

**A SYSTEMIC CONCEPTUALISATION OF MEMBERS' EXPERIENCES OF  
AN OBSESSIVE COMPULSIVE DISORDER SUPPORT GROUP**

by

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## Declaration

Student number: **34798390**

I declare that *A Systemic Conceptualisation of Members' Experiences of an Obsessive Compulsive Disorder Support Group* is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

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SIGNATURE

Mr Shai Friedland

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DATE

## Glossary

**Acceptance and Commitment Therapy (ACT):** ACT assumes that psychological problems are due to a lack of behavioural flexibility and effectiveness, and the goal of therapy is to help clients choose effective behaviours even in the face of interfering thoughts and emotions (Westbrook, Kennerley, & Kirk, 2008).

**Arachnophobia:** This is an extreme or morbid fear of spiders that is classified as a specific phobia (Reber & Reber, 2001).

**Body Scanning:** This is a meditative practice to help get us in touch with our bodily sensations moment by moment. The skill is to learn to bring attention to the body, part by part, step by step and then to directly observe and acknowledge whatever sensations are present (Tobler & Herrmann, 2013).

**Clinical Psychologist:** A psychologist working in the field where the concern is with aberrant, maladaptive or abnormal human behaviour (Reber & Reber, 2001).

**Cognitive Behavioural Therapy (CBT):** Involves the modification and relearning of maladaptive cognitive processes such as imagery, fantasy, thought, and self-image. Proponents of this approach argue that what a client believes about the things he/she does and about the reason for them can be as important as the doing of them (Reber & Reber, 2001).

**Generalised Anxiety Disorder (GAD):** A subclass of anxiety disorders characterised by persistent free-floating anxiety and a host of unspecific reactions such as trembling, jitteriness, tension, sweating, light-headedness, feelings of apprehension, and irritability (Reber & Reber, 2001).

**Habituation:** Being exposed to a feared stimulus repeatedly and for a considerable length of time and gradually the anxiety starts to decrease (Clarke, 2004).

**Mindfulness:** Involves consciously bringing awareness to the here and now, and doing so with an openness, rather than in a focused way (Tobler & Herrmann, 2013).

**Meditation:** A state used in mindfulness where there is extended reflection or contemplation (Reber & Reber, 2001).

**Social Anxiety Disorder (SAD):** Also known as social phobia and it is an anxiety disorder marked by a persistent fear of particular social situations in which the individual is subjected to possible scrutiny by others and fears that he/she will act in some way that will lead to being humiliated or embarrassed (Reber & Reber, 2001).

**Specific Phobia:** An anxiety disorder where the individual has a persistent fear of a specific stimulus object or situation (Reber & Reber, 2001).

**Subgroup:** The splitting-off of a sub-unit from a larger unit (Yalom, 1995).

## **Abstract**

This study explored the experiences of members of an OCD support group, utilising a qualitative design, social constructionist approach, and a systemic framework. Participants were obtained through purposive sampling; data was collected via face-to-face semi-structured interviews with four participants. It emerged that these participants attended two OCD support groups (initial support group and sub-support group). The participants' experiences were analysed using thematic analysis. Major findings: the participants' motivation to attend both support groups was to reduce their OCD symptoms and improve functioning. The initial support group was a professional-led psychoeducational support group while the sub-support group was a self-help psychotherapeutic group. The groups also complemented each other with information from the initial support group being implemented in the sub-support group. The participants reported to have benefitted from participation in both support groups as their OCD symptoms reduced and their daily functioning improved. Recommendations for future research were discussed.

**Keywords:** obsessive-compulsive disorder, social support, support groups, systemic framework, social constructionism, postmodernism, qualitative research, thematic analysis.

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## Chapter 1

### Introduction

#### 1.1 Background

Fear and anxiety have the basic function of signalling a perceived danger or threat that all humans understand and experience (Barlow & Durand, 2015). Fear is an unpleasurable emotion in response to a realistic threat or danger and helps an individual avoid danger in the immediate environment (Sadock & Sadock, 2007; Sue, Sue, Sue, & Sue, 2016). Anxiety is a feeling of unease caused by anticipation of a future danger, which may be internal or external, and helps an individual anticipate and prepare for important events (Sadock & Sadock, 2007; Sue et al., 2016). These immediate and perceived dangers may have adapted over time and across cultures but the emotions of fear and anxiety continue to play a central role in the survival and adaptation of the human species (Barlow & Durand, 2015). Unfortunately, anxiety can also impair functioning and disrupt lives if the anxiety is misattributed or is excessive. When anxiety becomes excessive or it is misattributed it may be regarded as a disorder (Barlow & Durand, 2015).

Obsessive-compulsive disorder (OCD) was categorised under the domain of anxiety disorders in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text revision; DSM-IV-TR; American Psychiatric Association [APA], 2000), as an individual suffering from OCD experiences severe anxiety and distress. However, OCD is currently categorised within the obsessive-compulsive and related disorders section of the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; American Psychiatric Association [APA], 2013) as it is regarded as a severe mental illness requiring attention and adequate screening (Reichenberg, 2014). According to the DSM-5 (APA, 2013, p. 235), “there are close relationships between the anxiety disorders and some of the obsessive-compulsive and related disorders (e.g., OCD)” with the International OCD Foundation (IOCDF) (2014), which is a leading worldwide non-governmental organisation (NGO) for individuals affected by OCD, suggesting that individuals diagnosed with OCD experience severe anxiety. Barlow and Durand (2015) state that individuals who require hospitalisation for severe anxiety are likely to have OCD. Barlow and Durand (2015) continue by stating that “with OCD, establishing even a foothold of control and predictability over the

dangerous events in life seems so utterly hopeless that victims resort to magic and rituals” (p. 163).

According to Sue et al. (2016) the primary symptoms in OCD are obsessions and compulsions. Obsessions are persistent anxiety-provoking thoughts, images or impulses (urges), while compulsions involve an overpowering need to engage in repetitive behavioural actions or mental acts to neutralise the severe anxiety or prevent the occurrence of a perceived dreaded event. The obsessions and/or compulsions consume at least one hour a day and cause significant distress and impairment in functioning. Individuals who experience intrusive, often irrational thoughts, images or impulses associated with obsessions, have difficulty controlling their thinking. The obsession and anxiety persists even though the individual tries to ignore it or shift it from his/her mind. If the compulsion is not performed or is not conducted “correctly” the distress or anxiety increases significantly. The obsessions and compulsions frequently occur together but they can both occur separately.

OCD is a chronic mental illness that affects both an individual’s thoughts and actions (Thobaben, 2012). Estimates of the lifetime prevalence of OCD range from 1.6% to 2.3% of the American population, and in a given one-year period the prevalence is 1% (Barlow & Durand, 2015). OCD ranks eleventh in the World Health Organisation’s (WHO) leading causes of health burden, globally (Üstün, Ayuso-Mateos, Chatterji, Mathers, & Murray, 2004). However, despite the above statistics, the average time it takes an individual with OCD to be correctly diagnosed with OCD is eight years from onset (Wang et al., 2005).

The delay in obtaining a correct diagnosis of OCD may be due to professionals often having difficulty diagnosing OCD as OCD shares a high comorbidity rate with other disorders such as depression and several anxiety disorders (Abramowitz, 2006). To complicate the identification of OCD, many OCD sufferers keep their mental illness hidden making it difficult for professionals, family, friends, as well as the general public to recognise that they have a problem (Abramowitz, 2006; Clarke, 2004). Heyman, Mataix-Cols, and Fineberg (2006) recognised that this secrecy around OCD symptoms may be due to possible stigma around mental illness and shame associated with OCD. The secrecy around OCD symptoms by an OCD sufferer leads to a failure to seek proper treatment, a worsening of the disorder, and possible further isolation (Abramowitz, 2006; Caspi et al., 2014; Clarke, 2004).

Because OCD creates a feeling of isolation and shame among sufferers, researchers have discovered, when compared to the general population, individuals with OCD tend to have more negative repercussions on their quality of life when it came to social functioning, emotional problems, and mental health (Olatunji, Cisler, & Tolin, 2007; Rodriguez-Salgado et al., 2006; Stengler-Wenzke, Kroll, Riedel-Heller, Matschinger, & Angermeyer, 2007; Torres et al., 2007).

With impaired social functioning, individuals suffering from OCD often have difficulty obtaining social support (Clarke, 2004; Hou, Yen, Huang, Wang, & Yeh, 2010). The impact of a lack of social support is that the individual with OCD is at risk of becoming isolated (Fennell & Liberto, 2007) and his/her OCD symptoms may progress (Nakashima, Isobe, & Ura, 2013; Thoits, 2011). Social support has been identified as any action or behaviour that functions to address multiple interpersonal needs that include relational (emotional support), conformational (reassurance of worth), and instrumental (tangible or informational) care (McGuire, 2007; Thoits, 2011; Uchino, 2004). McGuire (2007), Thoits (2011), and Uchino (2004) also explained that social support is not a single concept as it can function in two ways: tangible support (physical resources that benefit the individual) or psychological support (values, attitudes, beliefs, and perceptions). Social support has been known to help influence and motivate a behaviour change in a positive way (Clarke, Whelan, Barbour, & MacIntyre, 2005). Establishing support groups seems to have been a format that professionals working in the field of mental health and society in general have found to provide social support described above (Davis, 2008). Support groups are defined as voluntary groups where individuals with a mutual problem meet face-to-face to exchange advice and social support (Silverman, 2010).

Forsyth (2013) mentions that along with support groups, which may be leader-led or self-help groups, there are two other types of groups available for individuals with a psychological problem or life difficulty. The first type of group is a therapeutic group, which provides an individual with a space to overcome a psychological difficulty while in the company of supportive members. The second type of group is an interpersonal learning group in which an individual learns about him-/herself and builds positive relationships with supportive group members. Forsyth (2013) further highlights that a support group may contain elements of both an interpersonal learning group and a therapeutic group. There is growing evidence that participation in support groups for chronic mental illnesses for both individuals suffering from a mental

illness and their family members is connected to an improvement in that individual's condition as well as the ability of the family members to adjust to the individual's condition (Barak & Dolev-Cohen, 2006; Chien, Norman, & Thompson, 2004; Gilat & Shahar, 2007; Houston, Cooper, & Ford, 2002). Black and Blum (1992) highlighted the need for support groups for OCD when they found that many individuals with OCD whom they knew "needed additional support and education about their disorder" (p. 65) as well as had a need to "meet others who were similarly afflicted" (p. 66). Hollander et al. (as cited in Greist et al., 2002) also brought to light the need for OCD support groups by describing the high costs that OCD may incur, not only for the individuals with OCD but also their families and the communities within which they reside, and the increased need for help and support for individuals with OCD. Davis (2008), after having done research on OCD and OCD support groups in Texas, recommended future research into individuals with OCD and their perceived subjective normative views on participation in support groups as he found that support groups may be beneficial for individuals with OCD.

Research has been conducted on OCD (Abramowitz, 2006; Clarke, 2004; Foa & Kozak, 1986; Van Niekerk, 2009) as well as a limited amount of research on the experience of living with OCD (Fennell & Liberto, 2007; Haase, 2003; Singh, 2002). Many books have been written on firsthand accounts of living with OCD (Bell, 2007; St. John, 2011; Summers, 2000; Wells, 2006). Research has also been conducted on support groups in general and on the experiences of support groups, with the most prominent being cancer support groups (Spiegel, Bloom, & Yalom, 1981; Ussher, Kirsten, Butow, & Sandoval, 2006) but very little research has been conducted regarding support groups for individuals with OCD (Black & Blum, 1992; Broatch, 1996; Cooper, 1993; Davis, 2008; Tynes, Salins, Skiba, & Winstead, 1992). There are OCD support groups around the world and people with OCD have turned to these support groups for help and guidance regarding their OCD symptoms (IOCDF, 2014); however, there are still limited support groups for OCD around the world (Black & Blum, 1992; Davis, 2008; IOCDF, 2014). Support groups for OCD in South Africa are very limited with currently one formal face-to-face support group for OCD and one online OCD support group in South Africa (The South African Depression and Anxiety Group, SADAG, 2012). No research was found with regards to OCD support groups in South Africa. With the lack of formal support groups available for OCD sufferers in South Africa and the lack of research on OCD support groups in South



Africa, I saw an opportunity to investigate the experiences of members of the only formal support group for OCD in South Africa. I was also interested to explore whether support groups might be a useful addition to treatment for OCD and whether support groups might help with the social isolation and/or distress involved with individuals with OCD in South Africa.

There has also been very limited research conducted on OCD support groups from a qualitative perspective. The research on OCD support groups from a qualitative perspective in the South African context is non-existent. The information gathered in this study will hopefully bring about valuable insight from the participants of an OCD support group within the South Africa context.

This research topic also appealed to me as I have experienced the challenges caused by OCD such as the severe distress and the impairment in functioning, as well as the difficulties with the stigma attached to OCD, the isolation caused by the OCD symptoms, the need for support, and the success of well-designed treatment strategies for OCD. My experiences with OCD inspired me to start an online support group for OCD called OwnOCD ([www.ownocd.ning.com](http://www.ownocd.ning.com)). What stood out, and was significantly evident to me, was that even though this online support group was for people suffering from OCD and their family members, there were many people in this online support group who had a need for and had asked for a face-to-face support group for OCD in their area. The reasons they stipulated pertained to a desire for personal connection and sharing, and to physically meet and interact with other OCD sufferers. Due to the lack of face-to-face support groups in South Africa I plan on starting a face-to-face support group for OCD in the near future and the findings from this study will hopefully assist me in that process.

The gap in the research, along with my experiences with OCD and support groups as well as my passion towards OCD and support for OCD, impacted on my interest and curiosity in the experiences of the members of an OCD support group in South Africa.

I approached this research study with no preconceived ideas regarding the outcome and was of the opinion that the findings would contribute to knowledge about OCD support groups. I hoped that participants to this study would provide rich information about their experiences that when analysed and interpreted, would produce a cohesive picture about their experiences.

## **1.2 The Aim of the Study**

The purpose of this study was to explore members' experiences of an OCD support group with the aim of contributing to an understanding of these experiences and as such endeavour to add knowledge pertaining to possible effective treatment for individuals suffering with OCD. The intention of this study was to create a safe space in which the four participants could share their personal and unique experiences of being a member of an OCD support group. It was hoped that the in-depth and sensitive method of enquiry used in this study would yield rich information regarding members' experience of an OCD support group within the South African context.

Dickerson and Zimmerman (1996) explicate that social constructionism challenges the ideas that postulate a single account of reality. Rapmund (2000) suggests that single accounts of reality provide a context for pathologising those that do not fit into the overarching ascribed norms. Each individual has his/her own reality which is different to others' realities. These realities may become evident through an individual telling his/her story. Dickerson and Zimmerman (1996, p. 243) state, "people give order, coherence and meaning to events when they relate their stories." I therefore set out to provide the participants in this study with a space where their individual stories could be heard and acknowledged and that their experiences of attending an OCD support group in South Africa would add to the lack of research regarding OCD support groups in South Africa. My hope was that the participants' experiences of the OCD support group they have attended would also further encourage research into OCD support groups and their possible benefits to the treatment of OCD.

## **1.3 The Research Question**

The research question, which emerged from the background and the aim of the study discussed above, is the following: *What are members' experiences of an OCD support group?* The members were all individuals suffering from OCD who participated in an OCD support group.

## **1.4 The Design of the Study**

A qualitative design, with a social constructionist paradigm, was chosen for this study to produce rich descriptions of the unique and authentic experiences of an OCD support group by members of the OCD support group who suffer from OCD. I acknowledge that by doing research from a qualitative and social constructionist perspective, I am not a separate entity and I do not consider myself an objective or

neutral researcher (Becvar & Becvar, 2009). My presence therefore impacted on the participants and a co-construction of meaning was formed between the participants and myself. My postgraduate training focused on postmodernism and social constructionism (these concepts are discussed in chapter 3) and I thus became aware of the importance of understanding individuals' unique experiences. I am interested in understanding the meaning people have constructed about their experiences of the world. I therefore wanted to generate an in-depth understanding of the experiences of the OCD support group members. Purposive sampling (Durrheim, 2006) was used as the method of gaining relevant participants for this study. Four participants were chosen for this study from the one formal face-to-face support group for OCD identified in South Africa. Thematic Analysis, as discussed by Braun and Clarke (2006) and Terre Blanche, Durrheim, and Kelly (2006), was chosen as the method of analysing the information obtained from the participants. This method was used to organise the information into recurring themes. According to Braun and Clarke (2006), thematic analysis is a useful method to use when scrutinising an under-researched topic because of its ability to provide rich descriptions of people's lived experiences. After careful analysis, the participants' experiences were discussed and integrated with the relevant literature and theory where appropriate.

## **1.5 Chapter Outline**

This research study includes the following chapters:

Chapter 2, *Theory and Literature Review*, provides a description of the relevant theory and literature on OCD, social support and support groups. The chapter also discusses the systemic framework that is the foundation of this study. The history of the development of this framework is discussed. Applicable concepts in family systems theory are also highlighted and applied to the research topic.

Chapter 3, *Research Design and Research Process*, focuses on the research design and process within this study. The paradigm, the sampling method, the method used to gather data in this study, the analysis procedure, and the interpretation process in this study are highlighted. This study's credibility, transferability, dependability, and confirmability are then discussed. Lastly, the ethical considerations relevant to this study are mentioned.

Chapter 4, *Research Findings*, presents an introduction of each participant and a succinct description of their unique backgrounds and contexts. This chapter then focuses on the interpretation and analysis of the participants' stories. It highlights the

themes and subthemes that emerged after an in-depth analysis of the participants' stories.

Chapter 5, *Discussion and Recommendations*, is the final chapter and provides the reader with a discussion of the themes identified in chapter 4. This discussion includes the links between the identified themes and the relevant theory and literature outlined in chapter 2. The chapter also provides an overview and critical evaluation of the study. It includes strengths and limitations of the study, along with recommendations for possible avenues for future research.

## **1.6 Conclusion**

The next chapter will explore and provide a review of relevant literature and theoretical frameworks pertaining to OCD support groups, with a particular emphasis on OCD, social support, support groups, and systems theory.

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Note: The term “researcher” will be used throughout this dissertation to depict a general researcher. The terms “I”, “me”, and/or “myself” will be used throughout this dissertation to depict the researcher who did the literature review, carried out the interviews, and wrote this dissertation. I have used the subjective terms as I am using a social constructionist perspective with a systemic frame. It also highlights how I impact this research study, and that I am not removed from this study.

## Chapter 2

### Theory and Literature Review

#### 2.1 Introduction

According to the DSM-5 (APA, 2013), obsessive-compulsive disorder is characterised by the presence of a varied set of recurrent symptoms that include intrusive thoughts (obsessions) and rituals (compulsions). These recurrent obsessions and compulsions are time-consuming, cause severe distress, and interfere considerably with an individual's normal daily functioning, which includes occupational functioning and social functioning. Thobaben (2012) states that OCD is a chronic mental illness that affects an individual's thoughts and actions.

If the OCD is left untreated, individuals may experience a significant decrease in their quality of life due to the severity of the OCD symptoms, the distress it causes, and the impairment in many different domains of their lives (Olatunji et al., 2007; Torres et al., 2007). The most prominent domains affected by OCD are academic, occupational, social functioning, and home life (Rodriguez-Salgado et al., 2006). The DSM-5 (APA, 2013) also highlights that individuals with OCD may not be able to carry out work commitments and consequently experience financial difficulties. They may have difficulty completing their studies, struggle to make and/or maintain social relationships, and have problems in their relationships with family members and friends.

According to Clarke (2004), family members living with an individual with OCD undergo considerable stress as they may be drawn into the illness either by trying unsuccessfully to get the family member with OCD to stop the symptoms or by making allowances for the individual's OCD symptoms, which in turn perpetuate that individual's OCD symptoms and increase family tensions and dysfunction. Amir, Freshman, and Foa (2000) state that the stress upon the family members may also increase the levels of depression or anxiety within the family, which in turn may influence how family members respond to the member with obsessions and compulsions. Family members may respond negatively to the individual with OCD, resulting in a feeling of despair and guilt in both the OCD sufferer and his/her family members. OCD leaves not only the individual but also his/her family feeling helpless and upset, with all family members being unable to get on with their daily lives (Van Niekerk, 2009). The family members, through their despair, do not provide adequate support to the individual with OCD which leaves the individual with OCD isolated

from his/her family. The individual with OCD can therefore have a disruptive impact on the family system, which normally would be his/her immediate support structure, and the family system can have a disruptive impact on the individual with OCD.

According to Clarke (2004), some individuals with OCD may not confide in family members regarding their OCD symptoms and would therefore keep their mental illness a secret. Clarke (2004) suggests that OCD sufferers will also keep their mental illness a secret from their friends, another possible source of support. Heyman et al. (2006) recognised that the secrecy around this disorder may be due to the possible stigma and shame associated with a diagnosis of OCD. Therefore, OCD sufferers may not confide in their friends for fear of appearing different and losing these friendships, which in turn leads to a lack of social support from their friends either.

Forsyth (2013, p. 116) defines social support as “a sense of inclusion, emotional support, advice, guidance, tangible assistance, and spiritual perspective given to others when they experience stress, daily hassles, and more significant life crises.” According to Clarke et al. (2005), social support is known to help influence and motivate change in behaviour in a positive way. Nakashima et al. (2013) and Thoits (2011) also revealed that there are people who yield to an illness in the wake of negative life events, but that there are also those who do not yield to an illness. Their research found that high-quality relationships with people in their social environment were potential protective factors or buffers against the illness progressing. Social support may at times not only stop the progression of an illness or the decline of an individual’s health, but can be a factor in the individual recovering from that illness. These high-quality relationships may work as a buffer against added stress. According to Hou et al. (2010), individuals with OCD, as with other mental illnesses, require social support but they struggle to obtain the social support due to their impaired social functioning.

Davis (2008) believes that establishing support groups seems to have been a format that society has found to provide social support to individuals struggling to obtain support. Therefore, an individual with OCD who does not have adequate social support may join a support group outside the context of their family and circle of friends. A support group is a voluntary group in which the members share a common problem. The members of the support group meet in order to provide each other with advice and social support (Silverman, 2010). Previous research has found positive

outcomes from examining the effects of support group participation for other mental disorders (Barak & Dolev-Cohen, 2006; Gilat & Shahar, 2007; Houston et al., 2002) and chronic illnesses (Chien et al., 2004).

The IOCDF (2014) reports that even though OCD support groups are slightly limited around the world, many individuals suffering from OCD in countries around the world have turned to support groups, seeking social support and guidance. However, there are only two previous studies that have looked at face-to-face OCD support groups (Black & Blum, 1992; Davis, 2008), with both of these studies finding benefits to attending these OCD support groups. There is currently no research with regard to OCD support groups in South Africa. There also appears to be a limited number of OCD support groups in South Africa, with only one face-to-face OCD support group and one online support group for OCD in this country (SADAG, 2012).

This chapter explores relevant and recent literature appropriate to the study of: *A systemic conceptualisation of members' experiences of an obsessive compulsive disorder support group*. As literature on OCD support groups as well as the experiences of OCD support groups is limited and the topic addresses a gap in the literature, and predominantly within the South African context, this chapter will provide a detailed discussion and a review on the following topics that are fundamental in the study of members' experiences of an OCD support group: obsessive-compulsive disorder, social support, and support groups. A systemic framework will be discussed and outlined as this systemic framework forms the epistemology from which this topic will be studied.

## **2.2 Obsessive-Compulsive Disorder**

### **2.2.1 Defining obsessive-compulsive disorder**

The DSM-5 (APA, 2013, p. 20) defines a mental disorder as “a syndrome characterised by clinically significant disturbance in an individual’s cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behaviour (e.g. political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual,

as described above.” Obsessive-compulsive disorder is regarded as a mental disorder and is defined and categorised by both the major classification systems, namely the Diagnostic and Statistical Manual, both the Fourth Edition Text Revision (APA, 2000) and the Fifth Edition (APA, 2013) as well as in the International Classification of Diseases, Tenth Revision (ICD-10) (World Health Organisation, 1992).

This section discusses the criteria relating to OCD as in accordance with the DSM-IV-TR, the DSM-5, and the ICD-10. The DSM-5 is currently in use, and the current criteria for diagnosing OCD are contained in the DSM-5; however, all the participants in this study met the DSM-IV-TR criteria for OCD. The reason for the participants meeting the criteria for the DSM-IV-TR is that this study was conducted in the transition period between DSM-IV-TR and DSM-5, and the fact that the participants met a diagnosis of OCD before the release of the DSM-5. The changes between the two DSM editions are minimal but both have been provided, along with the criteria for OCD set out in the ICD-10 in order to give a thorough understanding of the criteria. The discussion around OCD will tend to shift towards the criteria in DSM-IV-TR, where necessary, throughout this chapter, as this appears more pertinent to the participants of this study.

**Table 1:** *Diagnostic criteria for obsessive-compulsive disorder*

<b>DSM-IV-TR</b>	<b>DSM-5</b>	<b>ICD-10</b>
The Diagnostic and Statistical Manual – Fourth Edition – Text Revision (DSM-IV-TR) (American Psychiatric Association [APA], 2000, pp. 462-463) lists the following criteria for obsessive-compulsive disorder:	The Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition (DSM – 5) (American Psychiatric Association [APA], 2013, p. 237) lists the following criteria for obsessive-compulsive disorder:	The International Classification of Diseases, Tenth Revision (ICD-10) (World Health Organisation, 1992) categorises obsessive-compulsive disorder as follows:
OCD falls under the section of <b>Anxiety Disorders</b> in DSM-IV-TR classification system	OCD falls under the section of <b>Obsessive-Compulsive and Related Disorders</b> in the DSM-5 classification system	OCD falls under the section of <b>Neurotic, Stress-Related and Somatoform Disorders</b> in the ICD-10 classification system
A. Either obsessions and/or compulsions. <b>Obsessions are defined by (1), (2), (3), and (4):</b> (1) repetitive and persistent thoughts, images, or impulses that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress	A. Presence of obsessions, compulsions, or both: <b>Obsessions are defined by (1) and (2):</b> (1) recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety	A. Either obsessions or compulsions (or both), present on most days for a period of at least two weeks. B. Obsessions (thoughts, ideas or images) and compulsions (acts) share the following features, all of which must be present: (1) they are acknowledged as originating in the mind of the patient, and are not imposed by



DSM-IV-TR	DSM-5	ICD-10
<p>(2) the thoughts, images, or impulses are not simply excessive worries about real-life problems</p> <p>(3) the person tries to ignore or suppress such thoughts, images, or impulses, or neutralise them with some other thought or action.</p> <p>(4) the person recognises that the obsessional thoughts, images, or impulses are a product of his or her own mind and not imposed from without.</p> <p><b>Compulsions are defined as (1) and (2):</b></p> <p>(1) repetitive behaviours (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be rigidly applied.</p> <p>(2) the behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralise or prevent or are clearly excessive.</p> <p>B. At some point during the course of the disorder, the person has recognised that the obsessions or compulsions are excessive or unreasonable.</p> <p>C. The obsessions or compulsions cause marked distress, are time-consuming (take more than 1 hour a day), or significantly interfere with the person's normal routine, occupational functioning, or usual social activities or relationships.</p> <p>D. The content of the obsessions or compulsions is not better accounted for by another Axis I disorder, if present (e.g., concern with appearance in the presence of body dysmorphic disorder, or</p>	<p>or distress.</p> <p>(2) the individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralise them with some other thought or action (i.e., by performing a compulsion).</p> <p><b>Compulsions are defined by (1) and (2):</b></p> <p>(1) repetitive behaviours (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.</p> <p>(2) the behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralise or prevent, or are clearly excessive.</p> <p><b>Note:</b> Young children may not be able to articulate the aims of these behaviors or mental acts.</p> <p>B. The obsessions or compulsions are time-consuming (e.g., take more than 1 hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.</p> <p>C. The obsessive-compulsive symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.</p> <p>D. The disturbance is not better explained by the symptoms of another mental disorder (e.g., excessive worries, as in generalised anxiety disorder;</p>	<p>outside persons or influences.</p> <p>(2) they are repetitive and unpleasant, and at least one obsession or compulsion must be present that is acknowledged as excessive or unreasonable.</p> <p>(3) the subject tries to resist them (but if very long-standing, resistance to some obsessions or compulsions may be minimal). At least one obsession or compulsion must be present which is unsuccessfully resisted.</p> <p>(4) carrying out the obsessive thought or compulsive act is not in itself pleasurable (This should be distinguished from the temporary relief of tension or anxiety).</p> <p>C. The obsessions or compulsions cause distress or interfere with the subject's social or individual functioning, usually by wasting time.</p> <p>D. Most commonly used exclusion criteria: not due to other mental disorders, such as schizophrenia and related disorders, or mood [affective] disorders.</p>

DSM-IV-TR	DSM-5	ICD-10
<p>preoccupation with having a serious illness in the presence of hypochondriasis).</p> <p>E. Symptoms are not due to the direct physiological effects of a substance or a general medical condition.</p>	<p>preoccupation with appearance, as in body dysmorphic disorder; difficulty discarding or parting with possessions, as in hoarding disorder; hair pulling, as in trichotillomania [hair-pulling disorder]; skin picking, as in excoriation [skin-picking] disorder; stereotypies, as in stereotypic movement disorder; ritualised eating behavior, as in eating disorders; preoccupation with substances or gambling, as in substance-related and addictive disorders; preoccupation with having an illness, as in illness anxiety disorder; sexual urges or fantasies, as in paraphilic disorders; impulses, as in disruptive, impulse-control, and conduct disorders; guilty ruminations, as in major depressive disorder; thought insertion or delusional preoccupations, as in schizophrenia spectrum and other psychotic disorders; or repetitive patterns of behavior, as in autism spectrum disorder).</p>	
<p><b>Specify if:</b></p> <p><b>With poor insight:</b> if, for most of the time during the current episode, the person does not recognise that the obsessions and compulsions are excessive or unreasonable.</p>	<p><b>Specify if:</b></p> <p><b>With good or fair insight:</b> The individual recognises that obsessive-compulsive disorder beliefs are definitely or probably not true or that they may or may not be true.</p> <p><b>With poor insight:</b> The individual thinks obsessive-compulsive disorder beliefs are probably true.</p> <p><b>With absent insight/delusional beliefs:</b> The individual is completely convinced that obsessive-compulsive disorder beliefs are true.</p> <p><b>Specify if:</b></p> <p><b>Tic-related:</b> The individual has a current or past history of a tic disorder.</p>	<p>The diagnosis may be <b>specified</b> by the following four character codes:</p> <p>Predominantly obsessional thoughts and ruminations</p> <p>Predominantly compulsive acts</p> <p>Mixed obsessional thoughts and acts</p> <p>Other obsessive-compulsive disorders</p>

As can be seen from the above criteria, OCD has shifted from the anxiety disorders section in DSM-IV-TR to the section called obsessive-compulsive and

related disorders in DSM-5. Except for the shift in section and a few word changes, the bulk of the criteria for OCD between DSM-IV-TR and DSM-5 remain the same. The most prominent difference between the OCD criteria in DSM-IV-TR and DSM-5 is in the specifiers section, with DSM-5 expanding on the “with poor insight” specifier in DSM-IV-TR. In DSM-5 the specifier insight range has been expanded and includes “good to fair insight”, “poor insight”, or “absent insight/delusional”. A tic-related specifier, which was not present in the DSM-IV-TR criteria of OCD, has also been added to the DSM-5 OCD criteria.

The conceptualisation of OCD in the ICD-10 and DSM systems appear to be similar, except for a few difference on specific features of the disorder. The differences that the ICD-10 mentions, that neither the DSM-IV-TR nor the DSM-5 mentions, are that the compulsive act must not be pleasurable and obsessions or compulsions must be present most days for at least two weeks. The DSM-IV-TR and DSM-5 specify a timeframe an individual might spend on their OCD symptoms (e.g., more than one hour a day) whereas the ICD-10 does not specify a timeframe. Lastly, the specifiers section in ICD-10 is also different to both the DSM-IV-TR and DSM-5. The ICD-10 does not specify insight or tic-related disorders but instead specifies whether an individual has more obsessions than compulsions/or predominant obsessions, if they have more compulsions than obsessions/or predominant compulsions, if the number of compulsions and obsessions are similar/mixed obsessions and compulsions, or if the individual’s OCD symptoms do not fit into either of the other specifiers. The DSM-IV-TR and the DSM-5 do mention that obsessions or compulsions may be more prominent than the other but they do not specify which is more prominent in a specific diagnosis.

### ***2.2.1.1 Obsessions***

Obsessions are “recurrent and intrusive thoughts, feelings, ideas, or sensations” (Sadock & Sadock, 2007, p. 604). Obsessions are not voluntary and/or pleasurable to the individual with OCD but are intrusive and unwanted, and cause severe distress or anxiety for the individual diagnosed with OCD (APA, 2000; APA, 2013). The individual with OCD may also tend to overvalue the perceived dangers associated with their disturbing thoughts, feelings, ideas, or sensations, which in turn increase his/her levels of anxiety (Abramowitz, McKay, & Taylor, 2008). A case of OCD can involve a single repetitive, distressing obsession or it may involve numerous obsessions and/or compulsions (Clarke, 2004). However, Clarke (2004) mentions that

the majority of OCD cases involve multiple obsessions and/or compulsions. Obsessions are recurrent and persistent and are therefore time-consuming, and significantly impede an individual's normal daily routine, such as his/her occupational functioning, social activities, and/or relationships (Sadock & Sadock, 2007).

### **2.2.1.2 Compulsions**

Compulsions, often referred to as rituals, are repetitive, stereotypical behaviours or mental acts that the individual feels bound to perform in response to obsessions or according to rules that need to be applied rigidly (Clarke, 2004; Van Niekerk, 2009). Compulsions are “uncontrollable, persistent urges for a person to perform certain acts/rituals to relieve unbearable anxiety or tension” (Thobaben, 2012, p. 211). These behavioural or mental rituals are either performed to strict, distinctive rules the individual enforces upon him-/herself or are excessive or senseless (Abramowitz et al., 2008). The purpose of the compulsion is to reduce anxiety and distress or prevent perceived harm befalling the individual or others. The compulsion is often carried out in response to an obsession (Abramowitz, 2006), with the typical aim being to neutralise or remove the obsession (APA, 2000; APA, 2013). The urge to perform the compulsion is difficult for the individual to resist, and can become too overwhelming to ignore (Van Niekerk, 2009). It is important to understand that even though the compulsion provides relief and a reduction of tension in the immediate future, the individual does not take any pleasure from carrying out these rituals (APA, 2000; APA, 2013). Compulsions are recurrent and are therefore time-consuming, and they significantly impede an individual's ability to follow a normal daily routine, such as their occupational functioning, social activities, and/or relationships (Sadock & Sadock, 2007).

### **2.2.1.3 Link between obsessions and compulsions**

The relationship between obsessions and compulsions is that the obsessions cause distress in the form of anxiety, fear, disgust, and/or shame, which then lead to the individual carrying out a compulsion; this provides temporary relief as the distress subsides in the short term (Abramowitz et al., 2008; Van Niekerk, 2009). Both obsessions and compulsions have different subtypes, as will be discussed in section 2.2.1.6, Subtypes of OCD, and at times the theme in the obsession can be linked to a theme in the compulsion, but this is not always the case (Sadock & Sadock, 2007). According to both DSM-IV-TR (APA, 2000) and DSM-5 (APA, 2013), obsessions and compulsions do not always need to link or co-exist. Therefore, an individual with

OCD may have both obsessions and compulsions; however, an individual can be diagnosed with OCD if he/she experiences either obsessions or compulsions.

#### ***2.2.1.4 Specifiers regarding insight***

According to the DSM-5 (APA, 2013), specifiers help to define a more uniform subgroup of individuals with a specific disorder who share certain similar features. The specifier also helps to convey additional information pertinent to the management of an individual's disorder, such as the planning of treatment.

Often, the degree of insight an individual with OCD has will vary across the different themes of his/her obsessions as well as over time with the same or different themes (Abramowitz, 2006). Many individuals with OCD can recognise the senselessness of their obsessions and compulsions (Thobaben, 2012). However, the “with poor insight” specifier in the diagnostic criteria of OCD in the DSM-IV-TR (APA, 2000) is used to indicate an individual who believes that his/her obsessions are rational, and that their compulsions are reasonable.

DSM-5 has extended the specifiers category of OCD to include not only “with poor insight” but also “with good or fair insight” and “with absent insight/delusional beliefs.” An individual who believes that his/her obsessions definitely will not, probably will not, or may or may not come true, is said to have good or fair insight into his/her obsessive-compulsive symptoms. An individual, who believes that an obsession probably will come true if he/she does not perform the ritual properly, is said to have poor insight into his obsessive-compulsive symptoms. An individual who believes that an obsession will definitely come true if he/she does not perform the ritual properly, is said to have absent insight or delusional beliefs about his/her obsessive-compulsive symptoms. Insight can vary over the course of the illness. The poorer the insight, the worse the long-term outcome may be (APA, 2013).

#### ***2.2.1.5 Subtypes of OCD***

OCD is a heterogeneous disorder that is composed of many different subtypes. Both the DSM-IV-TR (APA, 2000) and the DSM-5 (APA, 2013) state that the content of obsessions and compulsions may vary from one individual to another, but certain themes have been identified as being common. These themes tend to appear across diverse cultures and are reasonably consistent across time in adults who have the disorder. Individuals with OCD often have obsessions and/or compulsions in more than one theme.

The content of obsessions tends to be individualistic and is influenced by the individual's social and cultural contexts as well as personal experiences, with critical incidents in the individual's life being important (Clarke, 2004). Obsessions therefore have many different themes (Van Niekerk, 2009) but typical themes have been identified, as mentioned above. These themes include contamination, symmetry, completeness, sexual behaviour, aggressive behaviour and violence, pathological doubt, responsibility for causing harm, serious illness, obsessional slowness, morality, and religion (Abramowitz, 2006; APA, 2000; APA, 2013; Clarke, 2004).

Compulsions, as with obsessions, are highly specific to the individual, and this contributes to the heterogeneity of the disorder (Abramowitz, 2006). However, certain themes can be seen and extracted from literature and clinical cases on more frequently seen compulsions (Abramowitz et al., 2008). As there are overt compulsions that are seen as behavioural rituals and covert compulsions that typify mental rituals, themes are identified in both categories (Abramowitz, 2006). The overt themes include hand washing, excessive cleaning, excessive checking, repeating routine actions, symmetry (placing items in the correct order or place in order for balance to be restored), a need to ask or confess, repeating words, or counting out loud. The covert themes include saying a silent prayer to oneself, repeating words or phrases in one's head, counting silently, mentally neutralising, and avoidance (Abramowitz, 2006; Abramowitz et al., 2008; APA, 2000; APA, 2013; Clarke, 2004; Van Niekerk, 2009).

Many individuals with OCD have one of these themes but it is important to note that these themes do have overlapping aetiological mechanisms, and individuals with OCD can present with more than one subtype or theme (Abramowitz et al., 2008; McKay et al., 2004). Blashfield and Livesley (1999) as well as Clarke (2004) note that the grouping of subtypes of OCD facilitates communication between mental health professionals; the identification of a common aetiology of the disorder; the prognostication of the course of the disorder; and the effectiveness of a treatment option and plan to specific sufferers for certain themes within OCD.

#### ***2.2.1.6 Comorbidity with OCD***

Brown, Campbell, Lehman, Grisham, and Mancill (2001) state that diagnostic comorbidity refers to "the co-occurrence of two or more current or lifetime mental disorders in the same individual" (p. 585). Clinical mental disorders rarely occur in isolation, and individuals who have been diagnosed with one mental disorder have a much higher probability of meeting the criteria for another mental disorder (Caspi et

al., 2014; Hasin & Kilcoyne, 2012; Kessler, Chiu, Demler, Merikangas, & Walters, 2005). This comorbidity is important to note as it can disrupt both diagnosis and treatment, leading to a poor prognosis (Caspi et al., 2014). It may also be useful for research as it may suggest a common underlying aetiology (Sanislow et al., 2010). The comorbidity between two disorders may vary over time. OCD may present as the primary or secondary disorder in different individuals (Clarke, 2004).

According to Cordioli (2008) and Sadock and Sadock (2007), and it is rare that OCD occurs in isolation. There is frequent comorbidity between OCD and other related disorders (APA, 2013). The most common co-occurring diagnoses with OCD are anxiety and depressive disorders. The comorbidity between OCD and other anxiety disorders is also high, with many individuals with OCD experiencing added anxiety disorders or symptoms (APA, 2013; Clarke, 2004). DSM-5 (APA, 2013) reports rates of 76% of individuals with co-occurring OCD and another anxiety disorder. The most commonly co-occurring anxiety disorders with OCD appear to be generalised anxiety disorder (GAD), social anxiety disorder (SAD), specific phobia and panic disorder (Abramowitz, 2006; APA, 2013; Clarke, 2004). It is reported that as many as 63% of people with OCD have a co-occurring depressive disorder with 41% having experienced a major depressive episode or dysthymia in their lives (Abramowitz, 2006; APA, 2013). Bipolar disorder is also seen as a common co-occurrence with OCD (APA, 2013).

There is growing evidence and recognition of a wide range of psychological and neuropsychiatric disorders that may be related to OCD (Stein & Lochner, 2006). This is evident by the inclusion of OCD under a new heading, obsessive-compulsive and related disorders (OCDs) in the DSM-5 (APA, 2013; Storch, Abramowitz, & Goodman, 2008). Comorbidity rates for OCDs in individuals with a primary diagnosis of OCD have been on the increase (Clarke, 2004; Storch et al., 2008). Approximately 20% of individuals with hoarding disorder also meet the DSM-5 criteria for OCD (APA, 2013). DSM-5 (APA, 2013) does not provide any statistics but states that body dysmorphic disorder, trichotillomania, and excoriation disorder occur more frequently in individuals with OCD than in individuals without OCD. Persistent thoughts about illness can be present in both hypochondriasis and OCD, and can be obsessional, with repeated checking and reassurance seeking other common symptoms of hypochondriasis that resemble compulsive behaviour (Fallon, Rasmussen, & Liebowitz, 1993; Rasmussen & Eissen, 1992). These references are in

line with DSM-5 (APA, 2013), in which hypochondriasis is renamed illness anxiety disorder. Because it is a newly named disorder there are no exact comorbidities known, with DSM-5 (APA, 2013) referring back to hypochondriasis co-occurring with OCD (when the diagnosis was still called hypochondriasis). Tics or tic disorders, according to DSM-5 (APA, 2013), are common and co-occur with up to 30% of individuals with OCD. A tic disorder comorbid with OCD is common in individuals whose OCD manifested in childhood. There are no figures, but according to DSM-5 (APA, 2013), there are also signs of common co-occurrences between OCD and attention-deficit/hyperactivity disorder (ADHD), particularly in children.

Lastly, there appears to be comorbidity between OCD and substance use disorders (SUDs). According to Hasin and Kilcoyne (2012), individuals diagnosed with OCD are at a higher risk of using and abusing substances than the rest of the population. Denys, Tenney, Van Megen, De Geus, and Westenberg (2004) along with Mancebo, Grant, Pinto, Eisen, and Rasmussen (2009) also reported a large number of participants, in both of their studies, who had co-morbid disorders of OCD and SUDs. Mancebo et al. (2009) also found that out of the 12% of his study who had both OCD and SUD symptoms, 12% had an alcohol-use disorder, 11% had both an alcohol-use and a drug-use disorder (cannabis, cocaine, opioid, sedatives/anxiolytics), and 3% had only a drug-use disorder. Therefore, they conclude that alcohol appears to be the most prevalent of SUDs in co-occurrence with OCD.

### **2.2.2 Prevalence, gender and course of OCD**

There are no exact, official statistics on the prevalence of OCD in South Africa but, according to SADAG, (2012), OCD appears to occur at similar rates around the world, which includes South Africa. The statistics on the prevalence of OCD in this study are related to the American population; however, it can be used to gauge the prevalence of OCD in South Africa due to SADAG (2012) suggesting the rates in percentages are similar; with DSM-5 (APA, 2013) also suggesting that there is a similar prevalence rate of OCD internationally as in America.

Between 1.6% and 2.3% of the American population are affected by OCD, which makes it one of the most common psychological problems (Barlow & Durand, 2015). OCD ranks eleventh in the World Health Organisation's (WHO) leading causes of health burden globally (Üstün et al., 2004). OCD is also the fourth most common psychological disorder after depression, substance abuse, and phobias, with most individuals suffering with OCD for several years before they get a diagnosis and



treatment (Van Niekerk, 2009). The lack of diagnosis and treatment appears to be due to the failure of individuals with OCD to report symptoms, the high rates of comorbidity with other mental disorders, or the lack of screening for obsessions and compulsions by professionals (Abramowitz, 2006).

OCD was once considered a rare disorder (Wright & Hewlett, 1994), but it has since been found that one in 100 individuals currently suffer from OCD, with almost twice that number of individuals reporting having had obsessions and compulsions at some point during their lives (IOCDF, 2014). However, the percentage of people with OCD may be higher as this disorder is possibly underreported. As described above, it may be due to a lack of recognition of OCD by healthcare providers and therefore the underdiagnosing of the disorder; however, this may also be due to the stigma surrounding the disorder (Thobaben, 2012). The insight the individual has into the illogicality of their thoughts and actions creates a feeling of shame and secretiveness about their obsessions and compulsions. Individuals with OCD find it difficult to speak to their family, friends, general practitioners, and mental healthcare givers about their disorder (Thobaben, 2012).

OCD can have a severe impact on an individual's quality of life (Stengler-Wenzke et al., 2007). According to findings from El Sayegh, Bea, and Agelopoulos (2003), which is also highlighted in the DSM-IV-TR (APA, 2000) and DSM-5 (APA, 2013), OCD can affect many different functions of the person's life, including interpersonal interactions, work, and academic achievements. The symptoms are time-consuming and distressing, leading to possible social isolation.

It would appear that OCD manifests equally in males and females, with males having a slightly earlier age of onset (in the late teenage years) than females (in their early twenties) (APA, 2000; APA, 2013; Van Niekerk, 2009). Young adults between the ages of 18 and 24 years appear to be at highest risk for developing OCD (Sadock & Sadock, 2007). The onset of OCD is typically gradual and has a chronic, waxing-and-waning course if left untreated (Abramowitz, 2006; Stewart et al., 2004) with stress being a major factor in symptom production and severity (Van Niekerk, 2009). If this disorder is left untreated, it often runs a chronic, deteriorating course (Abramowitz, 2006; Olatunji et al., 2007).

### **2.2.3 Aetiology of OCD**

The aetiology of OCD remains a debatable subject. However, it is likely that a combination of biological, hereditary, and psychological factors contributes to the

development of OCD (Rossouw, 2012). Research suggests that there are higher rates of OCD in individuals with first-degree biological relatives with OCD as well as higher rates of OCD in monozygotic twins than in dizygotic twins (APA, 2013) which points to a hereditary factor. Sadock and Sadock (2007) also support the hypothesis that OCD has a significant genetic probability. Individuals with OCD are also believed to have different brain chemistry showing a biological causal factor, as individuals with OCD are thought to have too many or too few serotonin neurotransmitters in the brain (Rossouw, 2012). This theory is still inconclusive but has been postulated because serotonergic medication has proved helpful in the treatment of OCD (Abramowitz, 2006). Sadock and Sadock (2007) also support the hypothesis of a dysregulation of serotonin involved in the formation of OCD, but they add that there may also be dysregulation in the noradrenergic system in individuals with OCD. They also suggest that there may be a positive link between streptococcal infection and the development of OCD. The biological causal factor component is again highlighted by Sadock and Sadock (2007) when they mention the availability of data which suggests that there may be altered functioning in the neurocircuitry between the orbitofrontal cortex, caudate, and the thalamus in an individual with OCD.

The psychological causal factors fall within the cognitive and behavioural theories, which suggests that anxiety and the fear of harm befalling oneself or others are learned through errors of misappraisals of thoughts (Rossouw, 2012). Research indicates that people who do not meet a diagnosis of OCD tend to have the same or similar thoughts as those individuals with OCD (Abramowitz, 2006; Muris, Merckelbach, & Clavan, 1997). According to Abramowitz (2006) and Rossouw, (2012), individuals choose which thoughts or images they should pay attention to, and that usually people pay attention to thoughts that are more important or significant to them. The difference seems to be that individuals with OCD tend to attach more importance or significance to the bizarre thoughts than people without OCD normally do; individuals with OCD then try to neutralise those bizarre thoughts, and when they find a ritual that neutralises these bizarre thoughts and their anxiety level then drops, the individual with OCD incorrectly learns that this is how to deal with the bizarre thoughts. However, these rituals actually perpetuate the bizarre thoughts, and the symptoms of OCD get worse (Abramowitz, 2006; Rossouw, 2012).

The above section briefly highlights the latest findings on the aetiology and causal factors of OCD. Due to the limited scope of the dissertation and the causal factors not being the focus of the dissertation, I acknowledge the latest findings but I will not be elaborating on these findings further.

#### **2.2.4 Treatment of OCD**

The treatment that has been indicated as the most successful in treating OCD appears to be a combination of medication and Cognitive-Behavioural Therapy (CBT) (Anderson & Rees, 2007; Gellatly & Molloy, 2014; Thiel et al., 2014; Van Niekerk, 2009). According to Abramowitz (2009), the medications most effective for treating OCD are Anafranil, Zoloft, Prozac, Luvox, Paxil, and Celexa. Abramowitz (2009) continues by stating that these medications help reduce OCD symptoms by 20% to 40% within a 12-week period by increasing the concentration of serotonin in the brain.

CBT which according to Anderson and Rees (2007), Gellatly and Molloy (2014), Rossouw (2012), Thiel et al. (2014), and Van Niekerk (2009) is the most effective psychotherapy for OCD, attempts to disrupt the inaccurate or dysfunctional appraisals held by the individual regarding their obsessions and compulsions (Rossouw, 2012). Exposure and Response Prevention (ERP) is a strategy in CBT used to weaken the association between the obsessions, the feelings of anxiety, and the urge to perform the compulsion (IOCDF, 2014; Rossouw, 2012). Barlow (2010) suggests that it is important that trained professionals are competent in carrying out ERP techniques. If the trained person is not competent, the OCD symptoms their client is experiencing may not improve. It may harm those clients, as the symptoms do not improve, whilst still putting themselves through highly stressful and anxiety-provoking situations. However, if clients are taught the correct CBT techniques by a competent professional, they can be given homework and will eventually be able to carry out the CBT techniques themselves. According to Westbrook, Kennerley, and Kirk (2008), CBT consists of a combination of Cognitive Therapy and Behavioural Therapy. In order to describe CBT for OCD, the fundamentals of Cognitive Therapy and Behavioural Therapy will be discussed separately in order to give a thorough understanding of the components of CBT for OCD. The CBT components will also be divided into cognitive and behavioural elements. Barlow (2010) suggests that individual psychotherapy for individuals with OCD often includes the therapist first

implementing the cognitive element of CBT, and only once the client has an idea of his/her cognitions around OCD, would he/she implement the behavioural component.

Abramowitz (2006) and Clarke (2004) explain that Cognitive Therapy for OCD is used in order to give the individual with OCD information on obsessions and compulsions and to put both the obsessions and compulsions into perspective. The individual with OCD is made aware of how he/she gives certain thoughts negative appraisals. This negative appraisal leads to high levels of anxiety and dread that the obsession may in fact lead to the dreaded event. By completing a compulsion and “avoiding” a negative event from occurring, the anxiety subsides for a moment and the individual with OCD learns that by doing the compulsion his/her anxiety will subside. However, the obsession will re-occur and his/her anxiety levels will again rise. The individual with OCD does not learn that by confronting the obsessional thought without doing the compulsion his/her anxiety levels will initially rise but that eventually his/her anxiety will subside and the negative consequences that he/she believed might occur due to their obsessions in fact do not occur. By continuously avoiding carrying out the compulsion, the obsession begins to fade over time. Once the cognitive aspect of how the individual with OCD gives thoughts, images or impulse a negative appraisal and how his/her compulsions reinforce this negative appraisal is explained and this individual demonstrates that he/she understands this cognitive element, the behavioural component is attempted.

Behavioural Therapy for OCD, which consists of ERP, is conducted by asking the individual with OCD to rank their obsessions and compulsions, from most disturbing or difficult to stop or deal with, to the least disturbing or difficult to stop or deal with. With the help of the therapist, the individual will rank his/her obsessions and compulsions on a scale of 0 to 100, with 0 being not disturbing at all, and 100 being his/her worst obsession or compulsion and the one that will be the most difficult to attempt to combat. The individual, along with the therapist’s guidance, selects an obsession and a compulsion the individual with OCD is willing to work on that will be challenging enough while at the same time not be too difficult that the individual with OCD will terminate therapy. Usually the individual with OCD and the therapist will agree on an obsession around the 45-point mark on the scale. The individual with OCD is gradually brought into contact with the obsession physically or is instructed to purposefully think of the obsession instead of avoiding it, and is asked to avoid carrying out the compulsion he/she would normally complete if he/she had this

obsession. The individual's anxiety will initially increase and this will be uncomfortable, but when the anxiety reaches the top of its curve, it starts to subside and he/she realises that the anxiety will subside and that the dreaded event he/she feared did not occur. The individual with OCD now learns that he/she can have the obsessions but that he/she does not need to carry out the compulsion. The therapist and the individual with OCD will continue to work their way up the scale they have created together, and attempt more difficult obsessions and compulsions until they have worked through the toughest obsession and compulsion. The individual with OCD will still have disturbing thoughts, images, and impulses, as all people do, but the disturbing thoughts, images, and impulses will occur less frequently and he/she will now have the skills to deal with these negative thoughts, images, and impulses (Abramowitz, 2006; Clarke, 2004).

CBT for OCD is often conducted in individual psychotherapy and as explained above, it is an effective form of therapy for OCD. However, according to Anderson and Rees (2007), group CBT is also becoming prominent in the treatment of OCD. These two authors explain that the techniques used for individual CBT for OCD are the same techniques used in psychotherapy groups for CBT, the only major difference being that within the CBT psychotherapy group, the group members with OCD encourage each other to get their symptoms under control. Anderson and Rees (2007) and Steketee and Pigott (2006) explain that CBT psychotherapy groups are useful as a treatment option as there are a relatively small number of clinicians trained specifically in CBT for OCD around the world and the group format allows for more individuals with OCD to receive effective psychotherapy. Steketee and Pigott (2006) describe that in a therapy group for OCD individuals set goals for themselves to get their OCD under control, which lines up with their individual CBT therapy goals and in particular their exposure hierarchy, and then attempt to reach these goals either in the group space or as homework.

Prior to the 1970s, OCD was seen as a disorder from which recovery was poor. However, with the advent of CBT treatment, the chances of recovery have increased (Anderson & Rees, 2007; Gellatly & Molloy, 2014; Thiel et al., 2014). Today, there is a positive view that people diagnosed with OCD are able to lead a normal life again, with as many as 70% of individuals with severe OCD returning to normal daily functioning with the help of CBT (Abramowitz, 2006). Therapists guide the individual through an organised, step-by-step schedule. With time therapists have

reduced the amount of time they need to spend with the client during the programme, and have increased the amount of homework and self-help the client must carry out. Some research even indicates that OCD sufferers can successfully reduce their symptoms with minimal guidance from a professional, if they use written self-help instructions (Rosqvist, Thomas, Egan, & Willis, 2000). Rosqvist, Thomas, Egan, and Haney (2002) believe that to correctly administer CBT and ERP does initially require the expertise of a professional; however, once the individual diagnosed with OCD has learned the techniques from the therapist, he/she can carry out the exposures on his/her own. These authors explain that social support is needed in order to see the individual with OCD through this tough time.

Social support, however, may be difficult to obtain as many individuals with OCD tend to hide their symptoms from friends and loved ones for fear of rejection or because of the stigma attached to this disorder (Fennell & Liberato, 2007; Heyman et al., 2006). According to Ociskova et al. (2013), this fear of a stigma is known as internalised stigma or self-stigma. It is a term used for a process in which an affected individual adopts negative stereotypes that society holds against him/her. A person, who internalises prejudices, completely agrees with their content, believes that he or she is deficient because of having the stigmatised characteristics, and anticipates being rejected by society in reaction to public disclosure of the devalued attributes. Fennell & Liberato (2007) also found that this is especially relevant when the subtype of OCD an individual displays is not widely understood by the general public. OCD is more than merely the washing of hands, cleanliness, and wanting order and symmetry. Individuals may experience fear of physically or sexually harming another person, harm befalling loved ones or themselves or having an obsession about running someone over with their car. These subtypes of OCD, along with many others, may contribute to the individual with OCD feeling isolated and misunderstood by friends and family. They may also live in fear of how the public may respond to them, if the latter became aware of these obsessions.

Hollander and Stein (1997) highlight that support groups for OCD can be effective for individuals with OCD to join, after having had individual psychotherapy (CBT) in order to consolidate gains, as even when the OCD symptoms are under control it requires motivation to implement the techniques taught when the obsessive thoughts do get slightly worse during stressful times. These two authors also state that OCD support groups may be beneficial for family members of individuals with OCD

to join in order to learn how to deal with the individual with OCD. Forsyth (2013) states that support groups can be a good adjunct to treatment for a mental disorder as they can provide a space for interpersonal learning, educational insights, and therapeutic gains. Broatch (1996) mentions that OCD support groups serve to lower social isolation in individuals with OCD and that these support groups also serve as a pathway or a starting point to treatment for OCD, as the support group provides education about treatment to the individual with OCD. Broatch (1996) explains that an OCD support group may also motivate an individual with OCD to re-enter treatment if they have stopped a treatment programme. Black and Blum (1992), Davis (2008), and Tynes et al. (1992) described that OCD support groups are beneficial to individuals with OCD as they provide a space for them to get the social support they require as well as education on OCD. Steketee and Pigott (2006) also highlight the importance of OCD support group and the importance of their educational aspect. Steketee and Pigott (2006) argue that OCD support groups focus on an expert on OCD giving a talk on a topic related to OCD for half the meeting and then the rest of the meeting is opened up for questions and answers with the expert or other members of the group. Despite the above research on support groups being beneficial to OCD sufferers, there is currently no other relevant research available for these groups being used as a treatment tool for individuals with OCD. There is also no research in South Africa on OCD support groups being used as a treatment tool for individuals with OCD.

## **2.3 Social Support and Support Groups**

### **2.3.1 Social support**

According to Davison, Pennebaker, and Dickerson (2000, p. 205), “the experience of an illness is profoundly a social one.” When an individual goes through suffering, powerful emotions may be evoked which can elicit a desire for support. As described in the introduction to this chapter, Forsyth (2013, p. 116) describes social support as “a sense of inclusion, emotional support, advice, guidance, tangible assistance, and spiritual perspective given to others when they experience stress, daily hassles, and more significant life crises”.

Social support, according to Newcomb (1990), is a continuously evolving process throughout an individual’s lifetime. Social support includes a range of interpersonal exchanges that are reciprocal and bidirectional between an individual and other people within his/her social world. Human connectedness is a crucial

element to social support. Newcomb's (1990) idea of social support is added here to Forsyth's (2013) definition to emphasise the interactional process of social support.

Social support consists of interpersonal interactions that contain three components. These three components are social schemata, supportive transactions, and supportive relationships (Pierce, Sarason, & Sarason, 1996). Pierce et al. (1996) describe that a person develops a mental map or schemata from his/her past history and experience. He/she will use these schemata in order to predict the behaviour of others in order to gauge what their intentions may be. If an individual has received positive emotional support in childhood and adolescence, and this continues into adulthood, they may develop supportive schemata. They perceive the support from others in their social network as positive, and will likely seek out support when it is needed. This person will likely have a positive self-image and coping skills that will benefit him/her during stressful, highly emotional situations. Studies also suggest that individuals who have supportive schemata are more likely to provide positive emotional support to others (Sarason, Sarason, Hacker, & Basham, 1985). However, if the person has received negative emotional support or no emotional support during childhood, adolescence, and adulthood, that individual may develop an unsupportive schema. This individual may perceive others in his/her network as unsupportive, will not seek out their assistance when support is needed, and will be prone to have a negative self-image (Lahey & Cassidy, 1990; Sarason, Pierce, Bannerman & Sarason, 1993).

Cutrona and Russell (1987) have shown that in supportive relationships individuals experience higher levels of satisfaction when they receive as well as provide social support. Individuals in a relationship are both a source and a recipient of social support. Giving and receiving support are not isolated events. By giving support to another person, the individual who is giving the support is, at the same time, receiving support from that person they are giving support to. Therefore, by providing social support to another person helps manifest and maintain healthy functioning which in turn increases both individuals' self-esteem.

Behavioural exchanges between individuals that include supportive behaviour, support provision, and support seeking are useful in providing supportive transactions. Not all of these elements are needed but most transactions involve an individual seeking support from another individual (McGuire, 2007; Uchino, 2004). McGuire (2007), Thoits (2011), and Uchino (2004) suggest that supportive behaviour



consists of both emotional and instrumental support. Emotional support constitutes behaviours that convey a sense of caring for the individual (McGuire, 2007; Thoits, 2011). Instrumental support comprises behaviour that provides backing in a task-directed way (Thoits, 2011; Uchino, 2004). Instrumental as well as emotional support may occur simultaneously in a successful supportive relationship, as providing someone with instrumental support may be taken by the recipient as that individual is caring for him/her and hence emotional support also occurs (McGuire, 2007; Thoits, 2011; Uchino, 2004). The intentions of the support provider and the judgments made by the individual receiving the supportive behaviour are important and help facilitate coping with short term life events and long term functioning (Pierce et al., 1996).

Social skills play an important part in support-seeking behaviour. Williams (1995) believes that individuals who have acquired adequate social skills will seek out social support more often than individuals who have poorer social skills. In turn, seeking out social support will also improve the individual's social skills. People who seek support from those around them tend to cope better than people who do not seek support (Milgram & Palti, 1993). Individuals who do not seek out support are less likely to receive the support they need or desire (Searcy & Eisenberg, 1992). The individual who asks for help directly has a greater chance of receiving help than an individual who insinuates a desire for help (Pierce et al., 1996). The more individuals seek out help the more help they will receive and the more trusting they will be of others. The more trusting they are of others the more they will seek out help (Nakashima et al., 2013).

The way the support is provided as well as the timing of providing that support is also important. How the support provider gives the support, what the support provider says verbally, and how the support provider conducts himself/herself non-verbally will be assessed by the recipient of the support. When to give the support is then another consideration of the support provider, as the recipient needs to be ready to receive the support. Individuals who receive support too early may not develop adequate coping skills, and if they receive the support too late they may perceive themselves and the people around them as non-supportive. Support providers should also be aware of their own readiness to provide support. If they are not ready to give support, they may give support which is unwanted and this may damage the relationship (Pierce et al., 1996). However, the relationship between the support provider and support recipient is reciprocal and therefore the manner in which the

support recipient receives the support can also facilitate or damage a relationship (Pierce et al., 1996). A recipient may desire a certain type of support but he/she has the responsibility to make the support provider aware that the support offered is not relevant or required. This honesty will strengthen the relationship and give both individuals the opportunity to determine what support they need at a given time (Pierce et al., 1996).

Nakashima et al. (2013) have stated that an individual identifying with a group of people that are similar to him/her in certain aspects is important in achieving social support. They continue by stating that the higher the positivity of the group the individual identifies with, the stronger the individual will identify with that group of people. The stronger the individual will identify with a group of people, the larger will be the psychological base provided by that group of people, which will in turn build trust and intensify and widen the amount of social support the group can provide. The more strongly an individual identifies with a group of people he/she perceives to be similar to him-/herself in some aspect, the more positive the impact will be on that individual's mental health. Thoits (2011) also demonstrates that social support can act as a buffer against mental illness progressing.

Clarke et al. (2005) have also shown that support helps to motivate and influence a positive behaviour change for the support recipient. Family members and friends provide and receive support from each other in their daily lives. However, when this support is lacking in individuals' social and family environments, society has found other ways of providing support to those, particularly with physical and mental disorders. These support systems tend to be in the form of face-to-face or online support groups (Davis, 2008).

### **2.3.2 Support groups**

Individuals join various kinds of groups in an attempt to solve a problem. The individual may try solving a problem in a certain group by attempting to discard something or by seeking something else out. Certain groups, such as change-promoting groups, may provide a space for individuals to lose weight, help them with their depression, or remove irrational thoughts; or provide a space to learn new skills, gain insight into their behaviours, acquire a new repertoire of behaviours, and/or obtain a different outlook on life (Forsyth, 2013).

Forsyth (2013) identifies three types of groups, namely therapeutic, interpersonal learning, and support groups, any one of which individuals may use to

reach goals that they have difficulty achieving on their own. Forsyth (2013) states that therapeutic groups provide members with a therapeutic space in which they can overcome their psychological difficulties, particularly problems such as depression, anxiety, personality disorders, and trauma-induced stress. These groups are led by a mental health professional. Forsyth (2013) mentions several different types of therapeutic groups with one of these types of groups being a Cognitive-Behavioural Therapy group (CBT group). He states that CBT groups apply the principles of individual CBT psychotherapy within a group context. Therefore, the underlying precept of a CBT group is that problematic thoughts and behaviours are acquired through experience, so the development of healthy cognitions and behaviours and the avoidance of undesirable cognitions and behaviours are encouraged. Forsyth (2013) then speaks of interpersonal learning groups that help members gain a better understanding of themselves as well as build on their relationships with others. These groups are often led by professionals but can also be led by untrained, but competent, laypersons. The third group he mentions is support groups. He postulates that support groups provide members with an opportunity to learn how to cope with a problem in an environment in which all members have a common or similar problem.

Davis (2008) states that support groups can be online or face-to-face support groups. He mentions that online support groups are designed for individuals with a similar problem to log onto a website at a time convenient for them, to speak to others anonymously, and to get emotional support and educational insights about their common problem. Davis (2008) describes that face-to-face support groups are groups of people with similar problems who meet in a designated place to exchange information and to give and receive emotional support if the group is closed and there is confidentiality apparent. The group functions as a safe place or environment for individuals to share their feelings with others who have similar experiences (Barak, Bon-Nissim, & Suler, 2008). This exclusivity of symptoms and experiences has long been a factor in helping to create a sense of belonging among the members (Pilisuk & Parks, 1980). In the context of this study, the face-to-face support groups refer to a collective group of persons dealing with the problem of OCD.

In resource-limited settings such as developing nations, in this case South Africa, interventions that are practical, feasible, and cost effective are desirable. Support groups are offered most often free of charge to the members, they run at a time convenient to the members (e.g. after hours), and may be held in any suitably

convenient place (Simoni, Pantalone, Plummer, & Huang, 2007). Steketee and Pigott (2006) also highlight the cost-effective nature of support groups. This tends to fit the description of what may be needed in South Africa as well as other developing nations.

Forsyth (2013) states that support groups can be led by a mental health professional but are often overseen by a competent, knowledgeable layperson. Many of these groups may not hold a formal leadership position; the obligation of leadership then falls on each and every member of the group, particularly the members of the group who have been involved with the group for a long period of time. Therefore, according to Forsyth (2013), support groups are often called mutual-aid groups, mutual-help groups and/or self-help groups as the members rely on each other to both receive and provide assistance. Yalom (1995) also speaks of self-directed groups, which are similar to self-help groups as they also have no formal leader and the members rely on each other. He states that this type of group may form out of a formal leader-led group in which the members may believe that an authority figure is restrictive and growth inhibiting. Often a natural leader will emerge from the members and take on a leadership position, but this leader is still regarded as a layperson in the field. According to Yalom (1995) the natural leader will be required to be present at each group meeting, have struggled with or is still struggling to an extent with the common problem of the group, and has a good grasp on how to handle or treat the common problem. Yalom (1995) states that a self-directed group has value, it is helpful and can be effective as long as relationship difficulties and emotional difficulties within the group are attended to and not ignored. Problems in the group may, however, arise that are difficult for untrained individuals to deal with and it is advised that a professional be on hand to provide advice to the group members.

This distinction of the three groups described by Forsyth (2013), however, tends to become blurred, and many of the different group characteristics are carried over to the other groups. For example, a support group may provide group members with a space in which they may obtain therapeutic gains, educational insights, advance their interpersonal learning and learning about themselves, as well as an opportunity to give and receive emotional support (Forsyth, 2013). For the purposes of this study I will focus on support groups.

Kurtz (1997) describes a support group as “a non-profit collection of persons with a common problem for the purpose of emotional support and education that is facilitated by professionals and is linked to a social agency or a larger formal organisation” (p. 4). Many studies have recognised the benefits of support groups to individuals (Chien et al., 2004; Christie, Romano, Thompson, Viner, & Hindmarsh, 2008; Davison et al., 2000; Dobkin, Civita, Paraherkis, & Gill, 2002; Grande, Myers, & Sutton, 2006; Harvard Medical School, 2002; Jenkins, 1996; Peterson, Bergstrom, Sameulsson, Asberg, & Nygren, 2008; Pilisuk & Parks, 1980; Simoni et al., 2007; Spiegel, 1995). There are numerous support groups which focus on a variety of different health concerns, with many concentrating on a specific illness such as HIV/AIDS, cancer, alcoholism, bipolar disorder, depression, ADHD, and schizophrenia (SADAG, 2012). Support groups may exist for any variety of reasons, but Levy (2000) suggests that support groups fall into one of four categories, namely mental and physical health, family and life transitions, advocacy, and addiction. The support group members interviewed for this study attend support groups that fall within the category of mental health.

Not every individual with a health condition participates in a support group, especially if they get the support they need at home (Grande et al., 2006). However, there are people who do not receive the required support at home or do not want to burden family and friends. They may find the support of others helpful and refreshing (Citron, Solomon, & Draine, 1999; Dakof & Taylor, as cited in Grande et al., 2006).

The individual’s experience of illness may influence others around him/her but may also be influenced by the social environment surrounding that particular individual. Therefore, over the course of an illness, the individual may suffer broken relationships (Davison et al., 2000). A support group is its own social system because of the relationships between the members, the unique social environment (Daka, 2005), and each member having certain role expectations which may be different from group to group (Steyn & Uys, 1998). By joining a support group an individual may develop new relationships (Davis, 2008).

According to Forsyth (2013), support groups are unique and no support group will have the same structure and procedures as other support groups. However, Forsyth (2013) also suggests that even though each support group is unique, certain similar features can be extrapolated from most support groups. These features include the support group being problem-focused, in that all the members are dealing with a

common problem. The support group should also be relationship oriented; this means that members learn to trust each other and bonds are formed which may even continue outside the support group context. Most support groups are communal and provide a sense of a community to members. The members therefore create a sense of sharing within the group as they draw support and encouragement from the group but are at the same time expected to provide support and encouragement to others in the group. Older members maintain this culture by passing this on to newer members. The support group may also be seen as autonomous. Usually a support group is backed by an organisation but this organisation is silent and does not have a say in the functioning of the support group meetings. The support group stands alone and functions independently. This autonomy sets the group free from the code under which mental health professionals are bound. The members can therefore take a more practical, no-nonsense approach to dealing with theirs and other members' difficulties. The members take on more responsibility for the success and failure not only of the group as a whole but also of each individual member within the group. This responsibility can be therapeutically beneficial. The last consideration from Forsyth (2013) is that support groups are perspective-based. Each support group develops its own perspective with regard to the central problem, and establishes ways to counter the problem and provide support. This perspective on the problem and how to handle it as a group is passed on from one member to another, and a specific ethos is created and maintained.

### **2.3.3 The support group context**

Pierce et al. (1996) state that certain decisions need to be made with regard to the functioning of the group before the group members can convene. Decisions need to be made, usually by the group gatekeeper (who is usually the leader of the group or the individual who starts the group) about the physical context of the group, how members will gain access to the group, the number of group participants allowed at a given time, how often the group will meet, and the length of each meeting. In a group with no formal leader, the gatekeeper's duties usually fall on multiple members of the group, if not the whole group.

#### ***2.3.3.1 The physical context***

Bennis and Biederman (1997) believe that the physical attractiveness of the environment is not a requirement for group effectiveness. However, the environment of the group needs to fit the goals of the group. For example, the topics discussed in a

support group may be sensitive and the environment needs to be conducive to private interaction. A big open room, with privacy, no distractions and enough room for members to sit comfortably is ideal for support group meetings.

### ***2.3.3.2 Gaining access to the group***

The gatekeeper of the group will initially specify the requirements for joining the group, and how an individual gains access to the group. The group may be a closed group, which meets for a predetermined length of time and accepts no new members once the group has formed, or it may be an open group that has no predetermined termination date and accepts new members to replace those who leave the group (Chesler & Barbarin, 1987). Open groups, or groups with open boundaries, may have a predetermined life span but they usually continue to operate indefinitely, even though every couple of years there may be complete turnover of memberships and of leadership (Yalom, 1995). Group members may therefore be different over time and some members may move between different roles, but the group itself will be maintained by allowing new members to join. The gatekeeper will usually have a screening process for new members in order to maintain the homogeneity of the group, with specific reference to symptoms and experiences (Chesler & Barbarin, 1987). Closed group formats may be more practical in a setting where the group is assured of member stability. Such settings may be long-term psychiatric hospitals, prisons, military base and the like and occasionally in outpatient settings such as a group in which all members are concurrently in individual therapy for the group leader (Yalom, 1995). The gatekeeper will usually have a screening process for new members of the closed group while the group is forming but once the group has formed the screening process is usually stopped as no new members are permitted to join (Chesler & Barbarin, 1987).

### ***2.3.3.3 Size of the group***

The size of the group is a key factor in determining whether a group should commence. Too few members, less than three, is not sufficient for a support group to be viable as this might deviate from the group principles and begin to assume the characteristics of individual therapy. Too many members would also be undesirable as the more members there are the less time there will be for all the individual problems within the group. Having more members than what is required will negate the group becoming too small as not every member will come to every group meeting and the gatekeeper needs to consider that members will also drop out (Budman,

Demby, Feldstein & Gold, 1988; Chesler & Barbarin, 1987; Faulkner, Pearce & O'Keefe, 1995).

#### ***2.3.3.4 The duration of meetings***

Zarle and Willis (1975) argue that the duration of a group meeting should not be less than 60 minutes, but not longer than two hours. The ideal length of a meeting is around 80 or 90 minutes. Anything less than 60 minutes would not allow group members sufficient time to adapt to each meeting, describe their problems, and work through the pertinent issues planned for that meeting. Anything longer than two hours, and the participants would become fatigued, lose concentration, and discussions would therefore be less effective.

#### ***2.3.3.5 The frequency of meetings***

Zarle and Willis (1975) also argue that groups usually meet once a month or once a week. There is no set frequency with which a group may be more effective, but these two authors believe that the ideal frequency of group meetings for intense problems would be twice a month. This affords members an opportunity to process what they had heard during the previous group meeting, whilst at the same time not allowing too much time to elapse between meetings in order for the discussion of problems to continuously flow from meeting to meeting.

#### **2.3.4 Maintenance of the group**

Chesler and Barbarin (1987) argue that the gatekeeper, or the leader of the group, is responsible not only for the creation of the group but also for its maintenance. The gatekeeper is the only thread that initially ties the members of the group together. The leader needs to monitor the size of the group, disruptions within the group, progress of the group members, and the interpersonal relationships. Once the group has been running for a long period of time, older members of the group may begin to help the leader sustain the group. The leader may be self-appointed as he/she started the group or is the expert on the group topic; or the group may appoint a leader from its own ranks.

#### **2.3.5 Lifecycle of the group**

As can be seen from sections 2.3.3 and 2.3.4, the group formation begins long before the first group meeting, with the group leader making certain decisions and putting these decisions in place. According to Yalom (1995), human interaction is rich and complex and can be further compounded by grouping individuals with maladaptive styles together. Therefore, it is apparent that the course of a group, over a



certain length of time, will be complex and unpredictable. However, Yalom (1995) reiterates that there are certain forces acting on all groups that widely influence their course of development, and can initiate useful developmental phases through which a group may need to navigate. These stages will be highlighted below, but it is important to note here that, as Yalom (1995) points out, these developmental phases are seldom easily discerned, and there is considerable overlap between these stages as the boundaries of each stage are indistinct. The group also does not permanently graduate from one stage and tend to revisit previous stages. Yalom (1995) uses the term cyclical in that the group goes through a stage, but later on in its lifecycle the group may revisit or go through a stage that it has already passed through before.

#### ***2.3.5.1 First meeting***

According to Yalom (1995), individuals generally anticipate the initially meeting with trepidation that can be quite extreme. These fears may be allayed by the actual events of the first meeting, as the first meeting is invariably a success. This meeting may include a brief introduction where the ground rules are laid down. The group leader also begins to shape the group norms such as the group context (discussed in section 2.3.3) and, in particular, the orientation of the group (highlighted in section 2.3.2). There is usually a contemplative silence thereafter until one member begins to speak, usually about his/her reason for joining the group (e.g. about his/her problem or reason for seeking treatment) or perhaps his/her discomfort or fear of social interactions or groups. This often provokes similar comments from other members, and common ground begins to be established. According to Tuckman (1965), this phase falls under the forming stage of a group, where the members get to know each other, there are no clearly defined roles or responsibilities, and the leader takes on a dominant role.

#### ***2.3.5.2 Initial stage (after first meeting)***

Usually, there are two tasks which tackle group members initially. Firstly, the group members are to determine a method of achieving their primary goal, which is the reason they joined and secondly, they must focus on their social relationships within the group so that they can create a space in which to achieve their primary goal in comfort as well as to gain additional enjoyment emanating from group membership. In therapy groups, these two tasks happen concurrently and are interdependent (Yalom 1995). During this stage the group members attempt to gauge the relevance of the group, and how they are to achieve their primary goal. They are

also assessing the other members, trying to establish a niche role for themselves, and whether they will get along with the other members. The members typically put their best foot forward as they invest most of their energy into a search for approval, acceptance, respect, and dominance (Yalom, 1995).

Yalom (1995) argues that the members are therefore often testing, hesitant, and puzzled during this stage but they are also dependent. The members look to the group leader or gatekeeper for structure and answers as well as approval and acceptance. Therefore, many of their comments are directed at or through the group leader and the leader's statements are carefully examined for instructions relating to desirable and undesirable behaviour.

According to Semrad (as cited in Yalom, 1995), the content and communicational style in the group is often restricted and superficial at this stage, with many of the members searching for similarities. The topics are therefore discussed on a superficial level with the topics in therapy groups often about symptoms, previous therapy experiences, and medication. Through these topics, however, the members begin to realise that they are not unique in their experiences. This process offers substantial relief to the members, and lays the groundwork for possible group cohesion at a later stage. This stage also includes providing and pursuing advice, but again on a superficial level. Members will often attempt to provide some type of practical solution to another member's problem and through this show mutual caring and interest (Yalom, 1995). According to Tuckman (1965), this initial stage also falls under the forming stage of group development.

#### ***2.3.5.3 Second stage***

In Tuckman's (1965) model of group formation, the stage of storming follows the stage of forming. In this stage of storming, power struggles develop as members begin to clash as they vie for position in the group and try to establish themselves in relation to the other members and the leader. This stage calls for compromise but the group members may not yet be at the compromise stage. Yalom (1995) suggests that in this stage the group members moves away from their fixation on acceptance, approval, commitment to the group, definitions of accepted behaviour, and the search for orientation, structure and meaning, to a fixation on dominance, control, and power. Members try to jockey for a position of power over the other group members as well as the group leader. A hierarchy or social order is then created. Members tend to criticise and judge other members. They do give advice but it's not for acceptance

and understanding, advice is given to show a “better” way of handling a problem or the way it “should” have been handled. This power conflict may initially appear either overt or covert, but it often becomes overt and more apparent when new members who join the group are perceived to appear too dominant. However, according to Yalom (1995), this hostility and anger may not always be present and it may range in form and/or degree. The early development of a group may be heavily influenced by membership problems. This stage sees a high membership turnover, with members who struggle to work through the storming stage, dropping out. According to Yalom (1995), 10% to 35% of members drop out between the 12<sup>th</sup> and 20<sup>th</sup> meetings. This stage also has difficulties with regular attendance and punctuality, with members turning up late or failing to attend certain meetings. They are not yet fully committed, and are still trying to determine whether the group holds any benefits for them (Yalom, 1995). According to Yalom (1995), this membership turnover, absenteeism, and lack of punctuality threaten the early stability and integrity of the group. These membership problems may redirect the group’s attention and energy from its developmental task to the problems of maintaining membership.

Agazarian and Gantt (2003), when referring to systems-centered group development, highlight the authority phase of group development. This stage is similar to what Tuckman (1965) describes as the storming stage and what Yalom (1995) describes as the second stage of group development as the members in a group at this stage are preoccupied with control and power. Initially the members display passive stereotyping of others in the group, but this then moves to actively scapegoating other members. Agazarian and Gantt (2003) state that the passive stereotyping and active scapegoating may later be redirected from the members to the leader of the group; however, those member who remain in the group begin to realise that blaming others does not help them achieve their goals in the group.

#### ***2.3.5.4 Third stage***

Tuckman (1965) describes this stage as the norming stage of group development. In this stage roles and responsibilities are clearer and consensus begins to form. The members begin to agree with one another on big decisions and they respond well to leader facilitation. There is more commitment from the members, and some of the leadership roles in the group are now being shared between the members. The members also discuss group processes and the group structure openly and honestly. Yalom (1995) describes that this stage is the development of group cohesion

(will be elaborated upon in section 2.3.9). During this phase there is an increase of morale, mutual trust, and self-disclosure. The members tend to unite against the outside world, gain member support, and have pride in the group. They also tend to arrange after-meeting gatherings such as having a meal together or meeting for coffee. There is also considerable concern for members who do not attend a particular meeting. At this stage, group members are therefore concerned with intimacy and closeness. However, the group members begin to enjoy the unity after the storming stage and it is possible that they may still hold back on communication of negative affect due to them not wanting to disrupt group cohesion. If the members do get past this slight covert hostility and get to work through it in a cohesive group, then the group becomes a mature working group (see section 2.3.5.5).

Agazarian and Gantt (2003) highlight the intimacy phase in their viewpoints around systems-centered group development, which is similar to what Tuckman (1965) describes as the norming stage and Yalom (1995) describes as the third stage of group development. According to Agazarian and Gantt (2003), in the intimacy phase members of the group become more concerned with their relationships with each other and less concerned with their relationship with the leader of the group. They become close and friendships develop. However, there are a few members of the group who are not interested in relationships, and are intent on achieving their goals on their own. This does initially cause tension in the group, but in time members begin to recognise, acknowledge, and accept these members' differences.

#### ***2.3.5.5 Last stage***

Yalom (1995) states that in this last stage a mature working group has become established. This is an advanced group with true teamwork, resolute in reaching group and members' goals. Yalom (1995) also mentions that these goals may be achieved through structured meetings with structured activities, or by attending unstructured meetings, all depending on the group's underlying paradigm. The group typically stays in this stage but will have brief periods of going back into each of the previous stages, always though returning to this last stage. Tuckman (1965) calls this stage the performing phase as the members have a clear vision and understanding on how to achieve their goals. The members do disagree but this is worked through in a positive way, with necessary changes to processes and structure made. The group is able to work towards their goals while at the same time attending to any relationships issues, structure problems, and difficulties with process. The members become autonomous;

they look after each other and no longer lean on the group leader. They only require the group leader to prescribe the group task or activity and they undertake that activity without assistance or instructions from the group leader (Tuckman, 1965).

The performing stage according to Tuckman (1965) and the mature working stage according to Yalom (1995) is similar to what Agazarian and Gantt (2003), in systems centered group developmental stage, call the interdependent work phase. In this phase members of the group realise that to achieve their goals requires working with other group members despite any unresolved differences. They take responsibility for their roles in the group, and this allows the group to freely use all its resources to achieve group goals as well as those of individual members.

### **2.3.6 Subgrouping**

Yalom (1995) mentions that subgroup formation arises in the group from a conviction of two or more members that they can gain more from a connection with each other than with the entire group. Subgroup formation is inevitable in a group formation. Often members within the group who perceive themselves similar on many different types of relevant topics, such as age, gender, group status, and the like, tend to gravitate towards each other and form coalitions or subgroups. Socialising outside the group is often the first stage of subgroup formation and at times, two members of the subgroup may become sexually involved. Subgrouping can be disruptive to the larger group but it can also enhance the larger group from which it originates.

The members of the subgroup have a general code of behaviour suggesting that regardless of the issue, they will agree with each other to avoid confrontations in the subgroup. If the goals or the code of behaviour of the subgroup do not correspond to those of the group, the members' loyalties get tested. Therefore, subgroups can cause disruptions in groups as members may regard being part of a subgroup as more complicated and less rewarding. The member is caught in the trap of should he/she abide by the group rules of being free and honest and in so doing betray the subgroup or should he/she be dishonest in the group and keep subgroup loyalties (Yalom, 1995). Sexual relationships may also cause severe problems and disruptions in the group as the members will elevate their love/sexual relationships to each other above all other ties, even group and member ties, and group cohesion. These relationships may be elevated to a position above the primary goals they set for themselves initially. The other members may then feel betrayed. However, it is difficult for group leaders to prevent or forbid sexual relationships in the group as members of the group

do become close and intimate, and sexual relationships are inevitable. It frequently occurs that at least one of the members of the love/sexual relationship would leave the group (Yalom, 1995).

However, with the above in mind, subgrouping can also be effective therapeutically to the group and therefore not disruptive to the members. According to Yalom (1995), if the goals of the subgroup are in line with and consistent with the goals of the group, then subgrouping may enhance group cohesion. Therefore, what is important for an effective subgroup is that if anything happens within the subgroup, it should be highlighted and brought to the attention of everyone in the group and discussed openly. The members may then learn from the subgroup experiences. Yalom (1995, p. 339) underscores this when he states, “it is not the subgrouping per se that is destructive to the group but the conspiracy of silence that generally surrounds it.”

### **2.3.7 Concurrent individual therapy and group attendance**

According to Yalom (1995), individuals can attend both individual therapy and group therapy concurrently but neither is a requirement or a prerequisite of attendance in the other. He contends that problems arise when the paradigm the individual therapist works from differs drastically from the paradigm of the group or the group leader. If the individual therapist and the group’s paradigms match then they can complement each other. This suggests that the most optimum position for an individual if they are attending both individual therapy and a group, in which therapy is conducted, is for the individual therapist and the group leader to be the same person (Yalom, 1995). A problem with this may be that the group member initially finds the group less supportive than individual therapy as they get less attention. However, if the group member stays in the group he/she frequently begins to find the value in the group and will often decide to terminate individual therapy at a later stage and only continue with the group (Yalom, 1995).

According to the form 223 by the Health Professions Council of South Africa (HPCSA) (2004), a mental health professional should, if seeing individuals in different settings, at the outset describe the roles and responsibilities of all members and discuss the limitations of confidentiality. It is also important according to the form 223 of the HPCSA (2004) that the mental health professional avoids multiple/dual relationships with any members that they are involved with in

individual psychotherapy and/or group psychotherapy that blur the professional lines of a mental health professional's role.

### **2.3.8 The therapeutic value of support groups**

According to Lieberman (1979), by joining a support group, members already make a commitment to change. They are trying to facilitate change by actively joining the group. Yalom (1995) suggests that once the individual has joined the group, common therapeutic or curative factors are in operation in the change-promoting process of the group. These curative factors have been classified by Yalom (1995) as instillation of hope, universality, imparting of information, altruism, the corrective recapitulation of the primary family group, development of socialising techniques, imitative behaviour, interpersonal learning, group cohesiveness, catharsis, and existential factors. Forsyth (2013) mentions a few of these factors as well, and he believes that universality, hope, social learning, group cohesiveness, educational, disclosure and catharsis, altruism, and insight are important in the group-changing process. These factors will be discussed below, based on both Forsyth (2013) and Yalom's (1995) arguments. Each factor is described independently; however, it must be kept in mind that within group dynamics these factors are interdependent.

Instillation of hope appears to be a significant therapeutic factor and tends to have more value to newer members in the initial stages of their group experience. Hearing stories of how members have improved with regards to their disorder as well as observing improvements in other group members gives members the sense of hope that improvement is possible and achievable (Forsyth, 2013; Yalom, 1995).

According to Forsyth (2013) and Yalom (1995) universality may again be a factor that is more beneficial in the earlier stages of group therapy. Individuals with a disorder might have a sense of being unique and different to others. They will often conceal their symptoms or avoid social contact for fear of being regarded as unusual. They may experience loneliness and an attitude of "why me?" or "why am I different to everyone else?" The group forms a space in which the individual gets to meet and interact with people who have similar symptoms and experiences to themselves. This space shows the individual that they are not alone and that there are other people in the world like themselves. They may even come to view their symptoms and experiences as normal. Steketee and Pigott (2006) confirm that universality may be an important benefit in OCD groups as it can lead the individual with OCD to feel

accepted and it can also break down the stigma around OCD that leads individuals with OCD to isolate themselves and in turn be lonely.

Forsyth (2013) and Yalom (1995) describe that groups are rich sources of information and education. Members learn about their problems, or those of a loved one, from the other members in the group; members impart information to each other. This information may be how they dealt with a problem, what mental health professional they dealt with, what medication they were prescribed and their side effects, and the like. Members may perceive this information as more potent than if this information was only given to them by a professional due to the fact that a bond has been formed between the members and that the members in the group have lived this information. This information may be provided in a directive way by the members, such as giving direct advice or may be non-directive and the individual may learn from another member through a story they are relaying or the way they deal with problems as they surface in the group. Steketee and Pigott (2006) confirm that interpersonal learning is also a benefit in OCD groups, as the members learn from each other about their OCD symptoms as well as other parts of their lives with which they may be having difficulty.

The acts of giving information and emotional support have benefits to the individual receiving that information or emotional support but it may also have a positive influence on the individual giving the information or emotional support. The altruistic act of giving to the other members of the group gives the individual the feeling of being needed and valued. In the initial stages of therapy or when individuals first join the group they may consider themselves as burdens and that they have nothing of value to offer. When they realise that they can be of benefit to others in the group their self-esteem increases (Forsyth, 2013; Yalom, 1995). Steketee and Pigott (2006) also mention altruism as being a beneficial factor in OCD groups as members with OCD realise that they do have something to offer other individuals in the group.

According to Yalom (1995) a group can be seen as representing the member's primary family group. The leaders might assume the role of the individual's parents, and the other members might be seen as their siblings. The member might try and gain the approval or attention of the leader in the group as they might with their parents. Fighting among members may resemble sibling rivalry. On the other hand, alliances between them might point to siblings in a family getting along well. This is



important, as eventually the member will act towards others in the group as they would in their own family. This will give the leader the chance to observe how the individual behaves in his/her environment and in social interactions. The group represents a microcosm for the individual's social interactions outside the group. The members relive their family conflicts, but in the group they are able to get feedback and relive the experiences in a more constructive manner.

An individual who has problems with which he/she needs help, may have additional problems in his/her social interactions. A mental disorder may lead to stigmatising and an individual may withdraw from social interactions for fear of this stigmatisation. Others may avoid this individual due to the individual becoming too difficult to get along with. The group allows the individual to gain access to other people as well as a space to practice social skills. This social learning may also provide the person with the first real opportunity to receive feedback on his/her interactional style (Forsyth, 2013; Yalom, 1995).

The members of the group may start to imitate the behaviours of other members of the group as well as that of the mental health professional (Yalom, 1995). Albert Bandura (1986) postulates that people develop new attitudes and behaviours through experience. Social learning takes place when an individual observes and imitates other people. This imitative behaviour is a helpful factor as the individual observes how others deal with similar problems, and he/she may benefit by carrying out a similar behaviour or action. Steketee and Pigott (2006) believe that individuals with OCD may learn vicariously from other OCD group members through observing them, set goals and carry those goals out.

Forsyth (2013) and Yalom (1995) describe that interpersonal relations play an important role in support groups. People are part of a social environment and must be considered within their interpersonal relationships. A great deal of self-knowledge is gained through social interaction. People draw conclusions about themselves and their behaviours by observing others and monitoring their reactions to them. The more positive the perception of how others react to them, the more positive the individuals will view themselves and their behaviours, and they will continue as they are. If an individual perceives others to perceive them negatively, the more likely they will perceive themselves and their behaviours negatively and will either avoid those behaviours or try and change their behaviour in order to modify their self-perception. The members of the group serve as corrective guides for each other.

The support group may at first be seen as an artificial group, which doesn't have much significance. This opinion may change and group cohesiveness is a central concern with regards to how members view the group. A cohesive group is more attractive to members than a group that lacks group cohesion (Forsyth, 2013; Yalom, 1995). Groups with members who have a high regard for mutual understanding as well as acceptance of others are said to be cohesive; the more cohesive a group, the more effective the group's change-promoting skills (Forsyth, 2013; Yalom, 1995). If group cohesion is lacking, members may struggle to accept feedback, the group may not develop norms, and the members are likely to attend group meetings less often. The less frequently members attend group meetings, the less stable the group environment will be, and this impacts negatively on the groups influence (Forsyth, 2013; Yalom, 1995). Steketee and Pigott (2006) also highlight group cohesiveness in an OCD group as the members need a trusting, warm, and understanding environment in order to set and carry out their goals. The more cohesive the group is the more the members may be able to build larger social networks as they begin to trust other people.

Catharsis has historically been seen as an important part of therapy. The venting of emotional expressions may give the individual a sense of relief or freedom (Forsyth, 2013; Yalom, 1995). Catharsis, however, can only be achieved through interpersonal interaction, and not be carried out in isolation. Strong expressions of emotion may enhance the development of cohesion, as members who express these strong emotions openly and honestly to other members of the group tend to form close mutual bonds with these members (Forsyth, 2013; Yalom, 1995).

Individuals' perceptions of their own virtues are generally accurate (Kenny, Kieffer, Smith, Ceplenski, & Kulo, 1996; Levesque, 1997). However, in some cases, individuals' self-perceptions are inaccurate. According to Forsyth (2013), individuals may be suspicious of joining therapy groups because they recognise that the group may see them for what they are, and that this evaluation may not match their own self-definition. Although individuals tend to oppose information different from their self-view, when multiple individuals agree with these appraisals, the member is more likely to begin to believe these appraisals. When feedback is given in the context of a long-term, reciprocal relationship, it cannot be so easily rejected as biased or subjective. This context may intensify insight and self-awareness. In supportive,

accepting groups, members can reveal hidden aspects of themselves and in turn further intensify the strength of their commitment to the group.

Yalom (1995) describes that group members may realise that even though they proceed through life in social contact with others, ultimately they are responsible for their own lives. How we conduct our lives and the recognition of our mortality are existential factors which may be daunting to some individuals. The acknowledgement of these existential factors and coming to terms with them, knowing that they are a part of life, is another important factor with regards to the group and the support an individual gets. This factor appears significantly important in groups for which the problem is chronic and the individual and his/her family may have to come to terms with this problem being a part of their lives.

A therapeutic factor not mentioned by either Forsyth (2013) or Yalom (1995) but that requires mentioning, is empowerment. Fontaine and Fletcher (2003) maintain that one of the most important functions of a support group is to provide communication, information, or to promote active experiencing in order to empower group members with the knowledge on the tools they require to be successful in their recovery. This factor appears important for support groups in which the members require information on a problem (e.g., mental illness) and do not have sufficient knowledge or experience on possible effective treatments for their problem.

Lastly, Steketee and Pigott (2006) also highlight that another therapeutic benefit of an OCD group is role flexibility, as the group members can assume the role of facilitator as well as client with OCD. The members are able to learn empathy by putting themselves in others' shoes.

Each of these therapeutic factors may not be present in every group, but a combination of many of them will be present in most groups. These factors may also be present at different times throughout the lifespan of the group. Individual members also experience different therapeutic factors to other members at certain times in the group process. The most important point, however, is that many of these factors have a change-promoting aspect which is highly valued in groups when change is pursued (Forsyth, 2013; Stektee & Pigott, 2006; Yalom, 1995).

Forsyth (2013) mentions that group approaches to treatment are usually effective, at least as effective as individual treatments and more effective than no treatment. However, Forsyth (2013) mentions that group methods do not work for everyone. He reports that there are three cautions to groups as a therapeutic treatment.

The first being premature termination, which he describes as member of a group withdrawing from a change-promoting group before reaching his/her therapeutic goals. Premature withdrawal might occur because of failed expectations from the group or an insufficient match between the group member's goals and the leader's techniques. The second caution that Forsyth (2013) mentions, is that of a casualty in change-promoting groups. A casualty is a member whose psychological health declines rather than improves due to his/her experiences in the group. A casualty may arise in a group due to one significant event or multiple events occurring within the group that are perceived negatively by a member of the group and which tend to remain with that member and are not dealt with therapeutically. The third caution identified by Forsyth (2013), is that of over-helping. Forsyth (2013) describes over-helping as the group taking too much credit for a member getting better, and the member then becomes dependent on the group, without attributing any of their success to the work they did to achieve their goals.

#### **2.4 A Systemic Framework**

This study focuses on the experiences of individuals with OCD who attend and are involved in an OCD support group. Systems theory is useful in conceptualising, explaining, and understanding OCD support group members' experiences of the OCD support group. Instead of looking at each individual in isolation, this systemic framework will enable me to view and fully understand each individual and his/her experiences in the larger context of the OCD support group.

According to Forsyth (2013), a support group process, which includes the relationships between the members of the support group, is dynamic, complex, and multifaceted. Therefore, by adopting a systemic perspective, the ideas relevant to exploring and understanding relational and system dynamics can be explored; and with the processes, patterns, and rules underpinning the members' experiences of the OCD support group will be understood (Goldenberg & Goldenberg, 2013).

Becvar and Becvar (2009) highlight the reciprocal nature of systems by mentioning that systems impact and influence each other; and groups are more than a collection of individuals sharing a space. Therefore, looking at the individual with OCD or his/her family members in isolation would be reductionistic, and would ignore the relational context within these families, within the OCD support group as well as any other internal and external system or subsystem (Becvar & Becvar, 2009). Through the use of the systemic framework I will examine the experiences of

members of the OCD support group by looking at the support group as a whole and by taking the broader contexts into account.

#### **2.4.1 General systems theory**

General systems theory, first proposed by Austrian biologist Ludwig von Bertalanffy during the 1940s, was an attempt to circulate a theoretical model that had applicability to all living systems. Von Bertalanffy attempted to combine various concepts from systems thinking and biology into a universal theory of living systems, regardless of what the systems consisted of (Goldenberg & Goldenberg, 2013; Nichols & Schwartz, 2004). According to Von Bertalanffy (1968), a system can be defined as any entity maintained by the mutual interaction of its parts. These group elements or parts are interrelated by a dynamic interchange of energy, information, or materials into the product of the outcome, for use within or outside the system. This idea was validated by the English anthropologist and cyberneticist Gregory Bateson (1971, p. 243), who defined a system as “any unit containing feedback and structure and therefore competent to process information.” The system can be physical, biological, psychological, sociological, or symbolic, and can be composed of smaller systems, and can fall within a larger system; therefore, an organised entity can be seen as either a system or a subsystem, depending on the observer’s point of reference.

At the time, general systems theory deviated from the traditional scientific inquiry of the psychology field, which saw theorists and researchers focusing on certain thoughts, motivations, and intrapsychic processes within an individual, to the study of relationships, and the behaviour between people (Watzlawick, Beavin & Jackson, 1967). Nicholas and Schwartz (2004) proffer the opinion that Von Bertalanffy forged the idea that a system is a whole and is more than the sum of its parts, and that he believed that viewing each part in isolation was too reductionistic. To understand a phenomenon, attention should be given not only to individual elements but also to the interrelationships between group elements. The transactional processes occurring between the components of the system should be studied, and the emerging patterns and the organised relationships between the parts explored (Dallos & Draper, 2010).

This new and different way of thinking postulated by general systems theory can be applied to various contexts and is therefore seen as a meta-theory, or a theory of theories. The researcher, adhering to this way of thinking, is able to gain insight into the way in which each of the elements of a system mutually influence each other

and the dynamics that connect, contain, shift, and change the entire system. This can be achieved by exploring the patterns and behaviours of the entire system (Hoffman, 1981). The researcher views an individual or group in context by keeping in mind the larger and smaller systems which are interconnected (Becvar & Becvar, 2009). Thus, general systems theory proposes certain principles that are applicable to systems in general.

#### **2.4.2 Systems theory and the OCD support group system**

Systems theory is often used interchangeably with the concept of cybernetics (Carr, 2006). Cybernetics is a term coined by mathematician Norbert Wiener to describe the study of feedback mechanisms in self-regulating systems that originally emerged from the study of machines (Carr, 2006). However, Gregory Bateson and Norbert Wiener came into contact with each other at the Macy Conferences, which were a set of meetings in New York attended by scholars from various fields, and Bateson applied the ideas of cybernetics to living systems (Nicholas & Schwartz 2004). Systems theory has evolved and a distinction has been made between first-order or simple cybernetics and second-order cybernetics, also known as cybernetics of cybernetics. Becvar and Becvar (2009) state that first-order or simple cybernetics is the process according to which the researcher places him-/herself outside the system of observation and observes what is occurring within that system. Second-order cybernetics, or cybernetics of cybernetics, is the process according to which the researcher, who attempts to observe and change a system, is by definition a participant who both influences and is influenced by that system (Goldenberg & Goldenberg, 2013). For the purpose of this study I will adopt a first-order or simple cybernetic stance.

According to Becvar and Becvar (2009), the researcher explores what is going into the system and what is coming out of the system. The metaphor of the black box can be used in order to explain this input-output view. “The impossibility of seeing the mind at work has in recent years led to the adoption of the Black Box concept from telecommunications ... applied to the fact that electronic hardware is by now so complex that it is sometimes more expedient to disregard the internal structure of a device and concentrate on the study of its specific input-output relations .... This concept, if applied to psychological and psychiatric problems, has the heuristic advantage that no ultimately unverifiable intrapsychic hypotheses need be invoked,

and that one can limit oneself to observable input-output relations, that is, to communication” (Watzlawick et al., 1967, pp. 43-44).

Systems theory has some fundamental assumptions which differ from the traditional individual approach such as asking what, reciprocal causality, wholistic, dialectical, subjective/perceptual, freedom of choice/proactive, patterns, here-and-now focus, relational, contextual, and relativistic instead of asking why, linear causality, being reductionistic, objective, looking for the ultimate truth, and looking for either/or dichotomies (Becvar & Becvar, 2009). According to Hoffman (1981), systems theory does not focus on why certain things happen the way they do but rather focuses on the “what” and “how” of a certain phenomenon. Instead of searching for possible causes of an event, the systemic researcher diverts his/her attention to what is actually happening in the here-and-now, with regards to a certain event.

I do not see myself as part of the system (OCD support group). I am also not looking at why certain things are happening within the group. I am an outside observer, looking to describe the participants’ experiences of what is happening within the OCD support group. A systemic investigation, as explained by Becvar and Becvar (2009), focuses on describing what is happening with regard to a certain system or multiple systems, by asking questions such as: *Who are the members of the system? What are the characteristic patterns of interaction in this system? What rules and roles form the boundaries of the system? What distinguishes this system as separate from other systems? How open or closed are the boundaries of the system? How freely can information be transmitted into and out of the system?* In addition, the systemic investigation will put emphasis on the system’s ability to balance between stability and change. Whether the system has a tendency to move toward or away from order, will also be a focus of attention.

To better understand the participants’ experiences of the dynamics of a OCD support group from a systemic perspective, the following essential concepts of systems theory need to be addressed in order to form a framework.

#### **2.4.2.1 Recursion**

Becvar and Becvar (2009) describe that recursion, or circular causality, places the focus on interaction between people. The question of why is negated along with the notion of linear causality (A causes B, B causes C). The individual or group is not viewed in isolation but is seen as evolving within a context of mutual influence and

interaction with other individuals and groups. These systems influence each other recursively. The researcher does not look at the system in isolation or at its past events but views relationships and the context within which these relationships occur as of vital significance. The question of why and the search for a cause behind a phenomenon are replaced by the question, *what is happening in the here-and-now between the group members and between the OCD support groups and the larger systems* (Becvar & Becvar, 2009).

The importance of recursion for this study is that the members of the OCD support group are connected and impact or influence each other. However, the OCD support group is a whole system in itself, and also forms part of several larger systems that mutually influence each other (Becvar & Becvar, 2009). These larger systems may constitute the culture of the community, the religion of the community, members' family systems, the members' friends outside the group, therapists, psychiatrists, and the like. Through the use of a systemic conceptualisation, I am interested in taking into consideration the dynamics of the larger context within which the OCD support group and its group members interact.

#### **2.4.2.2 Feedback**

Feedback is a system's ability to self-correct. Becvar and Becvar (2009, p. 67) describe feedback as "the process whereby information about past behaviours is fed back into the system in a circular manner." Goldenberg and Goldenberg (2013, p. 97) see feedback as "reinserting into a system the results of its past performance as a method of controlling the system, thereby increasing the system's likelihood of survival." They contend that feedback loops are "circular mechanisms whose purpose is to introduce information about a system's output back to its input, in order to alter, correct, and ultimately govern the system's functioning and ensure its viability." The feedback process gauges and monitors for new information or fluctuations within the system, and regulates the system by adjusting for stability or change (Becvar & Becvar, 2009).

Feedback can be seen as either positive or negative. The positive and negative feedbacks indicate the impact certain behaviours can have on the system as well as how the system responds to those behaviours. Negative feedback is the process whereby a deviation in the system is opposed and the status quo is maintained. Positive feedback acknowledges that there is a deviation in the system, accepts the information the deviation is suggesting about the operation of the system, and



accelerates the deviation, or allows for change of the systems structures (Goldenberg & Goldenberg, 2013). For a system to survive, it needs both positive and negative feedback, in the process balancing their tendencies towards both stability and change. Whether a system requires positive or negative feedback is relative to context (Becvar & Becvar, 2009).

Feedback is an important aspect to consider when looking at the context of an OCD support group and its members. As an OCD support group evolves, certain rules and roles may develop or change and therefore disrupt group stability (Forsyth, 2013). For the group to survive, it requires feedback that allows the system to accommodate for change. The participants in this process react to the feedback from others and adjust their behaviour in order to maintain the status quo or allow for new ways of relating (Becvar & Becvar, 2009). Family members of the individual suffering from OCD who participates in the OCD support group require flexibility in order to maintain stability when the individual's and the family's feedback proposes stability, but it should also be open to change when the individual's and his/her family's feedback insists on a shift in structure (Hoffman, 1981).

#### ***2.4.2.3 Morphostasis and morphogenesis***

Keeney (1983, p. 70) states that “within cybernetics change cannot be found without a roof of stability over its head. Similarly, stability will always be rooted to underlying processes of change.” This alludes to a system having the ability to change within a context of stability and being able to maintain stability in a context of change. Morphostasis implies the system's tendency to remain stable. The system maintains a state of equilibrium within a context of change. This is achieved through negative feedback loops. Morphogenesis infers a system's tendency toward change, shifts or growth. The system moves towards growth while still maintaining stability and functionality. This is achieved through positive feedback loops. A well-functioning system requires a balance between both morphostasis and morphogenesis (Becvar & Becvar, 2009).

A well-functioning system will therefore resist change when it threatens the survival of the system. This well-functioning system will also have the capacity to change the rules of the system when change is necessary or required (Becvar & Becvar, 2009). If an OCD support group largely highlights stability by sticking to outdated rules and in turn morphostasis, it may find it difficult to accommodate for any changes and the system as a whole may be threatened. If an OCD support group

chiefly accentuates morphogenesis over morphostasis by allowing for too many or too frequent rule changes, the system may also be threatened (Goldenberg & Goldenberg, 2013). I will explore whether the participants experience if the OCD support group is able to maintain a balance between morphostasis and morphogenesis and if so, how the participants perceive this to be achieved.

#### ***2.4.2.4 Patterns, rules and boundaries***

Systems tend to function according to rules. These system rules encompass the characteristic relationship patterns within a system (Becvar & Becvar, 2009). Patterns are therefore habitual ways of interacting with others (Watzlawick, Weakland, & Fisch, 2011). Rules are evident through the observation of interactional patterns within relationships. The rules direct the observer to the values of the system and the roles adhered to within the system. The system's rules may be overt or covert, but are often unspoken rules that the members are not consciously aware of. The rules of a system differentiate that system from other systems and portray the system as unique. Thus, a system's rules along with the roles adhered to in the system seem to form the boundaries of the system (Becvar & Becvar, 2009). Goldenberg & Goldenberg (2013, p. 101) define boundaries as "a metaphoric line of demarcation that separates an individual, a sub-system, or a system from outside surroundings." They contend that "boundaries help define the individual autonomy of a sub-system's separate members, as well as helping to differentiate sub-systems from one another." These boundaries are not visible but can be seen by observing a system's repeated patterns of behaviour (Becvar & Becvar, 2009).

Boundaries also denote the hierarchical structures within systems. A system is part of a larger system or suprasystem and that system in itself acts as a suprasystem to smaller subsystems. These boundaries separate the sub-systems from each other but also maintain their membership to the larger suprasystem. These invisible boundaries regulate what information goes into and comes out of a particular system, and monitors if this information is compatible with the existing values and rules of the system (Becvar & Becvar, 2009). For example, if an individual wants to join an existing group, his/her characteristics and values would need to align with those of the group. The individual would also need to prove that he/she could fulfill a relevant role in the group (Preininger, 2007).

Families serve as larger systems from which the members come, and may influence how they interact within the support group system. In families with weak

hierarchies, parents may fail to offer joint leadership. Parentified children may take on executive functions, and these children would therefore behave like parents. Some of the members in the support group may take on leadership roles. In families with rigid hierarchies, parents may inappropriately abuse their power without taking account of the child's needs. Some of the members may take on a more submissive role in the support group. Difficulties within the hierarchy of a family may contribute to the parents not fulfilling their function of nurturing the growth of its members (Carr, 2006).

I am interested in exploring and understanding the participants' experiences of the rules, roles, and boundaries of the OCD support group, and what they perceive the patterns according to which the system behaves. I am also interested in the participants' experiences of the systems or subsystems connected to the OCD support group, how these connected systems or subsystems impact the OCD support group, and how the OCD support group impacts these connected subsystems and systems.

#### ***2.4.2.5 Open and closed systems***

An open or closed system refers to the amount of new information that will either be allowed or rejected by the system. An open system, according to Goldenberg and Goldenberg (2013, p. 102), is "a system with continuous information flow to and from the outside." Goldenberg and Goldenberg (2013, p. 102) define a closed system as "one whose boundaries are not easily crossed." How open and how closed a system is, is a matter of degree, with a well-functioning system finding a balance between the two states. However, a system may tend to be more open or more closed within certain contexts in order to ensure its survival and optimal functioning in that context (Becvar & Becvar, 2009).

A system may rigidly be too open or too closed, and this may be a danger to the system. When a system is at either extreme without reference to its context, the system could be said to be in a state of entropy. In this state the system tends to maximum disorder and may be dysfunctional, or collapse. If the system maintains an appropriate and healthy balance between being open or closed, the system may be in a state of negentropy or negative entropy. This system allows information into the system which may bring about change and may disregard information that threatens the survival of the system and therefore maintains stability (Becvar and Becvar, 2009).

From a systemic position, I am interested to explore the participants' experiences of whether the OCD support group is rigidly open, rigidly close, or flexible according to context, and how the participants perceive the flow of information to impact them and the OCD support group

#### ***2.4.2.6 Equifinality and equipotentiality***

Von Bertalanffy (1968, p. 40) defined equifinality as “the tendency towards a characteristic final state from different initial states and in different ways based upon dynamic interaction in an open system attaining a steady state.” Becvar and Becvar (2009, pp. 71-72) reinforce this argument by stating that “the system, as it is, is its own best explanation of itself; for regardless of where one begins, the end is likely to be the same.” Equipotentiality is the concept that same beginnings may result in different end states (Becvar & Becvar, 2009). Set rules or procedures will not always lead to the same outcomes for everyone. The question of what are the participants' experiences of what is happening in the here-and-now interactional patterns between the support group members and between the OCD support group and other connected systems, is emphasised as it is believed these interactional patterns maintain behaviour. This is done instead of looking for cause-and-effect sequences or what happened in the past.

#### ***2.4.2.7 Roles***

Each member assumes a certain role within the group which is mutually influenced by both that individual and the group combined (Haley, 1963). This role may be known or unknown to the individual and the group, but it is relevant with regard to the homeostasis of the support group (Hoffman, 1981). Each member's role helps to reinforce patterns of interaction within the group. They sustain the system's fundamental rules, structures, and boundaries. These roles are not necessarily static and different members of the group may fulfil certain roles within the group at different times (Haley, 1963). The system may also require that individuals within that system assume roles and functions complementary to one other. This notion of complementarity implies that within systems every behaviour has a logical complement (Becvar & Becvar, 2009; Goldenberg & Goldenberg, 2013).

I will examine the function of roles within the OCD support group by exploring the participants' perceptions of interactional behavioural patterns presented by the individual assuming the role. I will also be cognisant of the feedback relevant to that

member's role, generated from the responses of the other OCD support group members.

The roles many of these individuals fulfil in their families of origin should also be kept in mind. The most prominent may be the role of the Identified Patient (IP). According to Goldenberg and Goldenberg (2013, p. 25), "the family member with the presenting problem or symptom is called the identified patient (IP)." Family therapists, who understood the IP's symptoms from a cybernetic perspective, contend that the IP was expressing the family's disequilibrium. The IP may be expressing what other family members are thinking and/or feeling but are unable to express/acknowledge. The IP's symptoms may also divert attention away from other family problems or conflicts (Goldenberg & Goldenberg, 2013), and he/she will often assume the role of the scapegoat in the system. Anger, criticism, and negative feelings within the system are displaced onto the IP (Carr, 2006). It is possible that members in the support group may take on the role of the IP or the scapegoat in the support group if conflict arises.

#### ***2.4.2.8 Communication and information processing***

Agazarian and Peters (1981), Donigian and Malnati (1997), and Durkin (1981) all believe that therapy within a group format occurs due to the interactive process between the leader, the individual members, and the group as a whole. All three of these elements are interconnected and need to be considered in relation to each other. Therefore, it should be kept in mind that a change in one of these elements will bring about a change in both of the other two elements. Yalom (1995) argues that group processes are the verbal and non-verbal interactions which take place within a group, and are fundamental to change. Group process is what distinguishes group therapy from individual therapy. Yalom (1995) points out that group process is complex. The researcher therefore needs to explore the process behind multiple sequences of statements made by a number of people within that group context. Van Servellen (1984) believes that to understand group process, the researcher should explore the verbal and the non-verbal communication patterns within the group. This allows the researcher to gauge members' relationships in the here-and-now, within the context of the group.

Becvar and Becvar (2009) argue that communication and information processing are the central elements within systemic theory. The communication patterns and information processing can be explored by focusing on the interactional

patterns between people and, in this study, between members of the OCD support group. Becvar and Becvar (2009, p. 72) state “three basic principles form the foundation of this concept:

- Principle 1: One cannot not behave.
- Principle 2: One cannot not communicate.
- Principle 3: The meaning of a given behaviour is not the true meaning of the behaviour; it is, however, the personal truth for the person who has given it a particular meaning.”

Principle one implies that even not acting or behaving engages the person in an act or behaviour. It is not possible for someone to avoid acting or behaving. Principle two, which is connected to the first principle, infers that all behaviour within a certain context communicates something to the observer. An individual may not be communicating verbally, but non-verbal communication is always present. This non-verbal communication gives meaning to the silence, or to verbal communication when present. The third principle suggests that reality is subjective and not objective, and that each individual functions from his/her own frame of reference when experiencing an event. This alludes to the fact that the receiver can interpret any behaviour or communication in a variety of ways. None of these interpretations will be more correct than another. Each of the members of the OCD support group may have different interpretations regarding the OCD support group. However, each of these interpretations or perceptions will be equally true and equally valid for each member of the OCD support group (Becvar and Becvar, 2009).

Becvar and Becvar (2009) state that along with the three general principles, communication can occur in three different ways:

- verbal or digital
- non-verbal
- context

Verbal or digital messages are those conveyed by the spoken word. Non-verbal communication refers to how a message is received by another. It signals the sender’s intent and is therefore the relationship-defining mode of communication (Becvar & Becvar, 2009). Van Servellen (1984) describes that much of an individual’s communication is non-verbal. He states that in groups the observer may have a better understanding of relationships between members by taking non-verbal behaviours

into account. These non-verbal behaviours may be in the form of hand gestures, facial movements, seating arrangements, moving or leaning towards or away from another person, crying, smiling, and the like. Context denotes the situation in which the rules of a relationship will be determined and how a person relates to others. A change in context may bring about a change in the relationship between two or more people. Context includes the place where the communication takes place, the time the communication occurs, and between whom the communication occurs. It works along with non-verbal communication to further amend the meaning of a message (Becvar & Becvar, 2009).

The verbal messages, spoken of above, are referred to as content while the non-verbal messages and the context are together referred to as process. These two forms of communication are seen as being on two different levels of communication. When the content and process levels of a message match up, there is no confusion in the communication, and hence the relationship. The communication here is said to be congruent. If the two levels do not match up and the content of what the individual is conveying is different to the process of the message, there may be confusion in what is being communicated. This type of communication is said to be incongruent and may be a sign of problems in the relationship (Becvar & Becvar, 2009).

When a message is incongruent, the recipient of that message needs to decide which part of the message he/she should respond to. He/she may respond to the content of the message and neglect the process, or the individual may metacommunicate about the double meaning of the message. This metacommunication is referred to as communicating about the communication. Here the recipient may inform the sender that the content of the message appears to be unrelated to their non-verbal behaviour or the context in which the message is occurring. Clarification will then be sought (Becvar & Becvar, 2009). The rules of the relationship need to allow for metacommunication. If these rules are not in place then tension, anger, or defensiveness may arise from a metacommunicative response (Becvar & Becvar, 2009).

Communicating and sharing of information are the responsibility of both the sender and the receiver of a message within a certain context. This illustrates the wholeness of a system and the relationships that constitute that system. The researcher avoids looking for certain individual personality traits and concentrates on the interrelatedness between the members of a system and the system as a whole (Becvar

& Becvar, 2009). From a systemic perspective, I understand that communication and information processing are vital components for a well-functioning system such as the OCD support group. The different relationships within the system, in line with the participants' experiences, will be explored in order to understand the communication between members of the OCD support group.

#### **2.4.2.9 Wholeness**

According to Becvar and Becvar (2009), the concept of wholeness is a fundamental rule in systems theory. They illustrate that “the whole is greater than the sum of its parts” (p. 75). There are various elements in interaction within a system. The focus should then be on the relational aspect and on the context. Without viewing the system as a whole, behaviour cannot be understood. The behaviour of every individual within a system is interdependent and related to the behaviour of every other person within and connected to that system. Thus, behaviour is communication which influences and is influenced by others (Watzlawick et al., 1967).

Systemic theory postulates that the more the system increases, the more relationships are formed. The size of the OCD support group will determine the number of relationships that can possibly be present at any given time within that system. However, it must also be taken into account that each individual entering the OCD support group is also influenced by and influences relationships outside the OCD support group. For example, members of the OCD support group may be influenced and influence other members of the OCD support group, but they are also influenced by outside forces such as their family members, friends, work colleagues, and the like. I will examine the relationships between members of the OCD support group, and how outside relationships affect and are affected by the OCD support group members. It is important to bear in mind that it is not only the number of relationships under scrutiny but the form or quality of the relationship that may have the greatest impact on the pattern of interaction (Bateson, 1971).

#### **2.4.2.10 Relationship patterns**

Becvar and Becvar (2009) explain that individuals mutually influence each other, and it is the interaction that provides the context of a relationship. From a systemic perspective, it is important to understand how individuals define their relationships. Three relationship styles or patterns have been identified, namely complementary, symmetrical, and parallel relationships. These can be explored within the system as a whole as well as the context within which behaviours occur.



Complementary relationship patterns involve “a high frequency of opposite kinds of behavior” (Becvar & Becvar, 2009, p. 76). For example, the more dominant a person becomes the more submissive will the other become. Symmetrical relationship patterns are described as an exchange characterised by “a high frequency of similar kinds of behavior” (Becvar & Becvar, 2009, p. 76). A parallel relationship is characteristic of both the complementary and symmetrical styles. The members of this kind of relationship are both able to accept responsibility for the relationship and exchange one-up and one-down positions. The members are therefore flexible and are able to vary their communication patterns, their positions in the relationship, and their roles within that relationship in accordance with the demands of the system within a certain context (Becvar & Becvar, 2009).

Haley (1963) describes that defining a relationship is an ongoing process in which every interaction and behaviour is interpreted as either a confirmation of the definition or as a request for a different definition of the relationship. An individual manoeuvres in order to get the other person to do, say, think or feel something or comments on the other person’s behaviour. This ongoing process often includes the distribution of power and control within the relationship.

A system may be dysfunctional if the members of the system or the relationship rigidly follow either a symmetrical or complementary relationship irrespective of the demands of the system or the particular context within which the behaviour occurs. For a system to be healthy and well-functioning, there should be a mix of symmetrical and complementary relationship patterns that correspond to the demands of the system and the context. The individuals are flexible enough to show a variety of behaviours. The power or control struggle seems to be negated, and the members take on mutual responsibility for the relationship (Becvar & Becvar, 2009).

#### ***2.4.2.11 Homeostasis and change***

According to Watzlawick et al. (2011), there are two types of change, first-order change and second-order change. When first-order change occurs within a system, change appears to be logical; however, the rules or structure of the system remains the same. Often the attempted first-order solution is doing the opposite of the problem. First-order change can be effective within a system but also has the potential of perpetuating a problem. Many difficulties do not remain static but tend to escalate if no solution is found or if the wrong solution and more of the wrong solution is applied. The situation remains structurally the same but the suffering and tension

continue to rise within the system. This first-order change then may become the problem and a “game without end” ensues. A group or system that is mired in a “game without end” requires a second-order level of change to break this cycle. Second-order change is change of the system itself such as the rules and the structure of the system. Second-order change is often seen as illogical, as initially the activity the individual needs to carry out in order to achieve second-order change does not make sense to that individual attempting second-order change.

Looking at OCD from a systemic perspective, the individual suffering from OCD may feel immobilised. He/she has these obsessive thoughts, which everyone in fact has (Abramowitz, 2006). However, the individual fears that his/her obsessive thoughts will lead to an unpleasant or destructive future event (Abramowitz, 2006). In order to reduce the tension around this perceived dreaded event from occurring, the individual implements a first-order change or what he/she believes to be a logical solution. For example, the individual has an obsessive thought that he/she will be involved in a car accident. This is a disturbing thought and it sets in motion a bout of compulsive hand-washing. The act of washing hands reduces the tension around the likelihood of this dreaded event occurring, and the individual logically assumes that the tension will subside (Abramowitz, 2006). The individual believes that it would be illogical to allow the anxiety of the obsession to escalate. This first-order solution, of washing their hands, in effect exacerbates the obsession and it becomes a problem. The system is trying to maintain homeostasis and is structurally the same (Hoffman, 1981). If a second-order change, or an illogical solution is applied, such as allowing the obsession to present, allowing the anxiety to rise, and avoiding the compulsion or ritual, the rules of the game change. The individual realises that the anxiety will eventually subside and that it is unlikely that the dreaded event will occur. The illogical solution allows the individual to leap to another form.

The family members of the individual suffering from OCD may also feel stuck as they see the anxiety and distress the individual with OCD is going through. To them, the logical solution would be to help the individual carry out his/her compulsion or ritual, as it appears to reduce the distress and tension in the family. Family members often equate helping the individual carry out compulsions with support for that individual (Calvocoressi et al., 1995; Geffken et al., 2006; Peris et al., 2012; Reynolds et al., 2013; Storch et al., 2009). This logical or first-order solution may, however, perpetuate the individual’s problem and the tension and distress within

the family. The family begins to resent the individual suffering from OCD and tensions rise (Calvocoressi et al., 1995; Geffken et al., 2006; Peris et al., 2012; Reynolds et al., 2013; Storch et al., 2009). Tension may rise to a point where a positive feedback loop escalates and the family system destructs or jumps to a new form. It is difficult to predict the result of the system but taking an individual suffering from OCD or the family members themselves going to an OCD support group may be this illogical solution and the new form for the family. They may learn the illogical or second-order solution of dealing with a family member suffering from OCD from the members of the OCD support group. This second-order solution is to not encourage the individual's OCD by helping them or making it easy for them to carry out their compulsions. The family members should rather encourage the individual with OCD to avoid carrying out a compulsion. This is done within a context of providing support for the OCD individual, so the family members do not feel as if they are leaving the individual without any support.

The OCD support group members, family members of the individual with OCD and the individual with OCD are involved in a dance together. They are each influenced by the other's patterns of interaction. I am curious about the members' experiences of these patterns of interaction, what maintains these patterns of interaction, and whether these repetitive patterns need to be broken and how this can be achieved. The focus of my exploration will be directed at the members' experiences of the OCD support group system as a whole, and the rules that govern this system.

## **2.5 Conclusion**

The purpose of this chapter was to explore and provide a literature review on OCD, social support and support groups, and a systemic framework. The major concepts discussed with regard to OCD are the definition and classification of OCD; the prevalence, gender, and course of OCD; the aetiology of OCD; and the treatment of OCD. The major concepts discussed with regard to social support and support groups are social support, support groups, support group context, maintenance of the support group, characteristics of the face-to-face support group, and the therapeutic value of support groups. The most pertinent concepts discussed with regard to the systemic framework are general systems theory, and systems theory and the OCD support group. Research is limited with regard to OCD support groups and members' experiences of OCD support groups, and this literature review gives a background and

facilitates insight into vital components of OCD and support groups, and lays the foundation which allows me to explore members' experiences of an OCD support group.

## Chapter 3

### Research Design and Research Process

#### 3.1 Introduction

In this chapter, the research paradigm, research process, the research design, and ethical considerations will be discussed. The research paradigm will comprise terms such as postmodernism, constructivism and social constructionism, and qualitative research. The research process will comprise of the population used in this study, the data collection method, and how the data was analysed. The discussion will progress to the research design which will consist of the credibility, transferability, dependability, and confirmability of this study. Lastly, the ethical considerations of this study will be discussed in accordance with informed consent, confidentiality, and the researcher's (my) competence.

Social research is a continuous process, and as human beings we are embedded in the day-to-day process of understanding and interpreting the experiences of others. This study will focus on social research as it relates to an OCD support group and the experiences of the members of that OCD support group.

As explained in the chapter on theory and literature review, there is limited documented research with regard to OCD support groups and, in particular, virtually no research findings which describe the experiences of members of an OCD support group within the South African context. The aim of this study is therefore to augment research in this field in a meaningful way.

This research study, as is evident in all research studies, is guided by a set of beliefs and assumptions that inform my thinking and practice. Therefore, it is important to position the research within a certain theoretical model or paradigm. A paradigm is a system of interrelated ontological, epistemological, and methodological traditions (Durrheim, 2006). "Ontology specifies the nature of reality that is to be studied, and what can be known about it. Epistemology specifies the nature of the relationship between the researcher (knower) and what can be known. Methodology specifies how the researcher may go about practically studying whatever they believe can be known" (Terre Blanche & Durrheim, 2006, p. 6). The paradigm is a standpoint according to which a rationale for a research study is provided. The paradigm will also offer a platform on which I will base the methods of data collection, observation, and interpretation. The chosen paradigm is thus important as it impacts both the research question, *What are members' experiences of an OCD support group?* and

how the question will be researched. The research question and the methods employed should be congruent (Durrheim, 2006). This study focuses on a qualitative research paradigm.

### **3.2 Research Paradigm**

In chapter 2, a systemic framework was discussed with regard to the members' experiences of an OCD support group. This approach appears to fit well with my quest in understanding the process and dynamics occurring between members of the OCD support group. This systemic context needs to be taken into account when choosing what ontological and epistemological framework would be appropriate for this research design. Postmodernism and social constructionism were chosen as appropriate for this study.

#### **3.2.1 Postmodernism**

In order to discuss postmodernism a brief overview of positivism and modernism will be presented. Positivism postulates that what we perceive is a true reflection of the world (Gergen, 1994). This highlights that there is one true reality which is discoverable by the researcher. This positivist epistemology was crucial in the move towards modernism. Modernism appeared to be a move away from the romanticist perspective and the ideas of monarchy, superstition, and religion of the 18<sup>th</sup> and early 19<sup>th</sup> centuries (Becvar & Becvar, 2009). Becvar and Becvar (2009) continue and mention that modernism, during the late 19<sup>th</sup> and early 20<sup>th</sup> centuries, had its roots in science and logical reasoning. If something had been proven by science, it was said to be logical and rational. Modernism took the stance that the world is objective and is governed by universal laws (Carr, 2006). These universal laws or objective truth could be sought through systemic empirical investigation. The modernist perspective proposed that society or researchers should try and achieve a greater good or a grand narrative of society. This was believed to be achievable through scientific means (Carr, 2006). This rigorous, ongoing research that was conducted by an expert was believed to gradually accumulate value-free knowledge (Becvar & Becvar, 2009). The modernist view also claimed that language represented the objective, knowable world (Becvar & Becvar, 2009; Carr, 2006). Quantitative research methods are linked to modernist epistemology, and are often used by researchers working from this paradigm. However, this approach often overlooks personal accounts of events.

When people started to exhibit different views on what this ultimate truth or reality may be, each supported by a scientific grounding, researchers were confronted with a dilemma (Doan, 1997; Rapmund, 2005). This paved the way for postmodernism. Postmodernism has deconstructed the modernist perspective and it rejects the view of one universal, objective truth. It discards the idea that a single rational account or a grand narrative of the world can be attained (Becvar & Becvar, 2009; Carr, 2006). The world, according to the postmodernist stance, is not linear, it is uncertain and uncontrollable (Lynch, 1997). Becvar and Becvar (2009) state that postmodernism holds the view that reality is subjective, and that implies that there are a multitude of realities. Knowledge cannot be generalised (Lynch, 1997; Neuman, 1999). The idea of an expert is also abandoned, and the client or research participant has an equally valid perspective (Becvar & Becvar, 2009). All perspectives are equal and there is no specific correct view (Gergen, 1991).

The postmodernistic view also looks at a relational self. The focus of research would then be on individuals within relationships and not on the intra-psychic self (Kvale, 1992). The individual is not viewed in isolation. The idea that the individual has certain characteristics that are present and unchanging despite the context is also disregarded. The self is viewed within multiple relationships and may fluctuate within different contexts (Hoffman, 1992). Problems can only have meaning within a particular context and are conveyed through language (Becvar & Becvar, 2009). Individuals therefore co-construct their realities through language and within a particular social context. Doan (1997) points out that within postmodernism, the research participant and the researcher are subjectively involved in understanding and searching for meanings of an experience. Researchers working from this paradigm often tend to use qualitative research methods. Personal stories and experiences are often used in qualitative research, and are relevant to this study.

In this study, the participants' views were accepted as equal. The research findings were not used as a singular ultimate explanation of the experience of OCD support groups in general. The findings were not generalised and were understood to represent each individual's perspective within a certain context, such as the OCD support group. I explored the multiple relationships between members of the OCD support group, the language used, and how multiple realities were co-constructed. The postmodernistic stance appeared to be appropriate for this study.

### **3.2.2 Constructivism and social constructionism**

Constructivism and social constructionism are related concepts, and they are both inextricably linked to postmodernism. Both address the nature of knowing, and reject the notion of one true reality existing “out there” that can be known objectively. One can therefore not observe an objective truth about people (Becvar & Becvar, 2009). Constructivism and social constructionism, however, are not identical (Goldenberg & Goldenberg, 2013; Hoffman, 1990). Constructivism argues that what we perceive is not an exact replica of the world but our subjective reality based on our personal knowledge (Becvar & Becvar, 2009; Goldenberg & Goldenberg, 2013). Speed (1991, p. 396) concurs and states that constructivism is “the view that what we know is determined by our ideas, so that our view of reality is only that, a view, something constructed in our heads, invented by us. We can never know reality, we can only ever have views of reality ... Our ideas determine what we know.”

The world is not perceived passively but is actively constructed by the individual (Gergen, 1985). These personal constructions of reality are influenced by both internal characteristics and the external environment (Carr, 2006). These constructions organise experiences and have a dominant role in shaping people’s lives (Goldenberg & Goldenberg, 2013). If it is our ideas, though, that determine what we know, the origin of these ideas is important. Constructivism and social constructionism tend to differ as to the origin of our ideas, with social constructionism moving slightly away from the idea of the nervous system feeling its way around, to emphasising social interpretation and the inter-subjective influence of history, culture, family, and language (Gergen, 1985).

Social constructionism highlights that individuals’ beliefs are influenced by their social interaction with their communities. This interaction involves the conversations that people have with each other (Carr, 2006). Therefore, reality is socially constructed through language (Rapmund, 2000). Gergen (as cited in Harper & Spellman, 2006), believes that work from a social constructionist perspective should include: “a radical doubt in the taken for granted world; the viewing of knowledge as historically, socially and culturally specific; the belief that knowledge is not fundamentally dependent on empirical validity but is rather sustained by social processes; and ... that descriptions and explanations of phenomena can never be neutral but constitute forms of social action which serve to sustain certain viewpoints to the exclusion of others” (p. 99).



Burr (2003) adds to this by stating that language is central and not peripheral to how we see the world. He contends that language is not merely descriptive but constitutive. Through the medium of talking (verbally or non-verbally) and writing, we construct the way we see the world (Harper & Spellman, 2006). As we move through the world, we create ideas about it through conversations with the people around us (Hoffman, 1990). Our beliefs and meanings are fluid and are continuously evolving. Therefore, new experiences and conversations modify and test our perception of reality.

Social constructionism is the lens through which we perceive and experience the world (Hoffman, 1990). Social constructionism was chosen as the epistemological approach that guided this research. This epistemological stance allowed me to explore the discourses and the meanings of members' experiences of an OCD support group. I acknowledge that my personal belief system and the lens through which I view the world influenced this epistemological approach.

This study is only one of a multitude of realities that can be constructed with regard to the OCD support group. The literature review was constructed by myself and shows only one particular arc or understanding of OCD, support groups and members' experiences of an OCD support group. It cannot be regarded as the ultimate truth with regard to experiences of the OCD support group.

The participants in this study co-create their realities of the OCD support group through conversations they have with each other as well as other members of these OCD support group who did not participate in this study. Each participant's reality is fluid and changes continuously. This unique reality is also influenced by each participant's background which they bring to the group, such as their family, culture, and personal history. I am also aware that I was not an objective bystander and my beliefs of my own lived experience, my presence, my questions and my own story may also have influenced the members' experiences of the OCD support group. The research process was collaborative, with both participants and myself co-constructing the research reality. This research study therefore cannot be generalised and is specific to a particular time and place.

The chapter initially outlined three intertwined notions that a research paradigm takes into consideration. These concepts are ontology, epistemology, and methodology. The concepts of postmodernism (ontology) and social constructionism (epistemology) have thus far been explained, and this has been done in order to

provide a context for the research participants' stories. It also lays down the context in which I will base my findings and interpretations of those findings. Both these concepts are intertwined with the theoretical foundations of a qualitative research approach. Denzin and Lincoln (2000) reiterate this by putting forward that qualitative research attempts to understand how social experiences are created, and how those social experiences are given meaning. They suggest that reality is socially created. The following section will outline the qualitative research approach (methodology) used in this study.

### **3.2.3 Qualitative approach**

Social sciences comprise two different methodological stances. These are quantitative and qualitative stances which are markedly different with regard to their approaches to research. The main differences being that each approach makes use of different kinds of information as well as different techniques for information gathering and data analysis (Durrheim, 2006).

Quantitative and qualitative research approaches are based on different beliefs and assumptions of reality. They have different strengths and weaknesses, and are not opposing research approaches but rather alternative research approaches (Durrheim, 2006). The quantitative research approach is underscored by the modernist paradigm. This approach puts forward that reality can be known objectively through identifiable and measurable facts. The qualitative research approach is underlined by the postmodernistic paradigm. This approach posits that each individual holds a subjective truth of reality obtained via their personal experiences which are socially constructed and context dependent. This suggests that multiple realities exist (Rapmund, 2005). The subjective nature of each individual's experience or reality has found a place and an expression point within the qualitative research paradigm.

Durrheim (2006) points out that a quantitative approach to research would require the research process to commence with set categories and hypotheses regarding the chosen research topic. Data would be collected through methods and procedures that make use of numbers which are converted to statistical data. These methods and procedures are static, and are rigorously abided by throughout the research study. The data is used in order to confirm or refute the hypotheses, and to make broad, generalisable statements and comparisons. The causal relationship between variables is the focus of this approach (Denzin & Lincoln, 2000). Qualitative approaches to research allow a researcher to study a chosen topic in depth and in

detail. This may be achieved through methods and procedures that involve collecting or observing written or spoken language, and by identifying and extracting themes or categories from language. In-depth, detailed interviewing and/or observations are often the methods of choice. The questions will be more open-ended and exploratory (Moon, Dillon, & Sprenkle, 1990; Willig, 2008). These methods and procedures are fluid, flexible, and ever-evolving (Kopala & Suzuki, 1999; Moon et al., 1990; Willig, 2008). The focus of this approach is on the process and the meanings derived from that process (Denzin & Lincoln, 2000). This approach is therefore more inclined to bring about rich, descriptive information.

Whereas quantitative research appears to be more reductionist and linear, qualitative research appears to be more holistic and natural. I needed to be sensitive not only to the differing contexts of the participants of the study as a whole but also to the differing contexts of each individual participant. Their relationships, behaviour, and experiences should be considered in context (Denzin & Lincoln, 2000). In this study, the context of the support group and a second support group (this second support group is discussed and elaborated on in section 3.4.1: Sampling) as well as the broader societal context and each individual's familial context were taken into account.

With the quantitative research approach, the researcher's stance would have been objective and removed from the object of study. This would have allowed for the results of the study to be "value-free". The researcher's stance in a qualitative research study is more interactive with regards to the participants of the study (Babbie, 2010; Willig, 2008). A relationship between researcher and participants is actively developed in order to generate sharing of information and to facilitate open communication. This allows understanding of the meaning of experiences of naturally occurring complex events, actions, and interactions from the participant's viewpoint (Babbie, 2010; Moon et al., 1990).

Moon et al. (1990) characterise the relationship between researcher and research participant as a defining feature of qualitative research. They elaborate on this relationship by describing that the participants, within the qualitative research approach, are active, egalitarian participants and not passive objects in a research study. The researcher does not see him-/herself as an all-knowing expert but rather as a member in collaboration with the participants of the study (Babbie, 2010; Willig, 2008). Moon et al. (1990) contend that researcher and participants therefore assume

the roles of co-researchers. There is a collaborative process of gathering information and generating meaning. This facilitates a unique, richer, and deeper understanding of the perspectives surrounding a particular experience or experiences.

In the qualitative research approach, the researcher becomes the “primary data-collection instrument” (Moon et al., 1990, p. 360). It is therefore important to clarify the role of the researcher. The researcher’s biases should be reported from the outset when conducting qualitative research (Babbie, 2010; Willig, 2008). The research is therefore neither neutral nor objective (Becvar & Becvar, 2009). My own social and cultural context will therefore impact and influence the interpretation of the data. I acknowledge that the themes identified in this study are subjective and do not signify an absolute truth. The participants’ realities were identified through my eyes. I realise that the reader and/or other researchers may understand or interpret the participants’ experiences differently. Additional and/or other themes may be identified by others. This again points to the ongoing process of qualitative research. By making known my ontological and epistemological lens through which I observe and understand the world and this research study, the context has been laid in which the participants’ experiences will be understood. In the context of this study, it is possible that the findings may have been influenced by my worldview as well as by my use of a social constructionist epistemology.

The results of the qualitative research study are not generalisable to the larger population (Howitt & Cramer, 2008). In this study that would mean that I do not generalise the findings to every OCD support group and every member who takes part in an OCD support group. The results will vary across different contexts. Therefore, the meanings gathered from this study were generated from a specific context. The context was the OCD support group and each and every member had his/her own unique contributing contexts. The results were therefore not generalisable but may be transferable. The rich, descriptive information gives the reader the information on which to base whether he/she will be able to transfer the findings to other similar contexts (Howitt & Cramer, 2008).

It is evident from the above that a qualitative research methodology is compatible with a postmodern and social constructionist view of reality. This also corresponds to the approach of this research study. The qualitative research approach provided a platform on which I could gain in-depth experiences from members of the OCD support group. The qualitative methodology allowed participants to reveal the

individual, unique stories of their time spent in the OCD support group. It also provided a space in which methods that highlight the relationship patterns, themes, and dynamics of the members of the OCD support group could be applied.

As was discussed in the previous chapter, a systemic framework was employed in this study. A qualitative research methodology may be more effective in dealing with the complexity of systems. Systems theory, as with qualitative research, emphasises social context, multiple perspectives, complexity, individual difference, circular causality, recursion, and wholism (Steiner, 1985). This afforded me the opportunity to examine the experiences of each individual as a system, the OCD support group as a system, and the broader context (including the family context) as a system from the perspective of each participant. Todd and Stanton (1983) note that life and research are both “messy”. Qualitative research methodology provides a systemic, scientific, and wholistic way of looking at the OCD support group, with all its “messiness” intact.

### **3.3 The Research Process**

The essential process of this study is to investigate, explore, and document in detail the unique experiences of individuals suffering from OCD who attend or have attended an OCD support group. This study aims to explore descriptions and experiences of an identified unique phenomenon. It is essential to gain further understanding of this unique phenomenon since it involves personal interaction, the perceptions of those involved with the event or phenomena, and descriptions of the processes that characterise the event or phenomena (Babbie, 2010). Qualitative research is found to be more useful when one attempts to explore and understand the participant’s role in the process, as well as their experiences and perceptions (Babbie, 2010).

This study is exploratory in nature and seeks, in non-manipulative ways, to explore the experiences of individuals suffering from OCD who attend or have attended an OCD support group. The focus is on participants’ multitude of experiences and perceptions, and the meanings they attach to these events. The purpose of this study is to gain and to provide understanding and insight for myself, as well as for future professionals and laymen wanting to work or partake in this field to gain insight and further familiarise themselves with this unique phenomenon (Babbie, 2010).

The research process in a qualitative research study involves both the researcher and each participant (Terre Blanche et al., 2006). The participants and I created a partnership from the point of initial contact until the final report, which will hopefully extend beyond this research study. The process of relating to each other and co-creating meaning is an ongoing process. This means that this research study is not only a reflection of my views but a collaborative reflection on my views and each participant's views in this study (Terre Blanche et al., 2006). According to Denzin and Lincoln (2000), it is important to illustrate in detail the research process of this study such as the population sample, how I went about gathering participants, as well as how I collected information from the participants and analysed this information as this helps to put the findings of this research (discussed in chapter 4) into context and provides perspective. The following topics which outline the research process will be discussed: population, data collection, and data analysis.

### **3.3.1 Population**

A study population is defined as a large group of people from which a researcher wishes to draw conclusions (Babbie, 2010). The population includes all elements that meet certain criteria for inclusion in a study (Burns & Grove, 2003). For the purpose of this study, the population consisted of individuals suffering from OCD who attend or have attended an OCD support group. The following section highlights the population group for this study and includes the sampling approach and inclusion/eligibility criteria for this research study.

#### ***3.3.1.1 Sampling approach***

The aim of a research study is to provide greater detail in terms of the perceptions, understanding, and experiences of a particular group of participants, but not to make premature and general claims about these perceptions, understandings, and experiences (Smith, 2007). This is not to negate the fact that generalisations are at times important and appropriate, but the researcher is of the opinion that the focus should be on detailed descriptions that can be elicited from the research process (Smith, 2007).

According to Durrheim (2006), sampling is the selection of research participants. The selection of research participants involves who or what will be studied in a particular study. The phenomenon under study, whether quantitative or qualitative, will influence the sampling procedure (Durrheim, 2006). This is a qualitative research study, and I opted for a small sample that would provide rich,

detailed, and in-depth information regarding *members' experiences of an OCD support group*. It was therefore important to find a fairly homogenous, closely defined sample of individuals for whom this research would be significant (Smith, 2007). A sampling method called purposive sampling (Durrheim, 2006) was used in this study to gain relevant participants who could form a sample of individuals suffering from OCD, and who had attended and had been members of an OCD support group. Participants who could provide an in-depth understanding of their experiences of an OCD support group were selected.

### **3.3.1.2 Inclusion/eligibility**

Sampling in the interpretive paradigm is often purposeful and directed at particular inclusive criteria instead of being random (Babbie & Mouton, 2010). Due to the small size of the population of individuals suffering from OCD who attend or have attended and are/were members of an OCD support group in the South African context, as described in chapter 2, I selected the most appropriate-sized sample that I could from this population for this study. I did though follow criteria, set out by Henn, Weinstein, and Foard (2009), at the time of the sample selection. These criteria, which were slightly modified for this study, were the following:

- The participants all personally experienced the research topic, in other words, they were all met the criteria for OCD and are/were members of an OCD support group.
- The participants were willing to share their experiences of the research topic
- The participants were able to articulate their experiences and to provide me with descriptions of their experiences

With the aim to answer the research question, *What are members' experiences of an OCD support group?*, a comprehensive search for OCD support groups was conducted throughout South Africa in order to identify participants who could be invited to join this research study. This search included Internet searches, asking professionals who specifically treat individuals suffering from OCD, and contacting many non-profit organisations dealing with mental health. It transpired that there is currently only one active face-to-face support group for OCD in South Africa. I therefore had to assimilate my sample from this OCD support group. I communicated with the clinical psychologist who started and runs the support group, and obtained permission to contact the members of the group, after he consulted with the group members about this study. For confidentiality reasons, the only way to contact

members was through electronic mail. The members of the OCD support group who participated in this study did so voluntarily.

It would have been ideal to obtain participants for this study who had attended a minimum of 12 to 20 OCD support group meetings as research regarding group development from Yalom (1995) states that early group development is heavily influenced by membership problems. Yalom (1995) argues that 10% to 35% of individuals drop out of a group within the first 12 to 20 meetings; while an individual has usually made the necessary long-term commitment to the group once they have remained in the group for approximately 20 meetings.

However, due to there being only one OCD support group in South Africa from which to obtain participants (which had only been running for the past two years, at the time of the interviews, and had a limited number of members) I could not be overly selective of the participants I chose for this study. It was therefore decided, in consultation with the clinical psychologist who runs the OCD support group, that a requirement for participants to partake in this study would be for them to have attended a minimum of eight support group meetings. This does not line up with the 12 to 20 meetings spoken about by Yalom (1995) but due to the circumstances spoken about above, and taking into consideration the size of the OCD support group, it was hypothesised that eight meetings helps to provide a balance between obtaining a large enough sample population to choose from as well as be a significant enough amount of meetings for a member of the OCD support group to have notably experienced the OCD support group and report on those experiences.

Seven participants were initially identified to be participants in this study however only four of these seven participants met the full criteria to participate in the study. Three of the participants had not attended enough OCD support group meetings outlined in the criteria of this study. During the interview process, the four participants who met the full criteria to participate in this study, spontaneously mentioned and described a second OCD support group that they each helped to establish and that they each attend/attended along with the identified OCD support group. The second OCD sub-support group was described as an off-shoot of the initial identified support group. Each of these four participants had been involved in both OCD support groups for a significant period of time, and they provided rich, detailed information about both OCD support groups. Ethically, even though the second OCD support group was not initially the focus of this study, I could not ignore this



information on the second OCD support group, as it was in accordance with the research question and aim of this study (see chapter 1).

Therefore, for the purposes of this study, the sample selected was a small group of individuals with OCD who attend or attended the initial identified OCD support group as well as the second OCD support group. These four participants are not representative of the larger population of individuals with OCD who are members of an OCD support group, but their experiences are legitimate and can stand on their own and in their own light. This is in line with research from Babbie and Mouton (2010) and Henn et al. (2009) who state that the experiences of participants from non-representative samples should be legitimate and able to stand on their own.

### **3.3.2 Data collection**

According to Creswell (2012), interviews can be formal or informal, and are a means of transmitting information between participants and researcher. Interviews can range from structured to unstructured, and the decision to choose either format depends on the nature of the research question. For the purposes of this particular study, the primary source of data collection was an in-depth, semi-structured interview with each participant. These formal in-depth, semi-structured interviews were conducted in order to explore the experiences of individuals with OCD of an OCD support group setting (see Appendix B for a copy of the semi-structured interview conducted in this study).

As this research is a social constructionist study, the relationship between myself and each participant forms an integral part of in-depth interviews. Crotty (1996) highlights the fact that in-depth interviews not only require participants to relate their experiences of the phenomenon under study, but also requires the researcher to move from an observational position in a dialogue to a reflective position. This reflectivity emphasises the importance of the researcher in the research process (Crotty, 1996).

The semi-structured interview provides an opportunity for the researcher to hear the participants talk about particular aspects of their lives and experiences. The questions asked by the researcher function as triggers that encourage the participants to talk (Willig, 2008). Through these semi-interviews the participants of this study were able to relate their experiences of suffering from OCD and of being a member of the OCD support groups. I chose this method of data collection in order to elicit from the participant his/her experiences, taking care not to exert pressure or influence the

interview by allowing the participant to take the lead while I followed and probed the direction in which the participant steered the interview. In a semi-structured interview, however, the researcher does have some influence on the participant. This is in line with the social constructionist approach of the researcher and the participant being partners in the research process and co-creating meaning (Becvar & Becvar, 2009).

According to Willig (2008), interviews are normally audio-recorded, transcribed verbatim, and subjected to detailed qualitative analysis, in an attempt to elicit experiential themes from the participants' narratives. In this particular study, the semi-structured interviews with individuals suffering from OCD who are/were members of the OCD support groups were conducted, audio-taped, and transcribed. Each interview, approximately 90 minutes in length, was conducted and transcribed in English. The transcribed interviews were then used to identify themes. These themes are based on my understanding of each participant's experience.

### **3.3.3 Analysing the information**

It is important that the method used to analyse the information be congruent with the research paradigm. This is a qualitative study and will require an understanding and interpretation of rich, detailed, and thick information. According to Terre Blanche et al. (2006, p. 321), "a good interpretive analysis is to stay close to the data, to interpret it from a position of empathic understanding." I therefore became immersed in the information gathered, accepting that the information gathered is influenced by the individual giving the information, the context, the transactions between the participants and myself, language and the way I constructed the description. In qualitative research the researcher may become part of the information gathered, and it may appear that the data-collecting process only elicits sundry "bits" of life events or stories. The researcher therefore has the responsibility to stand back and view the information not only as fragments, but as a whole (Terre Blanche et al., 2006). Analysing information from a qualitative research perspective therefore requires the researcher to alternate between immersing him-/herself in the data and taking a meta-observational view of the information gathered. The researcher attempts to make the phenomenon under study familiar but would also like the reader to view the phenomenon from a new perspective (Terre Blanche et al., 2006).

In order to make sense of the information gathered from the interviews in this study I used a method of analysis called thematic content analysis (Boyatzis, 1998).

Thematic analysis seeks to identify and describe the most significant themes in a text at different levels (Attride-Stirling, 2001). This method allowed me the opportunity to become immersed in the information while also having the opportunity to reflect on the information as a whole (Terre Blanche et al., 2006). This method fits with this research study's qualitative paradigm. It allowed for interpretation and understanding of the rich, detailed, and thick information gathered from the interviews.

Braun and Clarke (2006) found thematic analysis a useful method with many advantages if used to study an under-researched topic. As described in chapter 2, limited research is available on the experiences of an OCD support group, and this topic can be considered an under-researched area. The advantages of using thematic analysis that are relevant to this research study described by Braun and Clarke (2006, p.6) are its flexibility, its simplicity and relative ease to apply, its accessibility to researchers with little or no experience of qualitative research, and its results that are generally accessible to the educated general public. It is also a useful method when working within a participatory research paradigm, with participants as collaborators, and it can usefully summarise key features of a large body of data and/or offer a rich description of the data set. The thematic analysis method highlights similarities and differences across the data set, generates unanticipated insights, and allows for social as well as psychological interpretations of data.

According to Braun and Clarke (2006), a disadvantage of thematic analysis is that it lacks clear and concise guidelines on how to apply it to data analysis. However, despite this disadvantage, Braun and Clarke (2006) found that it is a widely used method of data collection in the social sciences. In this study, I negated this disadvantage by conducting a thorough thematic analysis which, according to Braun and Clarke (2006), can still produce a very insightful analysis in order to answer the research question.

I also circumvented this disadvantage by strictly sticking to guidelines in a five-step process. Terre Blanche et al. (2006, pp. 322-327) provide these guidelines, which were followed in this study in order to analyse the information gathered. These guidelines are the following:

**Step 1: Familiarisation and immersion**

Here the researcher works with the text and not the lived experience. The researcher tries to make sense of the participant's world by immersing him-/herself in the participant's text. The researcher becomes familiar with the text by reading and

re-reading the text and making notes in order to attain an overall feel and a more holistic view of the text.

### **Step 2: Inducing themes**

In this step the researcher works through each transcribed interview in order to identify themes that stand out to him/her. Similar incidents are grouped together under certain themes. The researcher needs to find a sufficient number of appropriate themes which could be integrated meaningfully at a later stage meaningful but also needs to stay away from extracting too many themes. If too many themes are extracted, the researcher may have too many sub-themes and he/she may need to generate more main themes. The sub-themes will be placed under the main themes.

### **Step 3: Coding**

Coding entails “breaking down a body of data (text domain) into labelled, meaningful pieces, with a view to later clustering the “bits” of coded material together under the code heading and further analysing them both as a cluster and in relation to other clusters” (Terre Blanche et al., 2006, pp. 325-326). The researcher extracts similar information from the text and assigns a code to that information. These codes are grouped together under the same headings or themes.

### **Step 4: Elaboration**

This step involves looking at the themes and coding more closely. It entails exploring the themes in detail to uncover themes or sub-themes that may have been overlooked or missed during the initial induction of themes (step 2) and coding (step 3) phases. The researcher may revert to steps 2 and 3 and revise the themes and the coding system should it seem to be necessary. This elaboration stage may help the researcher view the data from different perspectives and to structure the material in different ways. This also gives the researcher the chance to structure the information in such a way that he has a good understanding of the information gathered. The elaboration stage as well as going back to stages 2 and 3 may be done repeatedly until no new insights emerge.

### **Step 5: Interpretation and checking**

This final stage involves the researcher presenting his/her interpretations of the phenomenon studied in written format, using the themes gathered from the thematic content analysis as subheadings. The researcher and his/her supervisor examine the interpretations in detail in order to identify any contradictory points, whether some interpretations are mere summaries, if the researcher over-emphasised any trivial

aspects, or if his/her prejudices may have clouded his/her judgment. This last stage also includes the researcher reflecting on his/her role in the collection and interpretation of the information.

I followed these guidelines in order to obtain recurrent themes in the members' experiences of the OCD support groups. The themes came about in very different ways in each participant's experiences, and it was my responsibility to uncover and link these themes, and to discuss the themes in relation to the relevant literature and theory. These themes and the discussion of the themes with relevant literature and theory facilitated greater understanding for myself, regarding these members' experiences of the OCD support groups.

### **3.4 Research Design**

Shenton (2004) proposes that the trustworthiness of qualitative research is often questioned and criticised by quantitative researchers. This may be due to the concepts of validity and reliability being addressed differently in a quantitative research design compared to a qualitative research design. Shenton (2004) believes that these criticisms of the qualitative research paradigm are unjustified, and that there are control structures in place which ensure that a qualitative research study meets the acceptable research standards and practices. Van der Riet and Durrheim (2006) highlight four control structures that can be used to assess the trustworthiness of qualitative research, namely credibility, transferability, dependability, and confirmability. These control structures are described below in more detail as well as how these control structures were applied and used to enhance the trustworthiness of this qualitative research design.

#### **3.4.1 Credibility**

According to Van der Riet and Durrheim (2006), validity in a quantitative study has the corresponding criteria of credibility in qualitative studies. Credibility implies that "research produces findings that are convincing and believable" (Van der Riet & Durrheim, 2006, p. 90). The techniques proposed by Shenton (2004), namely triangulation and thematic content analysis, were applied in this study in order to ensure credibility. Kelly (2006, p. 287) describes triangulation as "collecting material in as many different ways and from as many diverse sources as possible." In this study, triangulation was achieved by gathering information by means of evaluating existing literature, reviewing the participants experiences recorded during the semi-structured interviews in order to clarify what they meant, rereading and reviewing the

answers given by the participants in the semi-structured interviews, and also by engaging in dialogue with my supervisor.

### **3.4.2 Transferability**

Generalisability in quantitative studies corresponds to transferability in qualitative studies (Van der Riet & Durrheim, 2006). Transferability denotes findings that can be applied in other situations (Guba & Lincoln, 1989). Rich, detailed descriptions of contexts may be a way of achieving transferability (Van der Riet & Durrheim, 2006). This study ensured transferability by providing adequate contextual information and a detailed description of the phenomenon under study. This will hopefully enable the reader to transfer and apply the findings of this study to other OCD support groups.

### **3.4.3 Dependability**

Reliability in quantitative studies corresponds to dependability in qualitative studies (Van der Riet & Durrheim, 2006). In qualitative studies, it is therefore more important for the findings to be dependable. Van der Riet and Durrheim (2006, p. 93) describe dependability as “the degree to which the reader can be convinced that the findings did indeed occur as the researcher says they did.” They also explain that “dependability is achieved through rich and detailed descriptions that show how certain actions and opinions are rooted in, and develop out of, contextual interaction” (pp. 93-94). In this study, the guidelines set out by Stiles (1993, pp. 602-607) were followed as strategies to maintain a high level of dependability. These guidelines, which are relevant to this study, are outlined below.

- Disclosure of orientation. A social constructionist perspective was adopted in this study, which means that the interviews were a co-construction between my reality and the realities of the participants. I therefore disclosed my expectations for the study, preconceptions, personal values and theoretical orientation as these may have impacted the participant interviews.
- Explication of social and cultural context. The social and cultural context within which a study takes place should be highlighted. In this study, the social and cultural context of each participant was indicated by providing extensive background information of each participant. This background information was then integrated into the interpretation of that participant’s experience.

- Description of internal processes of the investigation. This indicates the impact the research process had on me. In this study I referred to my internal processes whilst progressing through the research process, and incorporating these in my interpretations.
- Engagement with the material. I needed to establish a relationship of trust with participants in order to obtain a deep understanding of their perspectives. This helped me understand the OCD support groups from the perspective of the participants. A semi-structured interview encouraged the participants to engage and freely share their perspectives. I also placed myself in the position of not being the expert by being non-judgmental, honest, and congruent.
- Iteration. I cycled between my personal interpretations and observations, and was constantly aware of the dialogue between theories and interpretations, participants and text.
- Grounding the interpretations. Interpretations were linked to the content and context of the interviews. This was corroborated by linking examples from the participant interviews to particular themes.
- Asking “what” not “why” questions. Participants’ experiences should be grounded in context, and this was facilitated by asking “what” questions instead of “why” questions.

#### **3.4.4 Confirmability**

According to Van der Riet and Durrheim (2006), confirmability of a qualitative study is preferred to objectivity in a quantitative study. Confirmability refers to the extent to which the research results reflect the views of the participants, and not the preferences or views of the researcher (Shenton, 2004). I ensured confirmability by minimising investigator bias (Shenton, 2004). This was done through the triangulation process referred to above, and by acknowledging my beliefs and assumptions. I also acknowledged my possible shortcomings and their potential effects on the study.

#### **3.5 Ethical Considerations**

Ethical considerations need to be taken into account in both quantitative and qualitative research studies. However, in qualitative studies it is especially important for the researcher to follow ethical guidelines. In qualitative research, the researcher is a guest in the private spaces of other human beings (Stake, cited in Denzin & Lincoln,

2000). This means that qualitative research uses human interaction in order to collect data. It was necessary to be sensitive and to follow the guidelines that protect the integrity of the research participants. It was therefore my responsibility to protect the participants of this study, and this was done in line with the Ethical Code of the Health Professions Council of South Africa (HPCSA), as suggested by Terre Blanche et al. (2006).

To ensure the ethical credibility of this study, I submitted a proposal to the Department of Psychology at the University of South Africa (UNISA) for approval prior to commencement of the study and obtained ethical clearance from the ethical committee at the Department of Psychology at UNISA. The three ethical guidelines that were followed in this research study were informed consent, confidentiality, and competence (Denzin & Lincoln, 2000; Kopala & Suzuki, 1999; Rapmund, 2005).

### **3.5.1 Informed consent**

Informed consent requires a researcher to provide research participants with sufficient information about the research study. I drafted a consent form for the participants (see Appendix A) and, as suggested by Drew, Hardman and Hosp (2008), included the following important information: Participants were given a comprehensive, clear description of the research study and what was required of each participant. This allowed the participants to make an informed and voluntary choice whether or not to participate in the research study (Wassenaar, 2006). Participants were informed that the purpose of this study is that of a Master's dissertation in Clinical Psychology. Verbal and written consent from each participant taking part in this study was obtained. Participants were given the assurance that this verbal and written consent was not binding, and that they could withdraw from the study at any time without prejudice (Kopala & Suzuki, 1999). I remained available to the participants after they had signed the informed consent, during the interviewing process, and after the interviewing process in order to answer any questions or address any concerns the participants had about the research process. The participants and I had an on-going, two-way communication between us during the research process. It was made clear to the participants that the interview process is defined as research and not therapy, even though they may gain personal insights, experience personal growth or change during the research process. I abided by the principles of non-maleficence and beneficence. I ensured that no harm would befall any of the



participants as a direct or indirect consequence of the research study, while also trying to maximise the benefits of the research study to the participants (Wassenaar, 2006).

### **3.5.2 Confidentiality**

Confidentiality refers to protecting another person's integrity and privacy by ensuring that protective measures are in place (Rapmund, 2005). In the context of this study, the participants' identities were protected through the use of pseudonyms. The clinical psychologist who runs the initial support group was not referred to by name by the participants in their interviews, and his identity was therefore also protected through the use a pseudonym. The identities of the members of the OCD support groups who did not take part in this study, that were mentioned by name in the interviews were also protected through the use of pseudonyms. The participants were given a clear description of who would have access to their information (my supervisor, a second transcriber, the examiners, and myself) and how this information would be used. I also informed the participants of the purpose of this research study, how this information would be recorded, how and where this information would be stored, and the way in which the information would be presented (dissertation) (Rapmund, 2005). The participants were assured that any published results of the study would be made available to them.

### **3.5.3 Researcher's competence**

Competence refers to the researcher's ability and capability to conduct a research study (Rapmund, 2005). I adhered to the suggestions made by Rapmund (2005), who states that the researcher also has the responsibility of adhering to the ethical guidelines set out for a particular study. I showed my competence to conduct this research study and my responsibility to adhere to the ethical guidelines set out by the HPCSA. I clarified my role to the participants, conducted the interviews in a professional manner, and maintained this professional conduct throughout the research process. I was also aware of my limitations, and when I needed assistance, guidance or intervention I referred to an appropriate professional. I also had my supervisor for assistance and guidance, who was to be called upon if and when I needed intervention (Rapmund, 2005). The study and collection of information remained within the ambit of my expertise.

Wassenaar (2006) states that a researcher has the responsibility to proceed with caution when conversing with a participant about intensely personal experiences. The participant may feel exposed and vulnerable while speaking about these personal

experiences, and should at all times be made to feel comfortable and at ease despite the intensity of the interview (Wassenaar, 2006). Information on OCD and an OCD support group can be sensitive, and participants' autonomy was respected at all times. The participants were not obliged to answer any questions he/she felt uncomfortable to answer. The contact details of a competent psychologist as well as specific helplines were available should the participants have required therapeutic assistance. It was made clear to participants that should they feel uneasy or uncomfortable, they should communicate this to me. If this uncomfortable feeling is persistent the participant has the choice to withdraw. It was also made clear to the participants that I reserved the right to stop the interview as is outlined by Wassenaar (2006) should I believe the participant is uncomfortable and stopping the research would be the best option for the participant.

### **3.6 Conclusion**

This chapter discussed the ontological, epistemological, and methodological stance of this research study. A research study needs to have a linked thread running through its spine and this chapter has the purpose of providing that thread. This chapter explained postmodernism as the ontological stance, social constructionism as the epistemological stance, and the qualitative research paradigm as the methodological stance of this research study. These stances appear to be interconnected, and their implications on this research study were discussed. They are also compatible with this research study's underlying systemic theory. The research process was also outlined with an emphasis on the study population, data collection, and thematic content analysis as the route taken in analysing the information. The research design was then discussed with regard to the credibility, transferability, dependability, and confirmability. The research design is in line with the qualitative stance of the research study.

Lastly, the ethical considerations adhered to in this study were discussed with particular reference to informed consent, confidentiality, and the researcher's competence. The next chapter will explore the themes generated from the participants' experiences of the OCD support group.

## Chapter 4

### Research Findings

#### 4.1 Introduction

This study focuses on the experiences of four individuals with OCD who attend an OCD support group in the South African context. As outlined in chapter 3, I identified one support group with a focus on OCD in South Africa. This identified OCD support group is steered by a clinical psychologist. A sample of four members of this support group was identified to be the focus of this study. However, as outlined in chapter 3, the focus of this study broadened during the interview process when it became evident that the participants in this study are/were also members of a second OCD support group (an offshoot of the support group steered by a clinical psychologist) which the members of the second OCD support group run independently. Although these two OCD support groups are separate entities, they are linked in that several individuals are members of both groups. For the sake of clarity and ease of reference, the support group started and steered by the clinical psychologist will be referred to as the *initial* support group and the OCD support group formed and run by individuals with OCD will be referred to as the *sub-support* group. The four participants in this study volunteered their experiences as members of both OCD support groups. The participants also gave rich, detailed information about both OCD support groups. The motivation to use the participants' experiences regarding both OCD support groups in this study was in line with the research question and the aim of this study, as both groups were perceived by the participants as OCD support groups and their experiences of both OCD support groups are regarded as valuable.

This chapter presents information obtained from the four participants about their experiences of both OCD support groups. As detailed in chapter 3, this study subscribes to a qualitative research method. Thematic analysis was used to carefully and accurately organise the information obtained from the participants into major themes and sub-themes. This chapter begins with concise background information about each of the four participants relevant to the study as it demonstrates each individual's life circumstances and mental functioning prior to joining the OCD support groups. Themes related to the participants' experiences of both the OCD support groups are then presented and include excerpts of the actual comments and statements, derived from the transcribed interviews, and which provide substance to

and verify the various themes.

It is important to note that the themes identified in this study are not considered mutually exclusive. They are considered interactive and could be used in a recursive manner. The themes may therefore interlink and overlap. It is also acknowledged that my “lenses” of understanding and interpretation at this time cloud the identified themes. These themes are therefore not meant to represent an ultimate truth about the realities of the participants of the two OCD support groups. It is further acknowledged that these themes are by no means exhaustive in describing the participants’ experiences of the two OCD support groups. Another person, looking through his/her particular lens, may highlight different themes and/or add to the ones presented here.

I deem it necessary to bring to the attention of the reader that this chapter, in the light of the limited scope of this dissertation, is exceptionally long. The length of this chapter can be attributed to the rich and thick experiences pertaining to the experiences of two different types of support groups and not only one. I have already explained why I have decided to use both sets of information in this study.

#### **4.2 Background of the Participants**

The four participants are considered to have had extensive personal experience as sufferers of OCD and as members of both OCD support groups. They attended the initial support group once a month for a minimum of eight months. They also attended the sub-support group three times a month for a minimum of six months. For purposes of confidentiality, pseudonyms were assigned to each participant in order to protect their identities and those of people related to them. From here onwards the participants will be referred to as Nick, Veronica, Nancy, and Frank. The participants referred to individuals connected to the two support groups by name, in the interviews, the clinical psychologist who runs the initial OCD support group as well as other members who attend both the OCD support groups although none of them were participants in this study. To protect these individuals’ identities as well, pseudonyms were assigned to all of them. The clinical psychologist from here onwards is referred to as Brad, while the other members of the OCD support groups that are mentioned are referred to as Stuart, Paul, Tracy, and Patty. The background of these members will not be provided as they are not participants in this study and are only briefly mentioned by the participants.

The participants gave detailed accounts of their backgrounds with regard to demographic details, OCD symptoms, treatment, comorbid disorders, family mental illness, family background, and interpersonal relationships. A concise description of the background of each participant will therefore include all of the above topics with relevant quotations from the text. The participants' details are presented below. The background information alluded to above will thereafter briefly be discussed.

**Table 2: Backgrounds of participants**

Participant	Age (years)	Gender	Duration of OCD	Time spent in initial OCD support group	Time spent in sub-support group	Attendance of both OCD support groups at time of interviews
1. Nick	32	Male	Official diagnosis - 2010	One year	Seven months	Still attending both OCD support groups
2. Veronica	26	Female	Official diagnosis - 2011 – but she recognised signs of OCD since age of 16	Two years – since inception of support group	Eight months	Left both OCD support groups two months prior to the interview
3. Nancy	25	Female	Self-diagnosed with OCD for a year. However, the clinical psychologist who runs the initial OCD support group confirmed the diagnosis of OCD while in the OCD support group (Telephonic communication, August, 2014)	Eight months	Six months	Still attending both OCD support groups
4. Frank	26	Male	Officially diagnosed in 2012	One year	Seven months	Still attending both OCD support groups

### Nick

**OCD symptoms:** Nick reported repetitive intrusive thoughts and images of cutting and hanging himself. When stressed, he would have these intrusive thoughts

and images every few seconds. He did not report any compulsive behaviour with regard to these suicidal thoughts and images: *I was having these suicidal thoughts about hanging and cutting. ... After that, I got imagery about hanging and cutting ... It would happen every few seconds, when I was stressed.* Nick also reported relational obsessions accompanied by compulsions of reassurance-seeking: *The OCD also flares up in relationships, like obsessions with jealousy ... obsessive thoughts, especially about peoples past sexual histories and also just intrusive thoughts about imagining they are betraying me or being untrustworthy ... or that they don't love me. ... At times I am so anxious because of the obsessive thoughts ... that I can't function. ... I need reassurance and that becomes a compulsion.* The reassurance Nick speaks about is that of continually asking his girlfriends how secure they are in the current relationship, and questions about his girlfriend's past relationships.

**Treatment:** Nick reported being hospitalised due to the severity of the OCD symptoms: *I went into the hospital voluntarily ... very early on after only a few weeks after I was diagnosed.* He stated that he takes different types of medication for the OCD symptoms. He also stated that he has attended individual psychotherapy prior to becoming a client of the clinical psychologist who runs the initial OCD support group: *I first did CBT about ten years ago ... for depression.* He currently attends individual psychotherapy, focusing on CBT for OCD with the clinical psychologist who runs the initial OCD support group: *I have been able to address it [OCD] through CBT... it was really effective.* The CBT treatment focused on habituation, body scanning, and exposures: *One thing I did was habituation, so if I got a thought or an image, say I want to hang myself ... [purposefully and continuously repeating that thought or image] ... say twenty times. The other thing I did was my exposures, so lying on my bed, breathing, and body scanning, chilling out and then thinking out what would be the worst case if it [the obsessional thought or image] actually happened and bursting into tears.*

**Comorbid disorders:** Nick stated that he has comorbid disorders. He reported to have been diagnosed with a depressive disorder in the past. He is currently diagnosed with bipolar disorder along with OCD: *I was diagnosed with OCD in 2010 and before that I've had depression for the last ten years, which was diagnosed as bipolar too in 2010.* Nick also described symptoms of social anxiety disorder (SAD) but he has not been officially diagnosed with SAD: *I also get slightly apprehensive talking to people in large groups, even in informal settings.*

**Mental illness in family:** Nick mentioned mental illness in his family. His father was diagnosed with a mental illness [schizoaffective disorder]: *I don't have a very good family history. My dad is schizoaffective.*

**Family background and interpersonal relationships:** Nick stated that he has difficult relationships with other individuals, such as his family and friends. He does communicate with his parents but he tends to have a superficial relationship with them and only divulges on a surface level what challenges he may be facing. Nick highlighted the superficial relationship with his parents by mentioning: *I told my parents about the OCD ... I am not very specific with them though, I just say my OCD is bad at the moment, because it is hard to say to your family, "oh I am having thoughts about my girlfriend's ex, or that kind of thing."* Nick also alluded to having a girlfriend as well as friends. However, he again did not divulge fully what he might be experiencing, particularly with regard to his OCD symptoms, to his friends and his girlfriend: *I have lots of friends but I don't really talk to them about details ... because they are quite intimate. There is stuff that my girlfriend and my therapist don't know, there is stuff nobody knows.* Nick's relationships with the people in his life seem to be on a superficial level. Nick therefore does not appear to have much social support with regard to the OCD symptoms he experiences.

### **Veronica**

**OCD symptoms:** Veronica mentioned that she experienced many different OCD symptoms that tended to change and evolve over time: *I have had a variety of OCD symptoms ... I have tried to combat OCD all this time but I just feel it creeps into everything else.* She reported that she used to have several compulsions and only one obsession. One particular obsession that she mentioned is that of contamination: *I obviously was scared of contamination. I didn't want to eat something that was dirty; I didn't want to wear clothes that made me dirty.* The contamination obsession was linked to several compulsions such as washing her hands, washing herself, checking, and counting: *I would always wash my hands excessively ... I also cleaned myself a specific way in the shower. Then I started checking my fork and my knife ... so I would analyse it like three times ... and then three by three (3x3) times, so nine times. Somehow that would mean that it was ok. ... Checking clothes every morning to three and then I would just switch off lights. That was a terrible compulsion ... to three, always nine, maybe more. And then I would check my room as well. I would check under the bed, check in the cupboard, check, check, check, check, checking.* Veronica

reported that she did not experience any other obsessions but she has also had severe anxiety that compelled her to carry out a ritual according to rules that must be applied rigidly: *I have run off a feeling. An anxiety feeling, a build-up, but no thought process behind it ... but you have to do it [because of fixed internal rules that the compulsion must be carried out in a certain way or you will have] ... extreme anxiety.*

**Treatment:** Veronica mentioned being hospitalised due to the severity of the OCD symptoms: *I was booked into a clinic ... that was enough to help my parents realise that it was something serious. It also helped me realise how serious it was.* Veronica has also tried different types of medication before she went on to a particular medication, which she reported to find effective for the OCD symptoms she was experiencing. At the time of the interview she was still taking the medication. She has also attended individual psychotherapy sessions, only after joining the initial OCD support group, with the clinical psychologist who runs the initial support group. She reported to have gone for CBT with this psychologist, in which she learned specifically to rationalise that the thoughts are not logical and that the resultant anxiety will eventually subside. She saw this clinical psychologist concurrently with her OCD support group attendance. At the time the research was conducted, she was no longer attending individual psychotherapy sessions with the clinical psychologist: *I went for intense sessions with the clinical psychologist ... and how I have managed to combated it [OCD] ... is to find out what the fear is and then target it or you rationalise it ... and push through.* Veronica also mentioned that mindfulness and meditation have had a big impact on how she lives her life. She was taught the techniques of mindfulness and meditation at the School of Philosophy, which is a therapy group she attends besides the two OCD supports. She joined this School of Philosophy group while attending the OCD support groups, and at the time the research was conducted, she was still attending this School of Philosophy group: *I have started at this school of philosophy and they have taught me how to live in the moment and meditation. Anxiety charges the behaviour and this mindfulness and mediation relaxes the body. Now I am very aware, so I know for example that I have turned off the tap.*

**Comorbid disorders:** Veronica acknowledged being plagued by a comorbid disorder. She was diagnosed with attention deficit disorder (ADD) [attention-deficit/hyperactivity disorder, predominantly inattentive presentation (APA, 2013)] while in school: *When I was at school I also had attention deficit disorder. ... I still*



*don't have long attention span. She has not been officially diagnosed by a professional as having a depressive or hoarding disorder, but she has diagnosed herself as such: I just started going to bed, I became depressed, I didn't want to get up in the morning. It had to be depression; I mean nothing else made sense ... I mean I had absolutely no energy for anything else, so ... I just had this routine of being so exhausted. No zest, no nothing. I am also a hoarder.* However, she does not give reasons as to why she thinks she has symptoms of a hoarding disorder.

***Mental illness in the Family:*** Veronica alluded to possible mental illness in her family. She mentioned that she believes her mother also has OCD as well as a hoarding disorder: *I think she [mother], well I don't think, I know that she is OCD ... and my mom is a hoarder.* However, Veronica is not clear about her mother's perceived OCD and hoarding symptoms. She described them in combination with each other: *So she has that irrational way of making decisions about something that is trash as we might just need it one day ... my mom would always be like "have you lost your pencils, have you lost your crayons, have you got everything. Have you got your pencil, have you got your eraser" ... like my mom made sure I was very grabby.*

***Family background and interpersonal relationships:*** Veronica reported that her parents were uninterested in what she may be experiencing when it came to her OCD symptoms: *My parents were disinterested, 100% disinterested.* She recounted that her family system was chaotic prior to joining the support groups. She mentioned that she knows that her mother cares for her and loves her but was unsupportive when it came to her OCD symptoms: *My mom is like a real mom's mom ... like super caring, too caring ... very supportive ... but not like "come Veronica we are going to get you better."* She also stated that her father lacked insight into her mental illness and was unsupportive. She report that he would push her to do certain things she struggled to do due to the effects of her OCD symptoms: *Then my dad loves me but he is like angry in the morning when I get up for work or for school ... and he would wind me up, because I am very slow. So, I always take too long in the bathroom, I will always be late for work and instead of being like "oh Veronica, why do you take so long?" every day, it was like "... You're keeping us late ... ah, we are going to be late today, hurry up [shouting]".* She believed that her parents may have actually made her experience of OCD worse: *My dad's reaction to that was aggroness [being aggressive] and obviously I would get anxious through that experience. ... I think*

*what happened is my dad fuelled my OCD.* She did not receive much social support from her parents when it came to her OCD symptoms.

Veronica did not receive much social support, with regard to her OCD symptoms, from her friends either when she was younger and prior to joining the support group for OCD. This may not have been due to her friends avoiding her but she suggested that she did not seek out support with regard to her OCD symptoms as she had a lack of understanding of what she was experiencing: *It was just like I was malfunctioned ... so when I was younger I didn't really chat to anybody because I didn't really know what was happening ... this way the same before I came to the support group* [both support groups].

### **Nancy**

**OCD symptoms:** Nancy stressed that she experiences both obsessions and compulsions. The content of the symptoms she experiences tend to evolve and adapt: *My symptoms change, so I keep obsessing about different stuff.* However, her symptoms do appear to fall within certain themes. She reported that she experiences themes of checking, relational and jealousy obsessions, health and pregnancy obsessions, what she calls “jinxing obsessions”, and avoidance. Nancy has obsessions of doubt as to whether she had locked the door even though in the back of her mind she knew she had locked the door. This would cause her extreme anxiety. This obsession would be accompanied by what appears to be a central compulsion of checking: *My OCD went crazy ... the obsessive checking. ... I would leave home and I still going to obsess about that I have left the door unlocked. Even though I have already checked it like five times ... with accompanying anxiety, constant anxiety.* She would experience health and pregnancy obsessions, and she would constantly go to doctors to check her health and pregnancy status: *I also think that I am pregnant ... and nothing can prove to me that I am not pregnant. Not the doctor, not tests, nothing ... and other obsessions of this sort ... like I use to obsess about [getting a] sickness [such as] ... tuberculosis to leprosy ... brain cancer, a brain tumor, or something like that ... and nothing proves to me that I am not sick, even tests.*

The relational or jealousy obsessions that Nancy speaks about appear to be her anxiety around a boyfriend cheating on her or leaving her. She then carries out the compulsion of continuously checking on her boyfriend: *My OCD is also very relationships related, so I would just like have an intrusive thought that my boyfriend is cheating on me. ... I would obsess and then check my boyfriend's Facebook, check*

*his e-mails, check his text messages ... check everything.*

Nancy described her “jinxing obsessions”. These obsessions and accompanying compulsions give an idea of how obsessions and compulsion are not necessarily linked in a logical manner. Nancy appears to have fears around dating certain men as well as obtaining a visa to come to South Africa from a foreign country, and if she does not carry out a certain activity the correct way such as running a certain distance or answering the doorbell before it stops ringing, she believes that a feared event may possibly occur: *Say I have this birthday party and I have to send out the birthday invitation for next Sunday and now I am obsessing that I am only jinxing the visa because I still haven't applied and I am not going to get my visa because I jinxed it. ... I was still in ... [Foreign country] ... so I started to obsess that if I was going to manage to run “that far” [a certain distance] then I know I am going to come back to Cape Town. If I didn't manage to run “that far” then I know that I wouldn't go back to Cape Town.* These feared events may be her not being able to date a certain man or not getting her visa. She mentions that she would therefore push herself to perform certain actions in a specific sequence to prevent these unrelated, feared events from occurring: *I couldn't even breathe but I would just run to the end even though I couldn't really do it anymore but then I would somehow force myself and then nearly die of heart attack at the end of the run. Similarly, there was a guy ... I wasn't even dating ... I just talked myself into the fact that this is the guy I am going to marry ... and if I am going to manage to reach the door before the bell stops ringing then I am going to be with this man.*

Nancy also described that she had an obsession around demons attacking her if she saw, heard of, or felt what she thought could have been related to a demon. Her compulsion linked to this obsession was to avoid anything related to demons, such as specific music, pictures or movies.

**Treatment:** Nancy is the only participant in this study who, at the time of the interview, had not taken or did not take medication for her OCD symptoms. She has never been to a psychiatrist and she has avoided an official diagnosis of OCD so that she did not have to go on to medication: *There are reasons why I didn't want to be diagnosed ... one of them being that I wouldn't go on medication.* She has, however, attended individual psychotherapy sessions in the past for family-related problems and for a specific phobia she was experiencing at the time: *I was in therapy for my family stuff ... [and] ... I was in therapy for my arachnophobia.* She also

attended individual psychotherapy sessions as a child because her family thought she was depressed. She has not, however, attended any individual psychotherapy sessions for her OCD symptoms. Of her own volition she has implemented mindfulness and meditation techniques, even before joining the OCD support groups, in order to get her OCD symptoms under control: *With the OCD, I just realised that I have to sort myself out, so I started meditating and I started doing mindfulness on my own and that's when it started to go better.*

**Comorbid disorders:** A professional has not officially diagnosed Nancy with any comorbid disorder besides a possible depressive disorder as a child: *I use to go to a psychologist ... she didn't diagnose me with depression but she thought I was depressive.* Nancy mentioned a possible yet unofficially diagnosed alcohol-use disorder: *I started to have an alcohol problem as well, just like drinking ... basically I was trying to drink myself to death.* She also experienced symptoms of a specific phobia ... *arachnophobia* [fear of spiders]. She does not, however, elaborate on these symptoms.

**Mental illness in the family:** Nancy described her mother as possibly having symptoms of OCD. *My mom was a control freak ... or is a control freak ... she would try control me [what she wears and does] ... I think my mum has OCD.*

**Family background and interpersonal relationships:** Nancy reported a difficult relationship with her parents before joining the support groups. She described her mother as over-controlling and unsupportive: *My mom always said that I am f\*#%\$ed up ... like that is the exact words that she used.* She then mentioned that she has a dysfunctional relationship with her father: *My father was the same [as her mother] ... and I thought that my problem was connected to my father because my father abandoned me and my mother when I was little and then he came back but then ... our relationship was very dysfunctional. ... My father doesn't show emotions. He told me that he loves me one time in my life and he was very, very drunk ... but he would express anger ... he got angry with me all the time.* She felt that she received no support from her parents: *My family would just get angry with me that I am crazy.*

Nancy reported that OCD affected her whole life. She also received very little support from other people in her life as well. She reported to forming friendships but found it difficult to trust people, and was therefore unwilling to confide in her friends about what she was going through with regard to her OCD

symptoms. She had particular difficulty with the men in her life: *Everything in our lives to this or other extent had an effect on our OCD. First of all I had a fear of men ... coming from my father obviously. ... I did however form friendships but I think because of my family background I don't really trust people that much. ... I actually had a very bad experience with my friends.* She does not, however, elaborate on this very bad experience.

### **Frank**

**OCD symptoms:** Frank mentioned compulsions without any obsessions. The compulsions Frank experienced were fluid and tended to transform: *It's a very intangible version of OCD ... abstracted version.* The compulsions tended to relate to anxiety more than a feared event occurring. He therefore felt compelled to carry out compulsions according to rules that must be applied rigidly. Frank experienced anxiety at a younger age and realised that if he memorises what he sees in a room or in a car according to specific rules, the anxiety subsides. He applied these rules rigidly and frequently as it helped the resultant anxiety subside. An example of these rigid rules is that he must scan the room or an object in the room with his eyes or an imagined laser beam from left to right. He must also scan the full room or object without leaving any piece of the room or object untouched with his eyes or imagined laser beams: *I can walk into a room ... and I'll basically know every nook and cranny of that room and the details in it, like fairly extensively, without trying, that's the weird thing. ... When it's the most intense ... there is a laser beam scanning whatever's there ... in the room (laser beam is imagined).* According to Frank, these rules, due to the frequency and duration of carrying them out, have become an unconscious process and have become an integral part of how he lives his life. He therefore has difficulty describing what these rigid rules are: *I now take in the details subconsciously of stuff that's there.* He stated that carrying out these compulsive acts provided him with relief from the anxiety: [Doing a compulsion] ... *it's just comforting I suppose.* Frank also described that he did not have an obsession around sexual activities but he had a compulsion to carry out promiscuous sexual acts in a certain way that would reduce his anxiety levels.

**Treatment:** Frank reported being hospitalised three times due to the severity of his OCD symptoms: *Basically it got to a point where I checked myself into a hospital and I was just wildly depressed and my OCD was completely out of control and it was hectic ... and subsequently I've been to hospital twice more.*

*The last time I went was just over two years ago.* Frank also reported seeing psychiatrists on an outpatient basis and being placed on medication for his OCD symptoms. At the time of the interview he was still taking medication. He also stated that he was seeing a therapist recommended to him by a friend. He did not report what type of therapy it was, but eventually terminated the therapy as he did not believe it was beneficial to him. He then went to see the clinical psychologist who runs the initial support group and who specialises in CBT for OCD. With the assistance of this clinical psychologist he appeared to learn how to get his OCD symptoms under control to some degree: *I started seeing the clinical psychologist ... he was specifically interested in OCD, which was great, and CBT ... and all these kind of very practical, very good ways to work with it and he taught me a lot.*

**Comorbid disorders:** Frank did not mention any official diagnosis of a comorbid disorder. He did, however, report having been possibly diagnosed with generalised anxiety disorder (GAD) a few years ago: *There had been other things at times, which psychiatrists have spoken about; something that came up was GAD.* He also stated that he had symptoms of a depressive disorder and a specific phobia: *I was ... depressed. ... I've also got a fear of heights and so walking over a specific bridge or on a mountain ... I can really get anxious.*

**Mental illness in the family:** Frank reported that he believes his father has undiagnosed OCD: *My dad's got OCD, not that he's diagnosed with it.*

**Family background and interpersonal relationships:** Frank mentioned receiving little support from his family. His parents were divorced when he was in late high school, which disrupted his family system: *My parents got divorced and it was quite messy and it had ... a lot of repercussions on the family.* He did not receive much support from his mother, and had very little contact with her after the divorce. He lived with his father but did not get much support, with regard to his OCD symptoms, from his father either. His father did not necessarily believe in OCD and was conservative in his worldview: *I've spoken to him [father] about my own experience [of OCD] ... he just went, no this is absolute, complete, modern bullshit, it doesn't exist. He's very staunch and conservative in a lot of his viewpoints.* He reported that his father was also quite controlling and they tended to get into fights with each other, with one fight leading to Frank being kicked out of the house: *What happened is I had a massive blow-out with him ... it ended up by getting physical, it was quite hectic, it really was. And basically after that he took*

*my car away from me and he kicked me out the house ... so, he basically disowned me ... at that time I moved out and I had to go live with my grandmother. ... My dad is really controlling. He's very difficult ... but I've managed to patch everything up with my dad.*

Frank stated that initially he did not confide in anyone about his OCD symptoms. He stated that he did not keep it to himself purposefully but he did not understand what was happening to him in order to tell other people. He commented that he therefore did not receive much support with regard to his OCD symptoms before joining the OCD support group. When asked whether he received any support with regard to his OCD symptoms, replied: *no, actually not.*

Frank appeared to have had difficult relationships with friends and a girlfriend before joining the OCD support group. He referred to two friends in particular with whom he began a business: *These two friends eventually distanced themselves [from him] ... two friends with whom I began a business ... said they are stopping the business but continued behind my back ... I was angry as we were supposed to be friends.* He also reported difficulties with a girlfriend whom he felt he *pushed away: I had a girlfriend ... and I think I did it [proposed group sex to her] purposefully to push her away.*

### **4.3 Themes**

As described in chapter 3, the participants gave rich, detailed descriptions of both OCD support groups. However, they made a clear distinction between the nature and their experiences of the two OCD support groups. Therefore, the themes in this chapter are divided into two main sections. Each section represents the participants' experiences of one of the OCD support groups. The first section represents the participants' experiences of the initial support group called the support group for OCD steered by a clinical psychologist. The second section represents the participants' experiences of the subgroup called the sub-support group for OCD formed and run by individuals with OCD. Under each of these two main sections, themes and sub-themes are identified. Summaries of the identified themes and sub-themes of the two OCD support groups are presented below in figures 4.1 and 4.2.

## Section A: Experiences of the support group for OCD steered by a clinical psychologist

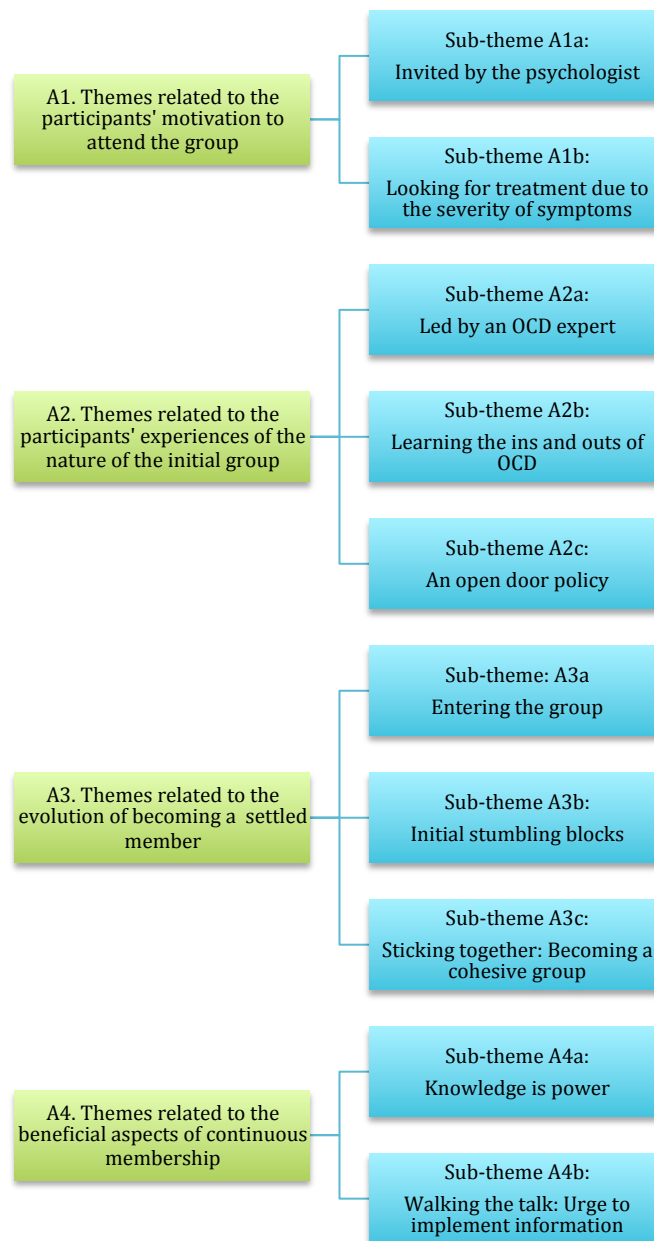
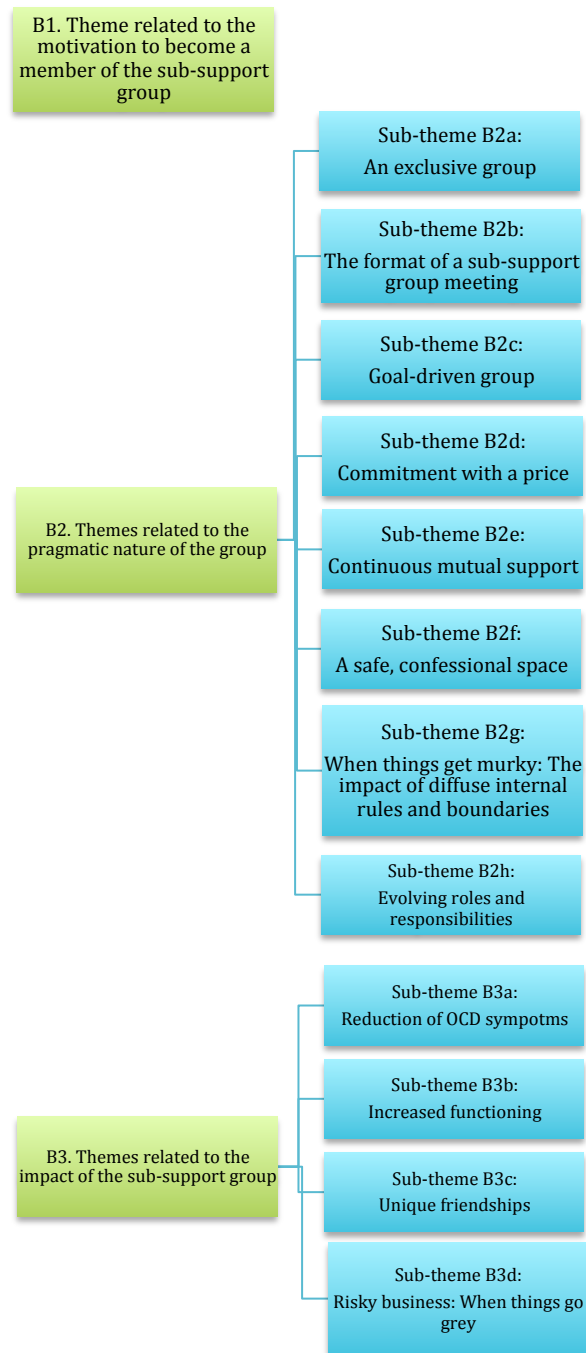


Figure 4.1: Summary of themes and sub-themes for Section A: Experiences of the support group for OCD steered by a clinical psychologist



## Section B: Experiences of the sub-support group for OCD formed and run by individuals with OCD



*Figure 4.2: Summary of identified themes and sub-themes for Section B: Experiences of the sub-support group for OCD formed and run by individuals with OCD*

#### **4.3.1 Section A: Experiences of the support group for OCD steered by a clinical psychologist (initial support group)**

This section will focus on the participants' experiences of the support group for OCD steered by a clinical psychologist, also referred to as the initial support group. The support group, founded and led by the clinical psychologist, is open to individuals suffering from OCD, their family members, and other interested parties. All four participants in this study have attended the initial support group. Each participant has attended a minimum of eight support group meetings. In the following section, the themes and sub-themes listed in figure 4.1 will be discussed in detail.

##### **A1 Themes related to the participants' motivation to attend this group**

The four participants volunteered information about their motivation to attend the initial support group. Nick and Frank had different motivating reasons than those of Veronica and Nancy. Nick and Frank were motivated to join this group by the clinical psychologist whom they had consulted for their OCD symptoms. Veronica and Nancy, in contrast to Nick and Frank, were self-motivated to join the initial support group by their desire to get help due to the severity of their OCD symptoms.

##### ***Sub-theme A1a: Invited by the psychologist***

Two of the four participants, Nick and Frank, attended individual psychotherapy sessions with the clinical psychologist, who founded the initial support group, before joining the initial support group. They both heard about the initial support group from the clinical psychologist running this support group. This clinical psychologist suggested and motivated each of these two participants to join the initial support group.

Nick reported: *I found out about the group through the clinical psychologist and he suggested I come and attend a group session [meeting] ... I was having a meltdown and I wanted to be on my own and I didn't want to go to this group ... but I still went.*

Frank also heard about this OCD support group from the clinical psychologist he was seeing, which was evident when he stated: *I started seeing the clinical psychologist ... and then he told me, we're going to start this group and I was like, it sounds great, I'll come.*

These two participants did not explicitly state that they trusted the clinical psychologist's judgment, but it is deduced from the transcript extracts that they did

trust the clinical psychologist's judgment sufficiently to take his advice to attend the initial support group. Nick mentioned that he did not particularly wish to attend the initial support group, but allowed himself to be motivated and persuaded by the clinical psychologist.

***Sub-theme A1b: Looking for treatment due to the severity of symptoms***

Two of the four participants (Veronica and Nancy) mentioned that they did not initially attend individual psychotherapy sessions with the clinical psychologist who founded and ran the initial support group. Veronica explained that she only began seeing the clinical psychologist (who founded the initial support group) for individual sessions after joining the initial support group: *I came to the first session [meeting of the initial support group] and I met the clinical psychologist. Then I made my first appointment with him.* Nancy reported that she has never had an individual psychotherapy session with the clinical psychologist who founded and ran the initial support group: *I haven't been to therapy with Brad.* Neither of them (Veronica or Nancy) was therefore motivated to attend the initial support group by the clinical psychologist who formed and ran the initial support group. These two participants commented that they were initially looking for help of their own accord, and that they were therefore motivated by their need to get help due to the severity of their OCD symptoms.

Veronica described her OCD symptoms as severe. This is alluded to in section 4.2: Background, under Treatment, where Veronica stated that she was hospitalised due to the severity of her OCD symptoms. She indicated that she attended therapy at a clinic. However, she did not feel that the therapy was beneficial and that although she had left the clinic, she was still desperate for help: *I did not understand what was going on with me. ... So I went to ... [therapy in a clinic] ... and although I don't feel like I have walked away helped at all I will be honest, I came away with the reality of how severe the situation was and that something needed to be done.* Although Veronica described needing help, she did not consider attending individual psychotherapy after leaving the clinic because she did not have confidence in the efficacy of the individual psychotherapy offered at the clinic. She also stated that she found it difficult to find a therapist specifically interested in OCD: *I did not get the help I would have liked... at the clinic ... but I was desperate for help. ... It is difficult to find professionals interested specifically in OCD.* Veronica described that she then discovered the initial support group (a little while after leaving the clinic)

through an OCD study she participated in and she was excited to join the initial support group: *I picked up a Cosmopolitan (magazine) and at the back of the Cosmopolitan there was an advert for this study [on OCD] in ... [a hospital] ... and I took this study ... and then through that I found out about the clinical psychologist and his support group ... so thank goodness they set this up ... all that time I was this floating, suffering human until I found the support group.* Veronica's motivation to attend the support group was therefore brought about by her dire need for assistance with regard to her OCD symptoms and their impact on various domains of her life.

Nancy reported that she found the initial support group by searching online for relatively inexpensive help for her OCD symptoms. Nancy is the only participant who mentioned that the support group is free of charge and that this was a motivational factor for her to attend the support group. However, according to Nancy her main motivation to attend the initial support group was to get help for her OCD symptoms: *My OCD symptoms were bad ... I Googled OCD support group ... [province in South Africa] ... and found this support group listed on some website. I joined because I wanted to learn how to handle my OCD properly, psychologists in SA charge crazy money and the group was for free.* Nancy described that she did not attend individual psychotherapy sessions for her OCD symptoms as she did not have a secure job or medical aid and could not afford the cost of private psychotherapy

## **A2 Themes related to the participants' experiences of the nature of the initial group**

During the interviews, each participant shared his/her perception of the nature of the initial support group relating to the type of support group, how it was being run, and what they expected the support group would offer him/her.

By reviewing each participant's transcript, I identified three sub-themes, namely a support group led by an OCD expert, learning the ins and outs of OCD, and an open-door policy.

### ***Sub-theme A2a: Led by an OCD expert***

The professional (Brad) who steers the support group is a clinical psychologist and is regarded as an expert on OCD and Cognitive Behavioural Therapy (CBT). He founded the initial support group, and organises and chairs all meetings. The four participants therefore mentioned that the support group has a clear leader, which is evident as all four of the participants refer to the initial support group as *Brad's group, Brad's one, or Brad's meeting.* Nick emphasised this point when he

specifically mentioned: *The main one [initial support group] was run by Brad.* According to the participants, the clinical psychologist not only leads the group but also educates group members on OCD. This is evident when the participants suggested that for the majority of each meeting the clinical psychologist, or an expert guest speaker, would give a lecture on certain topics related to OCD; these may have been about OCD in general or something more specific such as the subtypes of and/or treatments for OCD. The majority of the meetings therefore consisted of psycho-education on OCD, mostly by Brad.

Three of the participants (Nancy, Frank, and Veronica) reported that they value having a trustworthy expert steering the support group. These three participants perceived the clinical psychologist as knowledgeable with regard to OCD, that he has a good understanding of OCD, and that he has obviously done extensive practical work with individuals suffering from OCD. According to Frank: *He [Brad] was specifically interested in OCD, which was great and CBT and whatever, ACT [Acceptance and Commitment Therapy] and all these kind of very practical, very good ways to work with it [OCD] and he taught me a lot.* Veronica also recognised Brad's expertise: *Brad ... he is particularly interested in OCD ... and focuses on OCD.* Nancy also reinforced this view: *Brad knew a lot [about OCD].* These three participants seemed to respect the clinical psychologist's knowledge, expertise, and experience of OCD and were therefore able to trust him. Nancy emphasised the respect for Brad: *They [members] come to the meetings [and] listen to Brad saying what OCD is about and they are happy about it.* Frank also stated: *Running anything is, it's something that needs to be done properly and Brad was doing it because he was great.* Frank values and trusts Brad to such an extent that he uses what Brad says to explain his OCD symptoms. For example, Frank stated: *Brad has described me [his OCD symptoms] at points as being almost gaseous... I just kind of move between things to the point that I'm not even in that form.* Frank's OCD symptoms change and adapt, and he often seeks advice from Brad. In Frank's opinion the clinical psychologist is the person he and the other members turn to when looking for answers: *He [Brad] gives advice ... it's valuable.* Veronica concurred: *the support group was introduced by Brad and one of his clients ... but Brad is the boss ... I think Brad's group is so amazing because he is the boss, he guides the group and everyone looks to him for answers.*

### ***Sub-theme A2b: Learning the ins and outs of OCD***

The four participants described the support group as a source of valuable expert information. This is particularly evident as they refer to the initial support group as the *information group*. According to Veronica, *Brad's* [initial support group] *was an information station ... he would always give you different information and it was scary how much information there is*. As indicated in sub-theme A2a: Led by an expert, most, if not all, of the meetings are dedicated to psychoeducation. The clinical psychologist would provide information about OCD during the meetings by giving talks on particular topics relevant to OCD, after which time would be set aside for the members to ask questions regarding OCD and how it impacts their lives. The questions were mostly directed towards the expert. However, as the members began to trust each other, they began to discuss their OCD symptoms with each other, with the clinical psychologist still monitoring these discussions. In the initial support group, the members therefore learned from each other, but this was secondary to the information imparted by the clinical psychologist or another expert on OCD.

All the participants highlighted the educational aspect of this support group. For example, Frank stated that the support group is like *a university where a lecture is taking place. The members are students and Brad is the lecturer. The students get to ask questions to the lecturer about the topic and wait for answers ... some people* [members] *do give personal, practical examples as well* [during the group meetings regarding their OCD symptoms]. Nancy also highlighted this by stating that *Brad would talk about something like say doubt in OCD* [a certain topic related to OCD] *... saying "OCD is about doubting yourself" ... so they* [members] *come to the meetings to listen to Brad*. Nick reiterated the informational aspect of the group by stating: *This group was less about therapy and more about providing information*. Veronica's experience was also similar to those of the other three participants: *There were a lot of different topics* [about OCD] *and you would come there to find out about OCD... just all this really great information about what's going on. For like an hour and a half you just like absorbing facts that relate to you and why you do something because you don't understand it*.

### ***Sub-theme A2c: An open-door policy***

According to the four participants, the initial support group promotes a concept of open boundaries. This suggests that there are no rules in this group restricting new

members from joining every month. In fact, many of the members did not attend every month once they had joined and they would attend the group meetings on an “on/off” basis.

Nick described the open boundaries of the group and its impact on the group: *For example, Brad’s ones has open boundaries. ... It was continuously changing ... you have people coming and going.* Frank reiterated this by stating that the initial support group *happened every month and you did get to know the people there, but it [members] would change.* Veronica also highlighted that: *In Brad’s group ... it started off with once a month for a year. Then what happened is ... there were always new people coming.* Nancy confirmed the other three participants’ opinions: *With Brad’s group people would come for one meeting and then they wouldn’t appear for five months and then pop in six months later.*

The open-door policy, according to all four participants, also implied that anybody with OCD, their relatives, and/or other interested parties could attend the initial support group.

Information obtained from the four participants highlighted that despite the open boundaries, a core group of individuals did eventually begin to attend regularly. The support group was still an open group and this core group appeared to form spontaneously and not due to a change in the rules of the group’s boundaries. This is explained in further detail in sub-theme A3c: Sticking together: Becoming a cohesive group. This demonstrated that at a later stage the participants did experience more consistency with regard to members’ regular attendance of the group meetings; however, it was the core group that consistently attended, not the other members who were not part of this core group.

### **A3 Themes related to the evolution of becoming a settled member**

All four participants commented on their experiences of becoming and being settled members of the initial support group. The participants’ experiences about membership can be described in terms of an evolving process. This evolving process includes the participants’ very first experiences of joining the support group (their first support group meeting), their experiences of the initial period in the support group (which occurred in the following few meetings after their very first experiences), and their experiences at a later stage of their attendance in the support group. All the participants described some level of discomfort and/or anxiety during their first meeting in the support group. Notwithstanding the initial period of

discomfort and anxiety, Veronica and Nancy seemed to find their feet during this first meeting. Nick and Frank, on the other hand, did not seem to find their feet in this first meeting and mentioned stumbling blocks in their early experiences of the initial period in this support group. Despite these initial stumbling blocks, all four participants described that they did find their feet and that their experiences at a later stage in the support group were that of a sense of belonging and group cohesion.

All the participants elaborated on their relationships with each other and other members of the group. According to the participants these relationships evolved from their very first support group meeting, through their initial experiences, and into their later experiences of the support group. Therefore, this evolving process also included the relationships the participants formed with other members in the process of becoming settled members of the initial support group. These relationships were particularly important as they tended to impact on the level of trust each participant experienced in the group as well as the level of group cohesion. The more trusting the relationships and the more cohesive the group, the more the participants were able to explore their OCD symptoms; therefore, their relationships with each other and the other members (members of the initial support group who were not participants in this study) of the initial support group tended to change over time as the group progressed. Their relationships were initially on a superficial level and they did not divulge much about their OCD symptoms to each other. As stated above in Sub-theme A2c: An open-door policy, there was initially no consistency with regard to members' attendance. According to the participants, this may initially have contributed to the superficial relationships in the initial support group. However, the participants reported that there was a core group of members who eventually began to attend the support group's meetings regularly. This regular attendance allowed for the relationships between these members to deepen and a sense of belonging to form. This core subgroup became more cohesive as trust was established between the members who were part of this core subgroup, within the initial support group. The evolving nature of the relationships within the support group will also be explored within this theme.

This theme therefore explores the participants' experiences and relationships at different stages of their becoming settled members of the initial support group. The different stages that the participants described are divided into sub-themes,



namely their very first experiences of entering the group, the initial stumbling blocks, and sticking together: becoming a cohesive group.

***Sub-theme A3a: Entering the group***

All four participants commented on their very first experience when entering and attending their first meeting of the initial support group. As will be discussed below, all the participants experienced discomfort at their first meeting. However, Veronica appeared to experience slightly less discomfort or unease than the other three participants, and she managed to overcome this initial discomfort in the first meeting. Nancy described considerable discomfort but she also managed to overcome this discomfort in the first meeting. Nick and Frank described their first meeting of the initial support group as uncomfortable and their feelings of unease did not subside during the first meeting.

All four participants joined the initial support group at different stages of its development. Veronica was the only participant who had joined the initial support group at its inception and attended the first meeting. She mentioned that, *I started the group on the very first night. There was a lot of people there, so everybody was new, it was a new thing.* The other three participants, Nick, Frank, and Nancy joined the group later and at different stages.

Veronica reported that she was nervous joining the support group, but joining the support group at its inception may have eased her initial apprehension. She described feeling that everyone was new and they were all in the same boat. She reported that she did not have any preconceived ideas about the group and kept an open mind. However, she conceded that she joined the initial support group; desperately seeking information about the OCD symptoms she was experiencing. It was exciting for her to be a part of this new venture, so as nervous as she may have been, she mentioned that she was also excited to join: *I didn't have any expectations. I went with a very open mind ... I was desperate for anything and I am also quite a go-getter ... but I didn't have very many preconceived ideas about it. ... It was a bit nerve-wracking but ... it was also quite exciting, I thought I was part of something new ... I was quite excited to get to know and learn more.* Veronica highlighted that she got over her nerves and how positive she was about the first support group meeting: *I remember at the end of the first session [meeting] he [Brad] was like "oh well how often should we meet" and ... I was thinking like "every week, every week" ... and then we decided to meet once a month ... so ya.* Veronica's

anxiety eased when she realised that joining the initial support group was a new venture for all of the members, and when she found a sense of belonging in the initial support group from the first meeting.

Nick reported that when he arrived at his first meeting he felt anxious, vulnerable, and out of place. However, he also arrived late to this first meeting, which appeared to contribute to his high levels of anxiety and initial distress: *I went and came in late ... and I felt like I stuck out like a sore thumb. Everyone was staring at me and that is how I felt.* Nick then commented that this feeling of initial anxiety, discomfort, and distress did not subside during the first meeting. Despite this uncomfortable first meeting, Nick mentioned that he continued with the initial support group and the more meetings he attended, the more he began to enjoy being part of the initial support group: *Anyway, as I found the group subsequently, once I had been, I actually quite enjoyed it.* His reasoning for continuing with the initial support group despite his initial negative experience was that the group provided him with information, which he valued. He also had the opportunity to observe the other members interacting, which he also found interesting. Nick's reasoning for continuing in the initial support group was evident when he stated: *... [He stayed] because I am a bit of an information fiend [and the group provided him with information on OCD] ... and also I like people and watching people and dynamics and observing people. ... So those two together in a group is really interesting for me.*

Frank reported that his initial experience of the initial support group was *awkward*. He does not speak about being anxious but he mentioned that he felt awkward because the other people in the initial support group were strangers to him, which made it difficult to divulge any of his personal experiences, including his OCD symptoms. He highlighted this when he stated: *You don't know who you're dealing with, it's just somebody that's walked in off the street, you've never seen in your life before.* Frank mentioned that he therefore struggled to have a conversation with the other individuals in the group and took the decision to avoid subsequent meetings for a while. He was attending private psychotherapy sessions with the clinical psychologist at the time, and found the information mere repetition; he was bored: *So, I stopped really going to this information one in those days, because I knew everything they were talking about. I'd done so much therapy with the clinical psychologist ... that a lot of the stuff they were covering*

*was very boring to me ... and I wasn't able to talk or listen [communicate] to other people talking.* Despite this negative experience at his first meeting, Frank mentioned that he eventually returned to the group: *I went back to the group then one night, which I hadn't been for a long time ... so I was going again.* He did not state why he returned to the initial support group after leaving, but it can be hypothesised that, as stated in Sub-theme A1a: Led by an OCD expert, he trusted the clinical psychologist sufficiently to try the initial support group again to get more help as he was in need of professional help and support.

Even though it is stated in Sub-theme A1b: Looking for treatment due to the severity of symptoms, that Nancy was desperate for help, she was still hesitant to join the initial support group due to her past difficult relationships with family and friends (see section 4.2: Background, under Family background and interpersonal relationships). Nevertheless, she reported that she decided to attend the initial support group meetings as she was desperate for help and she knew she could leave after the first meeting if she did not find it beneficial: *So I didn't want to join the group because I had very bad experience with people and just with people reacting to my OCD, actually not even ... just to my behaviour. And like getting angry and upset with me and just you know saying bad stuff to me ... but now I was like ... I can just try it [the support group] once and I can never go back.* Nancy reported that she felt anxious as she believed that the other members of the initial support group would judge her. Her past had taught her not to trust other people. She thought that she may be different to everyone else in the initial support group, and felt uncomfortable speaking for fear of possibly being ridiculed: *I remember the first meeting, I was very anxious. ... I didn't want to go at all. ... I didn't feel comfortable in the beginning ... I didn't feel comfortable with the thought of talking ... because I thought, well that is what everyone always told me, that they didn't know that I am OCD but everyone thought that I am crazy. Like, because I am doing stuff, I am too emotional, or whatever, like I am just checking stuff ... so my experience with people was very bad.*

Similar to that of Veronica, Nancy's anxiety subsided relatively quickly in this first meeting as she began to realise that she was not an outsider at all, and that the other members of the initial support group were sharing similar experiences to what she was experiencing. She suggested that she found a sense of belonging in the support group: *Then everyone started to share their experience and it sort of encouraged me because what they were saying it was sort of my experience, it was*

*you know put into different words and with different names but they were describing the same stuff I would do.* She reported that she began to realise that, contrary to what other people have been telling her all her life, she was *more normal* than some of the other people in the support group: *I thought that it was very helpful just to know that there are people who think just like you ... because I think one of the worst things is that you think that you are so f\*#%ed up that no one else is that bad like you are.* She felt that some of the group members were worse off than her, which was a comforting thought: *You go to a group and then you go like “wow, these people are crazy.” Some people I would be like no, “like I thought I was crazy but this is crazy” ... just knowing that some people are worse than you, it’s also very helpful.* Nancy reported that she then began to speak during the group meetings because she felt that others could relate to her. The initial support group provided her with a space where her OCD symptoms were normalised. She emphasised this when she said: *So, I started to talk ... because some people I could be like I could really, really relate to what they were saying ... and then I just started to come to the meetings and feel more and more at ease there.*

In contrast to Frank and Nick who had not initially experienced a sense of belonging in the initial support group, Veronica and Nancy described finding a sense of belonging in the initial support group early on in their initial support group attendance. In order to understand how Veronica and Nancy found such a quick sense of belonging in the initial support group, their feelings before joining the support group need to be explained. Both Veronica and Nancy described feelings of loneliness due to a lack of understanding of their OCD symptoms. They described feeling as if the intrusive thoughts they were experiencing, which led to extreme anxiety and the rituals that they religiously carried out to reduce the anxiety, were unique and only happened to them. They questioned why they were so different to everyone else, and why no one else seemed to experience these OCD symptoms. They both therefore reported feeling like outcasts to society before they attended the first group meeting. Nancy described herself as feeling *like a freak*, before joining the initial support group. Veronica also highlighted this: *It is very difficult to understand what is happening to you ...you feel lonely as in like “what the hell is going on, nobody understands me.” Like words are just getting thrown around like obsessive-compulsive disorder but there are no facts ... it is quite lonely, not from like*

*a depression side but from, you know like “why is nobody else going through this” or why, you know, there is just separation.*

According to Nancy and Veronica, joining the initial support group showed them that they were not alone or outcasts as other people experienced similar symptoms to them. During the support group meetings they interacted with other individuals who have also been suffering from OCD, and this commonality rapidly led these participants to experience a sense of belonging. They could understand and relate to the other members. These experiences of acceptance, understanding, and being able to relate to other people were different to those experienced by both Veronica and Nancy before joining the initial support group, and this again contributed to the sense of belonging in the support group. Veronica emphasised this sense of belonging: *You don't know what is going on but when you sit in a group of people and you are like “oh this is the way I view ...” you are like “oh ya me too” ... that's what I am feeling. So, there is that sense of connectivity that you are not alone ... so, to find somebody that knows exactly what you are feeling makes you feel like you are a part of something ... there is a common understanding.* Nancy reaffirmed this sense of belonging: *I thought that it was very helpful just to know that there are people who think just like you. ... It's a group of people who understand each other.*

#### ***Sub-theme A3b: Initial stumbling blocks***

Sub-theme A3a: Entering the group, described all four participants as having experienced some discomfort when they arrived at their first initial support group meeting but that all of them, although some earlier than others, found their feet in the initial support group. Veronica and Nancy appeared to establish a sense of belonging during their first meeting in the support group, while Frank and Nick appeared to take longer to establish a sense of belonging in the initial support group. Frank and Nick were of the opinion that the open boundaries of this group (Sub-theme A2c: An open-door policy) may have been a stumbling block in their process of becoming settled members in the initial support group. They link their inability to establish a sense of belonging to what they perceived as their superficial relationships with the other members in the initial support group. According to these two participants, several factors contributed to this perception. For example, they were of the opinion that the open boundaries of the initial support group lead to a lack of consistency in regular attendance. Also, meetings were not only attended by adults with OCD, but also by children with OCD, as well as individuals without an OCD diagnosis such as family

members. Frank and Nick believed this negatively impacted the confidentiality of members' discussions during these meetings, and would influence the quantity and quality of what the members disclosed to each other. The open boundaries contributed to a lack of trust and negatively influenced the initial depth of the relationships formed between the members. Nick highlighted this process above when he reported that *it was harder in Brad's group, the larger group, to be honest [quality and quantity of content spoken about and lack of trust] with people because there were young people there and there were older people there and kids and people's parents and stuff [non-homogenous nature of the group] ... it was continuously changing [open boundaries]. It was inappropriate to talk about some of the OCD symptoms we were experiencing.* According to Frank the support group *wasn't purely anonymous and it wasn't a closed group [open boundaries] and that's not great, because obviously people aren't going to go into the next level [quantity and quality of content spoken about] ... there's obviously a level of trust that needs to be there and kind of comfort to be open and to be able to talk about it [lack of trust]. Obviously, it's not easy to talk about these things and somebody's not going to talk about them if five people they've never seen in their life just kind of walk in and it's not always the right environment [open boundaries].* The "things" Frank is referring to are the OCD symptoms they experience. Frank then also referred to the non-homogenous nature of the group and the involvement of family members and children: *Sometimes it's a mom with her teenage son, it wouldn't be appropriate to divulge specific OCD symptoms they were experiencing to the group, as the symptoms may have had sexual or homicidal content that was not appropriate for children to listen to. People feel uncomfortable talking in certain environments with certain people around [confidentiality of content spoken about]. They don't like it. So, as I say, it was awkward, because without that closed unit there isn't the platform for trust and confidentiality [lack of trust].*

Nick and Frank were able to overcome these initial stumbling blocks and eventually established a sense of belonging in the initial support group by forming a small subgroup of members within the initial support group. This will be discussed in more detail in the next sub-theme.

### ***Sub-theme A3c: Sticking together: Becoming a cohesive group***

All four participants suggested that they did begin to trust a few people in the group explicitly, even though it happened at different stages. They stated that a few

members (about six or seven people) began attending every meeting of the initial support group. These core members became a subgroup within the initial support group. According to Veronica: *at Brad's group the same people started pitching up*. Frank also mentioned: *so, kind of the same faces kept appearing*. All four participants in this study reported being part of this core subgroup. The members of this subgroup attended this support group regularly. They all suffered from OCD and were of a similar age (within a ten-year-age range). The subgroup developed spontaneously and appeared to play a significant part in the members' relationships, moving from a superficial to a more cohesive level.

From the information obtained from the participants, it became evident that the more often they all attended this initial support group, the more they began to trust the individuals of the core subgroup, and the more they shared their experiences with this core group of individuals. Nick stated: *I guess that level of trust comes after being around each other for a bit*. Veronica also mentioned: *I found the more you were in the group the more came out. You know, the more time you spent with the group the more came out and the more you talk about your problems the more people can help you through them*. Nancy and Frank both mentioned that after a while *you could trust these people*. Nick elaborated on this sense of belonging when he stated the following about the subgroup: *I can tell these people [the individuals in the core subgroup] anything ... I tell them more than I tell my girlfriend and even my therapist*. Frank reiterated this sense of belonging due to the subgroup when he stated the following about the individuals in the core subgroup: *We can often relate to one another on a certain level, so I think that's a big benefit that somebody actually understands and they can relate to it*. Therefore, according to the participants, the more these core members divulged to each other during the initial support group meetings, the more they began to trust each other and the more cohesive this group became.

#### **A4 Themes related to the beneficial aspects of continuous membership**

All the participants in this study suggested that there are benefits to continuous membership in the initial support group. The most salient benefits that all four of the participants alluded to are the importance of the information obtained about OCD, and the consequential growing need and desire to apply this information gathered from the group leader and other experts invited by the group leader. It was also the perception of all the participants that the information about OCD gathered in

the initial support group instilled in them the desire to take the next step, implying implementing this information. The benefits of obtaining information in the initial support group and the resultant urge to implement this information are discussed and explored further in the next two sub-themes.

***Sub-theme A4a: Knowledge is power***

As stipulated in Sub-theme A2b: Learning the ins and outs of OCD, the participants saw the initial support group as a source of information about OCD. Therefore, the participants were able to gain a wealth of knowledge on OCD and the impact of this disorder on their lives. All the participants concurred that gaining this information on OCD in the support group was valuable to them and an important benefit of the initial support group. Nick, for example, stated: *The informational OCD group has had a huge impact [on him and his OCD symptoms]*. The value and benefit of gaining this information differed between the participants but the most prominent benefits of this information mentioned by the participants were that of gaining insight into the OCD symptoms, self-empowerment of the participants, and breaking down the stigma around OCD.

Two participants (Veronica and Nancy) described how they learned about the OCD symptoms they were experiencing and how to make sense of these symptoms. Nancy recapped the idea of gaining information and insight when she mentioned that attending this OCD support group run by the clinical psychologist *is useful if you want to recognise if you have OCD*. Veronica and Nancy gained an understanding of what OCD actually is in relation to the symptoms they were experiencing. These two participants therefore gained valuable insight into their mental illness. This is underlined when Veronica described: *That although you don't walk away with some kind of new way of living [from the initial support group] it's like a new profound way of thinking and understanding on what's going on*.

Two participants (Nick and Veronica) mentioned that the information gained from continuous membership in the initial support group brought about self-empowerment for them. These two participants stated that they have progressed from needing help to being able to help themselves and provide help to others. They specifically stated that they have gone from fearing OCD to enhancing their expertise on the subject. They continued to state that they felt they have been empowered by the gathering of this information, and were in a position to confidently pass on information to the other members of the group. Nick in



particular stressed this self-empowerment: *OCD has gone from being something that I sort of feared, to something which I feel like I am an expert on now. That I can help other people with, that I managed to tame pretty much, or where I haven't, I can manage it, or that other people understand me.* Veronica also commented on the self-empowerment she gained through the support group: *It's [OCD] something that you can emotionally attack and like combat, so like the more information you get [from the initial support group] the better you are at getting rid of OCD. So from that point of view that was very, very great and amazing.*

Frank reported that as he had attended individual psychotherapy for OCD in the past and was already familiar with the information he was bored in the initial support group. Nevertheless, he considered the information obtained in the support group valuable in at least one aspect, namely that it helped him to break the stigma he perceived to be surrounding a diagnosis of OCD: *One of the strongest benefits is kind of crushing down of the stigma of OCD [through information].*

***Sub-theme A4b: Walking the talk: Urge to implement information***

Nick, Nancy, and Veronica stated that since they had been in the group for a while and had received invaluable information and insight into OCD which empowered them to understand what can be done to get the OCD symptoms under control, they developed the need to embark on the next step which they described as the urge to actively implement this information pertaining to treatment. The three participants felt that they had reached the stage where they had been enriched with a wealth of information on OCD and how to combat the disorder, but that they did not have the space to put the many different techniques they were taught to combat OCD, into practice. The information gained in the initial support group therefore emboldened the participants to put the OCD combative techniques such as Exposure and Response Prevention (ERP) (which will be explained and elaborated on in Section B) in action. The three participants argued that the information they received emphasised that change and control of OCD symptoms were possible if they implemented certain techniques. Their arguments are explained below in more detail.

Nancy postulated that: *it was a difference in attitude ... so they [some members] come to these meetings ... and then they come home and they still have OCD, nothing really changes. It's useful if you want to recognise if you have OCD. Sometimes if you just want to have someone to, you know, be like "oh other people*

*are like me.” So it’s useful to a certain extent but then it stops. Some of us needed the next thing.*

Veronica stated that you [are] *just getting information and you come here and you listen to people with the same problems month after month after month after month and you are not getting better ... OCD is your life, you have to instill some kind of change to make change.*

Nick reported that *in the first [initial] support group of the month, it is an informational one with instructions and then the second support group [sub-support group] ... we do exposures ... we needed this second group to implement this information [the information gained in the support group about combating OCD].*

Frank did not mention that he wanted to implement the information gained from the initial support group. He explained that he wanted to implement the information he gained from individual psychotherapy which he described as similar to the information imparted at the initial support group. He, like the other three participants, also required space in which to implement the information regarding treatment techniques he had obtained.

Frank mentioned: *I knew everything they were talking about [all the information he thought relevant to combat his OCD symptoms] ... I just wanted to get to more [be more active in implementing the information].*

Section A above covered the themes and sub-themes extracted from the participants’ experiences of the OCD support group steered by a clinical psychologist. The next section (Section B) will cover themes and sub-themes extracted from the participants’ experiences of the sub-support group for OCD formed and run by individuals with OCD.

#### **4.3.2 Section B: Experiences of the sub-support group for OCD formed and run by individuals with OCD**

This section focuses on the sub-support group for OCD formed and run by individuals with OCD. As explained earlier in this chapter, this subgroup emerged from the initial support group for OCD steered by Brad, the clinical psychologist. Nick commented on this sub-support group: *There is Brad’s monthly one [meeting] and then there is sort of the one [meeting] that has been more influential that we go to off the back of that ... it’s spun out of [the initial support group].*

The aim of the research study was to explore participants’ personal and unique

accounts of their experiences as members of the OCD sub-support group. The participants spontaneously offered rich information about the sub-support group which appeared to constitute a large part of their experiences attending an OCD support group. Their experiences of the sub-support group could therefore not be ignored, and required inclusion in the findings of this study. In the following section the themes and sub-themes listed in figure 4.2 will be discussed in detail.

### **B1 Theme related to the motivation to become a member of the sub-support group**

As discussed in Sub-theme A3c: Sticking together: Becoming a cohesive group, there was a core subgroup of six or seven people who regularly attended the initial support group, referred to in section A. It was also highlighted in Sub-theme A3c: Sticking together: Becoming a cohesive group, that all four participants in this study were part of this core subgroup. The participants stated that they began to realise that the members of the core subgroup are all *like-minded*, meaning that they were more aggressive in their pursuit of getting the OCD symptoms under control. They wanted to *do something* and *be more active* in combating the OCD symptoms they were experiencing. As mentioned in Sub-theme A4b: Walking the talk: Urge to implement information, these individuals who had been attending the initial support group for several meetings developed a need to put into practice certain well-known CBT techniques, which predominantly included ERP techniques that they learned from the clinical psychologist in the initial support group as well as in individual psychotherapy.

Two members of the core subgroup, Veronica and Paul, originally decided to meet separately to assist each other to put into practice these well-known CBT techniques that Brad, the clinical psychologist, had taught them in the initial support group. Veronica, one of the two original members of the sub-support group formed and run by individuals with OCD who decided to meet separately to implement the ERP techniques, is a participant in this study. She explained how she and another member, Paul, met to implement ERP techniques separately: *What happened was we had our main support group with Brad for a year and then I gravitated towards Paul [another member] ... and we started doing our own exposures together, so we had our own support group [sub-support group], just the two of us.* Veronica mentioned that she and Paul carried out exposures. They both strongly encouraged each other to face their obsessions. Veronica continued to explain that their meetings to put these

techniques into practice were extremely beneficial. She particularly stressed the benefit of meeting with Paul when she stated: *I will be honest like that's when my main thoughts of ... change [relating to her OCD symptoms] came because we would challenge each other ... we did these massive steps.* According to Veronica, these meetings with Paul lined up with her motivation and willingness to be serious in instilling change by practically and actively implementing what was being spoken about in the initial support group: *We would come away with goals each ... ya, it was a self-help group ... well it's basically a group where you would have to initiate your own productivity in getting better. So, the help relies on your actions.*

However, according to Nancy, when Veronica and Paul realised that their meetings to assist each other to implement the ERP techniques turned out to be beneficial, they decided to explain to the other members of the core subgroup what they were doing, who then decided to join them. Nancy confirmed this: *Two members were trying to do exposures together [which was helpful to them] and they were, let's try to have a different group ... we will be using what Brad is saying ... he gave us lots of useful techniques.* This sub-support group therefore came about when the other members of the core subgroup decided to join Paul and Veronica in implementing the ERP techniques. Veronica and Paul's meetings went from two people to a sub-support group of six or seven members. According to Veronica: *It was a small group of us about six or seven or sometimes five people that were really serious about getting better.* Frank echoed this: *There was about six of us that would kind of commit to doing this group and to one another and that's kind of how it started.*

The other three participants in this study (Nick, Frank, and Nancy) reported that their motivation to join Veronica and Paul in this sub-support group was similar to Veronica's motivation. They were motivated to become members of the sub-support group because of their need to instill change and to combat their OCD symptoms. They explained that the way to instill change was to do more than just passive listening to the clinical psychologist. They described that they wanted to meet more frequently in order to implement the information and the ERP (exposure) techniques they learned in the initial support group, and to assist others in doing the same. The participants reported that they believed that this sub-support group would turn out to be a form of therapy for themselves. Nick highlighted this when he stated: *Basically a few of us wanted to meet more often because we felt once a month wasn't useful enough, so we did that and saw there were a few of us committed to it ... we do*

*exposures. Frank underscored this motivation: We wanted to take it quite seriously because it's our time and it's our therapy basically. ... What has been, probably, the most exciting part about this support group [sub-support group] is that because one gets to know one another so well we do a lot of exposure therapy. Nancy agreed and said that Brad's meetings were more informative meetings ... like Brad would mention methods that we are supposed to use but without someone encouraging you to do that [use the information] ... you would be like "yes, yes I'm going to do it, it's a good idea" and then you forget about it and then you don't really do it. So, we thought it would be good to have a group of people with the same goal ... we are all a bit aggressive when it comes to fighting our OCD... that was the point of having this small group.*

## **B2 Themes related to the pragmatic nature of the group**

All four participants in this study shared their experiences of the pragmatic nature of this sub-support group formed and run by individuals with OCD. The nature of the sub-support group, as perceived by the participants, will be discussed in accordance with nine sub-themes, namely an exclusive group, the format of a sub-support group meeting, goal-driven group, commitment with a price, continuous mutual support, a safe confessional space, when things get murky: the impact of diffuse intergroup rules and boundaries, and evolving roles and responsibilities.

### ***Sub-theme B2a: An exclusive group***

All the participants referred to the exclusiveness of the small sub-support group, and to the clear rules relating to membership in the sub-support group, which created clear boundaries for the sub-support group. According to the participants, a clear rule of the sub-support group required the members to be committed to the sub-support group. The participants also emphasised that it was mandatory that all members had to be individuals with OCD. The participants confirmed that these clear rules with regards to membership in the sub-support group helped create a small, intimate, and exclusive group. This in turn allowed for a safe space with boundaries in which the members could trust each other and discuss their problems openly and honestly.

Veronica highlighted these clear rules and boundaries and the trust it helped build: *The second group was a small group of us about six or seven or sometimes five people that were really serious about getting better. ... You developed what felt like lifelong friends who you trusted.* Nick also emphasised the clear rules and boundaries and the value of clear rules and boundaries in building trust in the sub-

support group: *There were a few of us committed to it and made it quite closed ... deliberately. ... We just said that if we want to be able to open up to each other, then we don't want people coming and going the whole time, so we put it on lockdown ... so we could talk about personal stuff and be honest in our second group. So there were seven of us ... and it is self-selecting, as in everyone has OCD.*

The exclusiveness of the sub-support group and the value attached to commitment to the sub-support group is particularly evident when Nancy postulated that *one of the members wanted his friend to join, apparently also one of Brad's patients*. She reported that the group was initially happy to allow this individual to join as he suffers from OCD, but they had doubts as to his commitment to the group as a less committed member may impact on the group's context that promotes trust and honesty: *We were fine with that, we are fine with people joining but ... probably the only requirement is commitment, because ... with Brad's group people would come for one meeting and then they wouldn't appear for five months and then pop in six months later. Now we don't want that [in the sub-support group] because we are doing more of a therapy support group than an informative group*. At the time of the interviews, members had not yet made a definite decision whether or not to allow this person to join their ranks. Their reticence demonstrated how serious and unwavering they were in protecting the clear rules and boundaries of the sub-support group. They were not only concerned about the impact a possibly less committed member may have on the sub-support group, but they still required the group to be small and intimate. This is because the participants believed that the smaller the group, the stronger the group would be with regard to being a safe space in providing a context of greater therapeutic value. According to Frank: *The less people there are, the more of one another you have ... and I feel like since it went down to five it has probably been even stronger [therapeutically]*.

#### ***Sub-theme B2b: The format of a sub-support group meeting***

All four participants gave their impressions of an operational construct or format of a typical sub-support group meeting. According to the participants each sub-support group meeting was divided into three parts.

The participants explained the ***first part*** of each meeting, which lasted for a few minutes, as sitting together briefly and discussing any important events happening in each of their lives at the time, how their OCD symptoms were responding to their practising exposures, and how each of them could help another

member with any OCD symptoms they may be struggling with. The purpose of this first part of each meeting was therefore for the members to ‘check-in’ with each other. Nick underscored the importance of the ‘check-in’ process at the beginning of each sub-support group meeting: *One thing we always did was to go round to each person at the beginning and talk for a few minutes and say what they did [with regard to practising exposures], and say how they are doing and how their OCD was and people would chip in and say, well what about this or that.* [The other members also say] *Oh, that is interesting because I have exactly the same manifestations you do and we can help each other with that kind of thing.* Nancy repeated a similar experience to what Nick experienced at the beginning of each sub-support group meeting: *We will talk about, briefly, what is happening in our lives; try to quickly help each other.*

The participants explained that the **second part** of each meeting involved the prominent focus of the sub-support group, which was carrying out exposures. This is the part of each meeting where the participants put into practice the techniques they had learned in the initial support group. This is evident when, after describing the first part of each sub-support group meeting, all four of the participants declared: *We then do exposures.* Nick continued by referred to these exposures as *the dominant thing* [part/section of this group].

In order to put this second part of the sub-support group meetings into perspective, the participants explained the process of carrying out an exposure (ERP) as well as their experiences during this process. According to the participants, the exposures follow the ERP format, where members tell each other about their obsessions. They subsequently each rank their obsessions according to a hierarchy scale: from zero when a certain obsession causes no anxiety, to ten when a particular obsession causes them extreme anxiety. The participants then devise an exposure for a member of the group. The exposure tackles one of the obsessions on that member’s exposure hierarchy that is usually lower down on the hierarchy scale from which that member can later build on. The members press the designated member into carrying out the exposure in a supportive environment. Frank highlighted this procedure as follows: *Within this group we found that devising exposures for one another [after picking an exposure from that member’s exposure hierarchy] ... and then kind of being there to support and do [carry out] the exposure and everything like that, it’s amazing.*

The participants' descriptions of the exposures carried out in the sub-support group were detailed and expansive. Therefore, Nancy's experience of a certain exposure was selected as a suitable example of an exposure experience in the sub-support group as she gave a rich explanation of the implementation of the ERP technique and described an exposure that appeared to be impactful as two of the other participants (Frank and Nick) also mentioned the same exposure in their interviews.

Nancy described that she had an obsession regarding demons. She would obsess that there were demons around her and this frightened her. She experienced this obsession as severe and *ranked* this obsession close to a ten on the exposure hierarchy. The sub-support group members then devised an exposure for Nancy and another member of the sub-support group who also suffered from this type of obsession. Nancy explained this exposure around demons: *We did an exposure in which one of the members brought a locker and the locker was full of pictures of demons and with haunted stuff. And they put us [herself and the other member] in the locker ... and they made us listen to sounds of ... a scene from the Exorcist [a movie about demons] ... and we were supposed to sit with the fear [the fear of demons being around them and hearing the demons while in a confined space].* Nancy disclosed how her anxiety level rose during the exposure, how her anxiety was monitored, and then how her anxiety subsided without her carrying out the compulsion of avoiding anything to do with demons such as leaving the locker: *Then in the exposure you go through stages and you check what the anxiety level of the person is. So, we reached ten [level of anxiety], meaning like completely freaking out but then you just have to stay with it ... until your anxiety is more or less on a six out of ten, then you finish the exposure ... and then just sit with the fear afterwards.* Nancy explained that even though the carrying out of the exposure (being in the locker) was completed, the whole process of the exposure experience did not end with her getting out of the locker as her anxiety levels were still raised and it was important that she and the other members monitored her anxiety level at this point until it had subsided sufficiently: *You only finish the session [meeting] once the person is calm ... they could be like a three out of ten [on the anxiety scale] all their lives ... so meaning until they reach this point.*

All four participants commented that the way the sub-support group members carried out the exposures changed over time. Initially, they carried out one exposure for one member at each sub-support group meeting. Nancy explained: *Then we knew*



*this is someone's night [meeting] and we are doing their exposure.* Veronica's experience reiterated Nancy's experience with regard to carrying out one exposure for one member at each sub-support group meeting when she said: *What happened is that we would choose one person and then we would organise an exposure for them, so the focus [of the exposure] would be all about them.* Nick recounted an experience similar to that of Nancy and Veronica: *Everyone has taken their turn to do it [an exposure], and quite a major exposure.*

However, the participants mentioned one downside of the exposure procedure: each of them had to wait six to seven weeks before it was his/her turn to carry out an exposure. Veronica elaborated on this problem: *Then we would focus on one person and there were six or seven people in our group, so it would take seven weeks round to get to me [her exposure].* The way the participant's described combating the problem of each member only getting an exposure every six to seven weeks was to be creative and organise exposures that involved multiple group members. Therefore, an exposure was organised in such a way that it addressed more than one person's OCD symptoms (these exposures that address multiple members' OCD symptoms will be referred to as the multiple member exposures for ease of reference). Frank's experiences pertaining to the multiple member exposures were highlighted when he explained: *This is where it got to the point where basically we would all be in an exposure together We would actually create a scenario ... almost like a role play kind of thing and almost everyone's basically involved or maybe one person stands out to kind of just guide it.* Frank gave an example of a multiple member exposure by describing an exposure he carried out in the sub-support group which entailed that he video-recorded himself describing a variety of his promiscuous sexual activities of which included homosexual acts, and then viewing and listening back to the recording. However, while recording an exposition of his sexual acts and viewing and listening back to the recording, another member of the sub-support group, at the same time, also viewed and listened in on these recordings, in the presence of the whole sub-support group, as he (the other sub-support group member) had an obsession around being homosexual. Therefore, listening to Frank's recordings around his sexual promiscuity was an exposure designed to address both members' anxiety levels (Frank's anxiety, which he usually controlled by performing promiscuous sexual acts and the other member's anxiety provoked by obsessions regarding homosexual activities), and they were

both required to endure these anxiety levels without carrying out any compulsions.

Lastly, the participants mentioned that the *third part* of each meeting was to briefly discuss the homework they were each required to do before the next meeting. According to the participants, the homework was divided into two sections. The first section: to remind and motivate the member, who had carried out an exposure in the group meeting, that that member was required to continue practising that exposure at home after the sub-support group meeting. The second section: to discuss and plan what exposure they would carry out, and for whom, during the next meeting. The members would discuss this briefly in the group and come up with a few ideas. It was then the group members' responsibility to go home and think of different exposures and possible variations on these exposure ideas. They were then encouraged to bring these exposure ideas as well as any props needed to carry out these exposures to the next meeting. Veronica particularly underscored this third part of the sub-support group meetings when she discussed the exposures being carried out in the sub-support group: *It was really great because then you came home and you had homework and if it wasn't for yourself [practicing your exposures] it was for someone else [organising another member's exposure].*

#### ***Sub-theme B2c: Goal-driven group***

All four participants described the sub-support group as being goal-driven. This points to a group where all the members were actively involved in getting their OCD symptoms under control as well as assisting other group members to do the same, which is highlighted in every sub-support group meeting as can be seen in Sub-theme B2b: The format of a sub-support group meeting. According to all four of the participants, the ultimate goal of the sub-support group is therefore for each member to get their own OCD symptoms under control as well as supporting and helping all the other members of this sub-support group to get their OCD symptoms under control. Veronica clearly defined this ultimate goal when she postulated: *The final goal [of the sub-support group] is that you don't want to be living with OCD.* The ultimate goal of the sub-support group was also stressed when each of the participants described this sub-support as a *therapy group* for their OCD symptoms. The participants also expressed that in their experiences of the sub-support group they were both receiving as well as *providing* therapy to the other members. They stressed

that in their experiences what makes the sub-support group seem like a therapy group is their active stance in doing exposures with each other during the group time.

As discussed in Sub-theme B2b: The format of a sub-support group meeting, the participants explained that they draw up an exposure hierarchy and carry out exposures during every meeting. Therefore, the participants explained that in order for each member to reach his/her ultimate goal of getting all their OCD symptoms under control and helping or supporting other members to get all their OCD symptoms under control, they needed to carry out smaller goals and build on these smaller goals to reach the ultimate goal. They explained that each obsession tackled on each of their exposure hierarchies is a small goal. As each obsession on the exposure hierarchy is confronted and successfully managed, and although this may only constitute a small goal, it is nevertheless seen as a victory. Reaching a small goal encourages members to move to a more challenging exposure (the next small goal). The more of the smaller goals the participants reported they can tackle (exposures they carry out) successfully on their exposure hierarchies and other members' exposure hierarchies, the closer they get to reaching their ultimate goal for themselves as well as every other member of this sub-support group of getting all their OCD symptoms under control.

Veronica and Frank both accentuated the idea of smaller goals used to reach the ultimate goal. They therefore appeared realistic and dedicated, and approached their goals systematically. Veronica explained: *You would have a goal, so like we would have a small goal. Like the one girl was like I will check Facebook three times today, not 53 times; I will walk through the back door and I will not check the back door or I will close the garage door and I will not go back to check ... and that would challenge yourself, just a small little thing.* Frank explained a similar experience to that of Veronica: *All of our experiments [exposures] have shown that basically the further people push themselves [up their exposure hierarchy as well as in each exposure] the better they do [in getting their OCD symptoms under control].* The participants then commented that they help other members of the sub-support group reach their small goals by encouraging and challenging them to seek out the next obsession on their exposure hierarchies, and supporting them in their quest to avoid carrying out a compulsion when confronted with an exposure.

### ***Sub-theme B2d: Commitment with a price***

As described in Sub-theme B2a: An exclusive group, all four participants reported that the members of the sub-support group are all committed to the sub-support group and that they value this commitment and active participation. As also described in the same sub-theme, the members' commitment to the sub-support group promotes an honest, open, and trusting context in the sub-support group. Nick stressed this when he said: *We were committed to this second group. We had to be committed [to create a trusting space].* Nancy concurred: *It's a commitment.* The participant's also explained that along with helping to provide an open, honest, and trusting context, the commitment of the members is vital as each member in the sub-support group has a role to play in the multiple-member exposures. Veronica points out: *We were doing exposures, so if one out of the six [of the sub-support group members] isn't there, it's like one sixth of your exposure that's already been planned is not there. So that was a bit difficult, like we would do an exposure for Stuart but then Paul wouldn't arrive ... but he was the one organising Stuart's exposure and then there was this huge disappointment.* If a member does not attend a sub-support group meeting, the participants describe experiencing a feeling of loss, as they lose out on more ideas for exposures and support that that specific absent group member could possibly have provided had he/she been in attendance.

With all of the above in mind, the participants explained that there is high expectation and pressure to attend every sub-support group meeting. Veronica underscored this: *High expectation to be there every single week. If you are not there every single week then you have disappointed everyone.* The participants described that they can miss a meeting but if they do miss a meeting, they would require an extremely valid reason for missing that meeting. Nancy highlighted this: *Either I am very sick or there is another possible arrangement that I have to attend. It's not that I just feel like going out with my friends instead of going to the group.* Frank's experiences were similar to Nancy's experiences as he reported: *You can't just not arrive ... it's not like if you have something on really important once in a blue moon, you can't make group, obviously that's not a problem, but the point is when you start infringing on other people's treatment ... what's fair and what's respectful and basically it's more a question of etiquette really and as I've said, just respect for one another and we were aware of that.*

However, all four participants remarked that the commitment, which all of them conceded was valuable, does come with challenges. The participants experienced that if they have to attend the sub-support group three times a month (once every week for three weeks, and then they meet for the initial support group once a month, in the week that the sub-support group does not meet) it becomes extremely time-consuming. They recounted that they struggled to balance having to meet three times a week for at least 90 minutes at a time for this sub-support group, along with their initial support group attendance, possible individual psychotherapy, as well as any other activities in their daily lives. Veronica stressed: *It became quite a weight as well, it became quite a large chunk out of your week. I also go to the school of practical philosophy ... so that means half my week is gone ... so just from a timing point of view, I just think I got an overdose and then just got over it* [had enough of this sub-support group]. Nancy also experienced difficulties with regard to the time-consuming nature of the sub-support group meetings: *We would meet ... three times a month* [for the sub-support group] ... *so, you know then basically three of your four Thursdays a month are then taken* [excluding the initial support group attendance].

According to the participants, a geographical difficulty that the sub-support group had to contend with such as the venue not being close to where all the members live, and that the members therefore travel significant distances to attend the sub-support group meetings, was also a contributing factor that impacted the members' available time. Frank's experience confirmed this geographical difficulty: *Another limitation is geography basically, just where we meet, times, that's problematic and people have to go drive a long way and so it takes up a whole evening, from like 6:30 to ... we're probably home by 11:00, sometimes even later and that is a problem.* Nick when speaking about all of the above time-consumption struggles concurred: *It's really hard to cope with all those competing demands and requirements that the group would have.*

### ***Sub-theme B2e: Continuous mutual support***

The participants stated that they have all gone through, or are going through, the experience of OCD. They are partners in the same struggle, and find it easy to understand and empathise with each other. Veronica emphasised this understanding and empathy when speaking about another member: *When you have been struggling with something personally painful [OCD] that you don't understand, nobody*

*understands around you and then finally out of the blue you speak to somebody who does understand [another member of the sub-support group]. Knows exactly what you are going through and has gone through it all and is now on a road to recovery with a lot of positivity, you just absorb that positivity.* Frank also underscored this empathic understanding and feeling of belonging (which will be discussed in more detail in the next sub-theme) when he suggested that *the group members are like a sports team*, in which each person plays a specific role; the members together make the team work. Frank then continued to describe the group as *following the basic principles of a small community*, and that its members *work together to get better but do this in a supportive manner*. If one member is getting better, the whole team or community improves. This relates to the members of this group who depend on each other and at the same time display mutual support. He stated that the members would *go through the experience together*. This experience occurs within each sub-support group meeting as well as between sub-support group meetings.

Due to this mutual understanding described above, all four participants in the group emphasised that the group members provide continuous, valuable, and mutual support to each other. The participants described that the support is both mutual and continuous as they both give and receive support within each sub-support group meeting as well as between sub-support group meetings. Nancy highlighted this mutual support in the sub-support group: *So it's not always about people helping you it must be mutual, it's not about people helping you it's also about you helping the people. And even if you feel that you are sorted [OCD symptoms under control], you are still there [in the sub-support group meeting] because they have helped you and you have to help them.* Nick's also explained his experiences regarding mutual support within the sub-support group: *[It's] a sideways thing ... people who have the same condition and how can we learn from each other, support each other.*

All four participants seemed to value the fact that the mutual support is not only confined to the time spent in each sub-support group meeting, but it is continuous as the members keep in contact and give each other support and encouragement between meetings as well. Three participants, Nick, Frank, and Nancy explained that they predominantly keep in constant contact by means of a WhatsApp group they have created. By making use of the WhatsApp group these participants can message the other members if something pertinent may be happening in their lives or if they require support and/or advice urgently. Nick stressed this when he

stated: *We have a WhatsApp group so we can communicate in the week, in the day, see how people are doing and that kind of thing.* Frank's also explained: *We've got a WhatsApp group and if somebody's having a rough day or something they'll go up there and everybody will be like, give their two-pence-worth ... then people will be supportive and things like that.* Nancy's experiences are similar to those of both Nick and Frank as she mentioned: *We have a WhatsApp group. So if anyone is going bad ... there is always someone online at this point when you are experiencing something bad and they are there to say "no don't do that or you know that is not good for you" or something like that ... just a bit of support.*

Veronica also emphasised that she kept in contact with the other group members between meetings but did not mention the WhatsApp group. She reported that she kept in contact with a member of the sub-support group telephonically for help and support. She highlighted this: *We [herself and another member] had each other's numbers, so we would like ... every day we would like clock in [check up on each other] ... and we really supported each other and leaned on each other.*

#### ***Sub-theme B2f: A safe, confessional space***

The information obtained in this study indicated that group cohesiveness is a central concern as to how the participants view the sub-support group. The group was seen as being cohesive because the members described being comfortable and trusting enough to confide in the other members. All four participants reported that trust allowed for honest, valuable feedback to occur within the sub-support group. This feedback pertained to sensitive topics such as the impact of another member's interactional style, the way another member carries out an exposure, advice on their OCD symptoms, and the impact of their OCD symptoms on their personal relationships. All the participants described being able to give and receive honest feedback, which highlighted a cohesive group.

Nick emphasised the trusting and cohesive nature of the sub-support group by describing that in the sub-support group he gives and receives feedback *all the time*. An example Nick underscored is: *Frank observed that my clinginess, my needing reassurance, was actually this self-sabotage idea [self-sabotaging his relationships] ... a desire to be on my own to push the person away ... I never took it the wrong way, never got defensive because we had become friends so I never felt rebuked, ever, by any of them [Frank or any other of the group members] ... I*

*guess that level of trust comes after being around each other for a bit.*

Veronica also recognised the trusting and cohesive nature of the sub-support group: *Feedback ... definitely ... there was a lot of place for that ...* She claimed that when she and the other members of the group gave Stuart feedback about his irrational thinking, this feedback was honest, objective, and valuable and that Stuart accepted their feedback probably because Stuart realised that *“If all these people who really care about me and are sincere and really want what’s best for me are saying something that is different from what I am thinking then there might be another way than just the way I think” ... you developed what felt like lifelong friends who you trusted.*

Frank also perceived the sub-support group as being trusting and cohesive after he described both getting and giving feedback: *We’ll all [Frank and other group members] just get involved right into that person’s [another group member’s] life basically and kind of give lots of feedback. But there’s hectic stuff that happens in the group and it’s a very intense space ... hence why the group has to be so kind of tightly knit, so that people are comfortable enough to basically talk about these things.*

Nancy confirmed what Frank, Veronica, and Nick stated about feedback in the trusting cohesive group when she said: [Feedback is possible as] *it is a safe space there [in the sub-support group] ... you can say, “guys I want you to stop, I’m being very uncomfortable with that” ... [therefore] having a non-judgmental environment is very important.*

***Sub-theme B2g: When things get murky: The impact of diffuse internal group rules and boundaries***

As discussed in Sub-theme B2a: An exclusive group, the participants asserted that the sub-support group has clear rules and boundaries with regard to membership. However, according to the participants the sub-support group did not initially have any clearly defined internal rules and boundaries as the main focus of the sub-support group was on implementing ERP techniques and not on formulating internal group rules and boundaries. The impact of the initial lack of clearly defined internal rules and boundaries of the sub-support group was that clandestine sexual relationships developed between certain members of the sub-support group, which led to disruptions and a change in the dynamics of the sub-support group.



The lack of clearly defined internal rules, which led to a lack of clearly defined boundaries, was evident as there was no clarity and consensus between the participants with regard to spoken and unspoken rules within the sub-support group. According to Veronica and Frank, the initial spoken rules of the sub-support group were *more unspoken* and *more intuitive ... not like regimented rules*, while Nick and Nancy were of the opinion that initially there were no unspoken rules within the sub-support group, only spoken rules. There was also no clarity and consensus with regard to initial spoken rules of the sub-support group as Nick and Nancy emphasised the promotion of confidentiality as an initial spoken rule of the sub-support group, which was not emphasised by Veronica and Frank. Nick and Frank emphasised that an initial spoken rule of the sub-support group pertained to intimate sexual relationships between sub-support group members being forbidden, which was not emphasised by Veronica and Nancy.

Nick, Nancy, and Frank, highlighted the effects of the lack of clear internal rules and boundaries by experiencing with dissatisfaction on the clandestine sexual relationships between members of the sub-support group. Nick highlighted these unwanted sexual relationships when he mentioned: *there were two people in the group that had sex with each other ... and [one member] was making advances towards [another member]*. Frank also underscored the unwanted sexual relationships within the sub-support group by explaining: *One of the girls in the group slept with one of the guys ... there was stuff happening on a personal level and it came from two guys that were basically flirting with two girls*. Nancy concurred with Frank and Nick's comments regarding the unwanted sexual relationships within the sub-support group as she mentioned: *... [one member] had a thing [sexual relationship] with one of the members of the group*.

According to these same three participants, the impact of the clandestine sexual relations altered the dynamics of the sub-support group in two ways. Firstly, these three participants perceived a lack of honesty among their fellow sub-support group members, as these participants felt betrayed by their group members due to the secretiveness of the sexual relations among their fellow group members. Nick highlighted this when he said: *there was a dynamic [between the members] that existed there [in the sub-support group] that a lot of us [other members] weren't privy to, which is a bit unfair. It means that people are having a rapport that you are not*. Nick continued to stress that he felt the *dynamic of the group changed*

because he felt betrayed as he was open and honest with his fellow group members at all times, but these few members were not open and honest about their sexual relationships. Secondly, two members of the sub-support group who were involved in these secretive sexual relationships have both left the sub-support group after their sexual relationships became known to the other group members. .

By reflecting on the sub-support group process, Nick, Nancy, and Frank acknowledged the importance of clearly defined internal rules and boundaries for the sub-support group so as to protect the integrity and dynamics of the sub-support group. These participants explained that due to the common theme of each of the members having OCD, the members had insight into what their fellow members were struggling with. The participants therefore understood each other and were able to provide empathy to each other. These three participants continued to mention that the members of the sub-support group were also vulnerable to empathy, as their OCD symptoms may have made them feel lonely, as their family members and friends outside of the sub-support group did not appear to have insight into their OCD struggles. Due to the sub-support group members being vulnerable to empathy from another member who understood their OCD struggles, they began communicating intimate information to each other and therefore became close and formed intimate bonds with each other. The communicating of intimate information and the forming of close intimate bonds between each other heightened an emotionally charged environment, which was dangerous as internal rules and boundaries were not in place to protect the vulnerable members from becoming sexually and emotionally involved with other group members.

Nick reflected upon the dangers of an emotionally charged environment and the vulnerability of the sub-support group members: ... [The members understood each other and therefore] *you can relate to the person so strongly and that creates a quick, very rapid bond of trust and then that creates a forum in which those two people can improve their situation by discussing with each other* [about their OCD struggles]. ... [However] *Some people have become more than friends* [sexual relationships].

Frank also commented on the emotionally charged environment and the vulnerability of the sub-support group members: *I think it's natural that you connect with somebody quite deeply in an intimate group ... especially with OCD,*

*because it's that kind of feeling of this bizarre aloneness in what you're doing and you meet somebody and you connect with them and you share all this stuff ... but how to maintain those boundaries and keep it clean [non-sexual] as such, is obviously very important.*

Nancy's perceptions were similar to those of Nick and Frank. She agreed that the sub-support group should have clearly defined internal rules and boundaries because of the emotionally charged environment and the vulnerability of the sub-support group members: *You are sharing everything with them* [sub-support group members] ... [and] *because you have people* [members of the sub-support group] *who understand you, it is so tempting just to stick to them because they understand you. But ... it's not healthy for the group because if you too close ... you going to get personal and then ... too much that can happen there* [in the sub-support group]. Nancy continued to highlight how she and the other members of the sub-support group have reflected on the dangers of a lack of clearly defined rules and boundaries by mentioning that after the sexual relationships within the sub-support group became known to the other group members, the members made a spoken rule that no member should become sexually involved with another member of the sub-support group as it disrupts the sub-support group's integrity and group dynamics: *So it* [sub-support group] *should be completely not sexual and it is now. Right now it is our rule that nothing like this* [sexual relationships] *can happen* [between sub-support group members].

#### ***Sub-theme B2h: Evolving roles and responsibilities***

According to all four participants, the sub-support group required the members to take on different roles and functions within this sub-support group to what the initial support group required of them. A prominent difference between the two groups that all four of the participants described is that they call the sub-support group *our group*, which signifies that they, and not the clinical psychologist, primarily took ownership of the sub-support group. They all concurred that should the clinical psychologist attend a sub-support group meeting, his role would be that of an observer, which is different to his role in the initial support group. Frank illustrated this when he mentioned: *Brad only sits in on this group* [sub-support group] *every now and then but is not part of this group*. The participants further explained that they progressed from a passive listening role in the initial support group to an active role in the sub-support group of taking ownership and responsibility. The participants

described that due to them taking ownership and responsibility of the sub-support group, they identified two roles or functions that needed to be filled in the sub-support group, from the onset of the sub-support group, by one or two group members. Frank highlighted these two identified roles when he stated that *there were two functions that we realised needed to be applied, one was to basically manage the group, I suppose steer it or lead it as such and then the other was more sort of an administrative function, like this is when we're meeting and here at what time.*

According to Veronica, Frank and Nick, different members have filled these roles over time. Veronica reported that she was self-appointed to take on both the administrative and managerial/leadership roles when the sub-support group was formed. She reported to have carried out administrative duties in the initial support group, and then transferred this responsibility to the sub-support group when the sub-support group was formed; she also assumed the leadership position: *As the group [initial support group] grew it was too much for Brad to take on. ... So I took over that role as like the organiser ... as admin girl. ... So then obviously we went on to the other group [sub-support group] I was the person that organised that as well ... because I was doing admin for Brad I think it just developed that I would also run the second group [sub-support group].... So I was organising Brad's group and then I was organising the other group [sub-support group].* Veronica experienced these roles as fulfilling, although often quite stressful: *I had quite a lot of weight on my shoulders [doing administration and running the sub-support group]. ... But I will be honest I enjoyed it.* She explained that she was subsequently relieved of these duties without the other members openly discussing it with her. She reported that she felt *dequeened* and *demoted* when these roles were removed, even though they were removed from her, with her in mind, as she had too much on her plate.

According to Frank and Nick, the sub-support group members then split the roles of leadership/organisation and administration; Frank was appointed by the sub-support group members to take on the organisational/leadership role of the sub-support group, while Nick was appointed by the sub-support group members to take on the administrative role of the sub-support group. Frank underscored his identified group appointed role when he proclaimed: *Generally what happens is I sort of chair the group, I don't know if that's the right word, but I kind of lead it, I suppose ... they [sub-support group members] said to me, Frank would you lead it, we'd like you to lead it.* Nick concurred with Frank when he said: *Frank ... because we took*

*him on as our leader ... he was the one leading the group.* Nick also highlighted his identified group appointed role when he mentioned: *a secretarian* [secretariat] ... *I was the one sending the emails.* Frank explained Nick's duties in more detail: *Nick's our administrative role ... he does kind of the admin basically. He makes sure we've got keys to go to wherever we're meeting and sends out a mail saying what the agenda is for when we're meeting in the month.*

Besides the two clearly defined roles, leadership/organisation and administrative, the four participants also acknowledged the importance of the supportive roles each sub-support group member played according to their personality styles. These roles included giving supportive advice, providing empathy and comfort, and/or developing exposures for each other. For example, Frank, Nancy, and Nick described each other as being *insightful*. Each of them would therefore take on the role of giving valuable supportive advice to the other sub-support group members. Nick described Frank as *being compassionate* and he therefore tends to take on an empathic role in the sub-support group. Veronica characterised herself as *the connective person* in the group as she believes she is a friendly, open, outgoing, and sociable person who makes connections easily and forms close supportive bonds with others.

With regards to developing exposures, the participants described assisting other members to develop exposures as also being supportive as they are helping them in a supportive and constructive way to reach their ultimate goal of getting their OCD symptoms under control. This is highlighted when Frank described Nancy as *being creative* particularly when it comes to thinking of exposures, while Nick described Stuart, a fellow sub-support group member, as also being creative in thinking up exposures for other members of the sub-support group that are *therapeutically effective* as one of his many creative ideas are often 'spot on' to tackle another individual's obsession. Lastly, Nancy described herself as being *the responsible one* in the sub-support group as she always prepared for an exposure in the sub-support group, if not for herself, then to support another member.

### **B3 Themes related to the impact of the sub-support group**

According to the information obtained from all four of the participants, the sub-support group had a profound impact on their functioning and lives in general. The positive effects of being a member of the sub-support group impacted certain domains of the participants' lives such as each participant's OCD symptoms as well

as his/her occupational and social functioning. However, all four participants, while not mentioning any prominent negative impact of the sub-support group on themselves, did mention potential risks or likely downfalls within the sub-support group. According to the participants, these potential risks include possible “grey areas” or constituted possible ethical dilemmas for the participants and other sub-support group members going forward due to the therapeutic nature of the sub-support group. The following sub-themes focus on the participants’ perceptions of the impact of the sub-support group on their lives.

***Sub-theme B3a: Reduction of OCD symptoms***

According to all four participants, a benefit of attending the sub-support group meetings is that their various OCD symptoms have decreased since they first joined the sub-support group. The ERP techniques along with the support of the sub-support group members have helped them get their OCD symptoms under a certain degree of control. Nick highlighted the reduction of his OCD symptoms: *Now I am in a whole better place [with regards to his OCD symptoms] ... and I have learned an awful lot about OCD.* Veronica concurred: *I have really done a 360 degree, you know I was [before the sub-support group] in bed in an untidy room with just no meaning to life ... then I got better [OCD symptoms reduced] ... I have combatted most of my demons [OCD symptoms] ... I’ve come miles ... the support group [sub-support group] has saved me, definitely ... so that’s [sub-support group] helped me to like ‘un-mangle’ and ‘un-develop’ those problems [OCD symptoms].* Frank remarked that he is now *living life* without prominent OCD symptoms. Nancy also highlighted how the sub-support group helped her reduce her OCD symptoms when she commented: *Since I started the group [sub-support group] ... it’s actually amazing how I have changed ... the OCD symptoms have faded and I don’t check up on my boyfriend or ask for reassurance.*

***Sub-theme B3b: Increased functioning***

All four participants mentioned that since joining the sub-support group, not only have their OCD symptoms decreased, their daily functioning has also improved. The participants stressed that their occupational and social functioning in particular has improved. The increase of occupational functioning is evident when Nick stated: ... [Since joining the sub-support group] *I’m functioning a lot more at work, really on fire at work.* Veronica described her increased occupational functioning: *I think the support group has an impact in all spheres of my life ... [with one sphere being]*

... at work ... now I am a fully functioning human being in a high stress job, a normal real job. Frank gave his opinion regarding his improved occupational functioning: *The impact that it's [sub-support group] had on me this year has been the fact that I left my job ... [and] ... I started a business.* Nancy also mentioned her increased occupational functioning: *The OCD support group can help you with your life and not ... [only] ... with your OCD, like my situation right now ... finally ... having a proper job.*

With regard to their increased social functioning, the participants described that the sub-support group had helped to increase their social functioning in two ways. The first, mentioned by all four members, is that by helping to reduce their OCD symptoms the sub-support group in turn helped to improve their social functioning. The second, mentioned by Nick, Nancy, and Frank was that the sub-support group provided them with a space in which they could practise their socialisation skills, which in turn improved their social functioning.

Veronica explained that because her OCD symptoms have been reduced her relationships, *specifically at home* with her parents, have improved. They do not get into as many arguments as they did before she joined the sub-support group.

Nick highlighted that the sub-support group helped to reduce his OCD symptoms which in turn improved his social functioning when he said that before attending the sub-support group his OCD symptoms brought about jealousy within his relationships, which disrupted his relationships, but since his OCD symptoms have faded, particularly his obsessional jealousy, from being in the sub-support group, he is now *in a stable relationship*. Nick also brought to light the advantage of the non-judgmental socialising space the sub-support group provided him by expressing that before attending the sub-support group he had a fear of speaking in large groups but this has also improved: *Because of this separate group [sub-support group], I have managed to conquer my fear of public speaking.*

Nancy's social functioning was poor before she joined the sub-support group, particularly relating to her boyfriends and her father. She underscored the importance of the sub-support group helping her to improve her social functioning by reducing her OCD symptoms: *My relationship [with my boyfriend] is ok now because of the group [sub-support group] ... second, the relationship with my father [has improved] ... and this is also because of the group [sub-support group].*

Nancy also highlighted that before she joined the sub-support group she had a fear of men: *First of all I had a fear of men. Coming from my father obviously, I was just ... I didn't feel comfortable with men, like I didn't like men to be around, I didn't like to talk to men. I felt uncomfortable around men, I felt scared to a certain extent.* Her pre-sub-support group social functioning with men helped her to underscore the advantage of the socialising space the sub-support group provided her by mentioning: *Now I am in a group where I have four guys ... like I am not intimidated by men anymore, I am not intimidated by what they may think about me ... so I think the group can be a really good thing for people with OCD and even for people with social anxiety it can be a good thing for them to join because then they can overcome their social anxiety.* Nancy further illustrated the advantage of the socialising space provided by the sub-support group when she commented that if it were not for the sub-support group, she would not have been able to have the interview with me, the male researcher, because she used to have difficulty speaking to males.

As the other three participants have done, Frank gave credence to the sub-support group, which helped reduce his OCD symptoms, and in turn helped to improve his social functioning. He particularly mentioned that when his OCD symptoms faded, he became more comfortable with his sexuality. Not only have his sexual relationships improved but his relationship with his father has also improved: *I've kind of become a lot more comfortable with my sexuality and I'm living life [without prominent OCD symptoms]. This has really been, in some instances, a dream come true really. ... I also get along better with my father now [since being in the sub-support group].*

Frank also stressed the importance of the space the sub-support group provided for socialising; however, he postulated a different reason to Nick and Nancy's reasons for the importance of socialising in the sub-support group. Frank's reasoning was that the socialising also appeared to create a space where the stigma surrounding OCD could be broken. He stated that the members get to know each other and realise that fellow members are in many ways high-functioning individuals who live successful lives. According to Frank, he learned that if people who did not attend the sub-support group met one of the sub-support group members outside the sub-support group, they would not know that those people suffer from a mental illness such as OCD: *If I think of the people that I sit with [in the group] and you tell somebody that you go to a support group for OCD with people that are mentally ill, in some capacity. It*



*sounds morbid basically ... but if you just had to meet any of these people, one wouldn't say, oh that one's got OCD and he's not well.* Frank then elaborated on his statement by mentioning that if someone does attend a sub-support group meeting they could change their ideas around the morbid nature of mental illness, specifically OCD: *If those people [individuals who regard mental illness as being morbid] can see who is saying that [that they have OCD] and that person seems reliable and like a decent person ... then you're kind of breaking that kind of mental stigma of people that are uneducated and hopefully you'll get them to become more informed.*

### ***Sub-theme B3c: Unique friendships***

The four participants in the sub-support group reported that a benefit of the sub-support group was that they had become friends with the other members of the group. As described in Sub-theme B2g: When things get murky: The impact of diffuse internal group rules and boundaries, the participants tended to have insight into what other members of the group may experience with regard to their OCD symptoms, and the impact of those symptoms on their lives; they understood that member's difficult situation. According to the participants, this insight may have led to the sexual relationships within the sub-support group but, on the other hand, the insight the members obtained regarding each other's difficulties with OCD, also led to the formation of strong friendships within the sub-support group meetings. Due to the friendships which developed within the sub-support group meetings, members began to socialise outside the sub-support group meetings as well. The participants mentioned that they would go for a meal together after each sub-support group meeting. The participants also suggest that they then got invited to each other's personal events, such as birthday parties or baby showers. Veronica went so far as to say, *we are all a big family.*

Nick referred to the friendships he has made in the sub-support group: *People [members of the sub-support group] just get [understand] each other ... we have become friends. ... We do also speak and we socialise outside the group as well ... for example, Nancy came to my birthday party.*

Veronica also stressed the importance of the friendships she has made by being a member of the sub-support group: *I have become quite good friends with the people in the support group [sub-support group].* Veronica described that she keeps in contact with these sub-support group members who are her friends via Facebook

and/or email. In addition to communicating via Facebook and email Veronica also mentioned: *So, Tracy [another member of the sub-support group] she just had her baby and I went to her baby shower, visited her two weeks ago. ... I often see them [the other sub-support group members] in social settings, they all get invited to my birthday, and I get invited to their birthdays ... and it really felt sincere, you got to know these people really well, you feel like you can tell them anything because they know your deepest darkest secrets and you feel like you have got friends for life.*

Frank underscored that a benefit of the sub-support group is building friendships: *I think it's a really healthy relationships and its friendships.* He pointed out that the members socialise outside the sub-support group setting as well: *We'll go out and have a pizza afterwards [after each sub-support group meeting] and we'll kind of relax. We find that it's good to have like the kind of stiffness of the room itself and then also just like chill ... get to know one another well in a different sense. So, we know one another very well ... and as people have had birthdays ... everybody's invited everyone to come. So, it's like close enough like that.*

Nancy, in line with what Nick, Veronica, and Frank described about friendships between members of the sub-support group, also explained: *We are friends ... you do know each other very well because you listen ... we talk about everything ... probably more than you would tell a psychologist because you know those people are going to understand you; and like I said, a birthday party is fine, if it's a huge get together, you can invite everybody. We also go for dinner after the meetings.*

### ***Sub-theme B3d: Risky business: When things go grey***

Three of the four participants commented on two possible risks regarding the sub-support group. According to these three participants, namely Nick, Veronica, and Nancy, a possible risk and potential downfall of the sub-support group may be that they do not have a professional who specialises in OCD and OCD treatment in the sub-support group to lead the sub-support group by moderating the ERP techniques carried out in the sub-support group. Nick emphasised the risk of not having a trained professional leading the sub-support group: *I think not having Brad [psychologist] around [in the sub-support group all the time] was probably a pitfall as well. I think we should probably have had a moderator around, at least some of the time. ... Just to keep you on track.* Veronica concurred with Nick's

statement when she mentioned: *It would be better* [for the sub-support group] *if we had a trained professional at each meeting* [to be in charge].

These three participants believed that the sub-support group could potentially enter dangerous territory without a trained professional present to oversee the process, particularly because specialised therapeutic techniques, such as exposures, are being practised during the sub-support group meetings. They contended that this could lead to potentially intense emotionally laden situations that may require trained, experienced individuals/therapists to successfully deal with possible unforeseen consequences. Although they have never had a problem with an exposure or an emotionally laden situation they could not deal with without a clinical psychologist being present, they conceded that such a situation could arise in future. Nick gave his thoughts about not having a trained professional in the group: *I think the main thing was to check that we were doing exposures correctly and helping people rather than damaging them. For example, not finishing off properly then you might leave someone in a worse place, it might be counter-productive or whatever. Also, some of them are quite hectic exposures ... so there is a practical safety issue and that sort of thing.* Nancy agreed with Nick's statement of dangers potentially arising without a trained professional in the sub-support group: *The group is people who are not specialists who are trying to help each other ... so, it could be dangerous, I think, because we don't have a therapist in this other group* [sub-support group]. *So I can potentially see it as something, which could go wrong ... because it's very often like some anxiety that you have* [to deal with in the sub-support group].

According to Nick, Nancy, and Frank there could be another possible risk or potential downfall for the sub-support group. In Sub-theme B3c: Unique friendships, the four participants mentioned that they have become close friends with each other. Although Nick, Nancy, and Frank enjoyed and valued these close friendships, they were concerned that these close bonds may undermine members' objectivity, and may compromise the therapeutic value of the sub-support group as members may not be able to be entirely honest with each other, particularly when providing feedback to each other.

Nancy underlined this possible risk of being too close to fellow members of the group: [If the members are too close friends] *then you* [the members are] *not objective anymore, then you not listening to what another member of the group is saying.*

#### **4.4 Conclusion**

The main objective of this chapter was to present the information obtained from the participants by making use of a thematic analysis to organise the information into themes and sub-themes. Themes and sub-themes were identified and presented along with direct quotes from interviews with the participants. These quotes have been selected to support the conclusions and findings as well as to illustrate the themes and sub-themes identified from the information obtained from the participants. In the following chapter, a discussion of the themes and sub-themes presented in this chapter along with the integration of theory and literature will be provided. Chapter 5 will also include the strengths and limitations of this research study along with recommendations for future research in this field.

## **Chapter 5**

### **Discussion and Recommendations**

#### **5.1 Introduction**

This chapter reflects on the information obtained in this study. Core themes and sub-themes which emerged from the participants' accounts of their experiences of attending the initial and the sub-support groups will be discussed in relation to the relevant literature and theories. Subsequently, a brief overview and a critical evaluation of the study will be included. This chapter concludes by highlighting the strengths and limitations of this study, as well as recommendations for future research studies.

This chapter begins with discussing the four participants' backgrounds prior to commencing with the discussion on their experiences of the two OCD support groups. The participants were eager to share their life stories, and gave extensive background information before providing their experiences of the two OCD support groups. A discussion on the participants' backgrounds is included and this provides context and highlights the systemic framework of this study. According to Becvar and Becvar (2009), from a systems perspective, to view an individual in context requires that a researcher keeps the larger and smaller systems that reciprocally impact on that individual in mind. Looking at the participants' experiences of the two OCD support groups without providing a background discussion on each participant would ignore context and be reductionistic as larger systems such as a participant's family, culture and unique history, and the smaller systems such as the two OCD support groups, are reciprocal by nature and mutually influence each other (Becvar & Becvar, 2009).

#### **5.2 Backgrounds of the Participants**

From a systems perspective, Hoffman (1981) mentions that instead of trying to describe why or how a certain event occurred, the researcher or therapist is required to view what is happening in the here-and-now. However, Becvar and Becvar (2009) indicate that the systemic researcher or therapist, whilst exploring the here-and-now, should not overlook the impact an individual's background (larger system) may have on the here-and-now. As described above, each participant voluntarily communicated detailed information about him-/herself prior to joining the two OCD support groups. The background information pertaining to the participants provides a context in which each participant's experience of the two OCD support groups can be understood. Providing the background of each participant is also in line with literature pointed out

by Becvar and Becvar (2009), outlined in chapter 2, that communication is context specific. Each participant's background provides a context of who he/she is as well as indicates each participant's experiences of his/her progress in attending the two OCD support groups. Therefore, changes with regard to each participant's OCD symptoms, comorbid disorders, and functioning might be useful in understanding each participant's experiences of attending both OCD support groups. It therefore seemed appropriate to begin with certain aspects of the participants' lives before discussing their experiences of both OCD support groups. Each participant's background included the OCD symptoms he/she experiences/experienced, possible treatments he/she may have undergone, any comorbid disorders he/she may suffer from, possible mental illness in the family as well as each of their family backgrounds and interpersonal relationships before joining the two OCD support groups.

### **OCD symptoms**

According to literature from Olatunji et al. (2007), Sadock and Sadock (2007), Stengler-Wenzke et al. (2007), and Torres et al. (2007), OCD is a debilitating disorder that impacts on a person's quality of life. Each participant in this study appeared particularly eager to share his/her journey regarding OCD, which began several years before joining the two OCD support groups. The impact the OCD had on each participant's life prior to attending both OCD support groups appeared to be immense for all four participants. The OCD impacted on each of their relationships, their work, self-esteem, and their self-image, which is in line with how DSM-IV-TR (APA, 2000) and DSM-5 (APA, 2013) as well as research from El Sayegh et al. (2003), outlined in chapter 2, suggest OCD symptoms impact on an OCD sufferer's functioning. For three participants, their symptoms and the resultant impairment in functioning were so severe that they required hospitalisation.

Three of the four participants described having some obsessions without compulsions as well as some compulsions without obsessions. It is possible, according to the DSM-IV-TR (APA, 2000) and DSM-5 (APA, 2013) definitions of OCD, outlined in chapter 2, that an individual with OCD may have obsessions without compulsions as well as compulsions without obsessions. Two of the participants who experienced compulsions without linked obsessions, described that they carried out compulsions according to strict distinctive rules which reduced their anxiety. This is in line with research from Abramowitz et al. (2008) who concluded that compulsions may be carried out due to a set of strict distinctive rules that may not

be logical. Some of the participants experienced obsessions and compulsions that were linked together, however the way the obsessions and compulsions were linked did not appear to be logical. Notwithstanding the illogicality of the link, the compulsion did reduce the anxiety temporarily or negate the idea that a feared event would occur. According to Sadock and Sadock (2007), obsessions and compulsions do not need to be linked in any logical way but if they are linked, then they are often linked illogically. This link often appears irrational to the individual carrying out the compulsion as well. However, the compulsion is carried out despite its illogicality as the individual suffering from OCD believes that it reduces the anxiety levels the obsessions elicits, and also renders a possible feared event occurring in future, unlikely (Abramowitz, 2006).

According to research from Abramowitz et al. (2008) and McKay et al. (2004), OCD symptoms may also overlap, and they often do. An individual may have more than one subtype of obsession and compulsion at a given time. Clarke (2004) and Van Niekerk (2009) along with the DSM-IV-TR (APA, 2000) and DSM-5 (APA, 2103), also mention that OCD symptoms can manifest in similar ways as well as in a variety of ways. There appears to be unlimited possibilities as to the types of OCD symptoms an individual can present with. Some symptoms are universal; however, other symptoms appear to be culture and context specific. Symptoms are at times constant but can also evolve and change over time. OCD is therefore a heterogeneous disorder. This is evident in that all the participants displayed both similar and different subtypes of OCD to each other, with no clear distinctions between subtypes. Three participants also shared that the OCD symptoms they experience tend to evolve and change over time.

The illogical link between obsessions and compulsions, the lack of clear distinctions of symptoms, the symptoms tending to manifest in different ways, and the symptoms evolving – which are evident in each of the participants of this study – are highlighted in the literature as being common occurrences with individuals who have an OCD diagnosis. Without this information regarding OCD, it can be seen how confusing these misunderstood symptoms might be to an individual who has OCD. Due to the participants' lack of knowledge of their OCD symptoms, they all described that they felt isolated as they did not disclose, at all or fully, their OCD symptoms to their family members, friends, or partners and therefore no information was being imparted by them regarding what they were experiencing. This lack of disclosing also

gave the participants' family members, friends and girlfriends no chance to impart information to the participant. This secrecy the participants describe with regard to their OCD symptoms is in line with findings from Clarke (2004) and Heyman et al. (2006), outlined in chapter 2.

From a systemic perspective, Becvar and Becvar (2009) explain that all living systems need to maintain a balance between openness and closedness to ensure maximum order and functioning. If a system allows in too much information or not enough information, the system's identity and survival is in jeopardy. At either extreme, the system could be said to be in a state of entropy. As each of the participants are regarded as a system, two of the participants appear to have been in in a state of entropy prior to joining the two OCD support groups, as too little information regarding OCD was being imparted to them and they were imparting too little information about their OCD symptoms to others. The other two participants appeared to have been in a state of entropy, for similar reasons above, prior to attending individual psychotherapy for their OCD symptoms. The participants would therefore, from a systems perspective, be regarded as having been closed systems not allowing any information about OCD into their system and not disclosing any information about their OCD symptoms to other individuals in their lives (Goldenberg and Goldenberg, 2013) prior to getting help. However, each participant was open to getting treatment or information on OCD but it appeared as if the confusing nature of the OCD symptoms made it difficult for the participants to initially find effective treatment or any treatment at all for their OCD symptoms.

### **Treatment**

Findings from this study revealed that the participants in this study have all undergone some form of treatment for their OCD symptoms before attending the two OCD support groups. Veronica, Nick, and Frank received medication for their OCD symptoms. Nick and Frank did not specify the type of individual psychotherapy they received initially but they did receive individual psychotherapy for OCD. These two participants highlighted that after going for individual psychotherapy (paradigm of the therapy is unknown) they went for individual psychotherapy again with a different psychologist (who runs the initial support group) and received CBT treatment for their OCD symptoms. Veronica reported to having received CBT psychotherapy for her OCD symptoms while not attempting any other paradigm of psychotherapy for her OCD symptoms. Nancy



reported that she did not seek individual psychotherapy for her OCD symptoms but treated herself by doing mindfulness and meditation techniques. Research from Anderson and Reese (2007), Gellatly and Molloy (2014), Thiel et al. (2014), and Van Niekerk (2009) suggest that the combination of medication and CBT appears to be the most effective treatment for OCD. Veronica, Nick, and Frank received CBT treatment and medication before and/or during their participation in the OCD support groups. These three participants reported that the combination of CBT and medication was effective. Nick and Frank, who had received other forms of psychotherapy for their OCD symptoms, described that the combination of medication and CBT was the most effective treatment compared to other treatments they had been through for their OCD symptoms. The information that three participants had a combination of medication, and in particular CBT, and that they found this treatment approach effective, is important to note for this study as CBT plays an integral part in the foundations of the two OCD support groups which the participants of this study attended.

### **Comorbid disorders**

It appears to be rare to have an individual with a sole diagnosis of a mental illness without a comorbid disorder present (Caspi et al., 2014; Hasin & Kilcoyne, 2012; Kessler et al., 2005). OCD is no exception as individuals diagnosed with OCD more often than not have a comorbid mental disorder (APA, 2013; Cordioli, 2008; Sadock & Sadock, 2007). The literature, outlined in chapter 2, states that depressive disorders are particularly common comorbid disorders with OCD (Abramowitz, 2006; APA, 2013) with bipolar disorder also being common (APA, 2013). However, Clarke (2004) states that OCD and other anxiety disorders are also commonly comorbid. DSM-5 (APA, 2013) also highlights the high comorbidity between OCD and certain anxiety disorders. The most common comorbid anxiety disorders, according to Abramowitz (2006), Clarke (2004), and the DSM-5 (APA, 2013) are generalised anxiety disorder (GAD), social anxiety disorder (SAD), specific phobia, and panic disorder. According to the DSM-5 (APA, 2013), hoarding disorder is also comorbid and has a 20% comorbidity rate with OCD. Tic disorders and a diagnosis of ADHD may also both be common co-occurring disorders with OCD, specifically in children (APA, 2013). Literature also suggests that there is a common co-occurrence between OCD and substance-use disorders, particularly alcohol-use disorders (Denys et al., 2004; Hasin & Kilcoyne, 2012; Mancebo et al., 2009). It may be that OCD is the

primary diagnosis but OCD may also be a secondary diagnosis with an individual presenting another primary mental illness diagnosis (Clarke, 2004).

In line with the research mentioned above, which is stipulated in more detail in chapter 2, it is evident in this research study that comorbid disorders or symptoms of depressive disorders, bipolar disorder, ADHD, hoarding disorder, SAD, GAD, specific phobia, and alcohol-use disorder are prevalent among the participants in this study, along with a diagnosis of OCD. I hypothesise that the high number of comorbid disorders/symptoms prevalent among each of the participants, along with their severe symptoms of OCD, is a further indication of how chaotic each participant's life had been prior to joining both the OCD support groups. From a systemic perspective, this is again evident of each individual going through a stage of entropy (Becvar and Becvar, 2009) prior to joining the two OCD support groups.

It should also be kept in mind that the comorbid disorders or symptoms could also play a part in hindering an individual's progress in the support group. This was evident with three of the participants discussing their high levels of anxiety when socialising with other people in the group. This social anxiety had an impact on how they interact with other people and explored their OCD symptoms. However, as will be shown later on in this chapter, the OCD support groups may have some benefit not only for the symptoms of OCD, but possibly for other mental illness symptoms and disorders as well. Participants with a diagnosis or symptoms of SAD specifically stand out as possibly benefitting by being part of the OCD support groups.

### **Family mental illness**

Findings from this study indicate that all four participants mentioned that a family member of theirs has a possible mental illness. Three of the four participants suggest that at least one of their parents has an undiagnosed OCD. These findings are congruent with literature in DSM-5 (APA, 2013) and Sadock and Sadock (2007) as well as research suggested by Rossouw (2012) that point to OCD having a genetic link. I have included a short section about family mental illness as it demonstrates the difficult social environment the participants may have been dealing with prior to joining the two OCD support groups, as the literature from Clarke (2004), outlined in chapter 2, suggests that a family who has a member with a mental illness may undergo considerable stress, tension, and dysfunction. The participants' family environments seem to have more than one individual suffering from mental illness symptoms, which may have amplified the stress, tension, and dysfunction in their

families of origin. From a systems perspective, a system is seen as a whole and not individual isolated parts making up the whole. The interaction of the individual parts in the system is important (Becvar & Becvar, 2009). Every individual within a larger system is interdependent and the behaviour of one individual influences the other reciprocally (Watzlawick, 1967). Therefore, with more than one individual displaying dysfunctional patterns of relationships within the participant's family system, the more chaotic the family system may be, which reciprocally influences the participant and increases his/her dysfunctional pattern of relationship.

### **Family background and interpersonal relationships**

Findings from this study indicate that all four participants lacked effective and sufficient social support while they were struggling with severe OCD symptoms prior to joining the two OCD support groups. All four participants reported difficult relationships with their family members, particularly their parents. Three of the participants reported that they got into fights with their parents as their parents did not understand their OCD symptoms and the impact of their OCD symptoms. The family members finding it difficult to understand and deal with the participants' OCD symptoms is highlighted in chapter 2 in literature from Amir et al. (2000) and Fennel and Liberato (2007). From a systems perspective, the participants blaming their parents for not understanding their symptoms is a linear way of viewing and dealing with the problem as this tends to perpetuate the individual's position in the family as the Identified Patient (IP) (Goldenberg & Goldenberg, 2013). These three participants reported relationships with their parents which can be described as symmetrical relationship patterns (Becvar & Becvar, 2009), according to systemic principles. The participants' symptoms tended to impact on their family members, who became increasingly frustrated and angry, which in turn impacted on the participants as they became increasingly frustrated at not being understood. These symmetrical relationship patterns tended to escalate into both physical and verbal fights. For two of these three participants the symmetrical relationship patterns escalated to such a degree that one participant physically left her family system, behaviour which is highlighted in research findings by Heyman et al. (2006). The other participant's family distanced themselves from him by physically removing him from their family system, which is behaviour in line with research findings by Clarke (2004) and Van Niekerk (2009).

The one participant who did not report getting into fights with his parents mentioned that he does not fully report his OCD symptoms to his parents as his symptoms were difficult to explain. It appears as if he does not engage fully with his parents, lives far apart from his family, and may feel ashamed of having the OCD symptoms. This is in line with research findings, discussed in chapter 2, from Clarke (2004) as well as Heyman et al. (2006). From a systems perspective, this again appears to be a linear way of dealing with the IP position in the family as the member creates distance between him-/herself and family members in an attempt to reduce or avoid a chaotic family system (Becvar & Becvar, 2009; Clarke, 2004).

All four participants reported to having friends before joining the OCD support groups but they stated that they did not have enough trust in these friendships to fully disclose, or to disclose at all, any of the symptoms they were experiencing as well as how these symptoms were impacting their lives. They therefore isolated themselves from their friends, and report having superficial relationships with their friends. The participants did not report the basis for their trust issues with their friends but it is hypothesised that they were wary of the stigma surrounding OCD and the manner in which their friends would react to hearing they had a mental illness, which is in accordance with research findings by Heyman et al. (2006), outlined in chapter 2.

Three of the participants did not have partners prior to joining the two OCD support groups and therefore did not have a partner to rely on for support. One participant reports to having a partner but that he keeps his OCD symptoms a secret from her, which is again in accordance with literature from Heyman et al. (2006). The other participant reported that he had recently broken up with his girlfriend a few months prior to the interviews and distanced himself from this partner. He does not report his intentions for distancing himself from his partner as it appears to have been unintentional, but this unintentional distancing is again in line with research findings, outlined in chapter 2, by Clarke (2004) and Van Niekerk (2009).

Due to the participants' tumultuous and/or superficial relationships with family members, friends, and partners before joining the OCD support groups, as is described above, the participants appeared to have a lack of support. However, it was probably at a time when the participants required support the most, as stated by Davison et al. (2000) that support appears to be crucial for people, particularly

when they are going through a mental illness. Hou et al. (2010) also found that individuals with any kind of illness, physical or mental, require support. Studies have shown that support from high-quality relationships is in some instances a protective factor and act as a buffer against an illness progressing, may stop an illness, and may help an individual recover from an illness (Nakashima et al., 2013; Thoits, 2011).

The participants either experienced symmetrical escalations with their support structures or they self-isolated themselves from the support structures. Either way, the participants report chaotic relationships, which points to Von Bertalanffy's (1968) systemic principle of equifinality that no matter how the participants reported acting (keeping their symptoms a secret or disclosing their symptoms) the outcome was a chaotic family, friend, or partner system. The chaotic system then leads to the participants experiencing distance and more isolation. Therefore, at a time when the participants appeared to need the support, they did not receive the required support and seemed isolated, which is in accordance with literature, from Davison et al. (2000), outlined in chapter 2. This sense of isolation tends to be a common theme among the participants before joining the OCD support groups. The participants therefore experienced a disconnection between themselves and their support structures, which is important to understand as context for each participant's level of social support prior to attending the two OCD support groups.

Findings from section 5.2: Background of participants, display evidence that prior to joining the initial OCD support group and the sub-support group all four participants suffered severe OCD symptoms, had little education surrounding OCD, required therapeutic gains, suffered difficulties in their interpersonal relationships, and lacked some form of social support.

### **5.3 Discussion of the Results**

#### **5.3.1 Section A: Experiences of the support group steered by a professional (the initial support group)**

According to Chesler and Barbarin (1987), discussed in chapter 2, in order for individuals to join and gain access to a group they will initially be required to meet the specific criteria for joining the group. The gatekeeper of the group initially sets out these requirements. The clinical psychologist, who founded and leads the initial support group, is the expert and the gatekeeper of the initial support group. The

gatekeeper is therefore synonymous with the role of leader and expert in the initial support group. He set out the criteria and aims for joining the initial support group. The criteria to join this support group, according to the participants, are not stringent. It requires an individual to have some link to OCD. For example, an individual may be an OCD sufferer or he/she may be a family member or friend of someone who is suffering from OCD. OCD is the homogenous core of the initial support group. In this study, the initial support group focused on educational insights, provided mainly by the clinical psychologist, regarding OCD and the treatment of OCD. This is in line with research from Forsyth (2013), outlined in chapter 2, that one function of a support group is to provide members with a space to gain educational insights while also providing a member with a space to learn how to cope with a specific problem in an environment where all members have a similar problem.

#### ***5.3.1.1 Themes related to the participant's motivation to attend the group***

The information obtained from the participants suggests that two of the participants in this study were motivated by the clinical psychologist to attend the initial support group while the other two participants were self-motivated to attend the initial support group. Despite the four participants following different paths towards the initial support group, all four appeared to join for a similar reason, namely to get their OCD symptoms under control. They were all desperate to get their OCD symptoms under control as their OCD symptoms were severe, and they experienced significant distress and impairment in their daily functioning (see section 5.2: Background to the participants). Each participant also described co-morbid symptoms along with their OCD symptoms, which may have further increased their distress and impairment in functioning, and exacerbated their desperate need for help.

Veronica and Nancy stated that they desperately wanted to get their OCD symptoms under control, and while Nick and Frank did not outwardly state this reason for joining the initial support group, they were attending individual psychotherapy prior to joining the initial support group in order to get their OCD symptoms under control, which confirms their need for specialised help and treatment for their OCD. The initial support group was to be part of this treatment as the clinical psychologist they were seeing suggested they attend the initial support group. I hypothesise that Nick and Frank trusted the clinical psychologist enough to join the initial support group, and in addition to their loyalty to the clinical psychologist they also wanted all the help they could get. This need for help that all the participants

displayed, which led each of them to the initial support group, is in line with research from Forsyth (2013) as he states that individuals join groups, one of which is a support group, in order to solve a problem. This is also consistent with research from Yalom (1995) who states that individuals join groups to achieve a primary goal. In this study the problem of each participant's OCD symptoms, and the resultant distress and impairment in functioning, is clearly defined, and the primary goal is to get the OCD symptoms under control and to improve functioning.

One participant also mentioned that an additional motivating factor for her to attend the initial support group was that she was looking for an inexpensive way to get her OCD symptoms under control, and the support group was free of charge. This fits with the findings of Simoni et al. (2007) and Steketee and Pigott (2006) who state that interventions that are practical, feasible, and cost effective are desirable in developing nations, with support groups being good avenues of providing interventions in a practical, feasible, and cost-effective way as support groups are usually provided at no cost.

#### ***5.3.1.2 Themes related to the participants' experiences of the nature of the initial group***

Findings from this study indicate that all four participants spoke about the nature, the structure, or the functioning of the initial support group. The participants perceived three main aspects with regard to the structure of the initial support group. They described these three main aspects thus: that the initial support group was led by the clinical psychologist, the focus was on obtaining information regarding OCD, and that the group had open boundaries. The participants also discussed the impact of the leader-led group, the information imparted to them, and the open boundaries on the initial support group as well as on themselves. This description of the nature, structure and functioning of the initial support group by the participants as well as the impact of the structure of the initial support group on the participants and the group as a whole is important as Pierce et al. (1996), outlined in chapter 2, are of the opinion that in groups decisions are made about the functioning of the group as a whole, which in turn impacts on the structure of the group. From a systemic perspective, the structure of a group is particularly important in understanding how a group operates (Becvar & Becvar, 2009). The structure of a group is influenced by the rules and boundaries of the group (Becvar & Becvar, 2009; Goldenberg & Goldenberg, 2013) and the roles the different members of the group occupy (Haley, 1963).

The participants described that the clinical psychologist who founded the initial support group occupied the role of the leader and expert in the initial support group. The support group led by a mental health professional is in line with literature from Forsyth (2013), outlined in chapter 2. The clinical psychologist occupied this leader role by maintaining the group, by deciding on the topic of each meeting, and by chairing the meetings. The clinical psychologist taking on the role of the leader of the initial support group and thus maintaining the initial support group, after forming the group, is congruent with the findings of Chelser and Barbarin (1987), outlined in chapter 2.

Other than the role of leader, the participants did not describe any other specific roles at an early stage within the initial support group. The participants suggested that they respected the clinical psychologist as the expert on OCD, and they would arrive to listen to information being imparted by the clinical psychologist. The participants did mention that the space was available for them to ask questions and discuss their experiences pertaining to OCD amongst each other while still being monitored by the clinical psychologist; however, the major part of each meeting was reserved for them to receive information from the expert. The clinical psychologist had the resources and the information on OCD to run the initial support group. The clinical psychologist having the only clearly defined role in the early stages of the initial support group, assuming the dominant role in the initial support group and whom the members are dependent on, is in accordance with research from Tuckman (1965) and Yalom (1995), outlined in chapter 2. However, as the initial support group progressed, a core subgroup formed within the initial support group (which will be discussed in section 5.3.1.3: Themes related to the evolution of becoming a settled member) and the participants described that they became more comfortable sharing their stories regarding OCD to the other members. Veronica described that she also began to help the clinical psychologist carry out administrative duties for the initial support group. Clearly defined roles became more evident within the initial support group. Veronica taking on the role of administration in the initial support group is in line with literature from Yalom (1995), outlined in chapter 2, that states that members who have been in a group for a significant period of time begin to take on leadership positions in that group.

From a systemic perspective, all behaviour is interdependent and can only be understood by viewing that behaviour in a system as a whole (Watzlawick et al.,



1967). Therefore, it is important to explore the relationships between individuals within a system, and to understand the interactional pattern within those relationships (Watzlawick et al., 2011). There appears, particularly in the early stages of the initial support group, to be a clear complementary relationships pattern between the clinical psychologist and the participants of the initial support group (Becvar & Becvar, 2009). The clinical psychologist took the one-up position for the most part of each meeting, while the participants took the one-down position (Becvar & Becvar, 2009). This was not a rigid complementary relationship pattern as the participants described that at times they did ask each other and other group members questions and told their stories, which they learned from. According to Haley (1963), this system (initial OCD support group) would have an unequal distribution of power and control within the relationships due to the clear-complementary relationship patterns. However, Becvar and Becvar (2009) state that the relationship patterns should fit the demands of the system and the context. This system (initial OCD support group) therefore required clear complementarity relationship patterns for the most part in order to survive as the context was that of a psychoeducational support group, with the group facilitator as the expert.

As has been touched on briefly above, the participants experienced the nature of the initial support group to be that of a psychoeducational group. A support group having an educational nature is in accordance with findings by Black and Blum (1992), Davis (2008), Forsyth (2013), and Steketee and Pigott (2006), outlined in chapter 2. The clinical psychologist provides educational talks on various topics of OCD to the group members during each meeting but also invites other professionals to speak to the group about relevant OCD topics to complement his knowledge and expertise. The professional he brings in then takes on the role of co-expert for that meeting. Findings from this study therefore suggest that the way the initial support group was to confront the central problem of OCD was to provide education around this common problem; this is congruent to the findings of Forsyth (2013) and Kurtz (1997), outlined in chapter 2. The participants also described that they learned from each other and other group members of the initial support group, particularly as the group progressed and the core subgroup formed. The members exchanging information about a certain problem with each other is in accordance with research from Black and Blum (1992) and Forsyth (2013), outlined in chapter 2.

The participants also described that the initial support group had open boundaries, which means that the initial support group was flexible and allowed for individuals to join and leave the group at any time they desired. The flexible open boundaries of the initial support group are congruent with literature from Chesler and Barbarin (1996), outlined in chapter 2, that groups can be open. The open boundaries also allowed for family members and friends of individuals with OCD, as well as other interested parties, to participate in the initial support group. The only common link between the members is that of some connection to OCD. This allowed the individuals the comfort of knowing that they are not committed to the group should they attend a meeting, and that the group is there should they require information or support. However, the participants experienced that the open, flexible boundaries of the initial support group allowed for a lack of stability as the group size and membership fluctuated. The fluctuation occurred as new members would join sporadically and other members would attend infrequently, while some would drop out. The open boundaries had the impact on the participants of lessening their spontaneous disclosures of their OCD symptoms as they perceived a lack of stability and trust, which needed to be earned by repeated exposure to similar people and a build-up of positive identification with those people in the group, which is in accordance with literature from Nakashima et al. (2013). As the initial support group progressed, a core subgroup formed within the initial support group that at a later stage negated the impact of the open boundaries of the initial support group (to be discussed in section 5.3.1.3: Themes related to the evolution of becoming a settled member).

The open boundaries of the initial support group may also have played a part in the clinical psychologist's role as leader, as the participants did not initially know each other and the clinical psychologist was initially the only common thread among the members as he attended every meeting, which is in accordance with literature from Chesler and Barbarin (1987).

### ***5.3.1.3 Themes related to the evolution of becoming a settled member***

Findings from this study indicate that a prominent focus for the participants during the process of becoming settled members of the initial support group appeared to fall on the relationships the participants had with the other members of the initial support group. These relationships appeared to go through phases but eventually the participants experienced a build-up of trusting relationships with certain members of

the initial support group. This is in line with findings from Forsyth (2013) that a common feature of support groups is that they are relationship-oriented, which means that over time bonds are formed in support groups and trust begins to develop. Yalom (1995) also highlights the importance of relationships when he states that while members of a group are determining methods of achieving their primary goal which, according to the participants in the initial support group, is getting the OCD symptoms under control, they attend to a secondary goal of achieving social relationships that will create a space in which their primary goals can be achieved in comfort.

Information obtained from the participants in this study indicated that they all experienced going through different group developmental stages from the time they entered the initial support group (from their first meeting), to the time they became settled members in the initial support group. All four participants described their experiences when entering the initial support group at their first meeting. Each of the participants described feelings of discomfort, with three participants describing some anxiety when they first joined the initial support group. This feeling of anxiety prior to joining the initial support group and as the participants entered the initial support group for the first time is on par with literature on group development, outlined in chapter 2, by Yalom (1995).

Two of the participants (Veronica and Nancy) described that their anxiety and discomfort subsided during the first meeting and that they had a positive experience of their first meeting of the initial support group. They both described that they were more comfortable as they began to realise quickly that the other members of the initial support group had OCD experiences similar to their own. The fact that these two participants experienced their first meeting as a success as they found common ground with the other members is congruent with research from Yalom (1995) regarding the experiences of a first group meeting. The common ground such as the similar OCD experiences that Veronica and Nancy found with the other members of the initial support group also appears to be in line with literature, outlined in chapter 2, by Forsyth (2013) and Yalom (1995) on the concept of universality. Veronica and Nancy both found the initial support group to be a place where they could fit in and belong. This sense of belonging is also in accordance with research from Steketee and Pigott (2006) who describe that universality may be an important benefit of OCD support groups as it may lead to an individual feeling accepted and not isolated. After

the first meeting, the sense of belonging continued for both Veronica and Nancy throughout their initial phase in the initial support group. It appeared as if their early experiences of a sense of belonging and finding common ground negated any experiences of hostility within the initial support group, which often characterises the second stage of attending a group, according to literature, outlined in chapter 2.

The other two participants' (Nick and Frank) experiences of their first meeting in the initial support group were not a success, which is contrary to literature from Yalom (1995) stating that the first meeting is invariably a success. Frank described that his early experiences of the initial support group were negative as he could not see the relevance of the initial support group for himself, since he was getting similar information on OCD in his individual therapy. He left the support group due to the support group not being relevant and helpful to him at that stage. Frank dropping out after his first meeting is in accordance with the high drop-out rates early on in group development as suggested by literature from Yalom (1995), outlined in chapter 2. Frank did, however, attend the initial support group again at a later stage as he appeared to need all the help he could get, and he realised the relevance of the initial support group to himself (which will be described later). Nick also had a negative experience of his first initial support group meeting. His anxiety levels were high arriving at the first initial support group meeting which had an impact on his experience, but his initial anxiety appeared to heighten further as he also arrived late to the first meeting. This lack of punctuality early on in his group attendance also showed Nick's mixed feelings toward joining the initial support group as outlined by literature from Yalom (1995), as Nick wanted help for his OCD but he was not entirely sure of the benefit of the initial support group to himself. Unlike Frank, Nick did not drop out of the initial support group, but he persisted. Nick reports that he persisted with the initial support group despite his mixed feelings as he found some relevance to the initial support group, that of obtaining information on OCD and being able to observe other members of the group interacting, both of which he reported to enjoy. Both Frank and Nick's search for the relevance of the initial support group to their primary goal of getting help for their OCD symptoms is in line with literature by Yalom (1995), outlined in chapter 2.

In accordance with Veronica and Nancy, Nick and Frank did not experience hostility in their journey to becoming settled members in the initial support group. However, in contrast to Veronica and Nancy who benefited from experiencing

universality at an early stage, Nick and Frank's adjustment to the initial support group after the first meeting appeared to be hampered by the open boundaries of the initial support group. According to Nick and Frank, due to the open boundaries of the initial support group, there was initially a lack of stability and consistency surrounding the members attending the initial support group. The lack of consistency of members attending the initial support group impacted on Frank and Nick in that they did not have sufficient time to engage with the other members in order to build positive relationships. The lack of stability in the initial support group can be described as the group being non-homogenous. The open boundaries allowed for family members of individuals with OCD to attend the initial support group, and these two participants lacked trust and could not speak freely, as they believed family members did not understand what an individual with OCD actually experiences. The non-homogenous group also included children, and these two participants reported that the content of some of their obsessions was not appropriate to disclose when children were present in the group. They therefore initially had superficial relationships with the other members of the initial support group and did not trust them enough to divulge their OCD symptoms to them, which is in accordance with literature by Nakashima et al. (2013), outlined in chapter 2.

From a systems perspective, Nick and Frank blaming the open boundaries for their superficial relationships with other members in the group, may have been a linear way of viewing their early interactions in the initial support group as interactions are recursive (Becvar & Becvar, 2009). Therefore, Nick and Frank's lack of divulging their OCD symptoms may also have impacted on the other group members, in the process further perpetuating distance and superficial relationships. Recursively, this lack of divulging personal experiences may also have impacted on the quantity and quality of emotional support the members give to and receive from these two participants, which may have in turn impacted on each of these two participant's lack of trust in the other members.

Despite the open boundaries of the support group, experienced as a limitation by these two participants, their initial superficial relationships with members of the initial support group and in turn lack of early group cohesion, fit Yalom's (1995) research which states that group cohesion usually only develops at a later stage in the group formation. Semrad (cited in Yalom, 1995) continues that in the initial stages of group formation the content and communicational style are often restricted and

superficial, with many of the members searching for similarities. It therefore appears as if Veronica and Nancy found similarities within the support group quicker than Nick and Frank, despite the open boundaries of the initial support group.

The participants all mentioned that despite the open boundaries of the initial support group, they all eventually began to experience that there were a few members who attended the initial support group regularly and with whom they started to build relationships. These members got to know each other and formed a subgroup within the initial support group. The subgroup helped to bring about trust between these members and in turn group cohesion in the subgroup. According to both Forsyth (2013) and Yalom (1995), group cohesion is found in groups with members who have a high regard for mutual understanding as well as acceptance of others. These authors continue by stating that without group cohesion members will attend the group less frequently. This appears to be evident of the members experiencing the third stage of group development, called group cohesion, according to Yalom (1995), or the norming stage of group development described by Tuckman (1965). In these stages group cohesion develops between the members and there is an increase in morale, mutual trust, and self-disclosure. The participants beginning to experience group cohesion and trust in the other members is also in line with research from Agazarain and Gantt (2003) who highlight that group members go into the intimacy phase, which means that the members are concerned with their relationships with each other and become close, with some group members becoming good friends. These members can share intimate information with each other.

It is not, however, clear as to whether the whole initial support group had experienced group cohesion or whether it was only the participants in the subgroup who developed trust and group cohesion as all the participants in this research study became part of the subgroup. The participants in the subgroup were attracted to each other and the other subgroup members as they found common similarities such as their commitment to attending the initial support group meetings, they were all of a similar age, and they all had a goal-oriented mindset in trying to get their OCD symptoms under control. Yalom's (1995) findings on subgroup formation highlight the subgroup formation in the initial support group as he states that subgroup formation is inevitable in a group formation. Members who perceive themselves as similar in certain aspects gravitate towards each other and form coalitions or subgroups. He continues to state that subgroups can be disruptive to the bigger group

but they can also enhance the bigger group and be therapeutically effective. A subgroup enhances the bigger group when the goals of the subgroup align with the goals of the bigger group, and the members of the subgroup are open and honest with each other.

#### ***5.3.1.4 Themes related to the beneficial aspects of continuous membership***

Findings from this study indicate that all four participants in this study joined the initial support group in order to bring about a change, such as get their OCD symptoms under control and improve their functioning. This commitment to change by joining the initial support group is in line with literature conducted by Lieberman (1979), outlined in chapter 2. The participants' intentions for change by joining the initial support group are confirmed by Yalom (1995) as he mentions that there are common therapeutic factors in operation in the change-promoting process of a group. Some of these change-promoting factors are mentioned by the participants, and are relevant to the initial support group and to the participants' goals of getting their OCD symptoms under control and improving their functioning.

As described in section 5.3.1.2: Themes related to the participants' experiences of the nature of the group, the initial support group was primarily based on psychoeducation around the topic of OCD. All the participants mentioned that the longer and the more frequently they attended the initial support group, the more information they gained about OCD and the treatment of OCD. This is similar to literature described by Forsyth (2013) and Yalom (1995), outlined in chapter 2, that a change-promoting factor of groups is that groups are sources of information and education. The participants stated that the information gathered about OCD did bring about some form of change as they were thinking differently about the OCD symptoms they were experiencing, and had learned about certain techniques that they could apply in their attempt to reach their goals of getting their symptoms under control and improving their functioning.

Two participants gained an understanding and insight into their OCD symptoms. The understanding and insight developed from gaining information about the OCD symptoms. As discussed in section 5.3.1.2: Themes related to the participants' experiences of the nature of the group, the participants obtained information about OCD, mainly from an expert in OCD, but also from discussing their symptoms and experiences with other members of the group. The participants gaining understanding and insight into their OCD symptoms in a group from an

expert or from multiple group members is in line with literature described by Forsyth (2013), outlined in chapter 2.

Two of the participants also mentioned that gaining the information about OCD empowered them. This empowerment related to the participants' ideas that they felt that they now had the tools (CBT techniques, such as ERP) necessary to address their OCD symptoms, and that they could also benefit other people suffering from OCD as they could pass their knowledge about these tools on to others. This feeling of empowerment derived from communication and information provided in the initial support group about tools to be successful in recovery, is in accordance with literature conducted by and Fletcher (2003), outlined in chapter 2. This feeling of empowerment and the resultant benefits these participants realised they could provide to others, therefore also seems to fall in line with research from Forsyth (2013), Steketee and Pigott (2006), and Yalom (1995) about altruism. They state that altruism is an added value of groups as the individual enters groups considering themselves burdens, looking for help, and believing they have nothing to offer other people; but they soon realise that they do have something to offer, and their self-esteem rises. However, the initial support group did not seem to provide a space in which these participants could feel as if they were taking the control of their OCD symptoms into their own hands as well as being of benefit to others in helping to get their OCD symptoms under control. Therefore, the information on OCD was beneficial to the participants, but once they got to a point where they had absorbed a sufficient amount of information on OCD, they wanted to put this information into practice and help others put this information into practice.

One participant described that the information obtained from committed membership in the initial support group was that the information broke the stigma he perceived to be surrounding a diagnosis of OCD. Overcoming the stigma around a mental illness, such as OCD, as a therapeutic value of support groups is highlighted by literature from Forsyth (2013), Steketee and Pigott (2006), and Yalom (1995), outlined in chapter 2.

Having spoken of the value of the information the initial support group provided, all four participants described that they reached the point where they needed to be more active in putting the ERP techniques, which the clinical psychologist was teaching them in the initial support group, (for one participant the same information in individual psychotherapy) into practice. According to Anderson and Rees (2007),



Gellatly and Molloy (2014), Rossouw (2012), Thiel et al. (2014), and Van Niekerk (2009), the most effective psychotherapy for OCD has been shown to be CBT, with ERP being part of the behavioural aspect (Abramowitz, 2006). As discussed in chapter 2, the CBT treatment therefore involves both the cognitive aspect as well as the behavioural aspect (Abramowitz, 2006; Clarke, 2004; Westbrook et al., 2007). The initial support group, with a focus on psychoeducation around OCD, thus provided participants with the cognitive aspect of the CBT treatment, and the participants were now looking for a space to carry out the behavioural aspect of the CBT treatment.

From a systems perspective, it appears as if the participants acquired ample information in the initial support group for them to step out of the one-down position in the group (Becvar & Becvar, 2009). The avenue the participants reported to use to step out of the passive one-down position was to be more active and implement the ERP techniques. However, they struggled with this as the structure of the system (initial support group) did not provide opportunities for them to put into practice what they had learned. From a systems perspective, the initial support group stays in homeostasis (Hoffman, 1981) as a psychoeducational support group as it was only the core subgroup of individuals who had the desire to implement the ERP techniques and not all the members of the initial support group. The initial support group also has potential benefits as a psychoeducational group for other members joining the initial support group. The members therefore co-created another system, a sub-support group (which will be discussed in Section B), in order to apply the behavioural aspects of CBT and to get their OCD symptoms under control as well as help other members get their OCD symptoms under control.

### **5.3.2 Section B: Sub-support group for OCD formed and run by individuals with OCD**

At the time of the interviews, all four participants spontaneously mentioned that they attend or have attended another OCD support group that they themselves formed and ran. As stated above in section 5.3.1.4: Themes related to the beneficial aspect of continuous membership, from a systems perspective, the participants and the other members of the core subgroup did not challenge the homeostasis of the initial support group to meet their needs regarding the implementation of ERP techniques. They did not challenge the homeostasis of the initial support group as the members of the core subgroup were not the only members of the initial support

group, and the structure of the initial support group was that of a psychoeducational group, which could be beneficial for other members of the initial support group who require information about OCD (Becvar & Becvar, 2009; Hoffman, 1981). The participants and a few other members (all members of the core subgroup) co-created another system, which will be called the sub-support group. The sub-support group, formed and run by individuals with OCD who are not mental health professionals, is in line with literature by Forsyth (2013), outlined in chapter 2, who calls these groups run by laypersons, self-help groups, where the responsibility lies on each and every member, particularly members who have been part of a group for a long period of time. Yalom (1995) also highlights support groups having no formal leader and the members relying on each other, and he calls these groups self-directed groups. He states that often these groups arise out of formal, leader-led groups due to the members requiring a less inhibiting space than that which a leader-led group may be able to provide for them. This is in line with what the participants described in section 5.3.1.4: Themes related to the beneficial aspect of continuous membership, about the initial support group being a limiting space, due to them not being able to carrying out exposures in the initial support group.

Along with different types of support groups such as leader-led groups described by Yalom (1995), or self-help groups described by Forsyth (2013), Forsyth (2013) also identifies two other types of groups, namely therapeutic groups and interpersonal learning groups. He states that interpersonal learning groups are groups that focus on members getting a better understanding of themselves as well as providing a space for members to enhance their interpersonal relationships. On the other hand, Forsyth (2013) describes that therapeutic groups provide members with a space in which they can overcome their psychological difficulties. One of these therapeutic groups that Forsyth (2013) describes is a CBT group in which the principles of individual CBT psychotherapy are applied to a group of individuals. Forsyth (2013), having described the different types of groups, highlights that it is difficult to clearly distinguish between a support group such as a self-help group, an interpersonal learning group, and a therapeutic group as they often share several characteristics. This appears to be evident in the sub-support group in this research study as the sub-support group can be regarded as a self-help support group in which the members provide each other with information and emotional support, but there are

also elements of an interpersonal learning group present in the sub-support group; participants state that they obtained a better understanding of themselves and they built relationships within this group. The sub-support group also tended to have prominent elements of a therapeutic group, in particular that of a CBT group as outlined by literature from Forsyth (2013), described in chapter 2, as the participants describe applying the underlying principles of individual CBT for OCD in the sub-support group context. Literature by Anderson and Reese (2007), outlined in chapter 2, is also in accordance with the use of individual CBT techniques within a CBT group format, and is further evidence of the sub-support group portraying characteristics of a CBT therapeutic group. The sub-support group of this study contains elements of both an interpersonal learning group and that of a therapeutic group, which seem to be prominent distinguishing features between the sub-support group and the initial support group, with a specific focus on psychoeducation.

Chronologically, the sub-support group materialised after the initial support group but these two support groups run concurrently. They are separate groups as the meetings occur at different days and times each month, but they are also linked as the sub-support group emerged from the initial support group. The members who attend or have attended both groups following the same underlying paradigm of CBT in the sub-support group, as is the case in the initial support group. The sub-support group appears to also be a space for the members to provide each other with emotional support; however, the sub-support group tended to focus mainly on the implementation of CBT techniques, such as ERP, acquired in the initial support group. The initial support group appeared to focus on the cognitive aspects of CBT for OCD which included education on various aspects and domains of OCD, whereas the sub-support group seemed to take the next step and focused on the behavioural aspect of CBT for OCD. The participants' experiences of the sub-support group will be elaborated on in this section.

### ***5.3.2.1 Theme related to the motivation to become a member of the sub-support group***

As described in section 5.3.1.3: Themes related to the evolution of becoming a settled member, a core subgroup of about six or seven people was formed within the initial support group. These subgroup members gravitated towards each other as they all had an aggressive mindset and were goal-oriented in their pursuit of getting their OCD symptoms under control. They were also all of similar ages, and were

committed to the initial support group. These core subgroup members all had the same primary goal as the bigger initial support group, which was to get their OCD symptoms under control and in turn improve their functioning. This was important as Yalom (1995) suggested that for a subgroup to be effective, the primary goal of the subgroup should be in line with the primary goal of the bigger group. However, through the information obtained about OCD and the treatment of OCD in the initial support group, the way in which the participants believed they could achieve their primary goal shifted. They were motivated by the information they were getting about ERP techniques in the initial support group, and wanted to become more active in implementing this information. Instead of listening to the theory of how to carry out ERP techniques (exposures), these members became motivated to practically carry out the exposures and to take hold of their symptoms, lining up with the behavioural aspect of CBT, as described by Abramowitz (2006) and Clarke (2004), outlined in chapter 2.

Initially, two members of the core subgroup (Veronica, a participant in this study; and Paul, not a participant in this study) formed a coalition and began putting the ERP techniques into practice outside the initial support group meetings. This is in line with findings by Yalom (1995) stating that two members who perceive themselves to be similar in certain aspects within a group often form coalitions within that group. According to Veronica, she and Paul found similarities in each other as they had been in the initial support group for the longest period of time (both joining on the opening night), and had reached a point where they wanted and needed to put the ERP techniques into practice. However, they required each other's support in order to be encouraged to carry out their exposures. This is in accordance with the findings of Davison et al. (2000) who commented that an individual going through a difficulty in his/her life goes through suffering and powerful emotions and therefore requires support to help reduce the suffering and deal with the powerful emotions. The support an individual requires when going through a difficulty in his/her life, according to Forsyth (2013), can be interpersonal exchanges that provide an individual with tangible assistance, emotional support, guidance, and advice. Veronica described that she and Paul together formed the coalition, and enjoyed meeting to carry out exposures thus providing each other with tangible assistance, emotional support, guidance, and advice. It is evident that these two members attempted to achieve their primary goal of getting their OCD symptoms under control

and improving functioning through ERP techniques, which are highlighted by Abramowitz (2006) and Clarke (2004), outlined in chapter 2, but also with a focus on a comfortable social relationship between them where they could achieve support in the form of tangible assistance, emotional support, guidance, and advice. Trying to achieve their primary goal of getting their OCD symptoms under control and improving functioning, but also focusing on their secondary goal of achieving the primary goal in a comfortable social environment, are in line with findings from Yalom (1995), outlined in chapter 2.

These two members could not be considered a group as they were only two individuals at that time meeting to carry out exposures. This is in accordance with the literature on group size described by Budman et al. (1988), Chesler and Barbarin (1987), and Faulkner et al. (1995), outlined in chapter 2, namely that a meeting of less than three or four members is not sufficient to constitute a support group meeting as this may take on the characteristics of individual therapy instead of group principles. According to Veronica, she and Paul subsequently shared their experiences of carrying out exposures with the other core subgroup members, explaining to them the exposures they had been carrying out and how effective it had been. Veronica and Paul sharing their activities and their successes with the other core subgroup members is reflective of an effective cohesive subgroup. Yalom (1995) states that for subgroups to be therapeutically effective and to enhance group cohesion, any activity within the subgroup or between coalitions should be highlighted and brought to the attention of the other members of the group or subgroup. This is what these two members did, while at the same time suggesting that they (the core subgroup) meet together as a group to carry out exposures.

The other members of the core subgroup within the initial support group agreed to meet as a separate support group (sub-support group) to carry out exposures. The three other participants in this study highlighted that their reasons or motivation to become members of the sub-support group were similar to Veronica's motivation to meet separately to carry out exposures. They were motivated to become members of the sub-support group through their desire to achieve their primary goal of getting their OCD symptoms under control, and in turn improve functioning through carrying out ERP techniques whilst in a comfortable social context that provided them with emotional reassurance, tangible assistance, guidance, and advice.

From a systemic perspective, Veronica and Paul appeared to provide new information regarding their successful meetings to implement the ERP techniques, into the system (core subgroup). This new information is a deviation in the core subgroup, and if the members opposed this new information the core subgroup would have displayed a negative feedback loop process; however, the members accepted the deviation and allowed for change in the core subgroup's structures such as meeting separately to carry out exposures, and displaying a positive feedback loop process (Goldenberg & Goldenberg, 2013). The core subgroup required restructuring and became a sub-support group.

### ***5.3.2.2 Themes related to the pragmatic nature of the group***

From a systemic standpoint, exploring the interactional patterns of behaviour can identify the structure of a system. The interactional patterns of behaviour highlight the rules and boundaries of the system as well as the different roles members of the system occupy. The structure of a group (system) is particularly important in understanding how a group operates. The structure of the group lays the foundation or the context in which the members of the group and the group as a whole functions (Becvar & Becvar, 2009). It was evident from all four participants' interviews that the structure of the sub-support group is different from the structure of the initial support group, which is in accordance with Goldenberg and Goldenberg (2013) who state that the structure of a group makes a group distinct from other groups. The structure of the sub-support group is important as it set the context within which the members interacted. This space had been co-created by the members. Each of the four participants agreed on the overall structure of this sub-support group.

Even though Veronica and Paul told the other members of the core subgroup in the initial support group about the exposures they were carrying out, the sub-support group was only formed when all the members (six or seven of them) began to meet to carry out exposures, as explained in section 5.3.2.1: Theme related to the motivation to become a member of the sub-support group. When the sub-support group commenced, there did not appear to be one formal leader or gatekeeper within this sub-support group. The sub-support group members as a whole became the collective gatekeeper for the sub-support group and specified the requirements for gaining access to the sub-support group. Chesler and Barbarin (1987) highlight the importance of a gatekeeper as in their opinion the gatekeeper will initially specify the requirements of gaining access to a group. Pierce et al. (1996) indicate that in a group

with no formal leader the gatekeeper position can be fulfilled by multiple members of the group or the whole group. .

Findings from Chelser and Barbarin (1987), outlined in chapter 2, also describe that joining a group may be easy if a group has open boundaries but may be more difficult if a group has closed boundaries. The participants described that they saw how the open boundaries of the initial support group affected group stability and therefore wanted to make the sub-support group a more exclusive group. Yalom (1995) highlighted that open groups do not necessarily require stability from the members, but that closed groups both require and foster stability. The members therefore decided to implement a sub-support group with closed boundaries which, according to Chesler and Barbarin (1987), is a group that accepts no new members once the group has formed. However, even though the sub-support group did not accept new members, the participants did describe that they were willing to accept new members but that the new members would be required to go through a screening process to assess whether they meet the requirements of the sub-support group that would keep the group homogenous. The members requiring a new member to go through a screening process before that new member is given permission to join the sub-support group, in order to maintain the homogeneity of the group, is again in line with research from Chesler and Barbarin (1987), outlined in chapter 2.

The requirements to keep the sub-support group homogenous are that the group should remain a small group of individuals suffering from OCD who are committed to the sub-support group. This is in accordance with the research findings of Budman et al. (1988), Chesler and Barbarin (1987), and Faulkner et al. (1995), outlined in chapter 2. These authors suggest that the bigger the group, the less desirable the group may be for members as they each get less time for their problems, which in turn may lead to members not attending meetings and some members dropping out of the group. The participants experienced that the benefit of the closed boundaries for the sub-support group was that it provided a space for the members to be open and honest about their OCD symptoms and to be able to trust each other, thereby being more therapeutically beneficial. Findings from Barak et al. (2008) concur with the participants' beliefs as they state that closed boundaries of a group allow for a safe space for individuals to share their feelings with other people who have similar experiences.

As described in section 5.3.1.3: Themes related to the evolution of becoming a settled member, the individuals of the core subgroup within the initial support group began to develop group cohesion. As the sub-support group only consisted of members from the core subgroup with no new members attending the sub-support group due to the closed external boundaries (Chesler & Barbarin, 1987) of the sub-support group, the members knew each other, and were able to start their group development from the advanced third stage of group development described by Yalom (1995). This included group cohesion, also known as the norming stage of group development described by Tuckman (1965). Tuckman (1965) describes that within the norming stage, roles and responsibilities are clear, and consensus forms around the roles members occupy. However, even though the initial support group and the sub-support group are linked and there appeared to be group cohesion in the sub-support group, the members' roles and responsibilities were not clear at this stage as this was a newly formed group with structures different to those of the initial support group. The sub-support group, being structurally different to the initial support group, is in line with findings by Forsyth (2013) that no support group will have the same structure and procedures as another support group. A big difference or change in the structure between the two support groups is that the sub-support group does not have a mental health professional taking on the leadership position in the sub-support group. Daka (2005) also highlights that each support group is its own social system due to the varied relationships between the members; while Steyn and Uys (1998) remark that each member of a support group will have certain role expectations within the support group. Steyn and Uys (1998) continue by stating that these roles may be different from group to group due to each support group being distinct. From a systems perspective, these roles are also not necessarily static within a group, and different members of the group may fulfil certain roles within the group at different times (Haley, 1963).

Therefore, the participants specifically call this second group *our group*. This again signifies that the leader of the initial support group (clinical psychologist) is not the leader or gatekeeper of the sub-support group. The members who are all OCD sufferers started this sub-support group, after having been members of the linked initial support group for an extended period of time, and they themselves keep this sub-support group going. The members of the sub-support group, who were members of the initial support group for a significant period of time, beginning to lead the sub-



support group, is in accordance with the research findings by Yalom (1995), outlined in chapter 2. The members of the sub-support group not being health professionals and running the sub-support group themselves after a lengthy attendance in the initial support group, also falls in line with literature identified by Forsyth (2013) who stated that support groups can be run by laypersons. The longer individuals remain in a group, the more knowledgeable they become on that group topic. The obligation then falls on these members to take on a leadership position.

Agazarian and Peters (1981), Donigian and Malnati (1997), and Durkin (1981) all believe that therapy within a group format occurs due to the interactive process between the leader, the individual members, and the group as a whole. All three of these elements are interconnected and need to be considered in relation to each other. Therefore, it should be kept in mind that a change in one of these elements will bring about a change in both of the other two elements as well as the therapy carried out as a whole in the group. From a systems perspective, this interconnection of the leader, the members of the group, and the group as a whole, highlights the important concept of wholeness, that to understand the behaviour in the sub-support group, the whole system should be focused on as each individual's behaviour in the sub-support group is mutually influenced by the other members of the sub-support group as well as the sub-support group context as a whole (Watzlawick et al., 1967). The sub-support group not having the clinical psychologist as the leader prompted a new leader, which prompted a change in interactions between the members, and in turn the therapy.

Even though initially in the sub-support group all the members took on leadership or gatekeeper positions, Veronica specifically appeared to take on the role of leader in the sub-support group as she was doing both the administration and organising/running the sub-support group meetings. This is in accordance with Yalom's (1995) findings that in self-directed groups a natural leader will often become apparent from the ranks of the members and take on the leadership role even if he/she is a layperson. Yalom (1995) continues by stating that the natural leadership position requires someone who will be present at every meeting, has suffered from or is suffering from the common problem in the group, and knows how to handle or treat the common problem. These findings from Yalom (1995) appeared to be present with regard to Veronica as she had been in the initial support group for a significant period of time, was present at the majority of meetings, suffered from OCD, and knew the therapeutic techniques required for an OCD exposure. She had also been doing the

administration in the initial support group and she therefore naturally took on this administrative role and the organising/leadership role in the sub-support group.

However, as stated above, the sub-support group is a different system and it may have required members to occupy roles different to those they occupied in the initial support group. These different roles need to be accepted by the individual occupying the role and the other members of the group. The individual taking on the role of leader and the other members of the system needing to accept that individual's role of leader in the group as well. From a systemic perspective, this is suggestive of Haley's (1963) findings that roles within a group need to be mutually influenced by the individual as well as the group as a whole. Veronica initially and naturally took on these roles, but I hypothesise that the other members of the system did not fully accept Veronica in these roles. These roles were removed from Veronica by the other sub-support group members without consulting her, and even though the roles were removed with her welfare in mind, she felt *dequeened*. Frank and Nick then took on Veronica's previous roles. They took on these roles and tended to lighten the load, but more importantly, these roles were now mutually acceptable by both the group members and the members taking on these two roles as the members asked Frank and Nick to occupy these roles, and Frank and Nick accepted the offer. Two new natural leaders emerged once Veronica had vacated that role. From a systemic standpoint, as described by Hoffman (1981), the leadership roles evolved but eventually a new homeostatic plateau appeared within this sub-support group with the loss of Veronica as an overt leader and the emergence of Frank occupying the overt leadership position, with Nick in the form of a "sub-leadership" position to Frank in the sub-support group.

Despite the evolving leadership roles, the sub-support group seemed to develop quickly from the third stage of group development described by Yalom (1995) as group cohesion to a mature working group described by Yalom (1995) as the final stage of group development or what Tuckman (1965) describes as the performing stage of group development. According to Tuckman (1965), the members in this stage become autonomous and do not lean on the leader; they look to each other for help. Yalom (1995) is of the opinion that during this stage the members rely heavily on teamwork to reach the group's goals as well as their own. This is also in accordance with the group developmental stage of interdependent work phase as described by Agazarian and Gantt (2003), in which the members of a group realise that to achieve

their goals they need to work as a team and take responsibility for their roles in the group. The interdependent work phase of group development described by Agazarian and Gantt (2003), the performing stage of group development described by Tuckman (1965), and the mature working group stage of group development described by Yalom (1995), are evident as the sub-support group is described as being goal directed, as the members' primary goal is to get their OCD symptoms under control and improve functioning, and this is achieved by working as a team. The members of the sub-support group believe they can achieve this ultimate goal by carrying out smaller goals, which are each and every OCD exposure they carry out on their exposure hierarchy, as explained in the literature of Abramowitz, (2006), Clarke (2004), and Rossouw (2012), outlined in chapter 2. However, the members of the sub-support group also have another primary goal and that is to help their fellow group members get their OCD symptoms under control. The sub-support group members do that by creating and carrying out exposures in the sub-support group not only for themselves but also for their fellow sub-support group members. By creating and carrying out exposures together, the sub-support group members help to run the sub-support group as a team. If a group member is not involved in creating or carrying out an exposure, the exposure may not be, as the participants call it, *spot on*, meaning it is not a team effort.

The members of the sub-support group working as a team and requiring each member to play his/her interdependent part in the team (system), in order for the system to function to its maximum capacity, meaning well-thought-out, creative and effective exposures, highlights the systemic concept of wholeness described by Watzlawick et al. (1967), outlined in chapter 2.

Agazarian and Gantt (2003) and Tuckman (1965) describe that during this independent work phase or performing stage of group development, the members have a clear vision of how to achieve their ultimate (primary) goals. This is evident in this research study as the participants described that CBT, in particular being more active in implementing ERP techniques, was the way they would ultimately achieve their primary goals. Forsyth (2013) also highlights this clear vision of how to achieve an ultimate goal within a support group when he states that support groups are perspective-based, meaning that they find specific ways to counter the common problem in the group. Yalom (1995) explains that once the members of a group have a clear vision of how to achieve their primary goals, they then decide whether their

goals will be achieved through structured or unstructured meetings or activities. Yalom (1995) continues by saying that the underlying paradigm is often the deciding factor as to whether the meetings or activities of a group are structured or unstructured. As described in this research study, the underlying paradigm of this sub-support group is CBT, specifically ERP. Literature from Abramowitz (2006) and Clarke (2004), outlined in chapter 2, implies that ERP is quite a structured activity. Accordingly, all four participants underscore the format of each sub-support group meeting, and they mention that each meeting is quite structured, with the majority of the meetings dedicated to carrying out structured exposures. The exposures are similar to how Abramowitz (2006) and Clarke (2004) describe ERP for individual psychotherapy, where an exposure hierarchy is drawn up and an individual confronts each obsession on the exposure hierarchy by deliberately exposing him-/herself to that obsession and refraining from carrying out a compulsion. The difference between carrying out the exposures in individual psychotherapy and in the sub-support group is that in the sub-support group the members carry out the same exposures as they would in individual psychotherapy; however, in the sub-support group they are surrounded by supportive individuals, which is in accordance with the findings of Andersen and Reese (2007), outlined in chapter 2. Steketee and Pigott (2006) also highlight carrying out exposures for OCD in a group format when they state that in CBT group psychotherapy for OCD, a group member's goals line up with what their goals would be in individual CBT psychotherapy, particularly their goals in an exposure hierarchy and then that group member tries to reach those goals within the group or as homework.

I hypothesise, as no literature could be identified, that the other difference between carrying out exposures within individual psychotherapy and carrying out exposures in a group context, is that in individual psychotherapy the individual will get to tackle an exposure on their hierarchy each time they go for a psychotherapy session, but in a group context the members would not be tackling an obsession of theirs every time they meet. The participants described that in the sub-support group context, they would each only tackle one obsession or carry out one exposure for themselves every six or seven weeks. The participants mentioned that carrying out one exposure every six or seven weeks, due to the group only conducting one exposure for one member during each sub-support group meeting, tended to slow down their individual therapeutic progress in trying to get their OCD symptoms under

control. However, the members of the sub-support group discussed this delay in individual therapeutic progress (due to only one exposure for one group member per sub-support group meeting) openly and honestly, and through discussion they were able to change the structure of how they carried out exposures in a sub-support group meeting. The members decided that in each sub-support group meeting more than one sub-support group member's obsession would be the focus of an exposure, by being creative and allowing as many members of the sub-support group as possible to carry out an exposure as often as they can. The members being able to openly discuss the individual exposure problem in the sub-support group meetings and that this problem was addressed, again highlights the sub-support group being in the mature working group developmental stage that Yalom (1995) describes. According to Yalom (1995), during this stage the members tend to disagree but they work through the problem in a positive way and make the necessary changes to either process or structure. Therefore, the sub-support group members are able to work towards their primary goals while at the same time attending to any difficulties in the group structure.

From a systemic viewpoint, the sub-support group was earlier described as having closed boundaries; however, with the sub-support group members, being able to discuss the delay in their individual therapeutic progress openly and the other members accepting the problem as a problem, displays signs of the sub-support group having a balance between open and closed boundaries as the sub-support group requires open boundaries in order to allow new information into the sub-support group system (Becvar & Becvar, 2009). The changing of how the sub-support group members carry out exposures during each meeting, going from one exposure for one person per sub-support group meeting to exposures that involve multiple members, is a change in the structure of the sub-support group. This change in structure of the sub-support group, pertaining to a problem experienced by the sub-support group members, signifies a second-order change as stated by Watzlawick et al. (2011), outlined in chapter 2.

According to Yalom (1995), during the mature working developmental stage the members of a group are also able to work through any relationship issues. As with the structure of the group, this requires openness and honesty. The participants appear to be open and honest with each other and the other group members as is evidenced by the amount of feedback they give each other in the sub-support group. The participants give each other and the other group members feedback about their

interactional styles as well as anything relating to their OCD symptoms. They are also comfortable receiving feedback, which demonstrates that they trust each other. Imparting effective feedback in the sub-support group is in accordance with literature from Forsyth (2013) and Yalom (1995), outlined in chapter 2, who mentioned that feedback is integral as interpersonal relations play an important role in support groups. According to the systemic viewpoint, people are part of the social environment and must be considered within their interpersonal relationships (Watzlawick et al., 1967). Considerable self-knowledge is gained socially as people draw conclusions about themselves and their behaviours by observing others and monitoring their reactions to them. Therefore, the members of the group serve as corrective guides to each other within the sub-support group system, which is a process in accordance with the systemic principles discussed by Becvar and Becvar (2009) regarding feedback, outlined in chapter 2. However, for guidance to occur effectively through both the providing of feedback as well as the receiving of feedback, the members need to build up trust. Nakashima et al. (2013) point out that the more individuals seek out help, the more help they will receive and the more trusting they will be of others to give them help. The more trusting they are of others, the more they will seek out help. It does appear that the participants have built up enough trust between themselves to provide each other with effective feedback in a safe, non-judgmental space. This feedback is a way the members provide help for each other and again signals a cohesive sub-support group, as is similar to findings pertaining to groups and group cohesion by Forsyth (2013) and Yalom (1995), outlined in chapter 2.

The idea behind carrying out exposures and both giving and receiving effective feedback is to possibly induce some form of change. Within the sub-support group the change would appear to be to get the OCD symptoms of each member under control and to improve functioning. However, this was to be achieved in a social, supportive environment as Clarke et al. (2005) have shown that support also helps to motivate and influence a positive behaviour change. As can be seen in section 5.2:

Background, under family background and interpersonal relationships, all four participants described a lack of social support; however, the participants described that the sub-support group context is different as it was a safe, non-judgmental space in which the members could both provide and receive the necessary support to give

and receive feedback and implement ERP techniques effectively in order to make the change of getting their OCD symptoms under control and improving functioning.

Pierce et al. (1996) suggest that the way support is supplied is important. When giving and receiving support, both the recipient and the provider should be ready to accept and receive the support. This appeared to be evident in the sub-support group as the members felt a sense of universality (Forsyth, 2013; Steketee & Pigott, 2006; Yalom, 1995) and therefore felt a sense of understanding or insight (Forsyth, 2013) and empathy (Stektee & Pigott, 2006) for each other. They were able to put themselves in each other's shoes and understand what support each one required, which is in accordance with findings by Steketee and Pigott (2006) that members are able to learn empathy in a support group due to their role flexibility of being able to both provide and receive support and advice. Cutrona and Russell (1987) have also shown that in supportive relationships individuals experience higher levels of satisfaction when they receive as well as provide social support. Individuals in a relationship are both a source and a recipient of social support. Giving and receiving support are not isolated events. By giving support to another person, the individual who is giving the support is at the same time receiving support from that person they are giving support to. Therefore, by providing social support to another person helps manifest and maintain healthy functioning and in turn increases both individuals' self-esteem, which is in accordance with literature outlined by Forsyth (2013), described in chapter 2. From a systemic perspective, support is seen as a recursive process as both the giving and receiving of support mutually influences both the giver and the receiver of the support. Forsyth (2013) also mentions that most support groups are communal and provide a sense of community to the members. The members take on more responsibility for the success and failure not only of the sub-support group as a whole but also of each individual member within the sub-support group. This can be therapeutically beneficial. The literature above seems to reflect the participants' descriptions that they both give and receive support in the sub-support group. They described that both giving and receiving of support is beneficial to each other, and they tended to experience a sense of satisfaction when both giving and receiving support. This appeared to be therapeutic for the participants. Forsyth (2013), Steketee and Pigott (2006), and Yalom (1995) also state that the giving of support in a group can be therapeutic in that members learn that they have something to offer other people. They may have a sense of purpose and it is possible that their self-esteem also

improves. It is hypothesised that this sense of having something to offer others may also have been prevalent in the sub-support group as the participants are seen as being the IP in their families of origins (outlined in section 5.2: Background, under family background and interpersonal relationships) outside the sub-support group context, and they may feel as if they are a burden to others and have a lack of being needed. The giving of support and advice in the sub-support may have proven to the participants that within the sub-support group they are not a burden but are actually needed.

The giving and receiving of support within the sub-support group therefore appeared important, but it also appeared as if the type of support provided in the sub-support group was significant. McGuire (2007), Thoits (2011), and Uchino (2004), outlined in chapter 2, highlight the types of support by suggesting that supportive behaviour consists of both emotional support and instrumental support. As outlined in chapter 2, McGuire (2007), Thoits (2011), and Uchino, (2004) also highlight that instrumental as well as emotional support may occur simultaneously in a successful supportive relationship, as providing someone with instrumental support may be taken by the recipient as that individual is caring for him/her and hence emotional support is experienced. In line with the findings by McGuire (2007), Thoits (2011), and Uchino (2004), the participants described the support they receive in this group to be both emotional and instrumental. They described the instrumental support as members setting goals for each other, insisting that they each implement exposures, and guiding each other and giving each other advice through effective feedback. The members also support each other emotionally by providing empathy to the other sub-support group members, particularly when carrying out exposures. The sub-support group members also show emotional support by allowing for catharsis, to take place in the sub-support group in which they can discuss what is happening in their lives and any problems they may be encountering. This is in line with catharsis described by Forsyth (2013) and Yalom (1995) as a therapeutic value of groups, outlined in chapter 2. Again, in accordance with literature outlined by McGuire (2007), Thoits (2011), and Uchino (2004), the participants regard the instrumental support the members of the group provide each other as a sign of emotional support. The participants described that they learned that the way for them to get better is to carry out exposures. These exposures are tough and they often require a nudge from their fellow sub-support group members to implement their exposures. This nudge is



accepted as encouragement and concern expressed by their fellow members, knowing that this will help them get better. This knowledge of the members being there for them is translated into emotional support.

The participants described that the sub-support group context provided them with the non-judgmental space to achieve this mutual emotional and instrumental support. However, the participants also described that the mutual support they provided for each other continued outside the sub-support group context as well, as at times the sub-support group members required support for their OCD symptoms or life problems in general while outside the organised sub-support group meeting times, when they could not wait for the next sub-support group meeting to obtain this support. This mutual support outside the organised sub-support group meeting times, lines up with the findings by Forsyth (2013), suggesting that support may even continue outside a support group context. The members were able to provide this support to each other by staying continuously connected through the use of technology, particularly WhatsApp. Newcomb (1990) was not specifically talking about technology but his findings seem relevant here as he suggested that human connectedness is a crucial element to social support. This also appears to be similar to online support groups as Davis (2008) suggests that members of an online OCD support group are able to get online at any time and give and receive advice or support. The mutual support provided outside the sub-support group context is, however, slightly different in that the members of the sub-support group do not have an official online group, but they have found ways through technology to stay continuously connected, and obtain and provide continuous mutual support. They also meet face-to-face outside the sub-support group setting.

Despite describing the continuous mutual support, the communal nature of the sub-support group, and the participants experiencing universality, having insight and being committed to each other, the sub-support group was not only “clear sailing”, according to the participants. Therefore, the mutual understanding and insight the members of the sub-support group had for each other and each other’s symptoms allowed the members to become quite close and to create an emotionally charged environment as they each knew private and personal details about each other lives. This appeared to be different to the distant relationships the participants experienced outside the sub-support group context (highlighted in section 5.2: Background, under family background and interpersonal relationships). It is hypothesised that these close,

empathic relationships helped to bring about sexual feelings between members of the sub-support group. Yalom (1995) highlights the sexual feelings developing between members of a group when he mentions that subgroups may form within groups, with one type of subgroup often being a sexual relationship within the group. The participants mentioned that two members of the sub-support group did become sexually involved. Three of the participants described that when they found out about the sexual relationship within the sub-support group, they felt betrayed and it disrupted the functioning of the sub-support group as these members involved in the sexual relationship did not tell anyone else in the sub-support group that they were sexually involved and appeared to put their sexual relationship above the goals of the group. This is again in line with findings from Yalom (1995) who mentioned that sexual relationships within groups can cause severe problems and disruptions within the group as the members put their love/sexual relationship above the group and member ties, group goals, and group cohesion. The other members may feel betrayed and often one, or both members involved in the sexual relationships will leave the group. According to the three participants, ultimately, both members involved in the sexual relationship did leave the sub-support group.

The other anomaly the participants mentioned with regard to the structure of the sub-support group was the challenge of being committed to the sub-support group. The participants valued the commitment from each other within the sub-support group (as has been stated above) but it also appeared to place a burden on the participants as the sub-support group meetings became time-consuming, and a substantial part of their lives were dedicated to attending the sub-support group meetings. There does not appear to be any relevant literature available on the time-consuming nature of face-to-face support groups, but Davis (2008) suggested that one reason for online OCD support groups being formed is that members can go online and get support at a time convenient to them. However, despite the time-consuming nature of the sub-support group, the group cohesion and the mature working nature of the sub-support group, as described by Yalom (1995) can again be seen, as despite this challenge and difficulty with commitment, the participants described that they and the other members still arrived at each sub-support group meeting to both provide and receive help and support. It was therefore not a problem to be committed; the challenge was to continuously meet the commitment of the sub-support group.

### ***5.3.2.3 Themes related to the impact of the sub-support group***

The sub-support group provided a space for the participants to do the illogical. Instead of avoiding their OCD symptoms (which is characteristic of the disorder), the participants, with the support of the other group members, acknowledged their unique OCD symptoms and the effects thereof. The participants realised that avoidance of their OCD symptoms and the implementation of compulsions to negate their obsessions are only first-order changes as described by the systems perspective (Watzlawick et al., 2011), as avoidance of symptoms and implementing compulsions lead to short-term, temporary relief of symptoms and the perpetuating of OCD symptoms in the long-term. The avoidance of symptoms and the implementing of compulsions perpetuating the OCD symptoms is in line with literature by Abramowitz (2006) and Rossouw (2012), outlined in chapter 2. The participants realised that to get rid of their OCD symptoms they needed to induce a second-order change, as described by the systems perspective (Watzlawick et al., 2011), which was to implement the ERP techniques. The implementation of ERP techniques (part of CBT) in order to reduce OCD symptoms is in accordance with literature from Abramowitz (2006), Barlow (2010), Clarke (2004), and Rossouw (2012) outlined in chapter 2. Through the implementation of the ERP techniques along with the support of the other sub-support group members, the participants confirmed that they were able to achieve this second-order change. According to DSM-5 (APA, 2013), for individuals to have a diagnosis of OCD they need to display obsessions and/or compulsions and these need to be time-consuming or significantly interfere with the person's normal routine, occupational functioning, or usual social activities or relationships. The participants described that not only have their OCD symptoms faded but their lives have also changed. The participants all reported significant improvement in their functioning, whether at work or in their personal relationships. The participants have therefore negated some of the symptoms of an OCD diagnosis by being part of the sub-support group. Their obsessions and compulsions faded and their daily functioning improved, which is in line with the findings of Abramowitz (2006) that through the use of CBT treatment 70% of individuals with severe OCD return to their normal daily functioning.

However, it must also be kept in mind that three of the participants have had individual psychotherapy and have been on medication for their OCD symptoms concurrently with their attendance in the sub-support group, which may be other

factors that played a significant role in this second-order change. It is hypothesised that the concurrent sub-support group attendance with individual psychotherapy may have helped to decrease their OCD symptoms and improve functioning as the underlying paradigm of the three participants' individual psychotherapy was the same underlying CBT paradigm as the one followed in the sub-support group. This is in line with findings by Yalom (1995), outlined in chapter 2, that if individuals attend individual psychotherapy and a group, the most ideal situation would be that there should be no clash of underlying paradigms between the individual psychotherapy and the group attendance. Despite these other factors though, it is still evident from the participants' transcripts that the sub-support group has been able to create a context in which each of the individuals have undergone some form of second-order change regarding OCD by being part of the sub-support group.

Along with the participants' OCD symptoms fading and their daily functioning improving through getting their OCD symptoms under control, three participants also mentioned that their social functioning in particular improved due to the sub-support group providing a space for the sub-support group members to practise their social skills. The participants described that prior to joining both OCD support groups, they had poor social relationships. This is in line with research from Forsyth (2013) and Yalom (1995), outlined in chapter 2, that individuals who have problems with which they need help, may also have problems in their social interactions. According to Fennel and Liberato (2007) and Heyman et al. (2006), the reasons individuals may struggle with their social interactions are that a disease or illness can be stigmatising, and they may withdraw from social interactions for fear of this stigmatisation. Forsyth (2013) and Yalom (1995) suggest that others may avoid this individual due to the individual having been labelled as a person with a mental disorder and becoming too difficult to get along with. Pierce et al. (1996) also suggested that past relationships influence whether or not an individual seeks out future relationships and that if individuals do seek out future relationships, having had poor past relationships may have a negative impact on the quality of these future relationships. However, Williams (1995) reports that seeking out positive social support can also improve an individual's social skills. These three participants, despite their poor past relationships as well as their impaired social functioning, did seek out social support that they experienced as positive within the sub-support group and therefore gained access to a space to learn and practise their social skills. This social learning also provided the

participants with the first real opportunity to obtain honest and respectful feedback on their interactional style which led to improved future relationships. This is in accordance with literature by Forsyth (2013) and Yalom (1995), outlined in chapter 2. It is evident that the participants have been able to form positive relationships outside the sub-support group with their family members, friends, and boyfriends/girlfriends.

One participant also described that by socialising with other members of the sub-support group, he got to know the members well and realised that they are high-functioning individuals, despite their OCD disorder. This insight allowed by the support group context helped to break down the stigma he perceived to be surrounding a diagnosis of OCD. This is in accordance with research from Forsyth (2013) and Yalom (1995) that the more individuals socialise with others who have been diagnosed with a mental illness the more they may realise that these individuals are not different to themselves. Another participant highlighted that the social skills learned in the sub-support group may also be beneficial for other mental illnesses such as social anxiety.

Along with the sub-support group having an impact on improving the participants' relationships with their family members, friends, and girlfriends/boyfriends, the sub-support group also provided a space for the participants to develop new relationships in the form of friendships with each other and the other sub-support group members. The participants described that these friendships are unique as they developed from friends within the sub-support group context who see each other during the meeting times to friendships with each other outside the sub-support group setting as well. This is in accordance with research done by Forsyth (2013) that support groups are relationship-oriented, which means that the members of a support group learn to trust each other and bonds are formed, which may even continue outside the support group context.

This theme, thus far, has described the positive impact of the sub-support group on the participants. With regard to any negative impact of the sub-support group on any of the participants, the participants mentioned that they could not identify any negative impact on each of them from being a member of the sub-support group. However, three participants described that they are aware of possible "grey areas" within the sub-support group that, according to them, could potentially have a negative effect on each of them and the other members in the future. It appears as if these "grey areas" come about because even though the sub-support group is

classified as a support group by the participants, it developed into a therapeutic group as it became a therapeutic space in which the members could overcome psychological problems which, according to literature from Forsyth (2013), outlined in chapter 2, is characteristic of a therapeutic group. The sub-support group members are also implementing CBT techniques during the sub-support group meetings, which is similar to a CBT group. Forsyth (2013) again mentions that one type of therapeutic group is a CBT group. Forsyth (2013) then continues to describe that therapeutic groups require a mental health professional to lead the group due to the therapeutic group being a therapeutic space. This highlights one “grey area” mentioned by the three participants, as they described the sub-support group to be led by laypersons (themselves) and none of them are professionally trained to carry out therapeutic techniques and/or to deal with emotionally laden situations that may arise within a therapeutic context. These three participants appeared to be concerned about a member being a possible casualty in the future which, according to literature highlighted by Forsyth (2013), outlined in chapter 2, means an individual whose psychological well-being declines instead of improves as a result of certain experiences within a change-promoting or therapeutic group. These three participants have therefore suggested that a mental health professional be brought in to lead the sub-support group, which is also in line with research from Yalom (1995) who states that problems in a group of an emotional and/or relational nature may arise that may be difficult for untrained individuals to deal with, and it is advised that a suitably qualified person be on hand to provide advice to the group.

However, despite the three participants’ concerns regarding a therapeutic group context without a trained professional present, they described that they have not experienced any therapeutic difficulties with the ERP techniques or any emotionally laden situations in the sub-support group since inception up until the time of the interviews. It is hypothesised that this may be due to the participants and the other members of the sub-support group having been educated on CBT and ERP by the clinical psychologist, either in the initial support group or in individual psychotherapy, as well as the ever-present social support within the sub-support group; as findings from Rosqvist et al. (2002) found that administering CBT and ERP initially requires a suitably qualified person present to be administered correctly, but once the individuals suffering from OCD have learned the techniques from the therapist, they can carry out the exposures on their own; they only require social

support to guide them through the experience.

The other “grey area” mentioned by three of the participants is the potential for members of the sub-support group to become too close as friends and therefore lose objectivity with each other. By losing this objectivity the members may compromise the quality of the feedback they give their fellow sub-support group members/friends. There is no research that could be found to substantiate these findings. However, due to the participants describing the sub-support group as being a therapeutic space, the participants provided as well as received psychotherapy within the sub-support group. It is therefore hypothesised that these three participants may unknowingly be wary of the ethical dilemma of dual relationships as outlined by the rules of conduct pertaining to a psychologist set out in form 223 by the HPSCA (2004), despite the three participants being laypersons in the mental health field.

#### **5.4 Summary of the Findings**

The findings of this study confirm that the participants were individuals with OCD who experienced severe distress and impairment in functioning pertaining to various domains of their lives prior to joining the two OCD support groups. The participants were unable to control their OCD symptoms themselves, lacked social support from their immediate environment, and required professional help or treatment for their OCD symptoms.

The four participants reported different paths toward attendance of the initial support group, however all four of them were motivated to attend the initial support group by their dire need to get their OCD symptoms under control and improve their daily functioning.

The participants described the initial support group as a professional leader-led psychoeducational support group, which was defined by the participants as a context in which a clinical psychologist was the expert and provided the members with information regarding OCD and the treatment of OCD, which was CBT. Two participants described that they settled in the initial support group quickly, while the other two participants’ described their journeys of becoming settled members of the initial support group to have initially been hampered by the open boundaries of the initial support group. These two participants described that although the open boundaries allowed for easy access to the group, the open boundaries also endorsed a non-homogenous group and in turn less candid disclosure of OCD symptoms by these two participants. These two members did settle in at a later stage, and all the

participants experienced group cohesion as a core subgroup of members, who attended the initial support group regularly, became apparent. The participants reported benefitting from the information obtained in the initial support group as they gained insight into OCD and the treatment of OCD. They were also empowered by the information provided to get their OCD symptoms under control, and to support others get their OCD symptoms under control. The primary limitation for the participants of the initial support group was that the initial support group did not provide a space in which the participants were able to actively implement the therapeutic techniques outlined by the clinical psychologist.

The participants, who were all part of the core subgroup, described that they, along with the other core subgroup members, therefore co-created their own support group with the intention of having a space to implement the therapeutic techniques (ERP) being imparted by the clinical psychologist in initial support group. The participants describe this sub-support group as a self-help group, with elements of a therapeutic group and an interpersonal learning group. This sub-support group had no formal mental health professional as its leader, with some of the members taking on leadership positions. The sub-support group had closed boundaries with strict requirements to join. The closed boundaries allowed for a mutually cohesive space in which the members could provide each other with effective feedback on their interactional style and on their OCD symptoms, and also for them to effectively implement the ERP techniques, while in a supportive environment. The participants described that the members of the sub-support group worked as a team to implement the ERP techniques and they provided each other with mutual support that extended beyond the boundaries of the sub-support group meetings. The participants reported that they became good friends with the other members of the sub-support group; however, they were concerned about becoming too close as they may lose objectivity and in turn provide less effective feedback to each other. Two members of the sub-support group did become very close and a sexual relationship ensued, which changed the dynamics of the sub-support group as these two members subsequently left the sub-support group and the other members felt betrayed. The participants reported that they benefitted from attendance in the sub-support group as their OCD symptoms reduced and their daily functioning, such as their occupational functioning and in particular their social functioning, improved. The participants describe that the sub-support group does, however, have the risk of potentially being unsafe, as it appears



to resemble a therapeutic group without a trained person facilitating and overseeing the process. This may have shown how desperate the participants were to get their OCD symptoms under control, as they were prepared to take the risk of performing psychotherapy in the sub-support group without a trained professional present.

The participants described the two OCD support groups as complementary and that they were linked. They required the information on OCD and treatment for OCD supplied in the initial support group in order to implement the therapeutic techniques in the sub-support group. However, the two OCD support groups were described as different as each had its own characteristics, such as the initial support group being a professional leader-led psychoeducational group with open boundaries, and the sub-support group being a self-help, predominantly therapeutic group with closed boundaries.

From a systemic perspective it appeared that going through the journey of being members of the two OCD support groups impacted positively on the participants as they were all able to implement a second-order change in their lives by getting their OCD symptoms under control, improving their functioning, and forming friendships.

## **5.5 Strengths of the Study**

The literature review in chapter 2 indicated that there is limited research conducted on OCD support groups, and even less on members' experiences of OCD support groups. There appears to be no research conducted on OCD support groups and members' experiences of OCD support groups within the South African context. This research study therefore focused on this gap in the literature. This study gave me the opportunity to explore four members' unique experiences of two OCD support groups. It also provided an opportunity for four OCD support group members to share their experiences of attending the two OCD support groups. This study provided a broad overview of the four participants' experiences of both OCD support groups as the participants described that the two OCD support groups were linked, complemented each other and overlapped, with the two OCD groups both focusing on OCD and the treatment of OCD. This study also offered the four participants' experiences of each OCD support group as entities on their own, as despite the two OCD support groups overlapping, they differed with regard to their content and structure.

The four participants each have long histories of OCD and therefore they provided rich insight into OCD and the need for treatment. The participants

highlighted the severity of their OCD symptoms and the need for a second-order change (systemic principle) in their lives (Watzlawick et al., 2011). The participants in this study also have extensive experience in attending and being members of the two OCD support groups. They could therefore provide rich and detailed information regarding members' experiences of the two OCD support groups. The research design and research process outlined in chapter 3 of this study allowed for the rich and detailed accounts of their experiences pertaining to their OCD symptoms and both OCD support groups.

The social constructionist nature of this study allowed for a co-constructed reality to emerge between the participants and myself. In this way, the participants brought to the conversation their unique stories, understanding of their experiences, and the knowledge they co-created as members of the two OCD support groups. I was able to bring to the conversation my understanding, questions, and experiences. My experiences with OCD, my MA clinical psychology training, as well as my involvement with an online OCD support group meant that I have been exposed to the challenges faced by individuals with OCD. I have experience in engaging with OCD sufferers seeking treatment for their OCD symptoms. My aim as researcher was not to provide solutions but to collect data from the personal experiences of the two OCD support groups. My background helped me to focus this study on the experiences of the two OCD support groups and allowed me to be sensitive when dealing with the four participants of this study, which recursively (a systemic principle) (Becvar & Becvar, 2009) impacted on the participants being comfortable to share detailed accounts of their unique experiences of the two OCD support groups.

I am of the opinion that research conducted in South Africa is an ongoing process, and there continues to be a strong need for more research to be conducted in this field of intervention. By researching and exploring members' experiences of an OCD support group(s) in the South African context, the members could obtain a better understanding of their experiences. Professionals dealing with OCD sufferers may also benefit from this research study in that they may get a glimpse into understanding the experiences of OCD and the value of an OCD support group. These experiences cannot be duplicated but they are nevertheless valuable, authentic, and add to the knowledge of OCD and OCD support groups. It may also give the professional a glimpse into CBT for OCD and how much effort, assistance, and support it may take an OCD sufferer to get their OCD symptoms under control.

Hopefully, this study's contribution to the knowledge and insights will assist in tailor-made models for professionals or laypersons looking to start an OCD support group. It may also have the added benefit of being seen by someone suffering from OCD and give that individual some idea of how he/she may get the OCD symptoms under control and obtain social support.

## **5.6 Limitations of the Study**

The findings of this study are considered as adding a valuable contribution to literature regarding members' experiences of an OCD support group(s) in the South African context. However, a number of limitations do need to be recognised. The small sample size of this study is regarded as a weakness; nevertheless, the richness of the data collected through face-to-face interviews with this small sample size justified the decision to utilise this qualitative method of data collection. Due to the fact that only one formal OCD support group was found in South Africa, the participants who were interviewed in this study were located in the same geographical region. The four participants were also all within a similar age range and of Caucasian ethnicity. Therefore, findings are not necessarily representative of all population groups within South Africa. The study, being a qualitative study, allows for rich, detailed accounts from the participants. It does, however, restrict the generalisability of the findings from this study to other OCD support groups should the need arise. The social constructionist paradigm was described as a strengthening factor in this study while I was interacting with the participants. However, the social constructionist paradigm could also be seen as a weakness as I am aware that the themes and subthemes that I found, and my interpretations of the findings, may have been influenced by my own perceptions, background, and values. It is possible that other researchers may have highlighted and included different themes and subthemes than those I have included. Despite these relative weaknesses, the four participants' experiences resulted in sufficient meaningful data to be analysed and interpreted, and ultimately answered the research question.

## **5.7 Recommendations for future research**

This study sought to explore members' experiences of an OCD support group(s) to enhance understanding of the experiences of the OCD support group(s). Nevertheless, recommendations can be made for future research.

This study focused on the members' experiences of an OCD support group(s). The initial OCD support group is open to family members of OCD sufferers as well.

The family members' experiences were not captured in this research study. The participants in this study were all OCD sufferers. The literature on OCD and OCD support groups is very limited with regard to OCD family members' experiences of an OCD support group. Therefore, further research may be needed with regard to family members' experiences of attending or being members of an OCD support group, in the South African context.

This study consisted of a limited number of participants who were all of the same ethnicity and within the same age range. A much larger study could be conducted with participants of varying ages and cultures who participate in an OCD support group. The literature on cultural variances and age differences within an OCD support group is limited. Therefore, further research could be indicated in this domain as such a study could potentially improve understanding of OCD sufferers of different cultures and ages who attend an OCD support group, in the South African context.

The participants in this study described that due to the high risk of carrying out exposures the support groups should have a professional present as the gatekeeper. This research study does not focus on the experiences of a professional running an OCD support group. The literature on OCD and OCD support groups is very limited with regard to professionals' experiences of an OCD support group. Therefore, further research may be needed with regard to a professional's experience of running an OCD support group, in the South African context.

The participants in this study also described that attending an OCD support group can be demanding and time-consuming. The participants in this study have described that they may have found a way to counter this. They wanted to start an online support group for OCD. This research study focused on a face-to-face OCD support group. Therefore, there may be a gap in the research to focus on individuals' experiences of an online OCD support group, in the South African context. The benefits and values of an online OCD support group, in the South African context, may also be explored.

## **5.8 Concluding remarks**

The study explored the members' experiences of two OCD support groups, with one group being run as a professional-led psychoeducational group and the other being run as a self-help therapeutic group. The themes revealed that the participants' experiences were multifaceted. The participants' themes did reveal challenges and that the two support groups were different, but on the whole it appeared as if both the

OCD support groups complemented each other and were beneficial to the participants. In the process of undertaking this study, I gained a great deal of knowledge on members' experiences of OCD and the two OCD support groups, and it is my hope that this study will in turn feed valuable insight back into the members' experience of OCD and the two OCD support groups. The research study has brought me closer to starting a face-to-face OCD support group in my area. It is also my hope that this research study will contribute to breaking down the stigma surrounding OCD. It seems as if this research study has helped reveal untravelled research topics around the themes of OCD and OCD support groups. It is therefore my hope that this research study will stimulate interest in research into this field in the future.

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## Appendix A: Consent Form

### **PARTICIPANT INFORMATION AND INFORMED CONSENT**

Good day

You are invited to participate in a research project about experiences around your Obsessive-compulsive disorder (OCD) support group that will be used in a dissertation of limited scope. There is very little recorded information about the experiences of South African men and women regarding OCD support groups and the researcher would like to increase the knowledge in this field. It is hoped that this research study will contribute to a better understanding about what individuals with OCD and their family members think and feel about the OCD support group. This information can then be used to improve the OCD support group in question and open debate for further research in this field.

This information leaflet is to help you to decide if you would like to participate in the study. **PLEASE READ THIS DOCUMENT CAREFULLY BEFORE THE START OF THE STUDY.** Before you agree to take part in this study you should fully understand what is involved. If you have any questions, do not hesitate to ask me. You should not agree to take part unless you are completely happy about what is expected of you. In the best interests of your mental health, it is strongly recommended that you discuss with or inform your psychotherapist of your possible participation in this study, wherever possible.

#### **What will you be expected to do?**

The study involves asking volunteers to take part in a semi-structured interview. The completion of the interview may take about an hour and a half and will be a one-on-one interview. The interview begins with a few questions about you (age, income, your own and family history of OCD and support groups). Please remember that you do not have to state your name in the interview. The investigator will know who you are but your identity stays confidential. You can therefore feel free to be honest. The next part of the interview focuses on your beliefs around OCD, support groups and support groups for OCD. The interviews will also focus on your beliefs about the OCD support group. **PLEASE NOTE THAT NO FORM OF TREATMENT WILL BE OFFERED DURING THIS RESEARCH.**

### **Who will have access to my information?**

The implication of completing the interview is that informed consent has been obtained from you. Data that may be reported in scientific forums (such as journals) will not include any information that identifies you as a participant in this study. All information obtained during the course of this study is strictly confidential. The researcher, his supervisor and a second transcriber or coder will be the only people to have access to your confidential information. They will take all measures to keep the information confidential, safe and locked away.

Your participation in this study is voluntary and you can refuse to participate or stop at any time without stating any reason. Your withdrawal will involve no penalty or loss of benefits, but as data is anonymous, you must understand that you will not be able to recall your consent, as your information will not be traceable.

### **Has the research received ethical approval?**

Ethical clearance for this study was obtained from the Ethical Committee of the Department of Psychology at UNISA. The researcher is bound by the Policy for Research Ethics of Unisa. A copy of the Policy for Research Ethics of Unisa may be obtained from the researcher should you wish to review it.

### **What are my rights as a participant in this research?**

Your participation in this research is entirely voluntary and you can refuse to participate or stop at any time without stating any reason. Your withdrawal will not affect your access to other health care. The researcher retains the right to withdraw you from the study if it is considered to be in your best interest. If it is detected that you did not give an accurate history or did not follow the guidelines of the research and the regulations of the research facility, you may be withdrawn from the research at any time.

### **Are there risks involved in this research? Can any of these research procedures result in discomfort or inconvenience?**

Some people may be uncomfortable about the types of questions asked during the interview. We ask only that you be honest in your answers. You are welcome to let the interviewer know about your discomfort with certain questions and may decline to answer. The interview will take place in a private setting and at a time that is convenient for you. Only you and the person that will interview you will be present. The interview will be recorded. A word-for-word transcription will be done either by

the interviewer or a person hired to do the transcription. Any person hired for the transcription will be required to sign a confidentiality clause. Before the analysis, your name will be changed to a pseudonym to protect your identity.

**Insurance and financial arrangements**

Neither you, nor your medical aid will be required to pay for your participation in the study. You will also not receive any gifts or payment for participating in this study.

**Source of additional information**

If at any time during the interview you feel that you may be suffering from any negative or unpleasant symptoms, or you have any medical questions during the research, you are advised to consult your doctor. You are also advised to consult your therapist if you continue to suffer from the unpleasant experience. Please inform the researcher of any difficulties and discomfort you may experience. The numbers of help lines will also be given to you should you need any counselling.

**Confidentiality**

All information obtained during the course of this research is strictly confidential. Data that may be reported in, for instance, scientific journals will not include any information that identifies you as a participant in this research. The information you provide will be kept confidential by protecting identities. It must be noted, however, that the researcher's supervisor as well as a second transcriber or coder will have access to the information. These members will fall under the confidentiality agreement and no identifying information will be distributed. All the audiotapes and transcripts of the semi-structured interviews will be securely locked away and kept safe. Any information regarding your state of mental health will be held in strict confidence.

**Informed consent for the project entitled**

**A systemic conceptualisation of members' experiences of an obsessive compulsive disorder support group**

Kindly fill in the following information. Please note that this information will not be used by the researcher or his supervisor, to break confidentiality. Should the investigator need to contact you, however, these details will be necessary.

Telephone number (work): \_\_\_\_\_

Cellular phone number or after hours contact number: \_\_\_\_\_

E-mail address: \_\_\_\_\_

**Please inform the investigator of any changes to your contact details.**

**All participants must please complete this section**

*Tick the best answer for you.*

I would like to be interviewed for this research.

I would **not** like to be interviewed for this research.

I would be interested in participating in further research. Please keep my contact details on your database and contact me regarding new projects.

I would **not** be interested in participating in further research.

**Informed consent (Please complete this if you consent to participate)**

I hereby confirm that I have been informed by the researcher about the nature, conduct, benefits and risks of the study. I have also received, read and understood the above written information (Participant Information and Informed Consent) regarding the research. I am aware that the results of the research, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a research report. I understand that the researcher has a supervisor who will also have access to the information I provide. If a second transcriber is used, they will have privy to my confidential information, which I agree to. I may, at any stage, without prejudice, withdraw my consent and participation in the research. I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the research.

Participant's name \_\_\_\_\_ Participant's signature \_\_\_\_\_ Date \_\_\_\_\_  
(Please print)

The researcher herewith confirms that the above participant has been informed fully about the nature, conduct and risks of the above research.

Researcher's name \_\_\_\_\_ Researcher's signature \_\_\_\_\_ Date \_\_\_\_\_

Witness's name\* \_\_\_\_\_ Witness's signature \_\_\_\_\_ Date \_\_\_\_\_  
(Please print)

**Verbal participant informed consent (applicable when participant cannot read or write)**

The undersigned investigator have read and have explained fully to the participant and/or is/her relative, the participant information, which has indicated the nature and purpose of the research in which I have asked the participant to participate. The explanation I have given has mentioned both the possible risks and benefits of the research and the alternative treatments available for his/her illness. The participant indicated that he/she understands that he/she will be free to withdraw from the research at any time for any reason. I hereby certify that the participant has agreed to participate in this research.

Participant's Name \_\_\_\_\_

Researcher's Name \_\_\_\_\_ Researcher's Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness's Name \_\_\_\_\_ Witness's Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Please print)

Thank you for your time.

The Researcher  
Mr S Friedland

The Supervisor  
Mrs E. Visser

## **Appendix B: Semi-Structured Interview Template**

### Introduction

You are invited to participate in a research project about experiences around the obsessive-compulsive disorder (OCD) support group that will be used in a dissertation of limited scope. There is very little recorded information about the experiences of South African men and women regarding OCD support groups and the researcher would like to increase the knowledge in this field. It is hoped that this research study will contribute to a better understanding about members' experiences of an OCD support group. This information can then be used to improve the OCD support group in question and open debate for further research in this field.

Before you agree to take part in this study you should fully understand what is involved. If you have any questions, do not hesitate to ask me. You should not agree to take part unless you are completely happy about what is expected of you.

The study involves asking volunteers to take part in a semi-structured interview. The completion of the interview may take about an hour and a half and will be a one-on-one interview. The interview begins with a few questions about you (age, your own and family history of OCD and support groups). Please remember that you do not have to state your name in the interview. The investigator will know who you are but your identity stays confidential. You can therefore feel free to be honest. The next part of the interview focuses on your beliefs around OCD, support groups and support groups for OCD. The interviews will also focus on your beliefs about the OCD support group. PLEASE NOTE THAT NO FORM OF TREATMENT WILL BE OFFERED DURING THIS RESEARCH.

Your participation in this study is voluntary and you can refuse to participate or stop at any time without stating any reason. Your withdrawal will involve no penalty or loss of benefits. The researcher retains the right to withdraw you from the study if it is considered to be in your best interest.

The interview will be recorded. A word-for-word transcription will be done either by the interviewer or a person hired to do the transcription. Any person hired for the transcription will be required to sign a confidentiality clause. Before the analysis, your name will be changed to a pseudonym to protect your identity.



Some people may be uncomfortable about the types of questions asked during the interview. We ask only that you be honest in your answers. You are welcome to let the interviewer know about your discomfort with certain questions and may decline to answer.

If at any time during the interview you feel that you may be suffering from any negative or unpleasant symptoms, or you have any medical questions during the research, you are advised to consult your doctor. You are also advised to consult your therapist if you continue to suffer from the unpleasant experience. Please inform the researcher of any difficulties and discomfort you may experience. The numbers of help lines will also be given to you should you need any counselling. If you require any professional assistance the researcher can provide you with a psychologist number as well as the South African Depression and Anxiety Disorder Group's helpline number.

All information obtained during the course of this research is strictly confidential. Data that may be reported in, for instance, scientific journals will not include any information that identifies you as a participant in this research. The information you provide will be kept confidential by protecting identities. It must be noted, however, that the researcher's supervisor as well as a second transcriber or coder will have access to the information. These members will fall under the confidentiality agreement and no identifying information will be distributed. All the audiotapes and transcripts of the semi-structured interviews will be securely locked away and kept safe. Any information regarding your state of mental health will be held in strict confidence.

Thank you very much for agreeing to be part of this research study. Your time and information is vital to this study and is very much appreciated by the researcher.

### Background information

1. What is your age?
2. What is your gender?
3. Where do you live?
4. What is your occupation? / What school and grade are you in?
5. Can you tell me about your family?
  - a. Are you married/single/divorced/widower?
  - b. Who do you live with?
  - c. Do you have any siblings?
  - d. Do you have any children?
6. What is your relationship with your family members?
7. What is your relationship with your colleagues at work? / What is your relationship with your classmates/school friends?

### Questions about the member's OCD

8. Have you been diagnosed with OCD? If yes, by whom?
  - a. How long have you had OCD for?
9. Have you had treatment for your OCD? If yes, what treatment?
  - b. How long after realising the symptoms for OCD did you go for treatment? (At what stage of your OCD did you seek treatment?)
  - c. What was the duration of this treatment and was this form of treatment effective?
10. Tell me about the OCD you have been suffering from?
  - a. What were the prominent symptoms of your OCD?
  - b. Can you explain what the impact of these symptoms were/are on your life?
  - c. Did you have insight into your OCD symptoms? Did you believe your OCD beliefs were true, probably true, probably not true or not true?
  - d. Do you have any other comorbid (additional) mental health disorders? If yes, what are these disorders and what is their relation to your OCD (Did your OCD stem from your other disorder or was your OCD diagnosed first?)
11. What was/is your experience of having OCD?
  - a. What was the quality of your life before being diagnosed with OCD? How did your quality of life change after you were diagnosed with OCD?
  - b. To what extent does having OCD affect your everyday life, such as your relationships, work and/or leisure time?
12. What support was available to you when you were diagnosed with OCD? (Any support besides family)
13. Can you tell me about your families understanding and support of the OCD?
  - a. Who do you feel gives you support with the OCD?
  - b. Describe the type of help and support they give you?
  - c. Is/Was there any support you required that you did not get?

- d. What roles and responsibilities did you have in your family before you were diagnosed with OCD? What roles and responsibilities did you have in your family after you were diagnosed with OCD? How did these roles change?

Questions on the OCD support group

14. How long have you been a member of the OCD support group for?
  - a. Were you self-referred or referred by someone else to the OCD support group? (How did you find out about the support group?)
  - b. What prompted you to join the OCD support group?
  - c. What was your experience of entering the support group for the first time?
  - d. What are the main goals of the support group you are /were attending?
  - e. Are there any rules or regulations in the group?
  - f. Is this group a formal or an informal group?
15. How often do the support group members meet for a session?
  - a. How often do you attend the support group?
16. How long is a support group session?
17. Who runs the support group?
18. How many people attend the support group meetings?
19. Where do the support group meetings take place?
20. What were your expectations when joining the support group?
  - a. What do you believe was the value of the support group for you?
21. What was/is your experience of the OCD support group?
  - a. Has your experience changed over time?
22. What impact does/did the OCD support group have on you? (List the different impacts it had on him/her and then elaborate in each one)
23. What is the difference between attending a support group session run by a professional (psychologist) and a support group session run by the group members?
24. Do you feel you have a voice and a place in the OCD support group?
  - a. What roles and responsibilities do you have in the OCD support group and what roles and responsibilities do other people have in the group?
  - b. Have your roles and responsibilities changed in the support group over the course of time in the support group? How have your roles and responsibilities changed if they did change?
  - c. Have other members' roles and responsibilities changed in the support group over the course of the time in the support group? How have their roles and responsibilities changed if they did change?
  - d. Can Group members with a long history and in-depth knowledge of OCD be regarded as experts?  
If yes, what impact do they have on you and the group?
25. Did you form/Have you formed a bond with the members of the OCD support group?

- a. What kind of bond(s) have you formed? Do you keep contact outside of the support group? If yes, what kind of contact?
  - b. Do you believe having OCD allowed you to form these bonds? / Do you believe having OCD was a contributing factor or a negative, restricting factor in allowing you to form these bonds?
  - c. Single out a member who had a lasting impact on you? Can you explain/elaborate why he/she had a lasting impact on you?
26. How would you describe your relationship with the other members of the support group in terms of closeness, openness and distance, closedness? (What is your relationship to the other members of the OCD support group?)
- a. What impact did the relationships with other members of the OCD support group have on you?
  - b. How do you experience the communication between yourself and the other members of the OCD support group?
  - c. How would you describe the communication in the OCD support group, between everybody? (e.g. open, flexible, etc.)
  - d. Was it difficult for you to discuss your OCD and related problems with others in the support group?
  - e. How often do you have conversations with others in the group and what do you speak about during the support group meetings?
  - f. How would you describe your participation in the group? Do you see yourself as more active or more passive? And the other members? Are there more active or passive members and are they treated as the same?
  - g. Do your group members give you feedback? If yes, what feedback and did you believe this feedback was open, honest and trustworthy feedback? What was the experience of receiving the feedback? Did you benefit from it? Will you please elaborate?
  - h. Were you able to give feedback to other members of the group? If yes, what feedback did you give them (e.g. topics, issues, etc.)? What was the experience of giving them feedback and was it honest, open and trustworthy feedback?
27. Are there certain members of the group with whom you are closer to? Are there members with whom you do not get along well with? Do the members who you are friendly with cluster together in distinct subgroups?
- a. How do these subgroups form? (E.g. Do the members have similar kinds of symptoms, Have the members been part of the support group for a similar length of time, etc.).
28. What kind of support did you receive/What support was available to you in the support group?
- a. Do the members give you emotional support, practical advice or both?
29. Has the support group changed over time? If yes, how?
- a. How have you and other members dealt with new members arriving and older members leaving the OCD support group? (open or closed system)

30. What are the reasons that you stop attending the OCD support group? (If have left)
  - a. How did you deal with leaving the support group? (If you have left)
31. Were you able to carry what you had learnt in the OCD support group to the outside world?
  - a. What impact did the OCD support group have on your external relationships?
  - b. What impact did the relationships with other members of the OCD support group have on your external relationships?
32. Thinking of the sessions you attended, does one session stand out for you?
  - a. Can you please tell me about it so I can understand what happens in the support group?
33. What was your most challenging/difficult session?
  - a. Could you elaborate?
34. Do you believe individual psychotherapy for OCD and support groups for OCD complement each other?
  - a. Do you discuss your individual therapy in the group?
  - b. Do people bring their newly learned therapeutic skills to the support group?
  - c. How does your individual therapy impact on the OCD support group?
  - d. How does the OCD support group impact on your individual therapy?
35. How has your life changed since you joined the OCD support group?
  - a. What was the impact of the support group on your relationships with your family members, friends and colleagues external to the support group?

### Conclusions

36. What do you believe are the benefits of the OCD support group?
  - a. How do you think the OCD support group can affect people's OCD, in general?
37. How did you believe are the benefit from attending the OCD support group?
38. What do you believe are the limitations of the OCD support group?
39. Would you recommend the OCD support group to someone diagnosed with OCD?
40. In your experience, could support groups for OCD be difficult for people with OCD to attend? If yes, how so?
41. Is there any other information you would like to add?

We have come to the end of the interview but I would like to keep the communication channels open between us. If I have any further clarifying questions could I contact you? Do you have any questions you would like to ask me regarding the interview or the research study? If you think of anything you would like to know or ask me that you cannot think of now you may get in touch with me via e-mail or cell.

Thank you for volunteering to be a participant in this research study. Your input has been invaluable and the researcher appreciates you taking this time to be interviewed.