The Phenomenology of Obsessive Compulsive Disorder from the Perspective of the Adult Support Group Attendee

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Richard R. Thomas, Jr., MA

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This dissertation, by Richard R. Thomas, Jr., has been approved by the committee members signed below who recommend that it be accepted by the faculty of the Antioch University Seattle at Seattle, WA in partial fulfillment of requirements for the degree of

DOCTOR OF PSYCHOLOGY

Clinical Dissertation Committee:

Melissa Kennedy, Ph.D.
Chairperson

Bruce Duthie, Ph.D., ABPP

Sarah Baxter, Ph.D.

10/30/2010
Date
Dedication

To Andy Benjamin, Patricia Linn, and Melissa Kennedy for Believing in my Abilities
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This qualitative phenomenological dissertation utilizes the empirical descriptive phenomenological method, a modified Husserlian (1931) approach developed by A. P. Giorgi (1975, 1985, 1997) in order to lend voice to a vulnerable population of eight (four men and four women) adult Obsessive-Compulsive Disorder (OCD) sufferers while also gleaning a greater understanding of their in vivo (or lived) experience. Though extensive quantitative research into the disorder exists, this study utilizes the words of the participants and searches for emergent themes amongst their collective experience. This study addresses the treatment gap of this crippling disorder, increases community awareness, and allows for emergence of positive psychology themes. Results include situated descriptions of each participant, the emergence of six significant themes: Phenomenology of Symptoms, Experience with Treatment, Coping and Resiliency, Interpersonal Relationships, Co-morbidity, and Support Group Attendance, and a collective structural statement of their overall experience. Though severity of symptomatology varied amongst the participants, an overwhelming and pervasive sense of doubt, mistrust, and lack of control over one’s own thoughts, feelings, and/or behaviors permeated the data. In addition, participants described feelings of personal shame and stigma from living with their disorder. Furthermore, all displayed coping mechanisms skillfully adapted to their particular personalities and symptomatology. Unexpectedly, all participants included in this study were involved in a support group at the time of their interview, leading to rich and detailed description of their experiences at both personal and collective levels. Support group participation clearly benefited all participants in providing a safe and accepting environment in which to share their
experiences, learn the experiences of others, and gain perspective on their disorder. Furthermore, support group helped them to form community, learn about current ‘best treatment’ standards, and receive psycho-education and short-term exposure-response prevention interventions from mental health professionals directly tailored to their symptomatology.

*The electronic version of this dissertation is at OhioLink ETF Center, www.ohiolink.edu/etd
CHAPTER ONE

Introduction and Literature Review

Research has explored the construct of positive psychology and its significant contributions to the field, as well as the symptomatology of Obsessive-Compulsive Disorder (OCD). However, no known studies specifically view the lived experience of OCD through the lens of positive psychology. This dissertation remedies this deficiency by providing participants a phenomenological emergent design in which to discuss the adaptive aspects of their OCD treatment. Specifically, this research identifies the existence and/or prevalence of participant-specific resiliency factors, while also educating clinicians and theorists on the lived experience of the disorder.

Nosological treatments based on the Diagnostic and Statistical Manual of Mental Disorders, fourth edition, revised (American Psychiatric Association [DSM-IV-TR], 2000) address the downward spiral of mental illness. Positive psychology seeks to upend this spiral so that one may meet his or her utmost potential. The Broaden-and-Build model (BNB) proposed by Frederickson (1998, 2001) provides the positive psychology theoretical viewpoint for this study.

*Positive Psychology Movement*

“The science of psychology has been far more successful on the negative than on the positive side. It has revealed to us much about man’s shortcomings, his illness, his sins, but little about his potentialities, his virtues, his achievable aspirations, or his full psychological height. It is as if psychology has voluntarily restricted itself to only half its rightful jurisdiction, than the darker, meaner half” (Maslow, 1954, p. 354).

The father of positive psychology, professor and theorist, Abraham H. Maslow, Ph.D., recognized in his seminal work, *Motivation and Personality* (1954), that a need
exists for a positive viewpoint in clinical psychology. He posed the question: Why not study healthy individuals, adaptive abilities and human potential?

Many clinicians and theorists have answered Dr. Maslow’s call over the last four decades including Carl Rogers (1961,) Martin Seligman (1990,) and Barbara Frederickson (1998). During the 1990s, this movement of efforts became defined as the positive psychology movement (Snyder & Lopez, 2005). This collective movement posed the question: How can the psychotherapist help his or her client to live a more adaptive, fulfilling life?

Broaden-and-Build

Frederickson (1998) developed the groundbreaking BNB theory to help clinicians and theorists conceptualize and promote the healing power of positive emotions (PEs). Her model emphasizes the power of PEs in seeding human flourishing in order to raise a person to higher levels of well-being (Frederickson, 1998, 2004).

The BNB model assumes that negative and positive emotions have conflicting physiological, cognitive, and emotional purposes (Frederickson, 1998, 2001). Emotions are conceptualized as multicomponent response tendencies that unfold over short time periods and stem from an individual’s personal assessment of an event. Compared to a neutral state, negative emotions (NEs) have been empirically shown to lead to cognitive, emotional, and behavioral narrowing and survival-oriented behaviors such as sadness, fear, anger, jealousy, and anxiety.

However, PEs such as love, gratitude, hope, pride, happiness, amusement, joy, interest, serenity, sexual desire, and contentment have been shown to not only feel good in the present moment but also to serve as markers and signals of optimal well-being and
functioning in individuals (Frederickson, 1998, 2001). Frederickson, Tugade, Waugh, and Larkin (2003) demonstrated that PEs also increase and broaden one’s cognitive awareness while also encouraging exploratory, creative and playful behaviors.

In line with evolutionary psychology, Frederickson (1998) theorizes that our ancestors who succumbed to the urges sparked by PEs, such as joy and love, would have been pushed to explore their environments and interact with others, thus accruing greater personal resources as a result. Greater resources, in turn, allowed them to become more socially-integrated, healthy and resilient individuals–a complementary, reciprocal approach. As these same ancestors faced adversity, their greater personal resources would have increased their odds of survival and provided a greater likelihood of living long enough to reproduce and thus pass on their genes. Therefore, theoretically, the capacity to experience PEs has been genetically encoded in humans through this process of natural selection.

BNB theory posits that one’s ability to effectively thrive and flourish while facing adversity is directly related to the amount of PEs emoted in relationship to NEs (Frederickson, 1998, 2001). The theory complements client-centered therapy in that clinicians may use the power of PEs to help empower clients to ultimately serve as their own agents of change (Rogers, 1961). The major breakthrough for BNB arises from its positioning of PEs as both feel-good states and as gateways to accumulating and compounding enduring resources such as resiliency and social support systems.

In their study on resiliency, Frederickson et al. (2003) concluded that resilient individuals can be characterized as optimistic, zestful, energetic, and curious, and often hold more exploratory and creative approaches to life than less resilient persons.
Frederickson and her colleagues also found that the more resilient individuals hold a common attribute – positive emotionality. Specifically, these individuals were found to be highly skilled in eliciting PEs from their loved ones and close relations, facilitating an even more supportive social context. Furthermore, they held both high positive emotionality and a heightened capacity to rebound physiologically from stressful and/or adverse situations and events.

The Power of Positive Emotions

NEs arouse an individual’s autonomic nervous system resulting in increased heart rate, blood sugar, vasoconstriction, and blood pressure as well as the rapid production of cortisol by the autonomic nervous system (Frederickson et al., 2000). PEs, on the other hand, act as restorers and replenishers by broadening emotional and physical coping mechanisms and actions. When used over time, the researchers hypothesize that PEs will accumulate and compound, resulting in an increased array of tools such as resilience and broadened support systems (Frederickson, 1998, 2001).

Individual PEs carry phenomenologically distinct experiences; joy, for example, has been found to compel individuals to become exploratory and playful, resulting in creativity, discovery, and physical activity (Frederickson, 2004). Similarly, the act of exploration has been found to increase one’s knowledge and psychological complexity (Tugade & Frederickson, 2004). Further, contentment has been shown to elicit happiness and the desire for one to sit back and savor current life experiences and integrate them into his or her views of the world and self (Frederickson, 2004).

Frederickson and Losada (2005) demonstrated that PEs, such as interest and curiosity, produce more subsequent knowledge than do NEs such as boredom and
cynicism that were demonstrated to promote avoidance. The researchers also
demonstrated that PEs create experiential learning opportunities which in turn help an
individual to build more effective cognitive maps of one’s environment and develop
intuition. Crucial to BNB theory is the idea that PEs build resilience and act in of
themselves as resiliency-building tools or “buffers” that help one to combat adverse
situations and stressors (Frederickson et al., 2003).

Utilizing mediation analyses, Tugade and Frederickson (2004) found that
participants who scored high on self-report indices of psychological resilience also
reported experiencing more PEs in response to adversity both in the laboratory and in
daily life. Furthermore, the researchers found these individuals to hold more positive
meaning amidst adversity, a heightened ability to regulate their emotions, and an ability
to return to quicker baseline cardiovascular levels following a stressor. In conclusion,
PEs are positively correlated to resilience.

In a study following the September 11th attacks of 2001, Frederickson et al.
(2003) found that those who scored higher on measures of trait resilience were also found
to endure fewer depressive symptoms, experience more positive emotions, and were
ultimately found to be more likely to elicit positive meaning from the events than those
scoring lower on measures of trait resilience. These individuals were further
characterized as being able to quickly replenish their resources as well as being able to
develop new skills and knowledge. The researchers found that resiliency was positively
correlated with psychological resources such as life satisfaction, optimism, and
tranquility. This study lends further credence to BNB theory (Frederickson, 1998, 2001)
that when PEs are effectively used over time, they carry the distinct advantage of becoming enduring and habitual responses that also serve as reserves for times of need.

Tugade and Frederickson (2007) reported that those who are less resilient and have less experience using PEs may also have more difficulty generating PEs, especially during adverse times when an individual depletes his or her cognitive resources, thereby hindering one’s ability to effectively cope with the current stressor and/or adverse situation at hand. More resilient individuals were shown to automatically activate the power of PEs during stressful times, which in turn has been shown to free previously committed cognitive resources that grow stronger over time.

*The Undo Effect and Upward Spirals*

Frederickson (2001) theorized that PEs loosen or undo the negative physiological and emotional arousal effects of NEs known as the “undo effect.” The undo effect postulated that by increasing PEs, even when NEs are in excess, one may help to increase one’s cognitive, emotional and physiological repertories. Highly resilient individuals can be considered expert users of the undo effect.

Frederickson and Joiner (2002) spoke of the downward spiral of hopelessness and helplessness that is often displayed in depressive disorders. Through promoting narrowed and depressed moods, NEs were shown to help lead to such debilitating illnesses as clinical depression, anxiety disorders, aggression, violence, and suicidality, ailments that effect society in extremely negative manners. BNB theory (1998, 2001) stresses the healing power of PEs and that through cultivating and using them, one may in fact transform themselves out of a downward spiral of suffering and into a flourishing upward spiral of enhanced physiological and emotional health and well-being.
Clinical Implications of Positive Emotions

BNB has multiple implications for clinicians who should be on the lookout for both the presence of NEs and PEs in their initial assessments (Burns et al., 2007). In recurring sessions, clinicians should strive to help their clients cultivate more PEs and assign enjoyable activities that may also increase PEs outside of the therapy office. Interventions may also include inducing PEs in session by asking clients to describe their best of times or to reframe negative emotional assessments of situations.

Tugade and Frederickson (2007) also identified concrete examples of how clinicians may help their clients to cultivate and utilize PEs outside of the therapy office. These interventions included finding positive meaning in daily life through multiple pathways, such as positive reappraisal, problem-focused coping, and infusing ordinary events with positive meaning such as in appreciation.

Based on the above empirical evidence, future research focusing on how PEs can demonstrate effectiveness in treating OCD would be beneficial. Clearly, PEs are bound to help those suffering from OCD and cultivating them through the process of psychotherapy may also help to alleviate suffering and psychopathology as well as to prevent relapse.

An Introduction to Obsessive Compulsive Disorder

OCD is a chronic and disabling psychiatric disorder that affects humans across the lifespan and carries a lifetime prevalence rate of 2–3% and at any given moment, 1% of the population is estimated to be a sufferer (DSM-IV-TR, 2000). The fourth most common psychiatric illness afflicting Americans after phobias, substance abuse and
major depressive disorder, OCD is twice as common as schizophrenia or panic disorder and is the most common anxiety disorder to be specified as ‘serious’.

The average age of onset for childhood OCD ranges from 7.5 to 12.5 years and begins earlier in boys than in girls (Menzies & de Silva, 2003). Eighty percent of adulthood cases have been found to have a childhood or adolescent onset and periods of peak onset include puberty and early adulthood. The mean age of onset for adult OCD ranges from 22 to 36 years, with a 15% chance of the disorder occurring after the age of 35 years. Furthermore, men also tend to have an earlier age of onset in adulthood, although women eventually catch up and share equal representation overall. Once the disorder activates in an individual, it typically displays a waxing and waning course and carries only a 5% reported incidence of complete remission between episodes (Maj, Sartorius, Okasha, and Zohar, 2002).

OCD sufferers are plagued by recurrent, unwanted and intrusive thoughts (obsessions) that are ego-dystonic and/or engage in unwanted repetitive and ritualistic behaviors (compulsions) to neutralize and/or relieve the anxiety caused by the obsessions (DSM-IV-TR, 2000). Obsessions may include worries, doubts, or images that evoke anxiety or distress even though the individual, in most cases, realizes the irrational, unrealistic, and/or untrue nature of the thought(s). Common obsessions include religious and moral concerns or scrupulosity, cleanliness, and contamination concerns, while common compulsions include excessive hand washing/cleaning, counting, praying, and checking.

Those who suffer from OCD have been found to be extremely secretive in their behaviors so as to not appear “sick” or “crazy” and to avoid social ostracism and stigma
Many sufferers are able to conceal their intrusive thoughts and compulsive behaviors exceedingly well and may never receive a proper diagnosis and/or treatment. Furthermore, sufferers are often found to report relationship problems, social isolation, and low self-esteem and carry higher suicide rates than nonsufferers (Menzies & de Silva, 2003).

OCD is considered to be a valid diagnostic category cross-culturally. Worldwide, symptomatology is found to include religious, sexual, and morbid obsessions and varies primarily in terms of urbanization and religiosity (Lemelson, 2003). The World Health Organization (WHO; 1999) named OCD to be among the top ten most disabling illnesses in terms of loss of quality of life and personal income due to unemployment.

Furthermore, obsessive compulsive disorder-like behaviors have been observed between species such as the compulsive grooming behaviors displayed in dogs and rats and the elaborate courtship dances observed in birds (DSM-IV-TR, 2000). Most notably, canine arcal lick dermatitis is characterized by excessive biting, chewing and licking of the extremities (leading to hair and/or fur loss and lesions) and is often treated with serotenergic medications (Menzies & de Silva, 2003).

Though the exact physiological characteristics of OCD are unknown, the disorder is believed to be correlated with neurobiological structural and functional abnormalities that exist in the orbitofrontal cortex of the caudate, a territory of the striatum (Dougherty, Rauch, & Jenike, 2004). The serotenergic hypothesis of OCD postulates that the disorder is caused by a deficiency of the neurotransmitter serotonin in the path connecting the frontal lobes and the basal ganglia (DSM-IV-TR, 2000). However, the disorder is treatable and a recent functional Magnetic Resonance Imaging (fMRI) study has shown
that the successful use of pharmacotherapy and/or behavioral therapy can possibly invert these neuro-abnormalities (Dougherty, Rauch, & Jenike, 2004).

History of OCD in Western Society

Symptoms of OCD have been identified consistently in Western literature from as early as the seventeenth century (Menzies & de Silva, 2003.) Shakespeare’s character Lady Macbeth is believed to have been engaging in an obsessive-compulsive ritual when compulsively washing her hands of guilt. Before the advent of modern psychological theories and treatments, obsessions were considered by the medical community to be the work of outside, evil forces such as possession by demons and works of the devil. Exorcism was a popular method of treatment.

Janet (1903), drawing upon the research of Legrand du Saulle, is widely credited with having put forth the first psychological viewpoint of OCD, or obsessive-compulsive neurosis, as it was referred to during the beginning of the twentieth century (Menzies & de Silva, 2003). At the time, Sigmund Freud (1913) reported difficulty treating obsessive-compulsive neurosis with psychoanalysis and speculated on the disorder: “As to what factors can bring about such disturbance of development, the work of psychoanalysis comes to a stop. It leaves that problem to biological research” (p. 311). Efficacious treatment options for sufferers would not arise until the advent of the behavioral interventions of the 1950s and the advent of serotenergic pharmacotherapies in the 1960s (Clark, 2004).

Phenomenology of OCD

In the individual suffering from contamination obsessions, symptoms may manifest in the faulty appraisal of danger, such as the intense and disabling fear that one
has come into contact with a deadly airborne pathogen and that if he or she does not wash him or herself for five hours daily, he or she will infect his or her loved ones. Markedly, 90% of those who do not suffer from OCD report occasional obsessive thoughts and OCD sufferers are primarily distinguished by their inability to reach natural closure to their anxiety and/or worry while in the absence of such fears (Menzies & de Silva, 2003).

Compulsions may manifest in sufferers overtly as in washing and checking behaviors or covertly as in repetitive thoughts and/or mental checking (DSM-IV-TR, 2000). Compulsions are usually carried out ritualistically and in accordance to certain rules, patterns and/or fixed sequence with 75%–91% of sufferers reporting the presence of both obsessions and compulsions.

In the individual suffering from contamination compulsions, the compulsion may manifest in an intense need to scrub one’s body until he or she bleeds and in the individual suffering from scrupulosity obsessions, the compulsion may manifest in the need to pray for hours on end (DSM-IV-TR, 2000). Furthermore, certain triggering events, such as the sight of a needle or a knife, may also induce intense and anxiety-provoking obsessive thoughts and/or compulsions. Unfortunately, and to sufferers’ great dismay, the compulsions usually only temporarily relieve the anxiety and it quickly returns in the form of doubt and intense worry—resulting in an endless cycle of suffering.

The third most common subtype after checking and washing, respectively, is recurrent and intrusive thoughts of committing violent and/or sexual acts toward others and even loved ones (DSM-IV-TR, 2000). For example— a man deathly afraid that he struck a pedestrian on his morning commute to work or a postpartum mother who fears that she may harm her newborn infant against her will.
Sufferers of this third subtype often feel the compulsive urge and need to seek out reassurance from others that the feared act did not or will not occur (DSM-IV-TR, 2000). Repeated requests for reassurance among all subtypes are often guised as compulsive and ritualistic behaviors. Crucially, reassurance provided by both clinicians and loved ones has been found not only to be ineffective but may also worsen symptomatology by ultimately reinforcing the compulsions.

*Diagnostic Factors*

A national comorbidity survey revealed that only 26% of individuals with a lifetime history of a DSM-III diagnosis obtained specialist mental health treatment (Kessler et al., 1994). This number may be even lower in those that suffer from OCD due to the gradual and delayed onset of symptomatology, the secretive nature of the disorder, difficulty accessing appropriate medical and psychological treatment, and poor interviewing skills employed by general practitioners (Millar and Tallis, 1999).

Those sufferers who do end up receiving treatment see three to four medical providers on average and spend more than nine years seeking treatment before receiving an accurate diagnosis (Maj et al., 2002). Ultimately, it may take an average of 17 years from the onset of the disorder until the sufferer receives specialized treatment.

OCD sufferers oftentimes seek dermatological treatment for symptoms secondary to their compulsive washing behaviors (Friedman, Hatch, Paradis, Popkin, & Shalita, 1993). Clinical dermatological literature suggests that many ‘psychocutaneous’ skin diseases have anxiety or stress listed as a primary cause. After screening African American patients attending a dermatology clinic, one study found that 26% suffered from one or more anxiety disorders and 15% met the diagnostic criteria for OCD.
One study suggested that the true prevalence of the disorder vs. those who receive treatment is dramatically higher among OCD sufferers (57.3%) than for those suffering from schizophrenia (32.2%; Kohn, Saxena, Levav, & Saraceno, 2004). Furthermore, when OCD is detected, it is often misdiagnosed by practitioners as generalized anxiety disorder (GAD) or depression (Menzies & de Silva, 2003).

To receive a clinical *DSM-IV-TR* diagnosis of OCD, an individual must experience a significant disturbance in normal functioning, and/or engage in obsessive-compulsive activity for at least 1 hour per day (*DSM-IV-TR*, 2000). Furthermore, the individual must also realize the irrationality and/or illogical nature of his or her behavior. Unlike individuals who suffer from psychotic illness, the vast majority of OCD sufferers exhibit insight into the irrational and excessive nature of their behaviors. In some rare and severe cases, the individual may not exhibit insight and he or she may receive the diagnostic specifier ‘with poor insight’.

*Comorbidity, Differential Diagnosis and Prognosis*

Major depressive disorder carries the highest rate of comorbidity (30%) with OCD at the time of diagnosis and a lifetime prevalence rate of 70%, often complicating differential diagnosis (*DSM-IV-TR*, 2000). The disorder also carries a high lifetime-comorbidity rate with other anxiety disorders (52%) such as social phobia (Freeston & Ladouceur, 1999).

The most difficult psychiatric disorder to differentially diagnose from OCD is GAD (*DSM-IV-TR*, 2000). The main difference between the two disorders lies in the obsessive nature of the anxiety that is seen in OCD and not in GAD. Furthermore, the worries presented in GAD tend to be ego-syntonic, more realistic, and less intrusive as
those displayed in OCD.

Those who suffer from phobic disorders also display avoidance and fear behaviors similar to those seen in OCD, and both disorders are treated with similar psychological and pharmacological interventions (DSM-IV-TR, 2000). However, the main difference distinguishing the disorders is that the phobic sufferer typically displays distress only when faced with the feared stimulus and does not perform a ritualistic compulsion in response.

Furthermore, the ruminations displayed in depressive disorders are similar to those of obsessions and should also be differentiated (Menzies & de Silva, 2003). Thoughts in depressive ruminators also tend to be ego-syntonic and produce feelings of dysphoria that revolve around future or current events, while ruminative thoughts in OCD sufferers tend to invoke anxiety.

*Genetic Studies and Applications*

Like the psychiatric disorders in general, OCD is believed to carry a strong genetic basis (Pauls, Alsobrook, Goodman, Rasmussen, & Leckman, 1995). Studies show that 20% of the close relatives of a person suffering from the disorder will also suffer from OCD, and there is a strong likelihood that other family members will display at least some symptoms. Furthermore, identical twins are matched for OCD in at least 60–70% of cases, while dizygotic twins have been found to carry a concordance rate of 47–50%.

The disorder carries a rate of heritability of approximately 70%, and research suggests that the earlier the symptoms appear in life, the greater the likelihood of a genetic basis (DSM-IV-TR, 2000). One study suggests that the disorder demonstrates a
familial rate of suffering that is 3–12 times greater than that of the wider population (Chamberlin et al., 2005). Rapid developments in brain imaging and genetic technologies may lead scientists to eventually identify endophenotypes or genetically-based biological markers that are common in the families of people suffering from a psychiatric disorder and that this will greatly improve the odds of successful treatment (DSM-IV-TR, 2000).

Familial Phenomenology of OCD

Many sufferers are completely dependent upon their family members for everyday activities and functioning (Miller & Tallis, 1999). In families where one or more individuals suffer from the disorder, the secret is often kept by multiple family members, who also report experiencing shame, guilt, and fear of social stigmatism and ostracism.

Relatives of sufferers have been found to frequently have difficulty framing the bizarre and sometimes incomprehensible worries and behaviors performed by their loved ones as symptoms of mental illness (Stengler-Wenzke, Trosbach, Dietrich, & Angermeyer, 2004). One-third of the relatives of OCD sufferers have been found to provide reassurance to the sufferer and often assume responsibility for some of compulsive acts and rituals performed. When seeking treatment, relatives of sufferers may also feel misunderstood and rejected by medical professionals.

An Introduction to the Treatment of OCD

The ‘gold standard’ for the treatment of OCD in both children and adults is the combination of SSRIs and cognitive behavioral therapy (CBT) and exposure response/prevention (ER/P) therapies (Jenike, 2004). Standard talk therapies and
relaxation techniques have frequently been shown to be ineffective in the treatment of OCD.

In a meta-analysis of seventy-seven studies, the effect size of ER/P treatment alone was slightly higher, though not statistically-significantly higher, than SSRI treatment alone (Kobak, Griest, Jefferson, Katzelnick, & Henk, 1998). Further, a combination of ER/P and SSRI treatments returned a larger (though not statistically significant) effect size than ER/P alone. Therefore, a combined treatment of SSRIs and ER/P is recommended as the best course to follow, depending on client-specific characteristics— including severity of symptoms and co-morbidity of depression and extreme anxiety.

Pharmacotherapy

In as early as 1959, evidence was emerging towards the anti-obsessional potential of tricyclic antidepressant drugs that enhanced the availability of the neurotransmitter serotonin (Joel, 1959). Fifty years later, SSRIs continue to remain the first-line pharmacologic treatment agent for OCD. SSRIs, when used alone, tend to have a moderate, but sometimes dramatic effect in providing symptom relief (Jenike, Baer, & Minichiello, 1998).

The first psychotropic medication to receive FDA approval for the treatment of OCD was Anafranil (CMI), which was first introduced as an antidepressant in Europe. The first clinical trials for the use of CMI as a pharmacotherapy for OCD were conducted in the 1960’s, and since then, randomized, double-blind, placebo-controlled trials of SSRIs for the treatment of OCD have returned consistent reductions of 25–35% in Yale-Brown Obsessive Compulsive Scale (Y-BOCS) scores posttreatment. A 50% or greater
A reduction in Y-BOCS scores is considered to be ‘substantial improvement’ (the Y-BOCS will be discussed in further detail in the results section) (Dougherty, Rauch, & Jenike, 2004).

Multiple studies found that 40–60% of OCD sufferers respond to SSRIs overall and that no individual SSRI is particularly more efficacious than any other (Griest et al., 1995). Unfortunately, many OCD sufferers continue to display residual symptoms even while taking SSRIs (Dougherty et al., 2004).

On average, OCD diagnoses require a higher dosage of SSRIs than do treatments for depression, and the psychoactive effects of the drug have been found to require a longer duration to relieve symptomatology (Dougherty et al. 2004). For example, in the treatment of major depression, a sufferer may be prescribed 20–40mg of fluoxetine; while in severe OCD, the same individual may be treated with 80–100mg of the SSRI.

The sufferer of depression is likely to respond to pharmacotherapy within 2–6 weeks, while the OCD sufferer may take up to 10–12 weeks to show psychoactive effects (Dougherty et al., 2004). Reasons for these differences are unknown, though the duration of time required for immediate gene expression is offered as a potential explanation. Therefore, prescribers usually rapidly increase dosages so that the pharmacotherapy can begin taking effect within an effective therapeutic range as quickly as possible.

Dougherty et al. (2004) reports that side effects are a major concern with any psychiatric medication and though the majority of OCD sufferers taking SSRIs do not report difficulty tolerating side effects, some do. Common side effects of the SSRIs include sexual dysfunction, dry mouth, constipation, and insomnia. If sufferers do report such side effects, the first step should be to augment and/or modify treatment with a
different SSRI, preferably one known for not causing the particular side-effect(s) reported.

Upon full discontinuation of SSRIs, relapse is highly likely and is seen in approximately 80–90% of sufferers; although CBT and ER/P therapies may help in delaying and/or decreasing this number (DSM-IV-TR, 2000). In one study among sufferers who had responded to SSRIs and stopped taking them, the average time to relapse during the use of a substitute placebo was 63 days (Jenike, 2004).

Due to the expense, lack of availability, and time requirements of CBT and ER/P therapies, many sufferers only receive pharmacotherapy (DSM-IV-TR, 2000). Additional studies are needed in the area of psychopharmacology to further investigate and develop greater treatment options.

*Cognitive Behavioral Therapy and Exposure Response/Prevention*

Beck (1995) describes CBT for OCD as a psychological treatment that utilizes both cognitive and behavioral therapeutic change interventions to achieve reductions in obsessive and compulsive symptoms by modifying the faulty appraisals, specific core beliefs, and dysfunctional neutralization responses that are implicated in the etiology and persistence of obsessive beliefs. Certain behavioral techniques such as systematic desensitization, modeling, operant reinforcement, aversion relief, and relaxation therapy produced modest and mixed treatment responses (Whittal, Thordarson, & McLean, 2005).

Meyer (1966) is credited with having published the first successful treatment of OCD utilizing principles of CBT and coined the treatment “ER/P” which is based upon O. H. Mowrer’s (1960) two-stage theory of fear and avoidance. The first stage is defined
as a process of conditioning where an obsessional fear develops in response to an object that elicits an adverse reaction. For example, in the sufferer of contamination obsessions, this may include feeling anxious while handling money. The second stage results in a behavior that reduces the fear elicited by the object, such as immediately washing one’s hands, which, in turn, reinforces the behavior—ensuing a vicious cycle. Mowrer’s model was designed to break this pattern by paradoxically embracing the anxiety and finding that it would soon decrease in intensity on its own accord.

In ER/P, the sufferer repeatedly and intentionally exposes him or herself to increasing anxiety-provoking stimuli. For the sufferer of contamination obsessions, this may begin by handling a relatively mundane object, such as a piece of money, while working up to the ultimate goal of touching a public toilet seat, all while refraining from taking part in the resulting triggered compulsion, such as hand washing (Abramowitz, 1996). In a paradoxical manner, anxiety has been found to rapidly increase and then wane, challenging the obsession and teaching the sufferer to reappraise the fear and/or anxiety (Jenike, 2004).

In a review of the literature, 63% of OCD sufferers would be expected to show at least some favorable response to ER/P with outcome measured by lower posttreatment scores on the Y-BOCS (Abramowitz, 1996). Equally impressive is that these positive results were achieved in an average of 14 sessions.

Multiple studies involving 10–20 ER/P treatment sessions have consistently shown that the symptoms of OCD are ‘somewhat’ improved in 85% of sufferers immediately after treatment and ‘very much improved’ in 55% of sufferers (Jenike, 2004). Furthermore, at follow-up, the treatment gains remained high, with 75% of
sufferers remaining ‘much improved’ and 50% of sufferers remaining ‘very much improved’, with some sufferers requiring additional therapy. Further, 20–30% of clients have been found to refuse ER/P and a full 25% have been shown to fail to respond to treatment or are nontreatment-compliant.

If the clinician deems that the sufferer is likely to react successfully to ER/P, he or she first provides the sufferer with the rationale behind ER/P (Freeston & Ladouceur, 1999). Secondly, the sufferer is encouraged to create a “fear hierarchy” in which he or she creates a hierarchical scale rating objects, situations, or behaviors from evoking the greatest amount of anxiety to the least. Discomfort is subjectively measured by a ‘subjective units of discomfort scale’ or SUDS scale, which is a much like a 1 to 10 likert scale.

ER/P can be conducted both imaginably and in reality, or in vivo, though studies consistently show that in vivo is a more effective modality when warranted, such as with a fear of doorknobs but not with a fear of fire (Freeston & Ladouceur, 1999). Sufferers who report intrusive thoughts of a sexually abhorrent or violent nature are often encouraged to create vivid, detailed audio recording(s) of the feared act, and then to listen to the recording(s) repeatedly until the feared act begins to lose its power over the sufferer (Jenike, 2004).

Sufferers who refuse ER/P are likely to suffer from extremely high levels of chronic anxiety and to be characterized either as poorly motivated and/or having doubts about treatment effectiveness (Clark, 2004). Furthermore, there is a dearth of clinicians trained in CBT and ER/P, which may add to the already wide treatment gap of this disorder.
Support Groups

CBT-based ER/P support groups which typically meet bihourly from eight to twelve weeks at a time have been empirically shown by multiple studies to be as effective as individual treatment in decreasing symptom severity of OCD (Jaurrieta et al., 2008). Studies also returned similar attrition (or dropout) rates ranging from approximately 28% to 50%.

Support groups also carry the additional benefits of cost-effectiveness and community support (Anderson & Rees, 2005; Barga, Cordioli, Niederauer, & Manfro, 2005). Furthermore, one study found that treatment gains attributed to support group attendance were maintained for two years post-treatment and also carried a range of 44%-52% decreases in severity of symptomatology as measured by the Y-BOCS (Whittal, Robichaud, Thordarson, & McLean, 2008).

Alternative Treatment Strategies

Despite the lack of controlled clinical trials, there are several types of neurosurgery that are recommended as the treatment of last resort for severe treatment-refractory OCD (Jenike et al., 1998). These operations include anterior cingulotomy, subcaudate tractotomy, and limbic leucotomies, which all share the common objective of targeting and severing connections between specific nerve circuits in the dorsolateral and the orbitomedial areas of the frontal lobes, as well as in the limbic and thalamic structures.

In a noncontrolled study of cingulotomies and capsulotomies, 45% of sufferers display reductions in the severity of their symptoms by at least 35% (Cosgrove and Rauch, 1995). Also, several adverse side-effects were noted such as seizure, weight gain,
and transient headaches, though changes in personality functioning were found to be rare.

Studies are currently underway to test the effectiveness of experimental treatments for OCD such as deep brain stimulation (DBS) and receptive transcranial magnetic stimulation (rTMS; DSM-IV-TR, 2000). In DBS, a surgeon implants electrodes at precise locations in the brain and connects them to an electrical generator in the chest, often referred to as a “brain pacemaker.” Theoretically, the method of therapeutic action is achieved by continuously or intermittently exciting or interrupting inhibitory neurons in the circuits where the electrodes are placed. Though research is preliminary, early studies suggest some improvement in OCD symptomatology.

In rTMS, pulses of magnetic energy currents are intermittently administered to the surface regions of the brain through the skull, and one preliminary study suggests possible treatment efficacy (Gabriels, Cosyns, Nuttin, Demeulemeester, & Gybels, 2003). Furthermore, this method does not include surgery as a coil is held near the scalp and the strength of the resulting magnetic field activates nerve cells within the brain, proving rTMS to be a much more targeted, and less-invasive, alternative treatment to electroconvulsive therapy (ECT). More studies on the alternative treatment methods are needed to establish efficacy prior to more wide-spread usage.
CHAPTER TWO

Method

Qualitative phenomenological research explores the essence of human phenomena through all its complexity (Creswell, 2003). Rather than quantifying symptom expression and searching for a cause and effect relationship, this study lends a phenomenological voice to a vulnerable minority group of OCD sufferers while also allowing for the emergence of positive psychology themes such as resiliency, coping, and treatment effectiveness. The collective experiences of the sufferers served as the basis for developing a coherent narrative that describes the rich lived experience of this group of sufferers.

This dissertation utilized the descriptive phenomenological method, a modified Husserlian (1931) approach developed by A. P. Giorgi (1975, 1985, 1997) to investigate the lived experience of the psychological phenomena of OCD from the perspective of the sufferer. The study underwent review and was approved by a university institutional review board.

Sample

Six to ten individuals, 18 years of age or older who were suffering from OCD and were receiving psychiatric and/or psychological treatment at the time of the interview formed a purposeful sample. Recruiting methods included use of flyers at a local community mental health clinic, professional networking, ads in the newspaper, and contact with community support groups. In recognition and appreciation for participation, respondents were offered a $25.00 gift certificate to a local mall.
Interview Protocol

Individuals who self-selected for participation in the study were contacted via phone to establish their age and whether or not they had been diagnosed with OCD in the past and/or were suffering from symptomatology of the disorder. If they met these two inclusion criteria, a fifteen minute telephone screening was scheduled.

During the screening phase, participants were administered the Y-BOCS (Appendix A) to assess symptom severity. The inclusion of this measure was not meant to serve as part of a mixed-methods design, but rather to act as a screening tool and to add greater reliability and validity to the results. The individuals were required to meet Y-BOCS criteria of ‘mild’ OCD or greater to be included in the study.

When the participant met these criteria, a 90 minute in-person appointment was scheduled at the conclusion of the screening. At the time of the appointment, participants signed and received a copy of an informed consent form (Appendix C) and a semi-structured interview schedule (Appendix B) was followed. The interviews were audio-recorded for purposes of verbatim transcription. At the completion of the data analysis phase, one final interview was conducted via phone to verify themes and/or content with individual participants.

Yale-Brown Obsessive-Compulsive Scale

Goodman et al. (1989a) developed the Y-BOCS as a semi-structured, clinician-rated symptom severity assessment tool to be used by clinicians internationally to quantify the severity of obsessive-compulsive thoughts and behaviors in sufferers. Not designed for diagnostics, this clinical tool assesses symptomatology severity and progress over the course of treatment. The scale measures obsessions and compulsions on 5
parameters which include: Duration/frequency, interference in social and occupational functioning, associated distress, degree of resistance, and perceived control over obsessions or compulsions.

Each item is clinician rated on a 5 (0–4) point scale and the numbers are totaled to derive a total YBOC-S score (yielding a maximum score of 40; Goodman et al., 1989a). The results are then interpreted based on this score. A score of 0–7 is subclinical; 8–15 is mild; 16–23 is moderate; 24–31 is severe; and 32–40 is extreme. Sufferers scoring in the mild range or higher should consider professional help in alleviating obsessive-compulsive symptoms.

Several psychometric studies of the Y-BOCS show the measure to have excellent inter-rater reliability and consistency, returning correlation coefficients ranging from $r=.80$ to $.99$ and a mean internal consistency estimate of $r=.89$ (Goodman et al., 1989b). Scores on the Y-BOCS have also been found to correlate strongly with other OCD assessment tools such as the Clinical Global Impressions Scale of OCD Severity (cGI-OCS; $r=.74$,) and moderately with the National Institute of Mental Health global obsessive-compulsive severity scale (NIMH-OC; $r=.67$).

**Validity and Reliability**

Open-ended questioning was employed during the semi-structured interview so as not to control content, narrow the response and/or meaning provided by the sufferers, and/or elicit researcher bias. All participants reviewed, signed, and received a copy of an informed consent form. Multiple sufferers were interviewed in order to establish a broader understanding of their experience and allow for the development of patterns and/or themes to emerge collectively from the data.
To ensure reliability and strengthen consistency throughout the data analysis phase of the study, a doctoral student also conducting a phenomenological research study for the purposes of his dissertation served as a research assistant. The research assistant ensured that the study returned accurate readings, codes, patterns and themes by acting as an inter-rater of the data.

During the final telephone interview, individual and group collective themes were reviewed and verified with the participants (except for one) in order to increase validity and reliability of the meaning units (MUs,) codes, and themes discovered. Participants were provided the opportunity via telephone to modify, strike, and/or add relevant information to their interview transcripts. Participant feedback from these interviews was also incorporated into the data and final report. All participants contacted offered additional comments and updates related to their current treatment experience.

The researcher also kept a personal journal throughout the research process to allow for self-reflection of how his biases and/or multicultural factors were elicited by the material in order to minimize biasing his professional judgment. Also, the researcher was mindful to include any information that could possibly negatively contradict any such discovered themes and/or patterns. The researcher also utilized peer debriefing with the research assistant to enhance accuracy of the data analysis process.

Data Analysis

Data analysis was conducted according to the phenomenological standard as set forth by A. P. Giorgi (1975, 1985, 1997), which is founded upon the works of Husserl (1931). After the initial transcription of the data, the researchers read through the
transcripts in their entirety in order to glean a general sense of the overall structure of the data.

The researchers then read through the transcripts for a second time with the goal of reducing, or breaking, the data into parts or MUs, which were used to give structure to the phenomena. In order to enhance reliability and validity, the researcher, to the best of his ability, bracketed all outside biases, presumptions, and past experience with the material so as not to cloud the experience as expressed by the participants (Giorgi, 1975, 1985, 1997).

MUs were identified and marked by the researchers every time a transition in meaning was discerned in the raw data. The researcher then utilized a process called imaginative variation to establish the essential psychological meaning, or central intuition of the MU and translated it into a heightened-psychological meaning unit (called a code). According to Husserl, when translating the psychological meaning of the raw data into a code, nothing is lost except the existential status of the data. The researcher then analyzed the interrelationships of codes across the entire data at multiple levels (Giorgi, 1975, 1985, 1997).
CHAPTER THREE

Results

Four males and four females representing three different ethnicities self-selected to contribute to this study and met full criteria. Their average Y-BOCS score was 17.5 (ranging from 26 to 10) and their average age was 39 (ranging from 25 to 65). The interviews were transcribed verbatim, the Giorgi (1975, 1985, 1997) method of phenomenological analysis was applied to the data, and HIPPAA guidelines of confidentiality and privacy were followed throughout.

MUs were delineated, psychological MUs were extrapolated, and codes were assigned via Atlas.ti data management software. A research assistant verified these codes, MUs, and psychological MUs; and when a difference between the two readers arose, the section was re-read in order to discern the most accurate meaning. Extensive client worksheets or “biographies” were also created and condensed in order to develop situated descriptions while utilizing *in vivo* codes and significant statements to better capture the lived experience or “voice” at both the individual and collective levels of the data.

*Situated Descriptions*

*Participant One*

Participant One (P1,) a female in her early fifties, reported a childhood onset of the disorder and endorsed symptomatology of both obsessions and compulsions (Y-BOCS=20). The phenomenology of her symptoms included fears of wearing certain “scary” articles of clothing to particular places out of a pervasive fear that the clothing
will be “unsafe” and that she will then be compelled to return and visit that place once again.

She reported that opening doors will trigger this obsession and that she has flown across the country to visit “unusual places” while spending “any amount of money” in order to fulfill the compulsion(s). In her words: “So it is a terrible, terribly debilitating condition, and I have to fight every day of my life for the walls to keep closing in…I have to continually, continually push those barriers, because it's so strong that it wants to… it wants to consume me.”

P1 displays insight into the irrational nature of her obsessions and compulsions and realizes that OCD is a chronic illness that will wax and wane in severity of symptomatology over the course of her lifespan. She is currently involved in psychotherapy and actively engaged in ER/P (such as purposefully wearing socks from separate laundry loads) and bibliotherapy. She is currently taking SSRIs and frequently attends support group where she feels “less alone, supported, and cared about.” She endorsed successful coping mechanisms of “prayer,” “continuing for the sake of the family,” and “thinking in a CBT mind-frame.”

P1 also poignantly described the stigma she feels of living with OCD by expressing a hope that more non-sufferers would discontinue believing that sufferers are “just doing this,” or “trying to purposefully annoy others,” and that they should somehow suddenly “snap out of it.” P1 also expressed frustration that non-sufferers appear to take “their freedom of mind” for granted. In her words: “It's [crying] a lonely life because you do want to hide it because you don't want people to think you're crazy or something, and there's a real flippant attitude towards OCD these days.”
Participant Two

Participant Two (P2,) a female in her early thirties, reported an adulthood onset of the disorder (Y-BOCS=15). She endorsed symptomatology of mostly compulsions with some obsessions and the phenomenology of her symptoms included pervasive fears that she would burn down her apartment building and that both analog and digital displays do not display the correct data. Her compulsions included setting multiple alarm clocks to wake in the morning, re-checking appliance settings, re-reading and tracing digital and analog displays with her finger, and re-reading passages in novels.

P2 is currently in psychotherapy and actively engaged in ER/P (such as leaving the stove on while leaving the house for thirty minutes.) She finds her psychologist especially effective: “I kind of think of him as the OCD detective. He did a very thorough search for different manifestations of OCD…” She also reported appreciation for her therapist’s ability to “think outside the box” in designing creative ER/P exercises. She engages in bibliotherapy, takes SSRIs, attends support group, and has insight into the chronic nature of her disorder.

Though she described initial resistance to attending support group due to fears of confidentiality issues, P2 reported that support group has helped her to reduce the “stigma involved in OCD” in learning that “OCD people are normal…not how they are portrayed in the media” and that this has been especially helpful in desensitizing her to sharing her experience with her family and loved ones. Furthermore, she finds that support group has helped her become “more compassionate and accepting,” “less upset and anxious,” and that it provides her with “other points of reference.” In her words: “And so it [support group] really helped me a lot in my personal life being able to talk to people I really care
about and telling them without - probably in a more coherent way and also without being as anxious or scared of what they might think because I’ve already done it a bunch of times. So that was helpful.”

*Participant Three*

Participant Three (P3,) a male in his early thirties described a childhood onset of the disorder (Y-BOCS=10). The phenomenology of his symptoms includes purely obsessions and no compulsive thoughts and/or behaviors. He endorsed suffering from “violent, horrific and intrusive images” that are oftentimes impulsive in nature. P3 reported that from the moment he wakes his “mind is racing” and he is immediately “worrying about everything.” Furthermore, he stated a pervasive fear that he may act on these impulsive obsessions.

P3 reported that viewing “scary thrasher, sci-fi, serial-killer, and horror” movies trigger his obsessions because the main characters in these movies often “do not have control over their thoughts and actions or minds.” P3 also reported that though he is not currently engaged in psychotherapy, he does engage in ER/P exercises such as purposefully “renting horror flicks,” and is currently taking SSRIs.

P3 described support group as “the best thing I’ve done” as through his involvement he has discovered that he “wasn’t alone” in his disorder and has learned to “catch obsessions early and nip them in the bud in the beginning.” Furthermore, he learned that the “last thing you do when you have OCD is stop coming to group, because it [OCD] will be back.” In his words: “And the biggest difference period, like I said was over three years ago when I finally decided to go with the meds and go to the support group, and do the ERP. Doing all those three things together was like, I can’t even
compare it to like how it used to be before… I can do things without having to mold my life around the OCD.”

**Participant Four**

Participant Four (P4,) a male in his mid-twenties, reported an early adulthood onset of the disorder (Y-BOCS=17). He reports symptom phenomenology of purely obsessions, intrusive thoughts, and violent and sexual images towards others, especially towards loved ones. He also endorsed feelings of excessive doubt, fears of being gay, and fears of being a pedophile. In his words: “There’s so much shame around the symptoms and me, the fears, like the pedophile fear, the aggressive fears…I just felt like the lowest rung on the ladder.”

P4 displayed strong personal insight into the fact that his OCD “attaches itself” to loved ones and inter-personal relationships. In great distress he proclaimed “the more important the person, the more distressful the thoughts” which he finds to be the “hardest thing” of living with the disorder. He reported “the end of relationships” as a particularly powerful trigger for these obsessions and displayed insight into the chronic nature of the disorder. Though he is not currently involved in psychotherapy he does take SSRIs, attends group, and is engaged in bibliotherapy.

P4 expressed having undergone ER/P “quite successfully” in the past especially to treat his “fear of being a pedophile.” His therapy involved going out into the community and purposefully spending time in areas where children congregate. Furthermore, he credits his involvement in support group as helping him “to tell my family” and learning the “effectiveness of medication” while also reporting that attending group “holds you accountable.”
Overall, P4 reported that attending support group is “the best thing I’ve done” as it “reminds you that you have it [OCD]” and allows him to feel “welcomed, understood, and accepted.” He endorses prayer as an effective coping mechanism and credits attending group with teaching him to be “more creative” in engaging in ER/P. Furthermore, he stresses the importance of remaining vigilant of new obsessions and/or compulsions so that he may “hit it early” and that this helps to make his disorder “more manageable.”

**Participant Five**

Participant Five (P5,) a male in his mid-twenties, reported an adolescent onset of the disorder (Y-BOCS=20). He endorsed symptomatology of both obsessions and compulsions that are primarily safety-related such as the pervasive fear of being personally responsible for harming others, especially those he loves. These obsessions and compulsions involve his vehicle, home, and workplace. In his words: “When you go do something, you go check something, you're not really even satisfied afterwards. Sometimes it's even worse!”

P5 also reported difficulty sleeping and that many of his obsessions and compulsions revolve around fears of falling asleep. Even though he may spend many hours checking over his vehicle, he realizes that his obsessions and compulsions are irrational. Though P6 is not currently engaged in psychotherapy, he does believe in the efficacy of ER/P, attends group, takes SSRIs, and is involved in bibliotherapy.

P5 spoke highly of his involvement in support group as it is “nice to talk to other people that have it [OCD]” and reported that through this experience he “gains perspective” on the severity of his own OCD. Also, he reported that he gains “free”
access to specialized clinical psychologists, and he credits group with helping him to
better identify obsessions and compulsions as they manifest in his daily life.
Furthermore, he reported an initial unfounded concern of attending group as it may cause
him to “pick up new obsessions and compulsions.”

He reported coping mechanisms of “making things different” in his environment
so as not to become “stuck in that rut” and immediately “starting exposures” as soon as
he noticed a “new obsession.” P5 also expressed widespread embarrassment over his
compulsive behaviors in stating that non-sufferers often “get mad” at him for his
compulsions and assume that he “believes” in his obsessions and compulsions. However,
he poignantly expressed that sufferers “hate” OCD and realize that their obsessions and
compulsions “don’t make sense.”

Participant Six

Participant six (P6,) a female in her late twenties reported a late-adolescence onset
of the disorder (Y-BOCS=13). The phenomenology of her symptoms included mainly
“obsessions about relationships” and work-related concerns about best “meeting the
needs” of those she serves. Her compulsions included “mentally-checking” things over
repeatedly in her mind and “analyzing to death” prior actions. She also described
scrupulosity obsessions regarding uncertainty of whether or not she should “be a
minister.” P6 reports insight into the chronic nature of the disorder and realizes that
obsessions will continually come up in “a little different twist.”

Though P6 is not currently involved in psychotherapy, she has received extensive
ER/P from a specialized anxiety clinic. She described her treatment as extremely helpful
as her psychologist utilized a “systemic” approach in identifying various manifestations
of OCD in her life. Furthermore, her psychologist utilized “loop tapes and scripts” as well as “imaginal exposures” to aid her in combating obsessions and compulsions. She is currently engaged in bibliotherapy, attends support group, and takes SSRIs.

P6 reported a strong favorable response to support group in that it helped her to “learn the effectiveness” of ER/P while also holding her accountable to “carry out” exposures between groups. She also reported that attending group has helped her to become “more open” about her diagnosis with others while also helping to guard against relapse. Furthermore, she reported the following helpful coping mechanism: “So what's helpful to me is kind of doing this certain method like asking friends what kind of thoughts they might have in certain situations to try and gauge what would be normal.”

Participant Seven

Participant Seven (P7,) a male in his mid-sixties reported a late-adulthood onset of the disorder (YBOCS=19). The phenomenology of his symptoms included mostly obsessions pertaining to a relationship many years prior. He endorsed some “mental compulsions” in the form of repeatedly “going over” and “revisiting in my mind” conversations and past experiences with the prior relational figure. In his words: “When, when it first came on, I couldn’t function at all. It was constant. It was all day long and it never let up. I just wanted to die.”

He expressed insight into the irrationality of his obsessions and actively engages in ER/P such as resisting obsessions and utilizing imaginal exposures in which he revisits moments in the past. He poignantly stated: “I’ve got to have a problem…something to make me miserable.”
P7 is currently engaged in psychotherapy including ER/P, attends support group, and takes SSRIs. He reported that attending group has been especially helpful in learning to identify how obsessions and compulsions manifest in his daily life. He also stated that group has helped him to put into perspective the severity of his symptoms as compared to other members.

P7 reported an especially effective coping mechanism of keeping a “constantly changing list” of prior successful distraction techniques that have helped to provide relief from his symptoms. Entries in this book include reciting the alphabet backwards, working on Sudoku puzzles, and listening to talk-radio shows. Furthermore, he reported that after starting therapy, the few “moments of calm” he experienced helped him to realize that there “might be a way out of this.”

Participant Eight

Participant Eight (P8,) a female in her mid-forties, reported an adolescent onset of the disorder (Y-BOCS=26.) The phenomenology of her symptoms include both obsessions and compulsions and she describes herself as “OCPD [obsessive compulsive personality disorder] and detail-oriented.” In her words: “Outward I seem to be doing okay. I do whatever I’m supposed to be doing, but internally I have a lot of obsession and anxiety, and emotional trauma. People don’t even know.”

She reported pervasive obsessive and compulsive thoughts and behaviors related to her physical appearance and health, as well as the appearance of her vehicle. These obsessions and compulsions have been strong enough to compel her to relocate across the country in order to relieve distress.
P8 displays insight into her suffering in stating that an “OCD brain in different” and though she is not currently engaged in psychotherapy or taking SSRIs, she does attend support group and is involved in bibliotherapy. She reported that though she is “not yet able” to engage in ER/P, as it is “too distressing,” she is “open” to it in the future. Furthermore, P8 reported that she learned about the effectiveness of ER/P through attending support group while also gaining perspective on the severity of her own symptoms, stating: “At least I can work!”

*Emergent Themes*

Six broad themes emerged collectively from the coded data and are displayed below in Table 1. Table 2 displays the frequency counts of the codes associated with each theme (that occurred amongst four or more participants.)

**Table 1**

*Emergent Themes*

<table>
<thead>
<tr>
<th>Experience with Treatment</th>
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<tbody>
<tr>
<td>Interpersonal</td>
</tr>
<tr>
<td>Phenomenology of Symptoms</td>
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<tr>
<td>Coping and Resiliency</td>
</tr>
<tr>
<td>Comorbidity</td>
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<tr>
<td>Support Group Attendance</td>
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</table>


### Table 2
*Emergent Themes, Codes, and Frequency Counts amongst Participants*

<table>
<thead>
<tr>
<th>Experience with Treatment</th>
<th>Interpersonal</th>
<th>Phenomenology of Symptoms</th>
<th>Coping and Resiliency</th>
<th>Comorbidity</th>
<th>Support Group Attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently Involved in Psychotherapy (4)</td>
<td>Reported a Family Member that Displays OCD-Related Behaviors (7)</td>
<td>Able to Identify OCD-Related Thoughts as Unwanted and External (6)</td>
<td>Reported Learning Effective Coping Mechanisms (7)</td>
<td>Reported also Suffering from an Anxiety Disorder (6)</td>
<td>Attends Support Group (8)</td>
</tr>
<tr>
<td>Engaged in Bibliotherapy (7)</td>
<td>Openly Shares Diagnosis with Loved Ones (7)</td>
<td>Displays Insight into Irrationality of Intrusive Thoughts and/or Behaviors (5)</td>
<td>Reported also Suffering from Symptoms of Depression (5)</td>
<td>Learned Effective Intervention to Lessen Symptomatology (6)</td>
<td></td>
</tr>
<tr>
<td>Currently taking SSRIs (7)</td>
<td>Directly Mentioned Chronic Nature of the Disorder (4)</td>
<td></td>
<td>Reported Finding a Community of Understanding Sufferers (6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reported being Misdiagnosed by a Mental Health Counselor (5)</td>
<td>Displays Insight into the Waxing and Waning Nature of the Disorder (8)</td>
<td></td>
<td>Aided in Learning to Identify Symptoms (4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Described Insight into Relationship between Stress and Symptom Severity (8)</td>
<td></td>
<td>Gained Personal Insight by Listening to Others (5)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Experience with Treatment

All participants were currently involved in a support group (that utilizes an ER/P model,) four were engaged in individual psychotherapy including ER/P, seven were involved in bibliotherapy, and all but one were currently taking SSRIs. Table 3 displays examples of meaning units and their corresponding codes that emerged from the data.

Five participants reported encountering mental health professionals who either completely missed or missed-diagnosed their disorder. In the words of a participant: “I went to counseling and they just diagnosed it as just an anxiety disorder. There wasn’t that, that much available for OCD, so they didn’t even say anything about that…And the techniques they were using to try and help me were actually, like today’s standards would actually make it worse. It would be the complete opposite that they would ask you to do.”

Table 3
Theme: Experience with Treatment

<table>
<thead>
<tr>
<th>Meaning Unit</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>“He’s been very creative with different types of exposure or ideas”</td>
<td>Currently involved in Psychotherapy</td>
</tr>
<tr>
<td>“everything we did lined up with all the reading that I was doing.”</td>
<td>Engaged in Bibliotherapy</td>
</tr>
<tr>
<td>“I take Zoloft.”</td>
<td>Currently Taking SSRIs</td>
</tr>
<tr>
<td>“And counselor upon counselor upon counselor I would go to and they had no idea that I had OCD.”</td>
<td>Reported Being Misdiagnosed by a Mental Health Counselor</td>
</tr>
</tbody>
</table>

Interpersonal

Seven of the eight participants reported having at least one family member that endorsed obsessive or compulsive symptomatology which lends even greater qualitative support for a genetic component to this disorder. Seven of the eight participants openly shared their diagnosis with family members and loved ones and three of the participants’
symptomatology directly affected their loved ones. In the words of one participant: “The more important the person was to me the more distressful the thoughts were.” Another participant described difficulty establishing relationships with others: “I have no energy left for anything else…I cannot really get involved with people. It’s kind of too much.” Table 4 displays examples of meaning units and their corresponding codes that emerged from the data.

**Table 4**

*Theme: Interpersonal*

<table>
<thead>
<tr>
<th>Meaning Unit</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>“my other son has OCD”</td>
<td>Reported a Family Member that Displays OCD-Related Behaviors</td>
</tr>
<tr>
<td>“I was never a person who tried to hide it.”</td>
<td>Openly Shares Diagnosis with Loved Ones</td>
</tr>
</tbody>
</table>

**Phenomenology of Symptoms**

Six participants were able to identify their intrusive thoughts as unwanted and external. In the words of one participant: “All the other OCD people I've talked to realize this, they know what they're doing doesn't make sense and they don't like doing it. They hate it.” Table 5 displays examples of meaning units and their corresponding codes that emerged from the data.

Five of the participants were able to realize the irrationality of their obsessions and/or compulsions. In the words of one participant: “But the thing with me - and I think this is typical of a lot of people with OCD is _____ I'll get over a fear, like I'll get over a huge milestone or something and then it'll attack from a different side and I won't realize that it's OCD.” In the words of another participant: “Living with OCD is like living with 'whack-a-mole’ because you get it going and you think, “Okay, this one stopped,” and then there's another.”
Four participants directly mentioned insight into the chronic nature of their disorder. In the words of one participant: “I’m like 110 percent better, and I don’t have this illusion that I’m cured. I’m always going to have OCD… I just deal with it better than I used to.”

Furthermore, all eight participants described symptomatology that waxes and wanes in severity over the lifespan and mentioned that stress increases their symptomatology. In the words of one participant: “OCD waxes and wanes. There are times when you really don’t do so bad; there are times when it gets much much worse, like after the birth of my children, as part of depression. Much much much worse.”

Table 5
Theme: Phenomenology of Symptoms

<table>
<thead>
<tr>
<th>Meaning Unit</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>“as soon as I - I'm able to identify it as OCD, then I can start to control triggers, compulsions, avoidances, everything and I can start to attack it.”</td>
<td>Able to Identify OCD-Related Thoughts as Unwanted and External</td>
</tr>
<tr>
<td>“on a deep down level, you know what you're doing makes absolutely no sense and it's crazy. Your normal mind knows that.”</td>
<td>Displays Insight into Irrationality of Intrusive Thoughts and/or Behaviors</td>
</tr>
<tr>
<td>“I’m not under the illusion I will be cured.”</td>
<td>Directly Mentioned Chronic Nature of the Disorder</td>
</tr>
<tr>
<td>“There are times when you really don’t do so bad; there are times when it gets much much worse.”</td>
<td>Displays Insight into the Waxing and Waning Nature of the Disorder</td>
</tr>
<tr>
<td>“if I’m stressed over something that it might increase the OCD more”</td>
<td>Described Insight into Relationship between Stress and Symptom Severity</td>
</tr>
</tbody>
</table>

Coping and Resiliency

Seven participants reported learning effective coping techniques as their disorder progressed in order to cope with their symptomatology. Three participants reported actively engaging in relapse prevention techniques as poignantly expressed by one
participant: “When I notice any little issues come up, I try and nip them at the bud in the beginning.” Table 6 displays examples of meaning units and their corresponding codes that emerged from the data.

Three participants reported accepting the fact that their illness will always be present as an effective coping mechanism in of itself. One participant describes: “And only about the last four years have I come to accept the fact that I'm not going to get rid of it any more than someone with heart disease or diabetes. It's a manageable but a chronic condition.” Furthermore, another participant states: “It's always going to be there…and so having the tools, having the experience, having the support is what makes the difference.”

A participant who received extensive treatment at a specialized anxiety disorder clinic had the following to say: “I will always have OCD and…OCD's going to come up with new things, you know, and you take some things and hit me in a new way and I need to be able to know how to respond to it…as long as I'm doing the maintenance stuff, which for me is doing response prevention as soon as I can realize that I am doing compulsion.”

<table>
<thead>
<tr>
<th>Table 6</th>
<th>Theme: Coping and Resiliency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meaning Unit</td>
<td>Code</td>
</tr>
<tr>
<td>&quot;I purposely got it so I only have to work four days a week instead of three, I mean instead of five, just because I, my stress level, like it would highly reduce my stress level.”</td>
<td>Reported Learning Effective Coping Mechanisms</td>
</tr>
</tbody>
</table>

**Comorbidity**

Six participants indicated suffering from an anxiety disorder in addition to the symptomatology of their OCD while five participants reported suffering from depression.
In the words of one participant: “The OCD brings on the depression, but its way worse than depression.” Furthermore, three described suffering from either insomnia or major difficulty falling asleep at night. Table 7 displays examples of meaning units and their corresponding codes that emerged from the data.

**Table 7**

<table>
<thead>
<tr>
<th>Theme: Comorbidity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Meaning Unit</strong></td>
</tr>
<tr>
<td>“Well I also have about a ten year history of anxiety.”</td>
</tr>
<tr>
<td>“more of my life has been a depression focus than an OCD, really.”</td>
</tr>
</tbody>
</table>

**Support Group Attendance**

As all participants reported currently attending a support group at the time of their interview, this dissertation has yielded intensive insight into their individual and collective experiences. All indicated that support group had been helpful in learning to live with their disorder while six participants credited attending group to gaining insight into effective coping mechanisms and learning that they are not alone in their suffering. In the words of one participant: “You meet real people who go to work and wear normal clothes and talk.” In the words of another participant: “Support group is the best thing I’ve done, to be honest.” Yet another participant considers support group “a little family.” Furthermore, two participants reported that attending support group has helped them to share their diagnosis with their loved ones. Table 8 displays examples of meaning units and their corresponding codes that emerged from the data.

One participant described watching new people come to group: “The first time they go in there they're anxious as hell, they hate it, they don't talk. A lot of people don't even say what their fears are, they just say, "I have OCD and I'm here.” But within a few
moments, every single one of them is different person, like it's a world of difference, like seeing people for the first time after a few group sessions, 'cause it's like they finally feel welcomed and understood and accepted.” Table 8 displays examples of meaning units and their corresponding code.

Five participants reported gaining positive insight and perspective on the severity of their own disorder by listening to others. In the words of one participant: “It's good just to sit back and hear other people and kind of gain some perspective on your own OCD because, you know, I'm so trapped in these obsessive thoughts that I think that that is the most important thing in the world.” Another participant describes the perspective he gained from a fellow support group member: “He’s got terrible problems, and way worse than me, and yet he goes around and helps other people.”

Four participants indicated that support group had been helpful in learning to identify obsessions and compulsions and gain insight into how they are manifested within their everyday lives. Three participants credited support group with helping them to learn the efficacy of ER/P and SSRIs in treating their OCD. In the words of one participant: “But when I went to the group, people are talking about how helpful the exposure therapy was and stuff. So I thought well is this something I really can manage and I can have a normal life, and I can, I don’t need to worry about things anymore.”

Table 8

<table>
<thead>
<tr>
<th>Theme: Support Group Attendance</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meaning Unit</td>
<td>Code</td>
</tr>
<tr>
<td>“Then I chose to go to the support group, and the support group helped tremendously.”</td>
<td>Regularly Attends Support Group</td>
</tr>
<tr>
<td>“But after treatment in this group I now have the tools to make it work right.”</td>
<td>Learned Effective Interventions to Lessen Symptomatology</td>
</tr>
<tr>
<td>“You're not the crazy person. You're just one of everyone else so it is kind of nice.”</td>
<td>Reported Finding a Community of Understanding Sufferers</td>
</tr>
</tbody>
</table>
“Oh I’ve started this new behavior and that probably because I’m - I have OCD.”

“Aided in Learning to Identify Symptoms”

“It's good just to sit back and hear other people and kind of gain some perspective on your own OCD because, you know, I'm so trapped in these obsessive thoughts that I think that that is the most important thing in the world.”

“Gained Personal Insight by Listening to Others”

Collective Structural Statement of Overall Experience

Though severity of symptomatology varied amongst the participants, an overwhelming and pervasive sense of doubt, mistrust, and lack of control over one’s own thoughts, feelings, and/or behaviors permeated the interviews. In addition, participants described feeling personal shame and stigma from living with the disorder. One participant likened the process of rumination to consistently and constantly being “assaulted” by intrusive thoughts and images and more than one participant described a feeling of “going crazy.”

Another participant describes the phenomenology of his obsessions in the following manner: “I cannot stop thinking about it…it goes on and on and on and on…it’s always in the back of my mind.” Yet another participant stated: “Whenever my OCD is attached to something logic goes out the window.” To add to these individuals’ levels of distress, the obsessive and compulsive thoughts often focused on family members and loved ones.

Of those who endorsed compulsions, a pervasive feeling of being unable to control one’s own thoughts, even after engaging in a compulsion, emerged. One participant explained in great frustration that sometimes obsessions become “worse” after engaging in a compulsive behavior. Another participant described a sense of “dread”
upon coming home to his family after work as he worries: “What am I going to have to do tonight?”

There appeared to be a decrease in severity of symptoms as participants became more aware of their disorder and thus better able to extend their locus of control from themselves to that of the disorder, i.e., ‘it’s my OCD, not me.’ Furthermore, all reported to have responded favorably to at least some form of treatment. In the words of one participant: “Once I can identify that it's OCD the world changes… The doubt is real… and I can start to attack it.”

Paradoxically and despite their suffering, all were employed, many had families, and most described excelling both in their schooling and their chosen career field(s). All sufferers described an ability to conceal their disorder from others, hence increasing their feelings of isolation. Furthermore, all displayed coping skills adapted specifically to their personalities and symptomatology and all showed great interest in contributing to this study.

Support group participation clearly benefited all participants in providing a safe and accepting environment in which to share their experiences, learn the experiences of others, and gain perspective on their disorder. Furthermore, support group helped them to form community, learn about current ‘best treatment’ standards, and receive psycho-education and short-term ER/P interventions from mental health professionals directly tailored to their individual symptoms. Finally, support group participation helped participants in learning to share their diagnosis and experience with loved ones.
CHAPTER FOUR

Discussion

Drawing upon the phenomenological experience of a group of four men and four women living with OCD and divergent in age, background, and race; this study offers significant clinical implications. Though participants did not directly express PEs, all participants displayed individual coping mechanisms tailored to their specific symptomatology while also reporting that attending support group has offered them enhanced methods of dealing with their disorder.

This study lends credence to Frederickson’s (1998, 2001, 2004) BNB model of positive emotions in that attending support group gave rise to greater positive emotionality in terms of acceptance, outlook, coping, resilience, and the accrual of a greater social support system. Surprisingly, attending support group in of itself has been shown to possibly trigger upward spirals while at the same time providing empirically-proven ER/P intervention training so that those living with the disorder may develop even greater tools to decrease the severity of their symptoms. This study offers an alternative view of the healing effects of positive emotions in that attending support group may help sufferers in increasing their resilience while also raising them to higher levels of emotional well being.

As defined by the DSM-IV-TR, all participants in this study displayed recurrent, unwanted, and intrusive thoughts and/or behaviors and most had insight into the irrationality of their symptoms (DSM-IV-TR, 2000). Also, many described difficulty reaching accurate diagnosis from mental health professionals, and all expressed a waxing and waning course of their chronic and disabling disorder.
In agreement with prior research, the vast majority of participants displayed a childhood onset of the disorder, comorbidities, and all indicated the need to conceal their thoughts and/or behaviors from others. Also, pervasive relationship difficulties and social isolation tendencies were both reported and observed. However, in disagreement with prior findings addressing familial epidemiology, seven of the eight participants in this study reported family members that displayed symptoms, a much higher rate than reported in other studies.

This study has allowed the researcher an intimate view into the nature of human resilience and how it arises from mental anguish. The fact that all participants were involved in a support group at the time of their interviews has granted an even more explicit view of this particular aspect of their individual and collective treatment experiences. Furthermore, this study supports prior qualitative research attesting to the cost-effectiveness and treatment gains provided in a therapeutic group setting.

Limitations

Though extensive measures were implemented to keep personal research biases to a minimum, some level of error amongst the data and its interpretation is inevitable. For example, even though this study uses the exact words of the participants wherever possible, no empirically-validated quantitative measures other than the Y-BOCS were employed. Also, the experiences as related by the participants were not verified by detailed medical and/or mental health histories, leaving self-reported comorbidities, diagnostics, and familial prevalence rates open to further question and/or criticism.

Participants also had the benefit of living in a metropolitan city with a well-established support group designed specifically for those living with OCD as an available
free resource. Also, due to the fact that participants were involved in a support group at the time of their interviews, the applicability of these results are limited and skewed towards those who have undergone positive support group experiences. Furthermore, all participants had been diagnosed by a mental health professional, all were motivated for change, and all were actively seeking treatment.

Finally, the generalizability of these results were certainly limited due the fact that all participants interviewed were involved in the same monthly support group. If this study had included a larger and more diverse pool of participants attending varying groups, results may have varied drastically. As on-going members of the same group, the participants were most likely biased towards positive evaluation of their group process. Furthermore, group members who had attended the group fewer times may have reported different experiences.

This study allows clinicians a first-hand glimpse into the lived experience of OCD while also offering compelling evidence for referring their clients to attend a support group and/or starting a support group themselves. However, additional studies are called for in order to determine whether support group attendance should be added to the ‘standard of care’ treatment practices of pharmacotherapy and SSRIs.

Also, very few support groups designed specifically for OCD exist outside of large metropolitan areas, and the need exists for the creation, development, and advertising of additional groups. Furthermore, research into the efficacy of online support groups for OCD is called for, especially for those living in rural and/or underdeveloped regions. In conclusion, further studies are needed to determine empirically-
supported support group models as well as qualitative and quantitative studies into their
efficacy.

**Recommendations and Areas for Future Research**

The most effective methods for educating the public while also reducing community stigma surrounding the disorder include utilizing media and/or professional organizations to disseminate basic psycho-educational materials as well as current professional ‘standard of care’ treatment practices. Furthermore, secondary care providers such as cosmetic surgeons, dentists, and dermatologists should also be directly targeted by campaigns to increase OCD awareness (Millar & Tallis, 1999). More widespread knowledge of the disorder will undoubtedly lead to greater treatment diagnostics and opportunities for sufferers.

Family members of sufferers must also be educated on the benefits of psychopharmacology and behavioral therapies, as well as the importance of not providing reassurance or engaging in ritualistic compulsions with their loved ones. Mental health professionals should take active roles in educating all the aforementioned groups.

On a more general overview, a dearth of data currently exists on the relationship between culture, ethnicity, and OCD. Positive psychology and phenomenological perspectives on the disorder are also lacking. Furthermore, stronger diagnostic and assessment tools are needed in order to aid clinicians in diagnosing and better treating the disorder. In conclusion, initial genetic studies identifying endophenotype markers specific to the disorder look promising and should continue to be explored.
Conclusions

This study clearly lends insight into the personal experience of those living with OCD and adds credibility to the ranking of this disorder amongst the World Health Organization’s (1999) ten most disabling illnesses in terms of loss of quality of life and personal income. However, all of these participants were actively seeking treatment of some kind at the time of the study leaving us to ponder the lived experience of those who do not have access/affordability to treatment and/or have been misdiagnosed?

Overall, there is a clear lack of clinicians trained in ER/P interventions aimed at treating OCD. Also, clinicians who are trained in these techniques are challenged by this study to become more systemic in their diagnostic inventories of how OCD manifests in their clients while also becoming more creative in developing ER/P interventions and bibliotherapy recommendations tailored to the needs of their clients.

In conclusion, this study lends qualitative support to previous quantitative studies outlining the beneficial and efficacious effects of support group treatment for OCD. However, greater research is called for in order to empirically-confirm these findings and develop a treatment modality that may be reproduced across the country. Also, the need for greater awareness of OCD and its treatment exists in both community and professional realms.
References


Appendix A

Yale-Brown Obsessive Compulsive Scale (Y-BOCS)
### Appendix A

Yale-Brown Obsessive Compulsive Scale (Y-BOCS)

#### Obsessive Rating Scale

<table>
<thead>
<tr>
<th>Item</th>
<th>- Item -</th>
<th>- Range of Severity -</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time Spent on Obsessions</td>
<td>0 hrs/day</td>
<td>0-1 hrs/day</td>
</tr>
<tr>
<td>Score</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Interference from Obsessions</td>
<td>None</td>
<td>Mild</td>
</tr>
<tr>
<td>Score</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Distress from Obsessions</td>
<td>None</td>
<td>Little</td>
</tr>
<tr>
<td>Score</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Resistance to Obsessions</td>
<td>Always</td>
<td>Much</td>
</tr>
<tr>
<td>Score</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Control Over Obsessions</td>
<td>Complete</td>
<td>Much</td>
</tr>
<tr>
<td>Score</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

#### Compulsion Rating Scale

<table>
<thead>
<tr>
<th>Item</th>
<th>- Item -</th>
<th>- Range of Severity -</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time Spent on Compulsions</td>
<td>0 hrs/day</td>
<td>0-1 hrs/day</td>
</tr>
<tr>
<td>Score</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Interference from Compulsions</td>
<td>None</td>
<td>Mild</td>
</tr>
<tr>
<td>Score</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Distress when Resisting Compulsions</td>
<td>None</td>
<td>Little</td>
</tr>
<tr>
<td>Score</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Resistance to Compulsions</td>
<td>Always</td>
<td>Much</td>
</tr>
<tr>
<td>Score</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Control Over Compulsions</td>
<td>Complete</td>
<td>Much</td>
</tr>
<tr>
<td>Score</td>
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</tr>
<tr>
<td>Compulsions</td>
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<td>Control</td>
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<tr>
<td>Control</td>
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<td></td>
</tr>
<tr>
<td>Control</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

Scores

- 0-7 Subclinical
- 8-15 Mild
- 16-23 Moderate
- 24-31 Severe
- 32-40 Extreme
Appendix B

Semi-structured Interview Questions
Appendix B

Semi-structured Interview Questions

Demographic Information:

Full Name
Address
Phone
E-mail
Year of Birth
Sex
Ethnicity

Initial Question:

1. As completely as you are comfortable with please describe your daily life.

Probes/Follow up Questions:

2. What is your experience of treatment?
3. How do you cope with the symptoms?
Appendix C

Antioch University Seattle Application for Approval to Use Human Subjects/Participants
Appendix D

Antioch University Seattle Application for Approval to Use Human
Subjects/Participants

This application should be submitted, along with the Informed Consent Document, to
the Chair of the Human Participants’ Protection Committee.

Name of Researcher: Richard R. Thomas, Jr., MA

Phone Number: *******  Email Address: *******

Department: AUS Center for Psychology Psy.D. Program

Advisor (if researcher is a student): Dissertation Chair: Melissa Kennedy, Ph.D.

Date Proposal Submitted: 08/05/2009 Date Proposal Approved: 8/18/2009

Title of Research Project: The Phenomenology of OCD from the Perspective of the
Adult Client

Funding Agency (if applicable): None

Project Purpose(s):

Research has explored the construct of positive psychology and its significant
contributions to the field, as well as the symptomatology of Obsessive-Compulsive
Disorder (OCD). However, no known studies specifically view the lived experience
of OCD through the lens of positive psychology. This dissertation seeks to remedy
this deficiency by providing participants a phenomenological emergent design to
discuss the adaptive aspects of their OCD treatment.

Specifically, this dissertation intends to identify the existence and/or prevalence
of participant-specific resiliency factors, while also educating clinicians and theorists
on the lived experience of the disorder. Ultimately, this study will expand the
research base on the phenomenology of OCD and help clinicians to bridge the
tremendous treatment gap for this disorder.

Describe the proposed participants: (age, sex, race, or other special characteristics,
such as students in a specific class, etc.)

Six to ten individuals, 18 years of age or older who are currently suffering from
OCD and are receiving psychiatric and/or psychological treatment will form a purposeful
sample. Participants will be accepted in order of referral without regard to age, gender,
race, ethnicity, religion, sexual orientation, disability, or marital status.
Individuals who answer the call for participation will be contacted via phone to establish their age and whether or not they have been diagnosed with OCD in the past and are currently in psychiatric and/or psychological treatment. If they meet these two inclusion criteria, a fifteen minute telephone screening will follow. During the screening, participants will be administered the Y-BOCS (Appendix A) to assess symptom severity. This measure is not meant to serve as a mixed-methods design, but rather to act as a screening tool. The individual must meet Y-BOCS criteria of mild OCD or greater to be included in the study.

If the participant does meet these inclusion criteria, a 90 minute in-person appointment will be scheduled at the conclusion of the screening. At the time of the interview, participants will sign and receive a copy of an informed consent form and a semi-structured interview schedule (Appendix B) will be followed. General requests for clarification such as “tell me more” will be used. However, no formal follow-up questions will be used other than those in the semi-structured interview schedule in an attempt to avoid leading the participant and to maintain integrity of his or her experience. The interview will be audio-recorded for purposes of verbatim transcription and data analyses. At the completion of the data analysis phase, the researcher will contact each participant to arrange a 30 minute telephone interview to share findings and double check content for accuracy. At this time, participants may request a copy of the completed study.

Describe how the participants are to be selected:

The participants are to be selected by means of a purposeful sample. Recruiting methods will include professional networking, flyers at local community mental health clinics, ads in the newspaper, and/or making contact with community support groups. Participants will be accepted in order of referral without regard to age, gender, race, ethnicity, religion, sexual orientation, disability, or marital status. In recognition and appreciation of their participation, regardless of whether or not they complete the interview process, respondents will be offered a $25.00 gift–certificate to a local mall.

Describe the proposed procedures in the project. Any proposed experimental activities that are included in evaluation, research, development, demonstration, instruction, study, treatments, debriefing, questionnaires, and similar projects must be described here. Copies of questionnaires, survey instruments, or tests should be attached (use additional pages if necessary).

The only assessment measure that will be administered is the Y-BOCS during the telephone screening. The Y-BOCS is considered the ‘gold standard’ of OCD symptom severity assessment.

Will questionnaires, tests, or related research instruments not explained above be used?
Yes ___ No ___X ___ If yes, attach a copy to this application.

Will electrical or mechanical devices (biofeedback, electroencephalogram, etc.) be used?

Yes ___ No ___X ___ If yes, attach a detailed description of the device(s) and their use(s).

Will audio-visual devices be used?

Yes ___X ___ No ___ If yes, attach a detailed description of the device(s) and their use(s).

A Panasonic digital audio recording device will be used for transcription purposes.

Current Risk (Acknowledge and describe any psychological, social, legal, economic or physical discomfort, stress or harm that might occur to research participants. How will it be held to an absolute minimum?):

As the interview will allow participants to discuss symptomatology of a psychiatric disorder, there is a possibility of psychological risk to the individual in the form of evoked anxiety and/or distress. This will be held to an absolute minimum by utilizing an open-ended interview schedule (Appendix B) and by allowing participants to control their own level of content and disclosure. Also, Dr. Melissa Kennedy, licensed psychologist, has offered one hour of psychotherapy to the participants at no cost, if desired. The researcher will inform each participant of this as well as his or her right to withdraw participation at anytime without the fear of reprimand or reproach.

Future Risk (How are all research participants protected from potentially harmful future use of the data collected in this project? Specify whether participation will be anonymous or confidential; and specify measures to ensure anonymity or confidentiality. If audio or video tapes are used, state specifically who will see them and the date they will be destroyed. All data must be maintained in a secured situation for at least one year after analysis and longer if the report is publicized?):

All information will be held strictly confidential under HIPAA guidelines for protected healthcare information. Participants will be asked to sign an informed consent form and receive a copy. Interviews will be audio-taped for accuracy and transcription purposes. Five years after completion of the study all research data will be removed from the safe and destroyed.
How do the benefits of the research outweigh the risks to human participants? This information should be outlined here.

A greater understanding of the lived experience of OCD and the treatment process will be of great help to clinicians and theorists alike. The treatment gap for this disorder is tremendous and there is a dearth of research on the combination of psychopathology and positive psychology themes such as what is working in treatment. Discussion may also facilitate participant recognition of the benefits of positive emotions and adaptive aspects of OCD.

Are there any possible emergencies that might arise in utilization of human participants in this project?

Yes __ No ____ X

What provisions will you take for keeping research data private?

Research data will be protected according to HIPPA regulations such as the use of a double lock system and the sanitation of identifying information from the final report. Audio tapes will be destroyed in concordance with AUS policy.

Attach a copy of the informed consent document as it will be used.

STATEMENT OF AGREEMENT: I have acquainted myself with the policies and procedures regarding the use of human participants in research and related activities and will conduct this project in accordance with those requirements. Any changes in procedures will be cleared through the Committee.

Signature of Principal Investigator(s) ________________________________  Date 8/04/09

For Research Conducted by Students: This research involving human participants, if approved, will be under my supervision. I have read and approved this proposal.

Faculty Advisor: ________ Melissa Kennedy, Ph.D.__________

Advisor Signature _____________________________Date: _______ 8/04/09_______

PLEASE SUBMIT AN ELECTRONIC COPY OF THIS INFORMATION TO: HSRC@antiochseattle.edu. Please also submit one hard copy to the Academic Dean’s office.

By completing and submitting this form I certify that:
• The information provided in this application form is correct.

• I will notify my Advisor/Committee Chairperson and the Chairperson of the Review Committee in the event of any substantive modification in the proposal, including, but not limited to changes in cooperating investigators and agencies, as well as changes in procedures.

• Unexpected or otherwise significant adverse events in the course of this study will be promptly reported.

• Any significant new findings which develop during the course of this study which may affect the risks and benefits to participation will be reported in writing to my advisor/Committee Chairperson, the Chairperson of the Review Committee, and to the participants.

• The research may not and will not be initiated until final written approval is granted.

• This research, once approved, is subject to continuing review and approval by the Advisor/Committee Chair and Chairperson of the Review Committee. The Principal Investigator will maintain complete and accurate records of this research.

If these conditions are not met, approval of this research could be suspended.

Richard R. Thomas, Jr., MA

Name of Principal Investigator:  Student ID #

08/04/2009

Email Address

Date

As Advisor/Committee Chair, I assume responsibility for ensuring that the student complies with University and federal regulations regarding the use of human participants in research. I acknowledge that this research is in keeping with the standards set by the University and assure that the Principal Investigator has met all the requirements for review and approval of this research.

Melissa Kennedy, Ph.D.

Name of Advisor/Committee Chair

08/04/2009

Date

Email Address
Antioch University Seattle Informed Consent Form

The Psy.D. Program supports the practice of protection for human participants in research and related activities. The following information is provided so that you can decide whether you wish to participate in the present study. You should be aware that even if you agree to participate, you are free to withdraw at any time, and that if you do withdraw from the study, you will not be subjected to reprimand or any other form of reproach.

The initial telephone screening will take approximately 15 minutes to establish symptomatology of OCD by means of a clinician-administered symptom severity assessment tool (Y-BOCS). A 90 minute in-person interview will be scheduled if the participant meets cut-off criteria of ‘mild’ OCD or greater.

During the 90 minute interview, the researcher will ask you open-ended questions about living with OCD. The interview will be recorded for transcription purposes. Your personal health care information will be held confidential and all identifying information will be removed during the research process. All audio-tapes will be destroyed upon completion of the study in concordance with AUS policy.

At the completion of the study, the researcher will contact you by phone to arrange a 30 minute telephone interview to share findings and double check content for accuracy. At this time you may request a copy of the completed study. After the final phone call, your gift card will be mailed to you.

There is a possibility that discussing the lived experience of your disorder may cause you distress. Every possible measure has been taken to keep this to a minimum, such as allowing you to control the content of the interview. However, if this session does cause you distress, you may contact Dr. Melissa Kennedy, licensed psychologist at ************ for a one hour psychotherapy session at no cost to you. You are free to withdraw at any time and in appreciation for your time, whether you complete the interview process or not, you will receive a $25 gift—certificate to a local mall. You may also request a copy of the completed study.

There is very little psychological research looking at the lived experience of OCD from the perspective of the sufferer. This study has the potential to help clinicians and theorists alike gain a greater understanding of the lived experience of OCD. Participating in this study may also help you better understand your own lived experience of OCD.
I have read the above statement and have been fully advised of the procedures to be used in this project. I have been given sufficient opportunity to ask any questions I had concerning the procedures and possible risks involved. I understand the potential risks involved, and I assume them voluntarily. I likewise understand that I can withdraw from the study at any time without being subjected to reproach. I may also ask for a summary of the results of this study. If I have questions I may contact the researcher, Richard Thomas, at ********** or his supervisor Dr. Melissa Kennedy, licensed psychologist, at **********.

Signature ___________________________________________ Date __________
Participant and/or Authorized Representative

Signature ___________________________________________ Date __________
Researcher
Consent to Audiotape

I, (print name) ___________________________, grant permission to Richard Thomas and to Antioch University Seattle the use of the audio recording for purposes of collecting data for the investigators’ research project. The tapes will be kept for 4 years in a locked safe and destroyed thereafter.

Signature ___________________________ Date __________
Participan and/or Authorized Representative

Signature ___________________________ Date __________
Researcher