To speak or not to speak

The experience of disclosing and concealing
my obsessive-compulsive disorder: A heuristic enquiry

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by any other person (except where explicitly defined in the acknowledgements), nor any material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or any other institution of higher learning.

Chris Lorigan

Date: 14.11.2018

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Almost always, when a person realizes he has been deeply heard, his eyes moisten. I think in some real sense he is weeping for joy. It is as though he were saying, "Thank God, somebody heard me. Someone knows what it's like to be me." In such moments I have had the fantasy of a prisoner in a dungeon, tapping out day after day a Morse code message, "Does anybody hear me? Is anybody there?" And finally one day he hears some faint tappings which spell out "Yes." By that one simple resonance he is released from his loneliness; he has become a human being again. — Carl Rogers (1980)

Abstract

There is a tendency among those living with obsessive-compulsive disorder (OCD) and other mental illnesses to conceal their experience and to delay or avoid seeking help, which can lead to negative mental health outcomes. This phenomenon has received very limited attention in the mental health literature, particularly from the perspective of the sufferer. The present heuristic self-search inquiry (HSSI) offers an in-depth exploration of the researcher's lived experience of concealing and disclosing an OCD diagnosis.

This study offers mental health practitioners augmented insights into the lived experience of OCD, insights that can enhance the clinician's empathic engagement with their client and strengthen the therapeutic relationship, which is widely understood to be the most crucial healing element of psychotherapy.

Several themes pertaining to concealment are outlined, including fear of reduction, fear of negative judgement, fear of rejection, and negative self-judgement, as are several themes pertaining to disclosure, including being known, the danger of disclosure and the fight inherent in disclosure.

Core psychodynamic elements underpinning the experience of OCD concealment and disclosure are discussed, namely a sense of feeling unworthy and unlovable, but also a sense of relief following disclosure.

Limitations of the heuristic research and implications for psychotherapeutic theory, practice, research and training are highlighted.

Contents

Chapter 1

I just can't say anything, except when I can: Introduction to the study

1. Introduction

In this chapter I discuss the context and background of the study, largely my experience of obsessive-compulsive disorder – which I define – and why I am asking my question. I consider my socio-cultural context and its implications for the broader relevance of this heuristic research. I outline the development of my topic of interest and how I came to my research question. I name the study's key point of concern, which is an examination of what it is that allows me to speak and what is it that keeps me silent about obsessive-compulsive disorder (OCD); I want to explore what I think and feel when I tell others I have OCD and what I think and feel when I do not or cannot. I begin from the premise that my voice and the voices of other sufferers are important considerations in the psychotherapeutic engagement with clients who find it difficult or impossible to disclose their experiences and who perhaps do not seek help as a consequence of their struggle.

2. Context: The scream both known and unknown

In no way is this easy; I am planning on disclosing and exposing a great deal about my OCD in the very act of writing a dissertation about what it is like to conceal or disclose my diagnosis. I am undertaking heuristic research, an in-depth examination of myself, as defined by Moustakas (1990). I see disclosure as "the process of communicating information about oneself … to another person" (Brohan *et al.*, 2012, p. 1).

I experience OCD as highly distressing. It is characterised by the presence of obsessions – "recurrent and persistent thoughts, urges or images that are experienced as

intrusive and unwanted" – and/or compulsions – "repetitive behaviours or mental acts

that an individual feels driven to perform in response to an obsession"; the obsessions

"cause marked distress or anxiety" and the compulsions aim to "reduce distress triggered

by obsessions" (American Psychiatric Association, 2013, pp. 235-236). The Psychodynamic

Diagnostic Manual (PDM) defines it similarly: "'Obsessions' are recurrent thoughts,

impulses, or images that impinge upon the affected person's mental functioning;

'compulsions' are actions, mental activities, and repetitive behaviours that the patient

experiences as 'compulsory' and that significantly affect his or her functioning" (Lingiardi &

McWilliams, 2017, p. 171).

I have been living with and suffering from OCD for 30 years, since I was 13. My

experience has been isolating, dysfunctional and replete with intense suffering. The

disorder seems to me to be highly aberrant and strange in the context of 'normal' human

experience, and consequently I have mostly ensured it remains secret. Hidden. I find it

profoundly difficult to tell people.

Severe anxiety has, at various protracted times in my life, accompanied my

thoughts, feelings, body and behaviours, often constantly and oppressively, although this

has lessened considerably in the past ten years. Like all OCD sufferers I have had the

perennial experience of getting locked and lost in an endless downward spiraling loop of

questioning, doubting, checking, fear, anxiety, checking, uncertainty, panic, desperation,

checking, despair, dread, suddenly knowing, relief, questioning, doubting, fear, checking,

anxiety, uncertainty…

For me OCD feels a lot like this:
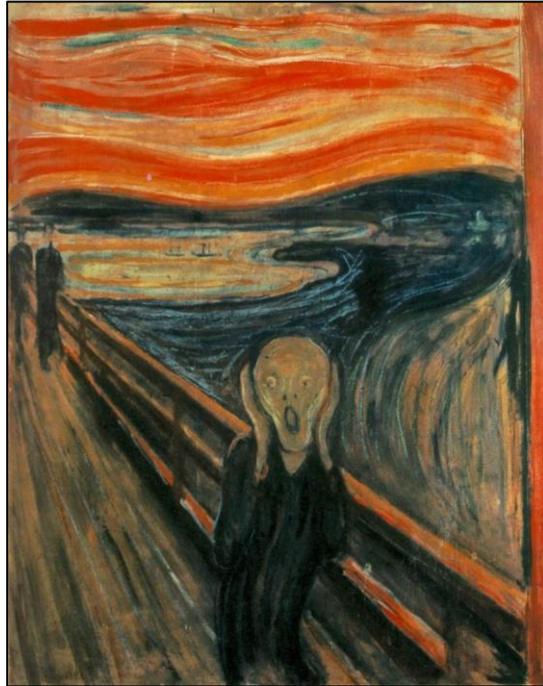
Figure 1: *The Scream,* Edvard Munch

This painting emerged as eminently more relevant to the present study than I could have anticipated. At its core the work is, in Munch's own words, "the study of the soul, that is to say the study of my own self" (Faerna, 1995, p. 16)*,* which fits with my chosen heuristic methodology and method, as I explain in chapter 3.

I find myself wondering what it is I am doing when I place this image here. I think I want people to know that OCD is not just about lining things up neatly on your desk, making sure the bathroom is clean, perfecting your child's birthday cake or checking all the doors and windows are locked before going to bed. For many sufferers it is more about checking one door lock intensely for half an hour, going back to bed, wondering if you did it, getting up again, anxiously checking for half an hour, going back to bed, being scared that it is not locked, trying not to get up despite feeling profoundly, viscerally, desperately compelled to, experiencing intense, scream-worthy anxiety, giving in, getting up … repeat.

It is suffering, distress and desperation. It is checking things or performing ritualistic behaviours, through no choice of your own because you absolutely have to and you absolutely cannot stop. For some reason I want people to know that, yet at the same time I do not want anyone to know – these are the experiences I am exploring in the present study.

3. Socio-cultural considerations and biases

I feel it is relevant to discuss my own socio-cultural context, for this is – in my view and as a reflection of my post-structural standpoint – the only perspective from which I can undertake and explicate what is essentially phenomenological research. I believe we exist within and are framed by society and culture (Haugh & Paul, 2008; Maroda, 2010; McWilliams, 2011); and it is a subjective, internal frame of reference, within that context, on which I am drawing. The research is about my experiences, but I also believe it to have broader implications for other sufferers and the wider psychotherapy community.

I identify as a white/Pakeha, middle-aged, middle class, heterosexual man of English, Scottish, Irish and German descent. I live in Aotearoa New Zealand, where I was raised by my mother after my parents separated when I was five. I have one younger brother. I have a wife and two young children. I am a psychotherapist. Before that I was a magazine editor and writer. All of this is relevant, for all of it places me within a specific context. Thus, I need to consider to whom the study is relevant; is it only relevant to me?; is it relevant to other people like me, or does it have broader implications?

I mention this here because it helps provide context for the study; background, culture and gender indicate my perspective and biases. People who are different from me might find disclosure either more or less difficult than I do; they might see it as a non-issue

or a significant one, and I want to be transparent about the fact that I am operating from a standpoint that will consider my experience within a very specific frame in 2018.

The NZAP Code of Ethics (2008) compels therapists in Aotearoa to factor in issues of "colour, creed, ethnicity, gender, sexual orientation, age, disability, social class, religion or political belief", which I need to consider. My socio-cultural position is a privileged one, one that holds a certain power, and I need to be aware of this as I make claims of wider relevance. The same must be said of the power differential inherent in the psychotherapeutic relationship: if our clients come to therapy experiencing difficulties speaking about their suffering or, indeed, if there are sufferers out there – female, LGBTQi+, black, brown, red, yellow, blue – who cannot seek help due to disclosure issues, then I do not want to assume they have the same experience that I do. I offer in the present study my unique experience, which I hope might open up a conversation about an aspect of OCD that has often been overlooked: the direct voice of the sufferers.

4. Masculinity

In Aotearoa New Zealand, the stereotypical male – within the dominant, Eurocentric, patriarchal, heteronormative, masculine cultural construct (Keppel, 2012; Worth et al, 2002) – is defined by self-reliance, toughness, physicality, getting on with it, being 'hard' and being in control (Bannister, 2005). Men can feel the need to live up to this ideal, and anything outside of it creates an 'other' (Brannon, 2005; Foss, Domenico & Foss, 2013; Hardiman, 2000; Worth et al., 2002). I am not sure if I entirely fit the stereotypical mould, and I may explore the implications this has on my experience of disclosing and concealing my OCD if they emerge as salient.

Moreover, my experience of disclosure, as a male, might be solely relevant to males 'like' me. For there is not a homogeneous position that can be taken when dealing with

'men'. Much of the literature on treating men categorises maleness in reductive, heteronormative terms that are not relevant to all men. In works such as Englar-Carlson and Stevens (2006) the word 'male' is used as a categorical term that attempts to generalise the male experience. I do not intend to generalise, as the study is focused on my experience; however, my gender experience is nevertheless a factor in my concealment and disclosure.

5. Finding my topic

When I began psychotherapy training four years ago I thought I knew what my Masters dissertation topic would be. And yet I have abandoned it. I had been in private psychodynamic psychotherapy for seven years at that stage and had found it profoundly helpful. Shedler (2010) writes that "the essence of psychodynamic therapy is exploring those aspects of self that are not fully known, especially as they are manifested and potentially influenced in the therapy relationship" (p. 98). He outlines seven distinctive features of the psychodynamic psychotherapy process: focus on affect and expression of emotion; exploration of attempts to avoid distressing thoughts and feelings; identification of recurring themes and patterns; discussion of past experience (developmental focus); focus on interpersonal relations; focus on the therapy relationship; exploration of fantasy life. I wanted to tell anyone who would listen that psychodynamic psychotherapy has been effective in helping me live with OCD and the intense anxiety that accompanies it, that it has helped me heal.

I knew that the most widely used clinical treatment for OCD was cognitive-behavioral therapy (CBT) but had found it largely ineffective for me on its own. I was becoming increasingly certain that the treatment of OCD needed to include a sufferer's

psychodynamics, an engagement with past and present patterns of relating and being. I believed that coming into deep contact with the experience of being oneself would provide emotional insight into the underpinnings of OCD and provide relief at a deep level. Because it had for me. The world, surely, needed to know that there was a viable albeit largely long-term alternative to exposure and response/ritual prevention (ERP), the CBT-based treatment of choice for OCD (Antony, Purdon & Summerfeldt, 2007; Swinson, Antony, Rachman & Richter, 1998) that compels a client to directly face the source of their anxiety and doubt in order to allow the exposure to gradually reduce, thereby extinguishing the checking behavior.

This troubles me because even though it can be helpful for symptom relief and behavioural change I believe it does not address any underlying elements that in my experience have fueled the disorder. This was to be the focus of my dissertation, however I eventually realised that I was in trouble: I already knew my answer. I was wedded to the outcome of the research; I was polemically articulating my preconceived thesis, and this got in the way of submitting a research proposal that objectively and authentically explored a genuine research question.

What I did realise, though, was that I was wanting, via that original dissertation topic, to say something to the world that was important to me, and this fact in itself was interesting; it was something I did not understand. It led me to consider what it was I might be wanting to say about OCD, to whom and for what purpose. This would involve revealing the OCD, which felt crucial and yet challenging. Thus I became interested in exploring my lived experience of the disclosure and concealment of OCD.

6. Finding my question, part one: A person of flesh

I was introduced to the following lines from a poem (Prendergast, 2015) entitled 'Vox

Poetica: A Surrender and Catch Found Poem':

> *How do you embrace a question*
> *as if it were flesh and warmth?*
> *How do you hold a question*
> *when it is slippery*
> *and leaves before you awake?*

This resonated for me because my dissertation question was proving slippery. So I

immersed myself in myself, this person of flesh, to find the missing pieces of knowing.

I gave it considerable thought. After I spoke in my dissertation class about my initial

topic on the benefits of psychodynamic psychotherapy for OCD sufferers, I had an email

exchange with another male student:

> *The tension to me seems like it could be; "why has*
> *psychodynamic psychotherapy been so helpful for me, as*
> *a sufferer of OCD, yet nobody else (generalisation)*
> *believes it to be so". If this tension is true I more fully*
> *understand your impulse to crusade, to prove*
> *something. This tension also feels like it could be a lonely*
> *place, that to be heard may ease that pain or even more*
> *sadly it may not. I think this is the story I became*
> *interested in hearing.*

I was moved to tears, which is highly unusual for me; I think it was the experience of having

someone engage with an understanding of me. I replied thus:

> *I am very moved that you have seen this and really*
> *appreciate you sharing it with me. Just having you*
> *respond like this with empathy is enormously*
> *therapeutic in itself. I'm very touched. I think you're*
> *on to something, I honestly do.*

7. Finding my question, part two: Polemic and Hamlet

After I had abandoned my initial topic I spoke to my academic supervisor about looking for a new area of enquiry, and she advised me to think about what it was I truly did not know. We spoke about this notion of wanting to be understood by saying something to the world, but settled more readily, at that stage, on exploring my current lived experience of OCD after ten years of therapy. I consequently came up with the following research question: "What is my current experience of OCD, and in what ways, if any, has this experience changed in the past 10 years?"

This was getting closer to an authentic heuristic enquiry; but, again, I think I already knew the answer – underlying the question was this polemic around demonstrating that psychodynamic psychotherapy was an effective treatment approach for OCD. I wanted to validate my journey. So I still did not have a legitimate question to which I had no preconceived answer.

At this point, Hamlet's famous words (Shakespeare, 1980, III.1.56-60) came to mind, resonating at a deep level with my experience:

> *To be, or not to be, that is the question:*
> *Whether 'tis nobler in the mind to suffer*
> *The slings and arrows of outrageous fortune,*
> *Or to take Arms against a Sea of troubles,*
> *And by opposing end them*

For me, in the context of OCD, this means that to conceal my experience is to "suffer the slings and arrows of outrageous fortune" and to disclose is to "take arms". I wonder: will disclosure end the suffering? I discuss this further in chapter 4.

8. Finding my question, part three: Fine tuning

I reflected on this for a week or so. I found an autobiographical book by a young New Zealand woman, Lauren Tomsett (2009), called *Obsessive-Compulsive Disaster*. A lot of her story mirrored mine and I respect her for disclosing so openly her lived experience. It inspired me. She "wanted to be understood" (p. i), she wanted to describe it so doctors, friends and family would "have an idea of what it was like" (p. 1). I remember thinking how brave she was, wishing I could do the same and feeling that what she had done was important.

This led me, again, to the notion of disclosure and what might be holding me back from speaking and from seeking help. I truly did not know the answer, and so I knew I had found the beginnings of a question. Initially I phrased it thus for my new research proposal: "What is it like to disclose and to conceal my obsessive-compulsive disorder (OCD) and how do I understand these experiences?" Further discussion with my supervisor following my extensive literature search had me arrive at the following question: "What is my experience of disclosing or concealing my obsessive-compulsive disorder (OCD)?" My supervisor and I had agreed that "what is it like" should more precisely be phrased "what is the experience" as it better aligned with heurism and the process/phenomenologically-oriented psychotherapy I have come to value as an OCD sufferer and psychotherapist. We also agreed that the "how do I understand these experiences" clause in the earlier question was unnecessary, as it was inherent in the first part of the question considering I was doing a heuristic enquiry that would involve exploring all aspects of my experience.

9. Key point of concern

In general, I do not want people to know that I have OCD; and yet part of me does want to talk or write about it even though this is extremely challenging. Consequently, I have mostly suffered in silence and loneliness. An examination of these phenomena lies at the heart of the present heuristic study. I want to examine what it is that allows me to speak and what is it that keeps me silent. I want to explore what I think and feel when I tell others and what I think and feel when I do not or cannot. I also want to discuss the ways in which these experiences might be relevant to other sufferers and to the field of psychotherapy. I believe sufferers' voices are missing, that my voice is missing from the extant literature on the subject.

10. Aim and scope

Primarily, the focus of the study is on the experience of disclosure and concealment of the fact that I have OCD, of the diagnosis itself – given the time limitations of this short dissertation, I do not explore the experience of revealing or concealing the specific obsessions and compulsions that constitute my OCD. I investigate what the implications might be regarding my in/ability to seek empathy, understanding, support and help.

The core aim of my study is deeper self-knowledge. As McWilliams (2004) argues, self-knowledge is a goal of psychodynamic therapy, but "a more profound goal is self-acceptance" (p. 137). I am seeking both; not only could this enhance my understanding of the research phenomena, it could support and deepen my psychotherapy work with clients suffering from 'secret' conditions.

I have, therefore, two further aims for the study that might broaden the relevance of my research findings: I hope to speak to people who suffer from OCD or other isolating

psychopathology or emotional distress, people who find it difficult to disclose their experience; I hope that others can relate to my experience on their journey with mental illness and that it might allow them to feel less isolated and to have the potential to heal, for there is a tendency among those living with OCD and other mental illness, particularly men, to conceal their experience and to delay or avoid seeking help (Picco et al., 2018; Poyraz et al., 2015; Robinson, Rose & Salkovskis, 2017; Steinberg & Wetterneck, 2017).

In addition, I hope to add to the existing knowledge around what it is like to disclose in order that clinicians better comprehend the difficulty clients face in revealing their experience with openness. This is known as "mental health literacy" (Picco et al., 2018, p. 84), which in turn leads to "recognition, management or prevention" (Jorm *et al.*, 1997, as cited in Picco et al., 2018, p. 84). Robinson, Rose and Salkovskis (2017) contend that one of the barriers OCD sufferers face is "concern about the reaction of health professionals" (p. 193). Thus, I would argue that it is important if not crucial for practitioners to know more about this experience, for "the awareness, kindness and understanding shown by first-line practitioners can be very important to those seeking help" (Robinson et al., 2017, p. 194); and, perhaps most relevant to the present study, "acknowledging a person's journey prior to seeking help is likely to foster trust between therapist and patient" (Robinson et al., 2017, p. 194). This fits with my hope that openness and an examination of the human experience can lead to more effective treatment.

11. Chapter summary

In this chapter I have defined disclosure and OCD and describe my experience of the disorder and its attendant anxiety. I discuss the idea that I want others to know more about OCD. I explore some of the socio-cultural and ethical elements that are inherent in my

undertaking of the study, including my biases. I begin to explore the study's wider relevance and introduce some of my thinking around the contribution my perception of the masculine experience might have on the research phenomena. I then discuss how I arrived at my research topic and how I refined this into a specific question. I then articulate a key point of concern, which is the voicing of my lived experience of concealing and disclosing OCD, and that my aim in doing so is threefold: I am seeking deeper self-knowledge; I want to offer my experience to other sufferers in order that they feel less isolated; and I wanted to augment practitioners' understandings of the OCD experience because concealment often means delays in help-seeking.

Chapter 2

What is known and not known: My literature (re)view

1. Introduction

In this chapter I discuss the literature review process and the fact that it helps

contextualise, justify and locate a given research interest, specifically in helping identify a

'gap' in current knowledge that leads to the formation of a precise research question. I

argue that I am looking to find whether or not anything approximating my experience is

present within the literature. I then characterise my heuristic literature review as a

subjective literature 'view'. I seek to find a 'gap' by focusing on published articles, starting

with the intersections between the disclosure and OCD literature.

I outline the parameters and process of my search, during which I found that there

is a significant lack of literature exploring the lived experiences of OCD sufferers and their

experiences of disclosure and concealment. I also found that sufferers tend to exhibit

considerable delays in help-seeking behaviour, which leads to negative outcomes, and that

this behaviour could be linked to difficulties in disclosing. I offer an in-depth critique of six

relevant papers in order to more closely outline the need for my study.

2. Finding the person in the experience

As I embarked on the literature search I consulted the Psychodynamic Diagnostic Manual

(PDM; Lingiardi & McWilliams, 2017), which briefly articulates some of the subjective

elements of OCD, but these seem to me to require expansion. What I also found in the

PDM was something I believed was crucial and pointed to the need for my research: that

OCD is a "façade superimposed on a deeper, hidden, more disturbed mental functioning"

(p. 172). To me this suggests there is something significant beneath the surface of OCD,

which again motivates me to explore my experience of OCD in the present study.

Before discussing the literature search and review I undertook, I will restate, for context and focus, my research question:

What is my experience of disclosing or concealing my obsessive-compulsive disorder (OCD)?

In a recent publication, Sultan (2019) contends that there are three key considerations when undertaking a literature review as part of a heuristic research process. These are: "To report your critical evaluation of the relevant literature; to identify gaps in the literature and help you make a case for the study; to locate your research study within the wider context of your topic, discipline or field" (p. 110). I will address each area in this chapter, although I will leave the first of these considerations until the end of the chapter once I have placed my own study "clearly on the academic map of knowledge creation" (Ridley, 2008, p. 1) as it seems to follow more logically: my process involved searching the current relevant literature, establishing whether or not there was anything 'missing' from that literature with regards to my area of interest, finding key relevant papers that resonated for me as a heuristic enquirer, and then addressing those more closely in order to further locate a place for my study.

Machi and McEvoy (2016) argue that a "complex literature review" (p. 3) like the one I am undertaking here provides readers with the "current state of knowledge about a topic" (p. 5) but it also articulates the ways in which the literature "leads to a problem or to a question requiring original research" (p. 5); in effect, there might be a "gap" (Ridley, 2008, p. 24) in the literature I need to find. I believe that the literature review provides both context and justification for a new research direction in a given field of enquiry.

3. My voice, my search

I was initially looking to see what had previously been written from the OCD sufferer's perspective about disclosing or concealing their experience. I wanted to see if my intended area of enquiry would contribute anything new to the field. I then wondered whether or not it would matter if others had written about this experience, or if my subjective and unique voice would simply contribute another salient colour to the spectrum of experience and the body of knowledge. I did not know the answer to this and would have to wait until my study and its explication were complete.

My literature search is not intended as an exhaustive or systematic review, for that is beyond the scope of the present dissertation. I see the heuristic literature review as more of a "literature view" (Keith Tudor, Professor of Psychotherapy, AUT, personal communication, 13 August, 2018), which is one's subjective, heuristic experience of the literature as one encounters it rather than a systematic process, and this is the approach I took; it aligns with my ontological and epistemological positioning, which I articulate in the next chapter.

What I can say is that the search was extensive, focused and ordered yet imbued with my subjective responding in the moment to the material I encountered and how it resonated for me with respect to my research question. It followed its own course yet verged on obsessive, however I did not dip into something pathological or distressing.

4. OCD and disclosure

I began by searching intersections between the OCD and disclosure literature. I focused on journal articles from the past ten years in order to make use of recent material and to contain my study given the time- and space-limited nature of a relatively small dissertation in a university setting.

I found myself focusing on published journal articles, largely because of Cooper's (2004) contention that research papers are probably the most important source, that they are generally more up-to-date and research oriented than, for example, book chapters. My personal rationale for taking this expedient approach has one core dimension: these are the sources perhaps most likely to be referred to and respected by academics, researchers and clinicians seeking perspectives on OCD and disclosure, and so I want to respond to these critically in order to eventually offer a new and accessible perspective framed by the most "focused and empirically rigorous" writing (Cooper, 2004). The net effect of this might be that more professionals within the field can have an augmented understanding of what their clients are experiencing and that this might lead to an increase in empathy for these clients – which is important because empathy lies at the heart of the therapeutic alliance (Rogers, 1980), and the therapeutic alliance lies at the heart of therapeutic efficacy (Kahn, 2001; McWilliams, 2004; Haugh & Paul, 2008).

5. Looking for the gap/framing the study

I next undertook extensive searches of the most comprehensive databases relevant to the field of psychotherapy – Web of Science, PsycInfo, ProQuest and British Library EthOS – using various combinations of terms such as 'obsessive-compulsive disorder', 'OCD', 'client experience', 'patient experience', 'talking about', 'disclosure', 'revealing' and 'heuristic'. This yielded few results – there was very little literature of close relevance, very little from the OCD sufferer's perspective about what it is like to conceal or disclose their diagnosis. This is consistent with an argument offered by Probst (2014): "Literature from the perspective of the diagnosed individuals themselves is surprisingly scant" (p. 235). Bril-Barniv, Moran and Naamen (2017) concur: "People with mental illnesses face

the dilemma of whether to disclose or conceal their diagnosis, but this dilemma [has been] scarcely researched" (p. 573). Steinberg and Wetterneck (2017) also agree, arguing that there is a "limited level of knowledge on seeking help for OCD" and that "there is [therefore] a particular need for in-depth studies" (p. 195). Robinson, Rose and Salkovskis (2017) found "no qualitative studies specifically examining the barriers and enablers in seeking help for OCD" (p. 195) and argue that "it is vital that we ask people with OCD directly" about this (p. 195). I feel there is a gap here that I can help to fill.

6. Not foreclosing

At this stage I had very little idea of how to name my experiences concealing and disclosing OCD – what those experiences are or how they feel with any depth – in order to focus the research, and therefore I did not know quite how to proceed; I did not want to foreclose on my heuristic self-search by using terms or concepts that may not be salient for me before I had engaged in my immersion or incubation phases and tuned in to my experience via the heuristic processes of indwelling, tacit knowing and intuition (Moustakas, 1990).

In order to start somewhere, I broadened my search to include mental illness more generally. I found that a lack of disclosure is, at least in part, attributable to perceived experiences of stigma and shame (Bril-Barniv, Moran & Naamen, 2017; Waugh, Latham, Sherring & Henderson, 2017). Indeed, Charles and Bentley (2018) contend that the stigma surrounding mental illness is "the most formidable obstacle to future progress in the arena of mental health" (p. 33), but again there was limited material from the sufferer's perspective. I next searched the literature for intersections between stigma, shame and the OCD experience.

7. Delays in help-seeking

What I found was that OCD stigma appears to be connected to significant delays in help-seeking; OCD sufferers seem to delay help-seeking because of perceived discrimination and judgement associated with their diagnosis and experience (Belloch, del Valle, Morillo, Carrió & Cabedo, 2009; McCarty, Guzick, Swan, & McNamara, 2017; Picco *et al*., 2018; Poyraz *et al*., 2015; Robinson, Rose & Salkovskis, 2017). In fact, Belloch *et al*. (2009) point out that just 34–40 per cent of OCD sufferers "have ever received mental health treatment" (p. 257) and that there is an average delay in treatment seeking of 7.6 years. Belloch *et al*. (2009) contend that these delays have received limited attention. The present study aims to shed light on my experience of concealment in this regard; I believe my lived experience perspective is important as it might help provide insights into what clients are experiencing as they face the dilemma of disclosure, and an understanding of this might offer clinicians a window on how to engage with these clients.

Because, as Picco *et al*. (2018) argue, "delays in seeking appropriate treatment result in negative outcomes" (p. 84). Wheaton, Sternberg, McFarlane and Sarda (2016) agree: "Research has linked self-concealment to negative health outcomes, including several forms of psychopathology such as depression, suicidal behaviors, social anxiety and eating disorders" (p. 44). Wheaton *et al*. (2016) argue that "self-concealment [is] related not only to OCD symptoms but also to attitudes about seeking therapy" (p. 47). Their results "suggest a need for further exploration in this area" (p. 47).

Despite this connection between stigma and sufferers' unwillingness to disclose and seek help, there is a "minimal amount of research on the stigma of OCD" (Chasson, 2018, p. 56). The aim of my research is to shed light on this and other related phenomena

if they emerge as a salient part of my experience; for, as Spragg and Cahill (2015) contend, "service users' perspectives are integral in the formal evaluation of mental health services" (p. 2).

My own story includes delays in help-seeking; seeking help meant I would have to tell someone, and this was, for whatever reason, a distressing consideration.

8. Shame

Shame also emerged in the literature as a significant contributor to non-disclosure and delays in help-seeking, and so I also seek to explore this aspect of my lived experience if it emerges. At this stage, the word does not resonate in the context of disclosing OCD.

According to Wheaton *et al*. (2016), "in addition to provoking anxiety, OCD symptoms are also associated with feelings of guilt and shame" (p. 43). Harrington (2014, citing Hyman & Pedrick, 2005) argues that "people with OCD are typically secretive and shameful of their obsessions and compulsions and consequently disguise their difficulties" (p. 85). In the context of shame, she points out that "most individuals with OCD wait years, and even decades, to seek any help or support for their mental health issues" (p. 85). Wetterneck, Singh and Hart (2014) argue that shame is dealt with via escape, which arguably equates to avoidance and a reluctance to reveal the disorder to others.

Wetterneck *et al*. (2014) point out that recent literature explores the presence of shame within the OCD experience, but contend that this research is limited and "has not accounted for the different symptom dimensions of OCD" (p. 180); they do not articulate the experience of shame, nor the experience of revealing OCD. Furthermore, Fergus, Valentiner, McGrath and Jencius (2010) contend that "the somewhat equivocal relationship between shame and OCD … suggests that further elucidation of the

relationship is needed" (p. 814), while Steinberg and Wetterneck (2017) contend that there is a "dearth of research" (p. 276) in this area.

9. CBT

Spragg and Cahill (2015) argue that the presence of shame in the experience of OCD disclosure has undergone limited exploration in the cognitive-behavioural therapy (CBT) literature, which is significant and perhaps troubling given that CBT is the "treatment of choice [for OCD]" (Spragg and Cahill, 2015, p. 2), its "first-line treatment" (Wheaton *et al*., 2016, p. 43, citing Koran & Simpson, 2013; NICE, 2013). Fergus *et al*. (2010) argue that the shame of having OCD leads to "feelings of worthlessness and being exposed" (p. 811), however these experiences are not explored or described in the literature by sufferers, nor are they situated within a context of disclosing OCD. As Greene (2009) argues, "the crucial question is what underlies the decision processes and creates conditions for likely disclosure," (p. 227). I am seeking to explore this underlying domain in order to offer an impression of the fuller, person-centred experience of a sufferer with the aim of offering mental health practitioners insight into the barriers to treatment. If heuristic research "retains the essence of the person in experience" (Douglass and Moustakas, 1985, p. 43), then this is what previous studies into OCD seem to have neglected. It is my intention to explore and articulate this essence in the present study.

10. Examining the OCD-disclosure literature

The following section articulates my more in-depth response to and critiques of the literature relating to and framing my topic and question. This is not intended as an exhaustive interpretation of the literature; rather it is a close, subjective and heuristic

reflection on aspects that I feel more specifically suggest the need for my research. Nor is it intended as data for my heuristic process *per se*; it is a way to more deeply explore the gap I have identified within the field of OCD, disclosure and mental health. As Machi and McEvoy (2016) suggest, the critique offered here is intended to help "define a new unanswered question … requiring new primary research" (p. 109). In other words, it should help strengthen my case for the present study. I look for "gaps, contradictions, omissions and debates about the research subject" (Machi and McEvoy, 2016, p. 109) so that a thesis position can be legitimately drawn. I wondered what this thesis position might be for me, and so I began to read each article closely.

As I have said, there were very few relevant articles in my literature search; those I am examining intuitively stood out to me as significant. At the conclusion of my literature search, I was left with six papers that helped me situate my study with specific reference to the OCD-disclosure intersection. I will examine each in turn, in ascending date order. I interrogated them with two key parameters in mind: the presence of lived experience of OCD and disclosure/concealment; and the presence of objective assumptions or abstractions about OCD and disclosure/concealment. In other words, is there anything approximating my voice or experience as an OCD sufferer in these papers? I chose these parameters as I felt they would help emphasise whether or not the gap I had begun to identify was actually present. I also considered each paper's direct and indirect relevance to my topic in other spheres, as noted in each discussion.

10.1 Belloch, del Valle, Morillo, Carrio and Cabedo (2009)

This paper – entitled 'To seek advice or not to seek advice about the problem: The help-seeking dilemma for obsessive-compulsive disorder' is quantitative, which stands in

contrast to my qualitative research methodology and focus. Thus, participants seem reduced to numbers and a sense of their experience is lost or at least watered down and filtered through an objective, positivist procedure that for me lacks the human voice I am considering for my research.

This Belloch *et al.* study aimed to explore the reasons OCD sufferers would and would not seek professional help. I argue that help-seeking requires disclosure, so is relevant to my study, yet I recognise that help-seeking from professionals is only one dimension of what I am considering as disclosure in my study: disclosure to friends, family, colleagues etcetera are not explicitly researched in the article, which I seek to address because I believe support from those close to a sufferer is an important consideration in healing.

The paper mentions "fears about revealing the content of the obsessions to other people" (p. 258) but articulates nothing of what this fear might feel like for the sufferer; in my view the word fear here is a denotative abstraction, and one that gives no colour to human experience. I am left wondering how these people felt. Moreover, the sentence above refers to the content of OCD not the diagnosis itself, so differs from my focus significantly.

The researchers mention "fear of negative reactions from others", citing "social rejection" as a consequence of disclosure (p. 258). However, there is, within the same sentence, a notable shift from a sufferer's perspective on this social engagement to the perspective of the receiver of the information "regarding the person as being bad or malicious, mentally ill or dangerous" (p. 258), thereby sidelining the sufferer's experience. Were this worded differently ('feeling as though they are regarded as bad or malicious', for example), the discussion would have stayed with the sufferer rather than diverting away

from them. I want to know what the sufferer was feeling.

The researchers write that a factor influencing concealment "could be" fear (p. 258). This "could be" is notable in that it denotes something that is unknown. Is it fear? If so, what does that fear feel like? How intense or debilitating is it? What are its impacts? What is the sufferer afraid of? I intend to explore these phenomena in the present study.

The paper discusses the measures within the study and the questions used to gain data, most salient of which for the present discussion is the authors' *Interview on Help-Seeking*. The intention behind the questions in this interview seems reasonable to me – seeking to uncover the reasons for delayed help-seeking – although this is not a particularly phenomenological, experience-near approach, as it focuses more on *why* than *what* is experienced or *how* it is being experienced (Day, 2018). The responses shed some light on what it might be like for sufferers to disclose – for example: " I felt ashamed", "I feared", "I felt sad" (Belloch et al., p. 261). These are important words from sufferers themselves, however they seem too brief and without colour or shape, without a deepened sense of the experience: it leaves me wondering what "sad" or "afraid" feel like, what sense is made of this sadness or fear and what the effects on the person are other than stopping them from speaking, all of which relate to the gap I am attempting to address. For me this recalls Douglass and Moustakas's (1985) commentary on heuristic explication:

> In a study that focuses on the experience of anger,
> differentiating may define the relation of anger to worry, guilt,
> fear, frustration, hurt, criticism, and rejection; we may discover
> the places where anger is evoked … the situations … and the
> people… All contribute to a heuristic understanding of the
> phenomenon as an experience of being-in-the-world (p. 52).

The authors argue that delays in seeking help "have not been empirically explored from the point of view of the patients themselves" (p. 258). The use of the term "empirically" suggests to me a quantitative, positivist bias that arguably limits an exploration of human subjective experience in its fullness; I am, through the present research, aiming to open rather than limit an articulation of human experience.

Furthermore, the study is focused on the Spanish context; thus, I wondered how relevant it might be to me and my specific New Zealand socio-cultural context. To what extent, if any, might it reflect my voice? The researchers themselves speak to this, stating that their study design precludes cross-cultural comparisons.

10.2 Harrington (2014)

This thesis – entitled 'Emerging from the wreckage: The exploration of mental health, stigma, and my experience of living with obsessive-compulsive "disorder"' – includes aspects of OCD disclosure I felt drawn to because it is a first-person account. The author discusses stigma, shame and fear from her perspective, which led me to wonder how my experience, as a male, might be similar or different.

Harrington's words spoke to me. Her voice was present and redolent with feeling. I felt like I could see some of myself in her experience. Of the fear of disclosure to others, she writes: "They would tear me apart/And hold up my screaming pain/Only to shatter my heart" (p. 84). I can feel her experience here in a far more palpable and potent way than the use of the word 'fear' in isolation can offer. Having disclosed to her mother, she writes: "I have never been so disgusted with myself in all of my life" (p. 92). This is the first time I have encountered the word disgust in my literature search and in all of my previous reading, with the exception of material examining

contamination obsessions. This use of the term was not related to contamination obsessions; it was about telling one's mother about OCD for the first time. For me this feels far more painful and descriptive than the word 'shame' alone can convey. And while disgust is not a word that resonates for me, I appreciate hearing another sufferer's experience – I feel I understand her distress more deeply. Harrington says that revealing her secret to her mother was like being stabbed, and again these descriptive, emotive words help me to better comprehend the pain of her lived experience, and these are the kinds of experiences I want to add to and/or expand on in the present study.

10.3 Ozertugrul (2015)

This paper – entitled 'Heuristic self-search inquiry into one experience of obsessive-compulsive disorder' – stood out to me because it is a rare exploration and explication of an individual's lived experience of OCD. It represents, therefore, a courageous example of first-person, client-centred self-disclosure that adds to the "therapist-centred" (Ozertugrul 2015, p. 216) literature on OCD. I can hear some of my voice in his experience, but not what it is like to *reveal* the experience.

Ozertugrul himself argues that the study was needed in order to fill a gap in extant literature around the "experiences, feelings and actions of an individual with OCD" (p. 218). Ozertugrul's stance in this paper is one I relate to in the context of my own research: that, as a humanist, "the focus is on the person, not the problem" (p. 233). Ozertugrul sought to "add to the existing research in terms of what really takes place inside the mind and how that relates to the world outside" (p. 218), which aligns with the aims of my study, although it seems to suggest a bias toward cognition (the mind) over emotional experience, and I

believe both need to be considered.

I also found it an important paper in that it argues for the usefulness of heuristic self-search inquiry in understanding OCD; in concluding the paper, Ozertugrul transparently articulates a belief with which I approach the present study: that heuristic research in itself – the journey into oneself and the new insights that ideally abide in that search – can be healing. This recalls McWilliams' (2004) contention around the importance of self-knowledge in psychoanalytic or psychodynamic psychotherapy, and for me this is central to the process of psychotherapy for our clients.

10.4 Picco, Abdin, Vaingankar, Jeyagurunathan, Chong and Subramaniam (2016)

This paper – entitled 'Association between recognition and help-seeking preferences and stigma towards people with mental illness' – deliberately comes from a non-Western perspective; and, as with the Belloch *et al.*, (2009) study, I wonder about its differences from my study given my socio-cultural context. The Picco *et al.* study comes out of Singapore and refers directly to its relevance there.

However, the paper is framed by an arguably universal notion of mental health literacy that transcends socio-cultural schema in that this literacy can exist in its own unique form in any given context. In other words, clinicians' and the general public's knowledge of mental illness is important no matter where you live because, as Picco *et al.* argue, "the inability to correctly recognise mental health disorders can result in inappropriate help-seeking and delays in treatment seeking" (p. 84, citing Jorm, 2000). It is this literacy that my study seeks to augment.

The paper cites Australian studies (Wright, Jorm & Mackinnon, 2012; Yap, Reavley & Jorm, 2014) that support this phenomenon; the Australian context is socio-culturally closer

to my Aotearoa New Zealand context than the Singaporean one, and thus I see some of my story reflected here. Still, I wonder if the idea that the recognition of mental health disorders can improve treatment seeking is, in fact, relevant in every socio-cultural context. I would like to explore my lived experience in my specific context.

The paper's finding – that correct recognition of mental illness is associated with less preference to seek help from informal sources but increased preference to seek help from mental health professionals due to less perceived stigma – does not quite align with or reflect my experience with any fullness. There were times when I was unwilling to seek help from *any* source, and I want to explore this. I do, however, feel that it is generally easier to disclose my illness to mental health professionals than to friends and family, I just do not understand how this is so or what it is like; for me the Picco *et al*. study sheds little light on this phenomenon.

The study suggests that recognition involves labeling and that labeling can result in stigma. The contention seems to be that labeling can have negative implications for sufferers, and this gets closer to aligning with parts of my topic: it leans toward the disclosure of a diagnosis rather than the content or symptoms of a sufferer's experience. The study suggests that a label such as OCD can lead to delays in help-seeking because disclosure is difficult. It does not, however, explore why this might be the case or what the individual experience is like, which is what I would like to contribute.

The researchers' use of the word stigma throughout the paper seems to be an abstraction and is taken for granted in the experience of mental illness, including OCD. The researchers do not define the term, and it is as though it holds a singular, universal meaning and experiential quality. The term seems to be a catch-all that does not resonate for me and calls for further explication to give it a human colour. If I offer a hypothetical

phrase – "I feel stigmatised" – I find it means little in comparison to, for example, "My stomach tightens, my heartbeat is palpable and I want to scream and hide at the same time". These are the kinds of qualities I am seeking to explore in my study because I think they will give other sufferers a voice and provide mental health practitioners with understanding, empathy and client-centred literacy.

The study investigated the public's attitudes toward mental illness, including OCD. It is not, therefore focused on sufferers themselves. It does, however, attest to the kinds of contexts and attitudes sufferers like me can face as they seek to disclose and/or seek help. It leads me to think about my own experience of stigma and its relevance to my disclosures.

The study is quantitative rather than qualitative. Again: is my experience represented here?

10.5 Wheaton, Sternberg, McFarlane and Sarda (2016)

This quantitative paper – entitled 'Self-concealment in obsessive-compulsive disorder: Associations with symptom dimensions, help-seeking attitudes, and treatment expectancy' – opens with a statement that immediately stood out as problematic in the context of my own research, especially considering it seems to be one of the study's foundations: "Not surprisingly, individuals with OCD are often reluctant to disclose the content and frequency of their obsessions" (p. 43). Notwithstanding the fact that this statement attests to the focus being on disclosure of the *content* of OCD rather than the diagnosis itself as it is in my study, the statement contains a number of assumptions and biases.

I wonder why it is "not surprising" that OCD sufferers might be reluctant to disclose. For me this betrays a prejudice or stigmatising attitude on the part of the researchers, an assumption that the obsessions are inherently shame-worthy and need concealment. I

wonder to which individuals the researchers are referring; I wonder what "often" means. I wonder why these individuals are reluctant and what disclosing means for them.

Another question mark I have is that the study uses participants who self-identified, in some cases publicly (online), as having OCD. These are people who have, therefore, already disclosed enough to partake in the study, and so the research cannot take into consideration the experiences of those who find it impossible to disclose.

The study examines dispositional self-concealment – that is, those participants for whom self-disclosure in general is not naturally or characterologically favoured. And yet the participants are those who are more able to disclose than those who cannot participate – to study them as dispositionally self-concealing seems paradoxical. Moreover, I find the link between dispositional self-concealment and the concealment of OCD itself – the link at the heart of the Wheaton *et al*. study – to be tenuous: I am self-disclosing and transparent both personally and as a practising psychotherapist (I am influenced by Jourard (1971) and Maroda (2010) in this, as I believe therapist self-disclosure can foster client disclosure), yet I am highly reluctant to disclose my OCD to anyone. The Wheaton *et al*. study finds that those with OCD are more likely to conceal any aspect of themselves than a control, non-OCD group. This describes nothing but correlation; the way I read it, one variable, OCD, is implicated in a tendency to self-conceal or vice versa. The researchers note that the OCD group was comprised of significantly more females than the non-OCD control group. Might this also contribute to the results in some way?

The study examines OCD via four "most consistently reported symptom domains" (p. 44) or content themes such as contamination and hand washing. I see a problem here, too; for surely, if disclosure is difficult for those with OCD, there might be plenty of other non-reported domains that are not taken into account here and could alter the results

were they apparent. This attests to the need to more deeply understand the subjective experiences of OCD before we make too may assumptions. For example, only one of my symptom dimensions is present in this study, one of the least troubling. Thus, I am not represented here and I imagine others are missing too.

Moreover, the study describes no phenomenological dimension in the OCD experience of self-concealment. It employs the Dimensional Obsessive Compulsive Scale (Abramowitz *et al.*, 2010) to determine the severity of these symptom dimensions. These are rated 0–4, and one of the qualities they assessed was distress. This is not person-centred; it has no colour, no sense of human experience. What does distress even mean? What if my distress is at level 4 sometimes and level 1 at other times? What if it is level 5 or 43?

And again, the study is based on a premise of disclosure of OCD content rather than diagnosis itself. I wonder if it could be the diagnosis of OCD that might keep some sufferers from seeking help, which is a largely absent dimension I wish to explore.

The study outlines its limitations, and from my perspective they potentially invalidate the research. Primarily this: "No formal diagnostic interview was conducted with [the individuals who self-identified as having OCD] to confirm a diagnosis or evaluate comorbid conditions" (p. 48). Did the individuals have OCD and, if so, to what extent? One's subjective assessment of one's own OCD is not in itself problematic, however to use this group as an exemplar could be confounding. Furthermore, unawareness of comorbidity – or, indeed, such things as character styles (Johnson, 1994) – is confounding, in that we do not know how may of the participants, in either the OCD or the control group, suffer from conditions or personality structures that limit or increase their tendency to self-conceal.

The researchers conclude that their self-concealment findings "may be an important factor to consider in relation to OCD" (p. 48). This seems appropriate, and paves the way for further investigation.

10.6 Robinson, Rose and Salkovskis (2017)

I found that this article – entitled 'Seeking help for obsessive compulsive disorder (OCD): A Qualitative study of enablers and barriers conducted by a researcher with personal experience of OCD' – has a much more human feel to it, as participants' voices emerge. In exploring barriers to and delays in seeking treatment, the paper at one point discusses participants' experiences of concealment of the disorder by framing it in terms of its relationship to stigma from people in general and doctors specifically. Stigma is not defined, however, remaining an abstraction with no sense of what it feels like or how it impacts upon an individual. In saying that, though, the study does give more of a flavour of the experience through quotes from participants such as "I felt embarrassed" and "it is a sense of shame" (p. 199). I am still left wanting to know more about how the participants felt, what might be underlying this shame, what they experienced and why this might stop them from disclosing.

A sub-theme that received scant explication in this paper was that of patients "feeling too vulnerable" (p. 202). A participant says they were feeling "exhausted, so ill, and stressed" (p. 202), which gave me a sense of what vulnerability might have truly felt like for that person. I would like to add my voice to this in order to strengthen or broaden the findings.

The word fear – or derivatives of it – is used 21 times in the study, yet I was left with no sense of what that fear experience actually felt like beyond denotative abstraction. The

paper's first author felt that this fear element had been "underestimated" (p. 207) in previous research that employed "checklist/survey" (p. 207) methods, which again motivated me to add my voice and experience to the extant literature.

I found myself appreciating the fact that the researchers considered OCD concealment from many angles, which is uncommon in the literature. However, the sub-themes were not discussed in the kind of depth that gave me a feel for the participants' lived experience. The researchers themselves implicitly acknowledge this as they seek to understand the participants via observation; they offer simple hypotheses that I found wanting. For example, while discussing the "I can manage" dimension of non-help-seeking participants, the researchers state "this could be seen from the outside as a form of stoicism or even heroism … [that] could be linked with … high levels of responsibility" (p. 207) that they see as part of the OCD experience. I cannot help seeing this as an assumption with a lot of 'coulds' associated with it – I get no sense of what this stoicism might be like, what informs it, or if it even exists; I would like to hear more about this from the participants themselves.

11. Chapter summary

This chapter outlines the context of the present study and the ways in which I went about locating a 'gap' in the extant literature that might justify the asking of my question. I briefly discuss that my literature search and review process was underpinned by a heuristic sensibility favouring the subjective and post-structural response, which I see as more of a literature 'view'. I began my search by extensively exploring the intersections between the disclosure and OCD literature and give detailed examples of how I went about my search of published articles pertaining to psychotherapy. I found that there is a dearth of literature in

my area of concern from the sufferer's perspective, and thus there is limited sense of human experience; I seek in the present study to address this limitation. I argue that difficulty disclosing leads to delays in help-seeking and negative outcomes, which my study seeks to address. I discuss the prevalence of shame and stigma in the literature, which seem to be abstractions without a human element. I then offer an in-depth critique of six relevant papers, which again highlights the gap in the literature around sufferers' experiences of OCD and disclosure or concealment and provides justification for the study I have undertaken.

Chapter 3

Ways of looking: Methodology and method

Your visions will become clear only when you can look into your own heart.
Who looks outside, dreams; who looks inside, awakes. – Carl Jung (1962)

1. Introduction

In this chapter I define in general terms the heuristic methodology and method as

delineated by Moustakas (1990). I outline some of Moustakas's influences and

philosophical foundations and explore a critique of the potential for the methodology to be

self-absorbed and therefore less generalisable. I discuss my own ontological and

epistemological position in undertaking the research, which includes my subjective focus

from post-structural and phenomenological paradigms. I then outline my specific heuristic

methodology and method, which align with Sela-Smith's (2002) heuristic self-search inquiry

(HSSI). I critique heurism and offer some thoughts on alternative methodologies. I then

discuss my method in more detail.

2. A focus on the self

For the present study I am using a variation on the heuristic methodology described by

Moustakas (1990), aligning myself more closely with Sela-Smith's (2002) heuristic self-

search inquiry (HSSI) in order to fully explore my inner experience. I expand on HSSI below.

      Heuristic research is a "process of internal search through which one discovers the

nature and meaning of experience" (Moustakas, 1990, p. 9). An issue, problem, challenge

or theme is focused on with a full inner, introspective, reflective awareness so that the

researcher can "come in touch with new regions of [him or her] self" (Moustakas, 1990,

p.9). For me this aligns with the notion that psychodynamic psychotherapy seeks the growth of a client toward deeper self-knowledge and self-acceptance (McWilliams, 2004).

As Etherington (2004) contends, my "self" will become my "major tool"; I will use "intuition, tacit knowing and felt sense to illuminate the "person at the heart of the work" (pp. 16-19). In short, the researcher is researching his or her own experiences, aiming to "reveal the *actual* experience" (Douglass & Moustakas, 1985, p. 45; italics mine). The researcher experientially (and phenomenologically) seeks to uncover "that which is, as it is" (Douglass & Moustakas, 1985, p. 40).

3. Undertaking heuristic research

The heuristic method as Moustakas (1990) conceptualises it comprises seven core concepts; these are the mechanisms of engagement with the self and the research question, the inextricably linked and non-linear processes underpinning each stage of the enquiry. The following outline is a brief example of how I understand and engage with each of these:

- Identification with the focus of enquiry: I explore and "become one" with the question (Moustakas, 1990, p. 15).

- Self dialogue: I engage back and forth internally, again and again in an open way, with the phenomenon and my experience of it as it develops.

- Tacit knowing: I just know; an implicit, untapped source of meaning; unique perceptions, feelings, intuitions, beliefs and judgments are sought.

- Intuition: Somehow knowing I know; a bridge between implicit and explicit knowing formed via indwelling.

- Indwelling: To gaze "unwaveringly" inward (Moustakas, 1990, p. 24); to remain with the experience without requiring it to take distinct shape; to allow intuition to flourish.

- Focusing: Precise engagement with the experience; mindfully noticing what it is that is thematically emerging internally in relation to the research phenomena.

- Internal frame of reference: Subjectivity. I wonder if there is any other way to understand anything?

These concepts appear in various forms throughout the heuristic process, with no structure or prescription. They emerge during each of the six phases of heuristic research (Moustakas (1990). These phases are:

- Initial engagement: In which I find and grapple with the topic, the question and the research frame; am I passionately driven to enquire about this and find something previously unknown about it?

- Immersion: In which I fully live (and journal) the experience of truly wondering about and feeling what it is like to disclose or conceal my OCD

- Incubation: In which I will 'leave' the research to allow my tacit and unconscious knowing to emerge, for my intuition to develop

- Illumination: In which I might find new and unexpected insights, themes and qualities

- Explication: Involves re-immersion in the data as I seek to understand, clarify and delineate the core or dominant themes within the research phenomena

- Creative synthesis: In which I will express the transformational nature of the research experience

These phases are at times non-linear, building on each other and occasionally looping back – for example, I found that illumination and explication occurred throughout the research process.

4. Looking in to see out

Heurism stood out as the most appropriate fit for my research question for three key reasons: firstly, my question is a deeply personal one that seems to call for what Moustakas (1990) described as a "steady inward gaze" (p. 13) before I can come to new understandings of myself. Secondly, this process will help me to better know myself and my contribution to – my role in – the therapeutic relationship (McWilliams, 2004; Shedler, 2010; Stolorow, Brandchaft & Atwood, 1987), widely believed to be the most crucial element of the healing endeavour of psychotherapy (Haugh & Paul, 2008; Kahn, 2001; McWilliams, 2004). Thirdly, I think the study will contribute to the field of psychotherapy because it will give clinicians and researchers a rich, colourful insight into what it is like for a person to be immersed in the distress of an OCD concealment/disclosure dilemma, which could also aid the development of a strong therapeutic relationship. I also argue that this phenomenon has some relevance to the concealment and disclosure of mental illness more generally.

5. Toward heurism

Moustakas (1990) names several influences, of which two in particular – Michael Polanyi and Sidney Jourard – felt eminently relevant to me as I considered my research topic and heuristic methodology.

Polanyi's (1966) articulation of the tacit dimension of human knowing posits the idea that we can turn our attention inward to find what we are perhaps intuiting – what we know without knowing we know it. In considering tacit knowing to be one of the seven concepts or processes of heuristic research, Moustakas (1990) argues that it underlies all heuristic discovery. He gives the example of a tree: we know without knowing that a tree is a tree based on a sense inside ourselves that the sum of its parts somehow generates the sense of treeness. I wonder, though, about the steps prior to this, namely that one needs to be taught what a tree is, taught that the concept of tree exists.

Or perhaps treeness is a poor example: perhaps an emotional knowing is more relevant here, because even a naïve infant 'knows' the feeling of distress or joy without needing to know what it is or what word is used to describe it. The implications of this seem to me to be relevant to the present study: I experience something when I cannot disclose OCD but I do not know what it is. I believe, though, that I know tacitly, and an heuristic inquiry might help me to comprehend what that is.

For me this is closely related to the psychoanalytic notion of the human unconscious, first introduced to the field of psychotherapy by Freud (1896) and remaining as one of its foundational concepts. This is material that lies deep within us, material we might access as we explore our inner experience. Moustakas (1990) believes that ignoring this dimension means "we restrict the potential for new awareness and understanding … the depth of meanings that are inherent in every significant human experience" (p. 22). It is this new awareness I am seeking in the present study.

Polanyi (1966) postulates that "indwelling … is the proper means of knowing man and the humanities … the mind of a person can be understood only by reliving its workings" (p. 16). Indwelling became one of Moustakas's (1990) phases of heuristic research and the key means of self exploration. Polanyi also argues that it is not just the mind that can be understood in this way, but that tacit knowing, discovered through indwelling, is the root of *all* knowledge (1966, p. 55).

Jourard's (1971) writing is cited in Moustakas's (1990) work and has helped inform my understanding of the heuristic methodology and its relationship to psychotherapy practice. In exploring the underpinnings of heurism, I found that Jourard (1971) believed a therapeutic alliance based on authenticity, empathy, congruence, acceptance and trust is paramount, and that the dyadic effect – the idea that therapist disclosure encourages client disclosure – would be key to the facilitation of this. Jourard (1971) argues that the client's disclosures in themselves are therapeutic because they have probably not been able to know or express themselves authentically before. They have found parts of themselves previously unknown to them. Jourard (1971) aligns knowledge of our "real selves" (p. viii) with good health: if we know ourselves as fully as we can, we can achieve growth. This reflects one of the aims of the present study.

I came to see therapist self-disclosure as a useful technique, but if I am to use it, then surely I need to know myself deeply first; I need to know my own unconscious or tacit dynamics. This would require a self-reflective enquiry – such as that inherent in heurism – and the present study has allowed access to some of the deeper recesses of my experience, which in turn has allowed me to better comprehend what might be going on for a client who is finding disclosure difficult.

6. Philosophical foundations

I am seeking here to articulate my interpretation of heuristic epistemology in order that the reader has a clearer sense of how I have approached my research. I was drawn to self exploration for my dissertation because I had many unanswered questions about my OCD and why I hide it. The answers, surely, come from within and from my engagement with the world as a subjective individual. I embarked on this philosophical enquiry in order to explore my ontological standpoint, seeking to understand – primarily for my own edification – whether or not I could argue a case for using myself as the focus of research. Thus, in order to understand the methodology I have chosen, I explored its philosophical underpinnings, which, for me, have subjectivism at their core. I found it was important to think broadly about subjectivity, as its presence seemed to me to have potential implications for the validity of heurism – in short, I was wondering about the validity of subjectivity in research, a topic I explore more fully in my discussion chapter.

Offering a critique of heuristic enquiry, Del Loewenthal (personal communication, 24 April, 2018), who has written on heurism (Loewenthal & Winter, 2006), suggested to my heuristic study group that the methodology is "too self-centred"; he wondered about the presence of the Other and argued that heurism assumes we are not "subject to authority". This gave me pause; I was already underway with my heuristic research, and here was a suggestion, from a prominent psychotherapist and researcher, that it was not valid in a fundamental way: it may not be relevant to anyone but the researcher. It left me wondering if I should take note of what this authority was saying and change my methodology; I wondered about the applicability and generalisability of subjective introspection and self-refection in research. Moustakas (1990) contends that the

judgement as to the validity of the heuristic research lies solely with the researcher at the conclusion of the six stages of the enquiry. I would argue that this does not complete the picture: surely, if I take as my foundation the idea that subjectivity is the only true measure of 'reality', then it will be the receiver of this new knowledge who will make the decision about the validity of the study – for them.

So I decided to read and think about heuristics and its epistemology and what had drawn me to it in the first place. I felt my story would have relevance to others and to the field of psychotherapy, but I needed to establish a firm foundation and justification for exploring and explicating it heuristically.

Bertrand Russell (2005) suggests that subjectivism – "the doctrine that knowledge is merely subjective and that there is no external or objective truth" (Oxford English Dictionary, 2000) – derives from Descartes; and Husserl, noted as one of the originators of phenomenology (Smith, 2013), concurs with this assessment (Smith, 2003). This perhaps lends weight to the heuristic approach I am using, for as Rose and Loewenthal (in Loewenthal & Winter, 2006) and Ozertugrul (2015) contend, heurism is phenomenological.

Moreover, Descartes gave us *cogito, ergo sum* – I think, therefore I am – which I interpret as core to human experience and meaning-making; in fact, in discussing phenomenology, Smith (2003) argues that Husserl believed "it was the recognition of the subject, of one's own conscious self, as the one indubitable, apodictically certain being … that was Descarte's historical achievement" (Smith, 2003, p. 12). In the conceptualisation of heurism, Moustakas (1990) draws from Descartes, essentially naming the *cogito* as "the perspective of the heuristic researcher" (p. 11). This helped me make the decision to use heurism to explore my lived experience.

Subjectivity is foundational to Husserlian phenomenology, which focuses on "the meaning things have in our experience, notably the significance of objects, events, tools, the flow of time, the self, and others, as these things arise and are experienced in our 'life-world'" (Smith, 2013). Thus, phenomenology privileges the individual and the "concern for the coherence and ultimate basis of experience" (Dostal, 2000, p. 53). As Dostal (2000) argues, "a leading impulse of Husserl's early work is to turn away from the construction of abstract theories to the concrete description of the 'things themselves'" (p. 53). For me this means that the first person perspective is central to the experience and perhaps the understanding of ourselves, others and the world. As Grant and Giddings (2002) argue, truth is subjective, which suggests to me that one might be able, through subjective exploration and explication, to move beyond abstractions toward a felt sense of the essence of a phenomenon, which is precisely what I am attempting in the present study: to find a deeper understanding and articulation of my experience of disclosing or concealing my OCD.

7. A paradigm blend: Post-structuralism and interpretivism

For me, heurism and phenomenology are underpinned by a post-structural (and, to a lesser extent, an interpretivist) paradigm. Again, subjective experience is front and centre: in the post-structural paradigm, "research accounts will always be partial and subjective, even contradictory, because meanings are 'multiple, unstable and open to interpretation'" (McCouat & Peile, 1995, p. 10). Use of the word 'meaning' here is noteworthy, for it suggests interpretation of some kind has taken place, even if it is a singular, subjective and slippery meaning.

According to Grant and Giddings (2002), interpretivism is Husserlian (back to 'the things themselves') and enquires into "what it is to be human" (Grant & Giddings, 2002, p. 16). This is what I am trying to achieve in the present study, for I see each individual's experience of the world as unique, as their 'truth'. Reader-response criticism, for example, posits that each reader finds his or her own meaning in a text and, in fact, is writing the work as they read – as the post-structuralists contend, there is no one correct interpretation of a text (Abrams, 1988; Brooks & Browne, 2012). Hence, I believe it is incumbent upon me, especially as a psychotherapist, to privilege individual experience – including my own – as I encounter clients and their perspectives on the world, especially considering the potential socio-cultural differences between us in the bicultural and multi-ethnic context of Aotearoa New Zealand. This is reflected in the phenomenological process of psychotherapeutic engagement, which studies the "structures of consciousness as experienced from the first-person point of view" (Smith, 2013). According to Langdridge (2013):

> The phenomenological method is focused on rich description of how the world appears to people rather than drawing on theories which move beyond experience itself. So when thinking psychologically we try to stay as close as possible to how things are experienced by people and attempt to understand what the world is actually like for other people, rather than fit people into our existing theories of how we operate (p. 2).

Human experiences are broad and deep and evasive; they "range from perception, thought, memory, imagination, emotion, desire and volition to bodily awareness, embodied action and social activity, including linguistic activity" (Smith, 2013). I want to use heurism to explore and articulate my experience, my 'truth'. In contrast, positivist,

quantitative paradigms arguably equate to an empirical search for an unequivocal Truth (Grand & Giddings, 2002; capitalisation mine); I do not expect to find something finite or to uncover cause and effect.

The post-structural paradigm from which I operate in this study privileges the primacy and inevitability of subjectivity, and the lens is focused on multiple, unstable and interpretable experience; the words used in some of the literature I review in chapter 2 – such as "afraid" and "sad" – appear to me to offer singular meaning and cannot be universal because language is connotative, socio-culturally situated and subjective (Grant & Giddings, 2002). It is for this reason that I have outlined my socio-cultural context in the first chapter: it is impossible, from the post-structural perspective, to "stand outside the traditions or discourses of [my] time" (Grant & Giddings, 2002, p. 20).

I am interested in expanding my understanding of words such as "afraid" and "sad" and articulating a rich human experience. According to Grant & Giddings (2002), the post-structuralists contend that our sense of ourselves as "conscious, knowing, unified and rational" (Grant & Giddings, citing Weedon, 1997, p. 21) is illusory. So while I make an attempt at explication during my research, this process cannot result in objective truth. It will be, necessarily and wholly, *my* truth, which is precisely what I am seeking as I answer my research question. There will be complexity and contradiction, which Grant and Giddings (2002) acknowledge stand in contrast to attempts at simplification or reconciliation, and my experience of concealing and disclosing my OCD will evade a pinning down. All I can do is explore, wonder and keep exploring; I will rest, always tentatively, on new insights, which for me describes the process of practicing psychotherapy.

8. Heuristic self-search inquiry (HSSI)

Sela-Smith (2002) argues that heurism involves a "free-fall surrender to the process …

of personal, subjective experience [which is akin to] a leap into the darkness" (p. 70).

My intention is to align with Sela-Smith's departure from Moustakas's method, a

departure she has called heuristic self-search inquiry (HSSI). This research method

aligns closely with the present study in that I am the sole subject of enquiry. I have, as

Sela-Smith (2002) suggests, "no hypotheses or expectations regarding outcomes" (p.

83); I am trying to be as open as possible to what comes as a result of my surrender

as I discover what it is to be me. Again, this recalls for me the process of

psychotherapy as defined by Shedler (2010), which I have outlined in chapter one.

For Sela-Smith (2002), it is the subjective, internal search that is key: it leads

to the tacit dimensions of one's inner world, and to feeling and knowing oneself. Sela-

Smith (2002) argues that interviewing other research participants – the approach

employed by Moustakas – stands in conflict with the heuristic notion that "there can

be only one subject for self study and that is 'I'" (Sela-Smith, 2002, p. 78); Sela-Smith

believes that the researcher's internal focus on their own experience gets lost

beneath an engagement with observed interviewee phenomena. Moreover, her ideas

link with what I have argued above regarding subjectivism and post-structuralism:

"my outer world is formed of my inner world" (Sela-Smith, 2002, p. 85).

In the present study I am seeking insight into my own experience with no

expectation to make objective sense of it. As Sela-Smith (2002) points out, "the

feeling response, as experienced, is valid as it is" (p. 79); she argues that the study

needs to be a "self-focus on feeling an experience" rather than "thinking about and

observing experience" (2002, p. 82). For me the latter approaches positivism and

ignores a "story of transformation" (Sela-Smith, 2002, p. 82) that lies at the heart of both the heuristic and the psychotherapeutic endeavour. This is why I have chosen HSSI: because deep, introspective reflection without judgement could help me understand and accept my experience as it is.

HSSI is a step into the unknown of the experiencing self; Sela-Smith (2002) argues that there is "no controlling the process" (p. 83). However, I cannot forget that Moustakas (1990) also writes of this surrender, this free and open defiance of "the shackles of convention and tradition" (Douglass & Moustakas, 1985, p. 44). Sela-Smith's (2002) critique of Moustakas hinges on the idea that those who follow his method do not fully surrender inwardly because they are largely focused on the "explication of experience [from] coparticipants" (p. 70), and, again, I want to avoid this by using HSSI. Sela-Smith (2002) contends that Moustakas, by using participants, moves away from self-experience as "the single most important guideline in pursuing heuristic research" (Douglass & Moustakas, 1985, p. 46), but I wonder if this is an absolute: Might the heuristic researcher not explore his or her own experience even if it is in response to interviewees, and is this not an important consideration when thinking about the dynamics of the therapeutic relationship? For, as Douglass and Moustakas (1985) argue, "one's ability to encounter other people and the world is no less important than the facility for plumbing one's own self experientially" (p. 51).

I am drawn to HSSI because to me it seems closely related to the self-reflection students undertake as a core part of psychotherapy training at Auckland University of Technology (AUT). The 2018 handbook for PSYT808, *Reflexivity and Relational Skills II* (Solomon, 2018) states that the paper aims to: "Enhance and refine [students'] capacity to reflect upon [themselves] and others and to develop [their]

capacity to engage effectively with others in a manner consistent with good outcomes in psychotherapy" (p. 5). This recalls Moustakas's (1990) contention that heuristic self-search is commensurate with psychotherapeutic engagement itself. I believe this self-reflective process engenders a degree of inner knowing, which, again, is useful in understanding the dynamics within the therapeutic relationship.

The present study will focus on an aspect of my inner experience "whose nature is largely unknown" (Moustakas, 1990, p. 13). In doing so I will be "actively awakening and transforming my own self" (Moustakas, 1990, p. 13). For me this process again recalls McWilliams' (2004) contention that the client's self-knowledge and self-acceptance are the goals of therapy. Again my HSSI seems analogous to the practice of psychotherapy – of the growthful journey into one's somatic, emotional, cognitive and spiritual experience (McWilliams, 2004, 2011; Maroda, 2010). As Sela-Smith (2002) writes: "a relentless inward focus can lead to greater self-understanding, self-transformation, and reconstruction of a hindering worldview (p. 80). Psychotherapy involves a guided heuristic process for clients, one I am experiencing *in vivo*.

In my view, Sela-Smith's method in part reflects the post-structural paradigm from which I am currently working, but there is at least one notable exception: she contends that "the researcher is coming to understand something within that is also a human problem or experience" (2002, p. 64), suggesting a universality within a unique experience. For me there exists here a tension that I grapple with: While I acknowledge that post-structuralism privileges unique, subjective perspectives, one of my aims for the study is to extend the findings beyond myself, to contribute to the body of knowledge and speak to other sufferers and clinicians. I believe this tension

can be reconciled, as I discuss in the final chapter. For now, though, I approach this problem via the HSSI method, which seems far less focused on knowing than is the Moustakas method. An examination of some of the language used by Douglass and Moustakas (1985) might shed some light on this latter point.

9. Douglass and Moustakas (1985): Knowing, subtleties and OCD

My first response to this article – entitled 'Heuristic inquiry: The internal search to know' was from my perspective as an OCD sufferer. Its sub-title articulates a core and distressing experience for me: knowing, being sure, doubting again, seeking certainty; this is my OCD dynamic. Thus, a methodology that favours knowing felt a little challenging.

Moreover, one of my most pronounced learning edges as a new psychotherapist was that I had, in practice, a desire to know the answers, to be right, to fix. There is something of the OCD sufferer in this experience. I have had to work hard to pull back from this and to wonder more, to be more tentative and sit with not knowing the answer, not being the expert, and this has been a theme throughout my training; as one of my supervisors (Brian Broom, personal communication, 15 August, 2018) offered: "Good psychotherapy is never knowing what to do next".

The Douglass and Moustakas (1985) article is replete with language privileging knowing, and thus feels positivist in tone. The terms "essential meanings" (p. 39), "clarifying the meaning" (p. 40), "disclosing truth" (p. 40), "definitive exposition" (p. 40), "root out its meanings completely" (p. 40-41), "judging correctness or incorrectness" (p. 41), "the actual nature and meaning" (p. 43), "the truth of what is" (p. 44), "the knowing of the phenomena" (p. 48) contradict some of the core heuristic concepts and processes outlined

in the paper, and they certainly seem to contradict the post-structural paradigm I am

aligning with.

There are further examples of this contradiction. Douglass and Moustakas argue

concurrently for an accurate "description of the textures and structures of human

experience" (p. 40), which suggests a more phenomenological approach that favours a

subjective articulation over a definitive truth, yet they also write of "shadings and

subtleties of meaning" (p. 41), which seems not to fit with the accurate actualities they

seek. Likewise, they advocate "untapped aspects of awareness … that elude analysis or

explanation" (p. 49) while seeking to "know". Again, this is one of the reasons I leaned

toward HSSI, which seems to stand further back from 'definitive expositions' and

'correctness'.

10. Methodology or freedom?

Douglass and Moustakas (1985) offer a clear delineation of heuristic research. However,

another contradiction appeared as I explored the methodology and method, one that

contributed to my favouring of HSSI: the authors outline a clear methodology and method,

as does Moustakas (1990), while at the same time suggesting a heuristic researcher be

unbound my methodology. They describe heurism as an "attitude" (p. 42) rather than a

prescriptive approach; they suggest that heurism "has a path of its own" (p. 44), which

seems true in that there is no step-by-step requirement save the movement from initial

engagement to creative synthesis via a necessary incubation phase.

Thus, there do exist defined phases that could reflect the very "shackles of

convention and tradition" (p. 44) the authors are attempting to eschew. "Freedom",

"flexibility and "openness" (p. 44) appear as core tenets of this heuristic endeavor, and I am

not trying to say that they cannot co-exist with the six phases of heuristic research; what I am suggesting is that Sela-Smith (2002) offers an approach that moves even further from the aforementioned shackles. Douglass and Moustakas (1985) mention their denial of "predetermined methods" (p. 49) while offering predetermined methods. As Sela-Smith (2002) argues regarding Moustakas's (1990) later work: "he creates a methodological structure for a process that he himself states must take place free from methodological structures if it is to be authentic" (p. 77). Her HSSI methodology is certainly less definitive; it is a surrender to feeling, a surrender to experience as it is – there is no "controlling the process" (p. 83) and no method outlined. For me, as I subjectively encounter myself in my concealment and disclosure of OCD, this feels potently liberating.

11. Alternative approaches

I considered several other methodologies and methods, such as hermeneutic literature review, which will have allowed me to explore and explicate others' experiences of or ideas about OCD disclosure; however, this is not what my question requires. Moreover, there is very little published material to engage with in this area, particularly from the client's perspective; the same can be said for thematic analysis, which to me feels like a leaning toward a precise distillation or essentialism with which I was uncomfortable. I would, I believed, be left with abstractions rather than a felt sense, not to mention the fact that I had a distinct dearth of material with which to engage.

Hermeneutic phenomenology appealed, however I felt it would lead to circles of interpretation (Baynes, Bohman, McCarthy & McCarthy 1987; Grant & Giddings, 2002; Laverty, 2003). For me, this methodology seeks to make sense of phenomena,

and usually phenomena outside of oneself; at this stage of my inward exploration I was more interested in description and finding an essence of something rather than leaning closer to the seeking of objective 'truth'. My interest in the present study lies in articulating a quality, a sense of what it feels like to conceal or reveal an OCD diagnosis. I am not trying to make any definitive interpretation *per se*. In saying that, though, I want to reiterate the fact that I am, in part, working from an interpretive paradigm that looks for meaning; this position is not in conflict with my post-structural leanings, however this meaning-making is my own and is "partial and subjective" (Grant & Giddings, 2002, p. 20).

12. Method: My process

In keeping with the HSSI methodology, I approached the study with no firm plan or prescribed approach other than a desire to somehow address the six stages of heuristic research outlined by Moustakas (1990), although not in any preconceived order. I did this because I needed some framework to which to tether myself. It was also important for me that I had a precise question to anchor me and to focus the study.

From the outset I wrote a journal outlining my somatic, emotional and cognitive experiences, writing down whatever seemed relevant to my research topic of disclosing and concealing my OCD, no matter how insignificant it appeared at the time. This was a spontaneous, organic and unsystematic process; I opened myself as fully as I could to these experiences. I wrote my responses to acts of concealment and disclosure both past (from memory) and present, as well as to literature, film, music, art, clinical supervision and academic literature. I also wrote anything that struck me as relevant during my daily life – anything that related to the anticipation of disclosure, actual disclosure or the experience

of concealment. This was an intuitive process in itself; it was uncensored as it made its way into the journal and was part of my heuristic surrendering and immersion.

I experienced a period of incubation once I had been adding to my journal for several months. I took the time to complete other work for my psychotherapy training and engaged with the material on a tacit and intuitive level. I then returned to my journals but felt the need to re-immerse myself in a more focused way. This involved leaving home for a week, as I describe below. Next, I allowed for another incubation period of several weeks before writing my discussion.

13. Withdrawal and searching inward

I strongly felt that I needed space and solitude in order to deeply re-immerse myself in my journal data. I wanted as few distractions as possible so that I could feel and experience myself as I engaged again and again with my journal entries. To facilitate this I went away from home for a week. I left Auckland alone and drove to Lake Taupo, a large body of water in the central North Island of Aotearoa New Zealand. It is one of my favourite places – beautiful and restorative, redolent with memories of past holidays with my wife and, later, my family. But it is also associated with OCD and its accompanying intense anxiety. It is a place that represents both healing and suffering, and so I felt it might move me into a frame of being that could help me explore my experience of concealing and disclosing OCD.

The first thing that happened when I sat down to undertake this process in Taupo was that I had no idea what to do next. I wondered if this had something to do with the risk I am taking in disclosing my OCD in the act of writing this dissertation: perhaps I am scared of the exposure. I explored this during my immersion and the results are in the findings chapter. I then decided to look at someone else's heuristic dissertation for inspiration. This

was a mistake, as it confused me, leading me down a path that was not my own. I became a little anxious so I went for a run to clear my head and to relax. While I was out I decided to split the work into two categories: concealment and disclosure; I would then go back through all of my journaling, arrange the material into those two categories, and then re-immerse myself in them to see what themes emerged.

This process encouraged many written stream of consciousness responses that flowed as I engaged with the material in a freely associative manner. As Moustakas (1990) suggests, I became one with my experience; there was a kind of self-dialogue process, although this does not quite describe what happened: I focused on the material during indwelling, letting my tacit knowing emerge via intuition as to what felt subjectively important. This involved feeling: as Sela-Smith (2002) describes, it was a "stepping into the unknown within feelings", a "surrender into feeling-the-feelings" (p. 83). This provided moments of illumination I articulate in the findings chapter below.

I then repeated this process with the new material. In doing so, I deepened my experience, getting closer to some sort of felt quality. The feeling parts of me were not only sensate but expressed outwardly for me to explore again in writing. I tuned in to my thoughts, embodied responses and emotional experience.

During this process I found that I could not draw diagrams or charts to represent my experience; they simply did not seem to fit for me, while writing felt absolutely congruent; it is the form of expression I have engaged with personally and professionally my whole life, having completed an Honours degree in English, written fiction and worked as a magazine writer and editor. This is how I feel comfortable, and, in fact, it was not even a conscious decision: this is simply how my responses flowed out of me.

14. Chapter summary

In this chapter I have offered an outline of the heuristic method as an inward-looking search that aims to uncover the essence of one's experience. I have outlined its seven core concepts and the six phases of the process. I have discussed the ways in which this method is suitable for my topic and question, including the notion that the deeply personal and experiential nature of the question itself calls for introspection; this will hopefully provide me with new understandings of myself, including my role in the therapeutic relationship, but it could also augment mental health practitioners' understandings of what it is for sufferers to face the dilemma of disclosing or concealing their experience.

I argue that this might have implications on help-seeking behaviours. I discuss the influences on and underpinnings of the methodology and outline my philosophical standpoint in undertaking the research in the way I have undertaken it, and this includes details of my focus on subjective experience from a post-structural and phenomenological perspective. I then outline the HSSI methodology I employ in the study, which involves a free fall surrender into the self. I offer critique of Douglass and Moustakas (1985), including of their focus on 'knowing'. I discuss alternative approaches to my study. I end by outlining what I did during the study, which involved immersion in my experiences with the research phenomena, journaling and stream-of-consciousness re-immersion with the journal material in order to arrive at core themes.

Chapter 4

On hiding and being seen: My findings

1. Introduction

I am intending, via this study, to better understand my experience of concealing and revealing my OCD to others. Everything I have responded to and engaged with during the research has been in service of this goal. This chapter focuses on the themes that emerged from my research process, which is the explication of raw data in Moustakas's (1990) heuristic research methodology.

The themes are based on data gathered in my journals over a period of five months. I have articulated this process in the method section of my methodology chapter.

2. Concealment of my OCD

This is my default setting, so to speak, and a large part of the present study seems to relate to *why* this might be as I explore the experience of concealing my OCD. The 'why' part seems to be explained, at least in part, by the themes outlined below.

2.1 Theme 1: Concealment and fear

On its own, the word fear is an abstraction, a denotative piece of isolated language. And yet language is metaphor; it is connotative and coloured and contextual and means something particular to each person experiencing it in each moment it is experienced. What does this fear mean to me when I think about disclosing my OCD?

One of the things I spontaneously responded to during my research was a YouTube clip (Ruudzik2, 2008). In 2017, two of my music heroes took their own lives.

Chris Cornell of Soungarden and Audioslave, and Chester Bennington of Linkin Park were highly regarded, famous and wealthy musicians. Both battled mental health problems and hardly anybody knew what that experience was really like for them. Despite ostensibly having it all, these two men could no longer live.

I discovered a clip (Ruudzik2, 2008) of these two men performing together; I find it very powerful. These are the words they are singing, from a song called 'Crawling' (Linkin Park lyrics, n.d.):

Crawling in my skin
These wounds, they will not heal
Fear is how I fall
Confusing what is real

There's something inside me that pulls beneath the surface
Consuming, confusing
This lack of self control I fear is never ending
Controlling
I can't seem
To find myself again
My walls are closing in

(Without a sense of confidence I'm convinced
That there's just too much pressure to take)

I've felt this way before
So insecure

Crawling in my skin
These wounds, they will not heal
Fear is how I fall
Confusing what is real

Discomfort, endlessly has pulled itself upon me
Distracting, reacting
Against my will I stand beside my own reflection
It's haunting how I can't seem
To find myself again
My walls are closing in

As I watched the video I had many responses, first of which was that these men were creatively disclosing their pain. During my immersion in the video, the following stream of consciousness journal entry emerged:

> *They can speak. Or can they? Why can't I? In their way they did. Did anyone listen? Will anyone fucking listen? Fear. Fear. Dread. What will they think of me? That's the key. Sharp tears gather. Anxiety brews and churns in my guts. I want to be there with them and tell them. Hold them. Why is this? They are me and I am them. We are men and we are tough and flawless and strong and invulnerable. Or what? Inside I am still and burning and dead and alive and afraid and yearning. Yearning? To be known. But then they will know all of it. I can't. And yet they are gone. Gone. Where am I? They are so alive. And yet dead. So powerful, so vulnerable; so adored, so alone. Men and sweat and guts and strength and voice and voice and voice. Where's my voice?*

I then left the lyrics, the clip and my response alone for a number of weeks' heuristic incubation, which involved tacit knowing and intuition, before returning to them. Then I wrote another response as I again immersed myself in these words – involving heuristic intuition, illumination and explication. I wrote a spontaneous series of words, this time without punctuation as it seemed to emerge freely, untethered, from within:

> *awe loss pain envy fear power hurt hidden determination fight*
> *pity hero guts voice courage secret scared alone gone*

I then went back to these words and noticed my embodied responses more this time. There was a feeling of leaping out of my body, of my soul/guts/self needing to explode into the world. It was nervy and energised and it was moving upwards and it gritted its teeth and said no and why. It filled my abdomen and chest. It was colourless and shapeless and free. Yet it is tied down inside by chains of dread. I continued exploring in

this vein. My responses contributed to a theme I could begin to explore: Fear. Here is

what I felt and wrote:

> *Leaping out of my body, my soul/guts/self needing to*
> *explode into the world. It was nervy and energised and it was*
> *moving upwards and it gritted its teeth and said no and why.*
> *It filled my abdomen and chest. It was colourless and*
> *shapeless and free. Yet it is tied down inside.*

Several of the papers I explored in my literature review (Belloch et al., 2009; Harrington,

2014; Robinson et al., 2017) mention fear as part of the OCD disclosure/concealment

experience, although none of them give much of a colour or flavour of this from a

sufferer's perspective, nor do they provide much of a sense of what sufferers might be

afraid of. What has emerged for me in the present study is fear in a number of

dimensions, which I will explore in turn as I approach the core of an internal experience.

2.1.1 Concealment and fear of reduction

As I immersed myself in the experience of concealment and disclosure or thinking about

concealment and disclosure, I realised that the diagnostic label of OCD, when it was

applied to me almost 25 years ago, helped me understand the 'crazy' and distressing

thoughts I was having and their attendant repetitive behaviours. I had a thing, an illness,

that was doing this; it was not that I was a freak. It had a name. It was known. And yet,

perhaps because no one actually told me it was not my fault, it also started to define me

to myself; I became OCD, not Chris with OCD, especially when it was at its worst and I was

consumed by it all day every day.

But even when it was not consuming me it was still an internal badge that was a core part of my identity; yet it was a badge I needed to hide – and not, I have discovered, out of shame, a word that pervades the OCD literature (American Psychiatric Association, 2013; Belloch, 2009; Harrington, 2014; Lingiardi & McWilliams, 2017; Robinson, 2017; Wheaton, Sternberg, McFarlane and Sarda (2016); it was out of fear that I would be reduced to this by others as I was almost reducing myself. It has become clearer to me now that I am afraid others will see only this and everything else I am will fall away. Not out of shame for being this way, but out of the loss of being seen for the rest of me. If OCD is a core part of my identity, then the risk of being reduced is even greater. I will be lost, 'annihilated', simply because this one thing comes to dominate. Others will not take me seriously because how can they trust a crazy person who has to keep checking everything? That is how I have always experienced the prospect of OCD disclosure and why I have hidden it, despite limited concrete evidence to support this.

There has been *some* evidence, though, and I have found that it has been enough to scare me. I have only told three male friends that I have OCD; I just cannot bring myself to disclose to others due to the fear of reduction. When I told the first friend he seemed empathetic and caring, yet a lack of knowledge about it, which he admitted to, generated in me a feeling of being seen one dimensionally, being defined by OCD. To me it seemed to drive something unspoken between us, emphasising my weirdness, my otherness.

I do not think he got it, and I remember thinking the same thing when I told my father a year or so later. He had not heard of OCD, and so I explained it. I found this very difficult, as it felt like I was describing something weird and I was a failure and that this was all he would see. My father seems to me to be a strong, resilient, self-reliant, rational

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and in-control person. I felt small, young and freakish telling him. Both occasions made me wish I had concealed my OCD. And thus I often conceal it now.

2.1.2 Concealment and fear of negative judgement

This dimension did not emerge as a new idea, but I found new ways of experiencing and understanding it. I had a sense that I was afraid to reveal my OCD because I would be judged negatively, but I did not have a sense, before embarking on this study, of what this truly meant or felt like – or what the specifics of that judgement might be. My immersion process resulted in a series of words and terms that began to flesh out this experience. It is significant that many of these feelings and thoughts came from the mere *anticipation* of how I would be judged rather than how I was *actually* judged.

I imagined that, upon disclosing my OCD to certain people – some of my male friends, for example – I would be judged as weird; a crazy, broken freak; a flawed failure; a loser unable to control his thoughts and behaviours and urges and fears; that I was not manly or worthy of being liked; that I had no power or did not deserve any; that I was weak at my core; that I was, therefore, not worthy of being accepted and therefore was unacceptable and unlovable. I sat with one friend one evening and came very close to telling him, yet I felt a rush of fear in my abdomen and chest connected to the terms above: I would be, in his eyes, a weird, broken failure, and I was afraid I would be abandoned – which feeds directly into the next theme.

2.1.3 Concealment and fear of rejection

I am painfully familiar with rejection. It feels like a fundamental part of my history. My parents separated when I was five and it felt like my father had abandoned me, that I had

somehow done something to cause this, that I was not good enough. When I was thirteen and fourteen I experienced protracted and torturous bullying in the form of social ostracism and mockery at my all-boys high school; I became a pariah simply, I believed, for being me. I never knew what I had done or why they did not want to be friends with me, why they seemed to hate me.

It probably had nothing to do with OCD, which emerged after the first experience of rejection at age 13. I began to believe there was something wrong with me. I was abandoned and more lonely than I can express. I once stood at the top of the school's tower block intending to end the pain but I could not. Two lines from Green Day's song 'Boulevard of Broken Dreams' (Armstrong, Dirnt & Cool, 2004) contributed during the present study to my exploration of loneliness with regards to concealment: "I walk a lonely road/ The only one that I have ever known"; "And I'm the only one, and I walk alone". I responded in this same way to a line from the Rise Against song 'Disparity by Design' (McIlrath, 2011): "And like a single domino/ That falls while the rest stay vertical". This is a powerful lyric because it pulls at the core of my previous experiences of ostracism, loneliness and failure, as if everyone else had been okay except for me because I had fallen as a result of both ostracism and OCD; if I disclose further I will stay fallen because everyone else is sane and I am a 'crazy freak'. And yet this line also contributed to a sense of power in me, of agency and resistance and anger at the injustice of this; it held a sense of fighting back or getting back up again despite what others might think of me. This contributed significantly to my creative synthesis below.

While immersed in the present study I watched the film *Red Sparrow* (Chernin, Zaillian, Topping & Ready, 2018), immediately thinking of concealment. In the film, a double agent of Russian and American intelligence is about to become immersed in a

Russian training programme before embarking on a deadly career; as she is about to leave for the training her mother tells her: "Hold back, don't give all of you; that is how you survive". This resonated for me, and there was something in the word "survive" that struck me as important. That to give all of me, to reveal my OCD, would mean I could disappear or figuratively die. To be known for OCD is to be abandoned and annihilated perhaps?

It was also significant for me that the person saying these words was a woman. I found it powerful that she advocated a kind of hiding with which I was feeling familiar. I find it easier to tell females that I have OCD, but, of course, not all females. For example, I have not told my mother, and I have realised that I am afraid she will reject me because of it, that she will think I am a loser or a freak or weak, inherently a failure. This is probably not true, but it is a dynamic within me. I wonder if she would advocate not giving all of me to her or anyone else. This suggests another rejection, and an important one: I have told girlfriends and female friends far more readily than male friends, whose masculinity generates more of a sense of weakness in me. There seems to be more of a risk of rejection from the latter, more of a risk that I will be seen as weak or vulnerable and therefore a failure as a man, or, more potently, failure as *me* and, again, unworthy.

This risk cuts deeply. It recalls my past distress of experiencing rejection and loneliness, which I would like to avoid. It makes me feel that I cannot fit in to the world as a man with agency if other men see me as weak for suffering from OCD. As if suffering is weakness and failure and ends in annihilation. I then thought of Hamlet's 'To be, or not to be' (Shakespeare, 1980, III.1.56), a soliloquy that is reflected in the title of this dissertation. *Hamlet*, one of Shakespeare's great tragedies, depicts the interpersonal and existential experiences of the eponymous protagonist, whose great distress following the

death of his father and the subsequent marriage of his mother and uncle is virtually too much to bear as he seeks revenge. I found I was experiencing this famous line, within the context of OCD concealment and disclosure, as representative of the concealment I was exploring: suffering must be concealed, and that this is "not to be". Not to be could mean not to exist, but it also means to "suffer/ the slings and arrows or outrageous fortune" (Shakespeare, 1980, III.1.57-58), for me the potential negative consequences of disclosure.

This led me to think about another character, Iago in another of Shakespeare's tragedies, *Othello* (Shakespeare, 1968). Iago is the play's antagonist, a malign, jealous man bent on traitorously harming Othello, his military superior, despite appearing honest. Early in the play, Iago says, "I will wear my heart on my sleeve/ For daws to peck at" (I.1.65-66); daws are crows, and the line suggests to me that to reveal or expose one's real self makes one vulnerable, and this will be dangerous. This resonates for me, as it suggests others will reject me if they know about my OCD. I think this is why I have been hiding. I feel deeply the sense of my own weakness and I want to hide it from others as well as from myself. I do not want to be profoundly lonely again, nor do I want to find myself in tears at the top of a building. I do not want to be reduced to a one dimensional non-man, defined in others' eyes, or my own, as 'weird OCD person'.

2.1.4 Concealment and fear: A synthesis

I also discovered during this process that these three fear dimensions are interconnected. Fear of judgement is based on fear of being reduced and consequently rejected. I will then be alone, unwanted, unworthy and unlovable. Being unworthy leads back to being alone and the cycle repeats. I wrote it in my journal:
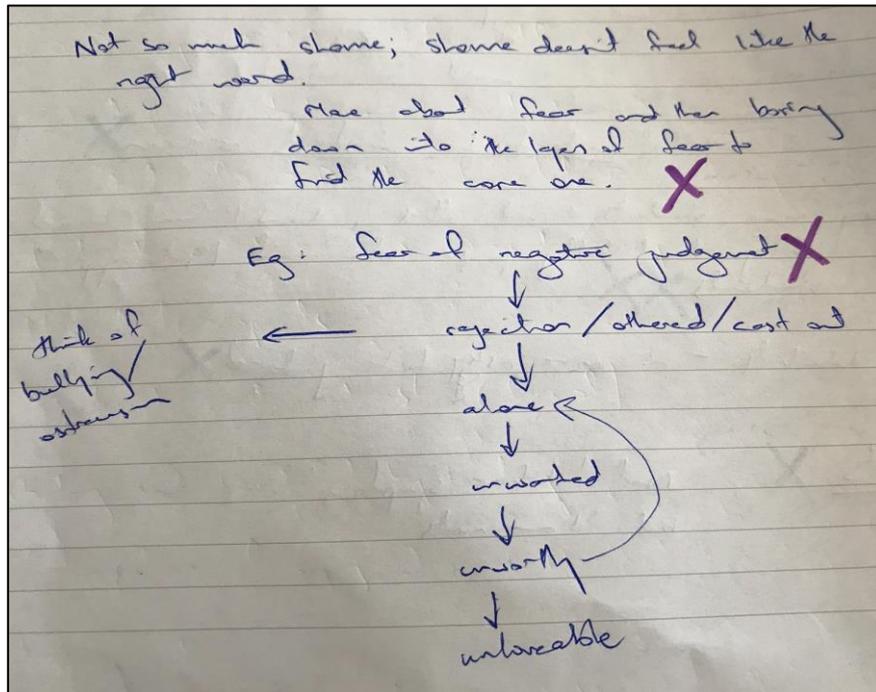
Figure 2: A synthesis of my fear

I started wondering about why the loop goes back from unworthy to alone and not from

unlovable. It is as though unlovable is a backwater I could get stuck in forever; perhaps

this is my deepest fear. Or perhaps the word fear is not strong enough and I am, in fact,

terrified. What I noticed was that the word unlovable is very different from the word

'unloved', the latter tracing a directional movement from the outside, the other, toward

me. 'Unlovable', on the other hand, suggests there is something innately or essentially

wrong with me and that is why I am rejected. Do I believe I am fundamentally unworthy

and deserving of rejection? Is this why I often cannot disclose my OCD?

<u>2.2 Theme 2: Concealment and safety</u>

The obvious corollary of concealing out of fear is concealing to stay safe. So what does safety mean? What might it look like? The *Red Sparrow* quote above – "Hold back, don't give all of you; that is how you survive" – suggests that safety means staying alive, figuratively and literally avoiding the sense of impending annihilation I have described in my discussion of rejection. And yet am I really avoiding unworthiness or do I carry it within me? By not disclosing I am attempting to stay okay in others' perceptions regardless of how I perceive myself. I am hiding the way I perceive myself (as unlovable and unworthy) because I believe it might be the only way others will see me; I think: how could they see me in any other way if I believe I am unworthy?

So self protection is key to the concealment. And it makes sense: to my mind, people can be judgemental, stigma exists, people do not understand mental illness in general and OCD in particular. This has, in large part, to do with the perennially hidden nature of the disorder, but it also has to do with media representations of OCD. When I watched the film *As Good As It Gets* (Brooks, Johnson & Zea, 1997) I felt (and feel) angry about how the male protagonist, Melvin Udall, is portrayed. He suffers from OCD and is also not a very pleasant person to be around. It is not this juxtaposition that bothers me – although this is a factor because it is hard to empathise or care about him until we see later that he has a heart and can be vulnerable – it is the way I see his OCD represented.

I think this warrants further explanation, particularly around how it made me feel. When we first meet Melvin in the film he is characterised as a mean person who loves nothing; his neighbours actively dislike him because he is obnoxious, rude, heartless and uncaring, which we see repeated throughout the film (at one point his love interest, Carol, calls him a "crazy man" and his neighbour calls him an "absolute horror of a human

being"). He then goes into his apartment and performs some OCD rituals – locking the door five times, turning on the lights five times. He then washes his hands with two fresh bars of soap in scalding hot water before discarding the soap in the rubbish bin. His OCD is represented as a kind of quirky character trait that comes with no overt suffering or distress on Melvin's part; in saying that, he finds it very hard to visit his psychiatrist, and I do not think this is simply because the pavement outside has a lot of cracks in it that Melvin has to compulsively avoid; I think he is saying it is hard to seek the help he knows he needs, and this is something I can identify with. I found myself hoping he could get the help he seeks. As he leaves the psychiatrist's office he addresses the patients gathered in the waiting room with "What if this is as good as it gets?", which I found to be a poignant moment that I explored further. What if, I wondered, concealment in order to remain safe is all I have? What if my life will be about suffering and hiding? Melvin seems to find it difficult to speak about OCD, calling it an "ailment", and this I can relate to: the words obsessive-compulsive disorder or its initialism OCD are very difficult for me to voice and feel laden with connotations of crazy, as I have discussed. Melvin also says he started taking his medication for OCD because he wants to be a better man. I found this troubling because it suggests that having OCD means I am not a good enough man. This again recalls the themes above and certainly reflects part of my experience of concealment.

It is only when Melvin is distracted by his burgeoning love for Carol that he experiences some relief from his compulsive door locking, realising he has forgotten to do it. The same thing happens the end of the film when Melvin and Carol begin a romantic relationship: Melvin opens a door for her and accidentally steps on a crack he previously would have compulsively avoided, and yet now he does not seem to mind. For me there is something here about OCD relief coming once one experiences an opening of one's

relational world, once love begins to flourish. I wondered what the film is trying to say

here: that OCD is somehow a disorder of the capacity to love and be a good person? Does

this mean that I see myself as lacking the capacity to love or be loved, or do I see myself

as a bad person and is this why I cannot disclose? Do I see myself as a 'crazy man'? I am

avoiding being thought of as a crazy man by others by concealing my OCD, but would I

agree with them? Or is the film saying something else to me: that to love and to be loved

for all you are, as Melvin ultimately is, is healing? In order for this to happen, I would need

to be seen for all of who I am, including for OCD.

2.3 Theme 3: Concealment and self-judgement

When I looked back through my journal and my responses to the material, I noticed the

lurking presence of self-judgement; I had not previously – consciously – known that this

was such a salient part of my experience of OCD concealment. I notice what I have written

about this in the present study, and realise that in writing it I am still immersed in an

ongoing heuristic self-search process.

When discussing bullying I wrote "Something wrong with me" (p. 62), as if I was

responsible for the treatment I received, the ostracism and mockery; this is interesting

because an exaggerated sense of responsibility is one of the underpinnings of OCD

(Lingiardi & McWilliams, 2017; Shafran, Watkins & Charman, 1996).

When discussing my suffering I wrote about a "sense of my own weakness and I

want to hide it from others as well as from myself" (p. 64), which suggests I have an

internal negative judgement that motivates my concealment. In terms of having an

internal identity defined by OCD, I wrote about being a "weird OCD person" (p. 64), and I

"became OCD" (p. 59), that I reduced myself to OCD. I went on to think about the word

'unlovable', noting that it is a term that seems more inherent within me than the word 'unloved' suggests, which seems to come from a more external source. I wonder if I believe, because I have OCD, that I am unlovable. I wonder, too, if I carry a sense of my own unworthiness within me, and I wonder if this is because of seeing myself as a 'crazy man'.

This theme is a powerful one for me to consider. It suggests the difficulty in disclosing OCD lies with an internal pathogenic belief, as defined by Weiss (1993), that I am unworthy and therefore do not want others to know this or do not wont to confront it. This is a challenging thing to consider as I wonder what I think of myself. Are my fears of judgement, rejection and reduction a projection? Perhaps this is the key to my inability to disclose.

3. Disclosure of my OCD

Sometimes when I have disclosed I have been afraid and other times I have not – the latter are the times I have felt safe, when I have trusted the receiver of the information or have not expected rejection. What follows is an articulation of the disclosure themes that have emerged during the present study.

3.1 Theme 1: Disclosure and being known

I discovered that part of me wants to disclose because I wish to be known for all of who I am, to not have to hide, despite how hard it is to reveal OCD and risk reduction, negative judgement and rejection. I also found that part of me wants people to know how much I have suffered; this I found surprising because it seemingly contradicts the feeling I have that people will think I am weak and flawed and unworthy if they know of my suffering.

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However, what emerged is that it feels dangerous to simply tell someone I have OCD without them knowing how much I suffer from it and that I am a worthy person who is under siege. Perhaps I want people to know of my pain because this makes me somehow important or special or a fighter or worthy of sympathy and care. Perhaps I am seeking to be rescued and helped. I wonder if this might help reduce the reductionism I am afraid of. The tension here, though, is that to not be in control could be seen as a sign of weakness.

I wonder who I want to be known by. It feels like the answer is 'everyone'. Or perhaps it is simply that I want to be known by me. What I notice here is that my first, intuitive sense is that I want to be known by men. To be accepted by men. And I wonder about the gap this represents in my life. Perhaps this theme reflects a need in me to be truly known and accepted as a man regardless of the OCD element. This is a rare thing in my life, but I am wondering if this is because I have not let myself be truly known. My wife, for example, knows almost everything about my OCD, as does my female psychotherapist, and I feel safe and understood with them, like the authentic and accepted me. I have yet to experience this with men.

This acceptance from my wife and psychotherapist stands in contrast to most of my disclosure experiences. For example, I recently told someone I like and trust – a female psychotherapist-in-training – that my dissertation was a heuristic self-search into OCD disclosure. I had never mentioned my OCD to her before, and I felt like I was admitting something I should have admitted to her before, like I had been somehow deliberately withholding or lying because I did not have a good enough relationship with her. I felt she would judge me for, or be hurt by, me not saying something sooner. This came as a surprise to me, and I felt empty and disingenuous. I spoke of OCD in a matter-of-fact, impersonal way in order, I think, to protect myself, and yet I desperately wanted

to tell her more so she would know me. Consequently I felt we lost some of our connection because I was holding back.

3.1.1 Disclosure and being known: Relief and wholeness

Although it fits into the same theme as the one I have just been discussing, I feel this section warrants a distinct space.

Part of my dissertation involved a presentation of the work to staff and students at AUT. This was a way demonstrating what I was doing and how I was progressing; it provided an opportunity to hone my topic and get feedback before continuing with the work. I found this a challenging thing to contemplate, as it would involve disclosure of my OCD. In this case, though, I had no choice, which is not the usual situation.

I was asked to provide a title and short abstract of my dissertation, which would be sent to psychotherapy students and staff. This was something of a challenge for me. I found I was unable to provide this information openly, and so did not mention OCD, substituting 'mental illness' because I could not face the idea of so many people knowing. I later reflected on this as I continued with the dissertation, wondering what it would be like to disclose via a public piece of research. I then considered putting an embargo on the work, which I discuss below.

I did not realise until the morning of the presentation how much I was affected by the task: I had a headache, I was nervous and I had barely slept. I believed I was nervous about my performance as a presenter, but when I explored this I came to the realisation that this was possibly an unconscious self-protective adaptation against feeling over-exposed in front of people who could, I believed, judge me negatively.

I used the presentation as heuristic research material for the present study, and while I was preparing it I found that I wanted the audience to know how much intense suffering OCD caused me, that it is not trivial. This emerged as one of the key aspects of the presentation, which described and explicated OCD while demonstrating and contextualising my research topic and question. I was living the heuristic process, discovering as I disclosed my OCD what it was like to be doing so. What I found was that I was only mildly anxious, afraid that I would get something wrong or not represent myself or the disorder 'correctly'. I was afraid of what people would now think of me, as I have discussed above. Negative judgement and rejection loomed. I felt embarrassed and vulnerable, ready to be reduced; I felt nervous, I felt my leg trembling; I felt exposed, open to judgement, a freak, but this feeling did not last long, replaced by a feeling of relief and joy: I was in a room of people I see as 'safe' – psychotherapists – and I received an overwhelmingly warm, supportive and caring response. I was hugged by several lecturers and students. One of the lecturers said he was "blown away" and another said she would "trust me more" if I was her therapist and she knew this. I felt very accepted and it was wonderful. I felt known. I felt valid and worthy and I was moved almost to tears as I wrote in my journal about my experience.

I also felt relief, something I have experienced in the context of OCD very few times and never so viscerally: I felt like a whole person. The fears were gone in that room in that moment and for a large part of the day, and I was free despite or perhaps because of my vulnerability and the openness with which I had exposed it.

I felt this relief and wholeness 18 years ago when I first told my girlfriend, now wife, that I have OCD. I cried freely and openly as I told her, for I was going through one of my worst crises and the relief of speaking it out loud was profound. The fact that she

listened without judgement and loved me regardless was very moving and paved the way to further help-seeking.

This recalls the Rise Against lyric I introduce above regarding my fear of rejection and loneliness: "And like a single domino/ That falls while the rest stay vertical" (McIlrath, 2011); my most powerful response to this line is one I wrote: "And so the domino got back up". The domino has fallen alone, and yet the courage to stand and to speak of suffering inheres a strength with which I am, during this heuristic research process, coming into contact.

There have been other occasions when disclosure was received with compassion and offered me relief. My wife continues to respond with empathy to my vulnerability, as have my two psychotherapists. The psychotherapy students I have told have received the disclosure with compassion. One of the two psychiatrists I have seen seemed unflinchingly caring, as did all of my psychotherapy lecturers and supervisors. A male friend suffering from his own acute experience of mental illness also received my disclosure with compassion and without judgement, and this is noteworthy because he is one of the few men I have been able to disclose to and I think I felt safe because he too was vulnerable.

3.2 Theme 2: Disclosure is dangerous

This theme is inextricably linked to the fears I have outlined above: if withholding is safe, then revealing is not. And yet I have just demonstrated to myself that disclosure can be safe and does not necessarily involve reduction, negative judgement and/or rejection.

However, one of the responses I had to my dissertation presentation was from a lecturer who strongly advised me to consider putting an embargo on the dissertation so

that it is not publicly available. I know she had my best interests in mind, because she was especially concerned that it could be detrimental for me as a new psychotherapist to have clients know these things. I considered her concerns carefully, noting, however, that one of the aims of the present dissertation is that I want OCD and other mental illness sufferers to have an experience of concealment and disclosure represented in the literature from a sufferer's perspective. Another aim that would fall away were I to embargo is the opportunity the dissertation offers clinicians in providing some insight into their clients' struggles with speaking and seeking help.

The embargo suggestion made me feel as though I had something to be afraid or ashamed of, that if a client knew it could harm our work together. This recalls and in some ways legitimises my fears of judgement, rejection and reduction, but it is more than that in this context: it somehow weakens my validity or wholeness as a professional and as a person – at least, that is my subjective response.

This dissertation may be dangerous because it involves so much disclosure. What I found as I wrote, particularly while I was away in Taupo, was that OCD and anxiety crept into my experience. Each morning as I sat down to work I found I could not concentrate, that I was too anxious and constricted, and so I went for runs in order to 'burn' this off, which worked. This reminded me of my struggles in my first degree, English: every time I sat down at home to write essays I deeply felt I had to maintain my A average. This was a performance and I had to get it as right as possible to prove I was worthy. Achievement in English was so tied up with my identity and self esteem that the anxiety became crippling. I sought perfection in order to remain good enough. My experience in Taupo was very similar and something I had not experienced to any significant degree at other times during my psychotherapy training. I feel it had something to do with representing myself

accurately in the present study so that I would be seen and known in the 'right' way, and this felt dangerous because it came with the risk of rejection because wrong is reject-able. This is, for me, a core part of OCD; there seems to be an 'or else' connected to it: get it right or else you will not be worthy. Thus, disclosure connects to the reductionism fear: what if they do not get it, do not get me and think I am just a crazy, broken freak?

3.3 Theme 3: Disclosure is a fight

Therefore, disclosure can feel like a fight. During my immersion I thought again of Hamlet and the dialectical halves of his famous "To be, or not to be" soliloquy (Shakespeare, 1980, III.1.56). Here Hamlet seems to be facing a choice between "continuing to live and committing suicide" (Spencer, in Shakespeare, 1980, p. 268), with "To be" meaning continuing to live; I found myself associating this element with disclosure – to disclose means to live as myself, to not hide. For me this opposes Hamlet's views on living, which he equates with suffering the "slings and arrows of outrageous fortune" (Shakespeare, 1980, III.1.58). Considering the word order in the soliloquy, for Hamlet "to be" is to "suffer/ the slings and arrows", while not to be is to "take arms" (Shakespeare, 1980, III.1.59), to oppose and to "end" the suffering (Shakespeare, 1980, III.1.60), a word order I found myself reversing as I explored disclosure: for me, fully living involves disclosure and taking "arms against a sea of troubles" (Shakespeare, 1980, III.1.59-60). Thus, to take arms means to fight against negative judgement, rejection and/or reduction. In other words, disclosure feels like it requires bravery and fighting, while to conceal (not to be) involves suffering. Does this mean that, for me, concealment is burdensome and painful? Does this mean that disclosure can provide the opposite? Is it a relief?

4. Chapter summary

In this chapter I have outlined and explicated the themes that emerged during my study. I have divided the findings into two parts: Concealment and Disclosure. The themes within the concealment section are: Concealment and fear (of reduction, negative judgement and rejection), which seems to have at its core a sense that I am unworthy and unlovable; Concealment and safety; Concealment and self-judgement. The disclosure themes are: Disclosure and being known (Disclosure: relief and wholeness); Disclosure is dangerous; Disclosure is a fight.

Chapter 5

Looking back to move forward: Discussion

1. Introduction

In this chapter I look back on the study as a whole, reconsidering the research question and the literature in the light of the findings. I discuss the potential embargo of the dissertation and what it could mean to disclose publicly. I then outline some of the limitations of my research before exploring the implications of my findings from four angles: psychotherapeutic theory, practice, research and training. While there is still a heuristic sensibility to this discussion, with my subjective explication implicit in it, I am seeking to more objectively explore the outcomes of the research.

2. The question and the findings

My heuristic process was a deeply immersive experience that took me into parts of myself I did not know were there. Yet these parts were exactly what I was looking for as I sought to answer my research question, 'What is my experience of disclosing or concealing my obsessive-compulsive disorder (OCD)?'

I came into very close relationship with this question and myself-within-the-question during my research process. The heuristic method I use seems to have captured the complexity of the 'answers', the complexity of my experience, which has helped me to understand the barriers to my own help-seeking. Jourard (1971) aligns knowledge of our "real selves" (p. viii) with good health: if we know ourselves as fully as we can, we can achieve growth. This addresses one of my aims in the present study.

I approach this discussion chapter in two ways; the first is from a similar heuristic perspective – underpinned by phenomenology and post-structuralism – with which I approached the study: the discussion becomes, to an extent, my subjective response to the findings, although it is also informed by a more objective, rational and critical stance, a new angle from which to explore the findings and their implications. The second approach is to consider what I have found from four angles: I discuss the implications for psychotherapeutic theory, practice, research and training. In order to do this, I am going to return to the opening chapter and look again at what I set out to do.

In the beginning, as I was searching for a topic and research question, I found myself wanting to "say something to the world that was important to me" (p. 7) about my experience of OCD, yet I was not sure what that was; this led me to think about the concealment and disclosure of my diagnosis because *any* study of OCD from my perspective would inherently require disclosure. This felt challenging in itself. The next step was to find what it was that I truly did not already know, and again there seemed to be a focus within me on understanding and communicating my own experience. What I found was that I had no idea what it feels like to conceal my OCD and what it feels like to disclose it. I had simply either disclosed or not and left it at that, with no examination of what lay underneath the experience or what impact it had on me. My question emerged, and with it the key point of concern:

> …an examination of what it is that allows me to speak and what is it
> that keeps me silent. I want to explore what I think and feel when I
> tell others and what I think and feel when I do not or cannot (p. 1).

I discovered during the literature review that there is a dearth of writing and research on the lived experience of OCD in general and on the issues surrounding sufferers' disclosure

and concealment experiences; in short, not much is known about what it feels like, particularly from a sufferer's perspective, to reveal or conceal OCD. I decided that I would provide this voice, from my subjective viewpoint, in order to open an area of knowledge that seemed to be missing. It was for this reason that I chose a heuristic methodology, as it would allow me to deeply explore, explicate and articulate my experiences. This gap in the literature suggested to me that the mental health community could be better informed about what it is like to seek help while in a state of distress about seeking help. I therefore feel I have fulfilled my desire to say something important to the world about my OCD in answering my research question.

The first aim of the study was greater self-knowledge, which would, I hoped, allow me to better comprehend who I am and to move closer to healing. As a practising psychotherapist, this, in turn, might help me understand my contribution to the therapeutic alliance. It might also enhance my understanding of my clients' experiences of concealment and disclosure of their own suffering. My mental health literacy would be augmented.

Some of my themes came as no great shock, although I had not previously comprehended consciously the extent to which they impact on my life. Fear of negative judgement, for example, was not a surprising discovery; however I was surprised by the extent to which it motivates my concealment and the way it is linked to the fear of being reduced to 'OCD person' and that this could, in turn, lead to rejection. I was also surprised about the experiences or core beliefs that underpin these fears: feeling deeply or inherently unworthy and unlovable. The fact that there is a negative self-judgement, too, was a new discovery, and one that attests to the depth of suffering that can attend the OCD experience.

I believe that these findings reflect some of the elements and goals of psychodynamic psychotherapy: to understand one's pathogenic beliefs (Weiss, 1993), to obtain self-knowledge (McWilliams, 2004), and to uncover one's hidden feelings and point of maximum pain (Hinshelwood, 1991; Malan, 1995). For me, then, the heuristic process runs parallel to the psychotherapeutic one in my study and has allowed for new insight. This sense of judging myself as unworthy could warrant further heuristic enquiry, but here it points to the notion that my exploration into concealment and disclosure offers me new understanding and profound benefit in my own journey as an OCD sufferer. In this sense, then, I feel that this process has, to quote Shedler (2010), fostered my "inner resources and capacities [and has helped me toward] a richer, freer, and more fulfilling" life (p. 107).

One of my most rewarding findings was that, through disclosure, I could actually experience feeling known, and that this resulted in a wonderful sense of relief; disclosure can therefore offer me the chance to feel like a whole person. Thus, one answer to my research question might be: "My experience of disclosing my OCD is one of feeling acceptable as I am".

I also found that concealment can be a self-protective measure; it can hinder the relief I have discovered. My aim of speaking to other sufferers is hopefully inherent in this finding and, in fact, in the very existence of this dissertation, which is why I have chosen to publish it: I have modelled disclosure and unpacked my experiences; I have found healing, wholeness and freedom in disclosure, that there is a relief, a release from the lonely cage of concealment.

Again, this is my experience and cannot be generalised – our experiences are unique and I am writing from the perspective of a middle-aged, middle class,

heterosexual, Pakeha New Zealand male in 2018; yet I find myself wishing, as I did at the start of this study, for my findings to provide a measure of hope in other sufferers because there are so few expressions of the experience in the literature. Even if this 'relief through disclosure' theme does not resonate with other sufferers, I hope that the articulation of an OCD experience in itself might; if, for example, the fears I have found are shared by another sufferer, there could be some relief in the knowledge that one is not alone. I have no idea whether or not this will happen, however what I do know is that not seeing my experience represented in the extant literature is very painful and isolating, which is why I have undertaken the study. Mental health practitioners, too, might find a new source of understanding here, which I discuss further below.

3. To embargo or not to embargo?

There exists a core tension at the heart of this dissertation: A wish or need for concealment and a wish or need for disclosure seem at times to coexist; I want to hide and simultaneously I want to freely be all of who I am and what I experience. Both aspects come with their own risks, benefits and complications. Regardless, the disclosures have felt like a relief and I have never regretted them, although I often feel vulnerable for a short period of time afterwards but this dissipates and I feel strengthened. The discovery in the present study that disclosure can be a fight and can lead to relief attests to this.

To embargo the present study means more concealment and this keeps me safe. Yet I am disclosing because I want to be known, and while this might have implications for my fledgling psychotherapy practice, I hope the benefits outweigh the costs. Because the other side of this is that disclosure can be liberating. However, I do not know right now what the costs might be, and this is the risk of publishing the dissertation. Should

potential or existing clients read the study, they will know a great deal about me; the study reveals some very personal fears and concerns, not to mention the OCD diagnosis itself. I wonder how clients might feel knowing I have OCD; I wonder if they will not trust me and I will therefore see or retain fewer clients.

I wonder how those who I do see will react to me, whether they keep their knowledge to themselves or not, while we are in therapy; could it influence the therapy negatively if they know too much about me? It is possible. Is it a risk I am willing to take, though? Could there be advantages to clients knowing these things about me? Might they trust me more because they know I have had lived experience of mental illness and suffering? Indeed, Kaufman (2016) found that therapists who self-disclose a mental illness were found by clients to be more "empathetic" (p. 77) than those who did not, while one of the writers and practitioners who influenced Moustakas's (1990) heuristic methodology, Sidney Jourard, argued (1971) that therapist self disclosure generates trust and begets client disclosure. As I mention on page 40, Jourard (1971) called this "the dyadic effect" (p. 66) and believed it underpinned a strong and authentic therapeutic alliance. Maroda (2010) has recently argued that therapist disclosure facilitates client disclosure, and in an earlier work contends (1999) that therapist self-disclosure is highly appropriate, entitling a book chapter "Why Self-Disclosure Works". I feel that self-disclosure could be a significant tool in helping to relieve any distrust a client may be experiencing, as it models a genuine way of being and encourages that way of being in the client (Jourard, 1971; Maroda, 2010). This process perhaps offers an interpersonal connection based on the client's sense of the therapist's credibility" (Henretty & Levitt, 2010). Maroda (2010) agrees, arguing that therapist self-disclosure will establish a therapist's "honesty and humanness" (p. 109), traits that perhaps appear to be at the

core of establishing a strong therapeutic alliance. She writes that "the client became much more expressive" (p. 109) as a result of her disclosures.

The problem here, for me, is that my disclosure via dissertation is not taking place in relationship with the client and I would have no idea that they have this knowledge of me unless they let me know. I do not know how this could play out in the therapy, for there is a risk that the client's perception of me, which is in the room with us regardless, could influence the therapy in a way I would be unaware of. This in itself could be problematic, however my intuition leans toward the notion that a client's knowledge of my suffering humanises me and could bring us into closer relationship.

4. My findings and the existing literature

At the commencement of the research I found there was very little in the existing literature about disclosure and concealment of OCD from the sufferer's perspective, which is consistent with findings from Probst (2014), Bril-Barniv and Naamen (2017) and Steinberg and Wetterneck (2017), the latter writing that "there is a particular need for in-depth studies" (p. 195) in this area. Moreover, Robinson, Rose and Salkovskis (2017) found "no qualitative studies specifically examining the barriers and enablers in seeking help for OCD" (p. 195), a gap I have attempted to address. To this end, I believe I have explicated significant barriers in seeking help for my OCD, largely based around the fear of disclosure and the concomitant safety in concealment. I found in the literature a correlation between sufferers' lack of disclosure and delays in help seeking (Belloch, del Valle, Morillo, Carrió & Cabedo, 2009; McCarty, Guzick, Swan, & McNamara, 2017; Picco et al., 2018; Poyraz et al., 2015; Robinson, Rose & Salkovskis, 2017), a phenomenon that has received limited attention (Belloch *et al.* 2009), and in part my research sought to

examine what it might be that contributes to or underlies this in order that the psychotherapy community better comprehend the sufferer's experience.

I closely examined six papers as I sought to find a gap in the literature that might justify my study. I want to look at these again in the light of what I have found. My findings move beyond an examination of how difficult it can be to disclose to professionals, which the Belloch, del Valle, Morillo, Carrio and Cabedo (2009) study focuses on; many of my findings extend to disclosure or concealment in the context of friends, colleagues and family members. I believe that once we know the dimensions of this avoidance, one's family, friends and health professionals can perhaps begin to address them and empathically support sufferers to seek help. Belloch *et al.* (2009) note that one dimension influencing concealment "could be … fear" (p. 258). My study has found that fear is indeed a significant dimension for me, and I have expanded on this with several sub-themes that articulate why disclosure can be difficult or impossible – fear of reduction, fear of negative judgement and fear of rejection. Neither the Belloch *et al.* (2009) nor the Picco *et al.* (2016) study offer much in the way of a human experiential element of this fear, which is something I have addressed in the present study.

Furthermore, Ozertugrul (2015) notes the dearth of writing about "experiences, feelings and actions of an individual with OCD" (p. 218), a dearth I have attempted to address with an articulation of my subjective experience. I noted in my examination of the Ozertugrul (2015) paper what appeared to be the researcher's cognitive bias in examining his OCD experience, and in contrast my study shows the emergence of emotional and embodied as well as cognitive experience, which suggests I have begun to expand the knowledge of OCD. Ozertugrul argues that the heuristic search in itself can be healing; I

have found this to be so: I know myself more deeply than before and have therefore satisfied one of my core aims for the research.

I noted in my examination of the Wheaton, Sternberg, McFarlane and Sarda (2016) paper that there was bias inherent in the following statement: "Not surprisingly, individuals with OCD are often reluctant to disclose the content and frequency of their obsessions" (p. 43). I argued that this suggested OCD was inherently shameful, and my findings rather than theirs begin to articulate why it might be that it is not surprising. Fears of reduction or rejection, for example, arguably add a previously absent dimension to this phenomenon. The Wheaton *et al*. (2016) study rates distress on a scale of 1–4, which gives very little qualitative sense of the human experience, a sense I have offered in my exploration. The researchers note that their findings around concealment "may be an important factor to consider in relation to OCD" (p. 48), and I believe my study is a contribution to this area of consideration.

Robinson, Rose and Salkovskis (2017) report a theme of patients "feeling too vulnerable" (p. 202) in their experience of OCD, however the researchers did not expand on this finding, and so I have attempted to address this. For example, I feel vulnerable in my disclosure and help seeking because of how it feels to anticipate negative judgement, reduction and rejection. I find it noteworthy that the paper refers to fear 21 times yet there is no sense of the qualities of this fear; the paper's authors point out that fear had been previously "underestimated" (p. 207). My study does not underestimate fear, instead offering a phenomenological expression of the experience.

The existing OCD literature is replete with references to shame and stigma (American Psychiatric Association, 2013; Belloch, 2009; Harrington, 2014; Lingiardi & McWilliams, 2017; Robinson, 2017; Wheaton, Sternberg, McFarlane and Sarda (2016). My findings do not overtly reflect this, and while shame and stigma may be inherent in my OCD concealment and disclosure experience, I believe I have begun to explicate some of the elements and experiences that underpin what for me have often felt like abstractions. I now feel that shame or fear of stigma has found deeper expression for me, that I have an expanded understanding of why I often cannot disclose my OCD.

The word 'shame' does not capture the experience in the same way as fear of rejection does, for example, or the feeling of profound loneliness that comes with it, the feeling of being the one who fell alone while all others stood. While exploring the feeling of fear of rejection I describe on page 63 the feeling of needing to hide because of a sense of my own weakness. In my creative synthesis I broaden this sense of shame beyond abstraction.

Of course, one could argue that fear of rejection inheres shame, yet I do not feel ashamed of the OCD; I feel scared of being judged for it. Again, though, stigma does not resonate for me and was not explicitly present in my findings. It does not feel like the right word and 'fear of stigma' might better serve to articulate the experience. Still, the word stigma does not feel experience-near. It seems to have required 'unpacking' of the type I have done while expressing the various dimensions of fear, safety and self-judgement. Picco *et al*. (2016), for example, discuss stigma as if it is a universally understood term without giving a sense of the quality of the experience; I have implicitly explored what it feels like for me to fear stigma, which I articulate thus:

They will not take me seriously because how can they trust a crazy person who has to keep checking everything? That is how I have always experienced the prospect of OCD disclosure and why I have hidden, despite limited concrete evidence to support this" (p. 60); "I would be, in his eyes, a weird, broken failure, and I was afraid I would be abandoned" (p. 61).

In producing a synthesis of my experience of fear (p. 65) I discuss feelings and fears of being unworthy and ultimately unlovable, both of which stem from my fear of rejection, and both of which extend far more deeply into human experience than the word stigma can convey on its own.

Fergus, Valentiner, McGrath and Jencius (2010) argue that "the somewhat equivocal relationship between shame and OCD … suggests that further elucidation of the relationship is needed" (p. 814), and I feel that my study provides some of that elucidation. While I was briefly discussing shame, OCD and CBT in the literature review chapter, I noted that Greene (2009) has suggested "the crucial question is what underlies the decision processes and creates conditions for likely disclosure," (p. 227), and I feel that my study has addressed this crucial question and examined what it is that underlies my decision process around disclosure. For example, I wrote under the sub-heading "Concealmant and fear of reduction" (p. 59) that I did not experience shame in this concealment element, that rather I felt afraid of being seen one-dimensionally as a misunderstood OCD person only, which was tied to a deeply held fear of rejection.

5. Limitations

One of the key limitations of the present study is that the researcher is the sole participant. This was a necessary factor, as the question itself was an inward-looking one,

and so the exploration inheres a limited perspective on the phenomenon of OCD concealment and disclosure. Mine is one person's perspective, one person's experience; it cannot be generalised, externally verified or replicated. Yet, as I have argued above, it offers an angle on the phenomenon that provides new information others can explore further for themselves and paves the way for future research. The study is located within a specific and therefore limited context, and was undertaken by a representative of a specific socio-cultural milieu, which is another salient limitation inherent in the one participant design.

The study was confined by the demands of an academic research undertaking, particularly regarding time constraints and the requirements of a formal dissertation as outlined by the university. Moustakas (1990) argues that, ideally, a heuristic study follows a "leashless" (p. 17) or un-delimited path, and Sela-Smith (2002) writes that there should be "no controlling the process" (p. 83) of heuristic surrender, and so any constraining elements such as time, word count and ordinary daily life have potentially limited my free engagement with the research phenomena: my study is leashed and cannot go on forever. Thus, the present dissertation exists as a snapshot of my experience in 2018, and there is, therefore, further scope for development of the research. Moreover, my immersion has not been total: Moustakas (1990) argues that "Everything in [the researcher's life] becomes crystallized around the question" (p. 28), and Sela-Smith (2002) contends that "the researcher is able to become intimately involved in the question during the immersion process to live the question" (p. 65). When one has a partner, children, work, clients, other university papers, home commitments and so forth, it is impossible to surrender completely all the time and live the research – not everything revolves around the question, although I did find it was almost always present and was

probably unconsciously present constantly. I had to make time for immersion and that time was limited. With more time other themes might have emerged and a deeper exploration might have taken place.

6. Relevance to the wider field of psychotherapy

I thus find myself wondering about the relevance of my findings, and so here I want to examine any implications for theory, practice, research and training in the field of psychotherapy.

6.1 Implications for psychotherapeutic theory

After reviewing the relevant literature, I started this heuristic study from the premise that the current theories around OCD are not adequately informed by an in-depth understanding of what it is to live with the disorder. This will, in turn, have implications for treatment, but for now I am suggesting that the themes of disclosure and concealment of my OCD include psychodynamic elements that warrant exploration. Through these, I feel my study can enrich the current understanding of OCD in general. My exploration of my fear of negative judgement includes psychodynamic dimensions that appear consistent with those outlined by Shedler (2010) – which I have included on page 6 – and this has resulted in a better understanding of my emotional experience of OCD; this could flesh out the PDM's definition of OCD, which states that obsessions "impinge upon the affected person's mental functioning" (p. 171) and that patients "may experience a sense of pain and isolation at being considered weird and unacceptable by others" (p. 173). I have added my lived experience to these ideas, which arguably is significant because it might mean an augmentation of current conceptualisations of the

disorder, and this could have implications for practice. I have also explored, as per Shedler

(2010), recurrent themes and patterns of my experience as they emerged; this, too, has

provided a deeper and more psychodynamic understanding of my OCD experience, and

again this could have implications for the conceptualisation and treatment of OCD.

My findings contribute to current knowledge in that there are very few theories

about OCD and delayed help seeking beyond abstractions around shame, stigma and, to

some degree, fear. My exploration of fear reflects a deeper, broader expression of my

experience of living with OCD and disclosing it in order to seek help, support or

understanding. Theories that OCD is shameful because it is stigmatised could be

expanded in the light of what I have found, particularly that concealment can protect

against being reduced, judged, seen as unworthy and rejected, but also that it can guard

against negative self judgement.

Moreover, within my study lie many rich psychodynamic veins. These are not

limited to disclosure and concealment, but arguably point to the underpinnings of the

disorder itself; this, too, could add to current theoretical understandings of OCD. For

example, my fear synthesis, repeated below, seems testament to psychodynamic

dimensions:
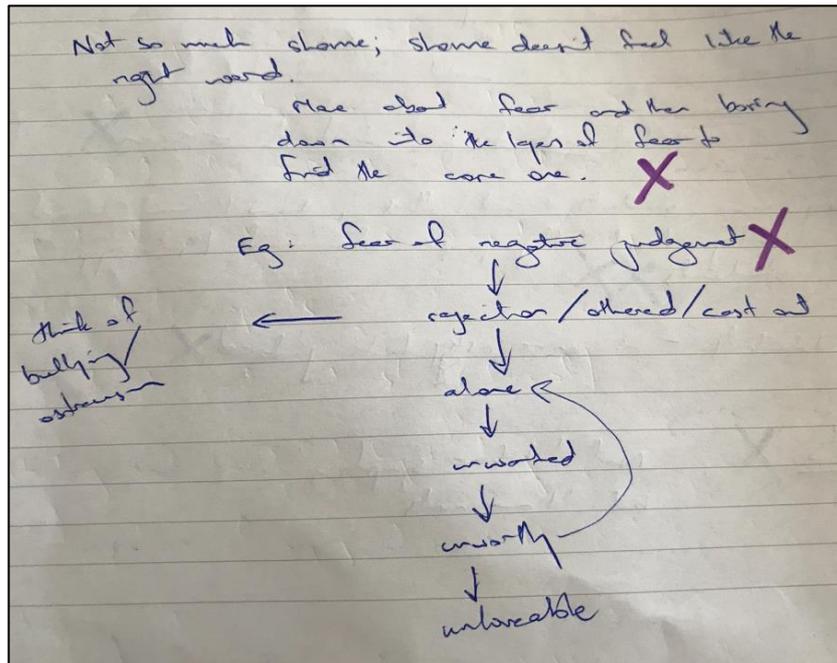
Figure 3: Fear synthesis

As a psychotherapist, this makes me wonder about where this sense of myself as

unworthy and unlovable comes from; here I have drilled down during my immersion from

fear of negative judgement and have ended up somewhere that could benefit from

psychodynamic psychotherapy in place of or alongside CBT. Furthermore, I mention in

chapter one the fact that the PDM refers to OCD as "a façade superimposed on a deeper,

hidden, more disturbed mental functioning" (p. 172). For me, particularly in the light of

my findings, this suggests the need to more deeply understand sufferers' experiences of

the disorder, an understanding that has been augmented by the present study as I face

into this deep sense of being unworthy and unlovable.

6.2 Implications for psychotherapeutic practice

If we were to theorise OCD in new ways, we might think about treating the disorder in

new ways: we might treat it psychodynamically or phenomenologically, with or without

the use of CBT techniques. If I were to be treated by a psychodynamic psychotherapist

who empathically explored my emotional experience with me – my deep fear of rejection, for example – we might begin to understand the dynamics that underpin and drive the disorder, and through this I might gain further self-knowledge and perhaps a measure of relief. This empathy is fundamental for the establishment of the therapeutic alliance, which itself is deemed essential for effective therapy (Kahn, 2001; McWilliams, 2004; Haugh & Paul, 2008).

Robinson, Rose and Salkovskis (2017) mention fear many times – for example, "fear of stigma as a barrier to seeking help" (p. 207). For me, this stigma is fear of reduction, negative judgement and rejection, which could provide the practitioner with a better understanding of the complexity the client experiences. This could mean an opportunity for the practitioner to treat a whole person and not a set of symptoms. As Dr Brian Broom, immunologist and psychotherapist at Auckland Hospital, wrote in a Mindbody Network newsletter (Broom, 2017), the client's material will emerge when "the **venue** shifts from one of information, expertise and fixing, to a **venue of *relationship*** between the *two persons*, the clinician and the patient" (bold and italics in original). For me this recalls Rogers' (1957) contention that "change does not occur except in relationship" (p. 96), and I believe that the therapeutic relationship can only be strengthened and become more effective through a connection with the sufferer as a whole person.

I also believe that the findings offer mental health practitioners another perspective on what it means for sufferers to delay help seeking. And if the client does walk though the door, the practitioner might have a better understanding of the what the person might be experiencing as they contemplate disclosure.

6.3 Implications for further psychotherapeutic research: My future studies

I would like to interview other OCD sufferers in a broader study that would qualitatively explore their experiences of concealment and disclosure of the disorder, especially if this means I could include participants from socio-cultural backgrounds other than my own. I would very much appreciate the opportunity to provide a wider, more diverse picture. As a white, middle-class, heterosexual male in 2018, I am simply a reflection of a certain subjective and socio-culturally situated experience. I want to know more.

I would also be interested in exploring the experience of disclosure and concealment of my specific OCD obsessions – the content of my OCD. For example, the study might explore my experience of disclosing x, y and z obsessions and their attendant compulsive behaviours in order to gauge any qualitative differences, which could then lead to an examination of the factors that might contribute to these experiences. This might help practitioners comprehend what it might be that stops sufferers from seeking help and/or how they experience their obsessions. If we knew more about this we could arguably better understand our clients and their needs.

While explicating the theme of 'disclosure and being known' (p. 69) I discovered that part of me wants to disclose because I wish to be known for all of who I am, despite how hard it is to reveal OCD. This led me to wonder about who it is I want to be known by, and I had a sense that I want to be known and accepted by men. There is, therefore, potential for further research into my OCD and its intersection with my experience of masculinity. I feel that in Aotearoa New Zealand, the stereotypical masculine traits of toughness, resilience, self-reliance and invulnerability outlined by Bannister (2005), Brannon (2005) and Foss, Domenico & Foss, (2013), could be factors in my difficulties disclosing, but I would need to explore this.

6.4 Implications for further psychotherapeutic research: Other researchers

Other researchers might add their heuristic, phenomenological 'answers' to the question I have explored; I am one voice expressing one subjective experience, and I believe that in adding more voices we might find new ways of thinking about treating the people who suffer from OCD. I would be interested in reading others' heuristic research that might expand the present study and provide more colour and illumination from lived experience.

There is also potential for research into the ways in which a sufferer's early developmental history and relationships with parents have contributed to their OCD experience, including their disclosure and concealment issues. These could then be explored in relation to the impacts of OCD on current interpersonal and therapeutic relationships.

I would also be interested in qualitative research exploring the concealment and disclosure of other mental illnesses in order to gauge whether or not OCD disclosure is qualitatively different from, say, that of depression or psychosis.

6.5 Implications for psychotherapy training

During my psychotherapy training, which was largely psychodynamic and relational, there was very little mention of OCD. When it was mentioned it was partnered with CBT, as per the current literature (Antony, Purdon & Summerfeldt, 2007; Swinson, Antony, Rachman & Richter, 1998; NICE, 2013; Spragg and Cahill, 2015; Koran & Simpson, 2013, as cited in Wheaton et al., 2016, p. 43). I have experienced very little mention of anything that might be underlying the disorder, and there has been limited discussion of how one might work

with a client with this diagnosis. I mentioned the diagnosis from time to time when I felt safe, but virtually never discussed my experience. I felt I would be misunderstood and reduced. I therefore believe that my findings can offer new information to those who train or supervise psychotherapists; there exists the potential for the disorder to come out of the shadows and be treated as a condition with the deeper dynamics and emotional realities that psychotherapists routinely explore with other presentations.

My findings perhaps suggest that CBT and exposure and ritual prevention (ERP), a symptom-based approach to extinguishing compulsive behaviour, may not go far enough toward understanding or healing OCD. The DSM-V and PDM note that OCD is an anxiety disorder, and I would argue that if we can treat other anxiety disorders with psychodynamic and relational psychotherapy then we could also do the same for OCD. I believe this is something that could be discussed during psychotherapy training in order that sufferers like myself feel less isolated.

7. Conclusion

I have articulated some of the barriers I experience when it comes to disclosing my OCD. My concealment and these barriers mean I have limited the support I could have received, and I have at times delayed seeking help and treatment. I have also found that disclosure can bring a sense of relief and wholeness. One of my aims was to offer other OCD sufferers insight into a lived experience; I hope that my study can add a human voice and colour to the spectrum of experience and body of knowledge pertaining to OCD as well as to the difficulties any mental health patient has in coming forward. I hope this might give other sufferers a sense that they are not alone and that speaking up and seeking support can be beneficial. I hope that mental health theorists and practitioners

find new insights here and that OCD can be treated in a way that honours its depth of experience.

I found that my experience was significantly under-represented, as are the voices of most OCD sufferers faced with the dilemma of concealing or revealing their diagnosis. For me there is a glaring hole in the collected understanding of what it is to tell a friend, a parent, a sibling, an employer, a doctor or, indeed, a psychotherapist, that one has OCD. This reluctance to seek help requires further exploration before the mental health profession can begin to comprehend what it is that is keeping sufferers from their practices and how to understand them when they do present.

Ozertugrul (2015) transparently articulates a belief with which I approached the present study: that heuristic research, the journey into oneself and the new insights that ideally abide in that search, can be healing. I feel that this philosophy reflects the process of psychotherapy. I found and began to understand new parts of myself through this research process; my fears found new expression, and I discovered a wholeness of being through disclosure. This has been immeasurably enlightening and rewarding.

Chapter 6

My intuitive response: Creative synthesis

1. Introduction

Moustakas (1990) argued that this phase of the heuristic process occurred once the researcher had become "thoroughly familiar with all the data in its major constituents, qualities and themes and in the explication of the meanings and details of the experience as a whole" (p. 31), which I believe is commensurate with how I feel at this point in my process. Moustakas (1990) contends that the creative synthesis springs from tacit knowing and intuition; he suggests that solitude and meditation are required, and so I gave myself plenty of space for the following expression to emerge. It began to develop while I was away by myself in Taupo, and I completed it in times of immersive reflection after I had completed the discussion. I "permit[ted] an inward life on the question to grow [and an] essence of the phenomenon investigated [to be] realised" (Moustakas, 1990, p. 32).

My creative synthesis incorporates three interconnected elements – a poem, two dioramas and a photo series. They emerged freely and from within. These three elements are inspired by two key phenomena: a song lyric and a lake.

2. Getting back up

The song lyric is from a melodic punk/rock band called Rise Against: "And like a single domino/ That falls while the rest stay vertical" (McIlrath, 2011), which for me reflects my perception of disclosing OCD. When I heard the line during my initial immersion phase it struck me that this is how I feel with OCD generally – that I am alone, that I have fallen

while everyone else is fine; this makes it very difficult to disclose the diagnosis. It also

recalls how I felt when I was ostracised at school. During my re-immersion/explication

phase, a response to my experience of this lyric emerged and I wrote: "And so the domino

got back up". For me this line reflects the courage and struggle of disclosure, but not only

that: it reflects the courage and struggle of living a life with OCD.

I then bought a box of dominoes and arranged them in a circle with one fallen

over. I was drawn to the cold, hard stainless-steel kitchen bench of my Taupo motel room

for this, as it seemed to represent the sense of the experience. I arranged the dominoes in

a circle and I note that most of them have their spots (or faces) directed at me, watching

me fall. I then went to the lake front and arranged them again as I thought about the

domino getting back up. It stands apart from the others, facing Lake Taupo.
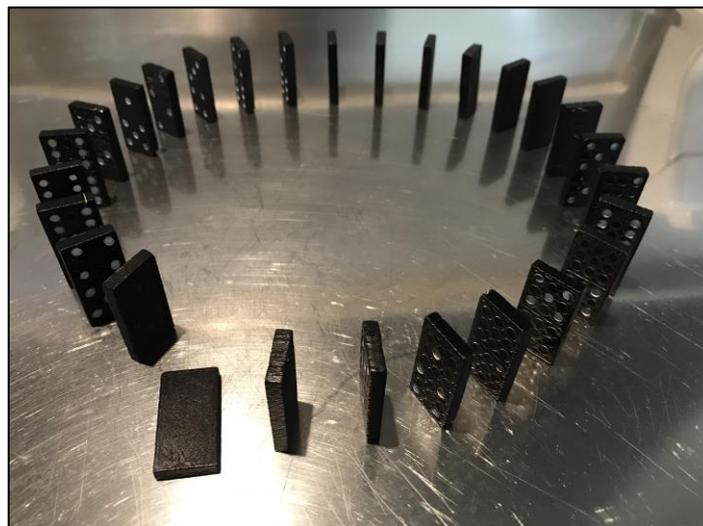
Figure 4: A single domino falls.

Figure 5: And so the domino got back up

3. The lake, the river and the dam: Not to speak and to speak

The second phenomenon that inspired my creative synthesis was Lake Taupo. For me it

represents not only the natural world, but how we sometimes interact with its flows and

freedoms unnaturally. I took a series of photographs that help represent my journey with

concealment, disclosure, fear, relief and wholeness. Lake Taupo is 186m deep, has a

surface area of 62,000 hectares and a total volume of 59km^3 (LAWA, n.d.) The lake is fed

by 30 sources and drained by just one: the Waikato River (ibid).

An enormous volume of water then surges powerfully through a narrow channel

and over Huka Falls just north of Taupo. It then flows onward as a wide, calm river before

being stopped by a dam at the Aratiatia Power Station. The dam is opened a few times a

day, letting the water surge again through a narrow, rocky canyon. This journey

metaphorically captures my experience of concealment and disclosure of OCD: Still, deep

waters; surging, captured for their energy and at the mercy of concrete, steel and human

engineering. When all the river needs is to keep flowing of its own accord. To not speak is

to be dammed. Perhaps I can now open that dam more readily.

Figure 6: Lake Taupo

Figure 7: The Waikato River gushes toward Huka Falls.

Figure 8: Huka Falls

Figure 9: Waikato River leaves Huka Falls

Figure 10: Aratiatia dam holds back the Waikato River

Figure 11: Waiting for the dam to open

And so the domino got back up

Lined up with all the others,

ready to fall together as dominoes do. Yet

it fell

        alone.

It lay   alone

Many times it

fell

face down and coldly observed.

Black; its coloured spots against the cold.

Inert.

A shapeless rectangle for whom rectangleness seems somehow wrong.

For whom lying alone seems somehow painfully right.

The others stood vertical and above and over and strong and better and free and together.

Their spots bright.

And I fell

or thought I would fall

if I was weak.

But the fall was not the end.

The fall was the beginning.

Scratched and chipped and afraid,

the domino waited and saw that all was not well.

Rolled onto its back and stared at the unknowing and unknowable sky.

The blue, the grey, the stars.

Because there was something or could be.

And so the domino got back up.

It watched a lake become a river.

Coursing and charging blue white,

surging over a fall

before calmly rolling on

To be stopped.

A wall.

The water, its weight and rage and power held back,

the craggy path beyond and ahead dry and waiting.

The domino did not wait for the dam to open,

For the energy of the river to be harnessed.

But took instead the craggy path beyond

References

Abramowitz, J. S., Deacon, B. J., Olatunji, B. O., Wheaton, M. G., Berman, N. C., Losardo, D., ... & Björgvinsson, T. (2010). Assessment of obsessive-compulsive symptom dimensions: Development and evaluation of the dimensional obsessive-compulsive scale. *Psychological Assessment*, *22*(1), 180. DOI: 10.1037/a0018260

Abrams, M. H. (1988). *A glossary of literary terms* (5e). Fort Worth, TX: Harcourt Brace Jovanovich

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (DSM-5®)*. American Psychiatric Publishing.

Antony, M., Purdon, C. & Summerfeldt, L. (2007). *Psychological treatment of obsessive-compulsive disorder: Fundamentals and beyond*. Washington, DC: American Psychological Association.

Armstrong, B. J., Dirnt, M., & Cool, T. (2004). Boulevard of broken dreams [Recorded by Green Day]. On *American Idiot* [AAC] United States: Reprise.

Bannister, M. (2005). Kiwi Blokes: Recontextualising white New Zealand masculinities in a global setting. *Genders OnLine*, 42. Retrieved from www.genders.org/g42/g42_bannister.html.

Baynes, K., Bohman, J., McCarthy, T., & McCarthy, T. A. (Eds.). (1987). *After philosophy: End or transformation?*. MIT Press.

Belloch, A., del Valle, G., Morillo, C., Carrió, C., & Cabedo, E. (2009). To seek advice or not to seek advice about the problem: The help-seeking dilemma for obsessive-compulsive disorder. *Social Psychiatry and Psychiatric Epidemiology*, *44*(4), 257. https://doi-org.ezproxy.aut.ac.nz/10.1007/s00127-008-0423-0

Brannon, L. (2005). *Gender: Psychological perspectives*. Boston, USA: Pearson

Bril-Barniv, S., Moran, G. S., Naaman, A., Roe, D., & Karnieli-Miller, O. (2017). A qualitative study examining experiences and dilemmas in concealment and disclosure of people living with serious mental illness. *Qualitative Health Research*, *27*(4), 573-583. DOI: 10.1177/1049732316673581

Brohan, E., Henderson, C., Wheat, K., Malcolm, E., Clement, S., Barley, E. A., ... & Thornicroft, G. (2012). Systematic review of beliefs, behaviours and influencing factors associated with disclosure of a mental health problem in the workplace. *BMC Psychiatry*, *12*(1), 11. doi.org/10.1186/1471-244X-12-11

Brooks, J., Johnson, B., & Zea, K. (Producers) & Brooks, J. (Director). (1997). *As good as it gets* [Motion picture]. United States: TriStar Pictures.

Brooks, W., & Browne, S. (2012). Towards a culturally situated reader response theory. *Children's Literature in Education*, *43*(1), 74-85. https://doi.org/10.1007/s10583-011-9154-z

Broom, B. (2017, August). The 'good' clinician: Default behaviours, and relationship-based 'expertise'. *Mindbody Network News Letter August 2017.*

Charles, J. L., & Bentley, K. J. (2018). Measuring mental health provider-based stigma: Development and initial psychometric testing of a self-assessment instrument. *Community Mental Health Journal*, *54*(1), 33-48. https://doi.org/10.1007/s10597-017-0137-4

Chasson, G. S., Guy, A. A., Bates, S., & Corrigan, P. W. (2018). They aren't like me, they are bad, and they are to blame: A theoretically-informed study of stigma of hoarding disorder and obsessive-compulsive disorder. *Journal of Obsessive-Compulsive and Related Disorders*, *16*, 56-65. https://doi.org/10.1016/j.jocrd.2017.12.006

Chernin, P., Zaillian, S., Topping, J., & Ready, D. (Producers) & Lawrence, F. (Director). (2018). *Red Sparrow* [Motion picture]. United States: 20th Century Fox.

Cooper, M. (2004). Literature searching [Handout]. Glasgow, UK: University of Strathclyde, Advanced Professional Training in Counselling Research

Day, E. (2018). *The phenomenological method in therapeutic practice*. [Unpublished PowerPoint slides]. Clinical Supervision, AUT.

Dostal, R. J. (2000). Subjectivism, philosophical reflection and the Husserlian phenomenological account of time. In Wiegand, O. K., Seebohm, T. M., Dostal, R. J., Embree, L., Kockelmans, J. J., & Mohanty, J. N. (Eds.). (2000). *Phenomenology on Kant, German Idealism, Hermeneutics and Logic: Philosphical Essays in Honor of Thomas M. Seebohm* (Vol. 39). Springer Science & Business Media.

Douglass, B. G., & Moustakas, C. E. (1985). Heuristic inquiry: The internal search to know. *Journal of Humanistic Psychology, 25*(3), 39-55. doi: 10.1177/0022167885253004

Englar-Carlson, M., Stevens, M. (2006). *In the room with men: A casebook of therapeutic change*. Washington, USA: American Psychological Association

Etherington, K. (2004). *Becoming a reflexive researcher: Using our selves in research*. London, UK: Jessica Kingsley Publishers.

Faerna, José María (1995). *Munch.* New York, NY: Harry N. Abrams.

Fergus, T. A., Valentiner, D. P., McGrath, P. B., & Jencius, S. (2010). Shame-and guilt-proneness: Relationships with anxiety disorder symptoms in a clinical sample. *Journal of Anxiety Disorders*, *24*(8), 811-815. https://doi.org/10.1016/j.janxdis.2010.06.002

Foss, S., Domenico, M., Foss, K. (2013). *Gender studies: Negotiating identity in a binary world*, Illinois, USA: Waveland Press.

Freud, S. (1896). *The complete psychological works of Sigmund Freud, Volume I*, 'Pre-psychoanalytic publications and Unpublished drafts', *The standard edition of the complete psychological works*, ed. Strachey, J. (1966), London: The Hogarth Press and The Institute of Psychoanalysis.

Grant, B., & Giddings, L. (2002). Making sense of methodologies: A paradigm framework for the novice researcher. *Contemporary Nurse*, 13, 10-28. https://doi-org.ezproxy.aut.ac.nz/10.5172/conu.13.1.10

Greene, K. (2009). An integrated model of health disclosure decision-making. In T. Afifi & W. Afifi (Eds.), *Uncertainty and information regulation in interpersonal contexts: Theories and applications* (pp. 226–253). New York: NY: Routledge.

Hardiman, M., (2002). *Ordinary heroes: A future for men*. Dublin, Ireland: Newleaf

Harrington, K. P. (2014). *Emerging from the wreckage: The exploration of mental health, stigma, and my experiences of living with obsessive-compulsive "disorder"*. (Masters Thesis, Wilfrid Laurier University, Ontario, Canada). Retreived from https://scholars.wlu.ca

Haugh, S. & Paul, S. (2008). *The therapeutic relationship: Perspectives and themes*. Monmouth, UK: PCCS Books.

Henretty, J., & Levitt, H. (2010). The role of therapist self-disclosure in psychotherapy: A qualitative review. *Clinical Psychology Review*, *30*(1), 63-77. doi-org.ezproxy.aut.ac.nz/10.1016/j.cpr.2009.09.004

Hinshelwood, R. (1991). Psychodynamic formulation in assessment for psychotherapy. *British Journal of Psychotherapy*, Vol. 8(2), 166-174

Hyman, B. M., & Pedrick, C. (2005). *The OCD workbook* (2e). Oakland, CA: New Hamburg Publications, Inc.

Johnson, S. (1994). *Character styles*. New York, NY: W.W. Norton & Company

Jorm, A.F., Korten, A.E., Jacomb, P.A., Christensen, H., Rodgers, B, Pollitt, P (1997). 'Mental health literacy': A survey of the public's ability to recognise mental disorders and

their beliefs about the effectiveness of treatment. *Medical Journal of Australia* 166, 182–186.

Jorm, A.F. (2000). Mental health literacy: Public knowledge and beliefs about mental disorders. *British Journal of Psychiatry* 177, 396–401.   https://doi-org.ezproxy.aut.ac.nz/10.1192/bjp.177.5.396

Jourard, S. (1971). *The transparent self*. New York, NY: Litton Educational Publishing

Jung, C. (1962). Memories, Dreams, Reflections [Website]. Retrieved from https://archive.org/stream/MemoriesDreamsReflectionsCarlJung/Carl+Jung+Quotations+sourced+final_djvu.txt

Kahn, M. (2001). *Between therapist and client: The new relationship*. New York, NY: Henry Holt and Company

Kalmbach Phillips, D., Harris, G., Legard Larson, M., & Higgins, K. (2009). Trying on – being in – becoming: Four women's journey(s) in feminist poststructural theory. *Qualitative Inquiry*, *15*(9), 1455-1479. http://journals.sagepub.com.ezproxy.aut.ac.nz doi/pdf/10.1177/1077800409347097

Kaufman, S. E. (2016). *The effects of therapist self-disclosure of a mental health condition on client perceptions of the therapist*. (Doctoral thesis, Philadelphia College of Osteopathic Medicine, Philadelphia, USA). Retreived from https://digitalcommons.pcom.edu/cgi/viewcontent.cgi?article=1386&context=psychology_dissertations

Keppel, J. (2012). Re-imaging the 'Kiwi Bloke': Low places and anxious spaces in Aotearoa New Zealand. Retrieved from http://researchcommons.waikato.ac.nz/handle/10289/7564

Koran, L., & Simpson, H. (2013). Guideline watch (March 2013): Practice guideline for the treatment of patients with obsessive-compulsive disorder (In APA Practice Guidelines). Arlington, VA: American Psychiatric Publishing, Inc.

Langdridge, D. (2013). *Existential counselling and psychotherapy*. London, UK: Sage.

Laverty, S. M. (2003). Hermeneutic phenomenology and phenomenology: A comparison of historical and methodological considerations. *International Journal of Qualitative Methods*, *2*(3), 21-35. http://journals.sagepub.com.ezproxy.aut.ac.nz/doi/pdf/10.1177/160940690300200 303

LAWA (n.d.). *Lake Taupo*. Retrieved September 5, 2018, from https://www.lawa.org.nz/explore-data/waikato-region/lakes/lake-taupo/

Lingiardi, V., & McWilliams, N. (2017). *Psychodynamic diagnostic manual-2*. New York, NY: The Guilford Press

Linkin Park lyrics (n.d.). Retrieved August 1, 2018, from https://www.azlyrics.com/lyrics/linkinpark/crawling.html

Loewenthal, D., & Winter, D. (Eds.). (2006). *What is psychotherapeutic research?*. London, UK: Karnac Books.

Machi, L., & McEvoy, B. (2016). *The literature review: Six steps to success*. Thousand Oaks, CA: Corwin

Malan, D. (1995). *Individual psychotherapy and the science of psychodynamics*. London, UK: Butterworths.

Maroda, K. (1999). *Seduction, surrender and transformation: Emotional engagement in the analytic process*. Hillsdale, NJ: The Analytic Press

Maroda, K. (2010). *Psychodynamic techniques: Working with emotion in the therapeutic relationship*. New York, NY: The Guilford Press.

McCarty, R. J., Guzick, A. G., Swan, L. K., & McNamara, J. P. (2017). Stigma and recognition of different types of symptoms in OCD. *Journal of Obsessive-Compulsive and Related Disorders*, *12*, 64-70. https://doi.org/10.1016/j.jocrd.2016.12.006

McCouat, M & Peile, C (1995): The micro politics of qualitative research traditions. *Qualitative research: Beyond the boundaries*. Curtin University of Technology & Sir Charles Gairdner Hospital, Fremantle, Australia.

McIlrath, T. (2011). Disparity by design [Recorded by Rise Against]. On *Endgame* [AAC] Colorado, USA: DGC

McWilliams, N. (2004). *Psychoanalytic psychotherapy: A practitioner's guide*. New York, NY: The Guilford Press.

McWilliams, N. (2011). *Psychoanalytic diagnosis: Understanding personality structure in the clinical process* (2e). New York, NY: The Guilford Press.

Moustakas, C. E. (1990). *Heuristic research: Design, methodology, and applications*. Newbury Park, CA: Sage Publications

New Zealand Association of Psychotherapists (NZAP). (2008). *Code of Ethics.* Retrieved on August 18, 2017, from http://nzap.org.nz/handbook/code-of-ethics/

NICE (2013). Obsessive-compulsive disorder: Evidence update September 2013. NICE clinical guideline 31. Retrieved from https://www.nice.org.uk/guidance/cg31/evidence/evidence-update-194847085.

Oxford English Dictionary. (2000). Oxford, UK: Oxford University Press.

Ozertugrul, E. (2015). Heuristic self-search inquiry into one experience of obsessive–compulsive disorder. *Journal of Humanistic Psychology*, *57*(3), 215-236. DOI: 10.1177/0022167815592503

Picco, L., Abdin, E., Pang, S., Vaingankar, J. A., Jeyagurunathan, A., Chong, S. A., & Subramaniam, M. (2018). Association between recognition and help-seeking preferences and stigma towards people with mental illness. *Epidemiology and Psychiatric Sciences*, *27*(1), 84-93. doi:10.1017/S2045796016000998

Polanyi, M. (1966). *The tacit dimension*. Gloucester, Mass.: Peter Smith

Poyraz, C. A., Turan, Ş., Sağlam, N. G. U., Batun, G. Ç., Yassa, A., & Duran, A. (2015). Factors associated with the duration of untreated illness among patients with obsessive compulsive disorder. *Comprehensive Psychiatry*, *58*, 88-93. https://doi.org/10.1016/j.comppsych.2014.12.019

Prendergast, M. (2015). Poetic inquiry, 2007-2012: A surrender and catch found poem. *Qualitative Inquiry*, *21*(8), 678-685. DOI: 10.1177/1077800414563806

Probst, B. (2015). Queen of the owls: Metaphor and identity in psychiatric diagnosis. *Social Work in Mental Health*, *13*(3), 235-251. https://doi.org/10.1080/15332985.2014.893946

Ridley, D. (2008). *The literature review: A step-by-step guide for students*. Los Angeles, CA: Sage

Robinson, K. J., Rose, D., & Salkovskis, P. M. (2017). Seeking help for obsessive compulsive disorder (OCD): A qualitative study of the enablers and barriers conducted by a researcher with personal experience of OCD. *Psychology and Psychotherapy: Theory, Research and Practice*, *90*(2), 193-211. DOI:10.1111/papt.12090

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality

  change. *Journal of Consulting Psychology*, *21*(2), 95.

Rogers, C. (1980). *A way of being*. New York, NY: Houghton Mifflin.

Russell, B. (2005). *History of western philosophy*. London, UK: Routledge

Ruudzik2 (2008, September 13). *Linkin Park ft Chris Cornell – Crawling/HHH* [Video file].

  Retrieved from https://www.youtube.com/watch?v=F_v1SLIt01Q

Sela-Smith, S. (2002). Heuristic research: A review and critique of Moustakas's method.

  Journal of Humanistic Psychology, 42(3), 53.

  http://journals.sagepub.com/doi/pdf/10.1177/0022167802423004

Shafran, R., Watkins, E., & Charman, T. (1996). Guilt in obsessive-compulsive disorder. *Journal*

  of Anxiety Disorders, 10(6), 509-516. https://doi.org/10.1016/S0887-

  6185(96)00026-6

Shakespeare, W. (1980). *Hamlet* (Spencer, T. J. B. Ed.). London, UK: Penguin.

Shakespeare, W. (1968) *Othello*. (Muir, K. Ed.). London, UK: Penguin

Shedler, J. (2010). The efficacy of psychodynamic psychotherapy. *American*

  Psychologist, *65*(2), 98. Retrieved from https://ovidsp-tx-ovid-

  com.ezproxy.aut.ac.nz/ ISSN: 0003-066X

Smith, A. D. (2003). *Routledge philosophy guidebook to Husserl and the Cartesian meditations*.

  Routledge.

Smith, D. W. (2013). Phenomenology. The Stanford encyclopedia of philosophy (Winter 2013

  Edition). E. N. Zalta, ed.

  http://plato.stanford.edu/archives/win2013/entries/phenomenology

Solomon, M. (2018). *Reflexivity and relational skills II* [Paper handbook] PSYT808 Reflexivity
and relational skills II. Retrieved from https://blackboard.aut.ac.nz

Spragg, M., & Cahill, S. (2015). 'Life just kind of sparkles': Clients' experiences of being in
cognitive behavioural group therapy and its impact on reducing shame in obsessive
compulsive disorder. *The Cognitive Behaviour Therapist*, *8*.
doi:10.1017/S1754470X15000100

Steinberg, D. S., & Wetterneck, C. T. (2017). OCD taboo thoughts and stigmatizing attitudes in
clinicians. *Community Mental Health Journal*, *53*(3), 275-280.
https://doi.org/10.1007/s10597-016-0055-x

Stolorow, Brandchaft & Atwood (1987). *Psychoanalytic treatment: An intersubjective
approach*. Hillsdale, NJ: The Analytic Press.

Sultan, N. (2019). *Heuristic inquiry: Researching human experience holistically.* Thousand Oaks,
CA: SAGE Publications.

Swinson, R. P., Antony, M. M., Rachman, S., & Richter, M. A. (Eds.). (2001). *Obsessive-
compulsive disorder: Theory, research, and treatment*. Guilford Press

Tomsett, L. (2009). *Obsessive-compulsive disaster* [Tauranga] NZ: L. Tomsett, 2009.

Waugh, W., Lathem, C., Sherring, S., & Henderson, C. (2017). Exploring experiences of and
attitudes towards mental illness and disclosure amongst health care professionals: A
qualitative study. *Journal of Mental Health*, *26*(5), 457-463.
https://doi.org/10.1080/09638237.2017.1322184

Weedon, C. (1997): *Feminist practice and poststructuralist theory*, Oxford, UK: Basil Blackwell.

Weiss, J. (1993). *How psychotherapy works: Process and technique*. New York, NY: Guilford Press.

Wetterneck, C. T., Singh, S., & Hart, J. (2014). Shame proneness in symptom dimensions of obsessive-compulsive disorder. *Bulletin of the Menninger Clinic*, *78*(2), 177- 190. doi:10.1521/bumc.2014.78.2.177

Wheaton, M. G., Sternberg, L., McFarlane, K., & Sarda, A. (2016). Self-concealment in obsessive-compulsive disorder: Associations with symptom dimensions, help seeking attitudes, and treatment expectancy. *Journal of Obsessive-Compulsive and Related Disorders*, *11*, 43-48. https://doi.org/10.1016/j.jocrd.2016.08.002

Worth, H., Paris, A., Allen, L. (2002). *The life of Brian: Masculinities, sexualities and health in New Zealand*. Dunedin, New Zealand: University of Otago Press

Wright, A., Jorm A. & Mackinnon, A. (2012). Labels used by young people to describe mental disorders: Which ones predict effective help-seeking choices? *Social Psychiatry and Psychiatric Epidemiology* 47, 917–926.https://doi.org/10.1007/s00127-011-0399-z

Yap, M., Reavley N. & Jorm, A.(2014). The associations between psychiatric label use and young people's help-seeking preferences: Results from an Australian national survey. *Epidemiology and Psychiatric Sciences* 23, 51–59. doi:10.1017/S2045796013000073