



University of the
West of England

Bond, M. (2015) *Experiences of mindfulness for clients with OCD: An IPA study*. DCounsPsych, University of the West of England. Available from: <http://eprints.uwe.ac.uk/27181>

We recommend you cite the published version.
The publisher's URL is:
<https://eprints.uwe.ac.uk/secure/27181/>

Refereed: No

(no note)

Disclaimer

UWE has obtained warranties from all depositors as to their title in the material deposited and as to their right to deposit such material.

UWE makes no representation or warranties of commercial utility, title, or fitness for a particular purpose or any other warranty, express or implied in respect of any material deposited.

UWE makes no representation that the use of the materials will not infringe any patent, copyright, trademark or other property or proprietary rights.

UWE accepts no liability for any infringement of intellectual property rights in any material deposited but will remove such material from public view pending investigation in the event of an allegation of any such infringement.

PLEASE SCROLL DOWN FOR TEXT.

Experiences of Mindfulness for clients with OCD: An IPA study

Miya Bond

Supervised by
Dr Gary Christopher, University of the West of England
Dr Naomi Moller, The Open University

Submitted in partial fulfilment of the requirements of the University of the West
of England, Bristol for the degree of Professional Doctorate in Counselling
Psychology

Faculty of Health and Life Sciences
University of West of England, Bristol

July 2015

Word count: 36,344

Table of Contents

Journal Article	5
Abstract	6
Introduction	7
Mindfulness	8
Mindfulness and OCD.....	8
Methodology	10
Participants.....	10
Data Collection.....	12
Results	13
Mindfulness as reassurance and memory aid	14
Mindfulness as distraction.....	16
When mindfulness fails	18
Discussion	19
Mindfulness as reassurance and memory aid	19
Mindfulness as distraction.....	20
When mindfulness fails	21
Summary of the negative impact of mindfulness in the context of OCD	22
Future Research	22
Implications for Practice.....	23
Limitations	23
References	23
Dissertation Abstract	28
Literature Review.....	31
Obsessive-Compulsive Disorder	31
Definition of OCD	32
Early References to OCD.....	33
Categories of OCD	34
Prevalence	34
Onset	35
Comorbidity	35
Impact.....	37
Aetiology.....	38
Theoretical Perspectives on OCD.....	40
Treatment Guidelines.....	49
Summary.....	51
Mindfulness	52
Mindfulness and Mental Health	53
Efficacy of Mindfulness Based Treatments	55
Disadvantages of Mindfulness.....	56
Theories of the Mechanisms of Mindfulness	57

Patient experience of mindfulness	59
Neurology of Mindfulness	60
Mindfulness and Cognitive-Behavioural Therapy.....	61
Summary.....	62
Mindfulness and OCD.....	63
Mindfulness OCD Research	65
Mindfulness and OCD Summary	68
Research rationale	68
Research aims.....	69
Research questions.....	70
Methodology	71
Design.....	71
Rationale for Chosen Methodology.....	71
Qualitative versus Quantitative	71
Epistemology	73
Rationale for IPA	74
Data Collection.....	77
Interview use in research.	77
Weblog as data	78
Email Interview	78
Ethical Matters.....	80
Ethical Approval	80
Informed Consent	80
Confidentiality.....	80
Risk	80
Participants.....	81
Number of Participants	82
Inclusion Exclusion Criteria.....	83
Transcription.....	85
Process of Analysis.....	85
Approach to Quality	88
Reflexivity	89
Bracketing Assumptions	89
The Researcher	90
Choice of research topic.....	91
Researcher's position on mindfulness	91
Influence of the Participants	91
Influences on the data.....	92
Being mindful in the process	92
Analysis.....	94
Key to Conventions Used in Transcriptions.....	96
Superordinate Theme 1: Changing Relationship to Thoughts	96
Sub Theme 1a: Non-judgemental acceptance of OCD thoughts and letting go	98

Sub Theme 1b: Thoughts are not facts	102
Superordinate Theme 2: New Way of Being	104
Sub Theme 2a: Mindfulness facilitates new sense of self / new way of being	104
Sub Theme 2b: Giving up wanting things to be different	105
Sub Theme 2c: Mindfulness helps participants be with anxiety	107
Sub Theme 2d: Increased awareness of body and emotions.....	109
Sub Theme 2e: Trusting the senses and being present	111
A summary of participants experience	113
Discussion	116
The Fit with Cognitive Behavioural Models.....	118
Mindfulness as a Tool or a Philosophy	127
Mindfulness as an Approach to Research	129
Conclusion	130
Implications for Practice.....	132
Implications for the Practice of Counselling Psychology	133
Limitations	134
Further Research.....	136
Concluding remarks	137
References	139
Appendices	155
Appendix A Introductory Letter.....	155
Appendix B Information Sheet	156
Appendix C Consent Form	158
Appendix D Interview Guide.....	159
Appendix E Example from Analysis.....	162
Appendix F Letter to OCD Clinics	168
Appendix G Project Protocol Summary.....	170
Appendix H NHS Ethical Approval.....	171
Appendix I NHS Research and Development Approval	175
Appendix J University of the West of England Ethical Approval	177
Appendix K Part of Reflexive Journal	179

"If the quality with which a person handles a difficult moment shifts by even one per cent, then that is an important shift, because it affects the next moment, and the next and so on, so one small change can have a large impact in the end."

- Zindel Segal, Mark Williams and John Teasdale.

Journal Article

The following journal article forms part of the research dissertation into the experience of mindfulness by people with OCD.

The dangers of mindfulness for OCD: An IPA study

Miya Bond^{1*}, Naomi Moller² and Gary Christopher¹

¹ University of the West of England

² The Open University

Word count (exc. figures/tables): 5,355

*Requests for reprints should be addressed to Miya Bond, University of the West of England, Coldharbour Lane, Bristol, BS16 1QY, United Kingdom (e-mail: Miya2.Bond@live.uwe.ac.uk).

Abstract

Objectives

Mindfulness has been proposed as a potential treatment for obsessive-compulsive disorder (OCD), a debilitating condition, which for many is life-long. However, it is not clear whether, and how, mindfulness is experienced as helpful by OCD sufferers. The current study explored the experiences of people with OCD who used mindfulness practices.

Design

Semi-structured interviews were carried out with participants who had been diagnosed with OCD between 1 and 40 years ago and who had experience of mindfulness.

Methods

Interpretative Phenomenological Analysis (Smith, Flowers & Larkin, 2009) was used to analyse semi-structured interview transcripts from seven participants (3 men, 4 women).

Results

The analysis revealed that all the participants considered mindfulness practice to be a beneficial adjunct to treatment for OCD. However, the study also found that mindfulness could, for some, be used or become incorporated into the OCD in ways that might be considered unhelpful.

Conclusions

The finding that there are possible areas of concern for the use of mindfulness in the treatment of OCD is discussed, alongside the implications for clinical practice.

Practitioner Points

- IPA study of OCD sufferers' experiences found unexpected negative consequences of using mindfulness practice.
- Mindfulness was used as an aid for reassurance, as a distraction, as a way to battle obsessive thoughts, and was incorporated into OCD rituals.

- Care may be needed when teaching mindfulness to people with OCD to reduce the likelihood of mindfulness being used solely to reduce short-term anxiety.
- More research is needed into the potential disadvantages and long-term effectiveness of mindfulness for OCD.

Introduction

Obsessive-Compulsive Disorder (OCD) is a debilitating mental health condition that is typically characterised by distressing thoughts, images, impulses and fears (obsessions) that lead to ritualised or repetitive behaviours (compulsions; DSM-IV: American Psychiatric Association, 2000). The obsessive thoughts may be connected to the phenomena that are the subject of OCD sufferers' obsessions, or to cognitions or beliefs about what will occur should they fail to carry out neutralising compulsions (Salkovskis, 1999).

The significant and long-term impact of OCD on sufferers and family members (Torres et al., 2006; Stengler-Wenzke, et al., 2006; Cicek et al., 2013) mandates that researchers work to establish good understandings of, and effective treatments for, OCD. However, currently no single theoretical model appears adequate to explain the full range of obsessive- compulsive phenomena experienced by people with OCD (Stanley, Turner, Heiser & Beidel, 2004). In combination with pharmacology, and based on the available research evidence, cognitive-behavioural therapy with exposure response prevention (CBT/ERP) is the standard recommended treatment in Britain (Eddy, Dutra, Bradley & Westen, 2004; NICE, 2005). However, the NICE OCD guidelines developed by the National Collaborating Centre for Mental Health indicates that despite many advances in pharmacological and psychological treatments for OCD their efficacy is still moderate, both in terms of the proportion of people who respond, and their average improvement (Fisher & Wells, 2005; NICE, 2006). The apparent low treatment efficacy of current standard treatments suggests the need to explore other approaches; one such that has garnered recent attention is mindfulness.

Mindfulness

There are many definitions of mindfulness. Kabat-Zinn defines mindfulness as “the awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding of experience moment by moment” (Kabat-Zinn, 2003, p. 145); while Siegel suggests that mindfulness is a state of internal attunement that includes curiosity, openness, and acceptance (Siegel, 2007) - to which Turner adds with an “attitude of equanimity” (Turner, 2009, p. 96).

Originating in eastern philosophy, mindfulness has been secularised and separated from its spiritual roots (Appel & Kim-Appel, 2009) and is now offered as a treatment strategy for many mental health disorders. These include Mindfulness-Based Stress Reduction (Kabat-Zinn, 2003), Mindfulness-Based Cognitive Therapy for relapse prevention in depression (MBCT; Segal, Williams & Teasdale, 2013). Mindfulness also constitutes a significant element of Dialectical-Behavioural Therapy for borderline personality disorder (Linehan, 1993) and Acceptance and Commitment Therapy (Hayes et al., 2006) and is increasingly being used in the treatment of a wide range of other conditions (Keng, Smoski & Robins, 2011). Mindfulness differs from conventional treatments in that change is not the primary focus; mindfulness does not preclude change, but sees this as secondary to a process of self-acceptance and self-understanding (Bishop et al., 2004).

The research base suggests that mindfulness based treatments are helpful in alleviating symptomology over a wide range of conditions and disorders (e.g. Chadwick, Newman Taylor & Abba, 2005; Finucane & Mercer, 2006; Brown, Ryan & Creswell, 2007; Roemer, Orsillo & Salters-Pedneault, 2008). Findings also show that mindfulness is an acceptable and well-liked treatment that has a significant positive impact on wellbeing and quality of life (Greeson, 2009).

Mindfulness and OCD

Currently mindfulness is not commonly used in the treatment for OCD; however, there are a number of reasons to suggest mindfulness may be an effective adjunct to conventional treatment as it addresses some of the underlying factors

known to affect people with OCD (Fairfax, 2008). Mindfulness encourages participants to observe current experiences in a non-judgemental manner and it is thought this may assist individuals to become habituated to intrusive thoughts, as well as reduce counterproductive thought suppression efforts (Hepburn et al., 2009). Fairfax (2008) conjectures that mindfulness-based therapies might also teach participants that 'thoughts are not facts', something which may be of particular importance in OCD to help to bring about metacognitive change and a reduction in *thought-action fusion* (where a thought about doing something is considered to be evidence for the action having taken place; Shafran, Thordarson & Rachman, 1996).

While there is some theoretical rationale for why mindfulness may offer hope to OCD sufferers, there is as yet little research evidence to support this (Hale, Strauss & Taylor, 2012). One quantitative study, comparing strategies to manage obsessive thoughts in OCD participants, found a reduction in anxiety following a mindfulness-based strategy compared to a distraction technique (Wahl, Huelle, Zurowski & Kordon, 2013). In a review of non-conventional interventions for OCD, Sarris, Camfield & Berk (2012) also found tentative evidence to support the use of mindfulness meditation, however the studies examined were not deemed methodically robust. Only one limited controlled pilot study of mindfulness for OCD has been published to date (Hanstede, Gidron & Nyklíček, 2008). The participants for this trial were a non-clinical sample of 17 Dutch students who had at least one OCD symptom. The study reported a significant reduction in OCD symptoms at the end of mindfulness treatment when compared to a control group.

Two qualitative studies provide preliminary evidence that OCD sufferers may find mindfulness beneficial. Wilkinson-Tough and colleagues (2010) investigated mindfulness-based therapy with three participants. By the end of their study all three participants had reduced their OCD symptoms to sub-clinical levels and two out of the three maintained this improvement at the two-month follow up. Hertenstein and colleagues (2012) performed semi-structured interviews with twelve participants suffering from OCD who had received eight sessions of an MBCT program following traditional CBT/ERP treatment, and drew preliminary

conclusions about the components of MBCT that were useful for OCD sufferers (self-acceptance, the acceptance of private events and the use of a three-minute breathing space).

One of the apparent benefits of mindfulness over pharmacology and CBT/ERP, in the treatment of OCD, is that there have been few, if any, reported adverse effects from the mindfulness treatment. Numerous research studies outline the positive effects mindfulness or regular meditation practice can have on health and wellbeing (Keng et al., 2011), however it is possible that in all this positivity negative consequences have been overlooked. Klainin-Yobas, Cho and Creedy (2012), for example, note in a review of 40 mindfulness studies that adverse effects were not addressed in a single study.

For the reasons summarised here, mindfulness is being increasingly promoted as a treatment for OCD (e.g. Schwartz & Beyette, 2009; Hershfield & Corboy, 2013). This is despite the fact that it is not yet established if mindfulness is effective or even helpful in treating OCD. It is also not clear if mindfulness may be potentially harmful; to date there has been little attention in the literature on reporting of adverse or negative responses to the use of mindfulness for people with OCD. Alderson (1999) argues for more qualitative research to inform healthcare decisions and services. In response to this lack of qualitative research and with the aim to improve service provision for people with OCD, this study thus explored the experiences of seven OCD sufferers who used mindfulness to help alleviate the symptoms and distress of their OCD.

Methodology

Ethical approval for this study was granted by the National Health Service National Research Ethics Service (South West – Cornwall and Plymouth), UK and ratified by the University of the West of England.

Participants

Information pertaining to the participants is listed in Table 1.

Table 1 Participants

Pseudonym	Gender	Age	Years since diagnosis/ onset of OCD	Mindfulness training or instruction	Continues to Participates in mindfulness meditation
Paul	M	34	7/28	Part of OCD treatment	No
Olivia	F	66	40/45	Part of OCD treatment	No
Carrie	F	26	2/14	Part of OCD treatment	For relaxation
Rhianna	F	47	9/23	8 week MBSR	No
Steve	M	44	18/30	Vipassana meditation training	Yes
Becky	F	39	1/5	8 week MBSR	Yes
Gordon	M	44	2/2	Self-help books and CDs	Yes

One participant was recruited after participating in an NHS OCD group in a secondary mental health setting where the first author worked; the remainder were recruited through notices placed on OCD websites, forums, or were ex-clients of two specialist OCD treatment centres.

All participants had a diagnosis of OCD. One participant was undergoing cognitive-behavioural therapy (CBT) for the OCD at the time of interview; all the remaining participants had undertaken some form of treatment for their OCD in the past. The interview included questions about current psychological functioning and all participants reported some current difficulties related to their OCD although one described herself as recovered from the condition. In addition, some of the participants reported experiencing significant levels of anxiety or comorbid depression; both anxiety and depression are typically found

in conjunction with OCD (Torres et al., 2006). None of the participants reported experiencing significant difficulties due to any other co-morbid condition. Some of the participants were taking medication in the form of SSRI antidepressants; this is normal practice for the treatment of OCD (NICE, 2006).

Six out of the seven participants had more than a years' experience of mindfulness practice; the seventh had practiced mindfulness for four months. Most had learnt mindfulness through formal training (a public MBSR course or as part of their OCD treatment); one had undertaken extensive self-help instruction (see Table 1 for further information).

Data Collection

Semi-structured interviews were used to collect the study data. Interviews are a well-established method of data collection in qualitative studies (Willig, 2013). Willig argues that interviews allow “participants to challenge the researcher’s assumptions about the meaning and relevance of concepts and categories” (ibid., p. 16).

The schedule for the semi-structured interviews was prepared in accordance with the recommendations of Smith et al. (2009). Questions were open-ended, and designed to invite participants to narrate and reflect upon their experiences of mindfulness practice and its effect on their OCD symptomology or their general wellbeing.

Analysis: The data were analysed following the steps for Interpretative Phenomenological Analysis (IPA) as outlined by Smith and colleagues (2009); IPA was selected because of the idiographic research focus on participants’ lived experience and sense making. IPA is theoretically rooted in critical realism (understanding that reality has an independent existence but is perceived and theorised in relation to our beliefs; Madill & Gough, 2008) with a foundation in three key areas of the philosophy of knowledge: phenomenology, hermeneutics and ideography (Smith et al., 2009). IPA was therefore considered appropriate to the research question and its aim of understanding rather than explanation.

Validity: Guidelines for enhancing the validity of qualitative research were consulted during the planning of the study (e.g. Elliott, Fischer & Rennie, 1999; Yardley, 2000; Flick, 2009) and the standard analytic processes for IPA, as set out by its developer, were also followed (Smith et al., 2009). In doing so, the researchers adhered to the following characteristics of good qualitative research: sensitivity to context, commitment and rigour, transparency and coherence (Yardley, 2000). A line-by-line analysis of the transcripts was undertaken by the main author, who also took the lead in the identification of the emergent patterns and themes within the data set. Confidence that the final themes accurately reflected the participants' experiences was achieved through grounding the analysis using examples from all participants that reflected the thematic structure. At each stage, the emerging analysis was discussed and developed through collaboration with the co-authors, who checked that the emergent themes accurately reflected the data and that the selected example quotes were relevant.

Reflexivity: The first author is a counselling psychologist in training and was drawn to this topic due to her clinical experience working with people with OCD. The second author is a Counselling Psychologist by training with an interest in mindfulness approaches but limited clinical experience with OCD. The third author is an academic Psychologist with a research interest in anxiety and mindfulness.

This research was conducted within a scientist-practitioner model, which makes explicit that the actions of a counselling psychologist cannot be separated from the economic, political and social contexts in which they operate (Bury & Strauss, 2006). This involves recognition that the research process was influenced by the researcher's inter-subjective experiences as a counselling psychologist, and other wider contexts.

Results

The analysis found three super-ordinate themes; the first two highlighted the participants' changing relationship to their thoughts and anxiety and demonstrated their awareness of developing a new sense of self and way of

being through the practice of mindfulness (Bond, 2015). For reasons of space, only the third theme “Mindfulness as a Guard” against OCD is described here. This theme is presented because it was both unexpected and has significant implications for the mental-health profession.

The Mindfulness as a Guard theme emerged as participants reflected on how they used mindfulness practice as an active strategy, or technique, to combat intrusive thoughts or compulsive behaviours. The theme contains three sub-themes: “Mindfulness as reassurance and memory aid”, “Mindfulness as distraction” and “When mindfulness fails”.

Mindfulness as reassurance and memory aid

Seeking reassurance is a common characteristic of sufferers of OCD (Veale & Roberts, 2014). This reassurance-seeking behaviour can take many forms, such as asking others to disconfirm beliefs or engaging in neutralising behaviours. Some of the participants of this study appeared to use mindful awareness to check the validity of their intrusive thoughts and thereby reassure themselves the thought was not true. In addition, one participant described using mindfulness to reassure herself she had performed compulsions in response to intrusive thoughts.

For example, Olivia talked about her anxiety as a “spike” that appears to take up her full attention, and how, with mindful attention, she brings herself back to experiencing the present moment. This paying attention to her senses in the moment provided her with a powerful argument against her intrusive thoughts.

I'll still get the spike and then at that moment I have to actually say, "Go through the list of: you know you didn't do it, no, no way, no senses, nothing else", which I call self-reassurance, which is much better than asking somebody else.

Olivia also used mindful awareness to check or reinforce her memory of events and this enabled her to reassure herself mentally that the event had not taken place: “I can actually think, ‘No you haven’t done that’, ‘You couldn’t have done that’ and I can just let them [intrusive thoughts] go.”

Similarly, Carrie also described using mindful awareness to combat intrusive thoughts. For example, Carrie explained how by “making myself aware“, she was able to test out a thought and reassure herself that she did not perform some unwanted action.

When I'm out and about, if I think I might have touched something or done something, I'll question what I, what was happening at that time. 'Okay, so you think you touched that? What, hand, what part of your hand did you touch it with? What finger did you touch it?'. And then you think, 'Well I don't know, because I didn't touch it did I?' So it's making myself aware.

Thus increased mindfulness awareness allowed Carrie to check back through her memory and argue against her OCD intrusive thoughts; so, like Olivia, she appeared to be using mindfulness as reassurance to manage the doubt created by her intrusive thoughts. Carrie also reported that if she began a compulsion, that she performed the ritual with more focused attention to “reinforce” or reassure herself that she had completed it. This use of mindful attention apparently reduced the need to repeat compulsive behaviours and thereby lessened the overall time Carrie would spend on compulsions.

I think, um, a lot of my OCD is around doubt, so being, doing a compulsion and then being doubtful that I've done it, so I've done it and my anxiety is reduced, then I sit down and I think 'I don't remember doing it,' so I have to do it again. Whereas being mindful it, it, well I don't know what the word is, it reinforces the fact that I've done it.

As these quotes show, some of the participants were using mindfulness to monitor their OCD in a way that kept them engaged in the thoughts and compulsions. What was clear was the participants found this helpful as it reduced anxiety and the time taken on compulsions and hence this provided great relief. This use of mindfulness appeared to enable the participants to gather strength to fight off the OCD. There is however, an indication here that mindfulness, although it was being used to reduce the symptoms of the OCD, was also becoming *part* of the OCD. Steve, who had more mindfulness

experience than many of the other study participants, had found that when he used what he labelled as “mindful checking” or “wrong mindfulness”, defined as: “performing mental checking with awareness” that his anxiety was reduced but this did not help reduce the symptoms of his OCD. Whereas he suggested that: “Right mindfulness for OCD is observing and radically accepting the obsessive thoughts and urges to perform compulsive behaviour – without doing it, just watching the urges to do it.” However, changing the response to thoughts, rather than using mindfulness to reduce anxiety was not the easy option as demonstrated by Steve’s comment: “Right mindfulness is remembered all the way to the peak level of anxiety.”

Mindfulness as distraction

Distraction, or what is sometimes termed refocusing, is promoted by some authors (e.g. Schwartz & Beyette, 2009) as a useful strategy for combating of OCD. All of the participants, apart from Gordon, talked about being more mindfully aware so they could notice that they needed to distract themselves, and some reported using mindfulness practices, such as performing an activity mindfully, as way to distract from problematic thoughts.

There were many instances in Olivia’s dialogue where she described using distraction. For example, Olivia described paying mindful attention to her surroundings to distract herself from thoughts of the contamination she fears from public drains: “And therefore I’ll listen to the birds, and instead of looking down at the drain I’ll listen to the birds and I’ll see the blueness of the sky and I’ll feel the air and it’s very, very grounding.”

Similarly, for Paul, distraction was seen as an important strategy to manage his OCD, “So obviously if I get an obsessive thought, I will say, obviously it’s my OCD, accept it, ignore it and refocus [on something else], and that is the key”.

Carrie likened mindfulness to being fully focused on a task, which itself distracted from the OCD: “I think it’s a bit like when you have an emergency at work, you know, everything kind of goes out the window for a moment doesn’t it? And you just focus on what’s going on.”

There is a general sense, in these and similar quotes, of the participants actively avoiding their OCD by focusing attention on something else. By distracting from the intrusive thoughts, Carrie, Paul and Olivia were also apparently giving themselves a period of time free of OCD so that they could renew the fight later on.

Becky seemed to need to avoid the symptoms of her OCD less than most of the other participants. Hence, Becky did not regularly use distraction, but instead talked about how she used her mindfulness training to stay with the thoughts, as she said, “respond more wisely and from a place of less confusion, or if you are feeling confused just let yourself be like that for a while without trying to act out on it”. However Becky also acknowledged that “a bit of distraction can help, you know, going for a walk and literally focus on the here and now”. This indicates clearly that although Becky had found a way to be much more comfortable with the symptoms of her OCD, she still needed to deliberately create some time to be free of her OCD.

While several participants described using mindfulness in a manner that was akin to the use of distraction, Steve did not advocate this approach. Rather, Steve warned against using mindfulness as a way to aid refocusing or distraction, something he termed a “false fear blocker”, because he had found this prolonged his OCD attacks. Instead, his advice was that:

To treat a longer lasting OCD episode it is necessary to recognize and eliminate all the false fear blockers so the thoughts and anxieties can be fully accepted and experienced with a mindful awareness.

The data raises questions about whether using mindfulness to distract from intrusive thoughts would be, for example when mindfulness was used as a form of checking, helpful in the long run. However, the participants’ discussion of this topic does evidence that many found this very useful, and that as a result they felt more hopeful about managing the burden of their OCD.

When mindfulness fails

In addition to reassurance and distraction, some participants described other ways in which they attempted to use mindfulness as a defence against their intrusive thoughts. In some of these descriptions, it was clear that there were times when participants could experience a rebound effect of the more intrusive obsessive thoughts, which they attributed to mindfulness dropping their guard down.

Paul for example used mindful awareness to ward off his OCD:

Everything can be fine, you can go through a spout of stressful situations and you will be okay and then, because you're not mindfully aware, then your OCD may come out of the closet, and it can at any time.

Paul's quote shows how he conceptualised his mindful practice as an attentional guard against his OCD, which he experienced as lurking always ready to attack him.

Rhianna similarly described how she used mindfulness to “strengthen the rational part of [her] brain”. This allowed Rhianna to take a more observing stance on her thoughts. However, this was not always successful and both Carrie and Rhianna used the word “battle” to describe how they struggled to use mindfulness to defend against being caught in an obsessive cycle with their intrusive thoughts.

[Mindfulness] makes me question the obsessions that come into my mind and I kind of battle with them a bit more rather than just giving in to them straightaway and carrying out the compulsion. [Carrie]

*That's the thing, I think the OCD is having a battle with [mindfulness].
[Rhianna]*

For Carrie and Rhianna, mindfulness was therefore essential to fight the OCD and the metaphor of a battle underlined how, for these two participants, when the shield of mindfulness failed they could experience being defeated by their OCD.

Gordon also talked about mindfulness strengthening his mind so that he could choose to respond to the thoughts in a different way, but his seemed to be a more gentle approach: “so it's just kind of just like taking a different path ... the mindfulness, yes it certainly strengthens my mind and allows me to do that”. However, while Gordon did not conceive of himself as caught in an OCD/mindfulness battle, he did report that mindfulness practice could also lower his defences against OCD thoughts.

Sometimes I can come out of a meditation and at just, at the key point an obsessive thought will sneak in and ruin it, and make me feel quite off for a while. [The OCD has] planted its own little IED in there.

Mindfulness practice for Gordon therefore had a bittersweet quality. On the one hand it was the way forward, on the other hand it could appear to leave him more vulnerable to the effect of an OCD thought; whose occurrence, when he was relaxed by his practice, was experienced like a terrorist explosion.

It appears that the study participants, to counter and resist OCD, sometimes experienced a conflict between their mindfulness and their OCD symptomology where sometimes victory went to the mindfulness, and sometimes to the OCD.

Discussion

Participants of this study regarded mindfulness practice as an extremely useful, if not essential, adjunct to cognitive-behavioural treatments and also a useful addition to the toolkit of strategies to combat OCD (see Bond, 2015, for fuller description of these findings). However, this paper has presented evidence that despite participants' positive experience of mindfulness practice, it had the potential to exacerbate OCD symptoms and be used in ways that may not be helpful for the long-term management of OCD.

Mindfulness as reassurance and memory aid

The data showed that four out of the seven participants had used mindfulness to provide reassurance about the nature of their intrusive thoughts or to reinforce that they had neutralised the thought with a compulsive ritual. In OCD theory, a need for reassurance is thought to stem from an inflated perception of

responsibility, which is a main tenet of the Salkovskis' (1985) cognitive-behavioural model of OCD. It is possible that participants were potentially using a different type of reassurance when they talked about the relief of 'mindfully' reminding themselves that their thoughts were due to OCD and that they could thus reassure themselves that they were not their thoughts. Abramowitz & Arch (2014) call this type of "it's not me, it's my OCD" reassurance 'self-coaching' and suggest it helps to improve meta-awareness of the OCD and strengthens the ability to engage in the exposure work required to eliminate compulsive behaviours. However, the way that participants talked about their use of mindfulness did not, in the view of the researchers, support the idea that the participants were always using mindfulness in this 'self-coaching' way. The distinction is important because in the cognitive treatment of OCD an overinflated sense of responsibility and reassurance seeking is generally seen as an avoidance strategy (Veale & Roberts, 2014) and part of the treatment involves bringing attention to this behaviour so it can be eliminated (Himle & Franklin, 2009).

In the current study, some of the participants also appeared to use mindfulness explicitly as a replacement for other reassurance-seeking behaviours. The questions are whether this mindful reassurance-seeking acts as a form of neutralising and whether this is helpful or not. The Salkovskis cognitive model of OCD and the apparent success of conventional CBT/ERP OCD treatment would imply that it is not, and indeed, it has been suggested that mindfulness may prevent successful exposure work in OCD by becoming a counter-productive neutralising technique (Fairfax, 2008). Mindfulness for some of the participants in this study would therefore seem to have been used for short-term alleviation of anxiety in a way that may not provide long-term benefit. This finding therefore has implications for the how mindfulness should be used in the treatment of OCD.

Mindfulness as distraction

Another finding of this research is that six of the seven participants reported that they had used, or were using, mindfulness to increase their ability to distract themselves from intrusive thoughts and four of those who used mindfulness this

way reported experiencing it as useful. This report is consistent with the empirical findings that distraction can be useful for phobia (Oliver & Page, 2003) and anxiety (Simon, Adler, Kaufmann & Kathmann, 2014). Studies examining the use of mindfulness techniques alongside distraction with obsessive intrusive thoughts have however found mixed results: Najmi, Riemann & Wegner (2009) found some benefit from focused distraction but Wahl et al. (2013) found no benefit of distraction.

Further, while there is still debate about the effect and use of distraction in the treatment of OCD (Gillihan, Williams, Malcoun, Yadin & Foa, 2012), in a summation of a number of studies Parrish, Radmosky & Dugas (2008) concluded that anxiety-neutralising strategies, such as distraction, have the potential to become counter-productive in the treatment of anxiety disorders. This suggests that while participants reported positive effects from using mindfulness to distract themselves that this too, in the long term, may potentially exacerbate the effects of OCD; significantly, this was also a view expressed by one of the participants based on his own experience of managing his OCD.

When mindfulness fails

This study showed that along with providing some participants with a mechanism for distraction and a potential source of reassurance, mindfulness also was used more generally to defend against the symptoms of OCD and that when this attentional guard failed intrusive thoughts sometimes gained more power or significance. This finding suggests that mindfulness may have been used as an aid to thought suppression. It has been suggested that metacognitive beliefs regarding the need to control or suppress thoughts are important factors in maintaining OCD (Purdon & Clark, 1999), and there is evidence that engagement in thought suppression is likely to result in the thought returning more frequently (Wegner, Schneider, Carter & White, 1987) and be counterproductive in OCD (Purdon, 2004; Najmi et al., 2009). If mindfulness was being used to suppress intrusive thoughts, this could explain the observed rebound effect after using mindfulness where, for some, the OCD thoughts became more intrusive.

The active use of mindfulness to suppress or protect against OCD intrusive thoughts was an unexpected finding, but it was not used by all participants. Those who did use mindfulness in this way appeared to be using it more as a tool or strategy, explicitly and almost exclusively, to combat their OCD symptomology. In contrast, other participants who had embraced mindfulness more broadly and adopted a non-striving attitude to a range of different experiences seemed more able to accept, and even welcome, their OCD (Bond, 2015). The use of mindfulness simply as a therapeutic technique has been questioned by Moss & O'Neill (2003) and this study would appear to indicate, that at least for OCD, that there might be an issue with incorporating mindfulness purely as a strategy to help combat symptoms.

Summary of the negative impact of mindfulness in the context of OCD

The use of the strategies outlined in this paper could be regarded as reluctance on the part of some of the participants to accept their intrusive thoughts and perhaps even the condition itself; this failure to accept their OCD challenges one of the main tenets of mindfulness, which is to be with experience exactly as it is (Kabat-Zinn, 2003). Therefore, there is a question as to whether the mindfulness practiced by some of the participants can truly be called mindfulness. This paper thus provides support for those like Moss & O'Neil (2003) who question whether mindfulness can be just another technique in mental health settings and whether it is helpful to deconstruct mindfulness into discrete components while stripping out any philosophical or cultural context.

Future Research

The analysis in this study found instances of mindfulness practice being conducted in a way that may not help in the long-term recovery from OCD. Therefore, more longitudinal studies are required to assess how people with OCD use and experience mindfulness to assess its effectiveness as an adjunct to treatment.

In this study, the term mindfulness was used by the participants to describe different components of mindfulness (e.g. increased attention and awareness, non-judging awareness and acceptance, being in the moment). Intuitively, it

would seem that these components might be helpful even when used in isolation. However, for OCD, there would appear to be problems with using increased attention without acceptance. More research is therefore needed to evaluate if the deconstructed components of mindfulness are sufficient to bring relief of OCD symptoms, or if mindfulness is more than the sum of its parts.

Implications for Practice

This study has important implications for both service providers and improving client care in all forms of OCD treatment. It identified that mindfulness was being incorporated into OCD compulsions in ways that contradict the current evidence base and accepted practice. As mindfulness reduced anxiety and distress, the participants reported this as helpful. Clinicians therefore need to be aware of these findings and be vigilant for ways in which mindfulness may be used for short-term relief, rather than as a long-term effective way to help manage OCD.

Limitations

The current study brings with it limitations inherent in the IPA qualitative method used, particularly the difficulty in generalising the findings beyond the current sample (Maxwell, 1992).

It should be noted that the participants in this study did not come from a wide socio-cultural background, and were exclusively Caucasian. However, the lack of variation in OCD across ethnic and social cultures reduces the impact of this limitation (NICE, 2006).

In addition, the sample was subject to bias in that all the participants had found the use of mindfulness in the treatment and management of their OCD useful. In view of this, the fact that participants' reports provide evidence that mindfulness may not always be helpful in the context of OCD is especially significant.

References

- Abramowitz, J. S. & Arch, J. J. (2014). Strategies for Improving Long-Term Outcomes in Cognitive Behavioral Therapy for Obsessive-Compulsive Disorder: Insights From Learning Theory. *Cognitive and Behavioral Practice, 21*, 20-31.

- Alderson, P. (1999). *On doing qualitative research linked to ethical healthcare*. London: The Wellcome Trust.
- Appel, J. & Kim-Appel, D. (2009). Mindfulness: Implications for Substance Abuse and Addiction. *International Journal of Mental Health Addiction*, 7, 506-512.
- Bishop, S. R., Lau, M., Shapiro, S., Carlson, L., Anderson, N. D. et al. (2004). Mindfulness: A proposed operational definition. *Clinical Psychology: Science and Practice*, 11(3), 230-241.
- Bond, M. S. (2015). *Experiences of Mindfulness for clients with OCD: An IPA study*. (Unpublished doctoral dissertation). University of the West of England, Bristol, United Kingdom.
- Brown, K. W., Ryan, R. M. & Creswell, J. D. (2007). Mindfulness: Theoretical foundations and evidence for its salutary effects. *Psychological Inquiry*, 18(4), 211-237.
- Bury, D. & Strauss, S. M. (2006). The Scientist-Practitioner in a Counselling. In D. A. Lane & S. Corrie (Eds.), *The Modern Scientist-Practitioner: A Guide to Practice in Psychology* (pp. 112-126). London: Routledge.
- Chadwick, P., Newman Taylor, K. & Abba, N. (2005). Mindfulness Groups for People with Psychosis. *Behavioural and Cognitive Psychotherapy*, 33, 351-359.
- Eddy, K. T., Dutra, L., Bradley, R. & Westen, D. (2004). A multidimensional meta-analysis of psychotherapy and pharmacotherapy for obsessive-compulsive disorder. *Clinical Psychology Review*, 24(8), 1011-1030.
- Elliott, R., Fischer, C. & Rennie, D. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, 38(3), 215-229.
- Fairfax, H. (2008). The use of Mindfulness in Obsessive Compulsive Disorder: Suggestions for its Application and Integration in Existing Treatment. *Clinical Psychology and Psychotherapy*, 15, 53-59.
- Finucane, A. & Mercer, S. W. (2006). An exploratory mixed methods study of the acceptability and effectiveness of mindfulness-based cognitive therapy for patients with active depression and anxiety in primary care. *BMC Psychiatry*, 6(14).
- Fisher, P. L. & Wells, A. (2005). How effective are cognitive and behavioural treatments for obsessive-compulsive disorder? *Behaviour Research and Therapy*, 43, 1543-1558.
- Flick, U. (2009). *An introduction to qualitative research* (4th ed.). London: Sage Publications Ltd.
- Gillihan, S. J., Williams, M. T., Malcoun, E., Yadin, E. & Foa, E. B. (2012). Common pitfalls in exposure and response prevention (EX/RP) for OCD. *Journal of obsessive-compulsive and related disorders*, 1(4), 251-257.
- Greeson, J. M. (2009). Mindfulness Research Update: 2008. *Complementary Health Practice Review*, 14(10), 10-18.
- Hale, L., Strauss, C. & Taylor, B. L. (2012). The Effectiveness and Acceptability of Mindfulness-Based Therapy for Obsessive Compulsive Disorder: A Review of the Literature. *Mindfulness*, Published online 01 August 2012, 1-8.

- Hanstede, M., Gidron, Y. & Nyklíček, I. (2008). The Effects of a Mindfulness Intervention on Obsessive-Compulsive Symptoms in a Non-Clinical Student Population. *The Journal of Nervous and Mental Disease*, 196(10), 776-779.
- Hayes, S. C., Luoma, J. B., Bond, F. W., Masuda, A., & Lillis, J. (2006). Acceptance and commitment therapy: Model, processes and outcomes. *Behaviour Research and Therapy*, 44(1), 1-25.
- Hepburn, S. R., Crane, C., Barnhofer, T., Duggan, D. S., Fennell, M. J. & Williams, J. M. (2009). Mindfulness-based cognitive therapy may reduce thought suppression in previously suicidal participants: Findings from a preliminary study. *British Journal of Clinical Psychology*, 48, 209-215.
- Hershfield, J. & Corboy, T. (2013). *The Mindfulness Workbook for OCD: A Guide to Overcoming Obsessions and Compulsions Using Mindfulness and Cognitive Behavioral Therapy* (Kindle Edition ed.). New Harbinger Publications.
- Hertenstein, E., Rose, N., Voderholzer, U., Heidenreich, T., Nissen, C., Thiel, N. et al. (2012). Mindfulness-based cognitive therapy in obsessive-compulsive disorder - A qualitative study on patients' experiences. *BMC Psychiatry*, 12.
- Himle, M. B. & Franklin, M. E. (2009). The more you do it, the easier it gets: Exposure and response prevention for OCD. *Cognitive and Behavioral Practice*, 16(1), 29-39.
- Kabat-Zinn, J. (2003). Mindfulness-Based Interventions in Context: Past, Present, and Future. *Clinical Psychology Science and Practice*, 10, 144-156.
- Keng, S. L., Smoski, M. J. & Robins, C. J. (2011). Effects of mindfulness on psychological health: A review of empirical studies. *Clinical Psychology Review*, 31(6), 1041-1056.
- Klainin-Yobas, P., Cho, M. A. & Creedy, D. (2012). Efficacy of mindfulness-based interventions on depressive symptoms among people with mental disorders: A meta-analysis. *International Journal of Nursing Studies*, 49(1), 109-121.
- Linehan, M. M. (1993). *Cognitive-Behavioral Treatment of Borderline Personality Disorder (Diagnosis and Treatment of Mental Disorders)*. Kindle Edition ed. s.l.:Guilford Publications.
- Madill, A. & Gough, B. (2008). Qualitative research and its place in psychological science. *Psychological Methods*, 13(3), 254-271.
- Maxwell, J. A. (1992). Understanding and validity in qualitative research. *Harvard Educational Review*, 62(3), 279-301.
- Moss, D. & O'Neill, B. (2003) Just another technique? Possibilities and paradoxes in working with mindfulness. *Clinical Psychology*, Volume 31, pp. 29-33.
- Najmi, S., Riemann, B. C. & Wegner, D. M. (2009). Managing unwanted intrusive thoughts in obsessive-compulsive disorder: Relative effectiveness of suppression, focused distraction, and acceptance. *Behaviour Research and Therapy*, 47(6), 494-503.
- NICE. (2005). *Obsessive-Compulsive Disorder: Core Interventions in the Treatment of Obsessive-Compulsive Disorder and Body Dysmorphic Disorder*. London: National Institute for Health and Clinical Excellence.

- NICE. (2006). *Obsessive compulsive disorder: Clinical Guideline 31 - Core interventions in the treatment of obsessive compulsive disorder and body dysmorphic disorder*. The British Psychological Society and The Royal College of Psychiatrists.
- Oliver, N. S. & Page, A. C. (2003). Fear reduction during in vivo exposure to blood-injection stimuli: Distraction vs. attentional focus. *British Journal of Clinical Psychology*, 42(1), 13-25.
- Parrish, C. L., Radomsky, A. S. & Dugas, M. J. (2008). Anxiety-control strategies: Is there room for neutralization in successful exposure treatment? *Clinical Psychology Review*, 28(8), 1400-1412.
- Purdon, C. (2004). Empirical investigations of thought suppression in OCD. *Journal of Behavior Therapy and Experimental Psychiatry*, 35(2), 121-136.
- Purdon, C. & Clark, D. A. (1999). Metacognition and Obsessions. *Clinical Psychology and Psychotherapy*, 6, 102-110.
- Roemer, L., Orsillo, S. M. & Salters-Pedneault, K. (2008). Efficacy of an Acceptance-Based Behavior Therapy for Generalized Anxiety Disorder: Evaluation in a Randomized Controlled Trial. *Journal of Consulting and Clinical Psychology*, 76(6), 1083-1089.
- Salkovskis, P. M. (1985). Obsessional-compulsive problems: A cognitive-behavioural analysis. *Behaviour research and therapy*, 23(5), 571-583.
- Salkovskis, P. M. (1999). Understanding and treating obsessive-compulsive disorder. *Behaviour Research and Therapy*, 37, 29-52.
- Sarris, J., Camfield, D. & Berk, M. (2012). Complementary medicine, self-help, and lifestyle interventions for Obsessive Compulsive Disorder (OCD) and the OCD spectrum: A systematic review. *Journal of Affective Disorders*, 138(3), 213-221.
- Schwartz, J. M. & Beyette, B. (2009). *Brain Lock: Free Yourself from Obsessive-Compulsive Behavior* (Kindle Edition ed.). HarperCollins.
- Shafran, R., Thordarson, D. S. & Rachman, S. (1996). Thought-Action Fusion in Obsessive Compulsive Disorder. *Journal of Anxiety Disorders*, 10(5), pp. 379-391.
- Siegel, D. J. (2007). *The Mindful Brain: Reflection and Attunement in the Cultivation of wellbeing*. New York: WW Norton & Company.
- Simon, D., Adler, N., Kaufmann, C. & Kathmann, N. (2014). Amygdala hyperactivation during symptom provocation in obsessive-compulsive disorder and its modulation by distraction. *NeuroImage: Clinical*, 4, 549-557.
- Smith, J. A., Flowers, P. & Larkin, M. (2009). *Interpretive Phenomenological Analysis*. London: Sage.
- Stanley, M., Turner, S., Heiser, N. & Beidel, D. (2004). Obsessive-Compulsive Disorder. In H. E. Adams & P. B. Sutker (Eds.), *Comprehensive Handbook of Psychopathology*. Dordrecht, The Netherlands: Springer Science+Business Media, Inc.
- Torres, A. R. et al. (2006). Obsessive-Compulsive Disorder: Prevalence, Comorbidity, Impact, and Help-Seeking in the British National Psychiatric Morbidity Survey of 2000. *American Journal of Psychiatry*, Volume 163, pp. 1978-1985.

- Turner, K. (2009). Mindfulness: The Present Moment in Clinical Social Work. *Clinical Social Work Journal, 37*, 95-103.
- Veale, D. & Roberts, A. (2014). Obsessive-compulsive disorder. *BMJ, 348*.
- Wahl, K., Huelle, J. O., Zurowski, B. & Kordon, A. (2013). Managing Obsessive Thoughts During Brief Exposure: An Experimental Study Comparing Mindfulness-Based Strategies and Distraction in Obsessive–Compulsive Disorder. *Cognitive Therapy and Research, 37*, 752-761.
- Wegner, D. M., Schneider, D. J., Carter, S. R. & White, T. L. (1987). Paradoxical effects of thought suppression. *Journal of Personality and Social Psychology, 53*(1), 5-13.
- Wilkinson-Tough, M., Bocci, L., Thorne, K. & Herlihy, J. (2010). Is Mindfulness-Based Therapy an Effective Intervention for Obsessive–Intrusive Thoughts: A Case Series. *Clinical Psychology and Psychotherapy, 17*, 250-268.
- Willig, C. (2013) *Introducing qualitative research in psychology*. 3rd ed. Maidenhead: Open University Press.
- Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology & Health, 15*(2), 215-228.

Dissertation Abstract

Mindfulness has been proposed as a potential treatment for obsessive-compulsive disorder (OCD), a debilitating condition that for many is life-long. However, it is not clear whether, and how, mindfulness is experienced as helpful by OCD sufferers. The aim of this research was to explore the experiences of people with OCD who used mindfulness practices in order to investigate these questions. A study into how mindfulness is experienced within the context of OCD is important to establish how OCD sufferers apply mindfulness both in the treatment of their OCD and more generally in their lives; to hear from them what understanding they have about how mindfulness affects their OCD; and to discover what they perceive as helpful or unhelpful.

Interpretative Phenomenological Analysis (Smith, Flowers & Larkin, 2009) was used to analyse semi-structured interview transcripts from seven participants (3 men, 4 women) who had lived with OCD for between 2 and 45 years and who had used mindfulness from four months to five years.

The analysis revealed that while mindfulness was not a cure for OCD, all the participants considered it to be a beneficial adjunct to, or replacement for, the existing treatment for OCD. Mindfulness helped participants change their relationship to intrusive thoughts and develop a new way of being more comfortable with themselves and their OCD. This finding has added to the limited research that has shown mindfulness practice can be a useful addition to the treatment for OCD. However, this study also found that mindfulness could, for some, become incorporated into the OCD in ways that might be considered unhelpful (see journal article).

The thesis discussion focuses on two main areas. First, it examines how the participants' lived experience of OCD sits alongside the dominant models of OCD outlined in the literature review. Second, the finding that there are possible areas of concern for the use of mindfulness is addressed within a more general discussion of whether mindfulness is useful just as a technique in the treatment of OCD. The discussion concludes with some implications for clinical practice and recommendations for further research.

Introduction

This dissertation explores the accounts that people with OCD give about their experiences of mindfulness. While there has been significant examination of OCD, both theoretical and investigational, the accumulated knowledge base falls predominately within a positivist epistemological and quantitative perspective and the voice of OCD sufferers is not well represented in academic literature (Murphy & Perera-Delcourt, 2012). The author of this study is a trainee counselling psychologist and this influenced the author's aim to provide a critical realist view that is more in keeping with the philosophy and character of counselling psychology practice. At this point, it should be noted that the author is aware of the tension between a counselling psychology position and the use of diagnosis such as OCD (Larsson, Brooks & Loewenthal, 2012). This subject is expanded on later in the dissertation, but with this in mind, the word treatment is often enclosed in single quotation marks to indicate the author is utilising a counselling psychology perspective to question the use of this term.

While many studies have demonstrated the benefits of mindfulness interventions for wellbeing and the 'treatment' of various medical and mental health conditions (e.g. PTSD, Wahbeh, Lu & Oken, 2011; borderline personality disorder, O'Toole, Diddy & Kent, 2012; psychosis, Dennick, Fox, & Walter-Brice, 2013), it will be shown there is as yet little research pertaining to its use with OCD. The following literature review will demonstrate both the debilitating nature of OCD and some problems with current treatments. If more people with OCD are to be offered a better quality of life then alternative 'treatments' or ways of managing the condition need to be found. It is hoped that this qualitative study will add to the current knowledge base and bring to the fore the voice of people with OCD, in order that more sufferers of the condition can be helped. It is anticipated that through increasing understanding of the complexity of how mindfulness is experienced by people with OCD, practitioners in mental health services will be better equipped to develop appropriate and effective ways of working with this client group. Furthermore, this dissertation will show ways in which mindfulness helped the participants develop new ways

of responding to their condition that, independent of any treatment regime, helped them manage their OCD.

Literature Review

This literature review examines the research relating to OCD and mindfulness and the use of mindfulness as a psychotherapeutic intervention for OCD. After providing an overview of OCD, it sets the context for this research study by providing a synopsis of the literature on OCD aetiology, theoretical perspectives and treatment. The topic of mindfulness is introduced with a brief coverage of its origins and some definitions, followed by an examination of the ways in which mindfulness has contributed to the psychotherapeutic treatment of a number of mental health issues and conditions. Some proposed mechanisms for how mindfulness effects change are also reviewed. Finally, the small number of studies exploring the use of mindfulness as a treatment for OCD are considered in more detail, with the aim of showing how this study fills a gap in the literature.

As will be shown, OCD is often a chronic and debilitating condition. A large percentage of OCD sufferers fail to access treatment or only do so after a considerable number of years of living with the condition, and when they do access treatment many fail to find full relief from symptoms and a significant percentage relapse following treatment. Whilst mindfulness is not commonly used in the treatment of OCD, there are a number of reasons to suggest it may be an effective adjunct to conventional treatment, since mindfulness may address some of the underlying factors believed to contribute to the symptoms or maintenance of OCD (Fairfax, 2008).

As will be noted in this literature review, the application of mindfulness to OCD is a relatively recent practice. Not only does this research aim to understand how mindfulness is experienced by those with OCD and how it may function as a 'treatment' for OCD, it is also hoped it will add significantly to the small amount of qualitative research into the lived experience of OCD sufferers - who rarely have a voice in current research (Murphy & Perera-Delcourt, 2012).

Obsessive-Compulsive Disorder

OCD is a mental health condition that was classified as an anxiety disorder in the fourth edition of the American Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; APA, 2000) however the DSM-5 version (APA, 2013) has seen

the creation of a grouping titled “Obsessive-Compulsive and Related Disorders”, which includes body dysmorphic disorder (a disorder in which a person becomes obsessed with imaginary defects in their appearance) and trichotillomania (a compulsive desire to pull out one's hair; Grohol, 2013). This separation has been made “to reflect the increasing evidence of these disorders’ relatedness to one another and distinction from other anxiety disorders” (APA, 2013, p. 235) and is not an indication that OCD is no longer considered an anxiety condition. Similarly, OCD is described as a Neurotic, Stress-related and Somatoform Disorder in the International Classification of Diseases (ICD-10; World Health Organization, 2010).

Definition of OCD

Both the ICD-10 and the DSM-5 describe and classify OCD in terms of its symptoms; which, according to the ICD-10, are: recurrent obsessional thoughts (ideas, images or impulses that enter the patient's mind repeatedly in a stereotyped form), or compulsive acts (ritualised behaviours performed as a symbolic and ineffectual attempt to avert danger), or both obsessions and compulsions. In order to receive a diagnosis of OCD it is not sufficient to have intrusive thoughts and compulsions, the symptoms must also cause distress (i.e. they must be ego-dystonic) or interfere with daily functioning. In addition, the diagnosis of OCD is ruled out where the behaviours result in the completion of inherently useful tasks (World Health Organization, 2010).

As a counselling psychologist, the author takes a critical stance on the idea that emotional difficulties are symptoms of an ‘illness’ located within a person and that these difficulties can therefore be diagnosed and treated in the same way as a medical condition. Lucy Johnstone (2008), a critic of the use of diagnosis, points out that in general medicine a diagnosis serves many purposes including: providing useful information to patients, enabling predictions about prognosis and outcome, being a basis for research and providing patients access to services; Johnstone argues it is much harder to identify similar benefits for a mental health diagnosis.

Another problem is that the system of categorisation of mental health conditions is potentially subject to unconscious bias. For example, Ian Parker argues that diagnostic systems such as the DSM or ICD classifications are contingent upon narrow historical and cultural conventions that favour modern, white, Western assumptions about the self, emotions and pathology (Parker, 2006).

On the other side of the argument, Norman Macaskill (2006) agrees that diagnostic labels can be problematic, leading to stigma, dehumanising and coercive treatment and the potential abuse of power, but argues that diagnostic labels can also provide meaning, relief or hope to otherwise confused or frightened patients.

The author was aware of the debate and controversy of the use of diagnostic labels within the mental health arena; however, when planning this study she chose to adopt a pragmatic approach. In order to recruit participants with a common experience of intrusive thoughts and compulsions and also to obtain ethical approval within the NHS it was a practical requirement to use the term OCD. However, the most compelling reason for the use of the term is the way it is used and accepted by people with OCD. In a qualitative study undertaken by Murphy and Perera-Delcourt (2012) into the lived experience of people with OCD, they concluded that participants valued a medical diagnosis of OCD as it provided them with an understanding of a baffling condition and gave them hope that they could recover.

Early References to OCD

OCD is not a modern phenomenon, as reports of individuals displaying symptoms of obsessions and compulsions appear as early as the 17th century; typically, these were classified as indications of religious melancholy (Stanford School of Medicine, 2012). In the 18th and 19th centuries, OCD was generally considered a form of insanity (ibid.). However in the 20th century, as scientific methods of discovery advanced, so did the understanding of OCD, and today people with OCD are no longer considered unable to distinguish fantasy from reality – though the amount of insight (the ability to recognise the senselessness of obsessions)

does vary (NICE, 2006). However, as will be seen, the condition is still perceived by many of its sufferers as a form of madness (NICE, 2006).

Categories of OCD

Although OCD is categorised in the DSM 5 as a unitary syndrome (APA, 2013), it is increasingly being regarded as a heterogeneous condition incorporating a number of different sub-types (Taylor, 2005). Categorisations based on the type of compulsions or behaviours, such as “washers”, “checkers” or “phobics”, have been suggested (Turner et al., 1979) but this type of categorisation is problematic as few OCD sufferers have distinct, non-overlapping symptoms (Mataix-Cols et al., 2002).

Calamari and colleagues (2004) found support for a seven-subgroup taxonomy that included: contamination, harming, hoarding, symmetry, certainty (characterised as a need to have absolute certainty on many issues, often to prevent harm occurring), obsessional and contamination/harming. However, they go on to say that, a taxonomy of this kind is only useful if it is found that each sub-group responds differently to treatment, and this has yet to be established.

Prevalence

Studies using community samples show an average lifetime prevalence of OCD to be 1% to 3% (Samuels & Nestadt, 1997; Wittchen & Jacobi, 2005). Using data from the 2000 British National Psychiatric Morbidity Survey, Torres and colleagues (2006a) found the incidence of OCD to be 1.1% in a sample of 8,580 individuals living in England, Wales and Scotland. In line with other studies, Torres et al. found OCD is more prevalent in females than males (1.3% vs. 0.9%) and declined with increasing age, from 1.4% among those aged 16-24, 1.2% aged 25-44, 1.1% aged 45-64 and 0.2% aged 65-74. They concluded that OCD is a “rare yet severe mental disorder”, and “is an atypical neurosis, of which the public health significance has been underestimated” (ibid., p. 1978).

Although the prevalence of OCD is less than some other mental health conditions, it is nevertheless a severe, stigmatising and debilitating disorder (Murphy & Perera-Delcourt, 2012). OCD is ranked by the World Health

Organization in the top 10 of the most disabling illnesses by lost income and decreased quality of life (Doron & Kyrios, 2005; Koran et al., 2007), and a US national comorbidity survey indicated that OCD is the anxiety disorder with the highest percentage (50.6%) of serious cases (Koran et al., 2007). It is therefore a condition that merits significant research effort in order to help alleviate symptoms and improve quality of life.

Onset

OCD typically starts in childhood or adolescence with over 80% of individuals having onset before the age of 18 (Riddle, 1998). Recent research has suggested factors that predict good treatment outcomes vary according to the age of onset (Langner et al., 2009). In a study of 63 OCD patients, Langner and colleagues also found that with early onset OCD (EOCD; typically before the age of 13) sufferers experienced a greater diversity of symptoms, more familial aggregation of the condition and more comorbid tic-disorders than those with late onset OCD (LOCD; typically after the age of 15). In a separate study, adults with EOCD and LOCD showed differences in the patterns of regional cerebral blood flow in the frontal-subcortical regions of the brain; as will be shown later, these regions of the brain are implicated in presentations of OCD (Taylor, 2005).

This is one of the many indications of the heterogeneous nature of OCD and why it is important that individual experience of the condition be considered.

Comorbidity

Estimates for comorbidity accompanying OCD vary from 60-75%, with, perhaps unsurprisingly, major depressive disorder being the most common comorbid condition. This is followed by generalized anxiety disorder, agoraphobia or panic disorder, social phobia, and specific phobia (Samuels & Nestadt, 1997; Torres et al., 2006b). Torres et al. (2006b) also reported that 12.7% of OCD sufferers screened positive for possible psychosis representing a larger percentage than would be expected in the general population.

Torres and colleagues (2006a) also found approximately 74% of individuals with OCD met self-screening criteria for at least one personality disorder, and slightly over 50% of those also met the criteria for two or more. This matched a previous

Scandinavian clinical examination that found 75% of OCD sufferers had a comorbid personality disorder (Bejerot, Ekselius & von Knorring, 1998). The same study also analysed personality traits and proposed that people with OCD are hypersensitive worriers, with a great deal of somatic anxiety and an inability to relax. They go on to suggest that such individuals seem to lack self-assertiveness, and avoid involvement with others. These traits have relevance for this study as will be described later when difficulties in recruiting participants are discussed.

A link with obsessive-compulsive personality disorder (OCPD; also known as anankastic personality disorder; a personality characterized by extreme perfectionism, preoccupation with neatness and detail, and a need to control one's environment) has been both disputed and corroborated in several studies (Bejerot et al., 1998). Albert and colleagues (2004) found the prevalence of OCPD was higher in OCD sufferers than in non-clinical individuals but they also found OCPD was higher in other populations so concluded that there is not a specific association between OCD and OCPD.

Although the above suggests there is a link between OCD and a number of comorbid conditions, Samuels and Nestadt (1997) suggest, “[c]omorbidity between OCD and another disorder may be an artefact of treatment seeking or a result of confounding by a factor associated with both disorders” (ibid., p. 66). They go on to offer an alternative explanation, that OCD and the comorbid disorder may share a common aetiology. Therefore, it would appear the relationship between OCD and other presenting issues may be a complex one.

It is also important to note that within a counselling psychology context the categorical nature of DSM descriptions of conditions might be rejected in favour of a formulation of the OCD sufferers' condition that embraces both the deficits and strengths that the person experiences, without the need to apply several diagnostic labels. As the next section highlights, OCD itself is experienced as shaming, without the additional burden of multiple diagnoses. However, the evidence that there is a high incidence of comorbid features to the condition is

further testimony to its complexity and severity and the importance of finding new ways to relieve symptoms of the condition.

Impact

There is good evidence that OCD significantly impairs quality of life for both sufferers (Torres et al., 2006b) and for family members (Cicek et al., 2013). In a study of the lived experience of OCD sufferers, Murphy and Perera-Delcourt (2012) concluded that individuals experience a “sense of overwhelming personal failure matched against age appropriate life cycle goals” (ibid., p. 1). In addition, OCD sufferers are more likely to report an impact on their social and work functioning than both non-sufferers and individuals diagnosed with other mental health conditions (Torres et al., 2006b). Torres and colleagues also note that individuals with OCD are “less likely to be married, more likely to be unemployed, more likely to have very low income levels, and more likely to have low occupational status” (ibid., p. 1983). This impact of OCD can therefore be viewed as multi-layered; behind the more obvious OCD symptomology, OCD affects sufferers’ ability to lead fulfilling lives. Macy and colleagues (2013) reviewed the literature on quality of life for OCD sufferers and conclude that patient satisfaction and functioning in their daily lives should be addressed directly by health care professionals and that quality of life should become one of the measures of effectiveness of any OCD treatment (Macy et al., 2013).

In their qualitative study, Murphy and Perera-Delcourt (2012) report on the lived experience of OCD sufferers. Their aim was to go beyond the psychopathology of OCD to explore psychosocial aspects of having the condition, as well as attempting to understand the impact of cognitive-behavioural treatment (CBT) on the participants. The OCD sufferers they interviewed described a sense of being rejected by others and this rejection had become internalized: “OCD bolsters a deficit identity through processes of self-stigma” (ibid., p. 11). The participants also appeared to find relief in a medical classification of their condition but described a “push-pull” tension towards CBT therapy, where relief at finding a treatment was countered by the loss of security and familiarity with their OCD. For them, it appeared to be important to have empathic encounters with health professionals who helped to transform the meaning of their OCD.

Both the evidence of the impact on the quality of life and the finding that for sufferers it is important to change the meaning of their OCD are relevant for this study, as is the role of self-stigma or shame.

Aetiology

Despite several epidemiological community studies of OCD a common aetiological cause has not been identified (Samuels & Nestadt, 1997). Indeed, the condition appears to be a heterogeneous one with a multiplicity of expression and range of symptoms, which, it has been argued, makes it difficult to establish a common cause (NICE, 2006). However, this has not stopped theorists presenting aetiological factors for OCD, which support their epistemological perspectives on the cause, maintenance and effective treatment for the condition. These theoretical perspectives and other possible aetiological factors are summarised here in order to demonstrate the complexity of current understandings of OCD and the possible individual nature of experience of the condition.

Genetics

The role of heredity in OCD has been debated and investigated from the earliest clinical writings on the subject (Carr, 1974). In a detailed study of the literature, Samuels and Nestadt (1997) found evidence for a genetic component to the disorder. For example, results from the Maudsley Twin Register show concordance rates for “obsessive symptoms or features” were 87% for monozygotic twins and 47% for dizygotic twins. However, in this and many of the twin and family studies, the genetic and environmental influences could not be separated, and controlled studies of twins raised together and apart are needed to establish any genetic component of OCD.

Based on the statistical likelihood that there is a genetic component to OCD, the OCD Collaborative Genetics Study was initiated to discover which genes were implicated. Although this study found a genetic linkage of OCD to regions on several chromosomes, no individual genes have yet been found to be linked to OCD (Nestadt, 2013).

Neurological Basis of OCD

As with the genetic link, speculation on a neurological cause for OCD was described as far back as 1917 by Constantin von Economo, a Romanian psychiatrist and neurologist (Rapaport, 1990).

Additional support for a neurological basis for OCD is that obsessive-compulsive symptoms can present in adults as a consequence of certain neurological conditions such as a brain tumour, Sydenham's chorea, Huntington's disease, fronto-temporal dementia, or as a complication of brain injury to the frontal lobe (Veale & Roberts, 2014). Also there is evidence that some people with OCD, when compared with control participants, have deficits on a range of inductive reasoning, executive functioning (e.g. planning) and some learning and memory tasks (Greisberg & McKay, 2003). However, this is not universal and when deficits do exist they tend to be mild (Taylor, Abramowitz & McKay, 2007).

It is thought that people with OCD have a malfunctioning of the so called "orbitofrontal loop" or "OCD circuit". This consists of a pathway in the brain from the basal ganglia (which is involved in voluntary motor control, procedural learning relating to routine behaviours or "habits", and cognitive and emotional functions) to the orbitofrontal cortex (responsible for social adjustment and the control of mood, drive and responsibility). This neurological mechanism in OCD is supported by evidence from neuroimaging studies that indicate abnormal activity in the cortico-basal ganglia circuits and other volumetric differences in parts of the brains of OCD sufferers (Lagemann et al., 2012). However, it is not yet clear how these contribute to the expression of OCD symptoms. In addition, there is the question of the direction of the correlation as it is not been shown that brain abnormalities precede the development of OCD; instead they may be due to an adaption to over-activity caused by long practiced behaviours (Nedeljkovic et al., 2011).

Interestingly as is discussed later, mindfulness practice has been shown to bring about changes in brain activity (Chiesa & Serretti, 2010) and there are therefore possible neurological factors which may support a useful interaction between OCD and mindfulness.

Trauma and Adverse Life Events

A number of studies have found evidence for an increase in the reports of childhood incidences of trauma or adverse life events in OCD sufferers (e.g. Lochner et al., 2002; Gothelf et al., 2004; Lafleur et al., 2011). However, this does not establish a causal link between life events and OCD, but may instead indicate that for those with a biological or psychological predisposition to OCD, a life event could be a triggering factor.

Social and Cultural Factors

There appears to be little evidence to support a socio-cultural explanation of OCD. Prevalence rates show consistency across different national studies (NICE, 2006). While the expression of symptoms of OCD may reflect socio-cultural factors, there is no consistent evidence that any social or cultural factor has any causal role (NICE, 2006).

Personality

As has already been discussed, there is mixed evidence for an association between OCPD (obsessive-compulsive personality disorder) and OCD. Despite some similarity in presentation, these are considered to be separate conditions, with one of the main distinctions being that with OCPD the individual perceives the obsessions and compulsions as rational and desirable; whereas in contrast, OCD sufferers typically find obsessions and compulsions extremely distressing.

It is important to note that the participants in this study met the criteria for OCD and not OCPD. This was also borne out by the language participants used to describe the symptoms of OCD and their struggle with the condition, e.g. they described their OCD experience as aversive.

Theoretical Perspectives on OCD

There are many different psychological conceptualisations of OCD but none fully explain the causes of OCD and, as will be shown, no one model adequately accounts for all the phenomena of the condition. Amongst the most prominent theoretical perspectives are the contemporary cognitive models, which are the main focus of this section and around which much of the dissertation discussion

is based. Before this, a brief coverage of the historical influences on the theories of OCD is given to provide historical context.

Historical Influences

At the beginning of the 20th century, the two figures who had the most significant contribution to the understanding of OCD, and who are still influential today, were the French psychiatrist Janet (Pitman, 1987; Janet, 2010) and the Austrian psychiatrist Freud (Freud, 1952; Moritz et al., 2011).

Janet's 1903 understanding of OCD, a condition he called psychasthénia, has much in common with more modern interpretations of the condition (Pitman, 1987). Janet's clinical observations led him to suggest that sufferers of the condition had a difficulty with tasks involving adaptation to reality and personal relationships and that obsessions and compulsions arise from attempts to address and reduce psychological tensions (Janet, 2010). As will be seen, this is analogous to a modern cognitive-behavioural understanding of the maladaptive use of compulsions to reduce anxiety caused by cognitions.

At the same time and in contrast to Janet, Freud drew on psychoanalytic theories to explain an individual's OCD symptoms. Freud determined that an obsessive-compulsive neurosis was the result of psychological defence mechanisms set up to respond to conflicts between unacceptable, unconscious sexual, or aggressive id impulses, and the demands of conscience and reality (Freud, 1952). The Janet and Freud conceptualisations of OCD are not just of historic interest as their influence can still be seen in present literature and in treatment guidelines for the condition (NICE, 2006), as discussed in the following sections.

Modern Psychodynamic Theories on OCD

The modern psychodynamic understanding of OCD acknowledges the evidence for a biological basis for OCD (DiCaccavo, 2008) but Gabbard (2001) argues that biologically created symptoms still have unconscious meanings to the patient that may lead the patient to be highly invested in maintaining and strengthening the symptoms. Perhaps more importantly, Gabbard goes on to say that compulsions and obsessional thoughts usually have interpersonal meanings that need to be addressed as part of the treatment. This is in conflict with current

treatment guidelines and is relevant to a discussion as to what extent the content of obsessive and intrusive thoughts needs to be tackled. This feeds into a debate, which is discussed later in this section, and in the discussion, about whether beliefs are important in the maintenance of the condition and to what extent there needs to be a focus on beliefs in the treatment of the condition.

Social Learning Theory

According to learning theory, OCD symptoms originate in learned negative thoughts and behaviour patterns resulting from traumatic life experiences (Carr, 1974; Mowrer, 1956). Based on Mowrer's two-factor model of fear, obsessional anxiety is acquired by classical conditioning and maintained by operant conditioning (Rachman, 1971). Whilst behavioural and learning approaches were the dominant empirical perspective on anxiety disorders from the 1920s until the 1970s they have received a great deal of criticism since then for failing to address individual differences in the development and expression of disorders (Mineka & Zinbarg, 2006). Carr, who was one of the first to suggest a model based on unrealistic threat appraisals, overestimation of probability, and cost of undesired outcomes, undertook a literature review and found no evidence for compulsions being the result of traumatic learning (Carr, 1974). However there is some evidence that the verbal transmission of dangerous thoughts (e.g. "my mother told me that dirt and contamination may be on doorknobs or toilet seats") may occur in OCD (Mineka & Zinbarg, 2006). The influence of the behavioural explanation of OCD however has led to the most effective treatment for OCD: exposure and response prevention (see section on Treatment Guidelines).

Current Cognitive and Behavioural Theories

Rather than focusing solely on behavioural extinction, cognitive-behavioural theories of OCD place an emphasis on the meanings individuals attach to their OCD symptoms. There are two influential models: the Salkovskis appraisal model and the meta-cognitive model. The first is based on the assumption that obsessions are caused by a misinterpretation of the significance of intrusive thoughts, images or impulses (Rachman, 1997). The second places less emphasis on the appraisal of intrusive thoughts and instead focuses on the beliefs about

the importance of thoughts (Wells, 2005). These two models are described in more detail below.

The Salkovsis Appraisal Model

The Salkovskis (1985) model of OCD recognised that although most people experience intrusive thoughts, for the OCD sufferer it is the particular salience of the thoughts, and the presence of dysfunctional assumptions about those thoughts, that leads to avoidance and compulsive neutralising behaviours. The compulsions are learned behaviours that temporarily reduce anxiety, and therefore become reinforcing as a strategy to deal with discomfort. However, this reduction in anxiety is short lived and the natural prevalence of intrusive thoughts creates a cycle of obsessive thought followed by neutralising behaviours. This cycle is maintained by dysfunctional beliefs about both the intrusive thought itself and the efficacy of the neutralisation (see Figure 1).

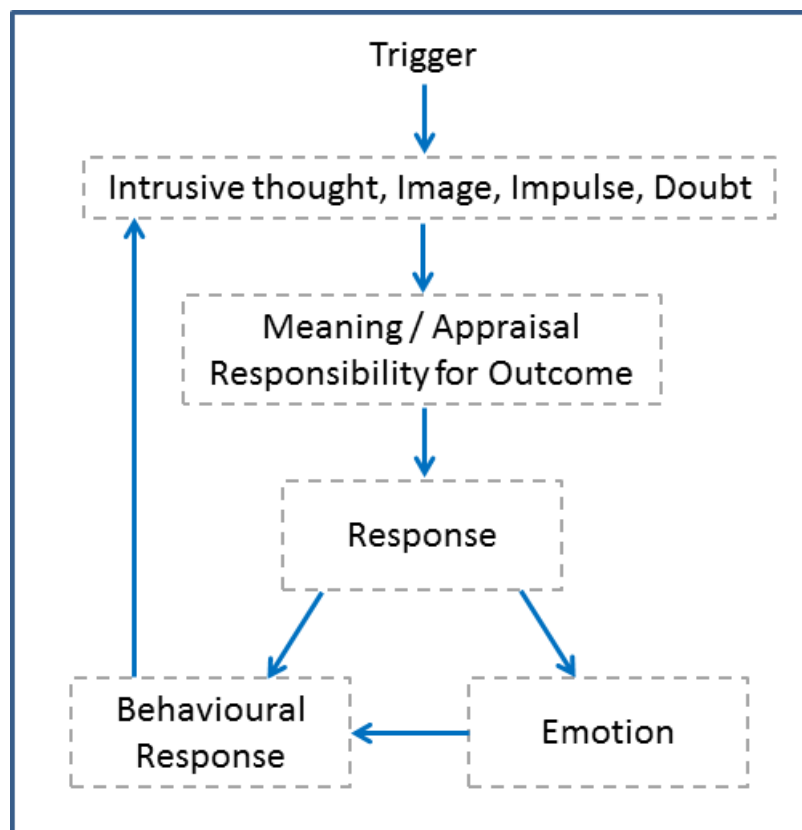


Figure 1 Summary of Salkovskis Appraisal Model of OCD (Salkovskis, 1985)

In his OCD model, Salkovskis (1985) acknowledges that pre-existing mood disturbance or dysfunctional schemata may be contributory factors but these are not required to explain the condition. The cycle of increased anxiety due to

intrusive thoughts, and unsuccessful attempts to neutralise these thoughts, is in itself sufficient to explain the obsessive-compulsive behaviour. This is in direct contradiction to psychodynamic perspectives, as there is no recourse to childhood difficulties or influences from the unconscious psyche.

The Obsessive Compulsive Cognitions Working Group (OCCWG, 1997) produced a summary of the cognitive contribution to the understanding of OCD, in which they have identified six distinct types of dysfunctional beliefs that play a role in the development of obsessions from intrusive thoughts: inflated personal responsibility, over-importance of thought, beliefs about the importance of controlling one's thoughts, overestimation of threat and an intolerance for uncertainty and perfectionism. These are briefly outlined here as they have relevance for the experiences related by the participants in this study.

Inflated Sense of Responsibility: Salkovskis placed the perception of threat and an inflated sense of responsibility as the core elements in the aetiology and maintenance of OCD (Salkovskis 1985, 1989, 1999). According to Salkovskis, people with OCD misinterpret normal intrusive thoughts as an actual risk of serious harm to themselves or to others. In addition, the person with OCD believes they are solely responsible for that harm and that they need to take action to prevent it (Salkovskis, 1989). This inflated perception of responsibility increases the anxiety and distress caused by thoughts, even when the likelihood of the thought actually happening is very low (Salkovskis, 2007) and this is what gives rise to neutralising compulsions and reassurance seeking behaviours (Salkovskis, 1985).

Not all evidence supports the Salkovskis model; Rachman and colleagues (1995) found that not all people with OCD have inflated responsibility in general, but that it was situation specific.

Notwithstanding the Rachman et al. (1995) findings, the importance of the role of inflated responsibility in OCD is now well documented (NICE, 2006; Veale, 2007) and has been supported by a number of correlational and experimental studies (Salkovskis et al., 1999; Williams et al., 2002; Snorrason, Smári & Ólafsson, 2011).

Over importance of Thoughts: Although unwanted intrusive thoughts are a normal part of consciousness (Clark & Purdon, 2009) in OCD they typically cause significant distress and can impair functioning. However, this negative impact of intrusive thoughts is also found in depression, generalised anxiety disorder, post-traumatic distress disorder and psychotic disorders (Beevers et al., 1999; Wells, 2002; Stockton, Hunt & Joseph, 2011). There is also significant evidence that non-clinical individuals have intrusive thoughts with similar content to those experienced in clinical disorders (Langlois, Freeston & Ladouceur, 2000; Belloch et al., 2004). However, it is the significance applied to intrusive thoughts that appears to differentiate their appraisal in OCD (Newth & Rachman, 2001). OCD sufferers place more importance on thoughts and are more likely to confuse thoughts with reality than non-sufferers (Purdon & Clark, 1999).

A well-reported feature of OCD is thought-action fusion (TAF; Rachman, 1993; Shafran, Thordarson & Rachman, 1996) which comes from the theoretical proposition that people with OCD assume that “a thought is like an action” (Salkovskis, 1985, p. 574). People with OCD have been found to place more importance on thoughts and are more likely to confuse thoughts with reality than non-sufferers (Purdon & Clark, 1999).

Control of Thoughts: Another thought related concept that appears characteristic of OCD is the belief that thoughts should be controlled in order to avoid harm and reduce distress (Salkovskis, 1985): Freeston and Ladouceur (1997) found that a sample of OCD sufferers used between 6 and 18 different thought control strategies.

It is speculated that this metacognitive belief that thoughts should and can be controlled, arises because of having unwanted intrusive thoughts (OCCWG, 1997). Thus, according to Salkovskis (1989), the person with OCD experiences a circular process whereby metacognitive beliefs influence the appraisals made of intrusive thoughts, and thereby shapes the aetiology and maintenance of OCD. In this way, Salkovskis suggests it is probable that metacognitive beliefs are both the consequence and causes of OCD problems.

Thought suppression is one particular thought control strategy that has been the subject of much research (e.g. Likierman & Rachman, 1982; Tolin et al., 2001; Magee, Harden & Teachman, 2012). Most research has indicated that thought suppression strategies are both futile and counter-productive (Likierman & Rachman, 1982; Wegner et al., 1987). However more recently, there is evidence that one particular form of thought suppression, termed thought stopping (a cognitive control technique to block an on-going thought sequence, usually followed by deliberate positive self-talk) can be effective (Bakker, 2009). In addition, Rassin (2001) found that suppression relieved discomfort in a non-clinical sample. Magee et al. (2012) found no evidence to support the hypothesis that a thought is either less likely to be suppressed or more likely to return for an individual with psychopathology than for a person without psychopathology.

Overestimation of Threat: Several studies have found a link between OCD and avoidance of risk (Carr, 1974; Salkovskis, 1985; Steketee, Frost & Cohen, 1998). Foa and Kozak (1986) suggested that this link is due to individuals with OCD having a difficulty with reasoning related to their excessive fear of harm; this causes them to view obsessive situations as dangerous until proven safe. Using the Everyday Risk Inventory (a measure of willingness to take risks in common situations), Steketee & Frost (1994) found a significant differentiation between OCD patients and non-clinical participants and concluded that OCD individuals “are more risk averse than non-clinical samples” (ibid., p. 294).

Intolerance of Uncertainty: Langlois et al. (2000) suggest that uncertainty about the meaning of intrusions as being potentially dangerous leads to anxiety and it has been observed that intolerance for uncertainty and indecision is common in people with OCD (e.g. Janet, 2010; Carr, 1974; Sachdev & Malhi, 2005; Cavendish, Gorini & Bellodi, 2006).

It has been found that, compared with patients with other conditions or non-clinical controls, individuals with OCD are generally slower to categorise objects, request more repetition of information, have more difficulty making decisions and show more doubt about their decisions (OCCWG, 1997). In addition, people with OCD, compared to other groups, also display greater doubt about the

correctness of their decisions (ibid.). However, it is not at all clear if this intolerance of uncertainty is a distinct and separate factor; Sookman and Pinard (2002) conclude that overestimation of threat and intolerance of uncertainty are highly related. It should also be noted that intolerance of uncertainty is a feature of disorders other than OCD, such as obsessive-compulsive personality disorder and dependent personality disorder (APA, 2000). The OCCWG note that it is not yet been shown that intolerance for uncertainty is associated more strongly with OCD than with other disorders (OCCWG, 1997).

Perfectionism: Perfectionism refers to the tendency to maintain high standards of performance and extremely self-critical assessments (OCCWG, 1997). As with the other cognitive beliefs, it is found in various psychological and personality disorders (Hewitt & Flett, 1991; Shafran, Cooper & Fairburn, 2002; Shafran & Mansell, 2001). However, some deem it to have a pivotal role in OCD (Frost, Novara & Rhéaume, 2002). In his 1903 work, Janet (2010) suggested that perfectionism initiates the development of psychasthénia and other early theorists have also emphasised perfectionism as central to OCD (Frost et al., 2002).

Meta-cognitive Model

Some authors have suggested that whilst the cognitive appraisal model has resulted in the development of highly effective treatments, it focuses too narrowly on the content of thoughts and beliefs (Wells & Purdon, 1999; Purdon & Clark, 1999). Purdon and Clark (1999) propose that a greater emphasis should be placed on the metacognitive aspects of the information processing system that monitors, interprets, evaluates and regulates the content and processes of cognition. In their model, the failure to control thoughts reinforces more metacognitive beliefs about the importance of the thought. When the beliefs about the meaning of thoughts intensify, the individual may then develop compulsions or neutralising strategies as a coping mechanism in an attempt to ameliorate the negative affect associated with the thought (Purdon & Clark, 1999). In this way, it is assumed that excessive reflection on metacognitions increases both negative appraisals and importance placed on the thoughts (see Figure 2).

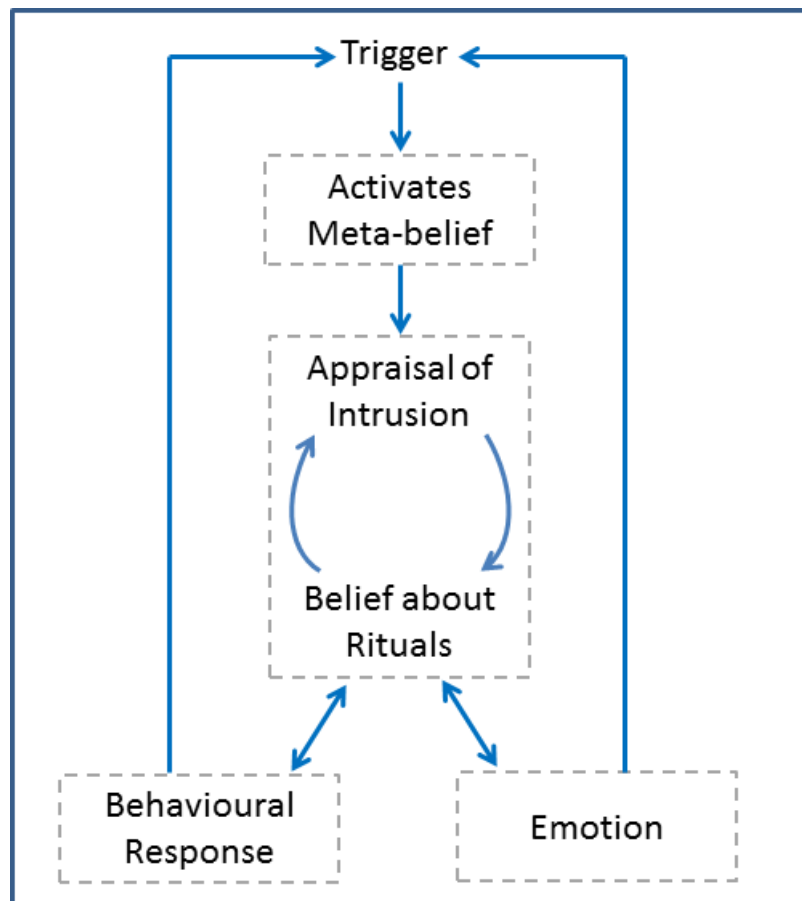


Figure 2 Summary of the Meta-Cognitive Model of OCD (Wells, 2005)

Applying the meta-cognitive model, it is not therefore necessary to modify lower order appraisals; instead, therapy would focus on modifying higher order metacognitive processes such as beliefs about the importance and power of thoughts (Wells, 2005).

Due to their similarity and for brevity and ease of reference, both the Salkovskis appraisal model and the meta-cognitive model will be referred to as cognitive models of OCD.

Are beliefs important?

The preceding cognitive and metacognitive theories of OCD assume that faulty beliefs and cognitions underpin the aetiology and maintenance of OCD. However, some authors have questioned whether dysfunctional beliefs or faulty appraisals always form part of the condition. In a study conducted by Taylor and colleagues (2006), the researchers identified two cognitive subtypes of OCD that were differentiated by their scores on the revised Obsessive Beliefs Questionnaire (OBQ; OCCWG, 2001). Approximately 50% of the OCD sufferers

were characterised by relatively high scores, compared to the control groups, on measures of obsessive-compulsive related beliefs (including inflated responsibility, perfectionism and the importance of thoughts); the other 50% did not generally differ from most controls on these same beliefs. This has implications for the cognitive models of OCD, which Taylor and colleagues conclude may not apply universally to all sufferers, but only to a subgroup of cases of OCD, or to particular symptom presentations (Taylor et al., 2006). Calamari and colleagues (2006) also used the revised OBQ to identify a low belief sub-group: 56% of their sample reported scores that were similar to the scores of both anxious patients without OCD and non-clinical comparison groups. They concluded that either there are a significant number of OCD sufferers for whom dysfunctional beliefs do not play a role in the condition, or alternatively, other belief domains or cognitive processing differences, not yet identified, may need to be included in the assessment of OCD.

Summary of Theories

Early theories of OCD relied on a psychodynamic or purely behavioural understanding of the development of psychological defences but these have been superseded by more recent interest in cognitive-behavioural approaches to mental health issues. Cognitive-behavioural theories appear to provide useful models to understand the symptomology of OCD. As the next section highlights, these theories underpin the current treatment options. However, as has been shown, cognitive-behavioural theories do not fully explain the aetiology of OCD and do not apply in all cases in the maintenance of symptoms. This study evaluates whether alternate conceptualisations for OCD that do not rely exclusively on a cognitive explanation may also have salience for the treatment of OCD.

Treatment Guidelines

The UK National Institute for Health and Clinical Excellence (NICE) produced a report in 2006 which summarised the outcome evidence for treatments for OCD and body dysmorphic disorder (BDD: which shares features with OCD and has similar treatments) for individuals from the age of eight upwards (NICE, 2006). In a systematic review of the literature on OCD, the report addressed questions on

service provision and reviewed both psychological and pharmacological approaches to OCD and BDD. The analysis of the OCD empirical literature allowed the authors of the report to conclude that: “The efficacy and effectiveness of CBT has been demonstrated” (ibid, p. 104). However, they also note that there are limits to its utility due to treatment refusal or dropout. Five meta-studies comparing CBT and pharmacology found that none reached any consistent conclusions about which treatment was more effective (NICE, 2006).

In the face of this uncertainty, the NICE recommended treatment guidelines outline a stepped care approach with brief CBT alongside a specific form of behavioural therapy called exposure and response prevention (ERP). This CBT/ERP is initially offered using self-help materials, telephone support or group therapy. Should this initial intervention not be effective, the recommended follow-up treatment is either a course of a selective serotonin reuptake inhibitor (SSRI) or more intensive face-to-face CBT/ERP. With children and young adults aged 8-18, the only significant difference in the recommendations is that, the SSRI should be offered in addition to CBT/ERP not as a replacement for therapy.

Based on these NICE OCD guidelines, the UK National Health Service (NHS) standard treatment for OCD is therefore pharmacology and/or CBT with ERP (NICE, 2005). However as previously mentioned, the NICE guidelines note that these recommendations are not effective for all OCD/BDD sufferers. A significant percentage (between 27% and 98%) of those prescribed medication (SSRIs and tricyclic antidepressants) report adverse effects, and many relapse after discontinuing the medication (NICE, 2006). Although combined CBT and ERP is an effective treatment, with improvement rates reported as 53% and 61% respectively (Fisher & Wells, 2005), the NICE guideline also cites studies that indicate that between 30% and 40% of OCD sufferers either decline or drop out of CBT/ERP treatment because they find it too distressing. When treatment refusal, drop out and relapses are taken into account only 55% of sufferers appear to gain benefit from CBT/ERP and of these only between 20% and 25% are symptom free at the end of treatment (Fisher & Wells, 2005). It is perhaps not surprising then that the NICE guidelines note, “people with OCD who are seeking help frequently indicate that they would like to be informed about a

range of other treatments” (NICE, 2006, p. 104). The guide therefore also includes a review of several treatments, which may be beneficial; these are yogic meditation, hypnosis, counselling, group cognitive analytic therapy, systemic therapy and others, but insufficient evidence was found to support their use. Mindfulness was not one of the reviewed treatments, nor is mindfulness cited in an evidence update report published in 2013 (NICE, 2013) which appears to reflect the continued research effort into CBT and pharmacology as the treatment options for OCD.

Refractory OCD

As just noted, some people with OCD fail to respond to the stepped treatment model and there are a number of in-patient or home-based treatment centres that offer intensive CBT or more bespoke treatments. In a study of an in-patient unit offering CBT/ERP 40% were found to show improvement in symptoms and 4% recovered fully (Boschen, Drummond & Pillay, 2008).

However, for some refractory OCD sufferers, conventional treatments do not appear to help (Eddy et al., 2004) and in some cases neurosurgery has been used to provide partial relief (Jenike, 1998). Whilst this is a treatment of last resort, that should only be offered after other treatments have been attempted for a period of at least five years (Christmas et al., 2004), arguably, it is a sign of the debilitating nature of the condition that it is available at all.

Treatment Summary

CBT/ERP and pharmacology are the recommended treatment for OCD. For a significant percentage of OCD sufferers, these would appear to be ineffective, or not well liked. For a few, neurosurgery is the final option. It is therefore important to understand what other mechanisms may be beneficial for those who have tried CBT/ERP and not found relief for their condition to help alleviate the symptoms of this incapacitating condition.

Summary

This review of the literature has shown that OCD is a relatively rare but debilitating condition. The early age of onset, typically long length of time before accessing help and comorbidity with other disorders are all associated with

significant impairment in social and work-related functioning. Although no definitive aetiological factors have been identified, there are a number of theories that propose OCD derives from cognitive dysfunction, but there is also evidence to support a biological basis for the condition.

The many theoretical models are primarily focused on symptomology and only partially explain this complex and distressing disorder. Whilst pharmacology and psychotherapy can be successfully employed to treat many people with OCD, it is clear that there are a significant number for whom the current treatment recommendations are not fully effective and hence there is a need for continuing research into alternatives. This study thus examines how OCD sufferers experience mindfulness in relation to their condition in order to add to the knowledge base.

Mindfulness

Mindfulness has its origins in ancient Buddhist philosophy and traditions. However, the mindfulness that is employed as a 'treatment' in Western psychology for a variety of physical and mental conditions has been secularised and separated from its spiritual roots (Appel & Kim-Appel, 2009).

There are a number of definitions of mindfulness, of which Kabat-Zinn's - "the awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding of experience moment by moment" (Kabat-Zinn, 2003, p. 145) - seems to most encapsulate the commonly accepted qualities of intentionality, awareness, acceptance and non-judgement. Another definition of mindfulness is that it is a state of internal attunement that includes curiosity, openness, and acceptance (Siegel, 2007) and an "attitude of equanimity" (Turner, 2009, p. 96).

Siegel, Germer & Olendzki (2009) agree with these definitions but argue that being mindful is more than being passively aware; instead "it helps us to recognize when we also need to cultivate other mental qualities – such as alertness, concentration, loving-kindness and effort" (ibid., p. 17). They go on to contend that when we become aware of what is happening, both internally and externally, we can become free from mental and emotional difficulties.

Within the mindfulness literature, awareness is the conscious registration of stimuli coming from the physical senses and the activities of the mind (Wahbeh et al., 2011). Although there is evidence for perception without awareness (Merikle, Smilek & Eastwood, 2001), awareness provides the most direct and immediate contact with reality and gives rise to consciousness (Baars, 1997) which in turn leads to cognitive and emotional appraisals and reactions (Zajonc, 1980). Brown, Ryan & Creswell (2007) note that these reactions are often discriminative in nature, whereby the stimulus is labelled 'good,' 'bad,' or 'neutral', and that the labels are often both self-referential and conditioned by past experience, and thereby assimilated, or made to assimilate, into existing cognitive schemas. This can lead to judgments being imposed, often automatically, on everything that is encountered (ibid.). Brown et al. (2007) suggest that this processing and judging has an adaptive benefit as it helps to maintain order and make sense of experience. However, a consequence of this is that things are not perceived directly but through a perceptual filter that can produce a distorted picture of reality.

In contrast to this conceptual mode of attention and awareness, mindfulness training involves the development of a receptive state of mind, wherein attention is restricted to registering what is being observed without applying judgement or labels. Mindfulness thus involves the capacity to be aware of internal and external events and occurrences simply as phenomena, not as constructions of the mind.

Mindfulness and Mental Health

Some believe mindfulness is becoming ubiquitous in mental health treatments (Hofmann et al., 2010). The interest in mindfulness is being driven in part by a reaction against the prevailing trend in therapy to focus on change as the primary goal. Siegel et al. (2009) argue that mindfulness does not preclude change but sees this as secondary to a process of self-acceptance and self-understanding; as Siegel et al. (2009) say "awareness and acceptance first, change second" (ibid., p. 19).

It is suggested that through practice, mindfulness improves awareness of experience: including thoughts, emotions, sensations and actions (Olendzki, 2009). Without this awareness, certain phenomena can remain hidden from conscious awareness (Brown et al., 2007) and thus several therapeutic interventions (e.g. Linehan, 1993; Kabat-Zinn, 2003; Hayes et al., 2006) incorporate mindfulness to encourage and practice a non-judgemental attitude and develop the ability to be in direct contact with uncomfortable experiences. This is thought to reduce impulsive or defensive reactions to those experiences (Ryan, 2005).

Practices to develop mindfulness have been formalised into a number of accepted manualised mental health treatments including: mindfulness based stress reduction (MBSR) for anxiety (Kabat-Zinn, 2003; Stahl & Goldstein, 2010), and mindfulness based cognitive therapy (MBCT), a relapse prevention treatment for depression (Segal, Williams & Teasdale, 2013). These and other so-called “third wave” approaches utilise mindfulness as an integral part of the ‘treatment’ programme; other examples are dialectical behaviour therapy (DBT) for personality disorders (Linehan, 1993) and acceptance and commitment therapy (ACT) for common psychological difficulties (Hayes et al., 2006).

Whilst these treatment approaches all differ in implementation details, they all challenge the universal applicability of the so called first-order change strategies (aimed at directly targeting overt cognitions, behaviours, and emotions) that are so prevalent in empirically based clinical psychology settings; and pay more attention to the context and functions of psychological phenomena, not just their expression (Hayes & Wilson, 2003). For example in developing MBCT, Teasdale, Segal & Williams (1995) noted that although CBT was effective for treating depression a number of people relapsed due to reactivation of the depressive thinking patterns. In order to prevent this relapse, Teasdale and colleagues combined mindfulness and CBT with the aim to help depressed people develop a detached or decentred view of their thoughts, including ideas such as “thoughts are not facts” and “I am not my thoughts”. Thus these third-wave treatments emphasise contextual and experiential change strategies in

which a person learns to relate differently to his or her experience, this is referred to as second-order change (Segal et al., 2013).

It is this second-order change mechanism and the awareness and acceptance of thoughts that potentially makes mindfulness interesting as a treatment for OCD: a condition where sufferers often find it difficult to challenge beliefs and cognitions (Steketee et al., 1998).

Efficacy of Mindfulness Based Treatments

In proposing to study how mindfulness is experienced by people with OCD it is useful to consider the evidence that indicates mindfulness is effective in alleviating psychological distress in general. In doing this the researcher is aware of a possible paradox in that mindfulness itself is based on the premise of not striving to achieve a particular goal; instead mindfulness leads towards experiencing things exactly as they are, not as they might be.

There are numerous research studies that suggest the positive effects mindfulness or regular meditation practice can have on health and wellbeing (Keng, Smoski & Robins, 2011). However, in a thorough review of the literature, Hofmann and colleagues (2010) found that, despite the increasing use of mindfulness-based treatments in medical settings, little is known about the efficacy of this approach for treating mental disorders. A few studies have looked the effectiveness of mindfulness for a number of different disorders and conditions (e.g. Baer, Fischer & Huss, 2005; Chadwick et al., 2005; Finucane & Mercer, 2006; Roemer, Orsillo & Salters-Pedneault, 2008). Most have found evidence to support the assertion that mindfulness-based treatments are helpful in alleviating symptomology over an increasingly wide range of conditions. However, few studies, to date, have sufficient numbers of participants, or use randomised conditions, which are required to make substantial claims about effectiveness. In the few randomised controlled trials (RCTs), the results are mixed (e.g. Koszycki et al., 2007; Vøllestad, Sivertsen & Nielsen, 2011; Fjorback et al., 2013).

In a meta-analysis of RCTs, Fjorback and colleagues (2011) found 13 studies that showed MBSR to be more effective than a waiting list condition or educational

materials for improving mental health, and MBCT to be superior to treatment as usual for relapse prevention in depression and equivalent to continuing antidepressant medication. Overall, the effect sizes related to improvement due to mindfulness treatments were moderate (Hedges's $g=0.63$ for anxiety, 0.59 for mood symptoms) but within the range reported in other psychological interventions; the effect sizes were also robust and maintained at follow-up (Hofmann et al., 2010).

Therefore, the available evidence appears to provide support for mindfulness being effective in improving mental health for some conditions. However, nearly all the studies so far have used a waiting-list condition for comparison and so must be regarded with caution. One recent study in the United States used an active control condition for comparison and found MBSR was no more effective than an alternative treatment (MacCoon et al., 2012). The safest conclusion is therefore, that further research needs to be carried out to show if, and when, mindfulness based treatment programmes are effective in alleviating mental health issues.

Disadvantages of Mindfulness

Apart from its apparent effectiveness in alleviating symptoms of anxiety and preventing relapse in depression, one of the benefits of mindfulness in mental health treatment, is that there have been few, if any, reported adverse effects. However, it is possible that negative consequences may have been overlooked. Klainin-Yobas, Cho and Creedy (2012), for example, note in a review of 40 mindfulness studies that adverse effects were not addressed in a single study. Unfortunately, it is not possible to determine if this is because no adverse effects were found or that they were not reported.

There is however some evidence for adverse effects of intense meditation (psychotic features, relaxation-induced anxiety, tension, impaired reality testing, confusion, disorientation, depression, depersonalisation and increased negativity) and the possibility of meditation triggering psychosis in vulnerable individuals (Sethi & Bhargava, 2003). Compson (2014) also noted that although there has been little research into 'meditation-induced' physical or psychological

injuries, a search of the Internet yielded many personal accounts from people claiming to have experienced mental or emotional breakdowns that were attributed to intensive spells of meditation. However, Compson goes on to argue that mindfulness as taught in its secularised way in mental health settings, and divorced from intense Buddhist practices, potentially poses less of a risk. Yet in contrast to the optimism expressed by Compson about secular/therapeutic mindfulness practice, Michal et al. (2007) found evidence for an inverse correlation between mindfulness and depersonalisation in participants who had suffered childhood trauma, some of whom did report negative experiences.

This is clearly an area that requires further investigation. This study thus aimed to add to the small amount of knowledge in this area by recording the lived experience of OCD sufferers practicing mindfulness meditation and explicitly inquiring about positive and negative aspects.

Theories of the Mechanisms of Mindfulness

If mindfulness has the potential to be an alternate ‘treatment’ for OCD then it is important to review how mindfulness is thought to bring about change. This will have relevance for the discussion section where mindfulness practice is contrasted with the prevailing cognitive-behavioural understanding of how change in OCD symptomology comes about.

Although a number of studies have found mindfulness to be a mediator in effecting change, the mechanisms through which mindfulness achieves its outcomes are not yet well understood (Shapiro et al., 2006; Hill & Updegraff, 2012; Keng et al., 2012).

Siegel and colleagues (2009) suggest that mindfulness brings about a change in how information in the brain is treated; a model that resembles modern cognitive theories of information processing. According to Siegel et al. (2009), mindfulness brings attention directly to sensory data as well as the thoughts and images that appear in the mind. This is a “bottom-up” way of processing that contrasts with the “top-down” schema-led processing that is thought to be normally used by individuals as a guide to managing their experience. According to Siegel and colleagues, the problem with “top-down” is that events and

experiences that do not fit with an active cognitive schema are typically discounted. In contrast with “bottom-up” processing, all events, feelings and sensory experiences are observed directly to reveal what is actually happening.

Similarly, Wells (2005) offers a way to understand how mindfulness can affect reaction to thoughts that is based firmly in cognitive behavioural theories of dysfunction. His theory assumes that psychological disorders are a result of disturbed metacognitions and these lead to cognitive biases (see Figure 2). This sets up a cycle whereby the activation of a dysfunctional pattern of cognitions maintains maladaptive emotion responses and strengthens negative beliefs and biases. Wells suggests that detached mindfulness, which is described as a state of “de-centred metacognitive awareness of internal events” (ibid, p. 353), is the antithesis of dysfunctional cognitive patterns and should therefore assist in bringing about therapeutic change by allowing greater flexible control over the selection of different thinking and behavioural strategies.

Others have also suggested that the concept of ‘decentring’ or the ability to distance and separate the self from the contents of conscious thoughts and emotions is implicated in the process of change brought about by mindfulness practice (Gecht et al., 2014). According to Segal et al. (2013), through this process, the ‘mindful meditator’ is able to step outside of their immediate experience and relate to negative thoughts and feelings differently. This allows an individual to observe their unhelpful thoughts or difficult emotions as internal mental processes rather than as negative aspects of the self (Teasdale et al., 2002). Similarly, Shapiro and colleagues (2006) have formulated a conceptualisation of the mechanisms of mindfulness and suggest that mindfulness training may lead to positive outcomes, such as psychological symptom reduction, by shifting people’s perspective toward their inner experiences: their term for this decentring is ‘*reperceiving*’.

However, as Gecht and colleagues (2014) point out, most studies regard mindfulness and decentring as distinct concepts, and there is conflicting evidence for decentring being a key mechanism through which mindfulness facilitates change. Gecht et al. concluded that decentring is important, but just

one of the ways which mindfulness brings about symptom reduction. In addition, they argue that while decentring mediates the relationship between mindfulness skills and symptoms of depression, mindfulness and decentring work to some extent independently.

As has been mentioned, there is a potential contradiction in any attempt to identify and document the process of change brought about by mindfulness practice; with mindfulness there is no explicit attempt to change the substance of thinking but simply to observe it. This is in direct contrast to cognitive-behavioural therapies where individuals are encouraged to change the content of their 'maladaptive' thoughts and assumptions (Westbrook, Kennerley & Kirk, 2007) or their relationship to thoughts by addressing meta-cognitive beliefs (Wells, 2002). The aim of mindfulness is to be aware of thoughts – not necessarily to change them.

Mindfulness is also not just about thoughts. It is also about awareness of emotions (Khong, 2011), sensations (Kabat-Zinn, 1982) and developing a non-judgemental and self-compassionate attitude (Kabat-Zinn, 2013). In one study, Kuyken and colleagues (2010) found that increases in mindfulness and self-compassion in patients undergoing MBCT treatment for depression mediated the level of depression at a 15-month follow-up. As with decentring, self-compassion was found to affect symptom change somewhat independently of mindfulness, leading Kuyken and colleagues to conclude that that mindfulness is multi-dimensional and that further work is needed to understand the mechanisms of change. This subject is returned to in the discussion section.

Patient experience of mindfulness

The current study aims to give voice to service user experiences. In this context, patient experience of mindfulness is important. There are good indications that mindfulness is an acceptable and well-liked treatment that also has a significant impact on wellbeing and quality of life (Greeson, 2009). One qualitative study found the majority of participants found a course of MBCT “acceptable, enjoyable and beneficial” (Finucane & Mercer, 2006, p. 10). This is important in the context of OCD where a significant percentage find conventional treatments

too distressful and drop out early (NICE, 2006). However, as has already been mentioned, it is possible that negative experiences of mindfulness may not have received sufficient attention in research (Klainin-Yobas et al., 2012).

Neurology of Mindfulness

The brains of individuals who participate in mindfulness meditation have been studied in order to determine if there is a neurological correlate of mindfulness. Davidson and colleagues (2003) compared electrical activity in the brain in a group of 25 participants of an MBSR group with those in a waiting list condition. They found increases in left-sided anterior activation, an area of the brain that is thought to be associated with more adaptive responses to negative and/or stressful events. Also, in line with theories of the effects of stress on the immune system (Webster Marketon & Glaser, 2008), Davidson et al. (2003) found that following participation in an MBSR group participants had an increase in the number of antibodies produced in response to an influenza vaccination; the amount of antibodies was also correlated with an increase in left-side brain activation; suggesting that mindfulness may help to reverse the physical effects of stress.

There is also evidence from laboratory studies that mindfulness meditation can improve attentional performance (Chiesa, Calati & Serretti, 2011; Malinowski, 2013). In support of this, brain-imaging research has found that mindful meditation can bring about modifications in the central constructs in the brain: the amygdala and the dorsal anterior cingulate cortex and parts of the prefrontal cortex, which are associated with attention, concentration, and emotion regulation (Chiesa & Serretti, 2010).

In a review of neurological studies, Chiesa and colleagues (2011) found evidence that even brief mindfulness training improved attention as well as attention switching in individuals with no prior meditation experience. In addition, they found a significant positive relationship between meditation experience, enhanced cognitive abilities and brain structural changes. There was however, no evidence for mindfulness affecting memory, executive function or other measures of cognition, and interestingly only one study found a significant post-

treatment increase in meta-awareness (i.e. participants showed a greater ability to view their own thoughts and emotions as transient mental events rather than as definitions of self).

In light of the evidence for a neurological basis of OCD, as well as the evidence in studies that show mindfulness meditation can alter some brain structures and processes, it is interesting to speculate if mindfulness could have an effect on OCD through neurological changes in the working of the brain.

Mindfulness and Cognitive-Behavioural Therapy

CBT now forms a major part of the therapeutic offering in the UK NHS for anxiety and depression (Clark, 2011). Its appeal is due to it being evidenced-based, cost-effective, short-term and amenable to being offered in a standardised and stepped approach to cater for moderate to more severe presentations (Layard, 2006; Williams & Martinez, 2008). As has been noted CBT incorporating exposure-response prevention is the recommended treatment for OCD (NICE, 2006).

The main premise in CBT is that how we think affects how we feel (both emotionally and physically) and how we act (Westbrook et al., 2007). Although the reciprocal nature of thoughts, feelings and behaviours is acknowledged, in CBT the thought comes first. Therefore, CBT brings about symptom reduction by challenging thoughts so to affect subsequent actions and emotional responses (a first-order change process).

In the treatment of OCD many find that attempts to change thoughts is not sufficient to stop compulsive behaviours and hence these behaviours are also confronted with ERP; also a first-order change mechanism. However, many people with OCD find CBT/ERP too difficult or distressing and drop out of therapy (NICE, 2006).

Mindfulness, as has been shown, does not attempt to change thoughts directly; the practice strengthens the ability to observe thoughts without judgement. Therapeutic change is thought to occur through a second-order change mechanism (Hayes & Wilson, 2003) where there is a shift in the relationship to

thoughts or actions. Rather than changing the thoughts or behaviours of an individual (first order change), second order change happens through a shift in the function of thoughts and an individual's relationship to events.

Mindfulness-based CBT would therefore seem, on first inspection, to be somewhat of an oxymoron. However, despite the shift of paradigm to a more contextualised approach to clinical practice and a focus on experiential and indirect strategies for change, acceptance and mindfulness-based 'treatments' have been increasingly incorporated within the cognitive-behavioural tradition (Öst, 2008; Williams, 2008). The level of integration of mindfulness and CBT varies between different approaches. For example MBCT appears to take a somewhat eclectic approach adding both CBT and mindfulness elements to the treatment plan, whereas in ACT mindfulness is more embedded in the 'radical acceptance' promoted as core to the approach. Notwithstanding integrated therapeutic approaches, there would appear to be a tension between mindfulness and CBT, which can lead to mindfulness being seen as technique or simply another option in the therapeutic toolbox. Moss and O'Neill (2003) appear to refer to this when they suggest that mindfulness challenges the goals and processes typically found in a clinical psychology practice.

Summary

Originating in eastern philosophy, mindfulness has now become a common treatment for many mental health disorders. It is utilised in both a manualised manner in MBSR, MBCT, DBT and ACT and more informally as an adjunct to stress and pain management, and other treatments. Whilst research into the effectiveness of mindfulness for specific conditions has shown mixed results, mindfulness is well received by patients and appears to improve wellbeing. As yet, the mechanisms of mindfulness are not well understood but improvements may come about through the altering of structures in the brain connected with attention and emotion regulation.

More research into the effectiveness and mechanisms of mindfulness is needed and it is hoped that this study will have made a contribution in this area.

Mindfulness and OCD

Although it is not commonly used in the treatment for OCD, there are a number of compelling reasons to suggest mindfulness may be an effective adjunct to conventional treatment for the condition.

An open and accepting curiosity towards experience is a key tenet of mindfulness alongside a non-judgmental acceptance of the moment-to-moment experience (Kabat-Zinn, 2013). This is regarded as a potentially effective antidote against common forms of psychological distress (including rumination, anxiety, worry and fear) which, as in OCD, involve the maladaptive tendency to avoid, suppress or over-engage in distressing thoughts and emotions (Keng et al., 2011).

In addition, a non-judgemental observation and acceptance, rather than a focus on change, which is a large part of the philosophy and practice of mindfulness (Bishop et al., 2004; Mace, 2008) may help to reduce the self-stigma and shame reported by OCD sufferers (Murphy & Perera-Delcourt, 2012).

From a behavioural perspective, mindfulness encourages participants to observe current experiences in a non-judgemental manner and this may assist individuals with OCD to become habituated to intrusive thoughts, as well as reduce counterproductive thought suppression efforts (Hepburn et al., 2009). Fairfax (2008) conjectures that mindfulness-based therapies might also teach OCD sufferers that 'thoughts are not facts' and this may help to bring about metacognitive change and a reduction in thought-action fusion (TAF). Many studies have shown moderately significant correlations between TAF and measures of OCD (e.g. Gwilliam, Wells & Cartwright-Hatton, 2004; Rassin, 2001; Smári & Hólmsteinsson, 2001). To date there has been little research on the effect of mindfulness on TAF; however, two studies have found that mindfulness reduced TAF in people with OCD (e.g. Hanstede, Gidron & Nyklíček, 2008; Wilkinson-Tough et al., 2010). Contrary to expectation however, in both these studies the reduction in TAF did not correlate with a reduction in OCD for all participants, particularly when measured at follow-up. The Hanstede et al. (2008) study, in particular, suggested that "letting go" (as measured by the 'letting go' subscale of the Southampton Mindfulness Questionnaire; Chadwick

et al., 2008) and not TAF may have operated as a mediator in the effects on OCD symptoms.

Whilst, the research supports a correlation between high levels of TAF and OCD, TAF is also present in other anxiety disorders, and is a common phenomenon in people who do not have OCD (Shafran & Rachman, 2004). There is a question therefore as to the importance of TAF, and Shafran and Rachman (2004) note that there is little relevant research on the role of TAF in the aetiology and maintenance of OCD. This is particularly relevant to this study as Fairfax (2008) argues that mindfulness may be effective in treating OCD specifically due to it 'ungluing' the association of 'thought as fact' seen in TAF.

Thought suppression is a strategy often used by people with OCD (Freeston & Ladouceur, 1997), and as discussed earlier, this is mostly viewed as counter-productive. One aim of mindfulness is to improve the ability to accept thoughts and allow thoughts to be present with no attempt to suppress or control them. Like TAF, this is thought to feature in the efficacy of mindfulness for OCD (Fairfax, 2008). However, the evidence for a link between mindfulness and a reduction in thought suppression is mixed. Hepburn and colleagues (2009) found MBCT did not reduce thought suppression as measured by the White Bear Suppression Inventory, but it did reduce self-reported attempts to suppress thoughts.

As has been discussed, the prevailing cognitive theories of OCD cite cognitions or meta-cognitions as significant in the maintenance of the condition. Mindfulness is assumed to have several effects on both metacognitions and their processing in the brain (Wells, 2002). However, Wells argues that unless mindfulness techniques are grounded in cognitive theory, by which he means targeted towards modifying erroneous beliefs, they will not be effective (ibid.). What Wells appears to be saying is that mindfulness practice on its own is not sufficient to bring about change. In giving voice to the lived experience of people with OCD using mindfulness, this study was able to comment on whether participants thought mindfulness was necessary and or sufficient to manage the symptoms of their OCD.

Mindfulness OCD Research

Mindfulness group programs or mindfulness interventions that target OCD have been examined in very few studies. As there is, as yet, no formalised OCD mindfulness treatment, the treatments referred to in these studies typically, but not exclusively, take the form of modified MBSR/MBCT programmes that also incorporate CBT elements to target OCD behaviours and maladaptive cognitive appraisals. The studies are summarised below.

Single Case Studies

Three single case studies have been published. Singh and colleagues (2004) reported on 'Janice', a 25 year old white female, who had what the authors described as "a very severe and intractable case of OCD" (ibid., p. 279) and would spend from 3 to 9 hours a day cleaning and washing her room. Janice had been treated with SSRI medication and CBT as an in-patient. Despite this, Janice's condition worsened to the point where she was unable to leave her room. The mindfulness treatment described in the case study was based on Buddhist principles with enhanced mindfulness meditation as the core of the intervention. At the end of her 16 week treatment Janice's OCD symptoms had not disappeared entirely but she reported being able to respond to "OCD urges" with less anxiety and was able to dispense with medication entirely. However, there is a difficulty in attributing the changes to mindfulness, as there were other parts to the treatment - such as helping Janice regard her OCD symptoms as strengths that she could utilise, rather than as problems that needed to be eliminated.

In a second case study, Patel, Carmody and Simpson (2007) reported on Mr X, a 25-year-old white male, who had refused conventional ERP because it was too distressing. Mr X was treated with an 8-week MBSR programme modified to include additional elements: psycho-education about OCD, discussion of symptoms and their meaning; and awareness of methods for coping with OCD (not specified). As measured by OCD psychometrics Mr X's OCD reduced from moderate to mild by the end of the 8-week programme and remained this way at the 3-month follow up interview. Despite this appearing to show evidence for the effectiveness of the mindfulness treatment, Patel et al. (2007) cite the

limitations of a single case study and the non-standard, non-manualised treatment as reasons to be cautious about making claims. As with the previous case study, it was not possible to separate the effect of the mindfulness treatment from the other elements of the treatment.

In the third case study, seven sessions of mindfulness (no CBT) was used to treat a 21-year-old male with OCD (de Zoysa, 2013). The patient reported an improvement to his OCD symptoms and a reduction in anxiety. There is unfortunately very little detail in this study about the treatment so it difficult to ascertain what in particular was helpful.

Randomised Controlled Trials

In what is probably the most empirically rigorous research to date, Hanstede and colleagues (2008) investigated the effect of eight one-hour sessions of mindfulness training on a non-clinical sample of 17 Dutch students whose scores on the obsessive-compulsive inventory-revised (OCI-R; a measure of OCD symptoms) indicated that OCD was impacting on their lives. Compared to waiting-list controls, the study found the intervention group had a significant reduction in OCD symptoms (as measured by the OCI-R), an increase in “letting go” (using metaphor to observe thoughts passing) and a reduction in thought action fusion at the end of 8 sessions. Hanstede and colleagues concluded that their results (albeit in a pilot study) showed mindfulness to be as effective as ERP but argued that mindfulness had the advantage of provoking considerably less distress in OCD sufferers. However, this latter point was not empirically tested.

Qualitative Studies

To date there have been two qualitative studies that have looked at OCD sufferers’ experience of the mindfulness treatment for OCD. Wilkinson-Tough and colleagues (2010) used an A-B-C replication case-series design with three participants. They investigated whether mindfulness-based therapy would be effective in reducing obsessive-intrusive thoughts, specifically through targeting thought-action fusion and thought suppression. Their mindfulness treatment consisted of mindfulness education and exercises drawn from a DBT skills

training manual presented over 6 weeks. Wilkinson-Tough et al. were specifically interested in the effectiveness of mindfulness on obsessive thoughts (rather than obsessive compulsions or the experience of OCD in general). By the end of the study all three participants had reduced their OCD to sub-clinical levels and two out of the three maintained this improvement at the two-month follow up.

In a German study, Hertenstein and colleagues (2012) performed semi-structured interviews with twelve participants suffering from OCD who had received eight sessions of a weekly MBCT program given as a follow up to a traditional CBT/ERP treatment. Overarching themes were deduced from the data based on their frequency of occurrence (content analysis) and there was no attempt to interpret or go beyond the descriptive in the analysis. Hertenstein et al. drew preliminary conclusions about which particular components of MBCT might be useful for OCD sufferers (self-acceptance, the acceptance of private events and the three-minute breathing space). However, as the interviews followed immediately on from the treatment it could be argued that the participants may not have had sufficient time to benefit fully from mindfulness, or used it long enough to either appreciate changes or reflect fully on its effect.

Service Audits

Two studies (Fairfax & Barfield, 2010; Fairfax et al., 2014) reflect on the use of mindfulness and its integration into a NHS secondary care group therapy for OCD. Fairfax and Barfield (2010) reported significant improvement in OCD symptoms for five group members but as the group therapy incorporated other elements, such as psycho-education and ERP, it is not possible to attribute these improvements solely to mindfulness. An audit of group therapy for OCD that included mindfulness, while providing evidence to support the effectiveness of mindfulness in the treatment of OCD, noted that not all participants found it useful (Fairfax et al., 2014); a lack of understanding of the concept and practice of mindfulness was cited as the most common reason for this. However, the limitations of the audit process meant that it was not possible to contact all those who did not find mindfulness helpful, or fully explore their experiences.

Research in Progress

At the beginning of 2014, Sussex Partnership NHS Trust secured funding to run a 19-month pilot RCT study to determine whether mindfulness-based ERP is more effective than ERP on its own (Strauss, et al., 2015). At the time of writing, this study still was unpublished, however it aimed to recruit just forty participants, which is relatively few for an effectiveness RCT, and the researchers themselves have stated that they do not expect to be able to answer the research question in full (Sussex Partnership NHS Foundation Trust, 2014).

Mindfulness and OCD Summary

It is not yet established if mindfulness is effective or helpful for most people in the treatment of OCD. In the small amount of research to date, there is limited data to illuminate how mindfulness might help OCD sufferers alleviate their symptoms or manage their condition. What is known is that OCD and mindfulness share some common factors: OCD has a neurological component and mindfulness is known to alter neuronal structures in the brain; OCD is related to maladaptive processing of thoughts and mindfulness aims to develop the capability to have a more discerning awareness of thoughts; OCD sufferers often have fixed beliefs that they find distressing and mindfulness encourages a non-judgmental observing stance to these beliefs.

Research rationale

In reviewing the literature on OCD, it is apparent that the majority is framed within a positivist epistemology and is broadly concerned with evaluating aspects of the contemporary cognitive-behavioural theories or the effectiveness of treatment strategies. There is also an almost complete absence from the literature of the voice of people with OCD with the vast majority of the research being quantitative or theoretical in nature. Similarly, but perhaps more surprisingly, the literature on mindfulness also reflects a positivist and quantitative bias. Quantitative research, by its nature, can only answer the questions that are asked. This study aimed to go beyond what was known or assumed and give a free voice to the participants.

The literature review also discussed the small number of studies that have investigated mindfulness interventions for OCD, however as discussed these had limitations, and one major problem: all the studies confined their enquiry into providing testimony to the effectiveness of mindfulness practice for alleviating the symptoms of OCD. Only the two qualitative studies gave voice to people practising mindfulness, but in neither study do the researchers go beyond the descriptive to make sense of the participants' experience, nor do they address broader questions about the use of mindfulness with OCD.

Perhaps the most compelling reason to study this area is the relatively poor outcomes for people with OCD who access treatment. As has been discussed, not only are there a significant number who do not improve, a large number of people drop out of treatment because they find it too difficult or distressing (NICE, 2006). It is hoped that this study can improve outcomes and quality of life for people with OCD.

For these reasons, it was thought that a qualitative interpretive enquiry into this field was needed to understand more about the lived experience of people with OCD who choose to practise mindfulness. This study was not restricted by any assumptions about the way mindfulness and OCD might be experienced. The use of qualitative methods allowed participants to express their views and this gave rise to rich, detailed and sometimes surprising data.

The author of this study, being a counselling psychologist, was also well placed to provide a critical and phenomenologically based interpretive analysis of the data, which thus added a perspective different from a prevailing medicalised view of OCD.

Research aims

The aim of this study was to investigate the phenomenological and lived experiences of mindfulness for participants with OCD, in order that their full experience of mindfulness and its relation to their OCD condition could be better understood. It utilised entirely the participants' subjective frame of reference and there was no expectation of what would be discovered.

The main objectives were to explore the impact of mindfulness on the participants' way of being, their sense of themselves and their OCD symptomology. The participants were asked to consider how they conceptualised the role of mindfulness in their treatment (i.e. what meanings did they ascribe to mindfulness in relation to themselves and their OCD) as well as how their experience of themselves and their OCD was affected by mindfulness practice.

Research questions

The aim of this study was to explore the lived experience of people with OCD who also practise mindfulness. With this in mind, the following questions were used to frame the interview process and to construct the interview guide (Appendix D).

1. What is the lived experience of mindfulness for someone suffering with OCD and how does the person make sense of that experience?
2. In what ways does being mindful, or mindfulness practice affect symptomology, wellbeing or quality of life? How is that experienced?
3. What are the helpful or facilitative aspects of mindfulness in the context of 'treating' or managing OCD? How is this experienced? What does helpful mean?
4. What are the unhelpful aspects of mindfulness in the context of OCD? How is this experienced? What does unhelpful mean?

Methodology

This section provides a description and explanation of the approach taken to both answer the research questions and give voice to the lived experience of people with OCD. The critical realist paradigm of the study will be introduced as well as the philosophical underpinnings and rationale for the chosen methodological framework of IPA. A reflexivity section is incorporated highlighting the author's reflective process during the initial design of the research.

The scope of this section moves from broader epistemological assumptions to detailed procedural descriptions and includes the steps taken to ensure this study was valid, of a high quality and ethically sound. It also includes a discussion on the significance of this topic for counselling psychology and what a counselling psychologist brings to research such as the current study.

Design

This was an interview-based study of the phenomenological lived experience of seven participants all of whom were OCD sufferers and mindfulness practitioners. The design adopted a qualitative methodology to explore the accounts the participants provided of their subjective lived experiences of mindfulness.

Rationale for Chosen Methodology

This study takes an alternative position to the dominant positivist epistemological position in psychological research (Willig, 2013). Positivist research typically adopts a quantitative design and assumes that it is possible to describe the 'truth' and 'reality' of the world and the people in it, which is independent of the process of viewing it (Willig, 2013). In choosing to undertake a qualitative study the researcher was influenced in part by the philosophy of counselling psychology, based as it is on humanistic principles.

Qualitative versus Quantitative

As was evident in the previous review of the literature, the vast majority of researchers in the fields of OCD and mindfulness take a positivist position and

there is very little published research that provides insight into the experience of people who have OCD or who practise mindfulness.

This was one of the reasons that the choice of qualitative over quantitative was a straightforward one. Another reason was that the research aim of exploring participants' lived experiences, and the meaning they ascribe to those experiences, fits with a qualitative approach that provides the opportunity to access meanings, perspectives and interpretations while remaining sensitive to all types of diversity (Willig, 2013). The author's choice to train as a counselling psychologist also reflects the importance she places on subjective human experience. It has been argued that counselling psychology exemplifies a particular epistemological approach, labelled the scientist-practitioner model (Woolfe & Strawbridge, 2003). Woolfe and Strawbridge state that behind this is the premise that counselling psychology will extend the concept of what is scientific beyond positivist perspectives to include qualitative, intersubjective accounts. These perspectives are seen by some to have particular relevance to psychotherapy practice, and to provide an alternative to nomothetic data (Smith et al., 2009).

The author also works in the NHS, where according to the National Health Service (NHS) Constitution, there is a commitment to involve and empower patients and members of the community to play a greater role not only in individual care and treatment but also in shaping health services. Barker (2015) advocates for more qualitative research in the NHS and cites evidence to indicate that in attempting to capture patient experience, the NHS has in the past relied heavily on quantitative data from outcome measures, questionnaires and surveys which fail to capture patients' diverse experiences. Entwistle and colleagues (2012) also suggest that qualitative input is needed when designing, delivering and commissioning NHS services and argues that the NHS has to be more responsive to individuals. It is hoped that this study will add to the small amount of idiographic knowledge available when thinking about the clinical provision for OCD in the NHS, and that this will lead to more helpful and effective interventions for OCD.

Epistemology

In order to answer this study's research questions the author has adopted a broadly critical realist epistemological position, but has also drawn on phenomenological epistemology.

Critical realism is one of a range of post positivist approaches that is positioned between positivism, with its assumption of a straightforward direct relationship between the world and our perception of it, and constructivism, which assumes that experience is never a direct reflection of our perception (Willig, 2013).

Although a critical realist approach assumes the data reflects what is happening in the world, it does not assume it does this in a self-evident way. Rather the data has to be interpreted in order to further an understanding of what lies beneath so as to understand fully the factors that may be influencing its production (Willig, 2013). The strength of critical realism for qualitative research lies in its ability to make sense of complexity; also that in the analysis of data it can draw on wider knowledge while respecting the importance of individual meaning (Clark, 2008). For this study, this meant the author was able to draw on her knowledge of both OCD (theoretical and clinical) and mindfulness (theoretical, clinical and personal) to help in the interpretation of the data while paying close attention to the meaning and significance offered by the participants.

Similarly, a phenomenological approach lies between the poles of positivism and constructivism. The phenomenological paradigm is concerned with experience, narrative and people's lived experience of the world (Langdrige, 2007) and aims to capture more of this subjective experience, (Willig, 2013). Hence, the aim of phenomenological enquiry is to study experience as it appears to people while recognising similar experiences can have various meanings at different times and in different contexts (Willig, 2013). In this way, a phenomenological approach offers an extension to what we can know about the world (Langdrige, 2007).

Combining epistemological approaches into a methodological pluralism is a valid stance. Willig (2013) argues that qualitative epistemological perspectives should not be thought of as mutually exclusive and combining approaches recognises

that data can express a number of different things depending on what questions are asked.

The questions being asked of the data in this study pertain to both finding new knowledge of the effect of mindfulness on OCD and the lived experience of people with OCD. Therefore, in adopting a pluralist approach, the author chose to combine critical realism with its assertion that reality independently exists with people's experiences and perceptions of this being subjective (Madill & Gough, 2008), and phenomenology, with its focus on lived experience (Langdrige, 2007) as this provided a good fit for the research questions.

The author's role as a counselling psychologist was also a factor in this decision. Critical realists attempt to promote a collaborative relationship with research participants (Robson, 2002), which is consistent with one of the guiding principles of counselling psychology to empower and support research participants (British Psychological Society, 2005). Counselling psychology itself also has a phenomenological focus and is concerned with understanding people's inner worlds and uncovering subjective truths (Strawbridge & Woolfe, 2003).

Rationale for IPA

Interpretative Phenomenological Analysis (IPA) was the chosen methodology for this research. The aim was to explore participants' experience of mindfulness and OCD and the meanings they attributed to this experience. There was a further focus on ascertaining helpful and less helpful aspects of mindfulness as it related to OCD. With seven participants, the focus on experience and meaning was explored in depth through a small number of cases, and this is consistent with the principles of IPA. Fortunately, IPA is a qualitative research approach that is compatible with both a critical realist and phenomenological epistemology (Reid, Flowers & Larkin, 2005) and aims to explore how participants make sense of a particular events or experiences through an in-depth examination of people's lived experiences and personal perceptions (Smith et al., 2009).

IPA started in health psychology with the publication of Jonathan Smith's (1996) paper that argued strongly for a new approach to research in psychology which

could capture and present experiential and qualitative data. IPA has since been used widely in clinical and counselling psychology research. IPA has its theoretical underpinning in three key areas of the philosophy of knowledge: phenomenology, hermeneutics and ideography (Smith et al., 2009). What follows is a brief description of each and its relevance to this study.

The basis of IPA lies in the principles and methods associated with phenomenology, and one of IPA's strengths is the ability to examine how people make sense of, or find meaning in, their experiences (Smith et al., 2009). Larkin, Watts & Clifton (2006) argue that IPA has two consistent aims: to understand and 'give voice' to participants' experience; and to interpret or 'make sense' of this experience from a psychological perspective. This was essential if the research aims of this study were to be answered.

IPA is also hermeneutic; the data is interpreted and ascribed meaning. Smith and colleagues (2009) talk about IPA utilising the 'hermeneutic circle' which denotes establishing a relationship between the whole and the parts of what is being studied. "To understand any given part, you look to the whole; to understand the whole, you look to the parts" (Smith et al., 2009, p. 28). This had relevance for how the data in this study was analysed and this will be covered later.

Perhaps of particular relevance to this study, IPA is fundamentally idiographic in its aim to capture in detail what an experience is like for a person and what sense the person is making of what is happening to them (Smith et al., 2009). This is in contrast to the nomothetic data typical in psychology research and particularly in the field of OCD. An idiographic approach aims for an in-depth focus on the particular and commitment to a detailed analysis, which is not possible in nomothetic research with its focus on aggregated data. People with OCD have rarely been heard (Murphy & Perera-Delcourt, 2012) and so it was particularly important that the methodology chosen gave prominence to individual accounts.

IPA was not the only methodological approach evaluated for this study. Two main qualitative alternatives to IPA were considered: thematic analysis and grounded theory. Thematic analysis was rejected on the basis that it is not

focused to the same extent on lived experiences nor does it provide the idiographic lens of IPA.

Grounded theory is in some ways similar to IPA in that it aims to represent participants' views of the world and involves systematically analysing data to identify themes and categories so as to capture the essence of the phenomena under investigation (Lyons & Coyle, 2007). This objectivist version of grounded theory is traditionally based in an epistemological position of positivism and realism where it is possible to describe what is 'out there' in the world, and hence from this position can be used to derive a hypothesis that can be empirically tested (ibid.). This form of grounded theory was in opposition to the author's epistemological position and the desire not to pre-judge the content of the data. However, there is a social constructivist version of grounded theory, where it is assumed that reality is constructed with knowledge considered to be created rather than found, and this knowledge must be considered provisional in the sense of it being historically and contextually located (Chamberlain, 1999). With constructivist grounded theory, the categories do not simply emerge from the data, but are constructed and shaped by the researcher through interaction with the data (Willig, 2013). In contrast to the objectivist form, the constructivist version of grounded theory does not generate an 'ultimate truth'; instead, it presents just one particular reading of the data. This then would appear to be a better fit with the author's epistemological position and the research aims. However, constructivist grounded theory takes a fundamental perspective of 'outside in' and attempts to explain the quality of experience in terms of wider social processes (ibid.). Whilst this is undoubtedly a useful thing to do, and there is indeed something lost from a full understanding of psychological experience if the wider context is not attended to, the aim of this research was to explore in-depth personal experience. Enquiry into the social, cultural or political environments surrounding the participants was not a focus of this study and therefore IPA, rather than grounded theory, was considered to be a more suitable method to meet the aims of the research questions.

Another important reason for choosing IPA is that the method is consistent with the principles of counselling psychology, and its concern with engaging with

subjectivity and inter-subjectivity, and respect for first person accounts as valid in their own terms (British Psychological Society, 2005). However, perhaps the strongest argument in favour of a phenomenological approach is the fit with the mindfulness epistemological roots in Buddhist psychology. According to Brown and Cordon (2009), Buddhist psychology and phenomenology share a common goal to discover the operation of the mind through first-person experience. This makes IPA an ideal fit for a counselling psychology study of mindfulness.

Data Collection

IPA is suited to methods of data collection that invite participants to offer a rich, detailed, first person account of their experiences (Smith et al., 2009).

Interviews were therefore selected as the primary source of data. These allowed participants to speak freely and reflectively, and to develop their ideas and express their concerns at length.

Five interviews were conducted face-to-face (two of these via Skype) and one by telephone. One participant, preferred to be interviewed by email. This participant also gave permission for data to be sourced from his online blog.

Interview use in research

Interviews are a well-established method of data collection in qualitative studies. Willig (2013) argues that interviews allow “participants to challenge the researcher’s assumptions about the meaning and relevance of concepts and categories” (ibid., p. 16). Moreover, according to Smith et al. (2009), the advantage of one-to-one interviews is that they are easily managed, allow a rapport to develop, and give participants the space to think and be heard. With this in mind, the research interviews were semi-structured but also guided by what the participant wanted to clarify and explain about their experience of mindfulness and OCD.

In line with IPA methodology, a semi-structured interview schedule was devised (Smith et al., 2009; see Appendix D). With semi-structured interviews, the researcher is guided rather than directed by an interview schedule. Not being tied to a fixed schedule allows a flexible approach that enabled participants to discuss particular areas of interest and new themes to emerge (McLeod, 2003).

In line with guidance for developing appropriate interview guides for IPA research (Smith et al., 2009) broad, open-ended questions were utilised.

The first interview was used as a pilot and some restructuring and reordering of the questions followed this. Subsequently there was a subtle iterative process whereby responses in previous interviews influenced questions in later interviews; however, the interview schedule remained constant throughout the remaining interviews. Ten broad open-ended questions were developed (see Appendix D).

Weblog as data

In addition to the interviews, one participant, Steve, provided data in the form of email responses and an electronic on-line weblog (blog). A blog is often a personal diary shared on the internet that provides a view into the lives and minds of their virtual authors. Hookway (2008) notes that blogging involves “placing private content in the public domain” (ibid., p. 96) and that researchers must pay attention to the potential for discursive display or performance. However, Hookway argues that the anonymity of the on-line blog actually allows bloggers to write more honestly and candidly. Hookway also goes on to point out that, similar self-presentation factors are at play in a face-to-face interview as in a blog and in neither case can one be certain that the participant in the research has been completely open.

For this research, the areas of interest to the research question were covered in the interview, but quotes from the blog have been included in the analysis where they provided further evidence in support of points raised by the participant.

Email Interview

Murray and Sixsmith (1998) outline some of the advantages and disadvantages of undertaking interviews by email. Participants have the opportunity to take their time over the response and reflect on their thoughts and feelings before responding, potentially leading to succinct but reflective responses. Murray and Sixsmith also suggest that because the interview process is extended over time the participant can take a more active part in constructing the interview and move away from a traditional researcher-interviewee relationship to a more

collaborative co-researcher one. One disadvantage is the increased potential to disguise the self as the invisibility inherent in the electronic communication enables the participant to, if they elect to do so, engage in a degree of deception about their age, gender, marital status, sexuality, etc. However, as James (2007) points out, this is not something that only occurs online.

Murray and Sixsmith (1998) also point out that it might be more difficult to gauge continuing consent via email, as visual cues as to the acceptability of a particular question are not present. In addition, debriefing at the end of the interview is more problematic as, unlike face-to-face interviews, the conclusion of the interview process may not be obvious.

With this in mind, a different process from the face-to-face or telephone interviews was used for the email interview. For this participant, there was the opportunity to read the online blog first, which provided much relevant data pertaining to the questions on the interview schedule. To avoid the situation of having the email data simply reproduce what was in the blog, this participant was asked to elaborate on the content of the blog that related to the broad interview questions. Two questions were emailed at a time concerning the same broad theme from the interview schedule. The choice of two was a compromise between wanting to move the interview along but not wanting to irritate with too many questions and the possibility that this might reduce the richness of data returned. This also allowed the researcher to follow up on the responses where necessary without the participant losing the thread of the topic. Whereas all the other interviews took place over the period of about an hour, the email interview took several weeks, as there would often be several days delay before responses were received. The researcher was aware of some concern and increased anxiety while waiting, as it was never certain that a response would appear. Despite the warning from Murray and Sixsmith (1998), there was however little problem with the conclusion of the interview and further emails were exchanged giving the participant the opportunity for a debriefing.

Ethical Matters

To ensure the quality and validity of the data the following ethical aspects of the research were considered and applied.

Ethical Approval

This study required both NHS ethical approval and local Devon Partnership NHS Trust Research and Development approval. This approval was received and ratified by the Faculty of Health & Life Sciences Research Ethics Committee on behalf of the University of the West of England ethics committee on 2nd August 2013 (see Appendices 8-10).

Informed Consent

Voluntary informed consent was sought from all participants in the study (see Appendix C), along with the option to withdraw from the study prior to analysis of the data. A consent form was signed by all participants. For participants that were not met face-to-face an electronic signature software package called EchoSign from Adobe Systems was used. This allowed participants to indicate consent in digital form. Validated E-signatures are legally enforceable in 27 countries and serve the same function as ink signatures.

Confidentiality

No personal data was recorded other than minimal demographic data pertaining to age and gender as well as some information regarding OCD diagnosis and experience of mindfulness. Transcripts were edited to remove identifying information. Pseudonyms were used throughout the transcription, analysis and writing up phases of the study.

A document describing which participant corresponded to which pseudonym and transcript has been kept securely, but separately from the research data, and will be destroyed when the research and assessment have been fully completed.

Risk

As a practicing psychologist, the researcher was aware that people with OCD can have particular difficulties talking about aspects of their OCD, particularly if the OCD involves intrusive thoughts of a personally distressing nature. Before the

interview, each participant was fully informed of the interview process and that they would be expected to talk about the experience of mindfulness and their OCD symptoms. They were also informed that they would not be asked to provide any specific information about the nature of their OCD or the content of intrusive thoughts. All participants were debriefed afterwards and the researcher checked out if the interview had affected the symptoms of their OCD in any way. The researcher was pleased to discover that none of the participants reported any negative consequences of being interviewed. All participants had both the researcher's email address and telephone number as well as the number of the director of studies and were encouraged to make contact should there be any problems following the interview.

Participants

Participant recruitment started in August 2013 (following receipt of ethical approval). It was decided to recruit adults over the age of 18. This was done primarily for pragmatic reasons in order to simplify the ethical approval process but there are also good methodological grounds for this decision. According to Marsden and Chowdry (Marsden & Chowdhury, 2009) paediatric and adult OCD share many similarities including presentation and treatment; however, children often lack insight into the unreasonable nature of their obsessions. It was thought therefore that child and adult experiences might be significantly different. This poses a problem for IPA, which requires fairly homogenous samples so that convergence and divergence can be studied in detail without having to pay attention to the differences between participants (Smith et al., 2009). Children were therefore excluded to increase the homogeneity of the participant sample.

It was originally hoped that a significant proportion of participants would be recruited from an OCD group run in an NHS mental health setting. However, due to the cancellation of this group and unforeseen problems in being able to contact previous group members, only one participant was found this way. The remaining participants were found through various other means: the study was advertised through notices placed on two OCD websites and one OCD forum (3 participants); two specialist OCD therapists agreed to forward an email seeking

participants for this study to previous clients (two participants); one of the OCD therapists, herself an OCD sufferer agreed to be interviewed. This last participant was not only an active mindfulness practitioner, but had attended an MBSR course and suggested ways in which mindfulness could help clients as part of the therapy she offered.

Overall recruitment of participants was more difficult than has been anticipated. The researcher had some early indication that there might be problems in recruitment when speaking to the five members of the NHS OCD group. One participant, whilst wishing to help, declined to take part because the symptoms of his OCD meant that he feared having a physical record of anything he said; for a similar reason he was also not willing to sign his name for the informed consent. Another participant in the group had concerns that talking about mindfulness, which he had found helpful, would stop it from working for him. A third person was willing to take part and signed the consent form but the nature of her OCD meant that she was unable to commit to a time or place to be interviewed. The fourth person in the group declined because he did not find mindfulness helpful and did not want to say anything that might reflect badly on the facilitators of the group.

Potentially a large number of people with OCD would have seen the request for participants either by email or on the web. The low number of responses to the various recruitment methods could be an indication that potential participants experienced difficulties similar to those found in the NHS group. It is also possible that the shaming nature of OCD might have made it difficult for people to volunteer to be interviewed. This is of a particular disappointment to the author because all the participants reported having an extremely positive experience of being interviewed, and more than one used the boost it gave to their confidence and self-esteem to make not insignificant changes to their lives.

Number of Participants

In IPA research, Smith et al. (2009) suggest that with less than three participants there may not be sufficient points of similarity and difference to develop meaningful themes and topics of discussion. However, with too many

participants there is a danger of being overwhelmed by the amount of data generated. Smith et al. point out that the primary concern of IPA is the detailed account of individual experience and the issue is quality not quantity. The authors go on to say “[it] is important not to see the higher numbers as being indicative of ‘better’ work”, and “[s]uccessful analysis requires time, reflection and dialogue, and larger datasets tend to inhibit all of these things” (ibid., p. 52).

In the same work, Smith and colleagues specifically reference professional doctorates, which they recognise present additional demands on researchers. They argue that between four and ten interviews “seem about right” (ibid., p. 52). The number of participants recruited for this study fell in the middle of this range and, in the researcher’s opinion, provided sufficient rich in-depth lived experience data to answer the research questions.

Inclusion Exclusion Criteria

The participants in this study were asked if they had OCD and the nature of their symptoms were checked to ensure these were consistent with a formal diagnosis of OCD. All but Rhianna said that they still suffered from OCD. Rhianna said she considered herself to have recovered but then offered the paradoxical statement “but I’m still in management of the condition”.

None of the participants said they had significant comorbid mental or physical health problem. Mild-to-moderate levels of depression and anxiety are typically present in patients with a diagnosis of OCD (Tükel et al., 2002). A brief verbal assessment was conducted to ensure that OCD was the primary presentation and that there was no other condition that would affect the participants’ ability to give informed consent, or would significantly affect their participation in the research. Many of the participants were taking medication in the form of SSRI antidepressants; this is normal practice for the treatment of OCD (NICE, 2006).

A summary of participant information is provided below in Table 2

Table 2 Participants

Pseudonym	Gender	Age	Years since diagnosis/onset of OCD	Type of OCD and intrusive thoughts	Mindfulness training or instruction	Continues to use mindfulness meditation
Paul	M	34	7/28	Ruminations sexual / religious, fear of blasphemy or harming children	Part of OCD treatment	No
Olivia	F	66	40/45	Contamination, (some checking), fear of disease & drains	Part of OCD treatment	No
Carrie	F	26	2/14	Contamination and checking, fear of dirt and germs	Part of OCD treatment	Yes
Rhianna	F	47	9/23	Ruminations, contamination and checking, fear of causing harm to others	8 week MBSR	No
Steve	M	44	18/30	Ruminations and checking, need to know trivial details, check facts	Vipassana meditation training	Yes
Becky	F	39	1/5	Ruminations, sexual, fear of harm to children	8 week MBSR	Yes
Gordon	M	44	2/2	Ruminations, fear of physical violence from or to others	Self-help books and CDs	Yes

As this table shows, the participants varied in the range of OCD symptoms, length of time with the condition and experience of mindfulness. For some participants their OCD manifested itself primarily in intrusive thoughts with few overt compulsions; these participants had mostly attempted to hide their condition from close friends and family due to the shame they experienced. For others the compulsions were more evident and these participants described spending long periods of time performing rituals or repeating the same action due to the anxiety they felt. All, apart from Carrie, had used mindfulness for

more than six months, some for several years. Carrie had used mindfulness for four months.

Transcription

The interviews were recorded in full, however following the recommendation from Smith et al. (2009), only material that was related to the research topic was transcribed. The transcripts included phrases such as “umm” and “you know” so that the transcript was as close to the original dialogue as possible for the purposes of analysis.

Smith et al. (2009) mention that transcribing is an interpretative activity. The process of transcribing the interviews was used as an opportunity to re-live the interviews, and to recapture the voices and emotions; not only those of the participants but also the researcher’s. All identifying features of participants were changed at the time of transcription in order to maintain anonymity. This included names, other individuals that were mentioned, place names and other identifying details as far as possible, in order to protect anonymity.

There was no transcription required for the emails or blog from Steve as his material was provided electronically. Any emphasis in the form of capital letters or extra punctuation has been retained in quotes from Steve’s blog.

Direct quotations from each of the participants are presented in the analysis section to illustrate themes and evidence points of interest.

Process of Analysis

An interpretative phenomenological approach was used to analyse the data. IPA is not a prescriptive methodology but the researcher followed, as closely as possible, the recommendations laid out by Smith and others (Smith, Jarman & Osborn, 1999; Storey, 2007; Smith et al., 2009) to ensure adherence to the methodology and the quality of the analysis.

In line with the steps laid out in Smith et al. (2009), the researcher followed the following process:

1. The transcripts were formatted in landscape with a wide margin on the right-hand side and a smaller margin on the left-hand side to allow for notes to be made. The lines were numbered for ease of reference throughout the analysis.
2. One transcript was read repeatedly to actively engage in the data and gain an understanding of the structure of the interview.
3. Initial notes about the transcript were made on the right-hand margin. At this stage, the aim was to stay close to the text and its meaning. The notes consisted primarily of descriptive comments and summaries of the narrative along with some connections, speculations and some preliminary interpretations at a very basic level.
4. Emerging themes, that captured the essence of the quote, were noted in the left-hand margin.
5. Through a process of abstraction (identifying patterns between themes) and subsumption (placing themes under others), the themes were grouped into a tentative structure of super-ordinate and sub themes.
6. Steps 2 - 5 were repeated for each of the other six interviews and the web blog, with the interpretation of each subsequent analysis being informed by the previous ones and earlier transcripts being re-read for evidence of newly emerging codes. This iterative process also included looking actively for disconfirmatory evidence, as recommended by Smith et al. (2009).
7. Patterns were identified across transcripts which led to a deeper understanding of which themes were common across participants and which seemed more idiographic or only represented in a sub-set of the data.
8. The transcripts were re-read several times and more interpretive comments added until a final set of themes was arrived at.

Smith et al. (2009) argue the strength of IPA is in the interpretation and warn against producing analyses that are too descriptive. The interpretation of the data in this study was both done at the individual line-by-line level and more holistically between and across the transcripts. Appendix E provides an example of an extract from a transcript of the analysis to illustrate both descriptive and

interpretative comments. In order to interpret the data Smith et al. suggest that the researcher take up a position that moves between a hermeneutics of empathy and a hermeneutics of suspicion. In this, they suggest that while it is permissible to have an interpretation of the data that questions what has been said it must remain rooted to the text and not be derived from an external frame of reference or theoretical stance. Despite this process being aided by actively coding using descriptive, linguistic and conceptual comments as outlined by Smith et al. (2009), the researcher found this the most challenging part of the analysis (for an example of this coding see Appendix E).

Although the steps 1-8 laid out above may look to be straightforward, they involved many hours of pouring over the data and merging and changing themes as a better understanding of the data arose. Some of the steps, particularly steps 5, 7 and 8 became a continual iterative process. At various stages during this iterative process, the research supervisors were consulted; their input helped the researcher to evaluate emerging themes against the data and ensure the quality of the analysis.

It has been mentioned that IPA is a hermeneutic method. There is of course a double hermeneutic in any interpretive qualitative research; to produce critical realist knowledge the researcher tries to make sense of the participants making sense of their experience (Smith et al., 2009). In order to do this the researcher had to be aware of some of the following biases and assumptions.

The researcher is a counselling psychologist and this research was conducted within the previously mentioned scientist-practitioner model which makes explicit the actions of a counselling psychologist cannot be separated from the economic, political and social contexts in which they operate (Bury & Strauss, 2006). With this is recognition that this research process was influenced by the researcher's inter-subjective experiences and by wider contexts. Although the research supervisors influenced the process of analysis of the data, the themes and how they were aggregated was primarily a choice of the author and is, therefore, in part a reflection of the researcher as she immersed herself in the data. The researcher is aware that it is probable that another researcher would

have made different decisions during the analysis of the qualitative data and, this research being grounded in IPA principles, the resulting analysis reflects the researcher's subjective attempt to make sense of the participants experience from a counselling psychology perspective. This is discussed further in the section on reflexivity.

The final stage of the analysis involved writing up the themes into a narrative account as presented later in this dissertation. Each theme description is supported by excerpts from the data to lend weight to the interpretation and allow the reader to evaluate validity for themselves.

Approach to Quality

Guidelines for enhancing the validity of qualitative research were consulted during the planning of the study (e.g. Elliott, Fischer & Rennie, 1999; Yardley, 2000; Flick, 2009) and, as described in the previous section, the guidelines and standard analytic processes for IPA, as set out by its developer, were also followed (Smith et al., 2009).

Yardley (2000) offers a set of four principles to use as a guide to measure the quality of a qualitative study: sensitivity to context; commitment and rigour; transparency and coherence; impact and importance. These were accepted and observed during the process of undertaking this study as outlined below.

The review of the literature on OCD and mindfulness ensured an initial sensitivity to context. The author's clinical work and personal experience of mindfulness also provided an additional perspective in which the interview data was situated. Ethical issues were considered to ensure that this study was sensitive to the experiences of the individual participants and also protected them. In addition, attention was paid to the author's role as a mental health practitioner, which was known to the participants, and the effect this may have had on the data (see section on reflexivity).

Evidence of 'commitment and rigour' is provided throughout this dissertation and evidenced in the in-depth engagement with the topic, the literature and the data. This is also shown throughout the analysis in the way the themes are fixed

to the texts of the participants. Supervisor input was invaluable at several key points to maintain the rigour of this process. The process of the analysis is also evidenced in the 'audit trail' found in the Appendices, a means recommended by Smith et al. (2009) of demonstrating rigour.

Coherence is evidenced in the clear fit between the epistemological stance and the IPA methodology used and the arguments for each (see sections on epistemology and rationale for IPA). The transparency of the analysis process is covered in the following reflexivity section.

It is hoped that the impact and importance of this study will be self-evident. This study had produced new knowledge that is of importance to clinical practice and the profession of counselling psychology. This is covered in more detail in the discussion section.

Reflexivity

The study was developed with a strong allegiance to the distinctiveness of counselling psychology including its emphasis on the relationality and intersubjectivity of experience and the importance of being a reflexive as well as a scientist practitioner.

Reflexivity in research involves the researcher deliberately reflecting on not only their values and biases that have influenced the research but also the social and political context in which the researcher and participants are embedded and how the researcher and participants influence each other (Haynes, 2012). However, reflexivity is more than the process of simply observing or examining, rather it involves a meta-analysis, or thinking about the thinking, and as such involves interpretation as well as reflection in order to make explicit the ways in which the researcher's values, experiences, interests and beliefs have shaped the research process (ibid.).

Bracketing Assumptions

IPA is a phenomenological methodology concerned with understanding first-hand lived experience of another person (Smith et al., 2009). According to Smith and colleagues (2009) this requires close active interpretive engagement on the

part of the researcher while at the same time the researcher is attempting to suspend presuppositions and judgments to focus on what is actually presented in the data (a process termed 'bracketing'). The notion of active interpretation and bracketing would, on first sight, be in conflict, which is perhaps why Smith and colleagues talk about "the attempt at bracketing" (Smith et al., 2009, p. 99) and recommend a reflective, cyclical approach to examining one's preconceptions. Husserl termed the process of attempting to avoid one's assumptions epoché (Langdrige, 2007); epoché involves developing a stance of doubting our 'natural attitude' in order to gain a greater critical understanding of the assumptions that influence lived experience.

With IPA, in order to privilege the participants' experience, the researcher needs first to be aware of their own assumptions and pre-conceptions. However, as Smith and colleagues point out, not all of these assumptions will be known before the data is heard and analysed. So in this study it was necessary at each stage to question assumptions in light of increasing knowledge of the participants' experience. The researcher employed epoché, in part by making notes in a reflective journal and also through consultation with colleagues and supervisors.

It was in the analysis stage of the research process where perhaps it became most difficult to bracket off assumptions and thus the researcher's identity became more apparent. However, by making the researcher's assumptions explicit in the reflective journal it was hoped that at least the lens through which the data was analysed was made apparent.

In order for the reader to judge to what extent the researcher successfully applied epoché some of information about the researcher, what influenced the choice of OCD and mindfulness as a study and other information is now presented (also see part of reflexive journal in Appendix K).

The Researcher

The researcher is a white, educated woman who entered the counselling psychology profession with a desire to help others and at the same time a wish to understand herself further. She does not have OCD, nor do any of her close

family or friends - but she does practise mindfulness. The researcher currently works as a psychologist in the NHS

Choice of research topic

The choice of topic was influenced both by her training as a counselling psychologist and by the researcher's work with OCD clients in the NHS. In this work, the researcher had become aware of the severe levels of distress OCD caused and the difficulties experienced by some sufferers while attempting to engage in treatment. So, although the research question is focused on the experience of mindfulness and its possible use in the 'treatment' of OCD, the initial interest was in finding out more about how OCD is experienced and to understand why the treatment so often fails. While discussing the topic with colleagues the researcher became aware of an NHS group treatment for OCD that incorporated mindfulness and this prompted the decision to focus on mindfulness as a way of gaining a window into one aspect of living with OCD, with the added bonus that the research might have an influence on clinical practice.

Researcher's position on mindfulness

The researcher has undertaken training in mindfulness and has noticed significant benefits from mindfulness practice. She has endeavoured to teach mindfulness to some of her clients and has designed and run a mindfulness group in a secondary mental health setting. The researcher would class herself as an advocate of mindfulness but also has concerns about how mindfulness is being seen as a panacea treatment for many mental health conditions without the evidence to support its use.

Influence of the Participants

The participants who were interviewed for this study reported that they had found it a positive experience despite the difficulty in disclosing personally difficult information. Their stated incentive was that something new might be learnt about their condition that might be used to improve treatment offered, particularly in the NHS, where not all the participants' experiences has been positive. The researcher felt an onus to accurately record and describe their

experiences, which at times increased the feeling of being 'deficient' as the researcher struggled to go beyond the descriptive to extract the meanings expressed. Epoché was perhaps most difficult when the researcher found it necessary to set aside her knowledge of OCD and its treatment and when she needed to draw herself back from slipping into a therapeutic rather than researcher role. The researcher's knowledge and experience of working with people with OCD, undoubtedly, helped her get into the participants' worlds but also created difficulties due to wanting to help them rather than just record their experience.

Influences on the data

Although the researcher was careful to exclude bias in the description of the research and did not reveal her own position on the topic, it was apparent that some of the participants assumed that the researcher was an active and keen mindfulness practitioner. Therefore, although participants were requested prior to the interview to include any experience whether it was positive or negative and were explicitly asked questions about what they found unhelpful, assumptions by some participants that this research was looking to confirm the use of mindfulness with OCD may have affected some responses.

Being mindful in the process

Conducting qualitative research is an intentionally personal activity distinguished from positivist research in which, in an attempt to control the research environment and minimise any factors that may intrude on the research process, the interests and values of the researcher are not acknowledged (Ryan & Golden, 2006). Bringing both mindfulness and therapeutic skills to the process of interviewing participants and analysing the data allowed the researcher not only to notice the process with what is hoped was a well-developed level of observation and acceptance but also to be aware of the judgements that arose during the analysis. Paying attention to these judgements allowed the researcher to focus in on areas of the analysis where epoché may not have been so successfully applied. These included: judgements about whether certain practices could be called mindfulness; opinions as to what was and was not helpful that did not reflect what participants themselves were saying; annoyance

when participants talked about receiving unhelpful treatment from NHS; a desire to take the OCD away and help clients; hope that mindfulness could help. Applying a mindful approach allowed the researcher to notice these and, it is hoped, thereby reduced their impact and influence on the analysis.

Analysis

After analysing the data from the seven participants and cross-referencing for themes, a story emerged of the participants' experience of mindfulness and OCD that was at times surprising, moving and inspiring. Three super-ordinate themes were formed from the ten sub themes as shown below in Figure 3.



Figure 3 Themes

The first theme “Changing Relationship to Thoughts” was perhaps the least surprising as it is a good fit with the cognitive explanations of OCD and this is also a known effect of mindfulness practice. Similarly, theme two, “New Way of Being”, can be thought to encapsulate many of the principles of mindfulness and indeed could have been titled “Mindful Way of Being”. The choice to use the word ‘New’ was to show that for all the participants, this theme described their sense of a changing self after starting to practise mindfulness and the novelty of this experience. For some this change was simply about noticing a change in perceptions or emotional and physical responses to their OCD. For others it went further; it signified a change in their sense of self and a giving up of striving

against the OCD that was liberating. It was at times incredibly moving to hear how the participants had been able to let go of some of their anxieties and self-judgements, had learnt to trust themselves and their perceptions and be more at peace with their condition. The final theme “Mindfulness as a Guard”, however, was unexpected. This theme indicated where mindfulness was used in ways that would seem to be counter to some of the principles of mindfulness, as well as potentially unhelpful for OCD. As indicated in the attached journal article, “Mindfulness as a Guard” was used more extensively by some participants than others and this is discussed further in the discussion. However, as will be seen, the quotations used to evidence themes one and two also show how mindfulness is used in two distinct ways by the participants.

The first two themes highlight an overwhelming endorsement for the use of mindfulness by the participants. It was seen as a useful, if not essential, addition to the conventional treatments for OCD. As will be seen, the participants reported the major instrument of change was the increased ability to separate a sense of themselves from the contents of their thoughts, while at the same time fostering an increased level of self-awareness giving insight into the OCD condition. The idea that mindfulness provides access to a new way of living with OCD is captured in both the first two themes “Changing relationship to thoughts” and “New way of being”; with the differentiation being the noticing and experiencing of purely cognitive changes related directly to OCD thoughts (theme 1) to more holistic or embodied changes (theme 2).

Quotations have been used throughout to illustrate themes and points of interest. These quotations have been punctuated to make them easier to read and minor edits made to aid the readability of the text. Care was taken not to alter the meaning of the quotes so as to remain true to the original dialogue. Material added by the researcher for clarification is enclosed in square brackets.

Key to Conventions Used in Transcriptions

The following conventions were used during the transcription process and will also be present in quotes used to evidence themes in the analysis.

- ... the participant tailing off or short pause
- [pause] a significant gap in the dialogue
- [laughs] indicates the participant expressing humour
- [inaudible] material that could not be deciphered from audio transcript

Superordinate Theme 1: Changing Relationship to Thoughts

This theme highlights how mindfulness had changed participants' experience of, and relationship to, their thoughts. Salkovskis (1985), along other proponents of cognitive theories of OCD, noted that while intrusive thoughts are not exclusive to people with OCD, it is the particular importance placed on the thoughts by those with the diagnosis that leads to the anxiety, distress and compulsive behaviours. Therefore, if these theories are correct, in order to achieve the alleviation of symptoms typical of OCD a significant change in either the contents of thoughts or participants' relationship to, or beliefs about, OCD thoughts would be expected. Although this study looked at the experience of mindfulness in the context of OCD, the researcher is very aware that the participants' experience of their OCD has a significant bearing on this. Therefore, as an introduction to this theme, there are some comments from the participants on how their intrusive OCD thoughts could affect them. This will help to provide some understanding of the level of distress intrusive thoughts caused the participants and give context to the changes attributed to mindfulness.

Many researchers have noted that the ego-dystonic nature of OCD intrusive thoughts or the perceived stigma of the condition can lead sufferers to conceal their OCD, sometimes for many years (Rachman, 1998; Newth & Rachman, 2001; Fairfax, 2008; Veale & Roberts, 2014). In line with this, some of the participants reported that their intrusive thoughts challenged their belief in themselves as a good or moral person. For example, some of Paul's ego-dystonic intrusive thoughts were about him being a paedophile: "And especially you know the worst type of thought you could ever imagine is child abuse."

Others described that having thoughts that they seemed unable to control or ignore caused them to question their sanity. For example, Steve summarises one of the reasons he kept his OCD secret for so long: “It is difficult for other people to understand – without thinking you are mad. So it is a long, lonely, shameful, embarrassing life of suffering.”

Becky recounted the distress OCD had caused her: “I think so, I was just going round and round in circles you know, when it got really bad, it was just so terrible it was causing me so much pain and everyone around me.”

Gordon summed up his OCD with: “All my fears and terrors and all the things horrible about OCD are looking to a horrible future or distortion or a perverse representation of the past.”

When describing her unsuccessful attempts to manage her thoughts, Olivia’s embarrassment made it difficult for her to name the nature of her intrusive thoughts: “Because of my thought, I think if I’m not actually controlling what I’m doing then I might do it without knowing, you know, the thing I’m afraid off.”

Some of the participants talked about their inability to turn the thoughts off, or be free from their OCD.

I have this all the time, the OCD, and the anxiety sometimes it's just background noise like a hiss of the radio that is not tuned. It is just when you start to listen to it too much and you start to try to make out voices and it - not that I actually hear voices in my head -but you know what I mean, try to interpret somebody from the static. [Gordon]

For Steve his intrusive thoughts came in the form of an attack, “Just a split second of a thought about it is enough to trigger an OCD attack.”

The effect of OCD had wider consequences for the participants. Some talked about effect on partners:

So my husband would check my clothes and a few minutes later I would have another spike. Then I think, gosh I begged him to do that and now,

and then you've got he's angry and I'm cross with myself, it was a total waste of time. [Olivia]

So it was with obvious relief that all the participants described changes in how they viewed and responded to intrusive thoughts; sometimes contrasting a new mindful approach with previous strategies which aimed to block or avoid thoughts. In general, the participants did not provide evidence for any change in the content of intrusive thoughts but showed how they were more able to tolerate the thoughts (sub theme 1a), and change their meta-belief about the nature of thoughts themselves (sub theme 1b). How this fits with a cognitive-behavioural approach to managing intrusive thoughts and theories about the mechanisms of mindfulness is covered in the discussion.

Sub Theme 1a: Non-judgemental acceptance of OCD thoughts and letting go

As has just been shown, some of the participants described their intrusive OCD thoughts in ways that indicated they experienced shame or embarrassment. Freeston and Ladouceur (1997) suggest that the direct consequence of this shame is that many OCD sufferers attempt to suppress, oppose or avoid intrusive thoughts. This contrasts with key attitudinal foundations of mindfulness practice: namely to have a non-judgemental stance and be an impartial witness to experience by noticing thoughts without trying to stop them; and to practice acceptance, or a willingness to see things as they are without trying to change them (Kabat-Zinn, 2013). According to Kabat-Zinn the aim of mindfulness practice is to reduce the need in people to force situations to how they would like them to be, which only creates tension and prevents change occurring.

Steve appears to allude to this when he speculates on the origin of OCD in his blog and comments: “The real cause is our lack of acceptance and our trying to stop or avoid or suppress these thoughts.”

Steve then went on to write that, “Mindfulness is necessary so that you don’t get involved with the automatic thoughts as you watch them. The mindful way out of an OCD attack is to stop avoiding and to fully embrace the anxiety and obsessive thoughts.”

These statements are presented in the blog in a very matter of fact in a way that appears to belie the struggle that Steve indicated he experienced being with his OCD thoughts, as demonstrated by his wry acknowledgement: *“But it requires courage and endurance.”*

Becky too talked about the need to accept but not engage in the intrusive thoughts: “The mindfulness just teaches you to be with all of the anxiety and thoughts, and acknowledge them, I suppose that's the important thing, I guess acknowledging them but not being swept away by them.”

Becky then went on to use a metaphor to liken her experience of her new way of experiencing intrusive thoughts to a radio being in another room.

So it's like the radio's in the other room, in a way. So I'm able to do that, I'm able to enjoy, even if I've been obsessing about something, I can still sit and really enjoy what I'm ..., watch a film, I can concentrate, it's like it's sort of buzzing away but it's not, it's not taking over.

This graphically shows how Becky was aware of the intrusive thoughts but by not trying to dispel them, she had reduced their impact. Becky was still aware of the ‘radio’ but she was able to pay it less attention and be more comfortable with her thoughts. This would appear to be a much more contented place for Becky, which contrasts dramatically with the distress of OCD.

Some participants talked specifically about how acceptance was the key to being able to let thoughts go. For Paul acceptance was the first of three steps to managing intrusive thoughts: “So obviously if I get an obsessive thought, I will say, obviously it's my OCD, accept it, ignore it and refocus, and that is the key.”

None of the participants said that it was easy to simply notice and accept intrusive thoughts. For example, Paul went on to say that he had first to be in a mindful state to notice the thought: “I don't always notice the thought and that's when there's a problem you know. I have to be mindful of what is happening, mindfully aware and then I can accept, ignore, you know refocus.”

More than one participant reported that at times it was much more difficult or even impossible to accept their thoughts, for example Rhianna said:

And when all the conditions are right and great, I can have ..., a thought can come in and I can dismiss it very quickly. If, and if I'm very stressed or under par then those thoughts can have more of an impact, and I have more of a battle going on.

This was one of many indications that the participants showed of the day-to-day difficulties in accepting their intrusive thoughts.

For Olivia there was real sense of desperation when she talked about the downward spiral created by attempting to control thoughts: "You obsess about everything when you're having a bad day. And so I think the mindfulness is essential for that, just to actually say, just let it go." This represented the continuous struggle Olivia had to accept and not engage in intrusive thoughts. Olivia described how she has the intrusive thought that she has fallen down a drain: "I am having thoughts about being wet or being stuck." Before mindfulness, Olivia had tried to control these thoughts and she alluded to this when she said with mindfulness she can: "Actually notice that I am having thoughts about being wet or being stuck or ..., without having to think about controlling the thoughts."

Of all the participants, Becky seemed to find this struggle least difficult. She appeared to have found a way to simply notice and accept her intrusive thoughts in a manner that also seemed to recognise obsessive engagement in thoughts as simply a manifestation of the mind's natural tendency to create meaning.

And I create a story, it's like a storyline that is going round and there is a little tune and the mindfulness helps so much with that because it makes you observe it, almost makes you friends with it in a way. And I think having an awareness of the way your mind gets hooked like that then can create fictional kind of worlds often out of very little.

Here Becky seemed to be aware that her OCD can cause her to 'create' her intrusive thoughts and not only is she able to simply notice this but also take pleasure from the recognition that this is just a trick her brain can play on her.

Having accepted an intrusive thought, all the participants, apart from Carrie, then described how they were able to use mindful practice or awareness to stop themselves engaging in the thought and letting it go: "And I have the ability, of when it's not too bad, I can just look at the intrusive thoughts and just watch it drift away." [Gordon]

In order to help Gordon accept and watch his thought drift away he said he found it useful to relabel the thought:

If I can call it a silly thought and depending on how, um how I am feeling on the day sometimes I have quite an intrusive thought or an OCD thought, sometimes I can just look at it and label it as "mmm" and that's enough to allow me to continue to function.

The "mmm" here appears to enable Gordon to distance himself from the thought- it creates a space for him to choose not to respond to it. Although Gordon found it helpful to label his OCD thoughts in this way, Becky did not: "The question of how to respond to the thinking, but the technique [mindfulness] teaches you not to judge yourself I think, you're meant to be just be calm with whatever you're thinking without a label on what you're thinking, letting it go." Others though also talked about relabelling intrusive thoughts as OCD thoughts, and as both Gordon and Becky seemed to gain similar benefit from their acceptance of and being with thoughts this difference is interesting.

Carrie appeared to find it most difficult to accept and let go of thoughts, instead she used mindful awareness to pay attention to the thoughts rather than "just giving in to them straightaway and carrying out the compulsion." Carrie also said: "It makes me question the obsessions that come into my mind and I kind of battle with them a bit more." In this way Carrie appeared to use mindfulness to defend herself against thoughts (see journal article).

In contrast to most of the other participants, Steve used mindfulness meditation itself as a way to accept and be with intrusive thoughts. He described how he used mindfulness to bring attention and awareness to intrusive thoughts and then meditation to bring awareness to the thought itself: “So I pause and meditate for a few minutes until the OCD [thought] has passed away.” This is obviously the opposite to thought suppression as Steve allows the thought to stay in his mind until it naturally fades. However, this also feels like a different way to use mindfulness to be with OCD thoughts. There is acceptance and ‘being with’ the thought in a very deliberate way but the question arises to whether the meditation has become a compulsive response to the thought.

As shown, acceptance of thoughts appeared to be a key feature of how mindfulness had helped all participants reduce the distress of their OCD.

Sub Theme 1b: Thoughts are not facts

As already discussed, there is evidence that OCD intrusive thoughts are perceived to be ego-dystonic, which can lead OCD sufferers to engage in numerous ways to avoid these thoughts (Purdon & Clark, 1999). This avoidance is partly driven by a belief that simply having the thought says something meaningful about the individual (Rachman, 1998; Salkovskis, 1985; Purdon & Clark, 1999), and/or that the thought is conflated with reality (Shafran et al., 1996).

There were many examples in the interviews of participants struggling with the nature of their thoughts. For example, Paul described his thoughts of being a paedophile: “But it’s difficult you know thinking, like the other day, that you might be one of them, you know like Jimmy Saville.”

Similarly, Gordon described having an intrusive thought after watching a Jack Reacher film: “And afterwards I was like, oh my God I'm going to become an assassin.”

Rhianna talked about her experience of having intrusive thoughts that she had deliberately harmed someone: “So I could have then a thought, or an image, oh did I just push somebody into the water?”

Carrie described being caught in a cycle of compulsions following intrusive thoughts. For example, she alluded to a need to count to make sure that she had performed an action a certain number of times: “You know I used kind of say right when I get to 15 I’ve done it, or if I do it to this [number] I’ve done it.”

The realisation that thoughts were just ‘thoughts and not facts’ appeared to be key to allowing participants to reduce or stop these strategies. For example, Steve talked about being able to recognise thoughts just as mental events: “Awareness that is watching the passing content of the mind. The awareness that knows that it is just thoughts.”

Others described being able to question the reality of the thoughts. Rhianna indicated this when she described how her OCD could lie to her: “Your OCD is bluffing you, and you don't listen to it, you ignore it.” Following mindfulness practice Carrie talked about being able to “battle” with her thoughts, because she was able to entertain the idea that they might not be true: “[Before] it would be - I thought it therefore it's definitely happened, so I've definitely got to wash my hands now, there wasn't, there was no doubt.”

Rhianna talked about using mindfulness to strengthen her “impartial spectator” that enabled her “to be able to distance yourself from your thought processes”. This distancing allowed Rhianna to question the validity of the thought. However, the way Rhianna talked about changing her relationship to thoughts also had a quality of separation from herself, almost as if she was giving instructions to herself from something that she had learnt and she needed to reinforce this by reminding herself. This contrasted with Becky who appeared to have come to the realisation that thoughts are not facts herself: “...and the whole thing is that the thoughts are horribly real because that’s what you’re thinking and realising you don't have to believe in them is just a revelation, it really is - thoughts aren't real [laughs].”

This was one of many examples in the interview data of where Rhianna and Becky appeared to approach mindfulness in very different ways. Rhianna’s description of how she used mindfulness was more akin to a technique that she applied to help her with her OCD, whereas Becky appeared to have embraced

the philosophy of mindfulness and, in applying mindfulness principles she had discovered, happily, that it also helped with her OCD. Looking at how the participants appeared to use mindfulness Becky and Rhianna would be at opposite ends of a mindfulness scale spanning from 'technique' to 'philosophy' with the other participants sitting in somewhere in between. However, it was the researcher's observation that the participants could also be classified broadly into two groups, either in the "mindfulness as a technique" or "mindfulness as a philosophy". This distinction is discussed further in the discussion and draws on evidence from all three main themes.

Superordinate Theme 2: New Way of Being

The second way participants found mindfulness helpful was in discovering that not just their thoughts but also their physical and emotional responses, as well as their attitudes, had altered in a way that allowed them to be more present and accepting of their OCD. This theme relates to participants experiencing themselves as holistically changed by the process of learning and practising mindfulness: not only did the participants think differently, the sub themes evidenced here show how they felt and acted differently too.

Sub Theme 2a: Mindfulness facilitates new sense of self / new way of being

The role of shame and stigma can be particularly problematic for people with OCD who may have ego-dystonic sexual or violent thoughts or believe that their condition is a form of madness (NICE, 2006). The shame and fear of OCD was evident in much of the language used by the participants, some of whom were reluctant to discuss the content of their OCD thoughts, as was evidenced by a previous quote when Olivia alluded to "the thing I'm afraid of"

For the majority of participants, mindfulness was valued because it had become an instrument to facilitate a view of themselves as someone who suffered from OCD rather than being defined by their thoughts or behaviours, like when Paul said: "You have to be mindful or you just think this is who I am, I am what I'm thinking." Similarly, mindfulness, as a practice, enabled Becky to question the idea that she was insane: "[mindfulness is] kind of like having a trust in yourself, and a trust in your own logic, you know, your own sanity that's really important."

All the participants described themselves as being more self-compassionate or less judgemental of others as a result of mindfulness practice. For example Paul showed this when he said “Not jumping onto your inner critic really and being separate from your thoughts.” Similarly, Olivia indicated less self-judgement with this statement: “Much more gentle, yeah I mean there was no ‘oh you're a bad person’, you know this was, this isn't me.”

Mindfulness practice also appeared to help some participant be less judgemental of others. For example, Carrie recognised a different response to noisy children on a train:

I probably would have started, start to have a bit of an argument in my head, you know, and, and, and be quite judgemental I suppose ... kind of thinking oh I wouldn't let my child scream the train down like that, be quite judgemental, and then I'd probably get quite angry with it and I suppose it would be a knock-on effect. [Carrie]

Paul went on to say that mindfulness had increased his self-esteem and made him more optimistic, “I’m a more positive person now.” Although Paul said this in direct response to a question, regarding whether mindfulness has brought about a change in how Paul views himself, the researcher noted that Paul talked about a number of different ways that he was managing his OCD differently, of which mindfulness was just one. Paul’s optimism may have been a direct consequence of the mindfulness practice, but Paul was one of the participants who used mindfulness more as a technique therefore the researcher was left with the impression that this particular change was a result of a number of factors, of which mindfulness played a part.

Sub Theme 2b: Giving up wanting things to be different

Mindfulness involves bringing one’s attention and awareness to the present moment with an attitude of non-judgmental acceptance (Kabat-Zinn, 2013). Acceptance involves experiencing thoughts, sensations and events as they are at the moment they enter one’s consciousness, without judging them as being good or bad, desirable or undesirable. All the participants talked about doing this and

how it had lessened the distress of the condition. For Steve and Paul this had a measure of resignation as they acknowledged that they would always have OCD.

What I radically accept is the obsessions and the anxiety, not because I like it, but because they are there at the moment. [Steve]

To stop waiting for or wanting things to be different, so I can accept it. [Steve]

The big thing is you know accepting your condition. [Paul]

Others talked about their acceptance in the moment as a different way of being with the OCD.

...the mindfulness has taught me things like to be calm, that um you know, that this will pass, this will go, these states come and go and so will happy states. That is the other thing about the acceptance, you know even the good things will pass and if you realise that even the good things will pass and the bad things will pass you realise that, you know, it's not so bad you just wait for the right bit to come past and focus on that. [Gordon]

I mean it's another way to live and you just remind yourself that you've got to live through the bad stuff as well as the good stuff. [Becky]

... because I don't want to be anxious about being anxious and the mindfulness just really helps me accept all that, accept the difficult feelings without striving. [Becky]

Becky went further than most in her acceptance and talked about welcoming in the feelings: “Whereas mindfulness teaches you to just sit with those very difficult feelings and then welcome them.” Going beyond simple acceptance into what seemed like genuine warmth for the OCD seemed to reduce further the distress of the condition and lead to a place of greater contentedness for Becky. There was a gentleness and contentedness to Becky’s welcoming acceptance of her OCD thoughts. Similarly, Steve talked about needing to “fully embrace the anxiety and obsessive thoughts”.

Becky had also appeared to have given up striving to be different whereas others, such as Steve, appeared to find it difficult to accept himself fully and his condition. This was evident when Steve said, “And I have always done my checking when nobody could see or know that I was actually doing something crazy.”

The participants therefore varied to the extent they were able to give up wanting to be different and to be accepting of themselves as someone with OCD. However, the participants attributed that the fact that this was possible at all was due to mindfulness.

Sub Theme 2c: Mindfulness helps participants be with anxiety

The standard treatment for OCD is CBT with ERP and this typically involves tolerating significant amounts of anxiety as the person with OCD is asked to face their OCD fears while not carrying out any compulsions or neutralising behaviours. Some participants, like Steve, stated that mindfulness had helped with the ERP part OCD treatment.

As I stop the checking the urge to check increases and the stressful feelings of uncertainty, doubt and anxiety increase. I then try to continue to NOT check and continue to be mindful of the thoughts, urges and feelings – letting it increase in strength, peak and decrease thereafter. [Steve]

Similarly, Paul talked about his difficulty in exposure work and how he used mindfulness to be aware of his anxiety: “And one thing I learned, it is really a mindfulness technique is actually to focus on where you're feeling the anxiety.”

Becky, who had tried CBT but not found it helpful, said she recognised the need to “just be” with the physical feelings and commented: “And just knowing you can do that helps, being with the physical, the physical kind of sensations that go along with anxiety and knowing that they're not so terrible - you need to sit still!”

All of the participants, apart from Carrie, mentioned that mindfulness had helped them endure the anxiety caused by intrusive thoughts. Rhianna noted that, due to her mindfulness practice, she was now able to become aware and simply be

curious about her physical symptoms of anxiety: “I just - ooh I think okay hold back a bit, don't respond, and even if my body has responded it doesn't mean that my... I don't have to respond, yeah.”

Rhianna, appeared to struggle most with reflecting on how mindfulness had affected her sense of an embodied self. This seems to be indicated in the previous quote, which tailed off in the middle and seemed to parallel a difficulty Rhianna identified with bringing mindful awareness to her body, because in her view she is a “head person” always caught up in thoughts. However, with mindfulness practice, Rhianna had become more aware of her physical reaction to anxiety and, as shown, was now able to make choices in how to respond.

Relaxation has been described as the antithesis of anxiety and a way to manage stress (Archer, 1991) and although relaxation is not the aim of mindfulness practice (Segal et al., 2013) other studies have shown that practicing mindfulness can lead to an increased ability to relax (e.g. Williams et al., 2011; Allen et al., 2009). This study found that the majority of the participants reported practising mindful meditation increased a feeling of calmness.

[pause] I think it's just a, it's a very good way of relaxing the mind and of calming the mind. [Gordon]

It's very relaxing, I fall asleep, even in a roomful of people I can fall asleep. [Becky]

I will use more time simply meditating on the breath, getting in deep states of relaxation and concentration. [Steve]

But no it doesn't take me very long to try and, to zone into, to concentrate on my breathing and relaxing. [Carrie]

Paul appeared to find it relaxing to meditate but he also reported feeling bored and had stopped formal mindfulness meditation practice: “You know I found it quite well boring really, I mean, it could, it could be relaxing. And I don't do it now, the meditation stuff I mean, I don't really do that now.” Paul talked about using mindfulness only for his OCD and it would appear from these quotes that if

he could not relate the use mindfulness meditation to a reduction in symptoms he had no reason to be doing it.

Similarly, neither Olivia nor Rhianna found mindfulness meditation practice relaxing or useful.

It didn't help at all no. On a bad day if I'd had a really bad spike and I was already obsessing like crazy it made my OCD worse. [Olivia]

Didn't feel, it had a relaxing kind of influence, not in a way that others benefited. [Rhianna]

Both Olivia and Rhianna described how attempting to meditate brought attention to intrusive thoughts and that this could sometimes increase anxiety (this is discussed in more detail in the journal article).

Sub Theme 2d: Increased awareness of body and emotions

Anxiety is probably the most common emotion experienced by people with OCD but the mindfulness definition of acceptance is allowing all experiences—whether pleasurable, neutral, or painful—to arise without trying to change, control, or avoid them (Kabat-Zinn, 2013). All the participants talked about paying more attention to their emotions and their bodies and how these two were linked.

Yeah, I quite often yes scan up my body and notice how it all feels, and... it does tell me to relax yeah. [Carrie]

Focusing my awareness on the breath – specifically the bodily sensation for the stomach rising and falling and refocusing awareness on the abdominal movement when I get sucked in by the OCD. [Steve]

A lot of it happens here in my chest. [Paul]

For Steve body awareness appeared to be an essential part of exposure work:

“Awareness of my body helps me to be mindful with the emotions during exposure and response prevention. Focusing on the body directs the awareness away from the obsessive thoughts and prevents checking.

Rhianna talked about being interested to notice her difficulty in listening to the physical sensations of the body: "I just find it curious and interesting and a bit amusing actually, I, I just think how much I missed, I don't listen to my body, how much I missed of my body."

The change of tense, from past to present back to past, is curious here and may be indicative of the difficulty Rhianna said she had letting go of thoughts in order to bring mindful attention to her body.

Gordon was able to use mindful awareness of body sensations to separate the physical manifestation of anxiety from intrusive thoughts.

And the same with tension in my stomach I get a lot of, I mean, and trembling and things like that and I can mindfully breathe into it or look at it. Or when I get those tensions they often precede the OCD thoughts and I can look at that and focus on that and they don't, um they don't join up. That if I, that I know if I'm getting the anxiety feelings in my stomach that, that can bring on the OCD thought, and if I'm just calm about it and focus on the tension in my stomach - like that's it, and I can move on.

Here, Gordon is indicating that the physical signs of anxiety can precede his intrusive OCD thoughts, and through mindfulness he can separate physical sensations from the intrusive thought. It is as though the awareness of the physical signs stops the intrusive thought from taking hold and becoming an obsession.

Not dissimilar to Gordon, Becky talked about how becoming aware of her body could take her away from thinking. However, for Becky this focus on the body sensations could be disturbing and she needed to bring to bear her resolve to observe the sensations, so that like Gordon, they did not fuse with the OCD thoughts.

The physical stuff can be very alarming but I think if you can focus on them and just experience them as sensations and no more than that,

then you know you are going to get to the other side of what's happening and that's the important thing.

Carrie used her awareness of body sensations and how they are related to her anxiety to gain insights into her symptoms, “And actually breathing quickly and, and getting that pain in your chest and feeling like you can't swallow isn't going to help the situation.”

Carrie reported here something that appears self-evident but it was the strength of her OCD thoughts that prevented her from being able to see this. Through using mindfulness, Carrie would now appear to have significantly more control over how she responds to the physical symptoms of her OCD.

As shown, all the participants were able to use mindfulness, in one way or another, to bring attention to physical sensations and emotions. With this increased awareness, they were able to change how they responded to the symptoms of their OCD.

Sub Theme 2e: Trusting the senses and being present

Many of the participants described that one of the difficulties with OCD is that it makes them doubt, not only their thoughts and feelings but also, their senses. Thus, a common theme in the interviews was how mindfulness had enabled the participants to engage and use their senses to help manage the OCD symptoms. However, how the participants made use of this differed. Olivia, for example, used mindful awareness to help her counteract what her OCD thoughts were telling her by utilising the evidence of her eyes:

Yes it's exactly the opposite, letting go of the control, trusting the senses that you have, because you know, I know my eyes, well I might be short-sighted but I can see it, I know what I'm seeing is true. [Olivia]

In this way, Olivia could reassure herself that the contamination that she feared was not there. There is a sense of hope borne out of desperation when Olivia said: “trust them, trust them again” and the way she said this had the same resonance noticed with Rhianna earlier of trying to reinforce to herself the thing that she knows will help her but that is difficult to do.

When Olivia is caught in an obsessive-compulsive cycle she described how she sometimes finds herself “stuck” staring unaware of what might be in her eye-line, as if in a hypnotic trance: “I’m not doing anything else other than staring.” This appears to be the opposite of mindfulness: Olivia’s eyes are open but she is unable to observe what she is seeing. When in this state, Olivia described directing herself to use mindful awareness, to “ground” herself and bring her attention back from the OCD.

So actually there's a radio here so why don't I say "but there's a radio there" you know, and then look up in here, this room, which is all blues and whites and very calm and look at that and the pictures. It's suddenly it's actually taking away from that huge spike and bringing you back to where you are, the present moment.

Olivia asks herself here “Why don’t I...?” which again would seem to indicate the difficulty she has in diverting her attention back from being “stuck” in her OCD.

Gordon, a triathlete, reported that since suffering with OCD, he had experienced problems with swimming. In order to head off the panic that could come from an intrusive thought of drowning, or that another swimmer could be dangerous, Gordon said he paid attention to the action of swimming and or the feel of the water, “There are times when I am just focusing on the bubbles coming off my fingertips as I stretch out and feeling the silkiness of the water and I’m so in the present.” Gordon recounted this with calmness, in stark contrast to the notion of panic about drowning, and an appreciable sense of relief: “Whereas when I’m focused on the inner sensations and the now, it's all okay.”

Carrie demonstrated how she utilises mindful awareness of her senses to lessen the need to perform OCD compulsions.

I think, um, a lot of my OCD is around doubt so being, doing a compulsion and then being doubtful that I've done it, so I've done it and my anxiety is reduced, then I sit down and I think I don't remember doing it so I have to do it again. Whereas being mindful it, it, well I don't know what the word is, it reinforces the fact that I've done it. [Carrie]

As covered in the journal article, Carrie also drew on sensory experiences to check whether an intrusive thought was true: “Okay so you think you touched that, what, what hand, what part of your hand did you touch it with, what finger did you touch it.” Carrie found great relief from being able to pay more attention to what she was doing.

Both Olivia and Carrie used mindfulness to bring attention to sensory experiences specifically to combat their OCD. In contrast, Becky described using the mindful awareness of her senses to focus on what was in her current awareness, which had the side effect of diverting attention away from her OCD thinking: “And also the formal practices can be very helpful, they help you train yourself to focus on your senses, who’s in front of you, listening to people.”

Both uses of mindful refocusing involved moving attention towards sensory experience and away from thoughts, however the purpose and result of the paying attention were very different. Olivia and Carrie both used mindfulness as a way of connecting to their senses to gather information to thwart their OCD thoughts, whereas Becky appeared to use awareness of her senses to become present and connected to those around her. This highlights once again a difference in the way participants used mindfulness.

A summary of participants experience

The two themes outlined in this section, “Changing Relationship to Thoughts” and “New Way of Being” and also the theme “Mindfulness as a Guard”, described in the journal article, attempt to capture the depth and breadth of the participants’ experience of mindfulness in relation to their OCD. In the first two themes, the participants indicated the perceived benefits and advantages of a more mindful way of dealing with the symptoms and consequences of their OCD. The third theme showed ways in which mindfulness, for some participants, had been added to a toolkit of active defence measures against OCD in ways that may in the long-term be counter-productive. In addition, as has been seen there were indications in all three themes of differences in the way participants were using mindfulness. For some, it was adopted as a different mind-set or philosophy and, for these participants, there was evidence of changes that went

beyond the symptoms of their OCD. For others, mindfulness was a technique to help with the particular problems of intrusive thoughts or other OCD symptoms and it is possible that this use of mindfulness will not be so helpful in the long-term.

However, while this is a conclusion of the researcher, all of the participants were clear that mindfulness was of real benefit to them. Thus, it would seem appropriate that the participants have the last word and provide their own summary of their experience of mindfulness.

Mindfulness is absolutely no magic cure for OCD, but it may be the ingredient that most current treatments lack. Mindfulness is not enough but it helps you to seek the additional help that you need. [Steve]

No, no the whole approach is the yeah the best, there's no way couldn't be helpful, it's such a kind ... technique and it's about unblocking everything, all the bad stuff, all the really awful stuff, all the terrible thoughts and welcoming them. [Becky]

I think I bring mindfulness in when I am struggling, when I am struggling I bring that in. [Rhianna]

You actually obsess about everything when you're having a bad day. And so I think the mindfulness is essential for that just to actually say "just let it go". And if you can be mindful then the OCD is not going to bother you. [Olivia]

Oh absolutely yes, if my OCD was cured tomorrow I would still carry on doing the mindfulness. I should have been doing this 20 years ago and then I would never have had OCD. [Gordon]

Um, for me [the best thing about mindfulness] is probably actually doing activities mindfully to, to reinforce to myself that I have done things because sometimes washing my hands or having a shower could take hours and hours. There were times when a shower could take up to 4 hours because I couldn't remember doing a certain part and then I

would have to go back to it, over and over again. So, it's been a life changer, so, so ..., I have a life back. [Carrie]

When I first found out that I had OCD, you know, I've been to deepest darkest places, you know, I was on suicide watch, but looking at it now I've come through the other side. It's something you know with OCD you are always going to have it but it's, you know but with creating new neural pathways, you know, with mindfulness, it can be managed and it can be changed, and yes I do feel positive about it. [Paul]

Discussion

The aim of this study was to investigate the lived experiences of people with OCD who also use mindfulness, so that the ways mindfulness are used and the benefits and pitfalls of mindfulness in conjunction with OCD could be better understood. From the data three superordinate themes developed, two of these are covered in this discussion; the third is described in the accompanying journal article. Perhaps least surprisingly, this study found that participants had, as a result of mindfulness, changed their relationship to their OCD thoughts; they were more accepting and less distressed by the thoughts and they had discovered that their thoughts were not always a reflection of an objective reality. In addition, mindfulness had altered participants' relationship to themselves as embodied, emotional beings and they had discovered a new, more present, more trusting way of being; they were more able to be with the physical symptoms of the anxiety connected with OCD and also described having more trust in both perception and somatic responses. These findings are in line with previous research that looked at the effect of mindfulness on anxiety (e.g. Brown & Ryan, 2003), and thus this study demonstrates how mindfulness could be helpful in the treatment of OCD.

Evidence was found in this study to support the dominant cognitive models of OCD. Participants described explicit changes to meta-cognitions (primarily the realisation that thoughts are not facts) and some changes to how thoughts were appraised. However, this was not the only factor that appeared to affect the participants' ability to manage their OCD symptoms; other factors are less well explained by purely cognitive models. For example, most participants did not report a change in the content of thoughts or reductions in the physical symptoms of anxiety (though participants had learnt new ways to relax); instead, they had found a better way, through mindfulness, to tolerate those thoughts and feelings.

What was particularly interesting and unexpected in this study was the different ways that participants drew on their mindfulness practice to help with the OCD. Some of the participants reported using mindfulness directly and actively as a

defence against the symptoms of OCD. For others, the changes in OCD symptomology were more of an indirect consequence of the mindfulness practice. For those using mindfulness actively as a tool against the symptoms of their OCD, there was evidence that mindfulness had become incorporated into the OCD in ways that might not prove to be helpful long-term (see journal article). For the other participants, their use of mindfulness appeared to extend beyond a technique to manage the OCD; it was adopted as a change in attitude, what could be described as a new philosophy for living, which affected many different aspects of their lives. These participants had appeared to embrace a self-compassionate, non-judgemental stance towards themselves, others and more particularly their OCD.

The study findings are important because the mechanisms of mindfulness that affect wellbeing and mental health are not yet well understood, and the differences highlighted in this study may help to illuminate what is most helpful about mindfulness, particularly in relation to OCD. Significantly, the study findings come from the lived experience of people with OCD, which has rarely been heard in the empirical OCD literature. There are various theories that may explain how and why mindfulness may be helpful (e.g. Shapiro et al., 2006; Fairfax, 2008), but this is the first time, to the author's knowledge, that the experience of mindfulness in relation to OCD has been analysed in depth. This study found good indications for the use of mindfulness with OCD, which supports other research that mindfulness is a useful addition to conventional treatment for OCD (Wilkinson-Tough et al., 2010; Hertenstein et al., 2012) and that it is well-liked by most who used it (Fairfax et al., 2014). This study also documented ways in which mindfulness was used that could be considered unhelpful for alleviating OCD symptoms. This latter finding would suggest that the use of mindfulness for people with OCD needs to be better understood, and further research undertaken, in order that clinicians are aware of any barriers, contra-indicators or ways in which mindfulness could potentially delay recovery from OCD. With a condition such as OCD, where a significant percentage fail to recover (Fisher & Wells, 2005), anything that can impact negatively on recovery is particularly significant.

Some of the key findings of this study were therefore that the use of mindfulness with OCD challenges the predominant cognitive model of OCD, and that mindfulness was being used, by some, purely as technique to aid management of the condition while others adopted mindfulness more broadly and beyond the context of their condition. There was also evidence that mindfulness was being incorporated into OCD compulsions in ways that contradict the current evidence base and accepted practice. These findings are further discussed here.

The Fit with Cognitive Behavioural Models

The first theme from the data related to how participants changed their relationship to their thoughts and beliefs. This provided evidence in support of cognitive models, but also indicated that mechanisms other than a change in meta-cognitions were also experienced by the participants.

In line with other studies that have found a correlation between mindfulness and a reduction in maladaptive worrying and ruminative thoughts (e.g. Raes & Williams, 2010; Heeren & Philippot, 2011; Verplanken & Fisher, 2014), this research showed that the participants had a more accepting and less distressing relationship with their intrusive thoughts. The participants still experienced intrusive thoughts, but these were less likely to be given salience or acted on. Participants described an increased ability to observe and be aware of their thoughts and had ceased to judge them negatively. Instead participants described being able to accept the thoughts with less accompanying distress and most could then just “let them be”. Participants also talked about realising that their thoughts were simply thoughts and not necessarily a true reflection of reality and hence had a more detached, observing relationship with their thoughts.

Fisher and Wells (2008) offer a model for the maintenance of OCD (see figure 2) that differs from other cognitive models by placing emphasis on the meta-cognitive beliefs about thoughts rather than the appraisals of the thoughts themselves. Wells (2005) proposes that a form of mindful awareness, called ‘detached mindfulness’, is the opposite of dysfunctional modes of thinking and should therefore assist in bringing about therapeutic change. The Wells (2005)

description of detached mindfulness includes the elements of mindfulness that can be ascribed to thought processes, i.e. consciousness of thoughts, comprehension of thoughts as events not facts, focused attention and flexible thought processing. Fisher and Wells (2008) argue that applying detached mindfulness to OCD allows the focus of awareness to shift away from the intrusive thought itself to meta-cognitions about thoughts and showed evidence that this brings about a significant reduction in OCD symptoms.

This study would appear to provide some support for the Fisher and Wells and other cognitive models. The thoughts that intruded appeared to be the same as had existed prior to undertaking mindfulness practice, but the participants were able to accept and not engage in the thoughts. The participants also indicated that they were able to observe and detach from the thoughts in a way that made the thought less significant. From a cognitive-behavioural perspective, this can be explained as evidence for either a change in the appraisal of thoughts or a shift in meta-cognitive beliefs. However, participants rarely commented on this and there appeared to be other factors, not to do with the appraisal of cognitions, that affected their ability to accept thoughts.

Shapiro and colleagues (2006) go beyond a purely cognitive explanation of change brought about by mindfulness and propose that what is crucial is a shift in perspective that they term 'reperceiving'. Their model is built upon three tenets of mindfulness (attention, intention and openness) but they argue that the model is more than the sum of the parts as each aspect helps and facilitates change through building on the others. They suggest reperceiving works through four mechanisms: self-regulation; values clarification; cognitive, emotional and behavioural flexibility; and exposure to emotional states with greater objectivity and less reactivity. This is a more complex, and arguably comprehensive model, than a purely cognitive one. The findings of this study would appear to be in line with the Shapiro et al. (2006) model as participants talked about their changed relationship to thoughts in terms of a non-judgemental acceptance rather than a cognitive re-evaluation. Further evidence for a more complex explanation of change is provided by Keng and colleagues (2012) who looked at mindfulness and self-compassion as factors mediating the positive effects following an MBSR

course; they found that changes in self-compassion and being less self-critical, in addition to changes in mindfulness, mediated reductions in worry. It is therefore possible that the changing relationship to thoughts, seen in people who use mindfulness, is connected to the mechanisms that facilitate a less judgemental, more accepting, way of being.

Another well-reported feature of OCD is thought-action fusion (TAF; Shafran et al., 1996) where people with OCD place more importance on thoughts and are more likely to confuse thoughts with reality than non-sufferers (Purdon & Clark, 1999). Participants in this study strongly implicated mindfulness in their ability to separate thoughts from more contextual information. Similarly, other studies have found that mindfulness reduced TAF in people with OCD (e.g. Hanstede et al., 2008; Wilkinson-Tough et al., 2010). However, the reduction in TAF in both these studies did not in every case correlate with a reduction in OCD (particularly at follow-up). The Hanstede et al. study suggested that 'letting go' (as measured by the 'letting go' subscale of the Southampton Mindfulness Questionnaire; Chadwick et al., 2008) and not TAF may have operated as a mediator in reducing the severity of OCD symptoms. Therefore, although mindfulness can reduce TAF, this may not in turn directly affect OCD symptomology. It is also possible that a reduction in TAF is not the cause of an increased ability to accept intrusive thoughts but is a consequence of it.

In this study, as with the acceptance of thoughts noted earlier, the participants' realisation that thoughts were not facts appeared to be linked to an increased ability to tolerate having such thoughts, which in turn enabled them to not give them prominence or pay them attention - this concurs with the Hanstede et al. (2008) findings. For some participants this seemed to occur spontaneously as a response to the mindfulness practice. This is important because it means that time spent on deliberate cognitive restructuring techniques to target TAF may not be necessary for all sufferers of OCD. Instead learning to accept the thoughts might be more helpful. The participants stated a clear benefit from the realisation that 'thoughts are not facts' and so the question of the mechanism of change and the connection with TAF would benefit from further investigation.

Despite reservations about whether the cognitive models are comprehensive enough to explain the changes described by the participants, overall, the first theme sits well with the cognitive models of OCD: participants described how they were more accepting of and less troubled by their thoughts. However, the acceptance and observation of thoughts as mental events did not appear to involve the re-evaluation or reappraisal of the thoughts themselves. Open accepting curiosity towards experience is a key tenet of mindfulness with a non-judgmental acceptance of the moment-to-moment experience (Kabat-Zinn, 2013). This itself is regarded as a potentially effective antidote against common forms of psychological distress (Keng et al., 2011). This study found evidence in the lived experience of the participants to support this assertion as participants were able to accept, and in some cases welcome, their intrusive thoughts; there was less evidence for a change in their appraisal of those thoughts.

The second theme in this study was firmly connected to a change in wellbeing for the participants. They described experiencing a changed sense of self, an increased ability to notice and accept emotional and body responses, and placed greater trust in sensory perceptions; all of which appeared to increase their ability to accept and manage the symptoms of their OCD. How these changes and observations relate to relevant theories and the present understanding of mindfulness and OCD is outlined below.

Although OCD is often considered primarily as a thought disorder (Rachman, 1997), studies which describe participants' experience of OCD show that many people with OCD have a dysfunctional relationship not only to their thoughts but with their whole private experience, including sensory perceptions, emotional states and feelings (Twohig & Whittal, 2009). In support of these findings, this study found that through mindfulness participants had developed a different, less judging and more compassionate view of themselves, their perceptions and experience. Accompanying this, participants described being aware of reduced anxiety connected with their OCD, and an increased ability to exist alongside their OCD symptoms. They had learnt to trust their senses and be present with different types of experience both internal and external to themselves.

The participants all described an increased ability to feel more self-compassion. Participants used terms such as shame and embarrassment to describe how they had experienced themselves and their OCD symptoms prior to mindfulness, and more than one participant referred to OCD as insanity or madness. This finding is in line with a theory for the concealment of OCD or its symptoms by sufferers (Newth & Rachman, 2001) in which it was noted that patients were troubled, shamed and frightened by their intrusive OCD thoughts and that their 'maladaptive interpretation' led to self-doubt and self-denigration. Newth and Rachman also note that an inability to control unwanted thoughts also led to patients interpreting this as an indicator of their 'decline towards insanity' (ibid., p. 459).

For the participants in this study, there was often a profound sense of relief in their dialogue when they reflected on their realisation that their OCD was separate from themselves, and the nature of intrusive thoughts did not define them or their character. This realisation allowed them to view themselves differently and with more self-compassion, which is of particular relevance because of the high levels of shame that are associated with being someone who has OCD (Murphy & Perera-Delcourt, 2012).

Self-compassion is closely aligned with a non-judgemental attitude and studies have shown a relationship between mindful self-compassion and both general wellbeing (Bluth & Blanton, 2014) and happiness (Hollis-Walker & Colosimo, 2011). Changes in self-compassion, independent of changes in mindful awareness, have also been shown to mediate reductions in worry (Keng et al., 2012).

The finding from this research that participants reported a less-judgemental stance towards themselves and their thoughts as a result of mindfulness practice has been observed in other studies. Wilkinson-Tough and colleagues (2010) measured non-judging acceptance following mindfulness in three participants with OCD, all of whom showed an increase in their non-judging acceptance score as measured on the Kentucky Inventory of Mindfulness Skills (KIMS). Similarly in a study of combat veterans experiencing post-traumatic stress disorder (PTSD),

Wahbeh and colleagues (2011) found that an increase in non-judgmental attitude (also measured using the KIMS) correlated with a reduction in PTSD symptoms. It is therefore possible that the changing relationship to thoughts seen in people who use mindfulness is connected not only to a change in cognitive processing but also to mechanisms that facilitate a less judgemental and more self-compassionate way of being.

Another factor that increased wellbeing was the participants' increased ability to respond differently to the intrusive thoughts and reduce the need for compulsions. Self-determination theory (Brown & Ryan, 2003) proposes that mindful awareness may be especially valuable in facilitating the choice of behaviours that are consistent with one's needs, values and interests. Brown and Ryan suggest that mindfulness may facilitate increased wellbeing through self-regulated activity and fulfilment of basic psychological needs (autonomy, competence, relatedness). In other words, awareness, a word used regularly by all participants in this study, can bring attention to a person's basic needs, making it more likely that the person regulates or changes behaviour to fulfil those needs. Many of the participants in this study indicated that due to mindfulness they were now more able to make different choices in response to intrusive thoughts; for some there were indications that this had started to become a more habitual process. It is perhaps not surprising that this in turn appeared to increase wellbeing and self-esteem as participants had a sense of being in more control of their lives.

The freeing up from intrusive thoughts or compulsions gave the participants more time for, and more pleasure in, other activities. The participants reported that mindfulness helped them to be more present and experience more pleasure in day-to-day activities. Research has shown that intrinsically motivated, so-called 'flow' activities, which are characterised by engagement with and attention to what is occurring, yield more enjoyment and an increased sense of vitality (Brown et al., 2007). All the participants reported increased wellbeing associated with better life experiences (e.g. being with others, enjoying nature). Becoming more present, or living in the present moment, is a major component of a mindfulness experience (Kabat-Zinn, 2013) and this has been positively

linked to wellbeing (Brown & Ryan, 2003). What was particularly interesting was how these in the moment experiences were linked directly to the participants' ability to avoid the symptoms of their OCD. Living in the present moment and undertaking mindful activities, in particular, was cited by more than one participant as an antidote to OCD.

Another aspect that helped increase participants' sense of wellbeing was their ability to manage their worry and anxiety. Responses to negative affect have been shown to alter the intensity of subsequent distress (Gross, 2002), and reappraisal, in which a negative feeling is reframed more positively, has been shown to reduce the intensity of fear and anxiety (Ochsner & Gross, 2008). The finding, in this study, that mindfulness appeared to mitigate the adverse consequences of habitual worrying and anxiety is also borne out in a large number of other studies (e.g. Brown & Ryan, 2003; Erisman & Roemer, 2010; Williams, 2010; Vøllestad, Nielsen & Nielsen, 2012; Verplanken & Fisher, 2014).

All the participants in this study connected their use of mindfulness with an increased ability to tolerate and be with the embodied expression of anxiety, however not all participants reported significant reductions in levels of anxiety. Correlations have been reported between increased body vigilance (conscious attention focused on internal bodily sensations) with elevated symptoms of anxiety (Schmidt, Lerew & Trakowski, 1997; Zvolensky & Forsyth, 2002). In contrast to this, the participants in this study reported an increase in body vigilance that was not associated with increased anxiety. Instead, many participants reported a state of open curiosity and willingness to experience physical sensations simply as phenomena and not as indicators that there was a cause for their anxiety, i.e. they were able avoid using the physical symptoms of anxiety to confirm their fears about their intrusive thoughts.

Increasing awareness and sensitivity to psychological, somatic, and environmental cues is a key component of mindfulness training (Kabat-Zinn, 2013) and it is thought that attention to these cues are important for the operation of healthy emotion regulatory processes (Brown & Ryan, 2003). It is therefore possible that a mindful monitoring process is what allowed the

participants to experience and not react to their physical signs of anxiety, and indeed, it did appear that those with greater experience of mindfulness were most adept at simply observing emotional responses. Kabat-Zinn et al. (1992) also suggest that prolonged exposure to anxiety and panic with sustained, non-judgmental observation of anxiety-related sensations, may lead to reductions in emotional responses. However, on the whole participants did not report significant reductions in anxiety in response to intrusive thoughts.

Greenberg and Meiran (2014) offer an alternate explanation. They acknowledge that mindfulness may enable people to both increase their control over and moderate emotions, but they also suggest that mindfulness may reduce the need for such control and regulation. It would appear that some of the participants in this study had a greater openness and willingness to explore their emotional experiences. For the participants, this increased contact seemed to increase tolerance for the negative emotions being experienced. Greenberg and Meiran suggest that increased contact with emotion along with increased detachment (from accepting thoughts and understanding that thoughts are not facts) may reduce the feeling of being overwhelmed by emotion. In line with Greenberg and Meiran, it would appear from this study it was a decreased need to control emotions rather than a reduction in affect that was found to be helpful to participants. This is a problem for the cognitive models that demonstrate a direct link between thoughts, emotional responses and severity of symptoms (see Figures 1 & 2).

Relaxation can be effective in dealing with anxiety. Most of the participants in this study commented on the relaxing effect of mindfulness meditation. Other studies have also noted that mindfulness can increase the ability to relax (e.g. Williams et al., 2011). However, as has already been noted, inducing relaxation is not the purpose of mindfulness. Indeed many studies on anxiety have compared mindfulness to relaxation techniques with mindfulness generally showing additional benefits beyond relaxation (Jain et al., 2007; Feldman, Greeson & Senville, 2010). For some participants, far from being relaxing, mindfulness meditation was found, on occasion, to increase anxiety and adversely affect the symptoms of OCD (see journal article). In general however,

the severity of symptoms in OCD have been related to general levels of stress (Morgado et al., 2013); so whilst the relationship of mindfulness to relaxation and its effect on anxiety may be a complex one, it is extremely likely that for some people with OCD the increased ability to relax brought about by mindfulness practice will have a real benefit.

Another factor that brought relief to participants and reduced stress was finding that mindfulness enabled them to pay more attention to their physical senses. Mindfulness involves paying attention to stimuli and sensory perceptions without interpretation (Kabat-Zinn, 2013). Most of the participants in this study commented on the mindfulness aspect of paying attention to their senses and the effect this had on their OCD. In most cases, the participants talked about how they had learnt to trust their senses, which was telling them something different from their intrusive thoughts.

The perceived failure of OCD sufferers in general to take account of, or trust their sensory perceptions and actions led Didonna (2009) to develop a therapeutic technique called Perceptive Experience Validation (PEV). The aim of PEV is to help people with OCD to validate their perceptual experiences in order to improve and objectify their memory, and thus lessen the anxiety and doubt inherent with OCD. Although described as a 'mindful attitude', PEV would appear to involve undertaking a cognitive examination of perceptions in order to provide arguments against OCD thoughts. Some of the participants in this study did appear to be using PEV-like cognitive reasoning and mindfulness as a conscious way of guarding against OCD, but this use of mindfulness may have undesirable consequences for the sustained relief of symptoms (see journal article).

Direct reference to sensory perception is not made in the cognitive models of OCD (see Figures 1 & 2); however, it can clearly provide information that affects the appraisal of intrusive thoughts and behavioural responses. The significant emphasis given by participants to trusting their senses, and the relief this provided would indicate that the evaluation of sensory experience in people with

OCD is an area that requires further investigation, particularly as this study had found it may be used in ways that might not be helpful (see journal article).

To sum up this section, this study has found evidence that supports the dominant cognitive-behavioural explanations of OCD. However, it has also shown areas where the cognitive models may not be sufficient to explain fully the changes in OCD symptomology experienced by the participants. This study would appear to show that there are many different ways in which mindfulness may contribute to the reduction of symptoms and distress associated with OCD that do not entirely fit with purely cognitive models, and has offered alternate explanations for the experiences of the participants based on the mindfulness principles of open curiosity, non-judgemental acceptance, self-compassion and being present. Moreover, a focus on cognitions overlooks the improvement in wellbeing and the increased ability to function in their daily lives that the participants described as important. This, as well as the reductions in the OCD symptoms, is a valid measure of how the participants experienced mindfulness.

Mindfulness as a Tool or a Philosophy

Although the use of mindfulness in ways that might not be helpful for long term outcomes in OCD has been covered in the journal article, the researcher would like to further discuss here the distinction between mindfulness used as a 'technique' versus mindfulness as a 'way of being' that draws on the experience of the participants across all three themes in this dissertation.

As has been mentioned in the literature review, mindfulness has been incorporated into several manualised mental health treatments (MBSR, MBCT, DBT, ACT). However, the way mindfulness is assimilated into the various treatments varies. Perhaps the contrast is most evident between DBT and MBSR. In DBT, whilst mindfulness is a core foundation of the treatment, it is taught as a discreet set of mindfulness 'how' and 'what' skills (Linehan, 1993), which are presented within the context of bringing about acceptance and change. Clients are encouraged to apply these mindfulness skills to their daily lives. Whilst instruction into mindful practices (such as mindful breathing) is given, clients are not expected to practise mindfulness meditation on a regular basis. In contrast,

meditation and the use of increased mindful awareness during normal activities forms a large part of MBSR programmes. With MBSR there is no emphasis on using mindfulness to achieve any particular goal (while noting there is a goal implied in the name), and there is more immersion into a mindfulness philosophy and therefore more opportunity for mindfulness to become embedded in the person as a 'new way of being'.

Three of the participants in this study had their first experience of mindfulness on an MBSR course or through formal mediation practice; one taught himself mindfulness from self-help materials; the other three participants had learned mindfulness within the context of an OCD treatment programme that combined both conventional treatments for OCD and mindfulness practice. It is the observation of the researcher that the three participants who had learnt mindfulness in the context of their OCD treatment, along with one other who was involved in running a treatment programme for OCD, who provided the greater part of the evidence for the theme of "Mindfulness as a Guard". These four participants appeared to be using mindfulness primarily as a technique to combat their OCD. There was a qualitative difference in the descriptions of OCD experience between these four participants and the other three. They used more words such as 'battle' and 'fight' and they explicitly talked about mindfulness as a tool to be used for their OCD; with one participant stating he only used mindfulness within the context of treating his condition. In contrast, the other three participants used language that indicated a more accepting or "welcoming in" attitude to their OCD; they also used mindfulness more widely and had adopted a mindfulness philosophy that had helped them experience many aspects of their lives differently – they seemed to have embraced mindfulness more fully.

Childs (2011) proposes that mindfulness has more to offer to psychology than just a technique for therapy. He notes the distinction between 'mindful' attention and acceptance techniques (unrelated to meditation) that are promoted in most manualised therapies and the meditation-linked practice of mindfulness (arguably more prominent in MBSR). Childs suggests that mindfulness, if fully embraced, has the potential to go beyond specific uses or

techniques taught in therapy to be the core of clinical practice. Similarly, Moss and O'Neill (2003) have questioned the practice of incorporating mindfulness into therapeutic practice in an unthoughtful way and comment on the fact that mindfulness itself is not goal focused, which creates tension in a therapeutic context where there is an intention and hope on the part of clinicians and clients for positive outcomes. In acknowledging this paradox, they suggest that perhaps "giving up hope in an end point" (ibid, p. 31) can be experienced as liberating and that this letting go of expectations may itself be helpful (and presumably assist to bring about positive outcomes). This giving up the struggle with their OCD was very evident for the three participants in this study who had embraced mindfulness as a philosophy, less so for the others. Interestingly, it was those that appeared to use mindfulness as a technique, with the goal to improve their OCD, who also seemed to be using it in ways that run counter to recommendations for the treatment of OCD (e.g. Gillihan et al., 2012).

This study thus highlights the potential difficulties in attempting to mix mindfulness with treatment. Although this can only be commented on in the context of this study, arguably there should be a wider debate of the role of mindfulness in psychological therapies. In addition, this is clearly an area that needs further exploration.

Mindfulness as an Approach to Research

The final words in this discussion are some reflections of the researcher on the process completing this study into mindfulness and OCD.

Childs (2011) advocates that research focussed on the use of mindfulness in therapy should use a mindfulness approach to research, including a phenomenological attitude to enquiry where the participant's subjective sense of improvement is privileged. Childs also notes that a focus on mindfulness techniques leads to identifying the processes of mindfulness that bring about change, while a focus on mindfulness itself has the possibility to add new knowledge to psychology.

In undertaking this study, the researcher has attempted to follow these precepts. She has viewed the data and literature with open curiosity and with no goal in

mind other than to observe and record what she found; while at the same time, the researcher has taken a critical stance on the prevailing cognitive models of OCD and some of the mechanisms of mindfulness. There has been an attempt to pay particular attention to describing and observing the data and using interpretation to provide sense and meaning rather than promote a hypothesis. The researcher has attempted to be mindfully reflective throughout and to balance being present with the data with critical observation. At many times the researcher was aware of her own anxiety, critical self-judgements and intrusive negative thoughts and was grateful that mindfulness allowed her to negotiate this with awareness. In the end, the researcher was able to notice and even welcome most of these experiences as simply part of the process of producing a doctoral thesis.

Conclusion

The participants in this study described their lived experience of mindfulness and OCD. They found many positive benefits of mindfulness including an increase in their wellbeing and a reduction in OCD symptoms. They voiced some despair in not finding mindfulness to be a cure for their OCD, but they had learned to live with both their condition and themselves in a less shaming, less judging and more self-compassionate way. They shared how they had learned to pay more attention in the present moment and expand their sense of connectedness to others.

The discussion has critically compared the participants' lived experience of mindfulness in the context of OCD with the extant cognitive models of OCD and found evidence that both supports these explanations for the maintenance of the condition and also evidence to challenge them.

The use of mindfulness in therapeutic settings is expanding. Even a superficial examination of recently published mindfulness and mental health literature will find mindfulness being suggested as a possible answer to wide range of mental health issues including worry, stress and anxiety (Vøllestad et al., 2012), depression (Teasdale et al., 2000), substance abuse (Witkiewitz et al., 2013),

eating disorders (Baer et al., 2005), insomnia (Lundh, 2005), borderline personality disorder (O'Toole et al., 2012), trauma (Wahbeh et al., 2011), psychosis (Dennick et al., 2013), health anxiety (Williams et al., 2011) and, of course, OCD (Hale, Strauss & Taylor, 2012). It would seem that mindfulness is being seen as a panacea treatment that can be applied to many conditions, not least of all because very few drawbacks have been reported (Klainin-Yobas et al., 2012). Although this study has shown that people with OCD can gain great benefit from mindfulness practice, it has also highlighted some significant concerns. It may be these concerns are unwarranted; however, it is also possible that clinicians will need to reconsider and re-evaluate treatment strategies when they are combined with mindfulness in order that mindfulness is not incorporated into the OCD symptoms and delay recovery. This topic of potential problems with mindfulness and meditation is discussed in several blogs and other online media (e.g. Karnaze, 2011; Brewer, 2014; Britton, 2014; Booth, 2014; Hay, 2015) with one comment from someone with a diagnosis of dissociation disorder stating that:

“Using mainstream ‘mindfulness’ to deal with trauma is like hitting yourself in the head with a hammer to take your mind off the pain of broken legs. Not only do you end up with deformed legs that never get set, you end up having much worse problems than that!” (Karnaze, 2011).

This whole subject of how mindfulness is used within therapeutic settings with people with mental health problems would appear to require much more in-depth investigation to guard against mindfulness adding to existing mental health difficulties.

Although additional research is clearly still needed, this study has added considerably to the existing knowledge and understanding of the lived experience of people with OCD who use mindfulness and it is hoped that this new knowledge can be used to improve the treatment and outcomes for sufferers of OCD.

Implications for Practice

This study has important implications for both clinicians and service providers who wish to improve outcomes and treatment for OCD.

All the participants in this study stated that mindfulness was a key component of their treatment, with one offering his belief that if he had practised mindfulness the OCD would not have developed. Those engaged in CBT/ERP therapy indicated that mindfulness helped with the exposure work by enabling them to observe intrusive thoughts and tolerate the increased anxiety provoked by the treatment.

Therefore, incorporating mindfulness into the treatment for OCD would appear to have real advantages. However, there is a cautionary note. This study also found mindfulness was used by some participants as a technique, primarily to treat the symptoms of their OCD, and importantly that mindfulness was being incorporated into OCD compulsions, in ways that contradict the current evidence base and accepted practice in the treatment of OCD (Gillihan et al., 2012). It was also used as a distraction and for reassurance, which are considered to be unhelpful for the sustained alleviation of symptoms. However, due the severe levels of distress experienced by people with OCD the participants reported these uses of mindfulness as helpful as they reduced anxiety and the time taken up by their OCD. Therefore, clinicians need to be aware that reports of the benefits of mindfulness with OCD may not correlate with long-term improvements in the condition. However, it is also possible that the way in which mindfulness can bring attention to experience means that these short-term strategies could be used successfully in the 'treatment' of OCD, if they are performed with full awareness and not simply used for distraction or avoidance. However, this has to be established.

The potential use of mindfulness for short-term relief of symptoms also has implications for how the results of randomised controlled trials are evaluated in clinical practice. If studies fail to take into account the different ways that participants in this study used mindfulness then these studies may over report the effectiveness of mindfulness.

Overall, participants in this study stated that mindfulness was not a replacement for CBT/ERP/pharmacology, and did not provide a cure, but was an important adjunct to conventional treatment. However, two participants had found it difficult to engage in CBT therapy stating it was too hard and distressing and they described mindfulness as a much gentler way to treat their OCD. Thus mindfulness, as a 'treatment' that is well tolerated, may offer hope for clients who struggle to engage with conventional treatments for OCD.

Implications for the Practice of Counselling Psychology

The current study can be said to have important implications for the practice of counselling psychology in relation to the treatment of OCD. A stated aim of the British Psychological Society (BPS) Division of Counselling Psychology is to "encourage outward facing research with clear applicability to clinical practice to address issues of concerns for populations" (The British Psychological Society Division of Counselling Psychology, 2014). Most of the treatment for OCD in the UK is undertaken within the confines of the NHS, and as Walsh, Frankland & Cross (2004) point out, "The NHS is based in the medical model and this is at odds with how the philosophy of counselling psychology is framed within the UK" (Walsh et al., 2004, p. 326). The current accepted conceptualisations of OCD are based within medicalised, cognitive models that place emphasis on standardised treatments. While this study has provided data that provides support for cognitive explanations of OCD and its treatment, it also showed how the participants were obtaining benefit from using mindfulness in ways that appear to go beyond the processes described in these cognitive models.

In undertaking this research, the author has shown that counselling psychologists have the ability to understand and critically evaluate the diverse issues that underpin clinical practice, and to evaluate both qualitative and quantitative research. The researcher has been able to use the discipline of counselling psychology as a vehicle to discover new knowledge beyond the confines of the manualised treatments for OCD. This knowledge may conflict, to some extent, with what is normal practice in the NHS thus promoting this type of knowledge will inevitably create a tension that may require counselling psychologists adopt a courageous attitude and, according to Walsh et al. (2004), perform "careful

manoeuvring” in their positions in services and “to modify the medical model system of relating from within the medical world, without compromising our or their standards and ethos” (ibid., p. 326). This is a challenge that this counselling psychologist has been prepared to take on.

Limitations

While this study has provided rich and detailed information regarding the experiences of people with OCD who use mindfulness, it is not without some limitations, which need to be acknowledged.

The current study brings with it limitations inherent in the IPA qualitative method used, particularly the difficulty in generalising the findings beyond the current sample (Maxwell, 1992) due to the small sample size used. There is also a requirement with IPA to find a reasonably homogeneous sample, so that, convergence and divergence can be examined in some detail without concerns that these factors are overly influenced by the diversity of the sample (Smith et al., 2009). The data and the findings cannot therefore be generalised to a wider population.

Smith et al. further suggest that the level of homogeneity will vary from study to study and it is important to find a sample for whom the research question is meaningful. Whilst it is true the research question was meaningful to all the participants, nevertheless the study may be criticised on a methodological basis for a lack of homogeneity: although all the participants had OCD, the nature of this OCD varied considerably. The manifestation of the OCD varied from thoughts about contamination, sexual deviancy and religiosity to the need to check continuously; some participants had significant overt compulsive rituals, others had few or none. The length of time the participants had suffered with OCD also varied considerably. While this reflects the variability of symptoms seen in people with a diagnosis of OCD, a more homogeneous sample may have allowed more inferences about the effectiveness and use of mindfulness to reduce symptoms of OCD (for example, the effect of mindfulness on checking compulsions). However, given the difficulties experienced in recruitment a more homogenous sample might have resulted in a significantly smaller number of

participants. Whilst Smith (2004) argues strongly for the single case study in psychology research, the author believes the breadth and diversity of experience is one of the strengths of this study. Similarly, the participants had varying experience of mindfulness: some participants were active mindfulness meditation practitioners, while others were not; some were self-taught, others has attended MBSR courses while the remaining had learnt mindfulness only within the context of their OCD treatment. This meant that the understanding and practice of mindfulness was undoubtedly different between the participants. However if recruitment had been restricted to only those with a similar grounding in mindfulness (for example participation in an MBSR course) there is the possibility that theme three, “Mindfulness as a Guard” would not have been as prominent in the data and hence some important findings might have been missed.

The participants were a mix of male and female but were exclusively Caucasian and all but one were British, thus the findings may have limited applicability to a more ethnically diverse population. However, the lack of variation in OCD across ethnic and social cultures reduces the impact of this limitation (NICE, 2006).

Most of the participants in the study had what might be described as mild to moderate OCD. One participant found it difficult to leave her house but the remainder were in education, had full or part-time jobs and were able to function well despite their condition. A study of people with more severe OCD symptoms might have come to different conclusions. However, given the problems experienced in recruitment for this study it is probable that this might be a very difficult group of people to access.

The sample was subject to bias in that all the participants had found the use of mindfulness in the treatment and management of their OCD useful. Indeed one participant was a specialist OCD therapist who taught mindfulness as part of the treatment. Perhaps because of this, participants made very few direct negative comments about mindfulness. This may reflect the participants’ genuine regard for mindfulness and the effect it had on them, but it may also reveal a reluctance to express criticism due to an assumption that the researcher was a mindfulness

practitioner in favour of its use with OCD. Although the researcher did not give her views on mindfulness prior to the interviews, a positive bias may have been assumed and this may have increased participants' reluctance to discuss negative aspects of their OCD. In view of this, the fact that participants' reports provide evidence that mindfulness may not always be helpful in the context of OCD is especially significant.

Despite these limitations, which were in part due to the nature of the methodology used and the difficulties in recruitment, the author, with the help of her research supervisors, attempted at all times to adhere to the principles of sensitivity to context, commitment and rigour as well as transparency and coherence (Yardley, 2000) to ensure that the limitations did not affect the value and quality of this study.

Further Research

The uses of mindfulness and how it is presented in therapeutic contexts clearly needs further investigation to attempt to answer some of the questions raised in this study.

In the context of OCD, future studies should examine the different ways that mindfulness may be being utilised (i.e. as a philosophy or as a tool or defence against the OCD), to see if this has an effect on its long-term effectiveness. In particular, whether it is helpful for managing the symptoms of OCD to use mindfulness as a technique, or whether this should be discouraged. Researchers involved in random controlled trials of mindfulness with OCD might need to ensure that the results are not affected by participants using mindfulness as short-term distraction or reassurance that could distort quantitative measures of effectiveness.

As previously stated, this study only recruited participants who found mindfulness beneficial and further research targeting groups who had neutral or negative experiences with OCD would be of great benefit to further understanding the interplay between mindfulness and OCD.

Other potential areas of research identified in this study would be to focus more on the role of embarrassment and shame in OCD and consequently the possible role for more compassion-focused interventions. In addition, it was clear that participants had been surprised in their ability to trust sensory perceptions following mindfulness. How the use of sensory input is affected by OCD and the implications for treatment are currently not well understood and would benefit from further study

OCD is not homogenous and although participants in this study found it beneficial, a question for further research is whether there are any contraindications for mindfulness-based treatments for some presentations of OCD.

As has been mentioned, OCD presents unique difficulties for attracting participants, not least of all the shaming nature of the condition, sufferers' isolation and secrecy and the particular nature of OCD symptomology. Future studies would need to address this problem and attempt to access people with OCD who might find it difficult to be interviewed. In hindsight, the author of this study could have used a short on-line survey, or participated in OCD support groups to connect with a greater number of OCD sufferers. In addition, participation at OCD conferences would have given more publicity to the research.

The author would also like to advocate the need for more qualitative research to give many more people with OCD a voice and to understand further their experience of living with OCD.

Concluding remarks

This study has found some interesting and unexpected consequences of the use of mindfulness in the treatment and management of OCD. Along with changing relationship to thoughts, a more compassionate sense of self and increased attention and awareness, mindfulness was used to provide an active guard against the symptoms of OCD. Mindfulness as a defence or technique was used more by some participants than others, and for them mindfulness was primarily seen as a way of treating their OCD. The apparent mechanisms of how

mindfulness was being used to bring about changes varied considerably between participants; some primarily utilising mindful awareness and acceptance solely to manage their OCD, while others extended their use of mindfulness to other aspects of their lives and had adopted, what could be described as, a mindfulness philosophy. Using mindfulness as a defence clearly provided relief from the symptoms of the condition, the question remains as to whether mindfulness used this way can provide long-term relief from the distress of OCD.

The study of mindfulness with OCD is still in its infancy. This research has added significant new knowledge to the area, and it is hoped this can be built on to improve further understanding of how mindfulness can help alleviate OCD symptoms and improve the lives of many more people with OCD. It has also added to the few discussions in the literature of how mindfulness is approached in therapeutic and mental health contexts. Mindfulness would appear to offer the potential to alleviate many mental health difficulties, however it also has the potential to increase distress or be utilised in unhelpful ways. Mindfulness may therefore not be a straightforward panacea that perhaps some in the mental-health profession would like it to be – particularly when allied with OCD.

References

- Albert, U., Maina, G., Forner, F. & Bogetto, F. (2004) DSM-IV obsessive-compulsive personality disorder: Prevalence in patients with anxiety disorders and in healthy comparison subjects. *Comprehensive Psychiatry*, 45(5), pp. 325-332.
- Allen, M., Bromley, A., Kuyken, W. & Sonnenberg, S. J. (2009) Participants' Experiences of MindfulnessBased Cognitive Therapy: "It Changed Me in Just about Every Way Possible". *Behavioural and Cognitive Psychotherapy*, 37(4), pp. 413-430.
- APA (2000) *Diagnostic and statistical manual of mental disorders. (4th ed. Revised Text)*, Washington, DC: American Psychiatric Association.
- APA (2013) *DSM 5. 5th ed. s.l.:American Psychiatric Association.*
- Appel, J. & Kim-Appel, D. (2009) Mindfulness: Implications for Substance Abuse and Addiction. *International Journal of Mental Health Addiction*, Volume 7, pp. 506-512.
- Archer, J. (1991) *Managing anxiety and stress. s.l.:Taylor & Francis.*
- Baars, B. J. (1997) Some essential differences between consciousness and attention, perception, and working memory. *Consciousness and Cognition*, 6(2), pp. 363-371.
- Baer, R. A., Fischer, S. & Huss, D. B. (2005) Mindfulness and Acceptance in the Treatment of Disordered Eating. *Journal of Rational-Emotive & Cognitive-Behavior Therapy*, 23(4), pp. 281-300.
- Bakker, G. M. (2009) In defence of thought stopping. *Clinical Psychologist*, 13(2), pp. 59-68.
- Barker, K. L. (2015) How can qualitative research be utilised in the NHS when re-designing and commissioning services?. *British Journal of Pain*, 9(1), pp. 70-72.
- Beevers, C. G., Wenzlaff, R. M., Hayes, A. M. & Scott, W. D. (1999) Depression and the Ironic Effects of Thought Suppression: Therapeutic Strategies for Improving Mental Control. *Clinical Psychology: Science and Practice*, 6(2), pp. 133-148.
- Bejerot, S., Ekselius, L. & von Knorring, L. (1998) Comorbidity between obsessive-compulsive disorder (OCD) and personality disorders. *Acta Psychiatrica Scandinavica*, Volume 97, pp. 398-402.
- Belloch, A., Morillo, C., Lucero, M., Cabedo, E., & Carrió, C. (2004) Intrusive thoughts in non-clinical subjects: the role of frequency and unpleasantness on appraisal ratings and control strategies. *Clinical Psychology & Psychotherapy*, 11(2), pp. 100-110.
- Bishop, S. R., Lau, M., Shapiro, S., Carlson, L., Anderson, N. D. Carmody, J., Segal, Z. V., Abbey, S., Speca, M. and Velting, D. (2004) Mindfulness: A proposed operational definition. *Clinical Psychology: Science and Practice*, 11(3), pp. 230-241.
- Bluth, K. & Blanton, P. W. (2014) Mindfulness and self-compassion: Exploring pathways to adolescent emotional well-being. *Journal of Child and Family Studies*, 23(7), pp. 1298-1309.
- Booth, R. (2014) *Mindfulness therapy comes at a high price for some, say experts.* Retrieved June 20, 2015, from theguardian: <http://www.theguardian.com/society/2014/aug/25/mental-health-meditation>

- Boschen, M. J., Drummond, L. M. & Pillay, A. (2008) Treatment of severe, treatment-refractory obsessive-compulsive disorder: a study of inpatient and community treatment. *CNS Spectrums*, 13(12), pp. 1056-1065..
- Brewer, J. (2014) *Is Mindfulness Harmful?* Retrieved June 20, 2015, from HuffPost Healthy Living: http://www.huffingtonpost.com/dr-judson-brewer/mindfulness-practice_b_4602714.html
- British Psychological Society (2005) *Guidelines for the Professional Practice of Counselling Psychology*, Leicester: The British Psychological Society.
- Britton, W. (2014) *The Dark Knight of the Soul*. Retrieved June 20, 2015, from The Atlantic: <http://www.theatlantic.com/health/archive/2014/06/the-dark-knight-of-the-souls/372766/>
- Brown, K. W. & Cordon, S. (2009) Toward a Phenomenology of Mindfulness: Subjective Experience and Emotional Correlates. In: F. Didonna, ed. *Clinical Handbook of Mindfulness*. New York: Springer.
- Brown, K. W. & Ryan, R. M. (2003) The Benefits of Being Present: Mindfulness and Its Role in Psychological Well-Being. *Journal of Personality and Social Psychology*, 84(4), pp. 822-848.
- Brown, K. W., Ryan, R. M. & Creswell, J. D. (2007) Mindfulness: Theoretical foundations and evidence for its salutary effects. *Psychological Inquiry*, Volume 18, pp. 211-237.
- Bury, D. & Strauss, S. M. (2006) The Scientist-Practitioner in a Counselling. In: D. A. Lane & S. Corrie, eds. *The Modern Scientist-Practitioner: A Guide to Practice in Psychology*. London: Routledge, pp. 112-126.
- Calamari, J. E., Cohen, R. J., Rector, N. A., Szacun-Shimizu, K., Riemann, B. C., & Norberg, M. M. (2006) Dysfunctional belief-based obsessive-compulsive disorder subgroups. *Behaviour Research and Therapy*, Volume 44, pp. 1347-1360.
- Calamari, J. E., Wiegartz, P. S., Riemann, B. C., Cohen, R. J., Greer, A., Jacobi, D. M., Jahn, S. C. & Carmin, C. (2004) Obsessive-compulsive disorder subtypes: an attempted replication and extension of a symptom-based taxonomy. *Behaviour Research and Therapy*, Volume 42, pp. 647-670.
- Carr, A. T. (1974) Compulsive Neurosis: A Review of the Literature. *Psychological Bulletin*, 81(5), pp. 311-318.
- Cavedini, P., Gorini, A. & Bellodi, L. (2006) Understanding obsessive-compulsive disorder - focus on decision making. *Neuropsychology Review*, 16(1), pp. 3-15.
- Chadwick, P., Newman Taylor, K. & Abba, N. (2005) Mindfulness Groups for People with Psychosis. *Behavioural and Cognitive Psychotherapy*, Volume 33, pp. 351-359.
- Chadwick, P., Hember, M., Symes, J., Peters, E., Kuipers, E., & Dagnan, D. (2008) Responding mindfully to unpleasant thoughts and images: reliability and validity of the Southampton mindfulness questionnaire (SMQ). *British Journal of Clinical Psychology*, 47(4), pp. 451-455.

- Chamberlain, K. (1999) Using Grounded Theory in Health Psychology. In: M. Murray & K. Chamberlain, eds. *Qualitative Health Psychology: Theories and Methods*. London: Sage, pp. 183-201.
- Chiesa, A., Calati, R. & Serretti, A. (2011) Does mindfulness training improve cognitive abilities? A systematic review of neuropsychological findings. *Clinical Psychology Review*, Volume 31, pp. 449-464.
- Chiesa, A. & Serretti, A. (2010) A systematic review of neurobiological and clinical features of mindfulness meditations. *Psychological Medicine*, Volume 40, pp. 1239-1252.
- Childs, D. (2011) Mindfulness and clinical psychology 84(3), 288-298.. *Psychology and Psychotherapy: Theory, Research and Practice*, 84(3), pp. 288-298.
- Christmas, D., Morrison, C., Eljamel, M. S. & Matthews, K. (2004) Neurosurgery for mental disorder. *Advances in Psychiatric Treatment*, Volume 10, pp. 189-199.
- Cicek, E., Cicek, I. E., Kayhan, F., Uguz, F., & Kaya, N. (2013) Quality of life, family burden and associated factors in relatives with obsessive-compulsive disorder. *General Hospital Psychiatry*, Volume 35, pp. 253-258.
- Clark, A. M. (2008) Critical Realism. In: *The Sage Encyclopedia of Qualitative Research Methods Volume 2*. s.l.:SAGE Publications, pp. 167-170.
- Clark, D. A. & Purdon, C. (2009) Mental Control of Unwanted Intrusive Thoughts: A Phenomenological Study of Nonclinical Individuals. *International Journal of Cognitive Therapy*, 2(3), pp. 267-281.
- Clark, D. M. (2011) Implementing NICE guidelines for the psychological treatment of depression and anxiety disorders: the IAPT experience. *International Review of Psychiatry*, 23(4), pp. 318-327.
- Compton, J. (2014) Meditation, Trauma and Suffering in Silence: Raising Questions about How Meditation is Taught and Practiced in Western Contexts in the Light of a Contemporary Trauma Resiliency Model. *Contemporary Buddhism*, 15(2), 274-297.
- Davidson, R., Kabat-Zinn, J., Schumacher, J., Rosenkranz, M., Muller, D., Santorelli, S., . . . Sheridan, J. (2003) Alterations in brain and immune function produced by mindfulness meditation. *Psychosomatic Medicine*, Volume 65, pp. 564-570.
- de Zoysa, P. (2013) The Use of Mindfulness Practice in the Treatment of a Case of Obsessive Compulsive Disorder in Sri Lanka. *Journal of Religion and Health*, Volume 52, pp. 299-306.
- Dennick, L., Fox, A. P. & Walter-Brice, A. (2013) Mindfulness groups for people experiencing distressing psychosis - an interpretative phenomenological analysis. *Mental Health Review Journal*, 18(1), pp. 32-43.
- DiCaccavo, A. (2008) Psychodynamic conceptualisation of obsessive thinking: An illustrative case study. *Counselling Psychology Review*, Volume 23, pp. 18-25.
- Didonna, F. (2009) Mindfulness and Obsessive-Compulsive Disorder: Developing a Way to Trust and Validate One's Internal Experience. In: F. Didonna, ed. *Clinical Handbook of Mindfulness*. New York: Springer.

- Doron, G. & Kyrios, M. (2005) Obsessive compulsive disorder: A review of possible specific internal representations within a broader cognitive theory. *Clinical Psychology Review*, Volume 25, pp. 415-432.
- Eddy, K. T., Dutra, L., Bradley, R. & Westen, D. (2004) A multidimensional meta-analysis of psychotherapy and pharmacotherapy for obsessive-compulsive disorder. *Clinical Psychology Review*, 24(8), pp. 1011-1030.
- Elliott, R., Fischer, C. & Rennie, D. (1999) Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, 38(3), pp. 215-229.
- Entwistle, V., Firnigl, D., Ryan, M., Francis, J., & Kinghorn, P. (2012) Which experiences of health care delivery matter to service users and why? A critical interpretive synthesis and conceptual map. *Journal of health services research & policy*, 17(2), pp. 70-78.
- Erismann, S. M. & Roemer, L. (2010) A preliminary investigation of the effects of experimentally induced mindfulness on emotional responding to film clips. *Emotion*, 10(1), pp. 72-82.
- Fairfax, H. (2008) The use of Mindfulness in Obsessive Compulsive Disorder: Suggestions for its Application and Integration in Existing Treatment. *Clinical Psychology and Psychotherapy*, Volume 15, pp. 53-59.
- Fairfax, H. & Barfield, J. (2010) A group-based treatment for clients with obsessive compulsive disorder (OCD) in a secondary care mental health setting: Integrating new developments within cognitive behavioural interventions—An exploratory study. *Counselling and Psychotherapy Research*, 10(3), pp. 214-221.
- Fairfax, H., Easey, K., Fletcher, S. & Barfield, J. (2014) Does Mindfulness help in the treatment of Obsessive Compulsive Disorder (OCD)? An audit of client experience of an OCD group. *Counselling Psychology Review*, 29(3), pp. 17-27.
- Feldman, G., Greeson, J. & Seniville, J. (2010) Differential effects of mindful breathing, progressive muscle relaxation, and loving-kindness meditation on decentering and negative reactions to repetitive thoughts. *Behaviour Research and Therapy*, 48(10), pp. 1002-1011.
- Finucane, A. & Mercer, S. W. (2006) An exploratory mixed methods study of the acceptability and effectiveness of mindfulness-based cognitive therapy for patients with active depression and anxiety in primary care. *BMC Psychiatry*, 6(14), pp. 1-14.
- Fisher, P. L. & Wells, A. (2005) How effective are cognitive and behavioural treatments for obsessive-compulsive disorder?. *Behaviour Research and Therapy*, Volume 43, pp. 1543-1558.
- Fisher, P. L. & Wells, A. (2008) Metacognitive therapy for obsessive-compulsive disorder: A case series. *Journal of Behavior Therapy and Experimental Psychiatry*, Volume 39, pp. 117-132.
- Fjorback, L. O., Arendt, M., Ørnbøl, E. & Fink, P. W. H. (2011) Mindfulness-Based Stress Reduction and Mindfulness-Based Cognitive Therapy—a systematic review of randomized controlled trials. *Acta Psychiatrica Scandinavica*, Volume 124, pp. 102-119.
- Fjorback, L. O., Arendt, M., Ørnbøl, E., Walach, H., Rehfeld, E., Schröder, A., & Fink, P. (2013) Mindfulness therapy for somatization disorder and functional somatic syndromes—

- Randomized trial with one-year follow-up. *Journal of Psychosomatic Research*, 74(1), 31-40.
- Flick, U. (2009) *An introduction to qualitative research*. 4th ed. London: Sage Publications Ltd.
- Foa, E. B. & Kozak, M. J. (1986) Emotional Processing of Fear: Exposure to Corrective Information. *Psychological Bulletin*, 99(1), pp. 20-35.
- Freeston, M. H. & Ladouceur, R. (1997) What do patients do with their obsessive thoughts?. *Behaviour Research and Therapy*, 35(4), pp. 335-348.
- Freud, S. (1952) Inhibitions, Symptoms and Anxiety. In: R. M. Hutchins, ed. *Great Books of the Western World: 54. The Major Works of Sigmund Freud*. s.l.:Encyclopedia Britannica< Inc.
- Frost, R. O., Novara, C. & Rhéaume, J. (2002) Perfectionism in Obsessive Compulsive Disorder. In: R. O. Frost & G. Steketee, eds. *Cognitive Approaches to Obsessions and Compulsions Theory, Assessment, and Treatment*. s.l.:Pergamon.
- Gabbard, G. O. (2001) Psychoanalytic Inquiry: A Topical Journal for Mental Health Professionals. *Psychoanalytic Inquiry: A Topical Journal for Mental Health Professionals*, 21(2), pp. 208-221.
- Gecht, J., Kessel, R., Forkmann, T., Gauggel, S., Drueke, B., Scherer, A., & Mainz, V. (2014) A mediation model of mindfulness and decentering: sequential psychological constructs or one and the same?. , 2(1), 18.. *BMC Psychology*, 2(18), pp. 1-13.
- Gillihan, S. J., Williams, M. T., Malcoun, E., Yadin, E., & Foa, E. B. (2012) Common pitfalls in exposure and response prevention (EX/RP) for OCD. *Journal of obsessive-compulsive and related disorders*, 1(4), pp. 251-257.
- Gothelf, D., Aharonovsky, O., Horesh, N., Carty, T., & Apter, A. (2004) Life events and personality factors in children and adolescents with obsessive-compulsive disorder and other anxiety disorders. *Comprehensive Psychiatry*, 45(3), pp. 192-198.
- Greenberg, J. & Meiran, N. (2014) Is mindfulness meditation associated with “feeling less?”. *Mindfulness*, 5(5), pp. 471-476.
- Greeson, J. M. (2009) Mindfulness Research Update: 2008. *Complementary Health Practice Review*, 14(10), pp. 10-18.
- Greisberg, S. & McKay, D. (2003) Neuropsychology of obsessive-compulsive disorder: a review and treatment implications. *Clinical Psychology Review*, 23(1), pp. 95-117.
- Grohol, J. M. (2013) *DSM-5 Changes: Obsessive-Compulsive and Related Disorders*. [Online] Available at: <http://pro.psychcentral.com/2013/dsm-5-changes-obsessive-compulsive-and-related-disorders/004404.html#> [Accessed 18 August 2013].
- Gross, J. (2002) Emotion regulation: Affective, cognitive, and social consequences. *Psychophysiology*, Volume 39, p. 281–291.
- Gwilliam, P., Wells, A. & Cartwright-Hatton, S. (2004) Dose meta-cognition or responsibility predict obsessive–compulsive symptoms: a test of the metacognitive model. *Clinical Psychology & Psychotherapy*, 11(2), pp. 137-144.

- Hale, L., Strauss, C. & Taylor, B. L. (2012) The Effectiveness and Acceptability of Mindfulness-Based Therapy for Obsessive Compulsive Disorder: A Review of the Literature. *Mindfulness*, Published online 01 August 2012, 1-8.
- Hanstede, M., Gidron, Y. & Nyklíček, I. (2008) The Effects of a Mindfulness Intervention on Obsessive-Compulsive Symptoms in a Non-Clinical Student Population. *The Journal of Nervous and Mental Disease*, 196(10), pp. 776-779.
- Hay, M. (2015) *When Mindfulness Goes Wrong*. Retrieved June 20, 2015, from GOOD: <http://magazine.good.is/articles/when-meditation-is-bad-for-you>
- Hayes, S. C., Luoma, J. B., Bond, F. W., Masuda, A., & Lillis, J. (2006) Acceptance and Commitment Therapy: Model, processes and outcomes. *Behaviour Research and Therapy*, Volume 44, pp. 1-25.
- Hayes, S. C. & Wilson, K. G. (2003) Mindfulness: Method and Process. *Clinical Psychology: Science and Practice*, 10(2), pp. 161-165.
- Haynes, K. (2012) Reflexivity in Qualitative Research. In: G. Symon & C. Cassell, eds. *Qualitative organizational research: core methods and current challenges*. s.l.:Sage.
- Heeren, A. & Philippot, P. (2011) Changes in ruminative thinking mediate the clinical benefits of mindfulness: Preliminary findings. *Mindfulness*, 2(1), pp. 8-13.
- Hepburn, S. R., Crane, C., Barnhofer, T., Duggan, D. S., Fennell, M. J., & Williams, J. M. (2009) Mindfulness-based cognitive therapy may reduce thought suppression in previously suicidal participants: Findings from a preliminary study. *British Journal of Clinical Psychology*, 48(2), ., 48(2), pp. 209-215.
- Hertenstein, E., Rose, N., Voderholzer, U., Heidenreich, T., Nissen, C., Thiel, N., . . . Katrin Külz, A. (2012) Mindfulness-based cognitive therapy in obsessive-compulsive disorder - A qualitative study on patients' experiences. *BMC Psychiatry*, 12(185), pp. 1-10.
- Hewitt, P. L. & Flett, G. L. (1991) Perfectionism in the Self and Social Contexts: Conceptualization, Assessment, and Association With Psychopathology. *Journal of Personality and Social Psychology*, 60(3), pp. 456-470.
- Hill, C. L. M. & Updegraff, J. A. (2012) Mindfulness and Its Relationship to Emotional Regulation. *Emotion*, 12(1), pp. 81-90.
- Hofmann, S. G., Sawyer, A. T., Witt, A. A. & Oh, D. (2010) The Effect of Mindfulness-Based Therapy on Anxiety and Depression: A Meta-Analytic Review. *Journal of Consulting and Clinical Psychology*, 78(2), pp. 169-183.
- Hollis-Walker, L. & Colosimo, K. (2011) Mindfulness, self-compassion, and happiness in non-meditators: A theoretical and empirical examination. *Personality and Individual Differences*, 50(2), pp. 222-227.
- Hookway, N. (2008) Entering the blogosphere': some strategies for using blogs in social research. *Qualitative Research*, 8(1), pp. 91-113.
- Jain, S., Shapiro, S. L., Swanick, S., Roesch, C. S., Mills, P. J., Bell, I., & Schwartz, G. E. (2007) A randomized controlled trial of mindfulness meditation versus relaxation training: effects

- on distress, positive states of mind, rumination, and distraction. *Annals of Behavioral Medicine*, 33(1), pp. 11-21.
- James, N. (2007) The use of email interviewing as a qualitative method of inquiry in educational research. *British Educational Research Journal*, 33(6), pp. 963-976.
- Janet, P. (2010) *The Obsessions and the Psychasthénie*. s.l.:s.n.
- Jenike, M. A. (1998) Neurosurgical treatment of obsessive-compulsive disorder. *The British Journal of Psychiatry*, Volume 173(35S) Supplement, pp. 79-90.
- Johnstone, L. (2008) Psychiatric Diagnosis. In: R. Tummey & T. Turner, eds. *Critical Issues in Mental Health*. s.l.:Palgrave Macmillan, pp. 5-22.
- Kabat-Zinn, J. (1982) An outpatient program in behavioral medicine for chronic pain patients based on the practice of mindfulness meditation: Theoretical considerations and preliminary results. *General Hospital Psychiatry*, 4(1), pp. 33-47.
- Kabat-Zinn, J. (2003) Mindfulness-Based Interventions in Context: Past, Present, and Future. *Clinical Psychology Science and Practice*, Volume 10, pp. 144-156.
- Kabat-Zinn, J. (2013) *Full Catastrophe Living, Revised Edition: How to cope with stress, pain and illness using mindfulness meditation*. Kindle ed. s.l.:Little, Brown Book Group.
- Kabat-Zinn, J., Massion, A. O., Kristeller, J., Peterson, L. G., Fletcher, K., Pbert, L., . . . Santorelli, S. (1992) Effectiveness of a Meditation-Based Stress Reduction Program in the Treatment of Anxiety Disorders. *American Journal of Psychiatry*, 149(7), pp. 936-943.
- Karnaze, M. (2011) *17 Ways Mindfulness Meditation*. Retrieved June 20, 2015, from MindfulConstruct: <http://mindfulconstruct.com/2011/02/04/17-ways-mindfulness-meditation-can-cause-you-emotional-harm/>
- Keng, S. L., Smoski, M. J. & Robins, C. J. (2011) Effects of mindfulness on psychological health: A review of empirical studies. *Clinical Psychology Review*, 31(6), pp. 1041-1056.
- Keng, S. L., Smoski, M. J., Robins, C. J., Ekblad, A. G., & Brantley, J. G. (2012) Mechanisms of change in mindfulness-based stress reduction: Self-compassion and mindfulness as mediators of intervention outcomes. *Journal of Cognitive Psychotherapy*, 26(3), pp. 270-280.
- Khong, B. S. L. (2011) Mindfulness: A way of cultivating deep respect for emotions. *Mindfulness*, 2(1), pp. 27-32.
- Klainin-Yobas, P., Cho, M. A. A. & Creedy, D. (2012) Efficacy of mindfulness-based interventions on depressive symptoms among people with mental disorders: A meta-analysis. *International Journal of Nursing Studies*, 49(1), pp. 109-121.
- Koran, L. M., Hanna, G. L., Hollander, E., Nestadt, G., & Simpson, H. B. (2007) *Practice Guideline for the Treatment of Patients with Obsessive-Compulsive Disorder*, Arlington, VA: American Psychiatric Association.
- Koszycski, D., Bengler, M., Shlik, J., & Bradwejn, J. (2007) Randomized trial of a meditation-based stress reduction program and cognitive behavior therapy in generalized social anxiety disorder. *Behaviour Research and Therapy*, Volume 45, pp. 2518-2526.

- Kuyken, W., Watkins, E., Holden, E., White, K., Taylor, R. S., Byford, S., . . . Dalglish, T. (2010) How does mindfulness-based cognitive therapy work?. *Behaviour Research and Therapy*, Volume 48, pp. 1105-1112.
- Lafleur, D. L., Petty, C., Mancuso, E., McCarthy, K., Biederman, J., Faro, A., . . . Geller, D. A. (2011) Traumatic events and obsessive compulsive disorder in children and adolescents: Is there a link?. *Journal of Anxiety Disorders*, 25(4), pp. 513-519.
- Lagemann, T., Rentzsch, J., Montag, C., Gallinat, J., Jockers-Scherübl, M., Winter, C., & Reischies, F. M. (2012) Early orbitofrontal hyperactivation in obsessive–compulsive disorder. *Psychiatry Research: Neuroimaging*, 202(3), pp. 257-263.
- Langdrige, D. (2007) *Phenomenological Psychology: Theory, Research and Method*. Harlow: Pearson Education Ltd.
- Langlois, F., Freeston, M. H. & Ladouceur, R. (2000) Differences and similarities between obsessive intrusive thoughts and worry in a non-clinical population: study 1. *Behaviour Research and Therapy*, 38(2), pp. 157-173.
- Langner, J., Manuela, L., Gisela, R., Michael, Z., Walter, H., & Christoph, P. (2009) Predicting Therapy Outcome in Patients with Early and Late Obsessive-Compulsive Disorder (EOCD and LOCD). *Behavioural and Cognitive Psychotherapy*, Volume 37, pp. 485-496.
- Larkin, M., Watts, S. & Clifton, E. (2006) Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology*, Volume 3, pp. 102-120.
- Larsson, P., Brooks, O. & Loewenthal, D. (2012) Counselling psychology and diagnostic categories: A critical literature review. *Counselling Psychology Review*, 27(3), pp. 55-64.
- Layard, R. (2006) Health policy: The case for psychological treatment centres. *BMJ: British Medical Journal*, Volume 332, pp. 1030-1032.
- Likierman, H. & Rachman, S. (1982) Obsessions: an Experimental Investigation of Thought-stopping and Habituation Training. *Behavioural Psychotherapy*, Volume 10, pp. 324-338.
- Linehan, M. M. (1993) *Cognitive-Behavioral Treatment of Borderline Personality Disorder (Diagnosis and Treatment of Mental Disorders)*. Kindle Edition ed. s.l.:Guilford Publications.
- Lochner, C., du Toit, P. L., Zungu-Dirwayi, N., Marais, A., van Kradenburg, J., Seedat, S., . . . Stein, D. J. (2002) Childhood trauma in obsessive-compulsive disorder, trichotillomania, and controls. *Depression and anxiety*, 15(2), pp. 66-68.
- Lundh, L. G. (2005) The role of acceptance and mindfulness in the treatment of insomnia. *Journal of Cognitive Psychotherapy*, 19(1), pp. 29-39.
- Lyons, E. & Coyle, A. (2007) *Analysing Qualitative Data in Psychology*. London: Sage.
- Macaskill, N. D. (2006) Psychopathology is a Reality and Psychodiagnosis is a Necessity. In: C. Feltham, ed. *Controversies in Psychotherapy and Counselling*. London : Sage Publications Ltd, pp. 113-131.
- MacCoon, D. G., Imel, Z. E., Rosenkranz, M. A., Sheftel, J. G., Weng, H. Y., Sullivan, J. C., . . . Lutz, A. (2012) The validation of an active control intervention for Mindfulness Based Stress Reduction (MBSR). *Behaviour Research and Therapy*, Volume 50, pp. 3-12.

- Mace, C. (2008) *Mindfulness and Mental Health: Therapy, Theory and Science*. Hove: Routledge.
- Macy, A. S., Theo, J. N., Kaufmann, S. C., Ghazzaoui, R. B., Pawlowski, P. A., Fakhry, H. I., . . . IsHak, W. W. (2013) Quality of life in obsessive compulsive disorder. *CNS Spectrums*, Volume 18, pp. 21-33.
- Madill, A. & Gough, B. (2008) Qualitative research and its place in psychological science. *Psychological Methods*, 13(3), pp. 254-271.
- Magee, J. C., Harden, K. P. & Teachman, B. A. (2012) Psychopathology and thought suppression: A quantitative review. *Clinical Psychology Review*, Volume 32, pp. 189-201.
- Malinowski, P. (2013) Neural mechanisms of attentional control in mindfulness meditation. *Frontiers in neuroscience*, 7(9), pp. 1-11.
- Marsden, A. & Chowdhury, U. (2009) Child and adolescent OCD. *Community Practitioner*, 82(11), pp. 42-44.
- Mataix-Cols, D., Rauch, S. L., Baer, L., Eisen, J. L., Shera, D. M., Goodman, W. K., . . . Jenike, M. A. (2002) Symptom Stability in Adult Obsessive-Compulsive Disorder: Data From a Naturalistic Two-Year Follow-Up Study. *The American Journal of Psychiatry*, 159(2), pp. 263-268.
- Maxwell, J. A. (1992) Understanding and validity in qualitative research. *Harvard Educational Review*, 62(3), pp. 279-301.
- McLeod, J. (2003) Qualitative research methods in counselling psychology. In: R. Woolfe, W. Dryden & S. Strawbridge, eds. *In Handbook of Counselling Psychology*. 2nd ed. London: Sage, pp. 74-92.
- Merikle, P. M., Smilek, D. & Eastwood, J. D. (2001) Perception without awareness: Perspectives from cognitive psychology. *Cognition*, 79(1), pp. 115-134.
- Michal, M., Beutel, M. E., Jordan, J., Zimmermann, M., Wolters, S., & Heidenreich, T. (2007) Depersonalization, mindfulness, and childhood trauma. *The Journal of Nervous and Mental Disease*, 195(8), pp. 693-696.
- Mineka, S. & Zinbarg, R. (2006) A contemporary learning theory perspective on the etiology of anxiety disorders: it's not what you thought it was. *American Psychologist*, 61(1), pp. 10-26.
- Morgado, P., Freitas, D., Bessa, J. M., Sousa, N., & Cerqueira, J. J. (2013) Perceived stress in obsessive-compulsive disorder is related with obsessive but not compulsive symptoms. *Frontiers in psychiatry*, 4(21), pp. 1-6.
- Moritz, S., Kempke, S., Luyten, P., Randjbar, S., & Jelinek, L. (2011) Was Freud partly right on obsessive-compulsive disorder (OCD)? Investigation of latent aggression in OCD. *Psychiatry Research*, Volume 187, pp. 180-184.
- Moss, D. & O'Neill, B. (2003) Just another technique? Possibilities and paradoxes in working with mindfulness. *Clinical Psychology*, Volume 31, pp. 29-33.
- Mowrer, O. H. (1956) Two-factor learning theory reconsidered, with special reference to secondary reinforcement and the concept of habit. *Psychological Review*, 63(2), pp. 114-128.

- Murphy, H. & Perera-Delcourt, R. (2012) '*Learning to live with OCD is a little mantra I often repeat*': Understanding the lived experience of obsessive-compulsive disorder (OCD) in the contemporary therapeutic context. [Online]
Available at: <http://onlinelibrary.wiley.com.ezproxy.uwe.ac.uk/doi/10.1111/j.2044-8341.2012.02076.x/full>
[Accessed 30 November 2012].
- Murray, C. D. & Sixsmith, J. (1998) E-mail: a qualitative research medium for interviewing?. *International Journal of Social Research Methodology*, 1(2), pp. 103-121.
- Nedeljkovic, M., Kyrios, M., Moulding, R. & Doron, G. (2011) Neuropsychological changes following cognitive-behavioral treatment of obsessive-compulsive disorder (OCD). *International Journal of Cognitive Therapy*, 4(1), pp. 8-20.
- Nestadt, G. (2013) *Obsessive-Compulsive Disorders Research*. [Online]
Available at:
http://www.hopkinsmedicine.org/psychiatry/specialty_areas/obsessive_compulsive_disorder/research/
- Newth, S. & Rachman, S. (2001) The concealment of obsessions. *Behaviour Research and Therapy*, Volume 39, pp. 457-464.
- NICE (2005) *Obsessive-Compulsive Disorder: Core Interventions in the Treatment of Obsessive-Compulsive Disorder and Body Dysmorphic Disorder*, London: National Institute for Health and Clinical Excellence.
- NICE (2006) *Obsessive compulsive disorder: Clinical Guideline 31 - Core interventions in the treatment of obsessive compulsive disorder and body dysmorphic disorder*, s.l.: The British Psychological Society and The Royal College of Psychiatrists.
- NICE (2013) *Obsessive-compulsive disorder Evidence Update September 2013*, Manchester: National Institute for Health and Care Excellence.
- O'Toole, S. K., Diddy, E. & Kent, M. (2012) Mindfulness and Emotional Well-being in Women with Borderline Personality Disorder. *Mindfulness*, Volume 3, pp. 117-123.
- O'Brien, B., n.d. *Bhavana: An Introduction to Buddhist Meditation*. [Online]
Available at: <http://buddhism.about.com/od/buddhistmeditation/a/bhavana.htm>
[Accessed 24 August 2013].
- OCCWG (1997) Cognitive Assessment of Obsessive-Compulsive Disorder. *Behaviour Research and Therapy*, 35(7), pp. 667-681.
- OCCWG (2001) Development and initial validation of the obsessive beliefs questionnaire and the interpretation of intrusions inventory. *Behaviour Research and Therapy*, Volume 39, pp. 987-1006.
- Ochsner, K. & Gross, J. (2008) Cognitive emotion regulation: Insights from social cognitive and affective neuroscience. *Current Directions in Psychological Science*, Volume 17, p. 153-158.
- Olendzki, A. (2009) Mindfulness and Meditation. In: F. Didonna, ed. *Clinical Handbook of Mindfulness*. New York: Springer.

- Öst, L. G. (2008) Efficacy of the third wave of behavioral therapies: a systematic review and meta-analysis. *Behaviour Research and Therapy*, 46(3), p. 296–321.
- Parker, I. (2006) Deconstructing diagnosis: psychopathological practice. In: C. Feltham, ed. *Controversies in Psychotherapy and Counselling*. London: Sage Publications Ltd, pp. 104-112.
- Patel, S. R., Carmody, J. & Simpson, H. B. (2007) Adapting Mindfulness-based Stress Reduction for the Treatment of Obsessive-compulsive Disorder: A Case Report. *Cognitive and Behavioral Practice*, Volume 14, pp. 357-380.
- Pitman, R. K. (1987) Pierre Janet on Obsessive-Compulsive Disorder (1903). *Archives of General Psychiatry*, 44(3), pp. 226-232.
- Purdon, C. & Clark, D. A. (1999) Metacognition and Obsessions. *Clinical Psychology and Psychotherapy*, Volume 6, pp. 102-110.
- Rachman, S. (1971) Obsessional ruminations. *Behaviour Research and Therapy*, 9(3), pp. 229-235.
- Rachman, S. (1993) Obsessions, responsibility and guilt. *Behaviour Research and Therapy*, Volume 31, pp. 149-154.
- Rachman, S. (1998) A cognitive theory of obsessions: elaborations. *Behaviour Research and Therapy*, Volume 36, pp. 385-401.
- Rachman, S. J. (1997) A cognitive theory of obsessions. *Behaviour Research and Therapy*, Volume 35, pp. 793-802.
- Rachman, S., Thordarson, D. S., Shafran, R. & Woody, S. R. (1995) Perceived Responsibility: Structure and Significance. *Behaviour Research and Therapy*, 33(7), pp. 779-784.
- Raes, F. & Williams, J. M. G. (2010) The relationship between mindfulness and uncontrollability of ruminative thinking. *Mindfulness*, 1(4), pp. 199-203.
- Rapaport, J. L. (1990) Obsessive compulsive disorder and basal ganglia dysfunction. *Psychological Medicine*, 20(3), pp. 465-469.
- Rassin, E. (2001) The contribution of thought–action fusion and thought suppression in the development of obsession-like intrusions in normal participants. *Behaviour Research and Therapy*, 39(9), pp. 1023-1032.
- Reid, K., Flowers, P. & Larkin, M. (2005) Exploring Lived Experience. *The Psychologist*, 18(1), p. 20 – 23.
- Riddle, M. (1998) Obsessive-compulsive disorder in children and adolescents. *The British Journal of Psychiatry*, 173(35S), pp. 91-96.
- Robson, C. (2002) *Real World Research*. 2nd ed. London: Blackwell Publishing.
- Roemer, L., Orsillo, S. M. & Salters-Pedneault, K. (2008) Efficacy of an Acceptance-Based Behavior Therapy for Generalized Anxiety Disorder: Evaluation in a Randomized Controlled Trial. *Journal of Consulting and Clinical Psychology*, 76(6), pp. 1083-1089.
- Ryan, L. & Golden, A. (2006) "Tick the box please": a reflexive approach to doing quantitative social research. *Sociology*, 40(6), pp. 1191-1200.

- Ryan, R. M. (2005) The developmental line of autonomy in the etiology, dynamics, and treatment of borderline personality disorders. *Development and Psychopathology*, 17(4), pp. 987-1006.
- Sachdev, P. S. & Malhi, G. S. (2005) OCD a disorder of decision-making. *Australian and New Zealand Journal of Psychiatry*, Volume 39, pp. 757-763.
- Salkovskis, P. M. (1985) Obsessional-compulsive problems: A cognitive-behavioural analysis. *Behaviour Research and Therapy*, 23(5), pp. 571-583.
- Salkovskis, P. M. (1989) Cognitive-behavioural factors and the persistence of intrusive thoughts in obsessional problems. *Behaviour Research and Therapy*, 27(6), pp. 677-682.
- Salkovskis, P. M. (1999) Understanding and treating obsessive-compulsive disorder. *Behaviour Research and Therapy*, Volume 37, pp. 29-52.
- Salkovskis, P. M. (2007) Psychological treatment of obsessive-compulsive disorder. *Psychiatry*, 6(6), pp. 229-233.
- Salkovskis, P., Shafran, R., Rachman, S. & Freeston, M. H. (1999) Multiple pathways to inflated responsibility beliefs in obsessional problems: possible origins and implications for therapy and research. *Behaviour Research and Therapy*, Volume 37, pp. 1055-1072.
- Samuels, J. & Nestadt, G. (1997) Epidemiology and genetics of obsessive-compulsive disorder. *International Review of Psychiatry*, Volume 9, pp. 61-71.
- Schmidt, N. B., Lerew, D. R. & Trakowski, J. H. (1997) Body vigilance in panic disorder: Evaluating attention to bodily perturbations. *Journal of Consulting and Clinical Psychology*, 65(2), pp. 214-220.
- Segal, Z. V., Williams, J. M. G. & Teasdale, J. D. (2013) *Mindfulness-Based Cognitive Therapy for Depression*. 2nd ed. New York: The Guilford Press.
- Sethi, S. & Bhargava, S. C. (2003) Relationship of Meditation and Psychosis: Case Studies. *Australian and New Zealand Journal of Psychiatry*, Volume 37, pp. 382-384.
- Shafran, R., Cooper, Z. & Fairburn, C. G. (2002) Clinical perfectionism - a cognitive-behavioural analysis. *Behaviour Research and Therapy*, Volume 40, pp. 773-791.
- Shafran, R. & Mansell, W. (2001) Perfectionism and psychopathology: a review of research and treatment. *Clinical Psychology Review*, 21(6), pp. 879-906.
- Shafran, R. & Rachman, S. (2004) Thought-action fusion: a review. *Journal of Behavior Therapy and Experimental Psychiatry*, Volume 35, pp. 87-107.
- Shafran, R., Thordarson, D. S. & Rachman, S. (1996) Thought-Action Fusion in Obsessive Compulsive Disorder. *Journal of Anxiety Disorders*, 10(5), pp. 379-391.
- Shapiro, S. L., Carlson, L. E., Astin, J. A. & Freedman, B. (2006) Mechanisms of Mindfulness. *Journal of Clinical Psychology*, 62(3), p. 373-386.
- Siegel, D. J. (2007) *The Mindful Brain: Reflection and Attunement in the Cultivation of Well-Being*. New York: WW Norton & Company.
- Siegel, R. D., Germer, C. K. & Olendzki, A. (2009) Mindfulness: What Is It? Where Did It Come From? . In: F. Didonna, ed. *Clinical Handbook of Mindfulness* . New York: Springer.

- Singh, N. N., Wahler, R. G., Winton, A. S. & Adkins, A. D. (2004) A Mindfulness-Based Treatment of Obsessive-Compulsive Disorder. *Clinical Case Studies*, Volume 3, pp. 275-287.
- Smári, J. & Hólmsteinnsson, H. E. (2001) Intrusive thoughts, responsibility attitudes, thought-action fusion, and chronic thought suppression in relation to obsessive-compulsive symptoms. *Behavioural and Cognitive Psychotherapy*, 29(1), pp. 13-20.
- Smith, J. A. (2004) Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology*, 1(1), 39-54.
- Smith, J. A., Flowers, P. & Larkin, M. (2009) *Interpretive Phenomenological Analysis*. London: Sage.
- Smith, J. A., Jarman, M. & Osborn, M. (1999) Doing interpretative phenomenological analysis. In: M. C. K. Murray, ed. *Qualitative health psychology ()*. : .. London: Sage, pp. 218-240.
- Snorrason, Í., Smári, J. & Ólafsson, R. P. (2011) The interaction effect of impulsivity and responsibility in relation to obsessive-compulsive symptoms. *Cognitive therapy and research*, 35(1), pp. 79-86.
- Sookman, D. & Pinard, G. (2002) Overestimation of Threat and Intolerance of Uncertainty in Obsessive Compulsive Disorder. In: R. O. Frost & G. Steketee, eds. *Cognitive Approaches to Obsessions and Compulsions: Theory, Assessment, and Treatment*. s.l.:Pergamon.
- Stahl, B. & Goldstein, E. (2010) *A Mindfulness-Based Stress Reduction Workbook*. Oakland: New Harbinger Publications, Inc..
- Stanford School of Medicine (2012) *Understanding Obsessive-Compulsive and Related Disorders*, s.l.: s.n.
- Steketee, G. & Frost, R. O. (1994) Measurement of Risk-Taking in Obsessive-Compulsive Disorder. *Behavioural and Cognitive Psychotherapy*, Volume 22, pp. 287-298.
- Steketee, G., Frost, R. O. & Cohen, I. (1998) Beliefs in Obsessive-Compulsive Disorder. *Journal of Anxiety Disorders*, 12(6), pp. 525-537.
- Stockton, H., Hunt, N. & Joseph, S. (2011) Cognitive Processing, Rumination, and Posttraumatic Growth. *Journal of Traumatic Stress*, 24(1), pp. 85-92.
- Storey, L. (2007) Doing Interpretive Phenomenological Analysis. In: E. Lyons & A. Coyle, eds. *Analysing Qualitative Data in Psychology*. s.l.:Sage., pp. 51-64.
- Strawbridge, S. & Woolfe, R. (2003) Counselling Psychology in Context. In: S. Strawbridge & R. Woolfe, eds. *Handbook of Counselling Psycholog*. London: Sage Publications, pp. 3-21.
- Strauss, C., Rosten, C., Hayward, M., Lea, L., Forrester, E., & Jones, A.-M. (2015). *Mindfulness-based exposure and response prevention for obsessive compulsive disorder: study protocol for a pilot randomised controlled trial*. Retrieved from Trials: <http://www.trialsjournal.com/content/16/1/167> [Accessed 31 January 2015]..
- Sussex Partnership NHS Foundation Trust (2014) *Mindfulness-Based Behaviour Therapy for Obsessive Compulsive Disorder: A pilot randomised controlled trial*. [Online] Available at: <http://www.sussexpartnership.nhs.uk/component/jdownloads/finish/2339/9023?Itemid=>

Q

[Accessed 31 January 2015].

- Taylor, S. (2005) Dimensional and Subtype Models of OCD. In: J. S. Abramowitz & A. C. Houts, eds. *Concepts and controversies in obsessive-compulsive disorder*. New York: Springer.
- Taylor, S., Abramowitz, J. S. & McKay, D. (2007) Cognitive-behavioral models of obsessive-compulsive disorder. In: M. M. Antony, C. Purdon & L. J. Summerfeldt, eds. *Psychological treatment of obsessive-compulsive disorder: Fundamentals and beyond*. s.l.:s.n., pp. 9-29.
- Taylor, S., Abramowitz, J. S., McKay, D., Calamari, J. E., Sookman, D., Kyrios, M., . . . Cheryl, C (2006) Do dysfunctional beliefs play a role in all types of obsessive-compulsive disorder. *Anxiety Disorders*, Volume 20, pp. 85-97.
- Teasdale, J. D., Segal, Z. & Williams, J. M. G. (1995) How does cognitive therapy prevent depressive relapse and why should attentional control (mindfulness) training help?. *Behaviour Research and Therapy*, 33(1), pp. 25-39.
- Teasdale, J. D., Segal, Z. V., Williams, J. M., Ridgeway, V. A., Soulsby, J. M., & Lau, M. A. (2000) Prevention of relapse/recurrence in major depression by mindfulness-based cognitive therapy. *Journal of consulting and clinical psychology*, 68(4), 615-623.
- Teasdale, J. D., Moore, R. G., Hayhurst, H., Pope, M., Williams, S., & Segal, Z. V. (2002) Metacognitive awareness and prevention of relapse in depression: empirical evidence. *Journal of consulting and clinical psychology*, 70(2), pp. 275-287.
- The British Psychological Society Division of Counselling Psychology (2014) *Division of Counselling Psychology Strategy 2014 - 2015*. [Online]
Available at: https://www.bps.org.uk/system/files/user-files/Division%20of%20Counselling%20Psychology/dcop_strategic_objectives_2014_2015.pdf
[Accessed 22 March 2015].
- Tolin, D., Abramowitz, J. S., Brigidi, B. D., Amir, N., Street, G. P., & Foa, E. B. (2001) Memory and memory confidence in obsessive-compulsive disorder. *Behaviour Research and Therapy*, 39(8), pp. 913-927.
- Torres, A. R., Moran, P., Bebbington, P., Brugha, T., Bhugra, D., Coid, J. W., . . . Prince, M. (2006a) Obsessive-compulsive disorder and personality disorder: Evidence from the British National Survey of Psychiatric Morbidity 2000. *Social psychiatry and psychiatric epidemiology*, Volume 41, pp. 862-867.
- Torres, A. R., Prince, M. J., Bebbington, P. E., Bhugra, D., Brugha, T. S., Farrell, M., . . . Singleton, N. (2006b) Obsessive-Compulsive Disorder: Prevalence, Comorbidity, Impact, and Help-Seeking in the British National Psychiatric Morbidity Survey of 2000. *American Journal of Psychiatry*, Volume 163, pp. 1978-1985.
- Tükel, R., Polat, A., Özdemir, Ö., Aksüt, D., & Türksöy, N. (2002) Comorbid Conditions in Obsessive-Compulsive Disorder. *Comprehensive Psychiatry*, 43(3), pp. 204-209.
- Turner, K. (2009) Mindfulness: The Present Moment in Clinical Social Work. *Clinical Social Work Journal*, Volume 37, pp. 95-103.

- Turner, R. M., Gail, S. S. & Edna, B. F. (1979) Fear of criticism in washers, checkers and phobics. *Behaviour Research and Therapy*, 17(1), pp. 79-81.
- Twohig, M. P. & Whittal, M. L. (2009) A Case of Obsessive-Compulsive Disorder. *Cognitive and Behavioral Practice*, Volume 16, pp. 3-6.
- van Os, J., Linscott, R. J., MyinGermeys, I., Delespaul, P., & Krabbendam, L. (2009) A systematic review and metaanalysis of the psychosis continuum: evidence for a psychosis proneness–persistence–impairment model of psychotic disorder. *Psychological Medicine*, Volume 39, pp. 179-195.
- Veale, D. (2007) Cognitive–behavioural therapy for obsessive–compulsive disorder. *Advances in Psychiatric Treatment*, Volume 13, pp. 438-446.
- Veale, D. & Roberts, A. (2014) Obsessive-compulsive disorder. *BMJ*, Volume 348, pp. 1-6
- Verplanken, B. & Fisher, N. (2014) Habitual worrying and benefits of mindfulness. *Mindfulness*, 5(5), pp. 566-573.
- Vøllestad, J., Nielsen, M. B. & Nielsen, G. H. (2012) Mindfulness-and acceptance-based interventions for anxiety disorders: A systematic review and meta-analysis. *British Journal of Clinical Psychology*, 51(3), pp. 239-260.
- Vøllestad, J., Sivertsen, B. & Nielsen, G. H. (2011) Mindfulness-based stress reduction for patients with anxiety disorders: Evaluation in a randomized controlled trial. *Behaviour Research and Therapy*, Volume 49, pp. 281-288.
- Wahbeh, H., Lu, M. & Oken, B. (2011) Mindful awareness and non-judging in relation to posttraumatic stress disorder symptoms. *Mindfulness*, 2(4), pp. 219-227.
- Walsh, Y., Frankland, A. & Cross, M. (2004) Qualifying and working as a counselling psychologist in the United Kingdom. *Counselling Psychology Quarterly*, 17(3), pp. 317-328.
- Webster Marketon, J. I. & Glaser, R. (2008) Stress hormones and immune function. *Cellular immunology*, Volume 252, pp. 16-26.
- Wegner, D. M., Schneider, D. J., Carter, S. R. & White, T. L. (1987) Paradoxical Effects of Thought Suppression. *Journal of Personality and Social Psychology*, 53(1), pp. 5-13.
- Wells, A. (2002) GAD, Metacognition, and Mindfulness: An Information Processing Analysis. *Clinical Psychology: Science and Practice*, 9(1), pp. 95-100.
- Wells, A. (2005) Detached mindfulness in cognitive therapy: A metacognitive analysis and ten techniques. *Journal of Rational-Emotive and Cognitive-Behavior Therapy*, 23(4), pp. 337-355.
- Wells, A. & Purdon, C. (1999) Metacognition and Cognitive-Behaviour Therapy: A Special Issue. *Clinical Psychology and Psychotherapy*, Volume 6, pp. 71-72.
- Westbrook, D., Kennerley, H. & Kirk, J. (2007) *An Introduction to Cognitive Behavioural Therapy*. London: Sage Publications Ltd.
- Witkiewitz, K., Bowen, S., Douglas, H., & Hsu, S. H. (2013) Mindfulness-based relapse prevention for substance craving. *Addictive behaviors*, 38(2), 1563-1571.

- Wilkinson-Tough, M., Bocci, L., Thorne, K. & Herlihy, J. (2010) Is Mindfulness-Based Therapy an Effective Intervention for Obsessive–Intrusive Thoughts: A Case Series. *Clinical Psychology and Psychotherapy*, Volume 17, pp. 250-268.
- Williams, C. & Martinez, R. (2008) Increasing access to CBT: stepped care and CBT self-help models in practice. *Behavioural and Cognitive Psychotherapy*, 36(6), pp. 675-683.
- Williams, J. M. G. (2008) Mindfulness, depression and modes of mind. *Cognitive Therapy and Research*, 32(6), p. 721–33.
- Williams, J. M. G. (2010) .Mindfulness and psychological process. *Emotion*, 10(1), pp. 1-7.
- Williams, M. J., McManus, F., Muse, K. & Williams, J. M. G. (2011) Mindfulness-based cognitive therapy for severe health anxiety (hypochondriasis): An interpretative phenomenological analysis of patients’ experiences. *British Journal of Clinical Psychology*, Volume 50, p. 379–397.
- Williams, T. I., Salkovskis, P. M., Forrester, E. A. & Allsopp, M. A. (2002) Changes in symptoms of ocd and appraisal of responsibility during cognitive behavioural treatment: a pilot study. *Behavioural and Cognitive Psychotherapy*, Volume 30, pp. 69-78.
- Willig, C. (2013) *Introducing qualitative research in psychology*. 3rd ed. Maidenhead: Open University Press.
- Wittchen, H.-U. & Jacobi, F. (2005) Size and burden of mental disorders in Europe – a critical review. *European Neuropsychopharmacology*, Volume 15, pp. 357-376.
- Woolfe, R. & Strawbridge, S. (2003) Counselling Psychology in Context. In: R. Woolfe, W. Dryden & S. Strawbridge, eds. *Handbook of Counselling Psychology*. London: Sage Publications, pp. 3-21.
- World Health Organization (2010) *The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines*. Geneva: World Health Organization.
- Yardley, L. (2000) Dilemmas in qualitative health research. *Psychology & Health*, 15(2), pp. 215-228.
- Zajonc, R. B. (1980) Feeling and thinking: Preferences need no inferences. *American Psychologist*, 35(2), pp. 151-175.
- Zvolensky, M. J. & Forsyth, J. P. (2002) Anxiety sensitivity dimensions in the prediction of body vigilance and emotional avoidance. *Cognitive Therapy and Research*, 26(4), pp. 449-460.

Appendices

Appendix A Introductory Letter



University of the West of England

Frenchay Campus
Coldharbour Lane
Bristol
BS16 1QY

Mindfulness and OCD Research

My name is Miya Bond; I am a qualified Psychological Therapist working for the NHS and also training to be a Counselling Psychologist at the University of the West of England.

I am in the process of carrying out some doctoral research that explores the experiences of people who have OCD and also practice mindfulness, and I am hoping that you will agree to take part so that as many voices as possible can be heard.

I would like to understand your experience of mindfulness and how you believe it might affect you or your OCD symptoms. The research will involve an interview about your experience, which will take place somewhere at your convenience, or by Skype or telephone. If you think you may like to take part, please provide me with a telephone number or email address so that I can contact you to explain the research in more detail and answer any questions you may have.

Yours sincerely

A handwritten signature in blue ink that reads 'Miya Bond'. The signature is written in a cursive, flowing style.

Miya Bond

Psychological Therapist

Email: Miya2.Bond@live.uwe.ac.uk
Tel: 01884 860969 / 07979 260384

Appendix B Information Sheet

Mindfulness and OCD Research Participant Information

You are being invited to take part in a research study. This leaflet is designed to give you information about what is involved in order to help you decide whether you would like to take part. Please read it carefully. At the end of this leaflet are contact numbers for you to call should you have any further questions or if you would like further information.

What is the research about?

This research aims to find out what is the impact of mindfulness training on people with OCD. The objectives are to understand your experience of the mindfulness and what effect this has had on you and the symptoms of OCD.

Why have I been chosen?

You have been approached because you have indicated that you have a diagnosis or suffer from OCD and have experience of mindfulness or mindfulness training and we wish to find out more about how sufferers of OCD experience mindfulness.

Do I have to take part?

No, it is up to you to decide whether or not to take part. If you do decide to take part, you will be asked to sign a consent form. If you participate but later change your mind, you are free to withdraw from the study without giving a reason. If you decide to withdraw from the study any data that has already been collected will be removed from the study. However, be aware that if you decide to withdraw at a very late stage, after the data has been collated for publication, it may not be possible to remove all your data.

What would the research involve?

There will be a short interview of up to one hour. This can take place face-to-face, or by Skype or by telephone. At this interview you will be asked to comment on your experience of learning mindfulness and how it affects you and your OCD symptoms. The interview will be tape-recorded and later typed up.

Your interview comments will be combined with those of the other people taking part in the research. I will look for common themes and might also illustrate these with direct quotes from the diaries or interviews.

What are the possible benefits and disadvantages of taking part?

I hope that the information from this study may help to improve understanding of how mindfulness can be used as a treatment for OCD and this may help to improve future therapeutic treatment for OCD.

Will it be confidential?

All information that is collected about you during the course of the study will be stored securely and used in accordance with the UK Data Protection Act (1998). When not being processed, all data and information about you will be locked in a secure place. Anything that may enable people to recognise you will be removed from the data. You will have the opportunity to choose a pseudonym for yourself that will be used for the purpose of the interview and applied to any quotes included in the final results. It will therefore not be possible to identify you as the contributor of any direct quotes that are used.

What will happen to the results of the research?

The research findings may be sent to an academic journal for publication and presented at academic conferences. I will produce a summary of the overall results of the study for you. If you wish to receive the final thesis (it may be quite long) I will be very happy to send this to you by email. Your identity will not be revealed in any report or publication.

What will happen if the research stops?

If for any reason the research stops, you will be informed and offered the chance to talk to me and or my research supervisor.

Who is organising and funding the research?

This research is being conducted as part of my Professional Doctorate in Counselling Psychology and is not funded.

What should I do if I have a complaint?

Should you be unhappy about any aspect of the research process, please contact either myself or my research supervisor.

What do I do now?

I hope you are still interested in participating in this research. I will be contacting you shortly to arrange a convenient time to talk through the research in more detail and complete the consent process.

Contacts

You may contact me before, during or following the research should any questions or concerns arise. You can also contact my academic supervisor, Naomi Moller.

Miya Bond
Trainee Counselling Psychologist

Mob: 07979 260384
Email: Miya2.Bond@live.uwe.ac.uk

Dr Naomi Moller
Director of Studies
Faculty of Applied Sciences
University of the West of England
Frenchay Campus
Coldharbour Lane
Bristol BS16 1QY

Tel: 0117 3282177
Email: naomi.moller@uwe.ac.uk

Appendix C Consent Form

Title of Project: **Mindfulness and OCD Research**

Name of Researcher: **Miya Bond**

Please tick or initial all boxes

1. I confirm that I have read and understand the information sheet dated 7th October 2013 (version 1.4) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.
3. I know I will be asked about my experiences of mindfulness.
4. I understand that individuals from The University of the West of England may look at the data collected during the study. I give permission for these individuals to have access to this data.
5. I am aware that the results may be published in an academic journal or presented at conferences.
6. I have been provided with contact numbers should I have further questions or concerns about this study.
7. I agree to take part in the above study.

Name of Participant Date Signature

Name of Person taking consent. Date Signature

Appendix D Interview Guide

The following interview guide was used to structure the interviews and ensure all the research questions were covered.

Preamble

Thank you for agreeing to take part, introduce myself and clarify the aims of the interview. Remind them that this will be taped and explain confidentiality. If written consent has not yet been obtained, get the participant to sign a consent form.

Background Information.

Ask about age, occupation.

Obtain a brief description of OCD.

Prompts: Age of onset, how long, what type, OCD in remission, therapy, anything else.

Obtain brief information about mindfulness practice.

Prompts: How long, how learnt, still practice, anything else.

General Prompts

- Can you tell me a bit more about that?
- Can you give me an example of that?
- What was it like, how did you feel about it?
- What sense did you make of that?
- What did that experience mean to you?

Questions

1. Let's start with your experience of learning and practicing mindfulness. If you can remember back to when you first encountered mindfulness.

Can you describe your initial response to the concept of mindfulness?

Prompts: How do you think you approached it?

What was the process of learning to be mindful like?

Prompts: emotions, thoughts?

2. Now thinking about mindfulness generally. This is asking you to think about how you experience mindfulness without thinking about or relating it to

your OCD.

How would you describe mindfulness?

How do you know you are being mindful?

What things help you become mindful?

What gets in the way of being mindful?

What is different when you are mindful?

Is there anything about mindfulness that you find difficult?

How has your mindful awareness developed over time?

3. Now I would like you to think about mindfulness in relation to your OCD

How would you say your experience of your OCD is affected by the mindfulness practice you do?

Prompts: How was OCD before/ how is it now?

Can you give an example of where mindfulness is helpful / how you use it?

Prompts: emotions, thoughts, body?

How would you explain / make sense of this?

Other ways / other examples?

Can you give an example of where mindfulness is not helpful?

Prompts: emotions, thoughts, body?

How would you explain / make sense of this?

4. Mindfulness and sense of self?

Has mindfulness changed how you view yourself?

Would anyone else notice any of the differences you have mentioned?

5. Have you noticed any other changes, either with your OCD or more generally, that you would put down to being mindful?

Prompts: Relationships / work / emotions / ability to cope?

How do you feel about this?

6. What difficulties, if any, have you experienced with your mindfulness practice?

How has this affected you?

How do you make sense of mindfulness not being helpful?

7. How would you describe your OCD condition now?
How do you feel about that?
8. How do you see yourself in the going forward with your OCD and mindfulness?
Prompts OCD symptoms, mindfulness practice
9. Anything else you want to add about mindfulness and your OCD or general well-being, your relationships, your work?
10. Are there any questions you would like to ask me?

Debrief

Ask participants about their experience of the interview process. Check if they have been affected, particularly any increase in OCD thoughts or symptoms. If they have advise to contact therapist/GP.

Give contact details and remind participants that Naomi or I can be contacted with any queries or concerns about the research.

Remind participants of the opportunity to be involved in the research during data analysis and offer to provide copy of final thesis.

Appendix E Example from Analysis

Example excerpt from the initial analysis of the transcript of the interview with Becky.

Key

Descriptive text

Conceptual comments

Linguistic comments and quotes

Lines 3-12

Describes doubt and shame of OCD.

Emphasis on doubt and responsibility, the what ifs

Uses 'again and again' a linguistic indication of the compulsions

Worried about how she is seen by others

Feels happier, getting a perspective

'And I create a story'

'almost makes you friends with it in a way'

Use of almost to indicate difficulty in being ok with OCD.

OCD takes something small and makes it much larger

'knowing other people do it'

'I'm not alone in it'

Sense of relief

'because I'm kind of obsessive'

'heightens the sense of it being a problem and me being a problem.'

Rejection of the medicalisation of OCD

Shame of OCD

Doubting

mindfulness helps to observe OCD

OCD hooks the mind

New way of being with OCD

Not engaging in thoughts

OCD is a lonely place.

Sense of self as "I'm wrong"

Lines 17-32

'It's hard the development of a mental illness'

This is not just the shame this is everything about OCD, remembering how it was.

'mindfulness it's given me ...I'm in control, more in control'

surrendering to the OCD which is not giving in to it but paradoxically gets more control over the OCD.

Mindfulness free her up. Not dependent on therapy

Learning mindfulness was straightforward

'it certainly didn't make me feel any worse'

Curious thing to say, perhaps expectation that it would make things worse

'throw away any expectations of a sense of cure'

Throw away opposite to passive resignation

'Because it's the struggle which is the worst part'.

This is a reference to the OCD. She is indicating how mindfulness avoids the struggle but also has changed her thinking about her OCD.

Describes OCD as something that just happens in her brain

Describing experience of breathing meditation and intrusive thoughts.

'Oh, it is so difficult, I still find it really difficult'.

Emphasis on 'so'

Superficially this is simply a statement that she finds the practice difficult but this is the third time she has used the word "difficult". Here she refers to how to respond to the thinking. Mindfulness gives the choice of how to respond but choosing not to give credibility to the thought – this is what is really "difficult".

More control, more hope
Independence from services

Contrast ease of mindfulness with difficulty of OCD
Giving up wanting it to be different

Accepting the OCD

OCD is not real

Meditation is hard

How it is to practice mindfulness

'remind yourself that for this little period of time you are just going to try and sit and focus on your breathing'.

This is so gentle compared to the battle of OCD thoughts.

'I found it so refreshing this idea of welcoming all thoughts good or bad and just letting them go.'

Unexpected joy

'block out bad thoughts'.

Relief in finding a better way to be with OCD.

Lines 39 - 58

Mindfulness is relaxing *'even in a roomful of people I can fall asleep'.* But doesn't want to fall asleep and miss out on the mindfulness.

Talking about not using mindfulness to make anything happen. Reduces the pressure of the meditation, can relax more.

'then I try not to treat the meditation as a way out of it, I think that's really important.' Noting the word 'try'.

'it's no good trying to push them away because that's what's so destructive about the obsessive thinking'.

OCD labelled not only as unpleasant, unwanted but as 'destructive'.

'So it's just to aim to be with them.'

Letting go of thoughts/being in the moment.

No labels on thinking

No judgements

Gentleness in mindfulness

Letting go of thoughts

Giving up trying to control thoughts

Mindfulness relaxing

Mindfulness too good to miss

Meditation not a way to treat OCD

Welcoming thoughts

Accept the OCD

Describing being with the physical sensations that accompanies thoughts. *'you need to sit still!'*.

Emphasis on 'still'

The fear of the OCD thought is that it is true and if it were true how could she bear it so being able to sit with the uncomfortable feelings helps with the knowledge that it is just a thought.

The courage to be with the thought and literally not run away from them. A strong sense of being in control.

[Sitting still is the opposite of some other participants who talk about getting up and moving (distraction?)]

Lines 58 - 64

Mindfulness is contrasted with CBT.

'your breath is, you've always got it.'

'much kinder approach', 'much lighter'

'such a good thing to do anyway, rather than a therapy'

Becky has embraced mindfulness as way to live rather than just as a strategy for OCD.

'mindfulness teaches you to just sit with those very difficult feelings and then welcome them'

'I mean it's another way to live and you just remind yourself that you've got to live'

Although Becky says more here this feels like the important part – remind yourself you've got to live - OCD is no life.

'turn the poison into medicine'

Another reference to how horrible OCD is.

Being with physical sensations /anxiety

Just a thought

Self viewed as being in control

Mindfulness always available

Different way, learning from anxiety

CBT is a battle, mindfulness more gentle

Joy in mindfulness

Mindfulness more than just for OCD

Letting go

Welcoming feelings

OCD is not living.

Learn to work with OCD

Lines 68-76

Talking about being present, being with others and not letting OCD be all there is

Lots of talk here about the difficulty in walking a line between observing thoughts and allowing the OCD to intrude. A real sense of tottering on an edge – one side is peace / contentment, the other side is destructive OCD.

This is like an awakening from the OCD. Becky is able to put the OCD into the background so it is not all consuming. Without the all-consuming nature and self-destructiveness of the OCD can to be in relationship to others.

'So rather than whipping up a storm' Not only a reference to OCD but also Becky's part in increasing the effects.

'finding a middle ground'

Being realistic, mindfulness does not take OCD away but allows Becky to be different with it.

'not being swept away by them'

Being in control

'So it's like the radio's in the other room'

'eventually it will eventually just go away'

'stop all the chatter'

Becky is saying If I stop messing with it, it will get better all on its own, it's the engaging in the OCD that gives it its power. It's not the intrusive thought, it's the credibility given to the thought.

'I'm not there yet not at all'

OCD is not gone. It is still a struggle.

Lines 82-89

Talk about the damage OCD can cause

'it was causing me so much pain and everyone around me'

'because I don't want to be anxious about being anxious and the mindfulness just really helps me accept all that'

Being present with others
Mindfulness one side,
OCD the other

Taking responsibility for
reactions

Not a cure

Being with thoughts and
feelings

impact of OCD reduced.

Less is more

Not a cure

OCD damaging to self and
relationships

Noticing thoughts and
feelings

Acceptance

Talk of the horribleness brings Becky back to the joy she has found in mindfulness.

'always be grateful', 'approach everything with a joyful mind'

Increased ability to see joy in everything. This isn't only about looking on the positive side. This is about looking inside oneself find an inner core of joy and strength.

Lines 90-92

Talk about how the OCD has a physical side and learning through mindfulness to focus on this experience

'it's made me much more aware of my body'

'The physical stuff can be very alarming'

'you know you are going to get to the other side'

Learning to trust that it won't be overwhelming. A belief that things will be different if she does not attempt to do anything to avoid the feelings.

Joy in mindfulness

Inner strength

Focusing on body, takes the focus away from thinking

Being with emotions

Appendix F Letter to OCD Clinics

Letter sent to two OCD clinics following contact by the researcher.



Faculty of Health &
Life
Sciences
Glenside Campus
Blackberry Hill
Stapleton
Bristol BS16 1DD

Tel: 0117 328 8487

Our ref: JMA/lt

16 September 2013

Dear

Re: Mindfulness and OCD
Principal investigator: Miya Bond
Ref No: 13/SW/0167

I am writing to confirm that the University of the West of England, Bristol ("UWE") has agreed to act as Research Sponsor in accordance with the Department of Health Research Governance Framework (2001) for the above research. UWE's acceptance of Research sponsorship is subject to ethics approval having been obtained.

UWE has made the following insurance arrangements for employees, and for students working under the supervision of a UWE employee, and where the project is included on an authorised UWE research register.

UWE has insurance cover for clinical trials up to £5m in the aggregate which includes cover for non-negligent harm. This cover is provided only when UWE (via Research, Business and Innovation) has approved projects with our insurers and they are then listed on our clinical trials register.

For research which is not deemed a clinical trial (i.e. not on UWE's clinical trials register):

- UWE's Professional Indemnity policy provides insurance cover for indemnity against legal liability for damages and claimant's costs and expenses arising out of any act, neglect, error or omission.
- UWE's Employers Liability Insurance is in place to protect UWE's employees if they are harmed whilst engaged on UWE business, should UWE be held legally liable.
- UWE's Public Liability insurance policy covers legal liability for third party personal injury, death, disease or illness to any person or loss or damage to third party property.

Details of the Employers/Public and Professional Indemnity policy covers are attached.

Yours sincerely

A handwritten signature in black ink that reads "Jennifer Ames". The signature is written in a cursive, flowing style.

Prof Jennifer M. Ames
Associate Dean (Research and Innovation)

Encl

Appendix G Project Protocol Summary

Study protocol submitted as part of ethical approval process.

Mindfulness and OCD Project Protocol Summary

- 1) Recruit up to eight participants with obsessive-compulsive disorder.
- 2) Follow up contact will be made by telephone with participants who complete the initial agreement with the purpose of providing further information about the study, the interviews and to obtain informed consent.
- 3) Arrange a convenient time and venue in which to carry out the semi-structured interviews.
- 4) Conduct the semi-structured interviews and record.
- 5) Encourage participants to choose a pseudonym to use throughout the interview and/or allocate a unique participant identification code.
- 6) Transcribe the interview data.
- 7) Carefully read and re-read the transcripts noting points of interest. Subject the data to Interpretative Phenomenological Analysis and gradually build up into a table of themes that most strongly capture the participants' experience. Research supervisors will also be consulted although only anonymised information will be shared.
- 8) Write up the project using anonymised direct quotations from participants to illustrate the results of the analysis.
- 9) Provide feedback on the results of the study to participants if requested. Make arrangements to disseminate the results of the study through presentations and publications.

Appendix H NHS Ethical Approval



Health Research Authority

NRES Committee South West - Cornwall & Plymouth

Bristol Research Ethics Committee Centre
Level 3
Block B
Whitefriars
Lewins Mead
Bristol
BS1 2NT

Telephone: 0117 342 1330

24 June 2013

Ms Miya Bond
Trainee Counselling Psychologist
Devon Partnership NHS Trust
Riversvale Centre
Litchdon Street
Barnstaple
EX31 8PJ

Dear Ms Bond

Study title: Clients' experiences of mindfulness as part of group treatment for OCD: An
REC reference: IPA study 13/SW/0167
IRAS project ID: 125267

Thank you for your letter of 20th June 2013, responding to the Proportionate Review Sub-Committee's request for changes to the documentation for the above study.

The revised documentation has been reviewed and approved by the sub-committee.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so.

Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the Co-ordinator Charlotte Allen, nrescommittee.southwest-cornwall-plymouth@nhs.net.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

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

Conditions of the favourable opinion

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

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

Management permission (“R&D approval”) should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation’s role in the study is limited to identifying and referring potential participants to research sites (“participant identification centre”), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

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

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

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

Approved documents

The documents reviewed and approved by the Committee are:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Covering Letter		03 June 2013
Evidence of insurance or indemnity	Public liability, Professional indemnity	27 July 2012
Interview Schedules/Topic Guides	1.0	03 June 2013
Investigator CV		18 March 2013
Letter from Sponsor		03 June 2013
Other: CV - Dr Gary Christopher		19 March 2013
Other: CV - Dr Naomi Moller		15 March 2013
Other: Introductory Letter	1.0	10 May 2013
Other: Initial Agreement	1.0	10 May 2013
Participant Consent Form	2.0	13 June 2013
Participant Information Sheet	1.3	13 June 2013
Protocol	2.0	28 February 2013
REC application	1.0	03 June 2013
Referees or other scientific critique report		14 March 2013
Response to Request for Further Information		
Summary/Synopsis	1.0	03 June 2013

Statement of compliance

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

After ethical review

Reporting requirements

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

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

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

Feedback

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

Further information is available at National Research Ethics Service website >
After Review

13/SW/0167

Please quote this number on all correspondence

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

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

sincerely

A handwritten signature in black ink, appearing to read 'PP: CALLO'.

Canon Ian Ainsworth-Smith Chair

Email: nrescommittee.southwest-cornwall-plymouth@nhs.net

Enclosures: *“After ethical review – guidance for researchers” (via email)*

Copy to: *Ms Leigh Taylor*

Mr Tobit Emmens, Research and Development Directorate, Devon Partnership NHS Trust

Appendix I NHS Research and Development Approval



Research and Development
Wonford House Hospital
Dryden Road
Exeter
EX2 5AF

Tel: 01392 674112
jayneclarke@nhs.net

30 July 2013

Ms Miya Bond
Trainee Counselling Psychologist
Devon Partnership NHS Trust
Riversvale Centre
Litchdon Street
Barnstaple
EX31 8PJ

Dear Ms Bond

Re: Trust Approval for Devon Partnership Trust

Study: Clients' experiences of mindfulness as part of group treatment for OCD: An IPA study.

Chief Investigator: Ms Miya Bond

Sponsor: The University of the West of England, Bristol (UWE)

References: DPT0256
13/SW/0167

NHS permission for the above research has been granted on the basis described in the application form, protocol and supporting documentation. The documents reviewed were:

Approved documents

Document	Version	Date	Date of ethics letter
Protocol	2.0	28/02/2013	24/06/2013
Participant Information Sheet	1.3	13/06/2013	24/06/2013
Participant Consent Form	2.0	13/06/2013	24/06/2013
Other: Introductory Letter	1.0	10/05/2013	24/06/2013
Other: Initial Agreement	1.0	10/05/2013	24/06/2013
Summary/Synopsis	1.0	03/06/2013	24/06/2013
Interview Schedule/Topic Guides	1.0	03/06/2013	24/06/2013

Permission is granted on the understanding that the study is conducted in accordance with the Research Governance Framework, ICH GCP (if applicable), and NHS Trust policies and procedures available at <http://rdeweb.exe.nhs.uk/default.asp?a=2&m=0>

Permission is only granted for the activities for which a favourable opinion has been given by the REC (and which have been authorised by the MHRA).

You are reminded that you must report to the R&D office any **adverse event or serious incident**, whether or not you feel it is serious. This requirement is in addition to informing the Chairman of the Research Ethics Committee which approved the study. The research sponsor or the Chief Investigator, or the local Principal Investigator at a research site, may take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety. The R&D Department should be notified that such measures have been taken. The notification should also include the reasons why the measures were taken and the plan for further action. The R&D Department should be notified within the same time frame of notifying the REC and any other regulatory bodies.

All amendments (including changes to the local research team) need to be submitted in accordance with guidance in IRAS. These changes must also be reported to the R&D Department. Likewise any change to the status of a project must also be reported to the R&D Department.

Please note that the NHS organisation is required to monitor research to ensure compliance with the Research Governance Framework and other legal and regulatory requirements. This is achieved by random audit of research and requests for study related data. You are also required to submit to the R&D office a **final outcome report** on completion of your study, and to provide interim reports on progress as requested. Should **publications** arise, please send copies to the R&D office, Wonford House for inclusion in the study's R&D file and the Trust's research publications library.

I would also like to remind you of the responsibilities of anyone who conducts research within the NHS, which are:

1. The Data Protection Act requires that you follow the eight principles of 'good information handling' as summarised in the guide for staff.
2. You must be aware of, and comply with Health and Safety standards in relation to your research
3. You must also be aware of NHS Indemnity Arrangements; summary details can be found in Appendix 1.

With best wishes for a successful study.

Yours sincerely



Dr. Peter Aitken
Directorate of Research and Development.

cc: Dr Hamilton Fairfax – Riversvale Centre
Tobit Emmens, R&D, DPT

Appendix J University of the West of England Ethical Approval



Faculty of Health &
Life
Sciences
Glenside Campus
Blackberry Hill
Stapleton
Bristol BS16 1DD

Tel: 0117 328 1170

Our ref: JW/lt

2 August 2013

Ms Miya Bond
Trainee Counselling Psychologist
Devon Partnership NHS Trust
Riversvale Centre
Litchdon Street
Barnstaple EX31 8PJ

Dear Miya

Application number: HLS/13/06/87

Application title: Clients' experiences of mindfulness as part of group treatment for OCD: An IPA study

REC reference: 13/SW/0167

Your NHS Ethics application and approval conditions have been considered by the Faculty Research Ethics Committee on behalf of the University. It has been given ethical approval to proceed with the following conditions:

- You comply with the conditions of the NHS Ethics approval.
- You notify the Faculty Research Ethics Committee of any further correspondence with the NHS Ethics Committee.
- You must notify the Faculty Research Ethics Committee in advance if you wish to make any significant amendments to the original application.
- If you have to terminate your research before completion, please inform the Faculty Research Ethics Committee within 14 days, indicating the reasons.
- Please notify the Faculty Research Ethics Committee if there are any serious events or developments in the research that have an ethical dimension.
- Any changes to the study protocol, which have an ethical dimension, will need to be approved by the Faculty Research Ethics Committee.

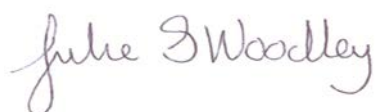
You should send details of any such amendments to the committee with an explanation of the reason for the proposed changes. Any changes approved by an external research ethics committee must also be communicated to the relevant UWE committee.

- Please note that all information sheets and consent forms should be on UWE headed paper.
- Please be advised that as principal investigator you are responsible for the secure storage and destruction of data at the end of the specified period. Please note that the University Research Ethics Committee (UREC) is required to monitor and audit the ethical conduct of research involving human participants, data and tissue conducted by academic staff, students and researchers. Your project may be selected for audit from the research projects submitted to and approved by the UREC and its committees.

Please note that your study should not commence at any NHS site until you have obtained final management approval from the R&D department for the relevant NHS care organisation. A copy of the approval letter(s) must be forwarded to Leigh Taylor in line with Research Governance requirements.

We wish you well with your research.

Yours sincerely



Dr Julie Woodley
Chair
Faculty Research Ethics Committee

c.c. Naomi Moller

Appendix K Part of Reflexive Journal

Excerpt from the researcher's reflexive journal following one of the interviews.

Interview with participant A

There are so many parts to this interview that are contradictory and at first sight confusing. During this interview I got a real sense of A struggling to make sense of how she finds mindfulness helpful for herself. A seemed much more comfortable talking about how mindfulness can help others rather than reflecting on her own experience. I found myself having to keep drawing A back to talk about herself and this was at times frustrating. At times, I felt like A was telling me why mindfulness should be helpful/unhelpful rather than telling me about her own experience.

I noticed I was really curious about her use of mindfulness. There is a clear distinction for A between mindful meditation, mindful presence (being in the moment) and mindful awareness. Only mindful awareness is actually helpful for A and this appears to be used partly as the way to reassure her and perhaps also as a compulsive distraction. Also while mindful meditation and being in the moment creates a calmness and quietness of the brain which actually allows the OCD thoughts to get hold. However this only came out later in the interview. At first mindfulness meditation was difficult (it didn't work for A), but only later in the interview it is bad. I was left wondering about this. Was A becoming more comfortable and feeling able to say something that she thought I perhaps did not want to hear? I noticed myself getting caught up in the busyness of A's descriptions of mindfulness and noticing my judgements about her responses: this is not mindfulness, this is not just observing. There is a parallel process here as I am not simply observing and I am already caught up in the trying to make sense of what A has said.

I noticed that when A talked about her OCD it was expressed with less emotion than previous participants. This may be because she is in remission, however I did wonder about this. There were occasional changes of tense that seemed to indicate that the OCD was not in the past. A is also a therapist so I am wondering

if this was part of a difficulty for A to identify with someone who has a mental health issue – particularly to someone who is also a therapist.

My impression is that although we spoke for a long time the data from this interview is different and at odds with previous data and I notice that I have some anxiety that the data won't somehow fit with the other interviews. I guess I am worried about the whole process, worrying where the next participant will come from, worrying if I will have enough data. It seems I may have attached this anxiety to this latest interview, and I guess I just have to allow everything to be exactly as it is right now – this mindfulness thing is not easy!