on the impact of observing another group member engage in a behavioural experiment in terms of his increased motivation.

...yeah it felt very positive, I was very happy to see that he could hold that cup of water without any negative thoughts or feelings. I think it did help me as well to realise that I could do it as well (Transcript 8, p 44, l 1972-1077).

A feeling of empathy and sense of hope had developed by observing another overcome the feared consequence that he would act on his thoughts and throw hot water over another person. This was achieved after a behavioural experiment was carried out in the group space involving another group member holding a cup of hot water. Sunny had observed his anxiety peak and come down when the group member confronted his fears that he would harm another person. This increased motivation and hope for change emphasises the importance of carrying out behavioural experiments in the group for promoting the realisation of the possibility of change and strengthening group cohesion.

Excerpt 3 - Paul

Paul described an increased sense of motivation to change by recognising that he and other group members were making progress.

...you are working on a task, and you get feedback as well, and you feel now you are actually doing something, and you can start to see the positive results and you are making some changes and also it keeps you motivated as well because you see other people also making changes as well, and you feel yeah, there like, something is working there, and you feel like you want to have a go as well (Transcript 7, p 35, l 845-856).

Getting feedback from other group members when working towards a goal helped Paul realise he was making progress. This observation that himself and others were beginning to make changes instilled hope in the effectiveness of therapy, which in turn motivated Paul to take further risks.

Excerpt 4 - Mia

Mia expressed her sense of joy and empathy towards another group member making progress after observing him successfully engage in a behavioural experiment.

I mean, to see that other person overcome their fear, it helped me, by I don't know making me feel happy (laughs) for them, so again that might be for selfish reasons, but I was happy for them, you know (Transcript 5, p 17, l 412-417).

Mia laughed when remembering this powerful moment in the group because she felt genuinely happy for the other group member after observing him tolerate his anxiety and make progress. Her indication that observing another make gains helped her for 'selfish reasons' highlighted her growing sense of hope for change in herself.

Group members' belief in the effectiveness of therapy had increased by seeing positive change in others, emphasising the importance of carrying out behavioural experiments in the group setting for instilling hope for change - a therapeutic factor vital in all therapy (Bieling et al, 2006). Positive relationships had developed by observing others make changes in the moment. The importance of providing space for reviewing homework and setting realistic goals in which participants began to take a more active role is highlighted and outlined in the following subtheme 'The Feedback Helped'.

3.4.3 Subtheme 3: ‘The Feedback Helped’

Giving and receiving feedback related to homework assignments was also a motivational factor, which was generated in the accounts of four participants. This process promoted a healthy sense of competition and increased compliance with negotiated homework.

Excerpt 1 - Sarah

Sarah reflected on her experience of giving feedback related to her negotiated homework assignment in the group setting.

*...umm I suppose every week we were going away and doing homework, and obviously you have to come back in, and you always want to have something **good** to share, you don't want to come in and say I haven't done anything sort of thing, so it's coming in and trying to have something good to feedback to everyone else so that everyone else, you all go away and try and **compete** with each other sort of thing, and say I have managed to do this this week (Transcript 2, p 21, l 508-521).*

Sarah described ‘having’ to come back to the group with something ‘good’ to share and ‘always’ wanting to have something positive to feed back to the group. She did not want to admit to not having done anything possibly due to fears of letting the group down, which may have triggered feelings of guilt and a fear of negative evaluation by others in the group. She had accepted the rationale concerning the importance of completing homework in order to generalise gains emphasised in this therapeutic approach. Her desire to please and ‘compete’ with other group members had further promoted compliance with her homework assignments.

Excerpt 2 - Laura

Prior to the excerpt Laura disclosed her sense of pride when sharing successes in the group described as the ‘sweetest feeling in the world’, leaving her feeling empowered. She reflected on how sharing successes in the group had a ‘knock-on effect’ in her life outside the group.

*...and I just, you know, it made, I think it gives me defiance, it gives you defiance, makes, made me more defiant, so I was like more defiant about fighting the disorder, more defiant about fighting my husband, well you have to wear spectacles and you have eczema and umm, you know, and I have to do all the laundry in some special pile, that's your problem so this is my problem, you know, so it's not like a **bad, it's not this bad problem**. This is your problem and I tolerate it the whole time umm, you know, so it has it made me more comfortable, made me more comfortable (Transcript 4, p 7, l 162-172).*

A sense of 'defiance' had developed within her after sharing her problem and progress made, which she emphasised by repeating the word four times in one sentence. After years of secrecy the experience of not being judged for her difficulties in the group had led her to choose to equalise the relationship by refusing to be judged by her husband anymore. Laura's comparison between her OCD and her husband's minor common physical ailments demonstrated her increased assertiveness. Her voice rose as she gave an example of how she challenged her husband who had been critical towards her in the past. Laura emphasised that her problem was not a 'bad' one, highlighting her new perception of the reduced severity of her issues. I felt moved and smiled as I listened to her demonstrating her defiance given her history of being silenced by her mother since the onset 20 years ago. I understood this to be her healthy attempts to 'resist' being badly treated, as highlighted by an approach to therapy by Renoux & Wade (1998), which informs my own clinical work.

Excerpt 3 - Sunny

Sunny explained how he benefited from other group members' feedback after identifying with others whom he perceived to have a similar problem in the group.

...so I think identifying with the same problems within some people, I think that actually helped me to find ways of how they would be dealing with the problem, and finding out ways they dealt with their problem, would have helped me deal with my problems as well. I think the feedback from everyone in the group, I think it did help so, I think it did help me think of ways of helping improve myself as a person (Transcript 8, p 13, l 316-328).

Sunny's identification with other group members' similar difficulties enabled him to generalise learning and identify ways of helping himself improve personally. This 'personal' improvement may have been related to increased self-esteem and personal development that was generated by meeting others, rather than reductions in his OCD. He described how the process of getting feedback relating to homework assignments was helpful for identifying further strategies, which he emphasised by repeating the word 'help', 'helpful' and 'helping' four times in his narrative.

Excerpt 4 - Laura

Laura reflected on the impact of sharing her progress in the group.

...because, you know, in the beginning, you know, I think I can't do it, I haven't done it for years, so I can't do it, and then when you do do one, the first one, even though it's like a silly little thing, umm, you know, you feel so empowered by that and as you start to go up your ladder it just feels, you know, it feels

great, it feels fantastic and being able to tell people feels fantastic (Transcript 4, p 41, l 1014-1020).

Laura expressed doubts about her ability to engage in behavioural experiments involving refraining from carrying out a ritual and tolerating her anxiety by saying 'can't do it' twice. Having engaged in rituals in response to her anxiety for years she doubted her ability to take the first step in therapy. Progress with a small goal early on in therapy had motivated her. She emphasised how 'fantastic' she felt, repeating this word twice when sharing her progress with other members in the group, which had empowered her to take further risks. She used her own term 'ladder' referring to her hierarchy of situations avoided and emphasised hope in reaching higher and harder goals. Being able to tell people about her progress was particularly significant for Laura who had felt silenced by her mother and husband who refused to acknowledge her OCD which had resulted in secrecy and shame.

Participants reported some significant changes stemming from the group process. The therapeutic factor 'altruism' (Yalom & Leszcz, 2005) had developed in the group. This is said to occur when group members benefit from helping one another. Participants described being motivated and empowered by sharing in the group, which helped by highlighting useful strategies and setting realistic goals. Motivation and risk-taking had increased by being in the group with others working towards a similar goal. One of the main aims of Cognitive Behavioural Therapy is to facilitate the client's learning skills to become their own therapist (Simmons & Griffiths, 2009). Participants shared the impact of skills learned in the group and how these had been internalised, suggesting this goal was achieved in group therapy, which is outlined in the following excerpts and narrative 'Being my own Therapist'.

3.5 THEME 4: - Being my own Therapist

Three subordinate themes were generated relating to skills learned in the group - demonstrating an internalisation of CBT theory. Participants spoke about how gaining insight into predisposing factors in childhood helped challenge self-blame by recognising 'It's Not My Fault'. Four participants shared how internalising the theory of CBT had facilitated an understanding of what keeps the problem going, outlined in the subtheme 'The Thoughts Will Come Anyway'. A third theme generated through six participants' accounts related to skills learned in the group for tolerating feelings 'The Anxiety Will Come Down' when refraining from engaging in reassuring behaviours. All participants illustrated a good understanding of the cognitive model and described how using the techniques learned helped them cope more positively with their difficulties.

3.5.1 Subtheme 1: 'It's Not My Fault'

The main aim of CBT is to develop an alternative less threatening account of the experience of OCD by challenging the inflated responsibility appraisal (Salkovskis, 1999). This theme was generated in the accounts of six participants and seemed clearly linked to the identification of relevant past experiences.

Excerpt 1 - Anna

Prior to the excerpt presented, Anna shared how group members had recognised the underlying theme of inflated responsibility underpinning rituals, despite the differences in content between each other's compulsive behaviour.

I think it helped me to see that I've, as a child I felt I had a large, a large sense of control, I think which was helpful because it allowed me pinpoint where it quite specifically, where the OCD could have developed from, which again helped me apply it all to Theory B, (ok), which kind of gave me an extended Theory B, not just that I worry about stuff, but that I worry about stuff mainly because I was an only child (Transcript 1, p 23, l 548-560).

Exploring her early experience had enabled Anna to make sense of the development of her inflated responsibility beliefs and internalise the concept of Theory B. The strengthening of this alternative theory that she was worried about, rather than actually being responsible for, causing harm (Theory A) is seen as essential and fundamental to change in CBT for OCD. The aim of behavioural experiments is to strengthen this idea rather than dispute Theory A (Salkovskis, 1999). Being an only

child who was overprotected by her parents had led Anna to worry about the welfare of significant others and the OCD developed as a strategy to manage her anxiety.

Excerpt 2 - Paramjit

Paramjit reflected on his increased understanding of the development of his problem, which challenged his sense of self-blame.

*...yeah just before, I was just kind of like... I don't know, in the sense that umm, I kind of knew what I was doing **was wrong**, but at the same time I just, I thought it was just like a habit, and it was just something I would just have to live with it, but I never really actually, umm, proper looked into it, **why** I was doing it, or maybe there might have been a problem that might have happened before, and that my OCD might have **stemmed** from that, and just the OCD group allowed me to explore why and just how to sort of deal with it (Transcript 5, p 3, 162-77).*

Exploring developmental factors in the group allowed Paramjit to challenge his perception that he was doing something 'wrong' emphasised by his loud voice suggesting previous feelings of guilt and self-blame. His voice was also raised, as he emphasised that he had 'never looked into why' as he shared his relief stemming from the identification of predisposing factors. Prior to the excerpt Paramjit had explained that when he was younger his relatives had moved from India to London and had lived with him. He had perceived his relatives as having less 'hygiene awareness' than himself, which made him vulnerable to developing concerns about cleanliness. Understanding the development of his problem challenged his perception that he was going 'crazy'. This is in contrast to his previous perception that his problems were a result of 'bad luck' or a habit he would have to live with which had resulted in a sense of helplessness and a lack of agency concerning change.

During participant validation Paramjit mentioned that the exploration of early experiences was helpful as he would not have made this link without being in the group.

Excerpt 3 - Sarah

Making a link between the experience of loss and the onset of her checking rituals made sense to Sarah as she reflected on her understanding of the development of her OCD.

*...well it gives you a sort of little bit of an explanation, as to why you are doing these things, and obviously if, you know, you have had a loss or something has happened in your life, then, then just the way you think about things every day, it's like you don't want to **lose** the things around you, so you are **doubly** making sure and things like that (Transcript 2, p 38, 1930-940).*

Prior to the excerpt Sarah mentioned how understanding the 'why' helped motivate her to change her current situation by giving her 'closure' on her past. She emphasised how much she didn't want to 'lose' anything else around her by raising her voice. After having experienced a loss in her earlier life her checking rituals were behaviours aimed at making 'doubly' sure she wouldn't lose things again. Sharing in the group had helped her pinpoint a cause previously considered but not fully realised.

Excerpt 4 - Paul

Paul shared how his inflated responsibility appraisal developed due to feeling responsible during childhood for preventing his parents arguing.

I think it came from when my parents were arguing, you know, when I was little, (umm) and I think the OCD probably started around that time. Umm, and I think it was a case of like, I thought maybe if I did certain rituals or something that nothing bad would happen, they would stop arguing, or nothing would happen to them, or to me, or somebody in the family, and I think that's when it all started and the therapist goes through all these questions and gets you into it deeper, and you realise that when you are a child you don't actually understand, you see things in black and white sort of thing, it's like, ok, it's not your responsibility, it's not your fault (Transcript 7, p 28, 1 683-701).

During childhood Paul witnessed his parents arguing which he had found distressing. He reflected on his desire to stop his parents arguing and his growing sense of responsibility to prevent bad things happening to himself and loved ones. Exploring his early experiences and underlying beliefs in the group through the use of Socratic questioning by the therapist, had led him to the conclusion that he could not have been to blame and it was not his fault. His voice was gentle as he disclosed this changed perception of himself, that he was not responsible for his parent's difficulties, a view that he had carried with him since childhood. Paul had recognised his tendency to engage in 'black and white' thinking as a child due to a lack of understanding. This revelation facilitated a sense of empathy for himself as a child and reduced his feelings of guilt.

Excerpt 5 - Sunny

Sunny reflected on the impact of exploring early experience with other group members.

...umm I just think the cases that we heard, some of the serious cases, I think it just personally made me feel that it's not their fault that they have their problem. I think it must have developed from an early age from since childhood

and they might not have known that those problems was going to become serious or not, so it was a bit upsetting to me (Transcript 8, p 26, I 627-636).

Exploring early experiences within the group had an impact on Sunny in terms of developing empathy for other group members and recognising the problem was not their fault. He described finding the recognition that others may have not known their problems would become more serious in later life as 'upsetting', highlighting his empathy for other members of the group. By attributing others' difficulties to past experience and the development of unhelpful beliefs he has indirectly challenged his own meaning about being responsible for causing harm. His comparison to others considered more 'serious' might have also reduced the perceived severity of his own difficulties.

Participants reflected on the development of the current problem, a process which indirectly challenged the meaning participants were attributing to their difficulties, a central aim of CBT. The inclusion of a discussion on early experience helped participants to make sense of the 'alternative theory' (Salkovskis, 1999) that difficulties are a result of worry based on past experience, rather than being actually responsible for causing harm. This inclusion of a discussion on early experience within the group setting promoted empathy and facilitated group cohesion in an earlier excerpt for Anna, during engagement in the group outlined in the subtheme ('We Built Trust' excerpt 1). Participants went on to discuss how theory had been internalised relating to the counterproductive nature of maintaining behaviours outlined in the following subtheme 'The Thoughts Will Come Anyway'.

3.5.2 Subtheme 2: 'The Thoughts Will Come Anyway'

Five participants shared how an understanding had been developed in the group in terms of what kept the problem going.

Excerpt 1 - Sarah

Sarah sounded adamant as she emphasised how she had learned that seeking reassurance from family and friends was counterproductive.

*...umm and just whatever they do, you don't have to, don't have to check with them, and say are you **sure you did** it this way, **what did you do?** Explain to me, and just get loads of information out of them, but coz, well obviously, the information well; went in previously, but it **doesn't resolve anything, it doesn't get you anywhere**, (umm), so I just sort of think ok fine ok, even though I am still thinking all the thoughts in my head, I'm just not going to ask them and obviously get them thinking, well why is she thinking that, you know, so I just,*

there is no point me asking them, 'Did you do that right, are you sure you checked it?' (Transcript 2, p 29, l 704-722).

Sarah raised her voice when she emphasised it 'doesn't resolve' and 'doesn't get you anywhere' demonstrating the strength of her belief in this new understanding that reassurance-seeking was unhelpful. She demonstrated how she previously demanded reassurance from family and friends by asking for clarification to ensure tasks had been carried out correctly. She recognised her previous need to 'get loads of information' from others to make doubly sure that tasks had been carried out properly was futile. Although she still doubted what others had done she made a choice not to act on it by refraining from asking. Instead she described how she tolerated uncertainty and as a result felt less concerned with what others thought about her thinking process.

Excerpt 2 - Paul

Paul described how he had come to believe that his rituals were irrelevant in terms of preventing intrusive thoughts.

...I think by realising that, you realise that, ok, you are doing all these things because you feel responsible or something, or you are having these bad thoughts so something bad might happen, or something, but it's a case of...but those thoughts will come anyway, and even if you do the rituals or not it wouldn't make a difference anyway (Transcript 7, p 29, 702-711).

Paul identified his inflated responsibility appraisal as the motivator of his rituals and also challenged his belief in the idea that 'thinking something can make it happen'. This is a common meta-cognition held by many people with OCD referred to as Likelihood Thought Action Fusion (Marino-Carper et al, 2010). This is a kind of 'magical' thinking which maintains that thoughts alone can result in action occurring. Paul's recognition that his thoughts will come regardless of the rituals, which he had previously carried out to prevent his thoughts coming true had directly challenged this idea.

Excerpt 3 - Mia

After having carried out a behavioural experiment in the group space and tolerated her anxiety, Mia shared her recognition of the futility of her rituals which had been providing her short-term relief.

...it was good to really try it, and actually really do it, umm because, like, over the years, I have told myself, you don't need to, you don't need to, you know, and in my head it doesn't make sense to do it. I know it's totally, it's pointless for me to do that thing whatever the ritual is, but it relaxed me, it relieved me, (yes) so by

not doing it I am unlearning something I have learned (Transcript 5, p 8, l 183-193).

Mia contrasted her previous tendency of repeating actions until she felt right by 'really' trying hard to tolerate her anxiety in the group setting. She referred to the compulsions like an addiction, which had provided instant gratification and overrode logic. She had recognised this for years but the group space where she had the opportunity to put skills into practice, had promoted a shift from intellectual recognition to a firm belief that her feared consequences would not occur.

Excerpt 4 - Paramjit

Having recognised that intrusive thoughts were universal, Paramjit no longer saw the need to dwell on his thoughts.

...instead of actually dwelling on it, all that you have to do, was just acknowledge it, and just sort of move on from it, and you don't need to dwell on it because everybody has that sort of thoughts or compulsive sort of actions, but it's just if you think too much into it then you will just pretty much spend all your life just sort of dwelling over it, but if you just acknowledge it and just let it slide, then it's definitely a better way of living your life and it's a lot easier (Transcript 6, p 7, 147-160).

Paramjit's words 'let it slide' were his own narrative relating to his new way of managing his thoughts. His choice of words implied that the thought was not dismissed but he was able to put it to one side and engage in life more meaningfully, resulting in less preoccupation. He found the new strategy easier than his old method emphasised by his words 'all you have to do' when referring to acknowledging but not engaging with his intrusive thoughts. As a result he indirectly challenged the meaning that he was going 'crazy' which had been reinforced by his previous strategy of 'dwelling' on his thoughts resulting in increased preoccupation and doubt. At participant validation I mentioned his choice of words 'let it slide' and he informed me that he was still using this expression to help refrain from engaging in intrusive thoughts. He further elaborated on how he often still exposed himself to his fears by touching walls or his feet and then his face. This specific intervention that had been demonstrated in the group and he was continuing to use, kept his OCD at bay. Since the group Paramjit had also completed a work placement where he had worked in an office handling money, something he was adamant he would not have been able to do prior to being in the group due to his fears of contamination.

Participants described increased insight concerning the nature of reassurance, the futility of rituals in terms of preventing intrusive thoughts, the unhelpful nature of dwelling on thoughts and increased

awareness of triggers. Participants seemed to enjoy discussing the development of new skills and appeared to be empowered by the internalisation of theory relating to key concepts in CBT, concerning the role of maintenance factors. It appeared that participants accepted the treatment rationale and were socialised to the model. Participants also described learning in terms of the development of new skills to tolerate anxiety more efficiently outlined in the following subtheme 'The Anxiety Will Come Down'.

3.5.3 Subtheme 3: 'The Anxiety Will Come Down'

Participants shared skills learned from internalising the theory and skills of CBT relating to tolerating feelings more effectively since being in the group. This theme was generated in the personal accounts of six participants.

Excerpt 1- Laura

Laura gave an example of how she used her new feelings of defiance developed by sharing with others in the group to refrain from taking up new rituals.

...well it's good, I just say oh fuck this (laughs) I am not going to do this, there is no way I am going to do this, you know, now I really am like, I don't even grace it, I don't even think about it, it's the last thing in the world I need. I am still trying to get rid of, I have got a whole stack of rituals I am eliminating them, the last thing in the world I want is a new ritual (Transcript 4, p 38, 1920-926).

Relating theory to her own difficulties had enabled Laura to view her compulsions as a choice and she began to examine her options concerning giving in to a ritual. Her sense of defiance was expressed by saying 'no way', 'don't even grace it' and the 'last thing in the world I want' revealing how she had internalised theory relating to the maintenance of her problem. She reflected adamantly on her refusal to engage in new rituals in the knowledge that she still had a 'whole stack' to eliminate. Her laughter after swearing highlighted her newly found sense of defiance to overcome her difficulties which helped her tolerate her anxiety more effectively.

Excerpt 2 - Anna

Anna emphasised how she had come to realise that accepting her anxiety in response to her intrusive doubts was a more helpful strategy than engaging with the content of her thoughts.

I think seeing that other person, as well as having the overall therapy process, for me personally has helped me not get so nervous, or just not, just completely put that idea to bed. I think, realise that it is or if I do still get nervous, it's much easier to say well you are getting nervous but that will go away, the anxiety will come down, because it is just an OCD thing rather than I haven't offended anyone. I don't need to be sort of conscious about having done anything strange (Transcript 1, p 17, l 395-408).

Anna described being more able to put her intrusions about offending others 'to bed' because she attributed her fearful predications to anxiety symptoms. She had challenged the idea that she will lose control and act on her thoughts, resulting in her feeling less self-conscious and embarrassed about what other people think about her. Her reference to it's an 'OCD thing' suggests that she has internalised the label of OCD which has enabled her to attribute less responsibility for her difficulties to herself.

Excerpt 3 Mia

Mia described her new strategy for dealing with intrusive thoughts by not engaging with the content and viewing her thoughts as nothing more than mental events (Ryan, 2004).

they are just thoughts (laughs) its just something that I have learned here, they are just thoughts (umm hum) and like as horrible as some of them might be, umm I have just got to keep telling myself you are not going to do, you are not going to do it you know (ok) so it again depends what kind of day I am having, some days I can tell myself it's just a thought and it's dismissed it and it's gone (Transcript 5, p49, 1202-1211).

It is possible that this strategy did not work for her sometimes because she was reassuring herself that she was not going to act on her thoughts which she emphasised by repeating to herself 'you are not going to do it'. She was still viewing her thoughts as 'horrible' suggesting there was more normalising work to be done. This could be achieved by carrying out a survey to more people concerning the content of intrusive thoughts with a view to gathering further evidence of the universality of thought intrusions.

Excerpt 4 - Sarah

Sarah reflected on how she was more able to accept help from others and ignore her anxiety symptoms since being in the group.

*...maybe letting more **people in** and trying not being too controlling over your **whole** environment, sort of thing, umm, and just able to not stress about things*

too much, and not keep going over, so if you do do something, I know that you get the anxiety level for a bit, like you say, still today after my daughter's help this morning I will be thinking about that a little bit, but I know it will ease off (Transcript 2, p 39, l 964-975).

Sarah described being more accepting of her anxiety since being in the group and having recognised that the symptoms will ease off over time. Her need to do things perfectly had previously prevented her from accepting help. She described being less controlling, emphasising the word 'whole' environment and gave an example of accepting help from her daughter who she had allowed to fill the dishwasher without checking it or demanding reassurance earlier that day.

Excerpt 5 - Marc

Marc described how he tried to tolerate his anxiety and manage his intrusions differently since being in the group.

...the obsession is there, but then what you do is just let the thought flow by, you know, that is was what we, the therapist, that that's what we do, what we learned, is like don't react with that thought, let it just flow by, just get into normal activity and don't react to that thought (Transcript 3, p 5, l 105-112).

Marc was more able to acknowledge his intrusive thoughts and let them go. He described his new strategy of 'letting the thoughts flow by' which represented his own narrative, demonstrating he had internalised theory relating to the maintenance of his problem. Like Paramjit who had developed his own language: 'let it slide', Marc had internalised theory relating to sitting with anxiety and not engaging with intrusive thoughts through instruction from the therapist. As a result Marc was able to refrain from reacting to his thoughts by attaching less significance.

In this theme participants demonstrated many skills that had been learnt through the process of group therapy and which were continuing to be used after the group had ended. This suggested that many of the therapeutic interventions that had been demonstrated in the group had been internalised and generalised outside the therapy setting. This is an essential aim for clients to keep working on their difficulties by practising being their own therapist. In particular the inclusion of a discussion on early experience seemed to have a dramatic effect in challenging the responsibility appraisal and generating empathy between group members. The final superordinate theme relates to previous fears of negative evaluation from others when carrying out compulsive behaviour and an improved quality of life since being in the group, outlined in the following narrative 'Restricted by Shame vs. Engaging with Life'.

3.6 THEME 5: Restricted by Shame vs. Engaging with Life

A theme relating to the impact of living with OCD was generated in the personal accounts. The first subordinate theme related to concerns about 'How I Am Seen' by others when carrying out rituals. This was contrasted with narrative related to an improved quality of life, as participants shared changes since being in the group outlined in the subtheme 'Life is More Vivid and Fun'.

3.6.1 Subtheme 1: How I Am Seen

This subordinate theme was generated in the accounts of five participants and related to fears of negative evaluation by other group members for one participant. Four other participants shared concerns about how they were viewed by friends, family, strangers and colleagues when engaging in compulsions.

Excerpt 1 - Paramjit

Paramjit had been apprehensive about sharing and was concerned about how others viewed him in the group.

...yeah um, I just thought some people might, umm might be umm, less than me, and just maybe sharing some sort of thing, other people in the group might think he is a bit crazy for umm say washing his hands for so long, like once you have washed them for 2 minutes they are clean, you don't need to wash them for like half an hour or 20 minutes or whatever (Transcript 6, p 15, l, 361-370).

Paramjit had remained silent for the first three sessions due to fears of exposing himself and being judged by others, suggesting he felt ashamed by his hand-washing rituals. He had predicted that other group members would think he was 'crazy' for the amount of time he spent engaging in washing compulsions and that others would be less severely affected by the OCD. His interpretation about what others would think about him may have represented his own view of his difficulties prior to meeting others in the group.

Excerpt 2 - Sarah

Sarah described everybody else in the group being 'open' as helpful in terms of her feeling more able to share with others in the group and compared this to her hidden self with friends and family.

...well I suppose it's, it's the same as with how you look at yourself like family, because you don't tell family, because you don't want them to know certain

things about yourself, and things like that, but I suppose in this group everyone was sort of quite open (umm) and that enabled you to be more (umm) open as well, if someone was disclosing something to you, you can disclose something to everyone (Transcript 2, p 6, l 123-135).

Sarah's ability to be more open in the group suggests that she felt safe and trusted other group members. She disclosed how she hid 'certain things' about herself from her family, demonstrating her struggle of living with a secret. Initially I had interpreted her secretive behaviour as indicative of feelings of shame. However, during participant validation Sarah explained that her behaviour was motivated by guilt due to how she was making family members, who did not understand the process, feel about the situation. She elaborated when asked to give an example and shared how her need for order and neatness had in the past led her to 'invade' her daughter's space to ensure that her clothes were folded neatly. She contrasted her previous behaviour with how she was managing to refrain from tidying her daughter's room, by allowing her daughter to be responsible for her own possessions since being in the group.

Excerpt 3 - Laura

Laura described the tension she felt when in public whilst trying to refrain from carrying out rituals due to concerns about what others would think about her.

...you know and it's like that too, you know, like you can't even follow a conversation or participate in a situation, because it's eating at you, that you haven't done this behaviour, and you can't do this behaviour because you're in the situation (umm) you are in a room with someone (umm) or you know, I mean I am not perfect now but it's just better (umm) you know (Transcript 4, p 12, l 275-282).

The urge to check was 'eating at her' as if it was gnawing and aggravating her. This sense of feeling compelled to check illuminated the extent of the anxiety felt, as she tried to refrain from ritualising when others were present due to a sense of shame. Laura described her struggle hiding her difficulties by saying 'you can't do this behaviour' when others are present. Her reference to not being 'perfect' but better, highlighted some residual difficulties despite improvements made during group therapy. The use of the term 'perfect' may represent some unrealistic underlying beliefs that could benefit from being further explored and challenged, as perfectionism has been considered an important variable that plays a specific role in the maintenance of OCD (Moretz & McKay, 2009).

Excerpt 4 - Marc

Marc reflected on his feelings of embarrassment which were triggered when repeating his checking rituals in public.

...I mean when I, yeah I do that, I do feel something like that people are they are watching me, and I do feel embarrassed yeah, when I do the checking and I keep on checking it and checking it, you know, what the hell is he doing that for, it's not nice so, (umm) and yeah then it, you become demoralised you know, and if you are being shunned you know, you are being shunned (laughs) (Transcript 3, p 65, l 1535-1547).

Marc expressed his embarrassment and belief that others were 'watching him', unable to understand his behaviour and negatively judging him, when he felt compelled to carry out checking rituals in front of others. He was very concerned about what others would think about him at the time and described feeling depressed afterwards, believing that others would reject him, expressed by his choice of word 'shunned'.

Excerpt 5 - Laura

Laura reflected on her difficulties living with her OCD in secret due to fears of being judged by her husband.

*...it is **very important** to him that I am (laughs) **very very** calm, and so, so like when I did tell him, in the beginning when we started dating, I said I have this problem and he was very aggressive about it, so after that I never really mentioned it, (umm) you know, it's just umm, you know, I mean it's just a non-discussed issue because he doesn't like it at all (right) and then actually, then occasionally not often, I mean I don't go on about it, but I'd say I went to the, to therapy, and then I would say to him, have you noticed I am not doing this, but actually I used to mask it so much that he didn't notice (Transcript 4, p 6, l 122-134).*

Prior to the extract Laura had disclosed how sharing with the group had a 'knock-on' effect enabling her to be more assertive with her husband and talk about the progress she had made with her OCD. She contrasted this with her previous tendency of choosing not to speak to her husband to hide the 'part of me that is crazy' through fear of triggering his aggressive response. Laura described her husband's unrealistic expectations of her to be calm, emphasising 'very' three times in one sentence. She described how difficult it had been to talk about her OCD, which had remained a 'non-discussed issue' at home after her husband's initial aggressive response to her disclosure. Since then she had kept her problem hidden by carrying out rituals in the bathroom or when he was not looking.

Sharing with others in the group enabled her to risk sharing her success of reducing behaviours kept 'masked' from him since they married 20 years ago. She acknowledged her adeptness in hiding her OCD to the extent that her husband hardly ever noticed - highlighting her struggle in living with a secret. Later on in the interview she described how her confidence had generalised to her professional role at work since reducing her rituals and becoming 'quicker' when changing environments. She felt less embarrassed about what others thought about her 'bizarre' behaviour and was less concerned that her professional status was being questioned negatively at work.

3.6.2 Subtheme 2: 'Life is More Vivid and Fun'

During the interviews five participants talked about changes they had made since being in the group which had resulted in an improved quality of life.

Excerpt 1 - Laura

Laura described an increased capacity to engage more meaningfully with people and life, which enabled her to experience a sense of enjoyment.

*...you know, you feel like, you lose, you just lose so much energy and vitality in life to this pointless thing, and it's, it's **so so frustrating**, so when it's reduced, you know, life just it kind of sparkles so much more, life is just so much more vivid and fun, and people are more fun (umm) because you are not, you know, it's horrible going into any new situation with your heart in your mouth that you can't concentrate (Transcript 4, p 11, l 267-275).*

The extent of Laura's frustration triggered by the recognition of the futility of her rituals was emphasised by raising her voice when she expressed 'so so frustrating'. She disclosed how she felt as if her vitality and energy had been lost as a result of her OCD before being in the group and contrasted this with her ability to engage in life more meaningfully. Her choice of word 'sparkles' illuminated the sense of happiness she felt when her OCD was reduced. Laura expressed her embodied response (Smith et al, 2009) to describe her emotions triggered by trying to keep her difficulties hidden from others. She referred to having her 'heart in her mouth' as if she was about to vomit with fear, illustrating the extent of the anxiety previously felt when trying to keep her difficulties hidden from others. Later in the interview she described feelings of frustration and feeling as if she had 'a monkey in her brain' when carrying out rituals in response to intrusive doubts about her bag being closed.

Excerpt 2 - Paramjit

Paramjit reflected on his increased ability to socialise since being in the group.

...I hang round with my friends. I am no longer sort of avoiding eye contact or kind of like looking away or anything. I am actually sort of socialising and engaging with everybody without the worry of sort of, maybe having something happen to me, maybe like someone touching me or having spit or just something sort of put on me, that I might consider to be dirty (umm) so yeah the group kind of acted as, as a sort of stepping stone to sort of getting back to socialising with everybody (Transcript 6, p 26, I 624-639).

Paramjit's intrusive thoughts that others would contaminate him had led him to stop engaging with people and avoid eye contact. Being in the group with others had provided exposure to his fears and as a result his strength of belief in his intrusive thoughts had reduced. He had disconfirmed his idea that others would harm him or spit in his face and this had a knock-on effect resulting in re-engagement with his friends.

Excerpt 3 - Sunny

Sunny described how he had taken up a new hobby since being in the group.

I have decided to take up a sport, so now I have got something that I enjoy doing, and I tried getting out the house a bit more more now than I used to. I used to be at home most of the day so I think by taking up a new hobby it did help; it has helped me improve my confidence and meeting new people and also trying to forget about my OCD (Transcript 8, p 24, I 565-573).

Prior to this excerpt Sunny had identified that when he was not getting enjoyment out of life, he was more inclined to control his feelings by tidying. Since being in the group and recognising this he had actively pursued other interests to lift his mood and as a result felt more confident and sociable. Actively engaging in other interests also enabled him to be less preoccupied by his OCD. Hyman & Pedrick (2010) suggest trying to fill the 'empty time' once consumed by rituals with meaningful productive activity as important to prevent setbacks and relapse.

Excerpt 4 - Sarah

Sarah explained how she was more able to accept help from others since being in the group.

...I suppose when other people do try to help you, I would get very controlling and sort of a bit snappy at them, but and that's when the anxiety levels would

get really high, and I would want to try and take over and stop them doing it, so I could do it myself but umm, or, and then check what they have been doing, but now I am just sort of, a couple of friends and that have come round and thrown stuff out, or my daughters just helped me tidy up at home as well (Transcript 2, p 28, l 677-691).

Sarah explained how she was now able to tolerate her anxiety and refrain from checking what others had done since being in the group. She reflected on how her previous behaviour described as 'controlling and snappy' was a response to her high levels of anxiety. Sarah felt she needed to control her environment, which stemmed from her perfectionist beliefs and doubts about others' standards, resulting in her refusal to accept help. Being in the group had enabled her to accept help from friends who had visited her at home and helped her discard some items previously hoarded. She had also accepted help from her daughter with the household chores.

Excerpt 5 – Mia

Mia reflected on her new ability to share responsibility for decision-making since being in the group, resulting in increased assertiveness.

...I have chilled out more, I am not as like, not as anal about planning as I used to be I don't think. I am not keeping the responsibility to myself either. I always felt that I need to be the one that plans things and I need to be the one that says 'let's go and do this', but at the same time if someone said to me 'what would you like to do?', I would be like, oh whatever makes you happy. So it's finding the balance there and I guess not being worried or think I am going to be judged upon what I'd like to do (umm) just stand my ground and, umm, let other people make decisions as well (Transcript 5, p 31, l 739-753).

Mia shared how she spent less time planning since being in the group. Prior to the excerpt Mia had given an example of the impact of her over-planning, resulting in her arriving at an airport nine hours before a flight was due to depart. Mia noticed her increased ability to share responsibility for making decisions and a reduced preoccupation about what others think about her. This enabled her to feel more confident about being assertive regarding her preferences in her relationships.

This theme reflected the benefits of group therapy relating to an improved quality of life. This related to an increased ability to engage meaningfully with people, taking up new interests, personal development, increased confidence as a mother and an increased ability to accept help from others. This increased engagement with life represented a change of underlying belief which is considered crucial in preventing relapse (Simmons & Griffiths, 2009). The implications for clinical practice, stemming from my interpretation of the five master themes are outlined in the following discussion.

Chapter 4: DISCUSSION

An overview of the findings generated by the analysis is presented and implications for theory are outlined. An aspect of the findings is related to Counselling Psychology and the implications for the content and structure of on-going groups are highlighted. Recommendations for change to the group programme based on the analysis are highlighted and recommendations for the role of the group in future clinical practice are explored. A critical appraisal of the study is presented outlining the strengths and limitations of the research and directions for future research and practice are considered.

4.1 Overview of Findings

The purpose of this study was to explore services users' experience of being in group therapy. Phenomenological accounts suggested that all eight participants valued the experience of being in a group with others who shared a similar difficulty. Participants reported a range of positive emotional, cognitive and behavioural consequences that were generated from meeting others with a similar problem for the first time and internalising key CBT theory and skills learnt within the group setting. Five superordinate themes were generated from the participants' accounts relating to the benefits of group therapy stemming from a reduced sense of shame. The analysis also highlighted factors that inhibited engagement in the group and generated implications for clinical practice. Reduced shame triggered by meeting similar others for the first time seemed to promote engagement with the group process and was pivotal in motivating participants to change. Conversely, a fear of being judged by other group members inhibited some participants from sharing in the group and prevented full engagement in therapy. The analysis highlighted how the group process stimulated many therapeutic factors highlighted by Yalom (1995); Yalom & Leszcz (2005); Kobak et al (1995); Bieling et al (2006).

The first three master themes 'Engagement', Normalising and Courage to Fight' relate to non-specific or common factors stemming from the group process. The fourth theme 'Being my own Therapist' relates to specific factors acquired by knowledge and skills provided by the therapist. The fifth theme 'Restricted by Shame vs. Engaging with Life' relates to changes which stemmed from the experience of being in the group and relating to others which were not specifically targeted by the therapist. This theme therefore reflects learning and change stemming from common factors. Participants in this study therefore benefited from both non-specific and specific factors with a

greater emphasis in the personal accounts of participants on non-specific factors. This finding that clients value both specific and common factors in CBT therapy is in line with Gershefski et al (1996) and Clarke et al (2004) findings and in contrast to Elliott et al (1989) and Paulson et al (1996) who only documented the helpfulness of non-specific factors.

Once engaged in the group participants described a profound sense of feeling accepted by other group members which enabled disclosure concerning previously hidden symptoms without a fear of being judged. Feeling accepted by others with a similar problem led to the development of group cohesion. Cohesion in the group often occurs when a sense of trust develops and group members feel supported by one another (Bieling et al, 2006). Participants described how identifying and relating to others with a similar difficulty led to the process of 'Normalising', a superordinate theme that dominated the transcripts. Sharing with a group of people experiencing the same or similar difficulties seemed to help participants overcome stigma, shame and a sense of isolation (as also reported by Kobak et al, 1995). That the group process disconfirms a sense of being alone is consistent with previous research exploring service users' perspectives of being in GCBT with others experiencing Bipolar Disorder (O'Conner et al, 2008). A sense of not being alone was also demonstrated in a study of GCBT exploring the experience of service users with an eating disorder (Laberg et al, 2001). This finding was further reported in a recent study exploring group therapy for people with hoarding difficulties (Schmalisch, 2010).

Whilst the concept of normalising is common in groups and important in terms of helping people feel less alone and isolated, transformational experiences in groups also occur from the encounter with difference (Thornton, 2004). Through social comparison in the group setting the therapeutic factor of 'exchange' was facilitated (Foulks, 1990). According to Thornton (2004) experiencing something as the same yet different can enable people to construct a personally meaningful modified identity. Comparison with others led participants to view themselves as less severely affected than they had previously considered and judge themselves less harshly. Merely by meeting others with a similar difficulty for the first time participants began to challenge the underlying meaning relating to being 'crazy' or 'bad'. This finding, that the process of social comparison indirectly challenged underlying beliefs, is consistent with previous qualitative research using IPA, examining the impact of GCBT for service users experiencing auditory hallucinations (Newton et al, 2007). The normalising process inherent in group therapy is a huge advantage of group therapy over individual because the process of social comparison promotes a central aim of CBT by challenging the underlying meaning which is viewed as crucial in preventing relapse (Steketee & Wilhelm, 2006).

Clients went on to feel motivated to change and seemed to benefit by helping one another. Motivation was also increased by a strengthened belief in the effectiveness of therapy facilitated by seeing others improve. The emphasis on encouraging a questioning stance in CBT promoted altruism as participants practised being their own therapists (Bieling et al, 2006). Group members particularly valued feedback and suggestions from the other group members due to the capacity to empathise with each other. This ability to be useful to others seemed to have the effect of raising participants' self-esteem as suggested by Kobak et al (1995). For example Laura's sense of defiance (excerpt 2 'The Feedback Helped') which developed from sharing her success in the group enabled her to challenge her critical husband. A healthy sense of competition also seemed to emerge, as observed by Van Noppen (1998) in her naturalistic trial, as participants wanted to achieve goals and have something positive to report back to the group (excerpt 1- 'The Feedback Helped'). The power of in-session behavioural experiments was commented on by four participants. After observing another group member tolerate his anxiety, participants came to believe that anxiety does not lead to a loss of control.

It became clear through the personal accounts that many participants had internalised key aspects of the cognitive model, a central concern for cognitive therapists in early therapy sessions. This was essential in helping participants become their own therapist, a fundamental emphasis of this approach (Abramowitz, 2009). Participants came to believe they were not to blame for the development of OCD. Exploring the participants' early experience was highly relevant and helpful in this respect. This exploration helped challenge the underlying meaning that was attached concerning being responsible for causing harm, a central aim of CBT for OCD. When sharing early experiences in the group participants discovered alternative narratives in which environmental factors were incorporated that shifted the sense of personal responsibility. This realisation could occur in individual therapy through the sharing of the common themes likely to predispose a person to OCD highlighted by Salkovskis et al (1999). However, sharing in the group promoted empathy, group cohesion and made the adoption of the 'alternative theory' (Salkovskis, 1999) that difficulties stem from worry rather than actually being responsible for harm, more believable by making it more tangible for the group as a whole.

Participants shared the unhelpful nature of strategies such as reassurance seeking, an inflated responsibility appraisal, engaging in compulsions to relieve anxiety and dwelling on intrusive thoughts. This understanding suggests participants had internalised key components of CBT theory in terms of specific behaviours that keep the problem going. Participants highlighted key skills

adopted by participants through the process of group therapy. These involved refusing to engage in compulsions, dismissing intrusive thoughts, recognising anxiety symptoms and tolerating uncertainty.

Participants described an improved quality of life since being in the group. This reflected an increased capacity to engage meaningfully with people, a sense of having been 'set free', taking up new interests, increased confidence as a mother and increased ability in accepting help from others. Increased engagement with life represents change at underlying belief and assumption level which is considered crucial in preventing relapse (Steketee & Wilhelm, 2006). This theme reflected the promotion of self-determination suggesting that a cohesive group setting can facilitate a central aim of therapy at the heart of Counselling Psychology - the belief in promoting fulfilment of potential of the person in the client role (Strawbridge & Woolfe, 2010).

It is worth acknowledging that out of the 15 participants engaged in group therapy only one dropped out. This compares favourably to the drop-out rate in individual therapy estimated to be 20%, highlighted by (Rachman & Hodgson, 1980), and supports (Anderson & Rees, 2007) observations that dropout rate was low in group therapy compared to individual. The therapeutic factor of universality (Yalom & Leszcz, 2005) inherent in group therapy could help overcome this problem by increasing motivation and group cohesion outlined by Kobak et al (1995) and Jaurietta et al (2008). Participants also highlighted some concerns about sharing in the group setting which have implications for clinical practice.

Participants felt inhibited about sharing due to feeling 'different'. Anna, who experienced violent and blasphemous thought intrusions, considered leaving the group after the first session due to a fear of being judged. She described feeling like a 'minority within a minority' following the shocked response of some group members concerning the content of thought intrusions found in the general population. Some group members felt unsure about sharing certain aspects related to the OCD. This concern about sharing represented uncertainty concerning symptoms and their relationship with OCD. One issue for Paul was a difficulty distinguishing between religious thoughts and behaviours that were part of his religion and those conceptualised as part of the OCD as highlighted by Bieling et al (2006). Paul felt fearful of disclosing his religious obsessions in the group due to doubts that others would be able to relate to him and fears of being judged. In fact Mia had expressed OCD behaviour related to her religion at the intake interview and both Paul and Mia shared the same religion and culture. This finding suggests that some discussion in the group about issues surrounding religious obsessions could be helpful in terms of normalising these concerns.

Mia was unsure if her repeating rituals related to food were associated with her previous eating disorder and did not want to reveal this in front of the group. Fears of being judged for her sexual preferences by others who shared her culture also led Mia to feel inhibited about sharing her progress made at home, which involved support from her partner. The symptoms of OCD represented a secondary gain as she believed she might resort to drinking or binge eating again if she did not carry out rituals. An exploration of her drinking and eating behaviour may have revealed a link to her OCD as she believed she must drink and eat in even numbers resulting in excess of consumption. This information could have been incorporated into the formulation to help her make sense of the problem. However, she felt unable to address this in the group due to a fear of negative evaluation about how she would be seen if she revealed what she described as the untrustworthy 'addict' part of herself. This fear of exposing a hidden or unacceptable side of a person's personality expressed by Paul and Mia has been highlighted as a common and often overlooked maintaining factor referred to as 'concealment' (Newth & Rachman, 2001). Concealment regarding certain aspects of the OCD prevented the normalising process and exposure to a less threatening perspective for these participants.

4.2 Implications for theory – Shame and its relationship to Cognitive Behavioural Theory

OCD is classified as an anxiety disorder in the DSM- 1V (APA 1994). Salkovskis (1989a; 1998) argues that a specific appraisal concerning responsibility for harm distinguishes OCD from other anxiety-based difficulties. The role of guilt in OCD has also been highlighted in terms of a maintaining factor (Veale, 2007). The inflated responsibility hypothesis has been confirmed by empirical research (Salkovskis, 2000) that demonstrated a responsibility appraisal was closely linked to OCD but not other mental health difficulties like anxiety and depression. However, in the current Cognitive Behavioural conceptualisation the emotion of shame is not integrated.

In all conceptualisations the emotional response in OCD has been associated with threat and danger (Clarke, 2004). This study highlighted that the emotion of shame which has been defined as 'acute arousal of fear of being exposed, scrutinised and judged negatively by others' (Gilbert & Trower, 1990) was highly relevant to the maintenance of OCD. Shame-based appraisals prevented participants disclosing aspects of the OCD in the group. The word shame derives from the Indo-European word meaning 'hide' and concealment is a central defining feature of shame (Gilbert, 1998). Anticipation concerning how others will evaluate negative information about the self can

result in keeping secrets to prevent rejection. Rachman (1997; 2003) suggests that obsessions persist because the person makes an erroneous view that the intrusion indicates something personally meaningful regarding the individual's character. Individuals prone to OCD attach significance to intrusive thoughts when the content has importance to the personal value system. When the content of the intrusion is viewed as dangerous, a sign of insanity or antisocial behaviour (Clarke, 2004) the person is more likely to attach a shame-based meaning. This was the case for many of the participants who took part in this study.

Questions remain regarding what kind of emotion shame is. It has been explored as an emotion in its own right, an auxiliary emotion and as a 'composite' linked with several other emotions (Gilbert, 1998). These include fear, disgust and anger with anxiety being central to the shame experience. Although both shame and guilt are associated with a perceived sense of wrong doing, guilt occurs when an individual blames one's own actions and the emotional response of shame relates to blaming the self (Tangney et al, 1996). Cognitions related to being viewed by others as inferior or flawed lead to behaviours such as hiding or concealing (Gilbert, 1998).

When experienced in a milder form shame serves to facilitate behaviour and is a necessary and desirable behaviour aimed at repairing harm. However, when extreme, shame can highlight an expectation of severe negative consequences including social rejection (Greenwald & Harder, 1998). The experience of shame is common in cultures that are highly integrated with individuals being known for their links to others and in particular cultures that engage in 'collective rejection' involving shunning or disowning family members (Gilbert, 1998). This may have been why Mia chose to conceal her sexual preferences from others in the group who shared the same culture (excerpt 2 – 'Blocks to Engagement'). Marc also feared being 'shunned' by others when he felt unable to hide his rituals in the presence of others. Paramjit remained silent in the first two group sessions due to a fear of being exposed as 'crazy' if he disclosed the content of his OCD and both Sarah and Laura spoke extensively about their hiding behaviours in front of their families and significant others. According to Gilbert (1998) a clinical challenge relating to shame is the importance of being aware of its presence and finding ways of coping with it other than hiding. This is a huge benefit of group therapy because the setting facilitates opportunities for helpful social comparison and sharing what could be perceived as negative information about the self.

4.2.1 Implications for Theory – Relationship of the findings to Social Psychology

The notion of social comparison is ‘intimately related’ to areas of Social Psychology and has often been reflected in the study of group dynamics (Guimond, 2006). Social comparison can involve upward and downward comparisons. People with low self-esteem often make downward comparisons which can have either a negative or positive effect (Wills, 1981). Laura made both made both a positive and negative comparison with other group members. This comparison challenged how she perceived the severity of her difficulties and motivated her to engage in therapy to refrain from getting any worse. Mia also made a downward comparison to a group member she felt was worse off and described feeling ‘lucky’ as a result.

Social Identity Theory concerns itself with the relationship between identity, personal self esteem and ‘collective self-esteem’ which can occur through social comparison (Aviram & Rosenfeld, 2002). It is argued that a negative self concept may be unavoidable when individuals associate themselves with a stigmatised group and being able to view others who are co-members of a stigmatised group may have a positive impact on self-esteem. Social identity theory was applied to adults with a learning disability who had undergone group therapy. Group members were initially concerned about how they were treated by members of other social groups, however after a sense of trust and safety had developed group members were able to discuss how they wanted to be treated by each other. The experience of being supportive to one another contributed to the development of collective self-esteem and challenged some of the negative beliefs related to the ‘stigmatised identity’ (Aviram & Rosenfeld, 2002).

Many participants in this study described a deep sense of shame that was experienced when describing the poor treatment they received from others and when making reference to feeling accepted by other group members, highlighted in the theme ‘They Sort of Understood’. Group members’ tendency to be secretive and hide difficulties from others may have resulted in a minimised social group affiliation due to being socially isolated. A sense of affiliation to a social group is an important area for enhancing self-esteem. This may have been the case in Paramjit’s narrative when he shared how he had stopped socialising with his friends completely before group therapy and described how the group had acted as a stepping stone to him re-engaging with his friends.

It is possible that the group members who chose not to participate in the research may have been more severely affected and experienced more significant psychological distress due to a poorer self-

worth than those who took part in the study. Aviram & Rosenfeld (2002) recommend treatment strategies focusing on strengthening the 'collective identity' in group work suggesting these may be effective in counterbalancing the negative consequences of stigma. The goal is to broaden the self concept beyond the stigmatised identity which can enhance collective self-esteem. This can be facilitated through a personal development exercise outlined in (4.7).

4.3 Findings - Relevance to Counselling Psychology

Since Counselling Psychology achieved status in the division in 1994, there have been a number of debates concerning the value system and model of science that is appropriate for the professional positioning of the discipline (Lyons & Cole, 2007). One debate includes the use of diagnostic categories borrowed from the discipline of psychopathology and clinical psychology to describe difficulties clients bring to therapy (Strawbridge & James, 2001). A fundamental dilemma is the use of categories in a discipline that embodies a humanistic value base when emphasising meaning and process from the client's point of view. This is in contrast to an expert position to classify 'disorders' from a diagnosis-focused approach emphasised by the DSM. In this study the acceptance of the diagnostic label of OCD appeared to have a positive impact for many participants. For example being referred to and participating in an 'OCD' group also had a positive impact in terms of challenging participants' sense of self-blame and shame. Many of the participants had internalised the label of OCD and found this to be useful in terms of being able to externalise their difficulties. The notion of a 'disorder' therefore can be useful to a client who may view the diagnosis as the beginning of externalising the problem. This can be experienced as a relief due to the recognition that symptoms are not self-induced, resulting in a less 'self-punitive concept' (Douglas, 2010).

This may have been the case for many of the participants in the group including Mia, Paul, Laura, Sunny, Paramjit and Anna. Accepting the label of OCD prompted Mia and Sunny to seek appropriate therapy. Laura described how her 'OCD always wants to grow' suggesting she was more able to externalise her problem by attributing her difficulties to a recognised problem which was previously viewed as her fault. Paramjit felt able to share 'any aspect' of his OCD after having identified with others. This is in contrast to previously believing his problem was a habit that he would have to live with - not aware that his difficulties were recognised as a specific problem. Mia referred to her difficulties as a 'disorder' after her experience of group therapy and shared how she had been unaware that therapy existed for OCD. She described feeling more able to speak openly about her OCD, suggesting increased insight into her problem after being in the group. Anna also described her tendency to be self-conscious as 'just an OCD thing' suggesting reduced feelings of shame. For these

participants who originally believed their difficulties were located internally, the concept of a 'disorder' that is socially and historically constructed was facilitated by exploring the early experience and social comparison. Sunny talked about 'OCD people, and made a comparison to 'ordinary' people, highlighting that he had internalised the label of OCD in a negative way before meeting others he perceived as 'normal' in the group. Participants were able to externalise responsibility for their difficulties and the acceptance of the label of OCD indirectly challenged the responsibility appraisal suggesting that the diagnosis was helpful to most participants. When clients are suffering from the disabling experience of OCD it can be helpful to be labelled with a diagnosis because the distress experienced becomes understood in terms of a 'thing' that is separate to the person. Implicit in a diagnosis is a hope for 'a cure' and support from mental health professionals (Milton, 2012). For people with OCD and many other anxiety-based difficulties self-esteem becomes lowered due to the 'relentless bully' that increases self doubt (Atcheson, 2012). The acceptance of a label may be particularly useful for this client group who tend to take too much responsibility and blame themselves for the development of their problem.

A diagnosis is a 'signpost' to increased understanding to consider with the client (Knowlson, 2012) and is often assistance to the client when tempered through the therapeutic encounter (Rumble, 2012). Although a diagnosis by itself tells us nothing of a client's history, (Boucher, 2012) recommends that Counselling Psychologists who are relational therapists 'go beyond' diagnosis into a human encounter, advocating the importance of developing an individualised way of working that emanates from the individualised formulation. This is consistent with the CBT approach that provides an understanding of the presenting concerns understood by a historical formulation.

4.4 Implications for Counselling Psychology practice – Content of on-going groups

In terms of the highlighted 'Blocks to Engagement' and reflecting on how participants' narratives can improve clinical practice, participants who felt 'different' from other members of the group felt less able to disclose symptoms. It would be useful to include at least two participants in subsequent groups with violent thought intrusions in line with suggestions by Bieling et al (2006). Another possibility would be to start the normalising process at the assessment stage by providing psychoeducation with a list of intrusive thoughts found in the general population (Rachman & Hodgson, 1980) alongside the rationale for therapy. Potential group members could be encouraged to carry out a survey with family and friends prior to starting the group and the results of this could

be discussed in the first group session. This may further facilitate the normalising process and prevent a shocked response in the moment, which had a detrimental effect on Anna.

The normalising process would continue as clients met one another and made comparisons with other group members. In the superordinate theme 'Being my own Therapist' Mia was still viewing the content of her thoughts as 'horrible' and reassuring herself that she would not act on her thoughts, despite having gone through the same normalising process as other group members (excerpt 3 subtheme 'The Anxiety Will Come Down'). It could be helpful in future groups for the group facilitators to disclose some personal intrusions to normalise concerns about the content of thoughts. The therapists could carry out a survey within the workplace so that group members could see that professionals including therapists, doctors and nurses also experienced intrusive thoughts. As the normalising process was significant for all participants and went a long way towards challenging underlying beliefs it could be beneficial to carry out this process for longer and in more depth as a way of helping clients internalise key theory.

Participants internalised many key aspects of Cognitive Behavioural Theory and were encouraged to read the self-help guide 'Overcoming OCD' (Veale & Wilson, 2005). In order to consolidate learning it could be helpful to ask group members to read particular relevant chapters alongside group therapy. Audio cassettes recorded in the therapist's voice could be given as an alternative for any group members who had difficulties reading or were visually impaired. It could be useful to highlight some case examples of famous people who have suffered OCD such as Martin Luther and Charles Darwin, who were plagued by intrusive thoughts and depression (Osborn, 1998).

Many participants described feeling understood by group members and contrasted this to feeling criticised by family, friends and strangers without OCD outside the group. This was particularly evident in the accounts of Sarah and Laura. Veale & Wilson (2005) suggest that criticism and hostility from family members is a common response stemming from frustration concerning the senselessness of OCD. However, negative responses can make OCD symptoms and quality of life worse, setting up a further vicious cycle. For this reason it may be important to include some information for group members to direct families and friends to read alongside therapy, outlining the best way to respond. Stobie (2009) recommends the incorporation of CBT skills that go beyond psychoeducation and argues that the development of idiosyncratic formulations of family members' beliefs and behaviours that are maintaining the problem should be developed and shared. Where family members are extensively involved it may be necessary to involve significant others in therapy and include family sessions in addition to group therapy.

It could be beneficial in future groups to include more case examples during the normalising process which could be extended in the early sessions of the group relating to issues of religion. Had Paul felt able to share his concerns in the group, strategies such as speaking to a religious leader and getting 'permission' to participate in therapy sessions could have been encouraged (Bieling et al, 2006). To help clients understand that blasphemous thoughts are no different to any other intrusive thoughts, the difference between 'true faith' which is meaningful, compared to meaningless repetitive intrusions which have an alien quality, could be explored (Osborn, 1998). Spending more time developing formulations emphasising that these will change, as new information unfolds and further links are made, may encourage disclosure with issues that clients feel unsure about. To facilitate the normalising process and demonstrate the rationale for therapy it could be helpful to include some case studies for group members to work on in pairs. Clients could be asked to answer open questions about the case such as 'what is the person worried about?' 'how does she feel about her intrusive thoughts?', 'what is she doing to increase the frequency and intensity of her difficulties?'. Pairs could feed back their answers to the wider group to maximise learning and demonstrate clarity concerning the function of a formulation. Engaging in this process prior to developing individualised case conceptualisations in the group may help group members to identify their own process and could facilitate an understanding of the rationale for therapy.

CBT is considered to be a skills-based approach to treatment and sample protocols outlined by Bieling et al (2006) do not include the development of historical formulations. However, sharing early experiences facilitated empathy and group bonding for some participants. The inclusion of this exploration appeared beneficial for therapy process and the development of group cohesion. Cohesion in the group influences motivation to carry out homework. Jaurietta et al (2008) suggest that these factors can improve efficacy and compliance to therapy which are highlighted as critical issues in individual approaches that are not yet appropriately solved.

The two participants who felt reluctant to engage in this exploration (Laura and Mia) had engaged in therapy and 'worked through' issues relating to their early experience in previous individual therapy. To facilitate sharing of past experiences it could be useful to explore how the client feels about this at the assessment stage. Potential group members expressing concerns about exploring their history in a group setting could be engaged in a conversation about the benefits of doing so. A rationale could be provided in terms of the relevance of challenging unhelpful underlying beliefs considered important in preventing relapse. Another benefit of highlighting a person's underlying assumptions

is that behavioural experiments can be designed at this level. Working with assumptions can highlight behavioural experiments aimed at developing more helpful beliefs.

Where exploring the early experience highlights that the person has been badly treated, oppressed, or victimised during childhood it could be helpful to engage the person in a discussion about how they resisted being badly treated. Healthy 'resistance' is a concept that is not usually explored in Cognitive Behavioural Therapy. Expression or non-expression of anger is often viewed as a difficulty with assertiveness, which mitigates the responsibility of the perpetrator, inadvertently blaming the victim. An approach to therapy called Response- Based Interviewing is based on the clinical observation that all victims resist being badly treated. Engaging people in a conversation about the details of their resistance can have the powerful effect of reducing shame and empowering clients.

During the initial assessment it would be worth exploring what clients would have difficulty exploring in the group and discussing these concerns to identify subtle maintaining factors and normalise some of these concerns. It would also be helpful to discuss any concerns about cultural issues prior to the start of the group and consider the needs of the whole group, once group members have been selected. This could be achieved by having a second individual session with particular participants prior to the group to discuss transparently any issues that may relate to engagement that the therapist might anticipate following completion of assessments.

Participants wanted to explain the impact of OCD prior to being in the group leading to the development of a theme 'Restricted by Shame vs. Engaging with Life'. Participants felt restricted prior to being in the group by feelings of shame and embarrassment concerning how they were perceived by others when engaging in rituals. Since shame and embarrassment can lead to the 'concealment' of obsessions (Newth & Rachman, 2001), it could be beneficial to provide space in the group for a discussion on what it is like to live with OCD and its impact on social functioning. Facilitating disclosure of concealed obsessions could also be prompted by further case examples, particularly relating to violent and religious intrusions. Group members could complete the 'concealment questionnaire' (Newth & Rachman, 2001) and be encouraged to engage in considered 'planned disclosure' to trusted individuals to disconfirm negative meaning associated with the concealed intrusion. This could be discussed within the group setting to encourage risk-taking and further facilitate the normalising process.

4.5 Implications for Counselling Psychology practice – Structure of on-going groups

Participants also shared recommendations concerning the structure of the sessions. The introduction of behavioural experiments in the group was highlighted as being significant and the inclusion of more of these was emphasised by three participants. There were no recommendations for change in terms of the material covered in the group suggesting that participants believed all was relevant. The two participants who did not see much utility in exploring the past did appear to understand the relevance for other members of the group and this was helpful in terms of increasing empathy and understanding within the group.

The positive impact of understanding developmental factors for reducing shame suggests that developing individualised historical formulations within the group setting is useful for participants. This together with the call for more practice in the group, highlights that the duration of the group could be longer to cover all the material and include more practice. Two participants also directly stated a need for further sessions. Sarah and Paul also suggested spacing out the frequency of sessions towards the end of the group to foster a further sense of being their own therapist. Two participants suggested inviting a 'guest speaker' to the group who had been through a group and improved. Paramjit offered to attend as a guest speaker because he wanted to be helpful to others in his previous position. Considering his apprehension about joining the group in the first place, this motivation demonstrates how valuable he found meeting others and the process of group therapy. During the participant validation meeting which was conducted one year later Paramjit reiterated his interest in participating in a future group as a guest speaker. To promote service user involvement and to benefit new members who might be apprehensive about sharing, it could be beneficial to invite clients who have completed group therapy to share their experience at the beginning of group therapy.

The effectiveness of a group is determined to a large extent by the make-up of its members. Viewing others as worse and less affected was motivating for some participants indicating the importance of including people at different levels of severity within the group. According to Thornton (2004) the potential for transformational experiences in a group depends on the optimum balance of the recognition of sameness sometimes referred to as 'mirroring' and 'exchange' which refers to recognition of difference. The observation that many participants benefited from their experience of

being on a different continuum of severity to others also has implications for practice in today's climate within the NHS.

Psychologists working in the Psychological Therapies Services (PTS) are now allocated clients with more severe and enduring problems. Clients with mild to moderate problems are referred to high-intensity workers in the Improved Access to Psychological Therapies (IAPT). A recent service initiative from the NHS trust where I worked was to consider forming separate groups in relation to the two different services. Should this be the case it is possible that group therapy would not generate as many therapeutic factors and be less effective as a result. This is due to the social comparison to others perceived as worse off or less affected which can instil the therapeutic factor of instillation of hope (Yalom & Leszcz, 2005) and serve as a motivational factor. Furthermore it is possible that a group comprising only severely affected OCD sufferers who often have an accompanying personality disorder involving a preoccupation with detail, would benefit less from time-limited therapy. Having observed only limited gains for the whole group these clients could even feel worse, reinforcing lack of hope for change. For optimal results the group setting would include people with different levels of severity regarding OCD symptoms suggesting a merge from the two services, PTS and IAPT being helpful in this respect.

4.6 Recommendations for the existing group programme

A group programme offered to people with mild, moderate and severe levels of OCD is proposed for a duration of 15 two-hour sessions, extending the current time limited group by three sessions. It may also be helpful to space out the sessions during the later stages of therapy to foster clients' independence and an ability to become their own therapist. It could be important to run the first 10 sessions on a weekly basis to allow for group cohesion and the development of individualised historical formulations in the group setting. From session 10 the group could be held fortnightly to ensure enough time is allocated to complete negotiated homework assignments and when behavioural experiments are well under way in the group setting.

Since the process of group therapy can facilitate many therapeutic factors essential for change, group leaders must be able to balance the delivery of techniques whilst at the same time being attentive to in-session process. Working with group process can have significant advantages in terms of enhancing outcome (Bieling et al, 2006). The recommended inclusion of a discussion on early experience suggests that the skills of the group leader should include empathy and an ability to foster guided discovery through Socratic dialogue. To maximise effectiveness the group should be

run by an experienced clinician and a co-facilitator who would reflect on the group process after sessions.

4.7 Recommendations for the role of the group in future clinical practice

A role for the group could be developed for pre-treatment work. Burlingame et al (2002) recommend pre-group preparation to clarify treatment expectations, define group ground rules and instruction related to role and skills needed for effective participation. Often new group members are apprehensive about joining the group. Preparing group members prior to starting therapy has been shown to have a beneficial effect on group cohesion and has been associated with reduced attrition (Burlingame, 2002). In contrast, poorly functioning groups have been associated with group members who have not been prepared to constructively use the group (Karterud, 1988).

It has been argued that the amount of progress clients make in therapy relates to the pre-treatment stage of change. Prochaska & Norcross (2010) suggest that action orientated therapies such as CBT may be more effective for people who are in the 'preparation or action stage' and may be less effective for individuals in the 'pre-contemplation or contemplation stage'. It may be useful to use a one-off group based on the first session of the group programme to focus on normalising strategies and to provide a rationale for the therapy before allocating clients to the waiting list for group therapy. Meeting others with a similar problem seemed to have an instant normalising affect for all participants and this indirectly challenged the responsibility appraisal, a central aim of CBT. This would represent a significant and helpful one-off intervention in preparation for group therapy. An understanding and increased awareness of the counterproductive nature of maintaining factors in terms of increasing the frequency and intensity of unwanted thoughts, might help raise awareness and motivate clients to engage in the 'preparation stage or action stage'. In these later stages behaviour can be modified in order to overcome and interrupt habitual patterns and adopt more helpful strategies (Prochaska & Norcross, 2010).

Stage of change related variables have also been identified as a good predictor of premature drop-out. Action orientated therapies such as CBT can be ineffective or even detrimental with individuals in the pre-contemplation stage (Prochaska & Norcross, 2002). This was evident in the one group member who dropped out. She had shared to another group member that she was avoiding having another child due to fears of activating her OCD, suggesting she may have been in the pre-contemplation stage of change. Consciousness-raising may have positively influenced a move from pre-contemplation to the contemplation stage due to increased awareness of her avoidance

behaviour in maintaining her fears. Offering pre-treatment work could also reduce waiting list times since a client will have been assessed and provided with some psychological input and psychoeducation in preparation for starting the group. Having understood the rationale for therapy clients may be less likely to drop out because of having the opportunity to think about what is involved in change before entering the group.

In terms of applying reflections from Social Psychology to group therapy it could be useful to include a personal development session early on in group therapy with a view to promoting a 'collective identity' (Aviram & Rosenfeld, 2002) within the group. The aim would be to promote a sense of group affiliation and ultimately prevent premature drop-out. Marmarosh & Corazzini (1997) found that strengthening collective identity increased group members' positive evaluation of the therapy group. Aviram & Rosenfeld (2002) recommend an 'identity' exercise which is introduced to highlight the notion of social group membership. Group members are asked to stand in a line facing one direction and the therapist asks members with certain group affiliations to take a step forward and observe who else is a part of the group. Initially starting with non-threatening descriptors such as colour of clothing, the emotional meaning of each classification increases as the exercise progresses. Later identification of similarities and differences could include likes and dislikes, ethnicity and religion. Discussion then focuses on how members felt when they were alone and everyone else was part of a different group compared with when part of the same group. The potential to integrate concepts from Social Psychology to group therapy may be especially important for individuals whose groups are burdened with a negative stigma because individuals may minimise social group affiliation and lose an important avenue for self-esteem enhancement (Aviram & Rosenfeld, 2002).

4.8 Critical appraisal of the study

4.8.1 Strengths

The research highlights some changes to the group structure and content based on the analysis of personal accounts from service users that can be easily implemented. Participants also provided positive feedback about the interview process which was described as 'consolidating' and helpful in terms of 'giving something back' after receiving a positive experience of group therapy. All participants who agreed to take part in the research responded to being contacted to provide a pseudonym and wanted to receive feedback. Participant involvement in this study highlights the value of service-user involvement emphasised at the Institute of Psychiatry 'Service User Research

Enterprise (SURE) and outlined by Rose (2001; 2003) for promoting empowerment of research participants - a central aim in the best practice guidelines (BPS, 2005).

Since the research was qualitative it could be criticised for being subjective. However, the criteria usually used to evaluate scientific rigour, objectivity and scientific value in quantitative research such as reliability, representativeness, validity and generalisability are less meaningful when applied to qualitative research (Willig, 2008). In qualitative enquiry the quality of research can be assessed using a set of guidelines set out by Henwood & Pidgeon (1992). One criterion suggested relates to the 'importance of fit'. In this respect it was necessary that the analysis was checked through by independent readings. The analytic categories were checked by my supervisor and an independent Chartered Counselling Psychologist experienced in the group approach, both of whom clarified the appropriateness of the chosen excerpts in relation to the theme titles. A second criterion involves the researcher 'integrating theory' within the research. Theory from different therapeutic orientations was integrated including Cognitive Behavioural theory (Salkovskis, 1998), Response-Based Interviewing (Wade, 1997; Renoux & Wade, 2008), Social Psychology (Guimond, 2006) and the Theory and Practice of Group Psychotherapy (Yalom, 1995; Yalom & Leszcz, 2005).

As a Counselling Psychologist researcher it was crucial that I prioritised the participants' subjective and intersubjective experiencing (Kasket, 2012). This was evident in the interview guide by the inclusion of open non-leading questions to promote freedom of dialogue. Recognition of care for the participants' subjective experience was informed by ethical considerations facilitating an informed choice about participating in the research. This was achieved by encouraging potential participants to contact the researcher to confirm a desire to participate after consideration of the Participant Information sheet rather than following them up. This was also evident in the handling of the interview when Sarah became tearful and I explored her emotional response and offered the opportunity for her to terminate the interview.

Counselling Psychologist researchers are also committed to developing democratic non- hierarchical relationships through the continued involvement of participants throughout the research cycle. This was achieved by being transparent and sharing the findings during participant validation which also served as a credibility check (McLeod, 2001). The excerpts and commentary was read by four participants who confirmed the accuracy of the interpretation and two (Paul and Sarah) made suggestions for change in the light of their reflections. The explanation of differences between the researcher's analysis and the participants' interpretations is referred to as 'sensitivity to negotiated realities' (Henwood & Pigeon, 1992). Paul spent some time making notes about the commentary and

clarified one aspect of the interpretation during participant validation and Sarah clarified her feelings and gave an example to support this (p74 – excerpt 2). Elliott et al, (1999) identified further guidelines for the evaluation of qualitative research. The sample in this study was ‘situated’ by each participant being described at appropriate times and before the first example of an extract. The analysis was also ‘grounded in examples’ relating to the process of analysis where some themes were collapsed and others discarded (2.10 p31) I also attempted to ensure that the analysis was ‘coherent’ in that it reads like a story (Elliott et al, 1999).

Finally, whilst it is inevitable that the researcher will influence the research findings (Landridge, 2007) it is important for the Counselling Psychologist researcher to ‘own one’s own perspective’ (Elliott et al, 1999) and demonstrate ‘sufficient reflexive reflexivity’ (Kasket, 2012). This is achieved by disclosing to the reader the influence of the researcher’s values and assumptions and by engaging in reflexivity at numerous points during the research cycle. Research concerning clients’ experiences of therapy has highlighted that clients will frequently ‘defer’ to their therapist (Rennie, 1994). Deferring involves clients withholding critical or challenging comments (Cooper, 2008) and concerning negative reactions and feelings from their therapist (Regan & Hill, 1992). For this reason it was important that I reflected on issues of power in the design stage and renegotiated my role from group facilitator to researcher in an attempt to minimise the impact of being in a dual role on the participants’ dialogue (2.4 p23). During the interviews I discussed how my pre-existing assumptions impacted on the interview process (2.9.2 p30) and how I used this reflection to improve my interviewing skills (2.9.3 p31). I described how I related to one of the research participants (2.12.1 p34) and how I used second-order analysis to identify the key theme of reduced shame which was influenced by my own feelings and informed by my clinical observations (2.12.1 p34). Acknowledging my own personal investment in group work (2.12.2 p36) facilitated further exploration, which resulted in the development of a theme ‘Blocks to Engagement’ which generated implications for practice.

4.8.2 Limitations

4.8.2.1 Researcher role

Qualitative inquiry involves ‘bracketing off’ assumptions about the nature of the phenomenon being studied as much as possible. McLeod (2001) argues that this process is very problematic for researchers who are also therapists - having spent many years becoming ‘socialised’ to their chosen theoretical orientations and specialisms. I have facilitated OCD groups and observed the process

inherent in group therapy for many years and like many researchers, I have my own agenda in terms of what I believe does and should work in therapy. Some of my observations were supported in the analysis such as the relevance of exploring early experience for the development of group cohesion. My clinical experience also influenced the order in which I presented the themes which parallel the stages in group therapy to help the story's 'coherence' (Elliott et al, 1999). McLeod (2001) argues that researchers who do not owe 'professional allegiance' to the therapy being studied may be more open to see what is happening and recommends non-psychologists to undertake research related to therapy. McLeod (2001) maintains that some participants may be inhibited from expressing doubt and criticisms or be reluctant to articulate disagreements openly due to being respectful to a person in a position of 'authority'. It is possible that some participants felt inhibited about expressing criticism of the therapy to an employee of the Trust who had conducted the initial assessment and referral for group therapy. Cooper (2008) suggests that one way forward for research on clients' experiences of therapy is that more studies could be conducted by 'genuinely independent' bodies or research teams who are allied to different therapeutic orientations to the one being explored. In this way findings are less likely to be unintentionally influenced by 'allegiance effects'. This relates to the 'tendency for researchers to find results that support their own beliefs, expectations or preferences' (Cooper, 2008) which occur in even the most rigorous research when the researcher is allied to the orientation being studied.

4.8.2.2 Group members that chose not to participate in the research

The total potential for research participants across the two groups was fifteen. One group member from the first group dropped out prematurely and a further six did not respond to the opportunity to be involved in the research. The feedback from one participant who did not take part suggested she worried about taking part in the study. Her OCD involved a fear of offending people and she openly admitted that she feared saying the wrong thing during the interview and then declined by email after further consideration. It is possible that there is a parallel process between residual shame that inhibited disclosure in the group for some participants and the decision not to take part in the research. To some extent the voices of those that choose to take part may have been 'privileged' and these participants may have been less severely affected by the OCD than those who did not take part. It is possible that clients who were more severely affected may feel more able to disclose or participate in research carried out by an independent body who is not perceived to be in a position of authority. Perhaps a referral for individual therapy may be important for these participants where more opportunity is afforded to develop a therapeutic alliance, and through the experience of a

primary relationship with a 'good object' (Klein & Riviere, 1964) the therapist is more able to assess individual difficulties, strengths and promote 'intrapsychic' change. In individual settings clients may feel more able to share secrets of the past that may be linked to current shame and learn to internalise the empathic and respectful attitude of the therapist (Feldman & Feldman, 2002)

Although many people improve in counselling and therapy there are a number of others who do not or even deteriorate. Research has indicated that 5-10% of clients get worse (Levy et al, 1995) and half of clients drop out (Wierzbiki & Pekaric, 1993) particularly after the first session (Brogen et al, 1999). Across the two groups only one participant dropped out of therapy which may suggest group cohesion was high in both groups. However, it could be beneficial to screen potential group members for motivation and to clarify any unrealistic or inaccurate expectations in further depth. There are various measures that assess characteristics which are believed to be most indicative to success in group work and which assess interpersonal behaviour that may influence an individual's ability to function in a group (De Lucia Waak, 1997). The Group Therapy Survey (GTS), (Slocum, 1988) assesses pre-group expectations and can be used as a basis for discussion, clarification and to screen out individuals who might not be appropriate for group work.

4.8.2.3 Appropriateness of research questions

Most commonly open-ended questions are used within IPA and these are generally couched in 'how' or 'what' questions (Smith & Osborn, 2003). The main research question was concerned with how clients experience being in a Cognitive Behavioural group with others who share a similar difficulty. This is an appropriate question for IPA because it is open-ended, seeking to understand more about a particular topic rather than attempting to explain it (Landridge, 2007). The research question is appropriately broadly framed (Smith & Osborn, 2003). The two supplemental questions seeking to understand the specific components that were perceived as helpful and less helpful aspects of group therapy are rather specific for an IPA study. Most commonly an exploration of helpful and or hindering effects of therapy has employed grounded theory methodology to analyse clients' dialogues (Rennie, 1990; Mortl & Von Wietersheim, 2008). Others have used discourse analysis to identify themes in the language people use to describe counselling experiences (Smith et al, 1993) and thematic cluster analysis to explore helpful and hindering aspects of therapy (Sherwood, 2001). Phenomenological research has been less utilised in research concerning helpful and hindering aspects of therapy. However, as the main aim was to explore clients' experience and meaning of being in the group, IPA was selected. It was hoped that embedded in the rich descriptions of

experience and through asking participants what they would like to change in the group, as well as what they believed could be improved, some benefits and pitfalls of group therapy may emerge.

4.9 Conclusions and Future Directions

Some of the gains generated by the analysis of participants' personal accounts, such as normalising though education and learning skills to manage the OCD more effectively, could be equally gained in individual therapy. However, the group offers a powerful vehicle for promoting many therapeutic factors. The process of being in a group has the implicit effect of reducing feelings of shame through social comparison which motivates clients to change, a huge benefit of group therapy over individual. The group process facilitated empathy within and between group members and challenged the underlying meaning that had been previously attached to the experience of living with OCD. Many participants highlighted improvements to their overall quality of life. These benefits of group therapy are more difficult to assess using standardised questionnaires, indicating the importance of qualitative assessment for ascertaining gains stemming from the group process. During participant validation one year after the interviews had been carried out Paramjit shared how he had been able to start work since being in the group, indicating that the benefits of group therapy can generalise and grow over time. The analysis highlighted that qualitative enquiry can complement existing quantitative research and promote a fuller understanding of therapy process, enabling practitioners to learn from clients' feedback and modify practice accordingly.

Although qualitative and quantitative research paradigms are associated with different epistemologies these are not necessary incompatible. Benefits arising from a combination of methods involve a greater proximity to the research participant using qualitative methods and greater generalisability involving quantitative methods (Lyons & Cole, 2007). In groups I have previously facilitated within the trust I have also monitored depression severity using the Beck Depression Inventory (BDI) at pre- and post- therapy and noticed that being in the group has a dramatic effect in reducing depressive symptoms. Perhaps this is due to a reduced sense of shame facilitated by meeting similar others that was evident in this study. In addition to using a semi-structured interview, a standardised questionnaire measuring depression severity could be administered at pre- and post- therapy. A further questionnaire could be used to assess the overall presence of therapeutic factors (Yalom, 1995). The Therapeutic Factor Scale (Butler & Fuhrman, 1983) could be administered in future groups at mid point or the end of the group to assess the overall helpfulness and provide quantitative assessment of the themes highlighted. Adopting a 'mixed methods' approach where qualitative and quantitative approaches are used within or across

stages of the research process can offer great promise for practising researchers, who would prefer to see methodologists develop techniques that are closer to what is used in clinical practice (Burke-Johnson & Onwuegbuzie, 2004).

In this study participants were drawn from two groups running in the same trust due to the time constraints involved in doctoral level research and the amount of time involved in gaining ethical approval across Trusts. Since submitting this research a study by (Schmalisch et al, 2010) has been conducted exploring therapeutic process in group therapy for individuals with hoarding difficulties. Although there is evidence to suggest that hoarding is a discrete psychological difficulty it is currently classified as a subtype of OCD. In this study the researcher observed the emergence of three of Yalom's therapeutic factors which were present in the current study, these being 'universality', 'group cohesion' and 'altruism'. Future process-based research on GCBT may ascertain the function of group process for people with OCD and other presenting problems. It could be useful in terms of further assessing 'transferability', which refers to the extent to which a qualitative study may hold applicability beyond the specific context (Willig, 2008) to use a larger sample, recruiting participants from different NHS trusts in future research. In order to more fully assess the unhelpful effects of therapy it may be helpful to target clients who do not complete therapy or explore in more depth the factors that participants felt hindered their progress in line with suggestions by Clarke et al (2004).

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Appendix A: Participant Information Sheet (version 2 16/10/2009)

Title of study:

Group Cognitive Behavioural Therapy for Obsessive Compulsive Disorder: A Qualitative Study

Researcher:

Melanie Spragg, Chartered Counselling Psychologist Barnet, Enfield & Haringey Mental Health NHS Trust, Senior Lecturer, University of East London. This research is being carried out for a doctorate thesis I am undertaking at the University of East London and is being supervised by Dr Sharon Cahill, Research Tutor, University of East London.

Purpose and background:

You have been invited to participate in a research interview about your experience of group therapy. Before you decide to take part I would like you to understand why the research is being done and what it would involve for you. All published research about the benefits of group therapy for OCD has measured improvements by differences in scores on questionnaires at the beginning and end of therapy. These studies have advanced our understanding about what form of therapy is most helpful for people with OCD in respect to reducing symptoms. What remains unclear is how and why these changes occur.

Who can take part?

I would like to recruit at least 10 people who have completed group therapy. I will invite you to share your experiences of being in a group with other people who share a similar problem to help clinicians understand the benefits of this approach from your point of view. I am also interested in finding out what specific components of the therapy you find helpful and, just as importantly, which components you find less helpful. Your views may inform the way in which future groups are delivered.

Do I have to take part?

Your participation in this project is voluntary and you are free to withdraw from the study at any time during the research process without explanation and this will not affect the standard of care you receive in the future.

What will happen if I take part?

If you decide to take part, after signing the consent form (see attached) you will be asked to attend a research interview lasting approximately one hour. This will take place in the Psychological Therapies Services at a time convenient to you. The interviews will be tape recorded with your permission and segments of the transcript will be reported in the study. Any information used in the research project will be made anonymous. You will be invited back to comment on the findings before the study is submitted and made available to the public and your feedback may be incorporated into the

study. All information gathered during the interview will be kept in strict confidence unless you disclose that you or someone you know is at risk of serious harm, in which case the appropriate authorities will be informed. The tape recording will be kept in a locked place and destroyed in confidential waste once the study is complete in line with recommendation set out by the Data Protection Act.

What will happen to the research findings?

The findings of this study will be written up as a doctoral thesis and may be published in a peer reviewed journal. You will not be identified in any of the reports or publications.

Will I be paid?

You will be paid £20.00 towards your time and travelling expenses.

What do I do next?

When you have had time to consider your involvement and if you decide to take part please complete your contact details on the card and return it in the stamp addressed envelope provided within one month. You can also contact me by phone or email. We can then arrange a convenient time for the interview to take place. If you have any questions, concerns or complaints regarding your participation in the research please feel free to contact me or my supervisor at any stage during the research process.

Contact information:

melspragg@hotmail.co.uk or 07960 307 605

0208 9512010 (Thursdays)

Appendix B: Consent Form (Version 2 16/10/2009)

Title of project: Group Cognitive Behavioural Therapy for Obsessive Compulsive Disorder: A qualitative Study

Name of researcher: Melanie Spragg, Chartered Counselling Psychologist, Senior Lecturer

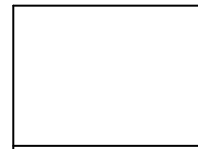
1. I can confirm that I have read and understand the information sheet dated 16/10/2009 (Version 2) for the above study. I have had the opportunity to consider the information and ask questions and have had these answered satisfactorily.

Please initial box



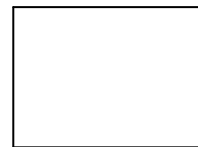
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

Please initial box



3. I understand that segments of my interview transcript and data collected during the study may be published in a peer reviewed journal.

Please initial box



4. I understand that relevant sections of my medical notes and data collected during the study may be looked at by individuals from the NHS trust where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.

Please initial box

5. I agree to my GP being informed of my participation in the study.

Please initial box

6. I agree to take part in the above study.

Please initial box

Name of patient

Signature _____

Date

Name of person taking consent

Signature _____

Date

Appendix C: Ethical Approval — University of East London



Sharon Cahill

School of Psychology, Stratford

ETH/10/93

29 January 2013

Dear Sharon,

Application to the Research Ethics Committee: Cognitive Behavioural Group Therapy for Obsessive Compulsive Disorder (M Spragg).

I advise that Members of the Research Ethics Committee have now approved the above application on the terms previously advised to you. The Research Ethics Committee should be informed of any significant changes that take place after approval has been given. Examples of such changes include any change to the scope, methodology or composition of investigative team. These examples are not exclusive and the person responsible for the programme must exercise proper judgement in determining what should be brought to the attention of the Committee.

In accepting the terms previously advised to you I would be grateful if you could return the declaration form below, duly signed and dated, confirming that you will inform the committee of any changes to your approved programme.

Yours sincerely

A handwritten signature in blue ink, appearing to read 'Simiso Jubane', is written over a faint horizontal line.

Simiso Jubane

Admission and Ethics Officer

s.jubane@uel.ac.uk

02082232976

Research Ethics Committee: ETH/10/93

I hereby agree to inform the Research Ethics Committee of any changes to be made to the above approved programme and any adverse incidents that arise during the conduct of the programme.

Signed:.....Date:

Please Print Name:

Appendix D: Ethical Approval — Barnet, Haringey & Enfield NHS Mental Health Trust



National Research Ethics Service

Camden & Islington Community Research Ethics Committee

REC Offices
South House, Royal Free Hospital
Pond Street, London
NW3 2QG

Telephone: 020 7794 0500 extn 36906
Facsimile: 020 7794 1004

06 October 2009

Ms Melanie Spragg
Chartered Counselling Psychologist
Barnet, Enfield & Haringey Mental Health NHS Trust.
Waller Pollins
Premier House
112 Station Road
EDGWARE, HA8 7BJ

Dear Ms Spragg

Study Title: Group Cognitive Behavioural Therapy for Obsessive Compulsive Disorder: A Qualitative Study.
REC reference number: 09/H0722/72
Old REC reference number: 09/H0720/107

The Research Ethics Committee reviewed the above application at the meeting held on 28 September 2009. Thank you for attending to discuss the study.

Ethical opinion

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research

This Research Ethics Committee is an advisory committee to London Strategic Health Authority
The National Research Ethics Service (NRES) represents the NRES Directorate within
the National Patient Safety Agency and Research Ethics Committees in England

governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>. Where the only involvement of the NHS organisation is as a Participant Identification Centre, management permission for research is not required but the R&D office should be notified of the study. Guidance should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.

As per the REC's discussion at the meeting, the REC did not think the proposal to recruit participants at the last session of their CBT intervention was ideal. You should give further thought to distinguishing between therapy and research and ensuring participants do not feel obliged to take part. Several options were discussed at the meeting, including introducing the idea of the study at an earlier stage but formally inviting potential participants by post after CBT sessions are complete, or provision of a card at the last session. Please confirm the method you decide on, ensuring participants have time to consider participation.

The Participant Information Sheet:

- Should be reformatted and given more attention. Please refer to the NRES guidance at: <http://www.nres.npsa.nhs.uk/applications/guidance/#InformedConsent>
- Should also state confidentiality may be breached if there is disclosure that requires action.

Please submit any revised documents to the REC for information.

The REC felt there is a strong possibility more than 6-8 participants will want to take part; as per the discussion at the meeting, the REC felt you ought to be aware of this.

If you have any questions about the Committee's decision, please contact the Coordinator – contact details in letterhead.

It is responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Covering Letter		06 August 2009
REC application		
Protocol		
Investigator CV	C.I.s CV - Melanie Spragg	
Referees or other scientific critique report		
Investigator CV	Supervisor's CV - Sharon Cahill	
UCL REC letter		07 August 2009
Participant Information Sheet: Appendix A		
Participant Consent Form		
Interview Schedules/Topic Guides	Appendix C	

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Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

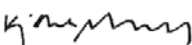
We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

09/H0722/72

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours sincerely


Ms Stephanie Ellis
Chair

Email: katherine.ouseley@royalfree.nhs.uk

Enclosures: *List of names and professions of members who were present at the meeting and those who submitted written comments*

"After ethical review – guidance for researchers"

Copy to: *Sponsor - Dr Kendra Gilbert, Senior Lecturer, University of East London*
R&D office - Barnet, Enfield & Haringey Mental Health NHS Trust

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Camden & Islington Community Research Ethics Committee

Attendance at Committee meeting on 28 September 2009

Committee Members:

Name	Profession	Present	Notes
Dr Adedotun Adenugba	Staff Doctor	No	
Professor David Caplin	Senior Research Investigator, Professor of Physics	Yes	
Ms Heidi Chandler	PA/Administrator	No	
Dr Claudia Cooper	MRC Research Fellow - Health Services Research and the Health of the Public	Yes	
Ms Stephanie Ellis	Former Civil Servant	Yes	
Ms Victoria Fox	Lawyer	No	
Dr Angela Hassiotis	Senior Lecturer in Learning Disabilities	Yes	
Mr Matthew Lewin	Journalist and Author	Yes	
Mr John Lynch	Co-opted member	Yes	
Dr Roshan McClenahan	Clinical Lead Speech & Language Therapist	No	
Ms Elayne Nasr	Co-opted member	Yes	
Ms Peggy Papada	Clinical Research Officer	No	
Dr Frederic Shaw	Sessional GP/GP Appraiser	No	
Dr Charlotte Warren-Gash	SpR Public Health/Academic Clinical Fellow	No	
Ms Eleni Yerolaki	Specialist Counsellor	Yes	
Ms Bidy Youell	Head of Child Psychotherapy	Yes	

Also in attendance:

Name	Position (or reason for attending)
Miss Katherine Ouseley	REC Coordinator

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the National Patient Safety Agency and Research Ethics Committees in England

Appendix E: Interview Guide

Preamble.

The researcher will thank the participant for coming, introduce herself and clarify the aims of the interview. The use of the tape recorder will be explained and issues of confidentiality outlined in the participant's information sheet will be addressed (Appendix a). If participant expresses verbal agreement, written informed consent will be obtained (Appendix b).

Background information.

It would be helpful if you could tell me a little bit about yourself such as your age, occupation and living arrangements before we discuss your experience of the group.

Significant moments:

Please think back to when you were first offered a place and what happened during the group. Please try to identify any moments that seemed important for you?

What was the most significant or important event/moment in the group?

Can you describe the event, what actually happened?

When did that happen?

Why was that important for you?

How did that experience impact on your life?

What changes have happened since being in the group?

What influence has the group had on the way in which you relate to others?

How do you think the group could be improved?

What would you have liked more or less of?

What would you like to change about the group?

Experience

Can you tell me about your experiences about being offered a place in the group and what it was like during the group?

How did you feel about being offered a place in the group?

What were your concerns? Hopes?

How did you experience the first session?

What was it like during the beginning of the group?

How did you experience subsequent sessions?

How did you experience being in a group with others who had similar problems?

How has being in the group changed the way you relate to other people?

How did you experience the end of the group?

What do you think about it now?

Is there anything else you would like to tell me about your experience of group therapy?

Participant's responses will be explored by the use of follow up questions, the use of silence to allow the participant to expand and other prompt or probing questions to explore the meaning from the client's point of view. These may include questions like:

Can you tell me a bit more about that?

Can you give me an example of that?

What was it like, how did you feel about it?

What sense did you make of that?

What did that experience mean to you?

Debrief

Ask participants about their experience of the interview process and give contact details and inform participants that the researcher or supervisor can be contacted if any queries or concerns about the research need clarification at any stage in the research process.

Remind participants of the opportunity to be involved in the research during data analysis and enquire how contact should be made when the preliminary analysis is ready.

Give contact details of local support agencies and other self-help information that may be relevant.

Appendix F: Information sent out to research participants

Dear

Thank you for participating in the research project. Your interview generated some interesting findings regarding the experience of group therapy which may influence the way in which future groups are delivered. I have enclosed a copy of the title page, acknowledgements page and the abstract to provide an overview of the project for your information.

The themes that were identified have been illustrated by excerpts from your interviews. I have used your chosen pseudonym when referring to the dialogue in the thesis to preserve confidentiality.

If you would like to discuss these findings further or review the particular excerpts I have included please contact me by 6th October 2011 and I will arrange a time to meet with you individually.

I could meet with you on a Thursday or Friday at the NHS Trust where you had your interview.

I look forward to hearing from you.

Kind regards

Melanie Spragg

Chartered Counselling Psychologist

**‘Life just kind of sparkles’:
Clients’ experience of being in a Cognitive
Behavioural Group and its impact in reducing
shame and blame in Obsessive Compulsive
Disorder (OCD)**

Melanie Spragg

A thesis submitted in partial fulfilment of the requirements of the School of
Psychology, University of East London for the degree of

Doctorate of Counselling Psychology

ACKNOWLEDGEMENTS

Firstly I would like to express my thanks and gratitude to my research supervisor Dr Sharon Cahill for all her support throughout the research process and sitting with my anxiety and excitement throughout the peaks and troughs. I would like to thank my line manager Dr Diane Foster for her support and encouragement regarding my change of role in the NHS for the duration of the research as well as Rosa for facilitating the two groups during this period. My love for, and apologies to, my daughter who has been so helpful and understanding over the last four years. I would like to thank Steve for helping me out with childcare in times of need and encouraging me in moments of uncertainty. I would also like to thank Cliff for his help with the interpretative map and for his support by being interested and understanding of my limited time. Most of all, thanks to all my participants for providing such rich personal accounts and being prepared to be involved in the research process. Thanks to Laura, Sara, Anna, Sunny, Mia, Paul, Marc, Paramjit and Rosa for providing such rich personal accounts. Your participation in this project has made this thesis possible and has really advanced my understanding of the benefits and pitfalls of group therapy which will influence further group work carried out in the trust, benefiting subsequent users of our service. I would also like to thank my Grandmother, Muriel, for her consistent belief in what I do. I dedicate this piece of work to you.

ABSTRACT

This is the first qualitative study highlighting service user feedback relating to the experience of being in a group with others who share a similar difficulty commonly known as Obsessive Compulsive Disorder (OCD). Eight participants were purposively selected from two groups and the researcher also carried out an interview with the therapist who facilitated both groups. The interviews were transcribed verbatim and analysed using Interpretative Phenomenological Analysis (IPA). A reflexivity section is incorporated in the methodology and prior to the analysis section which aims to highlight to the reader my process and reflective capacity during the research. Five superordinate themes were generated in the participants' personal accounts relating to the experience of being in group therapy. These were eventually labelled as 'Engagement with the group process', 'Normalising', 'Courage to Fight', 'Being my own Therapist' and 'Restricted by Shame vs. Engaging with Life'. Participants also commented on the helpful aspects of group therapy and made recommendations for change to the content and structure of the group.

The thesis documents my analysis relating to the meaning for participants who shared in a group with others who share a similar difficulty and highlights the significant benefits of the group process as an intervention. Recommendations for improvement to the content and structure of the group are outlined in the discussion and links to existing quantitative research are outlined. A critical appraisal of the study is presented and suggestions for future research are highlighted.

Key words: Obsessive Compulsive Disorder, Qualitative research, Group therapy.

Appendix G: Example of interview transcript

Descriptive Analysis transcript 4

Bold – in-vivo codes

Descriptive text

Conceptual comments

Linguistic comments

Lines 8-21

Describes enormity of relief of meeting others by the emphasis on huge

‘Never met anyone’

Explains enormity of this by repeating ‘Never met anyone, hadn’t met anyone, never been in contact’ three times in one sentence

‘So secretive’

Has kept problem secret for over 20 years possibly due to sense of shame/guilt. Worried about how is seen. Very comforted by meeting five others with same problem feels reassured and soothed by this and recognises not the only one

‘Knock on effect’ meeting others with same problem for first time leads to increased confidence /assertiveness to talk to husband about OCD for first time. Taking a risk with sharing hidden self to husband who doesn’t like hearing about it problematic relationship with others

Normalising meeting others ‘not the only one’

Hidden self, Shame and secrets
How I am seen

Increased assertiveness/risk taking.
Problematic relationship with others

Lines 28 -39

‘Part of me which was crazy’ *She says ‘was’ crazy suggesting now views problem differently since meeting others perceived as normal.* Compares self positively when younger to another who is talented others are normal too ‘related to her a lot’ *Apologies for compliments self fears I would think she is conceited.* *She wishes she had better therapy when younger.*

Lines 40-58

‘nothing you can do’ Describes lack of available therapy in the 80’s in South Africa when diagnosed sense of disappointment and frustration, hopelessness due to unhelpful advice by others Only went to therapy twice then accepted the situation Sense of being alone with problem

Lines 59-71

‘People who were worse off’ Compares self to mixed range of people and feels comforted and encouraged at recognition not coping as badly as when first joined group Increased confident about coping ability

‘I am cocking up so badly’ comforted, reassured and encouraged by seeing others on a continuum some worse some less

Normalising – others normal

Positive comparison with others

Being alone with the problem

Hopelessness

Comparison with others

Self viewed as coping better

Increased motivation to change by comparison

‘Get back in control’ Feels motivated to change by comparison with others on continuum emphasises very very encouraging to be with others. Describes group as community

Lines 79-88

‘Lost control again’ Describes previous positive experience of therapy and belief in change. She slipped so much after having children Childbirth critical incident for relapse resulting from increased responsibility

Lines 92-108

‘Courage to fight’ This is what she believes CBT gives you. Compares increased sense of courage to impact of OCD before therapy. She felt overwhelmed and ‘flooded’ by OCD whilst trying to manage looking after children and working. Accepted the OCD due to lack of resources after having children (critical incident) rather than contesting it. Increased motivation to fight from being in the group, this motivation previously lost.

Voice lowers feels guilty about relapsing

Lines 115-125

‘Aggression he can’t bear it’ Problematic relationship with husband who can’t bear this part of me – hostility from husband. Emphasises by using very three times husband’s expectations of role as mother and provider. Aggression from husband when mentioned problem leads to increased secrecy

Lines 127-142

‘Non discussed issue at home’ Husband doesn’t like it at all. Taking the risk of sharing changes with husband. Emphasises actually able to say because I wanted him to know how much I had done to change. Increased assertiveness compared to previous hidden secretive self who masked it

Lines 150 – 160

‘Funny side’ Sees humorous side of OCD when not so secretive. Emphasises recognises problem is ‘so stupid’ twice. Increased insight. Compares own behaviours with others same but different behaviour. Seems insane but same just different behaviour.

Lines 161-171

‘Defiance’ mentions defiance five times in one sentence. Associated with increased capacity to fight problem and challenge husband Asserting self. Compares problem to husband’s physical illness or poor eye sight.

Its not a bad problem’ Since meeting others feel less guilt recognition of problem as less severe

Lines 209-224

‘Terrified of neglecting the children’ Describes impact of OCD before therapy on ability to care for children. Fear of being responsible for harming them. Describes difference now increased confidence in role as mother can be outside and do shopping whilst keeping children in mind

Impact of critical incident

Risk taking

Impact before

Regained motivation

Problematic relationship with others

Expectations from others
Hidden self

Increased assertiveness

Hidden self

Increased insight

Problem viewed as less severe

Asserting self

Views problem as less severe

Increased confidence/
role of mother

Impact on life before

Lines 225-234

'Much more confident about being around them outside the house' Describes impact of OCD before therapy Impact on relationship with children emphasises enormity of problem by stating very compromised. It was horrible to live like that. Describes most significant change as increased competence as mother

Increased confident as mother

Impact on life before

Lines 234-250

'I am much quicker now' Describes increased confident at work due to being able to change environments more easily. *Emphasises change by stating much quicker twice*. Compares self before. Others noticing fear of how being seen as odd or bizarre due to OCD behaviours

Change

How I am seen

Lines 260-268

'Life just kind of sparkles' Describes increased capacity to engage in life when OCD is reduced. Improved quality of life. Compares to life before therapy. She feels frightened, can't concentrate or follow a conversation when urge to carry out ritual strong 'eating her'. Conflict between need to carry out compulsion and how she is seen.

Improved quality of life

Restricted vs. engaging

Lines 308-312

'I really wanted to stay' Describes loss of another group member who didn't come back after being distressed. Loss motivates her and others who want to stay and make use of the group. *Emphasises enormity of this by using 'certainly made me feel' and repeating 'really' three times*

Motivation to make use of the group

Loss of group member

Lines 324-328

'Fascinated by diverse group' *dynamic of group seen as interesting emphasised by saying 'so' interesting*. Compares self to others class and culture. Learning about other people's lives. So many different backgrounds others different but the same.

Compares self to others

Lines 344-365

'Very moving –the team can do stuff'

Empathy with others Seeing others improve increases hope and belief that therapy is working. Sense of working in a mutual team

Empathy with others

Seeing others improve

Lines 378 – 385

'Invested in other people'. Seeing others develop sense of humour described as moving empathy with others as get to know them better. Describes special relationship after getting to know each other

Increased hope

Empathy with others

Lines 434-443

'Secreting like mad'. Describes main change not taking on new behaviours. Refusal to accept in comparison to response to rituals before starting therapy. Increased insight to get things under control.

Change

Impact on life before

Increased insight

Lines 450-453

'Feeling back in control and more defiant'. Describes significant change. *Emphasises control and defiance by repeating twice*.

Back in control

Defiance

Lines 455-461

'Sweetest feeling in the world' Feeding back to the group. Describes looking forward to the meeting to share success in the group. Found this empowering *emphasises enormity of this by the use of 'hugely'*.

Lines 474-479

'Everyone going nuts trying not to do it.' Describes sense of working in a team by knowing others are having to discipline themselves in the same way.

Lines 474-479

'Whole day cluttered with it – can't live like that'. Describes gain by comparing impact of life before therapy. She was so terrified of setting OCD off she was avoiding all triggers. *Mentions getting in loops three times. Refers to relief when realised actually functioning – functioning mentioned three times to emphasise enormity of relief.* Improved quality of life – less frustration and functioning again.

Lines 510-584

'Very very unhappy teenager' Describes not liking thinking about past and onset when at boarding school. Maybe too painful to remember. *Emphasises very very unhappy during time of onset.* Relates to patterns of early experience – strong codes of duty that feel alien to you – exactly 'that was my childhood.' Compares early life to that of sister's kids who also have OCD but are happy and contented. Describes preference for here and now. Importance of acknowledging it and had worked through in previous session

Lines 585-600

'Really interesting to listen' *Repeats like to hear twice and really interesting to listen three times to others early experiences.* Compares content of own OCD to others and belittles own worry about 'doorknobs' in contrast to others devilish fantasies. Questions why not bothered by these since 'bedraggled by Catholicism' Repeats three times when referring to hearing where OCD stems from emotionally

Lines 664- 882

'I don't feel incompetent with children'. She used to be really worried *emphasises really twice.* She can go out with them more. Challenged perception of incompetent and increased confidence in role as mother to be more spontaneous with kids.

Lines 692-696

'Quite slow at the beginning' She thinks there was a slow build up and would have preferred to start fighting behaviour sooner in group. She was impatient to get started.

Feeding back to group

Working on it together

Impact of life before

Improved quality of life.

Understanding development

Understanding development

Challenged meaning

Recommendation for change

Lines 732-758

'OCD thrives on misinformation' Emphasises importance of reading self help book alongside therapy and thinks this should be mandatory. *Emphasises this should be stressed as very very important – you need to read it.* Throwing a spotlight describes more information about how OCD works leads to feeling compelled to be less secretive.

Lines 765-773

'Just another problem' views what doing as normal vs. thinking something very wrong with you when growing up because nobody else is doing it. Increased capacity to cope with it by meeting others and viewing problem as less severe.

Lines 774-784

'hostility from others – I must be a bad person'

Repeats used to incredibly distressed twice emphasising enormity of distress. Frustration at hopelessness of the situation was silenced about problem due to hostile reaction from mother which led to conclusion that must be a bad person. *Emphasises sense of being comforted by use of very and repeating work.* Challenges negative meaning by meeting others who do it.

Lines 785-801

'Water babies metaphor' Recognising not the only one through meeting others for the first time. Realisation that not alone and others have same needs and shared experiences. More able to relate to people who are facing the same battle unlike others. Increased empathy to understand symptoms.

Lines 876- 887

'Every time you don't do it you undermine it' Relates theory to self described as a process. Understanding theory and relating it to self leads to increased ability to view compulsions as a choice and examine this. Sense of her really understanding this and relating it to herself.

Lines 900-915

'Recognising bud of ritual' increased awareness insight of ritual beginning. Describes how OCD grows. Sense of increased awareness of how rituals become more elaborate. Knows how not to get new ones due to increased awareness of triggers.

Lines 920-934

'I just say oh fuck this'. How she uses increased sense of defiance to resist new rituals. Sounds animated and determined and makes a protest about not letting new rituals on board. *Emphasises determination of new knowledge by repeating I am not. There is no way, don't even grace it.*

Recommendation for change

Normalising

Problem viewed as less severe

Problematic relationship with others

Challenging meaning

Normalising

Not the only one

Shared battle

Relating theory to self

Increased insight

Change

Increased insight

Relating theory to self

Increased insight

Lines 1002 – 1050

'Feels fantastic to be able to tell people' Mutual sense of empathy for self and others when reporting back to the group. Describes huge sense of empowerment by managing to change after initially doubting capabilities.

Feedback to the group

Empathy for others

Risk taking