

'Life just kind of sparkles': clients' experiences of being in cognitive behavioural group therapy and its impact on reducing shame in obsessive compulsive disorder

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Received 16 May 2014; Accepted 24 February 2015

Abstract. This study explored the personal accounts of service users relating to their experiences of being in group cognitive behavioural therapy (GCBT) for obsessive compulsive disorder (OCD). Eight participants were purposively selected from two groups whose therapy had finished. These participants were interviewed, the data transcribed verbatim and analysed using interpretative phenomenological analysis (IPA). Five superordinate themes were generated: 'Engagement in the group process', 'Normalizing', 'Courage to fight', 'Being my own therapist' and 'Restricted vs. engagement with life'. The findings in this study have implications for theory in terms of the relevance of shame-based appraisals in conceptualizations of OCD. Suggestions for future groups include the importance of exploring the development of the problem in the group setting and highlight an important role for the group in terms of increasing motivation and preventing dropout. Directions for future research and implications for theory are explored.

Key words: Group therapy, obsessive compulsive disorder, qualitative research

Introduction

Evidence for the effectiveness of group cognitive behavioural therapy (GCBT) for obsessive compulsive disorder (OCD) is on the increase. Results from outcome research measuring symptom reduction pre- and post-therapy (Anderson & Rees, 2007; Jaurietta *et al.* 2008) suggest that contemporary CBT for OCD can be beneficial for clients when carried out in a group setting. Cognitive models of OCD (Salkovskis, 1989, 1998; Salkovskis *et al.* 2000) argue that a specific appraisal concerning responsibility for harm distinguishes OCD from other anxiety-based difficulties. In all current cognitive behavioural conceptualizations, the emotional response in OCD has been associated with threat and danger (Clarke, 2005); the role of guilt in OCD has also been highlighted (Veale, 2007). However, the significance of shame defined as 'acute arousal of fear of being exposed, scrutinized and judged negatively by others' (Gilbert & Trower, 1990) has been less explored in the CBT literature.

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Results from outcome research have led to CBT becoming the treatment of choice for people with OCD (as recommended by NICE, 2005). However, the Department of Health (1996) has also encouraged researchers to use alternative methods to generate evidence about the effectiveness of psychological therapies. Research on clients' experience of therapy contributes to this debate particularly in relation to questions about change process (Clarke *et al.* 2004) which is important since therapists' and clients' views of helpful and hindering events in therapy are often very different (Cooper, 2008). In group therapy, process research focusing on non-specific variables highlighted by Yalom (1995) such as 'group cohesion' have been described as similar to the therapeutic relationship in individual therapy (Bieling *et al.* 2006) but have received less attention in CBT literature despite the recognition that these processes are important across theoretical orientations (Yalom & Leszcz, 2005; Bieling *et al.* 2006). A key component of therapy evaluation relates to clients' experience of the service and recent UK government initiatives argue that service-users' perspectives are integral in the formal evaluation of mental health services. The importance of service-user feedback has been advocated by Rose (2001, 2003) for promoting 'the voice' and empowering research participants, a central aim of the best practice guidelines (BPS, 2005).

What remains unclear from the outcome research is an understanding of the therapeutic process and how people experience being in a group with others who share a similar difficulty. The specific components of the group approach which make a difference to clients' experiences remains underdeveloped in CBT literature. This study aims to complement the current outcome research by exploring therapy process from the client's point of view.

Method

The intervention (GCBT)

The fundamental premise of the cognitive model is that intrusive thoughts are experienced by everyone although less frequently and intensely than people who develop OCD (Salkovskis, 1998). The main motivator for compulsive behaviours is not the content of the intrusive thoughts but the negative meaning attached, which is often linked with guilt as well as anxiety due to an exaggerated sense of personal responsibility (Salkovskis, 1998). Some authors have suggested that OCD is further maintained due to thoughts being viewed as excessively important both in terms of their mere presence and their persistence (Thordarson & Shafran, 2002) which may reflect something intrinsic about the person. Cognitive approaches outlined by Salkovskis (1998) and Salkovskis *et al.* (1999), emphasize both maintaining and developmental factors in the conceptualization of OCD and have highlighted some predisposing factors. These factors include overprotective or neglectful parenting, exposure to rigid or extreme codes of duty, faulty and actual appraisals of being responsible for harm as well as the experience of criticism and blame in childhood. The aim of therapy is to promote a less threatening account of the person's experience through the development of an individualized formulation and engagement with behavioural experiments.

The initial sessions involved the setting of group ground rules which included the importance of confidentiality to promote a sense of safety. Group members were encouraged to contribute equally and to gently challenge each other's attempts to seek reassurance. This behaviour has been identified as problematic for the maintenance of OCD so group members

were instructed to inform their families and or carers to refrain from providing reassurance at home (Bieling *et al.* 2006). The early sessions involved normalizing whereby the therapist educated the clients didactically in the first instance about the universality of intrusive thoughts but then relied predominantly on Socratic questioning throughout the group therapy to enable the clients to own their discovery. The development of individualized cognitive behavioural formulations was carried out within the group setting. This included a discussion about relevant early experiences and the identification of the meaning attached to intrusions. During the early sessions some experiments were carried out to reinforce the formulation and to demonstrate the counterproductive nature of strategies such as thought suppression. The concepts of Theory A: '*I am a danger to myself and others who could be responsible for causing or failing to prevent harm*' and Theory B: '*For understandable reasons I worry about being responsible for causing harm*' were individually tailored and subsequent experiments were negotiated with a view to reinforcing Theory B rather than disputing Theory A (Salkovskis, 1999). Cognitive challenges concerning the meaning attached to intrusions were also employed. These included the use of continuum work and hierarchies were developed to inform behavioural experiments and document progress (Veale & Wilson, 2005). Homework was set each week and reviewed in the following session. As therapy progressed clients were encouraged to design each other's and their own experiments to increase confidence in acting as their own therapist and become better able to apply skills to their own difficulties (Bieling *et al.* 2006). Behavioural experiments were carried out during group sessions and *in vivo* for homework.

Clients† for the intervention

Exclusion criteria that prevented clients' being included in the group were active substance abuse, psychosis and suicidal ideation. Clients were included when a willingness to complete homework and attend regularly was confirmed. Clients were referred to the group by a Greater London Mental Health Trust and took part in twelve 2-h sessions of group therapy.

Participants and ethics

Potential participants were approached before therapy began and were offered the opportunity to be involved in the research once therapy was completed. After therapy had finished potential participants were given the information sheet for consideration. Eight participants contacted the researcher and volunteered to take part in the research from two groups. In the first group there were seven clients and one dropped out by session 3 without giving a reason. Four of the six remaining participants agreed to take part in the research. In the second group there were eight clients, who all completed therapy (four agreed to take part in the research). Ethical approval was granted by a NHS panel. Participants had completed their group therapy at least 6 weeks before being invited to attend a face-to-face semi-structured interview to provide an appropriate time for consideration of involvement. Four females and four males

†We have used the term 'client' to refer to those service users attending the group therapy and the term 'participant' for those who volunteered to take part in the research after their therapy had finished.

were interviewed (mean age 33 years). Three participants were white British, two were South African and three originated from Asia.

Interpretative phenomenological analysis (IPA)

The aim of this research was to explore participants' 'lived' experience of group therapy and the meaning individuals attribute to being in a group with others who share a similar difficulty. A further focus on ascertaining helpful and less helpful aspects of group therapy which may inform future interventions was explored. The focus on experience and meaning explored in depth through a small number of cases is consistent with the principles of IPA which aims to explore how participants make sense of a particular event or experience (Smith, 2008). Underpinning this approach is the theory of hermeneutics which endorses the relational nature of human beings (Smith *et al.* 2009). Interactions in group therapy are inherently 'relational', a component that is not often addressed in CBT protocols (Bieling *et al.* 2006). Research using IPA is seen as a dynamic process between participant and researcher and the role of the researcher in terms of influencing the data collection and interpretation (Eatough & Smith, 2007) is emphasized. Sense-making is viewed as a shared activity by participant and researcher resulting in a 'double hermeneutic' (Smith, 2008).

IPA was considered appropriate since the analysis was committed to understanding a particular experiential phenomena (client's experience of group therapy) and how it has been understood from the perspective of particular people in a particular context (Smith, 2008).

Interview procedures

The most common method of data collection in IPA is the semi-structured interview. This type of interview is a conversation where the researcher-interviewer engages with the participant to elicit their sense-making of an experience. The interview consisted of open-ended questions covering the main areas for investigation. Questions focused on significant moments and participants were encouraged to think about different time points during the group process, rather than particular components of therapy. This process aimed to ensure that responses were grounded in the participant's reality, rather than being imposed by the researcher. The interview guide offered an overall structure but the order of questions did not necessarily follow the order presented, allowing participants' freedom of dialogue and a lead in terms of directing the interview.

Process of analysis

Interviews were recorded, transcribed verbatim and then analysed to capture meanings and themes in participants' accounts through a step-by-step method and followed the analytical process suggested by Smith (2008) and Smith *et al.* (2009). Various practices were employed to promote reflexivity and service-user involvement. These included using the clients' own words to label most of the themes, the use of supervision and self-reflection. Counselling psychologist researchers are committed to developing democratic non-hierarchical relationships through the continued involvement of participants throughout the research cycle (Kasket, 2012). Differences between the researcher's analysis and the participant's interpretation were 'sensitively negotiated' (Henwood & Pigeon, 1992). This was

Table 1. *Superordinate themes and subthemes*

Superordinate themes	Subordinate themes	No. of participants reporting
Engagement in the group process	<i>'We built trust'</i>	4
	<i>'They sort of understood'</i>	5
	<i>Blocks to engagement</i>	4
Normalising	<i>'We are not alone'</i>	8
	<i>'We are not so different'</i>	6
Courage to fight	<i>'Power in numbers'</i>	7
	<i>'The Therapy is working'</i>	4
	<i>'The Feedback helped'</i>	5
Being my own therapist	<i>'It's not my fault'</i>	6
	<i>'The thoughts will come anyway'</i>	5
	<i>'The anxiety will come down'</i>	6
Restricted vs. engaging with life	<i>How I am seen</i>	5
	<i>'Life is more vivid and fun'</i>	5

achieved by being transparent and sharing the findings during participant validation carried out after the analysis was complete which also served as a credibility check (McLeod, 2001). The excerpts and commentary were read by four participants during a face-to-face interview who confirmed accuracy of the interpretation and two, Paul and Sarah (all names given are pseudonyms), made suggestions for change in the light of their reflections. The sample was 'situated' by each participant being described at appropriate times and the analysis was 'grounded in examples' and presented 'coherently' in that it read like a story (Elliott *et al.* 1999). Some themes were collapsed and others discarded after repeated engagement with the data which involved steps and reflexive processes to explore the narrative recommended by Landridge (2007) and Smith *et al.* (2009).

Analysis

The process of analysis generated five superordinate themes (Table 1) which contained several subordinate themes. A verbatim excerpt is presented as evidence for each theme. The superordinate themes can be considered to be 'over-arching' or umbrella themes (presented first in bold italics) followed by the subordinate themes (in italics).

Superordinate theme 1: Engagement in the group process

The first theme represents the importance for participants to feel trust in the group and acceptance by others, facilitated by identification with similar others and sharing experiences.

Subordinate theme: 'We built trust'

This theme was generated in the accounts of four participants.

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

I think from that moment where we had to talk about our childhood stuff, I mean some people talked about things that were obviously clearly very distressing to them, from that moment we really were, had to be bonded, there was no question I think.

Subordinate theme: 'They sort of understood'

A sense of being accepted and understood by others in the group was referred to by five participants, suggesting group cohesiveness was high in the group which facilitated increased disclosure (Bieling *et al.* 2006).

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

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

[Researcher: you look a bit upset are you OK?]

Yes it's fine, they sort of understood, it was like, you didn't need to discuss [pause, tearful] why ... now you are getting me started.

[Researcher: OK take your time]

So you could just say something to them [tearful] and they would be like, well I do that as well. You didn't need to explain why or what reason, etc.

Subordinate theme: Blocks to engagement

A fear of being judged by others led three participants to feel inhibited about sharing certain aspects of their OCD in the group.

Paul, aged 40, was unemployed and living at home. He described feeling unsure whether his religious thought intrusions could be conceptualized as part of his OCD or were related to his religious beliefs, which prevented him from disclosing these in the group. This uncertainty regarding certain symptoms and their relationship to OCD has been identified as a block to disclosure in group work (Bieling *et al.* 2006).

I am not sure others could relate to it, to do with prayers and religious stuff, religious thoughts and stuff like that. I felt like, whether what I believe, is right or wrong or is it OCD sort of thing, yeah, or is it religion or is it OCD?

Superordinate theme 2: Normalizing

Through identifying and sharing with others, participants seemed to feel less 'alone' and feel less 'different' to others in and outside of the group.

Subordinate theme: 'We are not alone'

Through social comparison the therapeutic factor of 'universality' was identified in all participants' interviews due to the gathering of people with similar problems, which is particularly useful for difficulties like OCD that are less common (Bieling *et al.* 2006).

Laura, aged 40, was married with two children and working full time. She used a metaphor from a Victorian fable, *The Water-Babies* (by Reverend Charles Kingsley), to describe her experience of meeting others with similar issues for the first time.

he's a chimney sweeper and then he gets transformed into a water baby, and he thinks he's the only water baby, and then one day he suddenly comes across a whole flock of water babies and they are all unhappy children who had been transformed to water babies.

Subordinate theme: 'We are not so different'

Through social comparison six participants viewed themselves as less different to others in the group, which had an indirect effect of challenging the meaning attached to intrusions, a central aim of CBT (Salkovskis, 1999).

Marc, aged 50, worked as a pharmacist. He reflected on the impact of meeting others in the group and realizing that OCD was a common problem.

well the condition I have, it's quite common, it's not like, I don't have to be down, I mean discouraged, just because I have OCD, I am useless or, you know, because people out there have this condition and yet they go on, they are not that useless, it is OK, it's like depression.

Superordinate theme 3: 'Courage to fight'

This superordinate theme related to increased motivation and strength to overcome OCD since being in the group and sharing with others, representing the interpersonal factor of 'altruism' where group members benefited from helping one another (Bieling *et al.* 2006).

Subordinate theme: 'Power in numbers'

A sense of working together in a team and of being in a shared battle was perceived as a motivational factor generated in the personal accounts of seven participants.

Mia, aged 30, engaged in rituals involving touching or repeating actions in response to intrusive doubts. She shared her experience of carrying out behavioural experiments and tolerating her anxiety in the group.

actually really putting it into practice, and I guess like knowing that other people are trying it as well, it's kind of nice, it was like power in numbers, kind of thing you know.

Subordinate theme: 'The therapy is working'

Four participants reflected on how seeing others improve through engagement with behavioural experiments strengthened the belief in the effectiveness of therapy and facilitated the therapeutic factor of 'instillation of hope' (Yalom, 1995) which motivated change. This observation demonstrated how the group setting provided an ideal arena for seeing others undertake tasks that had a positive outcome through 'vicarious learning' (Whitfield, 2010).

Sunny, aged 24, presented with ordering compulsions and a need to have things 'just so'. He reflected on the impact of observing another group member engage in a behavioural experiment.

it felt very positive, I was very happy to see that he could hold that cup of hot water without any negative thoughts or feelings. I think it did help me to realize that I could do it as well.

Subordinate theme: 'The feedback helped'

Giving and receiving feedback in the group was also a motivational factor generated in the accounts of four participants.

Prior to the excerpt Laura disclosed her sense of pride when sharing successes in the group, describing it as the 'sweetest feeling in the world', leaving her feeling empowered. She reflected on how sharing successes in the group had a 'knock-on effect' in her life outside the group and the perceived severity of her problems.

it gives me defiance, it gives you defiance, made me more defiant, so I was like more defiant about fighting the disorder, more defiant about fighting my husband, well you have to wear spectacles and you have eczema and I have to do all the laundry in some special pile, that's your problem so this is my problem so it's not like a bad, it's not this bad problem.

Superordinate theme 4: Being my own therapist

Three subordinate themes were generated relating to skills learned in the group demonstrating an internalization of CBT theory.

Subordinate theme: 'It's not my fault'

The main aim of CBT is to develop a less threatening account of the experience of OCD by challenging the inflated responsibility appraisal (Salkovskis, 1999). This theme was generated in the accounts of six participants and seemed clearly linked to the identification of relevant past experiences. This observation highlights the benefits of using a formulation-driven approach with an exploration of early life experiences in the group (Salkovskis *et al.* 1999).

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

I think it came from when my parents were arguing, you know, when I was little, I thought maybe if I did certain rituals or something that nothing bad would happen, they would stop arguing, or nothing would happen to them, or to me, or somebody in the family, and the therapist goes through all these questions and gets you into it deeper, and you realize that when you are a child you don't actually understand, you see things in black and white sort of thing, it's like, OK, it's not your responsibility, it's not your fault.

Subordinate theme: 'The thoughts will come anyway'

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

Paramjit, aged 22, presented with contamination fears and described how having recognized that intrusive thoughts were universal, he no longer saw the need to dwell on his thoughts.

You don't need to dwell on it because everybody has that sort of thoughts or compulsive sort of actions, but it's just if you think too much into it then you will just pretty much spend all your life just sort of dwelling over it, but if you just acknowledge it and just let it slide, then it's definitely a better way of living your life and it's a lot easier.

Subordinate theme: 'The anxiety will come down'

Six participants shared skills learned from internalizing the theory and skills of CBT relating to tolerating feelings more effectively (Leahy, 2009).

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

maybe letting more people in and trying not being too controlling over your whole environment, and just able to not stress about things too much, and not keep going over, so if you do something, I know that you get the anxiety level for a bit, still today after my daughter's help this morning I will be thinking about that a little bit, but I know it will ease off.

Superordinate theme 5: Restricted by shame vs. engaging with life

This theme relates to the impact of living with OCD before therapy which had resulted in a restricted life compared to engaging more fully with life and other people after therapy.

Subordinate theme: How I am seen

Five participants disclosed how they were secretive about aspects of their OCD before being in the group. However, Sarah described everybody else in the group being 'open' as helpful in terms of her feeling more able to share with others and compared this to her hidden self with friends and family.

I suppose it's the same as with how you look at yourself like family, because you don't tell family, because you don't want them to know certain things about yourself, but I suppose in this group everyone was sort of quite open and that enabled you to be more open as well, if someone was disclosing something to you, you can disclose something to everyone.

Subordinate theme: 'Life is more vivid and fun'

Five participants talked about changes they had made since sharing and making progress in the group which had resulted in an improved quality of life.

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

You just lose so much energy and vitality in life to this pointless thing, and it's, so so, frustrating, so when it's reduced, life just it kind of sparkles so much more, life is just so much more vivid and fun, and people are more fun because it's horrible going into any new situation with your heart in your mouth that you can't concentrate

Reflexivity and the significance of shame in the analysis

The researcher's response to the material presented in the personal accounts, particularly Laura's sense of defiance and ability to challenge her critical husband, led to a second-order analysis (Smith *et al.* 2009). The researcher found it helpful to conceptualize Laura's response as 'healthy resistance' (Wade, 1997). This approach to therapy informed the researcher's clinical work with victims who had been badly treated or oppressed. Being able to talk about

her OCD without fear of being judged in the group had reduced Laura's sense of shame. This had facilitated her to equalize her relationship by challenging her husband's negative perception of her difficulties which had remained a 'non-discussed' issue at home. Sarah too had been moved to tears when reliving her experience of meeting others who did not judge her like family and friends. Reflecting on the similarities in these two accounts helped to link the two narratives to the impact of reduced shame. The significance of this finding was noted implicitly and explicitly in many other of the participants' accounts. The reduction in shame stemming from identification with others and the ability to share previously hidden symptoms seemed pivotal in promoting group processes and motivating participants to change, a huge benefit of group over individual therapy.

Discussion

Five superordinate themes were generated from the participants' accounts relating to the benefits of group therapy. Reduced shame facilitated by the experience of meeting others with a similar problem for the first time seemed to promote engagement with the group process and was pivotal in motivating participants to change. Conversely, a fear of being judged by other group members inhibited some participants from sharing certain aspects of their OCD in the group and prevented full engagement in therapy. The analysis highlighted how the group process stimulated many therapeutic factors highlighted by Yalom (1995), Kobak *et al.* (1995), Yalom & Leszcz (2005) and Bieling *et al.* (2006). These therapeutic factors were reflected in the participants' accounts including 'group cohesion' which was generated in the theme 'Engagement with the group process'. 'Universality' which was identified in the theme of 'Normalizing' and the therapeutic factors of 'instillation of hope', 'vicarious learning', and 'altruism' which were represented in the theme 'Courage to fight'.

The process of normalizing was triggered through group members identifying and relating to similar experiences and was highlighted by all group members. It seemed to help participants overcome stigma, shame and a sense of isolation (as also reported by Kobak *et al.* 1995). That the group process disconfirms a sense of being alone is consistent with previous research exploring service-users' perspectives of being in GCBT who were experiencing bipolar disorder (O'Connor *et al.* 2008), eating disorders (Laberg *et al.* 2001) and hoarding difficulties (Schmalisch *et al.* 2010).

Whilst the concept of normalizing is common in groups and important in terms of helping people feel less alone and isolated, the recognition of difference can be equally beneficial (Thornton, 2004). The potential for transformational experiences in a group depends on the optimum balance of the recognition of sameness referred to as 'mirroring' and the recognition of differences referred to as 'exchange' (Foulks, 1990). In this group both the therapeutic factors of 'mirroring' and 'exchange' were facilitated through social comparison. According to Thornton (2004) experiencing something as the same yet different can enable people to construct a personally meaningful modified identity. Comparison with others more severely affected led participants to view themselves as less severely affected than they had previously considered and to judge themselves less harshly. Merely by meeting others with a similar difficulty for the first time participants appeared to challenge the underlying meaning outlined in the subtheme 'We are not so different'. This finding, that the process of social comparison challenges underlying beliefs, is consistent with previous qualitative

research using IPA, examining the impact of GCBT for service users experiencing auditory hallucinations (Newton *et al.* 2007).

The notion of social comparison is 'intimately related' to areas of social psychology and has often been reflected in the study of group dynamics (Guimond, 2006). Social comparison can involve upward and downward comparisons, the latter being largely made by people with low self-esteem which can have both positive and negative effects (Wills, 1981). In this study both positive and negative comparison appeared to motivate two participants, Mia and Laura, due to challenging the perceived severity of their problem and motivated them to engage in therapy to prevent a further deterioration in symptoms. Group members' tendency to be secretive and hide difficulties from others due to a sense of shame may have resulted in a minimized social group affiliation due to being socially isolated. Aviram & Rosenfeld (2002) applied Social Identity theory to data produced from adults with a learning disability who had undergone group therapy, suggesting that a sense of social affiliation is an important area for enhancing self-esteem. This was reflected in Paramjit's narrative when he shared how he had stopped socializing with his friends completely before group therapy and described how the group had acted as a stepping stone for re-engagement with his friends.

Importantly, participants came to believe they were not to blame for the development of OCD. This finding was identified in the theme 'It's not my fault'. When sharing early experiences in the group participants discovered alternative narratives in which environmental factors were incorporated that shifted the sense of personal responsibility and indirectly challenged the underlying meaning – a central aim of CBT viewed as crucial in preventing relapse (Steketee & Wilhelm, 2006).

Recommendations for future clinical practice

The cognitive model (Salkovskis, 1999) which invites an exploration of early experience through the development of a longitudinal formulation was useful in this group. Sharing in the group promoted empathy, group cohesion, and made the adoption of the 'alternative theory' (Salkovskis, 1999) that difficulties stem from worry rather than actually being responsible for harm, more believable by making it more tangible for the group as a whole. This exploration also helped clients identify emerging beliefs that further maintained the problem.

Where exploring early experience highlights that the person had been badly treated, oppressed, or victimized during childhood, it could be helpful to engage the person in a discussion about how they resisted being badly treated. 'Healthy resistance' may be understood as 'any mental or behavioural act through which a person attempts to expose, withstand, repel, stop, prevent, abstain from, strive against, impede, refuse to comply with, or oppose any form of violence or oppression (including any type of disrespect), or the conditions that make such acts possible' (cited in Wade, 1997, p. 25). An approach to therapy called Response Based Interviewing (Renoux & Wade, 2008) is based on the clinical observation that when possible victims resist being badly treated. Engaging people in a conversation about the details of their resistance can have the powerful effect of reducing shame. This intervention may be helpful in highlighting both cognitive and behavioural adaptive strategies the individual engages in to further empower clients.

A role for the group could be developed and used beneficially for pre-treatment work. Preparing group members prior to starting therapy has been shown to have a beneficial effect on group cohesion and has been associated with reduced attrition (Burlingame *et al.*

2002). Prochaska & Norcross (2010) also suggest that action-orientated therapies such as CBT may be more effective for people who are in the 'preparation or action stage' and may be less effective for individuals in the 'pre-contemplation or contemplation stage'. It may be useful to use a one-off group to focus on normalizing strategies and to provide a rationale for the therapy before allocating clients to the waiting list for group therapy. Meeting others with a similar problem seemed to have an instant normalizing effect for all participants and this indirectly challenged the underlying meaning attached through social comparison, a central aim of CBT (Salkovskis, 1999). This would represent a significant and helpful one-off intervention in preparation for group therapy. An understanding and increased awareness of the counterproductive nature of maintaining factors in terms of increasing the frequency and intensity of unwanted thoughts, might help raise awareness and motivate clients to engage in the 'preparation or action stage'.

Stage-of-change related variables have also been identified as a good predictor of premature drop-out. Action-orientated therapies such as CBT can be ineffective or even detrimental with individuals in the pre-contemplation stage (Prochaska & Norcross, 2002). This was evident in the one group member who dropped out. She had shared to another group member that she was avoiding having another child due to fears of activating her OCD, suggesting she may have been in the pre-contemplation stage of change. Consciousness-raising may have positively influenced a move from pre-contemplation to the contemplation stage due to increased awareness of her avoidance behaviour in maintaining her fears. Offering pre-treatment work could also reduce waiting list times since a client will have been assessed and provided with some psychological input and psychoeducation to facilitate self-directed learning (Veale & Wilson, 2005) in preparation for starting the group a few months later.

Participants also highlighted some concerns about sharing in the group setting which have implications for clinical practice. Three participants felt inhibited about sharing due to feeling 'different' and expressed uncertainty concerning symptoms and their relationship with OCD. 'Concealment' (Newth & Rachman, 2001) regarding certain aspects of the OCD prevented the normalizing process and exposure to a less threatening perspective for these participants.

Therapists could spend further time on normalizing through the use of case study vignettes including examples of the less articulated forms of OCD such as those linked with religious beliefs. The use of a 'concealment questionnaire' and suggested strategies to increase disclosure (Newth & Rachman, 2001) within and outside of the group may further enhance the normalizing process.

The observation that many participants benefited from their experience of being on a different continuum of severity to others also has implications for practice in today's climate within the NHS. For optimal results the group setting should include people with different levels of severity regarding OCD symptoms, suggesting a merge from two services, Psychological Therapies Service (PTS) and Improved Access to Psychological Therapies (IAPT) being helpful in this respect.

Implications for theory

In this study shame-based appraisals delayed some, and prevented other participants disclosing aspects of their OCD. The word shame derives from the Indo-European word meaning 'hide' and concealment is a central defining feature of shame (Gilbert, 1998).

Anticipation concerning how others will evaluate negative information about the self can result in keeping secrets to prevent rejection. Rachman (1997, 2003) suggests that obsessions persist because the person takes an erroneous view that the intrusion indicates something personally meaningful regarding the individual's character. Individuals prone to OCD attach significance to intrusive thoughts when the content has importance to the personal value system. When the content is viewed as dangerous, a sign of insanity or antisocial behaviour (Clarke, 2005) the person is more likely to attach a shame-based meaning. This was the case for many of the participants who took part in the study. According to Gilbert (1998) a clinical challenge relating to shame is the importance of being aware of its presence and helping the individual find ways of coping with it other than hiding. This is a huge benefit of group therapy because the setting facilitates opportunities for helpful social comparison and sharing. It is interesting to note that some of the participants originated from different cultures, including South Africa, Asia and India. The mainstream emotion research is based on Western individualistic culture which emphasizes 'independent concepts of the self' (Wong & Tsai, 2007). From this perspective shame is viewed as something 'bad or wrong'. In more collectivist cultures (where some of the participants came from) shame is associated with a code of ethics, can be valued or viewed as an appropriate response to having failed and not necessarily viewed as damaging to the wellbeing (Wong & Tsai, 2007). This can be seen from the narrative of one participant whom the authors choose not to identify to maintain confidentiality when he spoke about a dilemma about sharing in the group. Another participant from a collectivist culture also disclosed during the interview, how being gay had compromised an ability to reveal this and sharing other aspects of their progress in the group due to a fear of 'outing' themselves in a community considered a 'small world'. They wanted to protect their family from shame. This may have indicated a conflict between the family-defined 'we self' and the attainment of autonomy emphasized by Western individualistic culture (Puthenpadath & Culbertson, 2000).

Conclusions and future directions

In this study the researcher observed the emergence of five of Yalom's therapeutic factors, these being 'universality', 'group cohesion', 'instillation of hope', 'vicarious learning' and 'altruism'. The presence of three of these was also highlighted in a study by Schmalisch *et al.* (2010) exploring therapeutic process in group therapy for individuals with hoarding difficulties. These being 'universality', 'group cohesion' and 'altruism'. Future process-based research on GCBT could further illuminate the benefits of group therapy for people with OCD and other presenting problems. A larger sample, recruiting participants from different NHS trusts in future research may also add to the validity of such an evaluation.

The total potential for research participants across the two therapy groups was 15. One group member from the first group dropped out prematurely and a further six did not respond to the opportunity to be involved in the research. One refused at the outset due to time constraints and another expressed fears of saying the wrong thing during the interview and then refused by email after considering the information sheet. Her OCD involved a fear of offending people. It is possible that there was a parallel process between residual shame that inhibited and at times prevented disclosure in the group for some participants and the decision not to take part in the research. To some extent the voices of those who volunteered to take part may have been privileged and these participants may have been less severely affected by OCD

than those who did not. In order to more fully assess the unhelpful effects of therapy it may be helpful to target clients who have not in the past completed therapy or explore in more depth the factors that participants felt hindered their progress in line with suggestions by Clarke *et al.* (2004).

The value of asking clients about their experience of therapy is that clinicians can find out what works and why. This study highlights the importance of shame in OCD and how the group processes can facilitate its reduction, a finding that would not be elicited by outcome research. By identifying and relating to similarities and differences with others, participants experienced a reduced sense of shame that motivated them to change. The relevance of shame in OCD highlighted in this study indicates the importance for therapists to understand and work with issues of concealment (Newth & Rachman, 2001) an often overlooked maintaining factor in their clinical practice.

Summary of key points

Research into group therapy for OCD has traditionally used quantitative methods which have informed the NICE guidelines. However, process research is lacking in the area. In this study group therapy based on the model of Salkovskis *et al.* (1999) was carried out in the group setting. Eight participants took part in the study from a range of ethnic backgrounds and data was analysed using IPA after in-depth face-to-face interviews were carried out. The analysis highlighted four superordinate themes relating to the helpful and hindering aspects of group therapy. These were labelled as 'Engagement in the group process', 'Normalizing', 'Courage to fight' and 'Being my own therapist'. The researcher engaged in reflexive practice which resulted in the identification of the relevance of shame in the service users' personal accounts. The clinical and theoretical implications are discussed including the importance of understanding clients' motivation to change and recommendations for future research are highlighted.

Acknowledgements

The authors thank the participants for their involvement with the research.

Declaration of Interest

None.

Recommended follow-up reading

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Learning objectives

- (1) Understand the relevance of working with process in CBT groups.
- (2) Acknowledge the importance of formulation driven CBT in the group setting.
- (3) Understand the benefits of using qualitative methods to ascertain why Group CBT works.

Cognitive behavioral therapy (CBT) is a type of psychotherapeutic treatment that helps people learn how to identify and change destructive or disturbing thought patterns that have a negative influence on behavior and emotions. Cognitive behavioral therapy focuses on changing the automatic negative thoughts that can contribute to and worsen emotional difficulties, depression, and anxiety. These spontaneous negative thoughts have a detrimental influence on mood. Through CBT, these thoughts are identified, challenged, and replaced with more objective, realistic thoughts. Types of Cognitive Beha... Cognitive-behavioral therapy acts to help the person understand that this is what's going on. It helps him or her to step outside their automatic thoughts and test them out. CBT would encourage the depressed woman mentioned earlier to examine real-life experiences to see what happens to her, or to others, in similar situations. But when we are in a disturbed state of mind, we may be basing our predictions and interpretations on a biased view of the situation, making the difficulty that we face seem much worse. CBT helps people to correct these misinterpretations. Learn more about other: Depression Treatments. Solving life problems. The methods of CBT may be useful because the client solves problems that may have been long-standing and stuck. This shareable PDF can be hosted on any platform or network and is fully compliant with publisher copyright. Life just kind of sparkles: clients' experiences of being in cognitive behavioural group therapy and its impact on reducing shame in obsessive compulsive disorder. Melanie Spragg, Sharon Cahill. *The Cognitive Behaviour Therapist*, January 2015, Cambridge University Press. DOI: 10.1017/s1754470x15000100.