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SHAME AND TABOO IN OBSESSIVE-COMPULSIVE DISORDER: IMPLICATIONS FOR THE COGNITIVE-BEHAVIOURAL THERAPIES

Section A: A critical appraisal and narrative review of the association between taboo obsessions in OCD and outcomes following Cognitive-Behavioural Therapy.

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Section B: Overcoming the ‘Shame Shield': a preliminary grounded theory of how Cognitive-Behavioural Therapies may proceed in the presence of high levels of shame in OCD.

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Summary of the Major Research Project

Section A

This is a critical appraisal and narrative review of 11 quantitative studies, investigating the association between taboo obsessions in OCD and treatment outcomes following CBT/ERP. Sexual and religious obsessions were found to be associated with poorer outcomes following CBT/ERP (compared to OCD without such obsessions), with small effect sizes. The picture for violent obsessions was more complex, and synthesis was challenging due to methodological limitations of the reviewed studies. Research and clinical implications are discussed, including the possibility that these findings would be better explained by the covariation of taboo obsessions with feelings of shame.

Section B

This is an empirical study, using a grounded theory methodology to explore how CBT/ERP may proceed when OCD is characterised by high levels of shame. Twelve individual interviews, with 5 therapists and 7 experts-by-experience, led to the development of a preliminary grounded theory model. This introduces the concept of the "shame shield" to show how the presence of shame may function as a context which interrupts or slows down necessary therapeutic processes (which may proceed in different ways depending on the characteristics of the person and their therapist). Findings are discussed in relation to relevant theory and current clinical practice, considering study limitations and implications.

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Section A: Literature Review

A critical appraisal and narrative review of the association between taboo obsessions in OCD and outcomes following Cognitive-Behavioural Therapy.

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Abstract

This section used a systematic literature search, followed by a critical appraisal and narrative review of findings, to explore the association between taboo obsessions and treatment outcomes following cognitive-behavioural therapies. 11 relevant studies were identified, published between 2002 and 2022. Despite methodological limitations, findings indicated that taboo obsessions are associated with poorer treatment outcomes, with a small effect size. This outcome was clearer for sexual and religious obsessions, whereas outcomes related to violent obsessions were more mixed, perhaps due to imprecise conceptualisations in research. In discussing research and clinical implications, it is suggested that these findings might be explained by the covariation of taboo obsessions with feelings of shame.

Keyword(s): OCD, CBT, ERP, Taboo Obsessions, Unacceptable Obsessions

Introduction

"Obsessive-compulsive disorder" (OCD) is a diagnosis associated with particularly high levels of disability (Mathers & Loncar, 2006), along with low levels of access to (Kohn et al., 2004) and benefit from (Öst et al., 2015) treatment. It is characterised by obsessions ("recurrent and persistent thoughts, urges, or images that are experienced as intrusive and unwanted" - APA, 2013, p.235) and/or compulsions ("repetitive behaviours or mental acts that an individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly" - APA, 2013, p.235), which significantly disrupt a person's daily life. While some may challenge describing individuals as 'disordered' (e.g. Johnstone et al., 2018), OCD is a label which many people with lived experience find useful as a shorthand for their difficulties (e.g. Salkovskis & Edge, 2018). Lack of accurate diagnosis (when OCD symptoms are present) is associated with a variety of negative outcomes (Stahnke, 2021). Reflecting the current terminology of the academic literature, this MRP will discuss 'symptoms of OCD', while recognising that such constructions are not uncontroversial.

The recommended psychological intervention for OCD in the UK is Exposure and Response Prevention (ERP), with or without cognitive therapy (NICE, 2005). The core aim of ERP is to enable a person to tolerate a distressing obsession, without taking compulsive action to neutralise or prevent the distressing situation. This is variously understood as enabling habituation to anxiety-inducing contexts (Foa and Kozak, 1986) or as strengthening alternative emotional memories in relation to the distressing context (Craske et al., 2014). Although it is considered the gold standard in treatment, ERP has only a moderate response rate, with 50.0% of recipients achieving clinically significant change (43.4% with additional cognitive therapy; Öst et al., 2015). This may reduce to as few as 20% of recipients remaining well at long-term follow-up (Bloch et al., 2013).

One factor potentially contributing to these findings is the heterogeneity of experiences diagnosed as OCD (Bream et al., 2017). This has been recognised since the earliest days of the diagnosis (Lewis, 1936) as a challenge for the construct of OCD. Recent years have seen the reclassification of obsessional hoarding behaviour from a type of OCD to a separate "hoarding disorder" (Mataix-Cols et al., 2010) due to the extent of heterogeneity in presentation and treatment response, but OCD still includes experiences as diverse as excessive hand-washing, reassurance-seeking, and metaphysical preoccupations (OCD-UK, 2022).

One distinctly different variant of OCD which has been the subject of some controversy is that where a person may present without visible compulsions or "overt rituals" (Freeston et al., 1997). This is often described by people with lived experience of the condition as "Pure O" (Bretécher, 2013), although such a construction has been challenged robustly (Clark & Guyitt, 2007) due to the presence of mental compulsions such as thought control or compulsive prayer (Act Beyond OCD, 2022). Such presentations of OCD are often characterised by intrusive thoughts which the person finds abhorrent. In the academic literature these have been described as "unacceptable thoughts" (Abramowitz et al., 2003), "forbidden thoughts" (Bloch et al., 2008), or "taboo thoughts" (Pinto et al., 2008). The most common themes for such thoughts are sexual, religious, and violent in nature (Ruscio et al. 2010). Examples are given in Table 1. Regularly experiencing taboo obsessions is associated with a higher level of functional impairment, and a lower quality of life, compared to experiences of OCD without taboo obsessions (Vorstenbosch et al., 2012).

Table 1

Examples of Taboo Obsessions in OCD

Theme	Example
Sexual	Jules is in the middle of an important meeting when they suddenly experience intrusive images of their manager naked. The images feel so alarming, Jules tries to push them out of their head, but that doesn't help. Instead, more images keep popping up.
Religious	Francis is attending a religious service and suddenly thinks of something funny. He begins asking himself, "I can't believe I almost just laughed during Mass. There must be something wrong with me. Should I confess? Am I going to hell?"
Violent	Jennie is sharpening her pencil in a classroom when she suddenly has the thought, "This pencil is really sharp," followed by an intrusive image of herself hurting a classmate with the pencil. She may start thinking, "I could actually hurt someone. I shouldn't be in this class. I need to leave right now or I could endanger the other classmates."

Note. Adapted from https://www.treatmyocd.com/blog/pure-obsessional-ocd. © 2022 NOCD Inc

OCD without overt compulsions constituted a challenge for the early days of ERP therapy, as without a visible compulsion to target it was hard to proceduralise "response prevention". However, once mental compulsions were characterised (and understood to be functionally indistinguishable from overt compulsions; Freeston et al., 1997; Clark & Guyitt, 2007), ERP no longer required an external behavioural target. Thus ERP is still the recommended treatment for all presentations of OCD (NICE, 2005), including "Pure O". However, debate has remained in the literature about whether different subtypes of OCD may require different approaches to treatment.

Starcevic and Brakoulis' (2008) review found that taboo obsessions were associated with less favourable outcomes from CBT/ERP (compared to other subtypes of OCD), particularly religious and sexual obsessions. Similar findings were evident in the review by Williams et al. (2013), who found evidence that CBT/ERP for unacceptable thoughts may take longer, and be less effective, than for other OCD subtypes. In contrast, six out of nine studies reviewed by Thorsen et al. (2018) found that the presence of sexual/religious obsessions was

not associated with worse therapeutic outcomes (the remaining three did find a negative impact).

None of these recent reviews report a systematic literature search methodology. Some of their inclusions seem somewhat questionable, particularly Thorsen et al. (2018) who refer to papers where CBT and medication are not disaggregated in the analysis (Alonso et al., 2001), and studies carried out so long ago that their treatment protocols significantly differed from modern CBT/ERP interventions (Başoğlu et al., 1988; Foa & Goldstein, 1978). Furthermore all three reviews appear to limit themselves to studies with adult participants, potentially excluding findings of relevance in relation to paediatric samples. Thus it is not clear that these reviews are representative of the current state of research evidence regarding current clinical practice across the lifespan. Taken together they suggest that OCD where taboo obsessions are present may be associated with poorer treatment outcomes compared to other subtypes of OCD, but given the heterogeneity in the literature this is not yet clear and requires further investigation.

Rationale & Aims

Taboo obsessions in OCD remain an active area of research interest (e.g Gagné et al., 2021. Muslow-Davies & Anderson, 2022). Although several recent reviews have considered the evidence for the impact of such obsessions on treatment outcome, none of these reviews have used a systematic search strategy, or rigorously analysed the methodological approaches of the reviewed papers.

It is appropriate to re-review a domain when existing reviews lack validity, and the research area remains current (Garner et al., 2016). The current paper details a literature review, applying a systematic search strategy and quality appraisal, and addressing the three most common types of taboo obsession (Ruscio et al., 2010). To ensure an exhaustive search

(maximising ecological validity and applicability to the widest range of clinical contexts), the broadest possible inclusion criteria were applied, and two related hypotheses were assessed: the first relating to experimental designs which analyse at the level of symptom dimension (using regression analysis or other computational modelling), and the second relating to experimental designs which analyse at the level of participants with/without a certain symptom type (using mean-comparison statistics). (1) That the presence or severity of sexual, religious, and/or violent obsessions in OCD will predict poorer outcomes following CBT/ERP treatment; and (2) That people who experience OCD characterised by sexual, religious, and/or violent obsessions will show poorer treatment outcomes following CBT/ERP treatment, compared to people who do not experience such obsessions.

Method

Design

A literature review was planned using a systematic search strategy. A meta-analysis was considered as a possible design for this review, however the papers retrieved were insufficiently homogenous to support this (Russo, 2007). Papers were instead reviewed narratively, although effect sizes have been reported where possible in order to permit some limited quantitative synthesis (Bailar, 1997). Foregrounding effect sizes also enabled this review to consider findings which may (due to small sample sizes) be clinically meaningful without being statistically significant (Borenstein, 2009, p.299).

Search Strategy

A systematic literature search was carried out across the databases PsycInfo, Medline, and Web of Science on 27 October 2022. The aim was to identify any study where differential CBT/ERP outcomes in OCD were analysed according to symptom sub-type, even if this was

not the primary aim of the study. Three search categories were derived and linked with Boolean AND (see Table 2). Given the particular focus of this review on the three most common types of taboo obsessions (Ruscio et al., 2010), additional keywords were added in relation to this symptom dimension, along with words relating to common religious, sexual, and violent themes. These were chosen based on observations during exploratory literature searches, interactions with experts-by-experience, and further validated through supervision from clinical researchers with expertise in OCD. Full abstracts were searched, so that relevant research was returned even if analysis by symptom dimension was not the titular aim of the study.

The database search was augmented by hand-searching the reference lists of relevant papers (those meeting inclusion criteria, along with review articles of relevance to the research question).

Table 2

Database Search Terms

Criterion	Search String
Condition	OCD OR obsess*
Treatment	CBT OR "cognitive behavi*" OR ERP OR Exposure
Variation	religious OR sexual OR violent OR paedo* OR pedo* OR pure* OR unacceptable OR taboo OR intrusive OR scrupul* OR dimension* OR ego-dystonic OR sub-type* OR dystonic OR egodystonic OR subtype*

Inclusion/Exclusion Criteria

The PICOS system (Liberati et al., 2009) was used to guide the inclusion/exclusion of studies.

Participants

Clinically naturalistic samples were sought - this was defined as participants having accessed treatment for psychological distress, and having received a formal diagnosis of OCD (confirmed by clinical judgement, such as a diagnostic interview) as part of this process. Thus studies which applied diagnostic measures to samples of the general public were excluded. There were no exclusion criteria with regard to age or co-morbidity, to increase the scope and ecological validity of the studies reviewed.

Interventions

This review was interested in evidence-based psychological therapy for OCD, which at the time of writing meant CBT, including ERP (NICE, 2005). If studies included multiple different types of intervention, then the CBT/ERP condition must be disaggregated for purposes of analysis.

Older forms of therapy, such as those which would have been retrieved with search terms related to "behaviour therapy", were judged to be too distant from current treatment recommendations (NICE, 2005). In effect this limited the field to studies published within the last twenty years, although no formal date cut-off was used. Studies which described their interventions as CBT were considered eligible, along with those which named only ERP but acknowledged an approach more nuanced than the purely behavioural (e.g. the targeting of mental compulsions).

Control Condition

There was no requirement for studies to have a control condition for the purposes of this review.

Outcomes

Accepted outcomes included any quantitative measure of treatment response - this included measures of symptom severity or quality of life - which had been validated (for example through a published psychometric paper).

Study Design

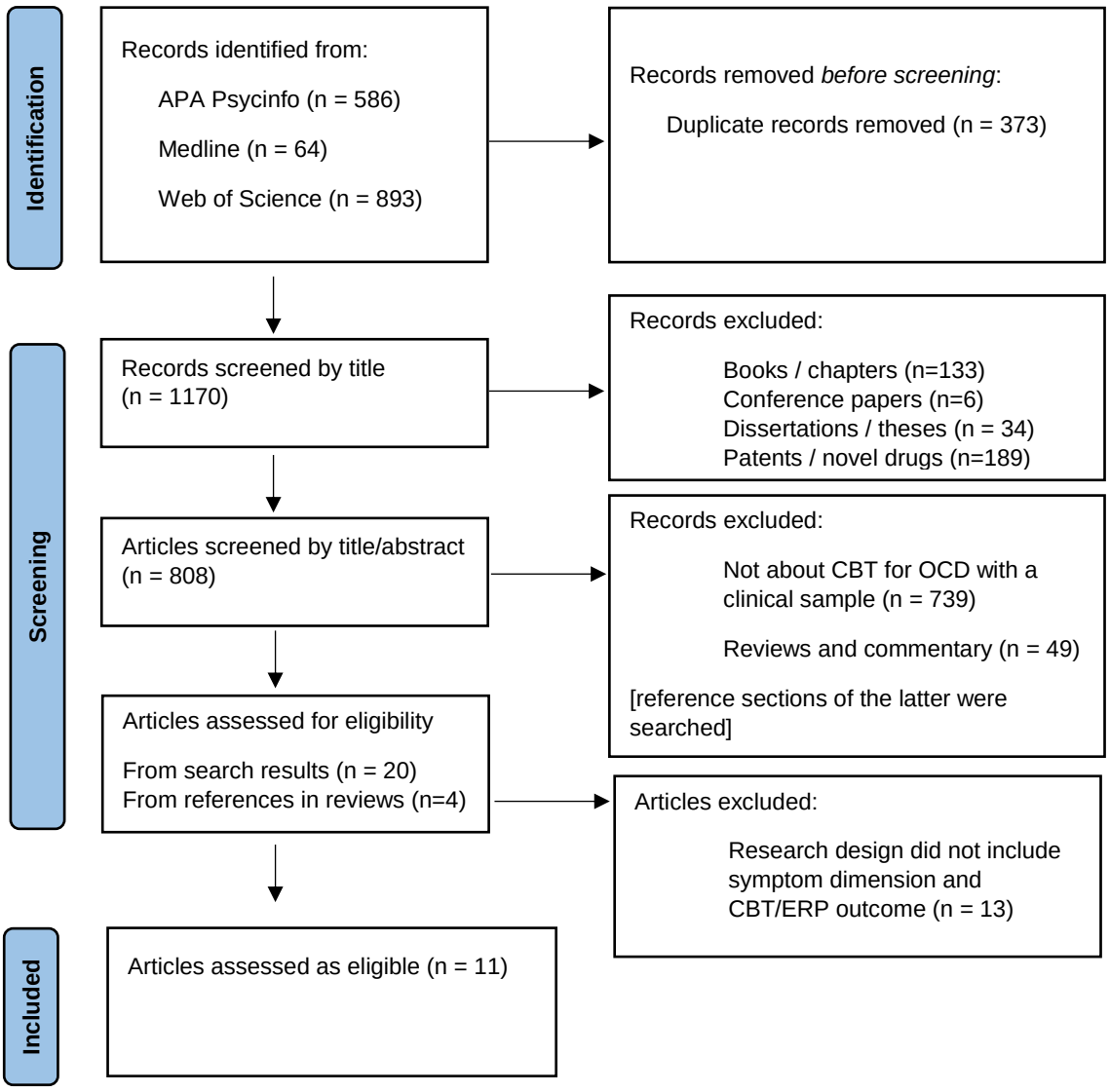
Studies were required to report the outcomes of CBT/ERP for OCD according to symptom dimension, in such a way that differential findings with regard to treatment outcomes for (people experiencing) sexual, religious, and/or violent obsessions could be distinguished. Eligible study designs included regression analysis with symptom dimensions as a predictor, or between-groups comparisons with symptom dimension as a grouping variable.

Search Process

The search yielded 1,543 results. Details were exported from the databases, and PRISMA guidelines (Page et al., 2021) followed to identify studies relevant to this review - see Figure 1.

Figure 1

PRISMA Flow Diagram (Page et al., 2021)



Quality Appraisal

Papers were assessed using the Joanna Briggs Institute critical appraisal tool for analytical studies (Appendix A). This aimed to ensure that reviewed findings were understood in appropriate context, including their likely validity and reliability (Porritt et al., 2014).

Methodological evaluation was undertaken from the perspective of the review question - that is to say, methodologies were evaluated in relation only to the aspects which addressed the question of OCD symptom subtype dimension impacts on CBT treatment. Studies may therefore have methodological strengths or weaknesses in other areas which are not addressed in this appraisal.

Results

Study Selection

The literature search yielded 1,543 records. After removing duplicates (373) and results which were not journal articles (362), 808 records remained. Titles (and abstracts, where necessary) were reviewed, and ineligible studies excluded (788). Of those 788, 49 records related to review articles, commentary, or case studies relevant to the topic of taboo obsessions in OCD. Where they could be accessed, the reference lists of these papers were hand-searched for potentially relevant studies; three were found. Ultimately 11 eligible papers were identified, summarised in Table 3.

Table 3

Summary of Papers

Paper	Sample	Intervention	Symptom dimensions / categories	Measures	Analysis	Overview of findings (expanded in Table 2)
Mataix-Cols et al., 2002	78 adults, USA Drawn from a study of 153 people: 59.9% male Age range unknown (M= 37.5, SD=10.6) Ethnicity not reported	1-10 sessions of ERP, either with a therapist or computerised, to include targeting of mental compulsions	Codes each Y-BOCS checklist symptom (0-absent, 1-present) then analyses summed total for each of 5 dimensions (from factor analysis of Mataix-Cols et al., 1999 – 'aggressive/ checking', 'contamination/cleaning', 'symmetry/ordering', 'hoarding', and 'sexual/religious')	Y-BOCS severity	Stepwise multiple regression, controlling for baseline symptoms & comorbid depression; chi-squared comparison between responders and non-responders.	Greater number of sexual/religious obsessions predicted a worse outcome – small effect size (explained 7% of variance) People with sexual/religious obsessions were less likely to be treatment 'responders' – small effect size (w=0.28)
Abramowitz et al., 2003	132 adults, USA 53.0% male Age range 18-65 (M=36.1, SD=13.9) 93% Caucasian, 4% Asian, 1% African American, 1% Arab, 1% Native American	15 sessions of ERP with qualified therapists, described as within CBT paradigm	Codes each Y-BOCS checklist symptom (0-absent, 1-present, 2-treatment target) 5 mutually exclusive clusters (from own cluster analysis - 'contamination', 'harming', 'hoarding', 'symmetry', and 'unacceptable thoughts')	Y-BOCS severity	Repeated measures ANOVA with post-hoc comparisons; reliable and clinical change indices	Appearance of a reduced likelihood of clinically significant improvement for 'harming' and 'unacceptable' obsessions –effect size could not be calculated.
Grant et al., 2006	Unknown number of adults, USA Drawn from a study of 293 people: 45.4% male Age range 19-75 (M=40.5, SD=12.9) 97.6% White, non-Hispanic	No standardised intervention – clients self-report as having received CBT.	Presence / absence of sexual obsessions only	CGI	Chi-squared comparison	No statistically significant differences between CBT outcome reported by people with/without sexual obsessions.
Rufer et al., 2006	94 adults, Germany Drawn from a study of 104 people: 62.5% male Age range unknown (M=32.9, SD=9.6) Ethnicity not reported	4 individual multimodal CBT (including ERP) sessions per week plus 1-3 group sessions, for an average of 9 weeks	Codes each Y-BOCS checklist symptom (0-absent, 1-present) then analyses summed total for each of 5 dimensions (from factor analysis of Mataix-Cols et al., 1999 – as above)	Y-BOCS severity	Stepwise multiple regression, controlling for medication use & comorbid depression; chi-squared comparison between responders and non-responders.	Greater number of taboo obsessions did not predict treatment response. People with sexual/religious obsessions were less likely to be treatment 'responders' – small effect size (w=0.12)

Paper	Sample	Intervention	Symptom dimensions / categories	Measures	Analysis	Overview of findings (expanded in Table 2)
Storch et al., 2008	92 youth, USA 53.3% male Age range 7-19 (M=13.6, SD=3.3) 94.6% Caucasian, 3.3% Asian, 2.2% Hispanic	14 individual 90-minute family-based CBT sessions, (weekly or intensive), with 'cognitive training' and ERP.	Codes each CY-BOCS checklist symptom (0-absent, 1-present) then analyses summed total for each of 5 dimensions (from factor analysis of Mataix-Cols et al., 1999 – as above)	CY-BOCS severity; CGI	Logistic regression to predict 'responders', then linear regression to predict CY-BOCS and CGI scores.. plus t-tests for each symptom dimension to see if there are significant differences in outcome	No statistically significant findings for CY-BOCS. Greater number of violent obsessions may predict better outcome for CGI – small effect size (β=0.34)
Farrell & Boschen, 2011	41 adults, Australia 36.6% male Age range 18-66 (M=32.1, SD=12.2) Ethnicity not reported	16-session group CBT program, including cognitive therapy and ERP	15 dimensions, origins not specified. Participant coded 'yes/no' for presence or absence of symptoms in each.	Y-BOCS severity	Unclear description but appear to run individual simple regression analyses for each subtype	Sexual obsessions (only) predict worse outcome – insufficient data to calculate effect size.
Williams et al., 2014	87 adults, USA 61.0% male Age range unknown (M=36.4, SD=12.3) 83.3% non-Hispanic White	15 90-minute ERP sessions including imaginal exposure and addressing 'mental rituals'.	Codes each Y-BOCS checklist category (0-absent, 1-present, 2-treatment target), then analyses summed total for each of 5 dimensions (from own factor analysis: 'contamination-cleaning', 'doubt-checking', 'hoarding', 'symmetry-ordering', and 'unacceptable/taboo thoughts'	Y-BOCS severity	Regression to predict post-treatment Y-BOCS score (controlling for pre-treatment score). T-tests for each Y-BOCS checklist sub-category.	Greater number of sexual/religious/ violent thoughts predict worse CBT/ERP outcome – small effect size (explained 6% of variance). People with sexual (d=0.30), religious (d=0.48), and violent (d=0.23) obsessions showed lower average Y-BOCS severity reduction compared to people without – small/medium effect sizes.
Chase et al., 2015	135 adults, USA 48.5% male Age range unknown (M=31.2, SD=12.3) 90.9% European American, 4.5% Hispanic American, 2.3% African American, 2.3% Other	Intensive CBT, between 12 and 96 hours/week for variable number of weeks, including ERP and 'cognitive restructuring'.	Severity score on each of 4 dimensions (from DOCS – Abramowitz et al., 2010 – 'contamination', 'responsibility for harm', 'symmetry', and 'unacceptable thoughts')	DOCS total & subscales	Repeated measures ANOVA with post-hoc comparisons, Bonferroni correction	Unacceptable thoughts associated with more severity at intake and discharge – but no statistically significant difference in treatment response across symptom dimensions.

Paper	Sample	Intervention	Symptom dimensions / categories	Measures	Analysis	Overview of findings (expanded in Table 2)
Højgaard et al., 2018	269 Nordic youth 48.7% male Age range 7-17 (M=12.8, SD=2.7) Ethnicity not reported	14 75-minute CBT sessions, both family and individual, including ERP.	Codes each CY-BOCS checklist symptom (0-absent, 1-present) then analyses summed total for each of 3 dimensions (from factor analysis of Højgaard et al., 2017 – 'contamination/cleaning, harm/sexual, symmetry/hoarding')	CY-BOCS severity	Various simple and multiple regression analyses. Multiple regressions controlled for age, gender, and comorbidity.	Greater number of sexual/religious/violent symptoms predicted worse CBT/ERP response on bivariate linear regression only – three other regression analyses found no effect. Multivariate logistic regression suggested that symptom dimension accounted for 3.5% of variance – a small effect size.
McGuire et al., 2019	48 youth, USA Drawn from a study of 71: 37% male Age range 8-17 (M=12.2, SD=2.5) 77.5% Caucasian	12 90-minute CBT sessions, family and individual, including ERP.	Codes each CY-BOCS checklist symptom (0-absent, 1-present) then analyses summed total for each of 4 dimensions (from factor analysis of Stewart et al. 2008 – 'aggressive/checking', 'contamination/ cleaning', 'hoarding', and 'symmetry/ ordering') plus 'miscellaneous'.	CY-BOCS severity; CGI; SUDs	Multi-level modelling	No statistically significant findings for CY-BOCS. Greater number of sexual/religious/ violent obsessions predicted **improved** outcomes for CGI/SUDs. Effect size could not be calculated.
Weidle et al., 2022	As Højgaard et al., 2018[a]		Presence / absence of sexual obsessions only	CY-BOCS severity	Regression analysis (linear mixed effects with variable timespline)	Presence of sexual obsessions predicted worse outcome at some time points. Effect size could not be calculated.

Note. (C)Y-BOCS: (Children's) Yale-Brown Obsessive Compulsive Scale. CGI: Clinical Global Impression. SUDs: Subjective Units of Distress. Outcome measures are described in detail on pp. 25-27.

a The studies by Højgaard et al. (2018) and Weidle et al. (2022) perform different analyses on the same base data, taken from the Nordic long-term OCD treatment study (NordLOTS; Thomsen et al., 2013).

Overview of Papers

Most studies took place in the USA, five with adult participants (Abramowitz et al., 2003; Chase et al., 2015; Grant et al., 2006; Mataix-Cols et al., 2002; Williams et al., 2014) and two with child/adolescent participants (McGuire et al., 2019; Storch et al., 2008). One study had adult Australian participants (Farrell & Boschen, 2011), while the remainder took place in north-western Europe with German adults (Rufer et al., 2006) or Nordic youth (Højgaard et al., 2018; Weidle et al., 2022). Reflecting these geographical locations, participants were predominantly white and English-speaking. Sample sizes ranged between 41 (Farrell & Boschen, 2011) and 269 (Højgaard et al., 2018; Weidle et al., 2022). In all but one case, participants received CBT/ERP therapy as part of a research study. In all cases, treatment was explicitly described as including a cognitive element. Precise treatment duration varied, but was usually between ten and sixteen ninety-minute sessions, delivered individually, in a group, or (in paediatric samples) with family.

All studies investigated the differential impact of OCD symptom dimension on treatment outcomes, either as a sole research question or as part of a suite of potential predictors being analysed for their respective contributions to treatment outcomes.

The majority of the studies constituted secondary analyses – data had been collected for other purposes, primarily treatment efficacy studies (Mataix-Cols et al., 2002; McGuire et al., 2021; Williams et al., 2014) or longitudinal outcome studies (Grant et al., 2006; Højgaard et al., 2018; Weidle et al., 2022). Where multiple arms of a trial were reported on in a paper, only the findings of relevance to participants who had experienced CBT/ERP were included in this review.

As only five studies had collected data directly to answer a research question related to symptom subtype analysis (Abramowitz et al., 2003; Chase et al., 2015; Farrell et al., 2011; Rufer et al., 2006; Storch et al., 2008), the potentially post-hoc nature of the majority of the analyses reviewed here may account for some of the methodological weaknesses and inconsistencies which are discussed in detail below.

Methodological Characteristics

Methodological inconsistencies affected the possibility of synthesis across the reviewed papers. Studies showed significant variation in how they operationalised both symptom dimension and treatment outcome. This summary is organised according to the categories of the JBI quality appraisal tool (Appendix A, summarised in Table 4), which was used to consider how valid and reliable the findings of these studies were in addressing the review hypotheses.

Table 4

JBI Methodological Appraisal

Paper	1. Were the criteria for inclusion in the sample clearly defined?	2. Were the study subjects and the setting described in detail?	3. Was the exposure [treatment with CBT/ERP] measured in a valid and reliable way?	4. Were objective, standard criteria used for measurement of the condition?	5. Were confounding factors identified?	6. Were strategies to deal with confounding factors stated?	7. Were the outcomes measured in a valid and reliable way?	8. Was appropriate statistical analysis used?
Mataix-Cols et al., 2002	Partial – refers to another study for this information.	Partial – refers to another study for this information.	No – participants needed only a single session of ERP to be defined as 'receiving treatment'.	Mostly – diagnostic interview (DSM and Y-BOCS); factor analysis used in other studies	Partial – symptom severity and depression. No mention of potential concurrent treatment or dropout.	Yes – treated as covariates in statistical analysis	Mostly – Y-BOCS is widely used but 40% cut-off for "responder" / "non-responder" is not justified	Yes – regression analysis
Abramowitz et al., 2003	Yes – everyone who passed through a certain clinic (with exclusions)	Yes – participant group well-described.	Mostly – treatment offered is described in detail, but client attendance/ engagement not measured.	Partial – diagnostic interview (DSM and Y-BOCS); novel cluster analysis.	Mostly – concurrent treatment, treatment non-completion. No mention of comorbidity.	Yes – participant restrictions; statistical confirmation of equality.	Yes – Y-BOCS is widely used, plus reliable and clinical change indices considered.	Yes – repeated measures ANOVA
Grant et al., 2006	Yes – everyone who passed through a certain clinic (with exclusions)	Mostly – detailed demographics but no description of setting.	No – there was no standardised treatment protocol.	Yes – diagnostic interview (DSM and Y-BOCS); presence/ absence analysis.	No – analysis of treatment outcome only a minor part of a wider paper		Partial – CGI is a limited, single-scale measure, but has been validated in the literature.	Yes – chi-squared comparison
Rufer et al., 2006	Yes – everyone who passed through a certain clinic (with exclusions)	Yes – participant group well-described.	Mostly – treatment offered is described in detail, but client attendance/ engagement not measured.	Mostly – diagnostic interview (DSM and Y-BOCS); factor analysis used in other studies	Mostly – concurrent treatment, treatment non-completion. No mention of comorbidity.	Yes – statistical confirmation of equality, covariate analysis.	Mostly – Y-BOCS is widely used but 35% cut-off for "responder" / "non-responder" is not justified	Yes – regression analysis
Storch et al., 2008	Yes – everyone who passed through a certain clinic (with exclusions)	Yes – participant group well-described.	Mostly – treatment offered is described in detail, but client attendance/ engagement not measured.	Mostly – diagnostic interview (DSM and CY-BOCS); factor analysis used in other studies	Mostly – concurrent treatment, treatment non-completion. No mention of comorbidity.	Partial – non-completers are analysed as non-responders.	Mostly – CY-BOCS is widely used but CGI a more limited measure	Mostly – appropriate tests chosen (questionably large number)

Paper	1. Were the criteria for inclusion in the sample clearly defined?	2. Were the study subjects and the setting described in detail?	3. Was the exposure [treatment with CBT/ERP] measured in a valid and reliable way?	4. Were objective, standard criteria used for measurement of the condition?	5. Were confounding factors identified?	6. Were strategies to deal with confounding factors stated?	7. Were the outcomes measured in a valid and reliable way?	8. Was appropriate statistical analysis used?
Farrell & Boschen, 2011	Partial – clinic attendees (exclusion criteria not given)	No – limited demographic / contextual information	Mostly – treatment offered is described in detail, but client attendance/ engagement not measured.	Partial – diagnostic interview (DSM and Y-BOCS); no explanation given for symptom subtyping.	Partial – symptom severity, concurrent treatment. No mention of comorbidity or dropout.	Yes – participant restrictions; covariate analysis.	Yes – Y-BOCS is widely validated, and outcome data analysed directly	Partial – reporting is unclear; large number of uncorrected tests?
Williams et al., 2014	Partial – refers to another study for this information.	Partial – refers to another study for this information.	Mostly – treatment offered is described in detail, but client attendance/ engagement not measured.	Partial – diagnostic interview (DSM and Y-BOCS); novel factor analysis.	Partial – symptom severity, concurrent treatment. No mention of comorbidity or dropout.	Yes – participants were 'stable' on medication and severity treated as covariate	Yes – Y-BOCS is widely validated, and outcome data analysed directly	Mostly – regression followed up with multiple (uncorrected) t-tests.
Chase et al., 2015	No – just states inclusion based on 'a variety of factors'	No – limited demographic / contextual information	Mostly – treatment offered is described in detail, but client attendance/ engagement not measured.	Yes – diagnostic interview and validated dimensional symptom scale.	Partial – concurrent treatment discussed only.	No – confound discussed but not controlled for.	Mostly – DOCS less widely-used than Y-BOCS, but a reliable and valid measure.	Yes – repeated measures ANOVA with **corrected** post-hoc tests.
Højgaard et al., 2018	Partial – refers to another study for this information.	Partial – refers to another study for this information.	Partial – refers to another study for this information.	Partial – diagnostic interview (DSM and Y-BOCS); cited factor analysis.	Partial – comorbidity discussed only.	Yes – covariate analysis.	Mostly – CY-BOCS is widely validated, but cut-off for 'recovery' not justified.	Mostly – regression analyses, questionable number?
McGuire et al., 2019	Partial – refers to another study for this information.	Partial – refers to another study for this information.	Yes – discusses treatment fidelity procedures	Partial – diagnostic interview (DSM and Y-BOCS); cited factor analysis.	No – no discussion of potential confounding factors.		Mostly – CY-BOCS widely used, but other measures	Yes – regression analysis
Weidle et al., 2022	Partial – refers to another study for this information.	Yes – additional detail provided in 'discussion'	Partial – refers to another study for this information.	Yes – diagnostic interview (DSM and Y-BOCS); presence/ absence analysis.	Partial – dropout discussed only.	Yes – analysed for systematic pattern, none found.	Yes – CY-BOCS is widely validated, and outcome data analysed directly	Yes – regression analysis

Inclusion Criteria, Subjects and Setting

All of the participants had accessed psychological therapy following a diagnosis of OCD, which was confirmed by researchers using semi-structured diagnostic interviews and psychometric measures. In most cases, participants were drawn from the population that presented to a certain clinic or clinics during a stated time frame, with some exclusion criteria. As a result, participants represented the populations which accessed support from these particular clinics. It was not always clear from the papers whether participants were enrolled in the study as a routine part of accessing care, or if they were recruited as a subset of those accessing care - if the latter, there may have been potential for bias in invitation processes.

Treatment Exposure

For the purposes of this review, the JBI 'exposure measurement' criterion was understood as relating to treatment for OCD with CBT/ERP. Such treatment has been manualised in various ways, but best practice requires the therapist to adapt their intervention to the client in terms of number of sessions offered and material covered (NICE, 2005). This may mean that excessive attention to treatment exposure reliability/repeatability could be seen to undermine the flexibility which is necessary for treatment effectiveness.

Nonetheless some studies demonstrated attention to the validity and reliability of their interventions - notably Farrell & Boschen (2011), who provided a session-plan for their intervention, and McGuire et al. (2019) who discussed the fidelity procedures followed to ensure therapist compliance with the CBT/ERP model. The majority simply reported the number of sessions offered - this was fixed for all participants in a given study, although it was not always clear how many of these were attended (in Mataix-Cols et al. (2002),

participants needed only have attended a single session of the ten offered to be considered to have received treatment).

More ecologically valid, but less replicable or generalisable, were the treatment 'exposures' of Chase et al. (2015) - a tailored CBT/ERP intervention of between 12 and 96 hours per week for a variable number of weeks. This was a valid course of CBT/ERP, even if not replicable/reliable. Grant et al. (2006) did not deliver the exposure themselves, but asked participants about outcomes of past CBT - therefore this was not a valid or reliable exposure.

Condition Measurement

Diagnosis of OCD was a strength of the reviewed studies. Most studies used standardised symptom checklists, directly or derived from the DSM-IV(-TR), confirmed by diagnostic interview. Thus all studies drew their participants from a similar diagnostic pool.

There was more diversity apparent when studies characterised the different types of OCD symptoms experienced by participants. Data-gathering was relatively consistent: six papers used the list of symptoms associated with the Yale-Brown Obsessive Compulsive Scale (Y-BOCS Symptom Checklist - version 1, Goodman et al., 1989 or version 2, Storch et al. 2010), four used its paediatric variant the CY-BOCS (Scahill et al., 1997), although one used the Dimensional Obsessive-Compulsive Scale (DOCS - Abramowitz et al., 2010).

Often considered the gold standard in OCD research (Mataix-Cols et al., 2016), the Y-BOCS symptom checklist provides a list of potential experiences which a person with a diagnosis of OCD may have. In the most recent version (Y-BOCS-II, Storch et al., 2010), the checklist included 29 potential obsessions and 38 potential compulsions, from 'ritualised eating behaviours' to 'fear of demonic possession'. These were presented in intuitive groups labelled 'sexual obsessions', 'checking compulsions', and so on. Participants' responses on

this checklist were used to generate variables for statistical analysis in a wide variety of ways. The two main axes of this variation were quantification and categorisation.

Quantification of Symptoms. The most common approach to quantifying symptoms was to assign a numerical value for each (C)Y-BOCS symptom. Either '1' when the symptom was present and '0' when it was absent (Mataix-Cols et al., 2002; Rufer et al., 2006; Storch et al., 2008; Højgaard et al., 2018; McGuire et al., 2019) or with the addition of a '2' for any symptom identified as a treatment target (Abramowitz et al., 2003).

Alternatively, this coding took place at the level of the intuitive (C)Y-BOCS categories, either 0/1/2 as above (Williams et al., 2014) or simply presence/absence (Farrell & Boschen, 2011). Two studies were only interested in sexual obsessions, and so coded presence/absence only for these (Grant et al., 2006; Weidle et al., 2022).

Thus in most of the studies, participants' symptoms were quantified by the presence or absence of different symptom types, being summed to produce a total. Only Abramowitz et al. (2003) and Williams et al. (2014) attempted to encode any information about symptom severity or impact, by double-scoring any symptom which was identified as a treatment target. Nonetheless it seemed that these approaches primarily functioned to quantify symptom *diversity* rather than symptom severity or clinical relevance. (In contrast, by using a dimensional measure of OCD severity, Chase et al. (2015) were more clearly quantifying symptoms by level of impact on the individual).

Categorisation of Symptoms. Across the 11 studies there were eight different taxonomies of symptom dimensions in OCD. In terms of understanding how CBT/ERP outcomes may be influenced by the presence of sexual, religious, and violent obsessions, many of the studies presented challenging confounds. This was particularly pertinent with regard to violent

obsessions which may be grouped with sexual and religious obsessions, in a separate category related to harm and checking, or sometimes (in dimensional factor analytic models) loaded equally across both factors.

Sexual, Religious, and Violent. Farrell and Boschen (2011) did not specify the origin of their fifteen symptom dimensions. They were the only study reviewed to distinguish sexual, religious, and violent obsessions as three unique categories. Two of the papers (Grant et al., 2006; Weidle et al. 2002) were specifically interested in the impact of sexual obsessions, and so grouped their participants categorically into those who reported sexual obsessions on the (C)Y-BOCS, and those who did not.

'Sexual/Religious' vs 'Aggressive/Checking'. Three of the studies (Mataix-Cols et al., 2002; Rufer et al., 2006; Storch et al., 2008) used the 5-factor model of Mataix-Cols et al. (1999) to group their data. This organised Y-BOCS Symptom Checklist data across five factors: "aggressive/checking", "contamination/cleaning", "symmetry/ordering", "hoarding", and "sexual/religious". Full factor loadings were not reported by Mataix-Cols et al. (1999) so it was not possible to know what confounding factors there were, but it seemed likely that sexual and religious obsessions loaded onto the 'sexual/religious' factor and violent obsessions loaded onto the 'aggressive/checking' factor.

'Unacceptable Thoughts' & 'Harm/checking'. Williams et al. (2014) used an updated version of the Y-BOCS Symptom Checklist (Storch et al., 2010) which attended more closely to mental compulsions. Like Mataix-Cols et al. (1999), their factor analysis also yielded five factors, but only two of these ("contamination-cleaning" and "hoarding") were similar to previous study. Williams et al.'s (2014) other three factors were "doubt-checking" (which was less inclusive than Mataix-Col's et al.'s (1999) "aggressive/checking"), "symmetry-ordering" (which now included counting/repeating obsessions), and "unacceptable/taboo

thoughts". Sexual and religious obsessions shared a high factor loading with the "unacceptable/taboo thoughts" group, while violent obsessions shared a high factor loading with both "aggressive/checking" and "unacceptable/taboo thoughts".

This shared loading of violent obsessions across two different categories was a characteristic shared by Abramowitz et al. (2003)'s cluster analysis. This divided their participants into five mutually exclusive groups, based on summed scores for each of 16 Y-BOCS symptom categories, labelled 'contamination', 'harming', 'hoarding', 'symmetry', and 'unacceptable thoughts'. There was significant overlap between the symptoms experienced by people in the 'harming' and 'unacceptable thoughts' clusters - both were characterised by high levels of violent obsessions and checking compulsions. However in the 'harming' category these were the most significant symptoms, whereas for people in the 'unacceptable thoughts' cluster there were also a high level of religious/sexual obsessions and mental compulsions. The 'unacceptable thoughts' cluster was associated with 90% agreement between different clustering methodologies, whereas the 'harming' category was the least reliable cluster with only 56% agreement.

This clustering was part of a body of work which would lead towards the development of the Dimensional Obsessive-Compulsive Scale (DOCS - Abramowitz, 2010). The DOCS included only 4 symptom dimensions (Abramowitz et al.'s (2003) 'hoarding' dimension having been removed with the separation of Hoarding Disorder - Mataix-Cols et al., 2010). In this review, one paper (Chase et al., 2015) used the four symptom categories of the DOCS - contamination, responsibility for harm, symmetry, and unacceptable thoughts.

Single Factor. Højgaard et al. (2018) cited their own previous factor analysis (Højgaard et al., 2017) to justify the use of three symptoms dimensions - harm/sexual, symmetry/hoarding, contamination/cleaning. Sexual, religious, and violent obsessions loaded onto the

harm/sexual factor, but certain CY-BOCS items which were associated with taboo obsessions in other dimensional models were instead included with the symmetry/hoarding factor: specifically “fear will be responsible for something terrible to happen” and “mental compulsions” (Højgaard et al., 2017, p.4).

McGuire et al. (2019) cited the factor analysis of Stewart et al. (2008) to justify the use of four symptom dimensions - hoarding, contamination/cleaning, aggressive/checking (which included sexual, religious, and violent obsessions), symmetry/ordering (which included counting and repeating). They then additionally included a ‘miscellaneous’ symptom dimension to capture symptoms their participants nominated for treatment which did not fit into the other categories - unfortunately without offering examples.

Confounding Factors

Various potential confounding factors were identified by the reviewed papers. Particular attention was paid to medication use (most commonly, participants were asked to hold this constant throughout their participation, to avoid medication changes being a confounding factor; additionally Rufer et al. (2006) used statistical analysis to confirm that medication use was not significantly different between comparison groups in their study). Other potential confounding factors which were observed and controlled for in statistical analysis included comorbidity (participants who meet the criteria for other DSM-IV diagnoses in addition to OCD), age, symptom severity at the start of treatment, and treatment dropout. No study paid attention to all of these potential confounding factors, but most studies addressed several of them.

Outcome Measurement

This was a qualified strength of the reviewed studies. Widely validated and reliable measures were used to quantify treatment outcomes, primarily the (C)Y-BOCS severity scale (Castro-

Rodrigues et al., 2018). However, three different versions of the scale were used - the original Y-BOCS (Goodman et al., 1989), the CY-BOCS (Scahill et al., 1997) and the updated Y-BOCS-II (Storch et al., 2010). Although all three measures have been found to be valid and reliable, and were similar in form and content, the differences between them will further complicate any synthesis from or comparison between the findings of the reviewed studies.

Two continuous outcome variables were derived from the (C)Y-BOCS; these were the raw post-treatment score (Farrell & Boschen, 2011; Mataix-Cols et al., 2002; Storch et al., 2008; Williams et al. 2014; Weidle et al. 2022) and the raw difference between pre- and post-intervention scores (Abramowitz et al., 2003; Højgaard et al., 2018; McGuire et al., 2019; Williams et al. 2014).

Alternatively or additionally, some studies generated categorical outcome variables by classifying participants as 'responders' or 'non-responders'. This was done either using the percentage difference between pre- and post-intervention scores (Mataix-Cols et al., 2002 - 40% reduction; Rufer et al., 2006 - 35% reduction) or by using a sub-clinical cut-off in the post-treatment scores (Højgaard et al., 2018, used a post-treatment score of 16 or below to operationalise 'treatment response' - a cut-off which has been described as "too lenient" by Öst et al. (2015, p. 162)). While the underlying measure itself was valid and reliable, such categorisations have not been widely validated, with the different cut-offs chosen in each study justified by precedent alone - although they were broadly in keeping with recent consensus around defining treatment response in OCD (Mataix-Cols et al., 2016).

Three of the eleven papers derived a measure of treatment efficacy from the Clinical Global Impression Scale (CGI - Guy, 1976). This was a single-item measure which used a 7-point likert scale to rate the participant's symptoms from 1 (very much improved) to 7 (very much worse). Storch et al. (2008) and McGuire et al. (2019) used a version of the CGI where a

clinician rates the participant's symptom-change, while Grant et al. (2006) used self-ratings. Participants scoring 1 or 2 were categorised as 'responders', and all others 'non-responders'.

Two further outcome measures were used, by a single study in each case. Chase et al. (2015) analysed change in DOCS score (overall, and in each of its four dimensional components). McGuire et al., 2019 analysed the change in participants' self-reported subjective units of distress (SUDs) across each session. This was a subjective and personal rating made as part of the therapeutic process, usually out of ten, although the authors did not specify.

Statistical Analysis

In general, studies selected appropriate statistical tests to explore the association of symptom dimension with treatment outcome. (Many of the studies explored different research questions with other statistical tests, but these were not appraised as part of this methodological critique).

The majority of the papers (Farrell & Boschen, 2011; Højgaard et al., 2018; Mataix-Cols et al., 2002; McGuire et al., 2019; Rufer et al., 2006; Storch et al., 2008; Weidle et al., 2022; Williams et al., 2014) used regression analysis to predict CBT/ERP outcome based on specified symptom dimensions. Symptom dimensions were sometimes entered into the model categorically (presence/absence used as a dichotomous predictor variable; Farrell & Boschen, 2011; Weidle et al., 2022) but most commonly, the number of symptoms endorsed in each category (with or without weighting towards treatment targets, as discussed under 'quantification of symptoms' above) was used as a continuous predictor variable (Højgaard et al., 2018; Mataix-Cols et al., 2002; McGuire et al., 2019; Rufer et al., 2006; Storch et al., 2008; Williams et al., 2014). Study designs of this nature constituted analysis at the level of symptom dimension – an individual participant's experience may be multiply represented in the model as their score for each symptom dimension would be considered by the model as

part of a different predictor variable. The results of such analyses were considered to be relevant to the first hypothesis of this review – that the presence or severity of sexual, religious, and/or violent obsessions in OCD will predict poorer outcomes following CBT/ERP treatment. Alternatively or in addition, mean-comparison tests were used to compare differences in outcome between participants who did/did not report symptoms within a particular dimension - such as chi-squared comparisons (Grant et al., 2006; Mataix-Cols et al., 2002), t-tests (Storch et al., 2008; Williams et al., 2014) or ANOVA (Abramowitz et al., 2003; Chase et al., 2015). Study designs of this nature constituted analysis at the level of the person, and were considered to be relevant to the second review hypothesis - that people who experience OCD characterised by sexual, religious, and/or violent obsessions will show poorer treatment outcomes following CBT/ERP treatment, compared to people who do not experience such obsessions.

One questionable methodological choice made by some studies was to repeat a large number of statistical tests of the same type. For example, Farrell and Boschen (2011) performed 15 regression analyses, and Storch et al. (2008) performed 10 t-tests, without applying any Bonferroni correction. This may have increased the chance of Type I error, or affected ecological validity by giving the appearance of 'p-hacking' (Head et al., 2015).

Conversely, some methodological choices seemed to increase the likelihood of Type II error. With the exception of Abramowitz et al.'s (2003) cluster analysis, all studies analysed data at the level of the symptom dimension rather than the level of the person, and often by counting the number of symptoms within a category. As a result, a person who experiences (say) a single strong religious obsession, negatively impacting their treatment response, might be invalidly understood as scoring "low" on taboo obsessions (as they only endorse one item),

reducing the likelihood that the model would find religious obsessions predicting poorer outcomes.

None of the studies reported any calculations of power, or other considerations which may have informed their choice of sample size - it was possible that negligible or ambiguous findings related in part to under-powered analyses. For example, Rufer et al. (2006) reported that only six of their 104 participants were experiencing sexual obsessions. Often, participant samples were selected for some other purpose, with symptom dimensional analysis as a secondary consideration.

Synthesis of Findings

The papers in this review presented a complex picture of the association between the most common types of taboo obsessions and treatment outcome. This was due in large part to the wide variety of symptom dimensions which were used in analysis, which did not always make it possible to identify the specific impact of sexual, religious, and/or violent obsessions. Overall, sexual and religious obsessions were generally associated (in 8/11 papers) with poorer outcomes following CBT/ERP, either at the level of the symptom dimension (presence of, or greater number of symptoms reported) or at the level of the person (and their individual response to treatment). When effect sizes were able to be calculated, these were consistently small. Findings related to violent obsessions were more ambiguous, with small effects reported in the hypothesised direction, but also in the direction of improved treatment outcomes.

Findings are summarised in Table 5, and are discussed below in relation to the two research questions according to outcome measure and taboo obsession type.

Table 5

OCD Symptom Categorisations & Relevant Findings

Categorisation	Paper	Adult/ youth sample?	Taboo obsessions grouped as:			Relevant Findings	
			Sexual	Religious	Violent	(C)Y-BOCS	Other Outcome Measures
Sexual, religious, and violent obsessions addressed individually	Farrell & Boschen, 2011	Adult	'Sexual obsessions'	'Religious obsessions'	'Aggressive obsessions'	'Sexual obsessions' uniquely associated with poorer CBT/ERP outcome ($F(1,37)=4.385$; $p=0.043$). Effect size could not be calculated.	-
	Grant et al., 2006	Adult	'Sexual obsessions'	-	-	-	**CGI:** No statistically significant difference ($\chi^2=0.301$; $p=0.583$), negligible effect size ($w=0.03$)
	Weidle et al., 2022	Youth				'Sexual obsessions' predict worse CBT/ERP outcome at 1- and 2-year follow-up ($p=0.040$; $p=0.037$) but not immediately following treatment or at 3-year follow-up ($p=0.116$; $p=0.092$). Effect size could not be calculated.	-
'Sexual/ religious' vs 'Aggressive/ checking' (Mataix-Cols et al., 1999)	Mataix-Cols et al., 2002	Adult	'Sexual/religious'		'Aggressive/ checking'	'Sexual/religious' obsessions associated with reduced likelihood of CBT/ERP response ($\chi^2=6.1$; $p=0.01$). Small effect size calculated ($w=0.28$). 'Sexual/religious' obsessions predicted 7% of the variance in a multiple regression – this constitutes a small effect size. No significant findings for 'aggressive/checking'	-
	Rufer et al., 2006	Adult	'Sexual/religious'		'Aggressive/ checking'	No statistically significant difference in CBT/ERP outcome for either dimension. However 'sexual/religious' obsessions approached significance ($\chi^2=3.26$; $p=0.07$). Small effect size calculated ($w=0.12$).	-
	Storch et al., 2008	Youth	'Sexual/religious'		'Aggressive/ checking'	No significant findings for either dimension. Insufficient reporting to calculate effect sizes.	**CGI:** 'Aggressive/checking' dimension non-significantly associated with increased likelihood of treatment response ($\chi^2=3.4$, $p=0.06$). Small effect size calculated ($w=0.19$). Finding confirmed by (uncorrected) t-test ($t(90)=2.0$, $p<0.05$). No effect found in logistic regression, but linear regression found 'aggressive/checking' predicted greater improvement ($\beta=0.34$, $p<0.05$). No effects reported for 'sexual/religious' dimension.

Categorisation	Paper	Adult/ youth sample?	Taboo obsessions grouped as:			Relevant findings	
			Sexual	Religious	Violent	(C)Y-BOCS	Other Outcome Measures
'Unacceptable thoughts' vs 'Harm/checking' (violent obsessions load onto both)	Abramowitz et al., 2003	Adult	'Unacceptable thoughts'		UT AND 'Harming'	No statistically significant findings for UT or 'harming' clusters, but the appearance of a reduced level of clinically significant change for both compared to other symptom dimensions.	-
	Chase et al., 2015	Adult	'Unacceptable thoughts'		UT AND 'Responsi-bility for harm'	-	**DOCS:** 'unacceptable thoughts' associated with significantly higher severity at intake and discharge (F=11.6, p<0.001). Effect size could not be calculated.
	Williams et al., 2014	Adult	'Unacceptable/taboo thoughts'		UT AND 'Doubt-checking'	'Unacceptable/taboo thoughts' predicted worse treatment outcome (B=2.09; p=0.02) while 'Doubt-checking' had no effect (B=-1.23; p=0.38). Overall symptom dimension accounted for 6% of variance (a small effect size). Follow-up t-tests found that sexual obsessions and violent obsessions were non-significantly associated with a reduced treatment response, with small effect sizes (sexual d=0.30, violent d=0.23). Religious obsessions were significantly associated with a worse outcome (t=3.17; p=0.032), with a small-to-medium effect size reported (d=0.48).	-
Sexual, religious, and violent obsessions all analysed together	Højgaard et al., 2018	Youth	'Harm/sexual'			'Harm/sexual' factor associated with worse CBT/ERP response (B=1.219; p=0.027) on bivariate linear regression only – multivariate and logistic regressions found no effect. Multivariate logistic regression suggested that symptom dimension accounted for 3.5% of variance – a small effect size.	-
	McGuire et al., 2019	Youth	'Aggressive/ checking'			'Aggressive/checking' factor may lead to worse CBT/ERP outcome - small effect size (β=0.14).	**CGI:** 'Aggressive/checking' factor predicted greater likelihood of being CBT/ERP 'responder' (B=-0.39; p=0.006). Effect size could not be calculated (only unstandardised regression coefficient provided.) **SUDs:** 'Aggressive/checking' factor predicted greater CBT/ERP response (p=0.04) with a large effect size (β=-0.51)

Note. (C)Y-BOCS: (Children's) Yale-Brown Obsessive Compulsive Scale. CGI: Clinical Global Impression. SUDs: Subjective Units of Distress. Outcome measures are described in detail on pp. 25-27.

Hypothesis 1: The presence or severity of sexual, religious, and/or violent obsessions in OCD will predict poorer outcomes following CBT/ERP treatment.

(C)Y-BOCS

Eight studies used regression analysis or other modelling to analyse whether presence or number of taboo obsessions predicted a poorer CBT/ERP outcome according to the (C)Y-BOCS severity scale. Sexual obsessions were most likely to be predictive in this way (6/8 studies found this), while religious and violent obsessions were only found to be predictive when they were grouped with sexual obsessions (religious, 4/8 studies; violent, 3/8 studies).

Sexual, Religious, and Violent. When sexual, religious, and violent obsessions were analysed separately, two studies found that the presence of sexual obsessions uniquely predicted a worse (C)Y-BOCS outcome following CBT/ERP (religious and violent obsessions did not) whereas presentations of OCD (including religious and violent obsessions). Farrell and Boschen (2011) carried out a series of unspecified tests (which appeared from the reported statistics to be logistic regressions) using presence/absence of each symptom dimension as a predictor of treatment outcome. They found that the presence of sexual obsessions (but not religious or violent obsessions) predicted a poorer outcome following ERP. Effect size could not be calculated. Weidle et al. (2022) only included the presence/absence of sexual obsessions as a predictor in their model, which they found to predict a smaller reduction in CY-BOCS severity following CBT treatment. Although visible throughout the graphed data, this finding was not statistically significant (according to a multi-level model) immediately following treatment and at three-year follow-up, but was statistically significant at 1- and 2-year follow-up ($p=0.040$ and $p=0.037$ respectively). An interesting observational finding was made about the number of people who did not did not

report sexual obsessions before treatment, but did during follow-up - this was interpreted with reference to the difficulty of disclosing taboo thoughts during assessment.

'Sexual/Religious' vs 'Aggressive/Checking'. When symptoms were grouped into dimensions based on the factor analysis of Mataix-Cols et al. (1999), two studies (Rufer et al., 2006; Storch et al., 2008) found that neither of the factors including taboo thoughts predicted CBT/ERP outcomes in a regression analysis. One study (Mataix-Cols et al., 2002) found that the number of symptoms endorsed on the sexual/religious dimension was a predictor of poorer CBT/ERP outcome, with a small effect size (symptom dimension explained 7% of the variance in the model).

'Unacceptable Thoughts' & 'Harm/checking'. Only one of the studies in this category carried out analysis at the level of the symptom dimension. Williams et al. (2014) found that their 'unacceptable/taboo thoughts' dimension (which included sexual, religious, and violent obsessions) significantly predicted poorer CBT/ERP outcome, with a small effect size (symptom dimension explained 6% of total variance). However their 'doubt-checking' dimension (which also included some violent obsessions) did not predict CBT/ERP outcome.

Single factor. The two studies which grouped sexual, religious, and violent obsessions together for analysis both weakly supported the hypothesis that endorsing a greater number of symptoms on this factor may have predicted a poorer CY-BOCS outcome following CBT/ERP. Højgaard et al. (2018) found that higher scores on their 'harm/sexual' factor predicted a smaller reduction in CY-BOCS score over the course of treatment, with a small effect size - symptom dimension explained 3.5% of total variance. However no effect was found in a similar multivariate regression, suggesting that the significant result in the bivariate regression may have been due to a confound between the "harm/sexual" category and another factor which was included in the multivariate analysis - perhaps age, as there was

a significant association reported between age and the level of "harm/sexual" symptoms. McGuire et al., (2019) found no significant predictive effect of the number of symptoms endorsed on their 'aggressive/checking' factor, on the change in CY-BOCS score. There was a small effect size in the direction of the hypothesis (β=0.14), but this should be interpreted with caution as β is considered an unreliable effect size for multivariate regression (Peterson & Brown, 2005).

Other Measures

Two paediatric studies (McGuire et al., 2019; Storch et al., 2008) analysed whether the number of taboo obsessions predicted a poorer CBT/ERP outcome according to the clinician-rated CGI severity scale. McGuire et al. (2019) additionally considered predictors of the change in SUDs (subjective units of distress) over the course of therapy. Contrary to the review hypothesis, these analyses suggested that the number of taboo obsessions reported may have predicted *improved* outcomes over the course of CBT/ERP, particularly when violent obsessions were present.

For McGuire et al. (2019) the number of 'aggressive/checking' symptoms reported (which included sexual, religious, and violent thoughts) predicted an *increased* likelihood of a person being defined as a treatment 'responder' on the CGI, and predicted a swifter reduction in SUDs over the course of therapy. For Storch et al. (2008), the number of symptoms reported on the aggressive/checking dimension (but not the sexual/religious dimension) predicted a greater improvement on the CGI-severity (although a logistic regression found that neither dimension predicted the likelihood of a person being defined as a 'responder').

Hypothesis 2: People who experience OCD characterised by sexual, religious, and/or violent obsessions will show poorer treatment outcomes following CBT/ERP treatment, compared to people who do not experience such obsessions.

(C)Y-BOCS

Five studies used mean-comparison statistics to evaluate whether treatment outcomes varied for people who did and those who did not experience certain types of symptom in OCD. People experiencing sexual or religious obsessions were found to experience worse treatment outcomes (compared to people without such obsessions) in 4/5 of these studies, while people experiencing violent obsessions were found to experience worse treatment outcomes (compared to people without such obsessions) in 2/5 of these studies.

'Sexual/Religious' vs 'Aggressive/Checking'. Of three studies using chi-squared analysis, two found that people who report sexual/religious obsessions were significantly less likely to respond to treatment: (defined as a Y-BOCS reduction of at least 40%) compared to people who do not report such obsessions, with a small effect size (Mataix-Cols et al., 2002, w=0.28; Rufer et al., 2006, w=0.12). The result from Rufer et al. (2006) did not reach statistical significance (p=0.07) but this may be due to an under-powered analysis (only six participants reported sexual obsessions). Storch et al. (2008) found no significant results, and did not report test statistics so an indicative effect size could not be calculated. None of these studies found a significant difference in outcome between those who did (not) report "aggressive/checking" symptoms.

'Unacceptable Thoughts' & 'Harm/checking'. Uniquely amongst the reviewed studies, Abramowitz et al. (2003) grouped their participants into clusters and made direct comparisons. They found no significant difference between their "unacceptable thoughts" or "harming" clusters, compared to clusters characterised by other types of obsession, neither on

a repeated measures ANOVA nor on a chi-squared analysis of the proportion of participants in each cluster who showed clinically significant improvement (Jacobson & Truax, 1991). However there was the appearance of a difference, with 46% and 59% of cases reaching clinical significance in the "unacceptable thoughts" and "harming" clusters respectively, while 70% and 76% of cases reached clinically significant change for the "contamination" and "symmetry" clusters.

Williams et al. (2014) performed independent samples t-test for the presence/absence of each of the symptom categories which loaded on the "unacceptable/taboo thoughts" factor. This found that the presence of each of sexual, religious, and violent obsessions led to a smaller symptom reduction on the Y-BOCS (compared to the absence of each of those symptoms), with small effect sizes (sexual d=0.30, religious d=0.48, violent d=0.23). Statistical significance was reached only by religious obsessions (p=0.032).

Other Measures

Three studies made between-groups comparisons based on other outcome measures - two using chi-squared comparisons based on CGI outcomes (Grant et al., 2006; Storch et al., 2008), and one ANOVA based on the DOCS (Chase et al., 2015). Grant et al. (2006) found that participants who reported sexual obsessions did not differ from those who do not report sexual obsessions, in terms of their outcomes according to the self-reported CGI. The effect size was negligible (w=0.03). Storch et al. (2008) found that people who reported "aggressive/checking" and "sexual/religious" symptoms respectively did not differ (in terms of likelihood of being classified as a 'responder' according to the clinician-rated CGI) from people who did not report those symptoms. However the "aggressive/checking" dimension tended towards significance (p=0.06), and may have reached it with a larger sample size. There was a small effect size (w=0.19) in the direction of *increased* likelihood of treatment

response. This was supported by a t-test (one of several which were carried out without Bonferroni correction), which found a significant difference in CGI score change between groups with and without "aggressive/checking" symptoms. Effect size could not be calculated.

Chase et al. (2015) found statistically similar reductions across all four symptom categories pre- and post-CBT. A post-hoc Bonferroni test showed that the "unacceptable thoughts" category (including sexual, religious, and violent obsessions) was associated with higher scores at both pre- and post-CBT timepoints.

Discussion

A systematic literature search was carried out to evaluate two related hypotheses: (1) the presence or severity of sexual, religious, and/or violent obsessions in OCD will predict poorer outcomes following CBT/ERP treatment; and (2) people who experience OCD characterised by sexual, religious, and/or violent obsessions will show poorer treatment outcomes following CBT/ERP treatment, compared to people who do not experience such obsessions.

The search returned 11 eligible papers. Due to the variety of ways that symptom dimensions were operationalised (nine different approaches across the 11 studies), synthesis of findings was a significant challenge. Small sample sizes potentially resulted in observable effect sizes in the hypothesised direction, without statistical significance. Notwithstanding these limitations, some patterns were apparent in the reviewed findings.

When treatment outcomes were measured using the (C)Y-BOCS severity scale, a greater number of sexual and/or religious obsessions was often found to predict poorer treatment outcomes. This finding was also present for dimensional and categorical outcome measures - people experiencing sexual and/or religious obsessions showed a smaller change in (C)Y-

BOCS severity score following treatment, and were less likely to be categorised as a 'treatment responder', with small effect sizes. Violent obsessions were less frequently associated with difference in treatment outcomes, however they were more likely to be grouped with non-taboo obsessions such as checking or doubting, meaning that findings in relation to violent obsessions were more difficult to tease out. When violent obsessions were associated with a poorer treatment outcome, this was also with a small effect size.

When treatment outcome was analysed based on the CGI, the presence of violent obsessions was associated with an *increased* likelihood of being defined as a treatment responder. One study (where all taboo obsessions were grouped onto a single factor) suggested that this was also the case for sexual and religious obsessions, while studies which analysed these separately suggested that sexual and religious obsessions had no impact on the likelihood of being defined as a treatment responder. The beneficial impact of the presence of violent obsessions was reported only in studies using the clinician-rated CGI with paediatric samples in the USA, and therefore may be specific to this context. McGuire et al. (2019) hypothesised that they found this effect for the CGI, but not the CY-BOCS, due to the intensity of distress associated with taboo obsessions when their participants first presented - which may mean that it is not a marker of effective treatment (reducing symptoms according to the CY-BOCS), but of effective normalisation / psychoeducation (reducing distress, according to the CGI).

Across these two main outcome measures, along with idiosyncratic measures used in only one of the reviewed studies, a picture emerges of a general pattern whereby OCD featuring taboo obsessions is associated with poorer CBT/ERP treatment outcomes than OCD without such obsessions, with a small effect size. However, these findings were often non-significant, or one significant finding appeared in the context of many null results. This effect was

particularly apparent for taboo violent obsessions, which were consistently categorised with non-taboo violent obsessions (which were not hypothesised to be associated with poorer treatment outcomes), likely weakening any association that might otherwise have been found.

While it is possible that larger sample sizes and more consistent operationalisation of symptom dimensions or outcome measures across studies would allow a clearer picture to emerge from the data, it is also possible that there is no direct association between symptom dimension and treatment outcome. The findings summarised in this review may instead be a consequence of confounding factors which were not identified in the studies. Publication bias may also play a role - there may be many more researchers who have analysed treatment outcome by symptom type, without publishing their null findings (Franco et al., 2014).

One potential confounding factor not attended to in these studies is the emotional profile of the OCD experiences. A large body of research in recent years has attended to the impact of feelings such as disgust (Bhikram et al., 2017), shame (Weingarden & Renshaw, 2015), guilt (Melli et al., 2017) and incompleteness (Schwartz, 2018). A common finding across these bodies of research is that CBT treatment tends to be less effective when the intensity of these emotions are high - this is unsurprising given that until 2013 OCD was classified as an anxiety disorder (APA, 2013). Anxiety-based formulations would be likely to lead to anxiety-focussed interventions, which may overlook the important role of other emotions in the aetiology and maintenance of OCD. Shame in particular has been found to be associated with sexual, religious, and violent obsessions (Laving et al., 2022), and may have promise as a potential covariate explaining the findings of this review.

Strengths and Limitations of this Review

This review used a systematic literature search strategy. In contrast to other recent reviews in this area (Starcevic & Brakoulis, 2008; Thorsen et al., 2018; Williams et al., 2013), this review can therefore be considered a comprehensive exploration of research relating to the differential impact of CBT/ERP for OCD where taboo (sexual, religious, and violent) obsessions are present, compared to OCD without such obsessions. Despite this strength, the diversity of included studies, in terms of their operationalisation of core concepts, has limited the possibility of data synthesis.

Another axis of diversity relevant to the interpretation of this review may be found in the variety of different types of CBT/ERP intervention which were featured (Table 3). While all treatments were described as including some cognitive and some behavioural elements, studies varied widely in the balance between the two elements, or did not record therapy content in detail. The choice to include this diverse range of studies may have diluted any evidence which existed for differential outcomes in regard to particular treatment approaches within the CBT paradigm. This complexity was deepened by the inclusion of participants across the lifespan, as the paediatric studies all included a family component in their interventions (which was not present in any of the adult studies). Furthermore, the presence of paediatric studies also added complexity with regard to other key variables such as duration of untreated illness: OCD is associated with a higher average delay between the onset of distress and accessing appropriate treatment, compared to other anxiety disorders (Altamura et al., 2010), such that under-18s presenting with OCD may be considered unrepresentative of the usual experiences of people with this diagnosis.

Conversely, this review may also be considered insufficiently comprehensive. For example, the exclusion of studies (in practice, particularly studies predating the year 2000) which did

not refer to their interventions as ‘CBT’ and/or ‘ERP’ excludes potentially relevant findings, and weakens the possibility for this review to consider changes in treatment effectiveness over time. However, such a limitation was judged to be appropriate given the significant developments which have taken place with regard to CBT/ERP for mental compulsions (Freeston et al., 1997), such that earlier work under the aegis of behavio(u)r(al) therapy would be significantly different from current evidence-based best practice (NICE, 2005).

This review made use of a structured methodological appraisal tool, the JBI Checklist for Analytical Cross-Sectional Studies (Joanna Briggs Institute, 2021), and calculated effect sizes (where possible). Therefore the findings of this systematic literature review can be considered more robust than the purely narrative reviews published in recent years (Starcevic & Brakoulis, 2008; Thorsen et al., 2018; Williams et al., 2013). However due to the heterogeneity of the reviewed studies, it was not possible or advisable to conduct a more formal meta-analysis of findings.

Care should be taken when generalising from the findings of this review. Based on participants’ demographic information (e.g. where ethnicity was reported, participants were between 77.5% and 97.6% white non-Hispanic), and the institutional affiliations of authors, reported results may be entirely limited to a few cultures in high income countries. This is a particularly pertinent limitation, as the nature of which sexual, religious, and/or violent thoughts are considered to be taboo may drastically vary with culture (Graham et al., 2016) which in turn may have important implications for CBT/ERP treatment outcomes (Nicolini et al., 2017).

Clinical Implications

Clinicians should be aware that taboo obsessions may be present in any person presenting for OCD treatment, whatever their primary presenting symptoms, and that the presence of sexual and religious (and perhaps to a lesser extent violent) obsessions may be associated with worse outcomes from CBT/ERP compared to OCD where such obsessions are not present. They could consider assessing for such experiences at intake, for example by routinely using a standardised measure of OCD symptoms such as the DOCS (Abramowitz et al., 2010) or the updated Y-BOCS symptom checklist (Storch et al., 2010), although they should be aware that particularly taboo thoughts may not always be disclosed at the start of therapy (Weidle et al., 2022). These tools may help to normalise taboo obsessions and facilitate disclosure.

Research Implications

While debates continue in the literature about the most appropriate taxonomy for symptom dimensions in OCD, it will be difficult for a clear body of research to develop. Based on the findings of this review, a particular challenge for the development of such cohesion comes from the ambiguity around violent obsessions - these have been understood by some researchers as a form of taboo or unacceptable thought, by others as a fear of harm, or sometimes both. Although researchers have attempted to address this ambiguity (Pinto et al., 2007; Williams et al., 2013), it may be that this area requires a more refined research instrument than the Y-BOCS symptom checklist, which records the presence of 'violent or horrific images', 'fear may harm others', without differentiating between obsessions around accidental harm (which may lead to physical safety-checking compulsions), and obsessions around one's own capacity for impulsive violence (which may lead to mental compulsions). Even the most nuanced exploration of the factor structure of the Y-BOCS (Pinto et al., 2008) finds that 'fear may harm others' loads across a taboo thoughts dimension (r=0.577) as well

as a doubt-checking dimension (r=0.412), perhaps as a result of this accidental/impulsive confound.

Further research is needed into factors which may explain the connection between taboo obsessions and poorer treatment outcomes. One promising avenue is the exploration of the emotions underlying obsessive and compulsive experiences, particularly the correlations which have been found between taboo obsessions and feelings of shame (Laving et al., 2022). It may be that the level of shame is a covariate which would benefit from further research attention, as shame in OCD has been associated with a need to modify or augment standard treatment (Bream et al., 2017; Weingarden & Renshaw, 2015).

Conclusion

Symptom heterogeneity has long been a challenge for the study of OCD treatment outcomes. Despite advances in OCD treatment which allow CBT/ERP to work more effectively with OCD characterised by taboo obsessions, studies continue to find a poorer response to treatment amongst those who experience sexual and religious obsessions. The picture with regard to violent obsessions is more mixed, perhaps due to confounds between violent obsessions which may evoke fear, and those which may evoke shame.

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Section B: Empirical Paper

Overcoming the ‘Shame Shield': a preliminary grounded theory of how Cognitive-Behavioural Therapies may proceed in the presence of high levels of shame in OCD.

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Abstract

Experiences of shame have been associated with a variety of negative outcomes in OCD, including reduced access and response to psychological therapy. Much has been said about how therapy may need to change to account for the presence of shame, but little empirical research has been carried out. As a result, a grounded theory methodology was chosen to explore how CBT/ERP may proceed when OCD is characterised by high levels of shame.

Twelve individual interviews, with 5 therapists and 7 experts-by-experience, led to the development of a preliminary theoretical model. This introduces the concept of "The Shame Shield" to show how the presence of shame may function as a context which interrupts or slows down three necessary therapeutic processes – "Establishing Trust and Safety", "Becoming Speakable", and "Effective Interventions". These processes may interact in different ways depending on the characteristics of the person and their therapist. Findings are discussed in relation to relevant theory and current clinical practice. Study limitations and potential clinical and research implications are discussed.

Keyword(s): Shame, OCD, CBT, ERP, Grounded Theory

Introduction

"Obsessive-compulsive disorder" (OCD) is a diagnosis characterised by obsessions ("recurrent and persistent thoughts, urges, or images that are experienced as intrusive and unwanted"; APA, 2013, p.235) and/or compulsions ("repetitive behaviours or mental acts that an individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly"; APA, 2013, p.235), which disrupt a person's daily life. While many people may challenge the labelling of individuals as 'disordered' (e.g. Watson, 2019), many experts-by-experience find 'OCD' useful as a shorthand for their difficulties (e.g. Salkovskis & Edge, 2018), while lack of accurate diagnosis (when OCD symptoms are present) is associated with a variety of negative outcomes (Stahnke, 2021). Reflecting the current terminology of the academic literature, this MRP will discuss 'symptoms of OCD', while recognising that such constructions are not uncontroversial.

Currently in the UK, the recommended psychological intervention for OCD is Exposure and Response Prevention (ERP), with or without additional cognitive strategies (NICE, 2005). The core process of ERP is to induce obsessive thoughts ('exposure') without engaging in compulsions to neutralise distress ('response prevention'; Foa, 2012). ERP is a behavioural approach, theorised to function by enabling habituation (Foa and Kozak, 1986) or strengthening non-anxiety memories (Craske et al., 2014) in relation to an anxiety-inducing stimulus. Additional cognitive strategies may focus on changing a person's beliefs around the meaning of their obsessions and the necessity of their compulsions (Bream et al., 2017), as according to the cognitive model of OCD these are characterised by catastrophic misinterpretations (Rachman, 1998). Despite wide application of these approaches (Hezel & Simpson, 2019), ERP shows only moderate response rates (50.0% of recipients achieve

clinically significant change, falling to 43.4% when augmented with additional cognitive therapy; Öst et al., 2015).

One contributing factor may be the heterogeneity within OCD as a diagnosis (Bream et al., 2017), which can describe experiences as diverse as fear of illness, unwanted sexual thoughts, and metaphysical rumination. In recent years various 'subtypes' have been proposed, with varying levels of clinical relevance (Williams et al., 2013). In one case the evidence of distinctness was compelling enough to precipitate the recategorisation of hoarding behaviour from a type of OCD to a separate "Hoarding Disorder" (APA, 2013). In other cases, the reliability and validity of OCD subtype constructs have been harder to establish, and clinical relevance harder to ascertain (Starcevic & Brakoulias, 2008; Thorsen et al., 2018).

The majority of OCD subtyping has focussed on categorising the troubling experiences themselves. For example, the Dimensional Obsessive Compulsive Scale (DOCS; Abramowitz et al., 2010), divides OCD experiences into four categories: 'symmetry', 'contamination', 'responsibility for harm', and 'unacceptable thoughts'. Disagreements exist around categorisation of certain experiences, particularly violent obsessions, which may be grouped with 'responsibility for harm', 'unacceptable thoughts', or both (Part A). While associations are consistently found between certain types of experience and a reduced likelihood of treatment response (particularly sexual, religious, and violent obsessions; Williams et al., 2013), effect sizes are small (Part A), and it may be that a covarying factor would better explain these findings.

Another promising framework for categorising heterogeneity in OCD comes from underlying emotional states. Historically, OCD had been categorised as a type of anxiety disorder, meaning that its symptoms were understood as deriving from feelings of anxiety. Recent updates to diagnostic manuals such as the DSM-5 (APA, 2013) and ICD-11 (WHO, 2018)

have created separate categories for obsessive-compulsive and related disorders (OCRDs). Although this re-categorisation is not uncontroversial (e.g. Abramowitz & Jacoby, 2015), research into the newly-created categories has led to an increased recognition of how other feelings may be fundamental in some presentations of OCD, such as guilt (Melli et al., 2017), disgust (Knowles et al., 2018), and incompleteness (Schwartz, 2018).

Shame-related OCD

Shame has become especially prominent in recent OCRD research. Shame is a self-conscious emotion involving an appraisal of the self as inherently bad (as distinct from guilt which involves an appraisal of one's actions as bad; Tangney & Dearing, 2002). Shame has been found to predict poorer quality of life in OCRDs more accurately than symptom severity (Singh et al., 2016). Potential explanations for this include the associations between shame in OCD and increased functional impairment (Weingarden et al., 2016), and barriers to treatment access (Glazier et al., 2015). A recent meta-analysis found that shame was particularly associated with unacceptable thoughts, harm obsessions, and symmetry concerns (Laving et al., 2022) - some of the same symptom dimensions which are often associated with reduced treatment efficacy. This opens up the intriguing possibility that *shame* may be a covariate which explains some of the variability in OCD treatment outcomes across symptom types.

When working with shame in OCD, it is important to distinguish between general and symptom-related shame (Bream et al., 2017, ch 4.4). While many presentations of OCD (and other forms of mental health difficulty) may be associated with general shame regarding one's distress or level of functioning, symptom-related shame is more interlinked with the OCD experiences themselves. This may include internal shame ('I am bad') or external shame ('others will think I am bad'), which are interconnected (Gilbert, 2011). Symptom-

related shame may include ‘primary shame’, potentially driving obsessions and compulsions (whereas general shame occurs only ‘secondary’ to the existence of mental health difficulties; Bream et al., 2017). Primary shame may drive OCD differentially across symptom dimensions - for example, when taboo thoughts are present, primary shame may be related to Thought Action Fusion (particularly the moral subtype whereby having a thought is perceived to be as immoral as acting on that thought, thus leading to compulsions such as thought replacement; Shafran & Rachman, 2004). In contrast, where symmetry or cleanliness concerns are present, primary shame may instead be related to intolerance of perceived imperfection (Wetterneck et al., 2014).

According to the two most common theories of how ERP functions (discussed above), it is plausible that OCD presentations where primary shame is driving compulsions would respond less well to ERP. It is not clear if exposure to shame-inducing stimuli leads to habituation in the same way as for anxiety-inducing stimuli (although it has been hypothesised that this is the case; Bream et al., 2017). Similarly it is not clear if non-shame memories can be strengthened through ERP, if the ERP tasks themselves trigger high and sustained levels of shame (which may be associated with the high levels of treatment discontinuation associated with ERP; Wheaton et al., 2016a). Therefore it may be that a greater focus on cognitive strategies, or some other approach, would show greater efficacy in working with shame.

Several suggestions have been made regarding more shame-sensitive treatment approaches in OCD. Weingarden et al. (2016) suggest adapted CBT, while Bream et al. (2017) suggest the integration of CBT with elements of Compassion-Focused Therapy (Gilbert, 2011). Two recent RCTs (Strauss et al., 2018, Twohig et al., 2018) explored the effectiveness of mindfulness-augmented and ACT-augmented ERP. What these approaches have in common

is a focus on cultivating non-judgemental awareness of present-moment experiences (Hayes et al., 2004). Neither study found evidence that the augmented approaches were superior to standard ERP. At present, the idea that ERP is less effective in the presence of shame, and that as a consequence of this treatment should be adapted or augmented, remains at the level of "practice-based evidence" (Barkham & Mellor-Clark, 2003).

Rationale for this Study

Although shame may frequently be targeted in therapeutic interventions for OCD (Singh et al., 2016; Bream et al., 2017), primary shame in OCD has only received recent attention and there have been few studies of how this occurs in practice (e.g. Spragg & Cahill, 2015). Given the lack of existing research, recent shifts in theoretical understandings of OCD, and the heterogeneity of the OCD construct, understanding remains at the "pre-paradigmatic stage" (Kuhn, 2012) - no one theory is widely accepted. Thus a qualitative, inductive method is appropriate, to explore current therapeutic practice without presupposing which interventions might be applied or found helpful when working with primary shame in OCD. The grounded theory "spiral" of methodologies (Mills et al., 2006) was judged to provide an appropriate foundation for this investigation, enabling the triangulation of different experiences from clinicians and experts-by-experience.

Research Aims

The study aimed to build on practice-based evidence to develop a preliminary grounded theory of how CBT/ERP for OCD may proceed (differently or not) when a high level of primary shame is present. As is appropriate to grounded theory (Hoddy, 2019), research questions were held lightly and used only to guide initial data generation.

Research Questions

1. How are obsessions and compulsions in OCD understood by experienced CBT practitioners and experts-by-experience when a high level of 'primary' shame is present, and is this perceived as different from other presentations of OCD?
2. How might CBT/ERP be offered or adapted when working with presentations including a high level of 'primary' shame?
3. Are any particular approaches perceived as (un)helpful when working with such presentations, and how do experienced CBT practitioners and experts-by-experience understand these interventions to work?

Method

Research Design

Abductive grounded theory (Hoddy, 2019) operates within the critical realist tradition - combining a realist ontology with a constructionist epistemology. It recognises the existence of a 'real' external reality, and the inherent limitations of any one data set or interpretation in accurately reflecting that reality. Working within this tradition, a modified version of the Corbin and Strauss (2015) approach was chosen to guide data generation and analysis.

Research design modifications were necessary due to the time-limited nature of the project, meaning that open-ended research was not possible, and theoretical saturation (a contested concept anyway; e.g. Nelson, 2017) could not be relied upon as the endpoint for data generation and analysis. Instead theoretical sufficiency (Dey, 1999) was pursued, with the aim of reaching conceptual depth (Nelson, 2017). A minimum sample size of 10 with a "stopping criterion" of 3 (as suggested by Francis et al., 2010, p. 1229) was identified as potentially sufficient to develop a preliminary grounded theory.

Participants

Inclusion Criteria

Individuals with experience of a cognitive behavioural therapy for shame-related OCD were considered to be eligible for this study. In practice, this was operationalised as in Table 1.

Table 1

Inclusion Criteria

Criterion	Implementation	
	Therapists	Clients
Experience of a cognitive behavioural therapy	BABCP accredited, or meeting the requirements for accreditation. Working in a modality recognised by the BABCP (Including CBT, ERP, ACT, CFT, Schema Therapy)	Self-report of experienced therapy.
In the treatment of shame-related OCD	Self-identify as having worked with a number of clients whose obsessions and/or compulsions have been driven by feelings of shame.	Self-report a diagnosis of OCD. Self-identify as having experienced obsessions and/or compulsions driven by feelings of shame.

Recruitment & Theoretical Sampling

Recruitment took place through online activity, which was amplified by various activists, researchers, and organisations in the domain of OCD. Recruitment materials included an advert and an information sheet (Appendix C), promoted on social media platforms including Twitter and Reddit (Appendix D). The use of online recruitment allowed for the advert to be dynamically updated as the study progressed, in pursuit of theoretical sampling aims.

Changes to the recruitment strategy were also driven by pragmatism - while the researcher worked hard to start conversations about "shame in OCD" and generate interest, early recruitment was sluggish. This is likely to have been exacerbated by the Covid-19 pandemic. Based on social media interactions it seemed that "shameful intrusive thoughts" was more legible to prospective participants than "shame-related OCD", and as a result advertising was refocussed to capitalise on this legibility.

Demographics

Twelve participants were interviewed - 7 clients, and 5 therapists with expertise in CBT for OCD. Their demographic information is summarised in tables 2 and 3. Clients (4f, 2m, 1nb) had an average age of 27, and an average age of OCD onset of 10. Therapists (2f, 3m) had been qualified for an average of 10 years, in roles including Clinical Psychologist, IAPT High Intensity Therapist, and CBT Therapist. All therapists had worked with a range of OCD presentations, and reported that their default treatment, in absence of high levels of shame (or other considerations), would be CBT with ERP.

Table 2

Demographic Characteristics of Client Participants

Participant	Gender	Ethnicity	Region	Age	Age of Onset
Client 1	Female	White British	England	36	8
Client 2	Male	White Other	England	24	17
Client 3	Female	White British	England	22	9
Client 4	Non-binary	Chinese	England	23	0
Client 5	Female	White Other	Scotland	24	7
Client 6	Male	Arab	Middle East	32	21
Client 7	Female	White British	England	30	11

Table 3

Demographic Characteristics of Therapist Participants

Participant	Gender	Ethnicity	Years in caring professions	Years CBT qualified	Professional background
Therapist 1	Female	White British	37	21	CPN / CBT Therapist
Therapist 2	Male	Arab British	12	3	IAPT High Intensity
Therapist 3	Female	Pakistani	32	6	IAPT High Intensity
Therapist 4	Male	White Other	16	4	CPN / CBT Therapist
Therapist 5	Male	White British	22	17	Clinical Psychologist

Procedure

Data Generation

Data were generated through semi-structured interviews (scheduled for one hour; actual duration 35 to 85 minutes) carried out over online video. The initial interview schedules (Appendices E, F) for client and therapist interviews were generated with the support of a paid expert-by-experience consultant, accessed through the Salomons Advisory Group of Experts by Experience. Schedules were adapted over the course of the research to support theoretical sampling, both pre-emptively (Appendices E, F) and ad-hoc (Appendix G) to support theory emergence (Charmaz, 2008; Foley et al., 2021). Given the focus on shame as a context, questions were developed to elicit comparisons between situations where shame is more or less salient – for example, asking therapists to describe how they would work with a 'typical' case of OCD, then to describe how their practice would differ from this (if at all) in the presence of high levels of shame.

Data Analysis

Interviews were audio recorded and transcribed. Transcripts were pseudonymised and imported into NVivo analysis software. Line-by-line coding (Appendix J) was carried out for all interviews, although as the model took shape this coding was increasingly informed by the emerging theoretical constructs, through clustering of data in NVivo and 'constant comparison' (Glaser, 1965) between the data and the labels applied to it (Appendix K). While abductive grounded theory does not use a concept of coding reliability (Hoddy, 2019), discussion with supervisors supported credibility and data-nearness of initial codes (Corbin & Strauss, 2015). In particular they supported this through enabling the researcher to observe and counteract presumptions and biases. A research journal further supported researcher reflexivity (Appendix I). Supervisors also supported axial coding through analytic questioning (Blumer, 1969), exploring how initial codes were connected by context or process. Memos, diagrams, and creative methods were used to deepen analysis and explore relationships between emerging categories (Appendix L). After testing multiple approaches for fit, the storyline method (Birks et al., 2009) was ultimately used to generate an abstracted and explanatory model, grounded in participants' data.

Ethical Considerations

This study was approved by the Salomons Institute Ethics Panel (Appendix B). The information sheet (Appendix C) and interview schedule (Appendices E, F) were reviewed by an expert-by-experience consultant to help ensure that the former would enable participants to give fully informed consent to the latter.

Ongoing Consent

Although participants had all signed consent forms, key points (including confidentiality and safeguarding) were reiterated at the start of the interview. As theoretical sampling progressed

and questions deviated from the original interview schedule, the researcher included caveats like “if you feel comfortable talking about..” to remind that questions were optional.

Participants received a ‘debrief’ email (Appendix H), including information about how to withdraw their data - nobody asked for this to take place.

Risk of Distress

The researcher used clinical judgement to be alert to signs of distress - none was observed. In case of hidden or delayed distress, the debrief email (Appendix H) included contact details for support organisations.

Information Security

Audio recordings were transcribed pseudonymously by the researcher, and then deleted. Transcribed interviews were stored on an encrypted hard drive, with extracts and codebooks shared with research supervisors only via secure email or video screen-sharing.

Quality Assurance

Corbin and Strauss (2015) lay out nine conditions that enable quality GT research. This study aimed to embody these as summarised in Table 4.

Participants were invited to review the generated model, both to ensure that it represented their experiences and to confirm that they were comfortable with their quotations (Appendix M). Four client participants responded, expressing full agreement with the derived model, and in once case further deepening analysis.

Table 4

Grounded Theory Research Quality Conditions (Corbin & Strauss, 2015)

Criterion	Characteristics of Research Process
Methodological consistency	Commitment to 'data-near' analysis, ensuring that theory is grounded. 'Abbreviation' of GT risked a merely descriptive study, but core concepts began to emerge sufficiently early that some degree of theoretical saturation was able to be reached.
Clarity of purpose	Although there was some ambiguity in recruitment, interviewing and analysis stayed clearly focussed on issues around CBT interventions for shame-related experiences.
Self-awareness	Use of a research journal (Appendix I) and memos (Appendix L) to keep track of my thinking as the research progressed - this enabled me to use reflexivity in pursuit of bracketing my assumptions, which supervisors also supported me in.
Training	I attended an extensive Salomons Institute lecture series, and received expert supervision.
Sensitivity to participants and data	Corbin & Strauss (2015) describe this as requiring "empathy, carefulness, respect, and honesty" (p.349). I have displayed this even potentially to the detriment of the research - for example, encouraging someone who expressed ambivalence not to participate unless they were certain, even though I was struggling to recruit.
Willingness to work hard	This is understood as meaning that "a qualitative researcher can't be in a hurry" (Corbin & Strauss, 2015, p. 349). Rather than rush to complete this research for a deadline earlier in the year, I have taken my time necessary to immerse myself fully in the data.
Ability to connect with the creative self	My creative self tends towards writing and performing activities, and I create more fruitfully in dialogue with another. While diagramming, I enlisted the help of a colleague with training in the visual arts to ask me generative questions and help me think of different ways of visually representing the data I was presenting verbally.
Methodological awareness	Decisions throughout the research process have been considered in terms of their implications within the frame of critical realist Grounded Theory - this can be seen particularly in the research journal (Appendix I).
Strong desire to do research	I was particularly motivated to do this research due to an interest in the space between theory and practice in psychological therapies - I experienced a strong drive to find out what happens "in the room", particularly with an under-served population such as people experiencing shame-related OCD.

Results

This project aimed to explore the process of CBT/ERP for OCD characterised by 'primary' shame. Despite a focus on taboo thoughts in some recruitment, participants spoke about a wide range of OCD experiences which may be driven by 'primary' shame - these included sexual, religious, and violent obsessions; themes around relationships, memory, and self-identity; contamination and neatness. Following interviews with five CBT therapists and seven people who had accessed CBT for OCD, data analysis produced four main concepts, summarised in table 5 and connected diagramatically in figure 1.

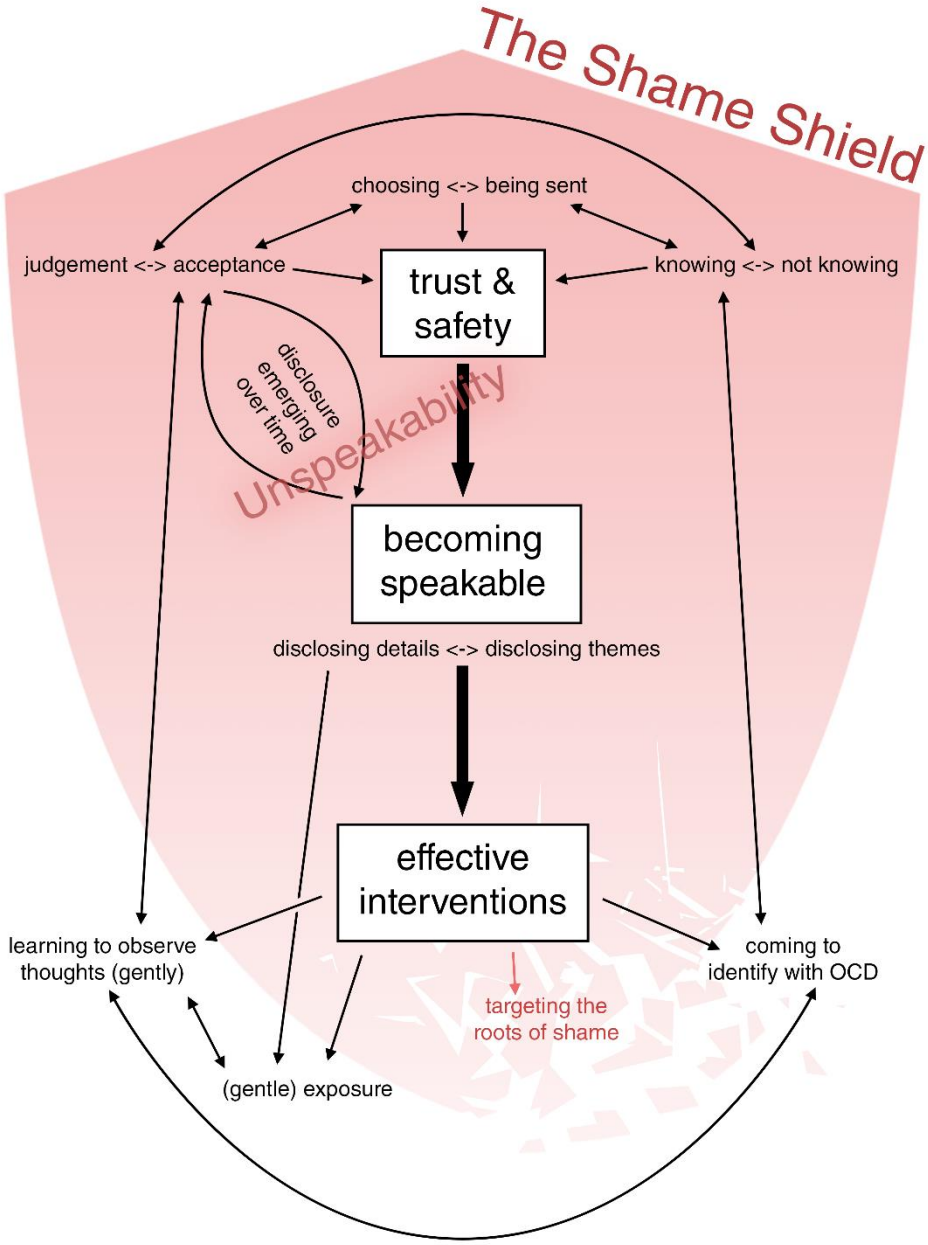
Table 5

Concepts and Categories

Concepts	**Sub-categories**
Establishing Trust & Safety	Judgement <-> Acceptance
	Knowing <-> Not Knowing
	Choosing <-> Being Sent
Becoming Speakable	Disclosure Emerging Over Time
	Disclosing Detail <-> Disclosing Themes
Effective Interventions	Coming to Identify with OCD
	(Gentle) Exposure
	Learning to Observe Thoughts (Gently)
The Shame Shield	Unspeakability
	Targeting the Roots of Shame

Figure 1

Conceptual Map



Establishing Trust & Safety

The therapeutic relationship was constructed by most participants as a precursor to effectively working with shame. This was characterised particularly in relation to trust and safety.

> **Client 1:** "...I wouldn't have been able to do that stuff at the beginning … I needed to build a trusting relationship with the therapist…"

> **Therapist 1:** "if you can use yourself and use a therapeutic alliance and the person feels safe with you, maybe you can actually go further than might be obvious."

> **Client 7:** "I trusted her enough to bear my shame."

This was a necessary condition; therapy was unable to proceed effectively without it:

> **Client 3:** "I just didn't get on with the practitioner … so I was like - I don't want any help anymore"

One therapist observed that a lack of attention to this element in their previous practice may have limited their ability to work with shame-based presentations of OCD:

> **Therapist 3**: "we know that's not the most effective way of building up a therapeutic relationship, but just because of the time limited nature…"

Although some participants felt that everyone deserved the same level of trust-building work:

> **Therapist 2**: "you're meant to be still kind, caring, considerate, professional, empathic, interested, curious - you're meant to be all of these things. And if you're having to be that *more* for a client who's presenting with shame, then you're doing something wrong with the other clients."

Particular processes contributing to the development of trust and safety are captured in this model as dimensional continua.

Judgement* <-> *Acceptance

This was identified as a particularly challenging axis when working with shame-related experiences. Many participants reported that early attempts at seeking help had reinforced shame, inhibiting their ability to access feelings of trust and safety in future therapeutic relationships.

> **Client 2:** "I felt judged. I felt small. I felt ashamed, massively ashamed … after that I didn't go back to a therapist for a while"

> **Client 6:** "[my current therapist is] very nice. You know she's not shaming. She's not judgmental"

> **Therapist 2**: "if we're suggesting experiments or scenarios that may induce shame … there's a very fine line betwixt suggesting something and being helpful, and being judgmental"

> **Client 1:** "I felt like she was accepting of me even when I was feeling at my most unacceptable, and that was really powerful."

Acceptance (/lack of judgement) had a reciprocal relationship with speakability and disclosure - with greater therapist acceptance enabling effective therapy, or even being therapeutic in its own right.

> **Client 3:** "as soon as I told her it, it literally went, the obsession … Just getting confirmation from someone who, like her, was like 'oh it's fine' … obviously that's not normally how therapy would work, but … just talking about it was enough."

Knowing <-> Not Knowing

One factor which supported clients in experiencing their therapists as non-judgemental was identified as the normalising effect of knowledge and understanding in relation to OCD:

> **Therapist 1:** "when people say, 'have you seen - have you heard this before? Have you seen people like me before?' That's such an important question for people to be asking you when they're testing you … am I safe with you? … or are you going to judge me like so many other people."

Absence of this knowledge was associated with experiences of being judged:

> **Client 2:** "Visual reactions … I could sense it in their voice. You become very very attuned or tuned in to people's reactions … the most blatant one was visual shock, literally 'Oh my God'."

However, therapist knowledge needed to be expressed carefully so as not to impact the client's sense of safety or acceptance:

> **Client 7:** "certain professionals that I've spoken to … 'I have sexually intrusive thoughts' … their response is like 'oh, another one of those' … that's a much better response than going 'you what?? You do what??' … but it's like … 'oh right. You're one of those' and they're so blasé about it … it didn't feel that good"

Choosing* <-> *Being Sent

Having a choice over your therapist was associated with the development of trust and safety:

> **Client 6:** "you are the client, you get to choose who is a good fit for you and who is not. Interview several therapists and see who is a good fit. And if it doesn't work for you, you always have a choice of leaving"

Whereas being sent to or assigned a therapist were generally associated with barriers:

> **Client 5:** "my mum sending me to counselling and I didn't really know what I needed and I wasn't really in the right kind of frame of mind to talk to someone"

Being able to select a specialist therapist was associated with the 'knowing' and 'accepting' conditions discussed above.

> **Client 1**: I sought therapy privately … it was a recommendation, a CBT therapist who specialises in working with people with OCD and trauma."

> **Client 5:** "my current therapist … just puts things on her website that are about really quite intense topics … that really kind of makes the shame a little bit less intense because you've addressed it before I have, so you already know"

However, some 'specialist' therapists were also experienced as unhelpful, perhaps due to a lack of training or oversight:

> **Client 2:** [regarding a social media 'celebrity' claiming to offer CBT] "he used [sessions] as a bit of an indulgence. He talked about his childhood. He talked about his experience. It was bizarre, he was saying very odd things and it really didn't help at all"

Becoming Speakable

Shame-related experiences were associated with a high level of 'unspeakability' within the data, and the process of overcoming this was a necessary step towards 'effective interventions'. Participants described the transition between the 'unspoken' and 'spoken contexts as a highly significant one, facilitated or inhibited by various factors - the one necessary factor being a safe and trusting therapeutic relationship.

> **Client 7:** "I'd never shared the thought out loud ever."
>
> **Client 4:** "it was very difficult to mentalize it, to express it. And even if someone could express it, they would feel too ashamed to mention it."
>
> **Client 6:** "it's a very personal thing that I don't feel comfortable telling them … they're not privy to knowing my story until I feel comfortable sharing it with them"

It is important to note that unspeakability potentially renders some things invisible, particularly to the researcher and to the therapist participants. It is not possible to judge with certainty how much remains unknown, either within a specific therapeutic interaction or within this model.

> **Therapist 1:** "I don't know how many people have held something back from me, but I'd be delusional if I thought there weren't a good proportion who had, who were frightened to tell me"

Disclosure Emerging Over Time

This was a reciprocal process between the "judgement<->acceptance" continuum and the act of speaking, as client participants iteratively test the safety of disclosure within the therapeutic dyad. It was important that this process should be client, not therapist, led:

Client 3: “I don't know why it took me so long, it just didn't feel like the right time, and I don't know if that's anything that therapists could have done differently or if it was just I wasn't ready.”

Therapist 2: “whenever she said she couldn't talk about something, I said ‘OK, that's fine. Do you mind - what aspect of it can we talk about? Do you feel like we can explore the impact?’.”

Clients may begin by sharing their less shame-related experiences, perhaps as part of building up the trusting therapeutic relationship:

Client 5: “When I first went to [therapist] and we were talking through like "what intrusive thoughts do you have" ... I went through the ones that are not as shameful … like ‘oh the stove is going to burn’ [before disclosing] harm OCD or relationship OCD.”

Client 3: “the session before I told her "there's something I really want to talk about, but I don't know if I should or what happens if I do?" [she] reassured me … and then the next session I was able to talk about it.”

However some therapists did not report observing any slow or delayed disclosures, which may be attributable to their working in time-limited service contexts, where shame-related experiences may be invisible or unshared:

Therapist 3: “I don't remember offhand any experiences where there was OCD where within the first session or two, it wasn't clear what the presenting problem was”

Disclosing Details <-> Disclosing Themes

Participants varied in whether or not they felt that disclosing shame-related experiences in detail was a necessary precursor to effective intervention - or even constituted an intervention in its own right.

> **Therapist 2:** "if you don't know what the shame inducing intrusive thought is or any of the imagery or any of that - that's fine, you can still work with intrusive thoughts. You can still normalise it"

> **Client 7: "**it's not that she didn't know what my thoughts were at that point, but to actually write out a specific thought or say a specific thought to her was like something that just never seemed that it would ever be possible, and even after four months of seeing her, the day I did that I was.. literally I just cried the whole way through, like almost to the point of hyperventilating"

> **Client 3:** "eventually I did tell what happened … there was no judgement … just telling someone like a therapist. I was like 'oh it can't be that bad then if they aren't reporting me to the police' … I didn't really worry about it anymore … obviously that's not normally how therapy would work, but for some reason I think just talking about it was enough"

Detailed speaking was also experienced as counter-therapeutic, particularly when knowledge or acceptance is lacking:

> **Client 2:** "because I was just so desperate to talk to someone, I ended up giving all the details and feeling quite used afterwards - like I'd just given everything and like they didn't know what - they had literally zero idea what I was talking about."

Thus unlike the continuua which describe the development of trust and safety above, any position on the "disclosing details <-> disclosing themes" continuum could potentially lead to effective interventions.

Effective Interventions

Participants described a variety of processes by which a person experiencing shame-related obsessions or compulsions might improve their wellbeing. This was constructed as a reduction in OCD symptoms, or an improved relationship to one's shame-inducing thoughts. It was not an absolute state of health or freedom from 'illness', but rather a liveable state of wellbeing:

> **Therapist 4:** "the OCI [measure of OCD symptomatology], I think it was like 10 so it's like, well, you're good to go then in my view"

> **Client 2:** "A world where you don't *not* have the thoughts - I will always have the thoughts - but where a majority of them don't ruin my day."

Learning to Observe Thoughts (Gently)

This process was evident in participants' reflections on the benefits of mindfulness, and of reappraising instinctive cognitions which follow from feelings of shame.

> **Therapist 1:** "we're not trying to challenge … we're working with the process and we're working with actually ultimately just being able to let thoughts come and go."

The importance of gentleness - not observing thoughts too intently - was underlined by client participants' reflections on therapy which had been less helpful, or even harmful. This included treatment which characterised shame-based experiences as 'irrational anxiety', and engaged using core CBT techniques such as thought records and thought challenging (described by participants as functioning to unhelpfully reinforce feelings of shame).

Client 5: “[some] CBT actually worsens OCD … thinking about something a lot and deconstructing the thought - that's exactly what I'm **not** supposed to do in ERP”

Therapist 1: “treatment can be very, very shaming if you're not careful, like you say: ‘here's a thought record’ … there's always that risk, I think, with treatment that you can end up trying to persuade somebody that - I don't know - they're not a paedophile”

Client 2: [on being asked to keep a thought record] “I look back at that CBT exercise as something which had made things 10 times worse … if you place importance on the thoughts, you are screwed because they're the most terrifying thing”

Instead, clients report experiencing less shame if they can observe thoughts without needing to directly engage with them:

Client 7: “you are not your thoughts … we aren't our thoughts and we're not responsible for them”

Client 6: “don't try to give those thoughts a life, they're irrelevant, you don't have to engage with them”

This therapeutic effect was supported by the process of “coming to identify with OCD”:

Therapist 1: “starting to recognise ‘that's my OCD pecking at my head’, ‘that's my OCD giving me a hard time’, rather than ‘it's the gospel truth’ … ‘these are the things my brain presents me with’ … it's a kind of mindful detachment.”

Client 5: “the meanness has been taken out of it … ‘that's OCD’ … ‘you don't actually think that’ … ‘you're just having a passing thought’.”

Coming to Identify with OCD

Engagement with the OCD construct supported a process of normalisation through understanding, which was associated with the "knowing<->not knowing" continuum.

> **Client 1:** "a big part of it for me was understanding that it could be OCD, and the fact that I doubted whether it was OCD was probably part of the OCD"

> **Therapist 1:** "I know there's a huge debate about diagnosis, but people really find it helpful to be able to categorise 'what the hell is wrong with me?'."

> **Client 3:** "I think I'm a bad person because I was unwell - not because I actually am."

This process was often made more difficult by the heterogeneous nature of the OCD construct, and the fact that shame-related OCD is less visible in popular cultural understandings of OCD:

> **Client 5: "**it's so under-represented and under-talked-about - in my circles people still think OCD is just cleaning and physical compulsions"

> **Client 4:** "I can't even think of one single physical representation of my OCD. I don't have to tidy my room three times a day. I don't have to wash my hands in boiling water."

(Gentle) Exposure

Exposure was seen as a key intervention by many participants. All of the therapists interviewed used ERP as a core part of their practice with OCD, although most of them expressed that they would make adjustments due to the presence of shame:

> **Therapist 1:** "if it's shame, they ain't gonna habituate … they're probably going to go and not come back and see you and you wouldn't blame them"

Many of the participants discussed the particular challenges of ERP when working with taboo intrusive thoughts:

> **Therapist 4:** “And obviously when you think of the ERP, we can't really expose him to be telling people those [abusive] words because ultimately it's going to be a problem.”

> **Client 5:** “Writing a story sounds terrifying to me, you know? 'cause that's like putting it on paper, but maybe that's the right thing to do”

Exposures can be self-directed in people who prefer to stay at the “disclosing general themes” end of the continuum:

> **Client 3:** “It's like I've learned from all the other exposures, and then those experiences filtered down to that one … I was able to apply it myself without her help I think.”

But detailed disclosure could also function as an exposure in its own right:

> **Therapist 5:** “one of the pieces of exposure work [could be] actually disclosing to someone that you have these thoughts, and these fears and doubts, and that other person not going ‘well, actually that's against your faith’, or ‘that's disgusting’.”

Clients were generally positive about their experiences of exposure work, although this was more challenging to apply to shame-related stimuli:

> **Client 3:** “I would always recommend CBT with ERP for OCD”

> **Client 5:** “writing a story - so for false memory OCD, it might be like writing a story in which the thing that you're afraid you did - whether that was like, harm someone or yeah, do something really bad - writing a fake story ... that's one that I struggle with because I'm like

‘well the worst case scenario is really bad, if I have done something like that’. I'm yet to get to a point where I'm like, ‘oh well, the worst case scenario is this, but I'm fine with that’.”

There was a sense that the gentle tone offered by third-wave variants of CBT may offer a more appropriate approach in these cases:

Client 7: “I think it's more coming about now about like acceptance commitment therapy and mindfulness. Uhm, I would say to definitely try and incorporate some of that into their therapy as well. Uhm, because ERP is like a really hardcore - you know? Do this! Be uncomfortable! Sit with it! It's quite you know, quite blunt, quite straightforward, quite harsh. And sometimes you need a bit of you know, self-soothing”

Therapist 1: “if the person has a lot of shame then I might blend that with the three circles from CFT to look at understanding the threat system.”

Therapist 4: “it's getting to the worst case scenario, imagining it, and then [clients can use a CFT technique] - a compassionate image.”

The Shame Shield

This construct surrounds and interrupts the other processes in the model. It shows diagrammatically how these may be blocked or slowed down by the presence of shame.

Client 6: “perfectionism is a seven-tonne shield to protect us against the feeling of shame.” (during data validation, the participant noted that this should be attributed to Brené Brown)

Therapist 4: “perhaps the ERP doesn't work because the shame is sort of like a core belief”

Therapist 2: “shame is also associated with larger levels of dropout”

The shame shield was understood to have various potential aetiologies, including family and cultural norms, along with trauma and personal thinking styles.

> **Therapist 5:** "particularly where faith comes in … there is that kind of cultural belief/expectation within a family about what the expectations of behaviour are, and of what the expectations of thinking, and what it means to be acceptable within your family unit."

> **Client 4:** "in [my culture of origin's] very intense, exhausting, almost suffocating environment, it's very easy for people to become very self diminishing … internalized, the social expectation within themselves"

> **Therapist 1:** "[in the history of clients presenting with shame-related OCD] I think there are fewer positive experiences. There are fewer experiences of being nurtured, and the world being safe"

> **Client 2:** "I feel very ashamed when I get angry. I feel very ashamed when I think about things sexually sometimes. I feel very ashamed when I feel lonely. I feel very ashamed when I feel like I am upset and putting a burden on other people. "

Cultural differences and marginalisation were identified as potential barriers to the "knowing<->not knowing" axis:

> **Client 4:** "I think the social and cultural element of how someone acquired a mental health problem is also very important … a contamination obsession, or superstitions, I think both of them can be quite different across different culture … if a self-help book didn't mention these examples, or if you come to talk to a GP or mental health worker and they didn't pick up these things because of the cultural difference … would not help the person in need …

the more intersectional identity you have, the more difficult you're probably going to feel confident in yourself at first. This is not your fault."

Unspeakability

One manifestation of the shame shield was the construction of unspeakability - which has a blocking / decelerating function on the reciprocal process between "judgement<->acceptance" and "becoming speakable".

> **Client 3:** "I was worried that talking about it would make it true … exposure was harder for [shame-related stimuli] 'cause I was like 'if I do an exposure about it then that means it's real, 'cause I'm making it more real by speaking about it'."

> **Client 4:** "I can sit here and talk about it with you without any difficulties, at least I think I'm quite chill about this now. But this is very very stark contrast to when I felt before … about those obsessive thoughts and how shameful I felt about myself for having them."

> **Therapist 4:** " I did 22 sessions with home visits and everything and he still never told me … [compared to someone who disclosed easily] I'm thinking, 'what was the difference' you see? And it must be the shame, must be the threshold of shame."

Targeting the Roots of Shame

While some participants reported the interventions discussed above to be sufficient to achieve desired outcomes, many expressed that feelings of shame may need to be targeted specifically.

> **Client 7:** "[shame is] such a huge part of the OCD but I feel like for me it's something that is so big that it kind of needs its own work, to focus solely on that."

> **Therapist 2:** “ignore the cause and the symptoms will just arise in a different fashion - shame is exactly the same.”
>
> **Client 2:** “from my experience, the only way you can address that shame is by realising that the shame is not only to do with the thoughts it's to do with the emotions”

This was seen as something that needed to be integrated with treatment for OCD, rather than sought separately.

> **Client 1:** “when we tried just doing trauma work without the ERP and more cognitive work also in parallel that was very difficult and I think I went backwards a little bit … doing the work in tandem worked much better.”
>
> **Therapist 1:** “[discusses a client’s trauma history] can I do the OCD piece of work without paying attention to that? Probably not … even if we don't have to do trauma work we probably are definitely going to need to do a piece of compassion work and look at the way she talked to herself, which was absolutely hideous.”

Discussion

The study aimed to draw on practice-based evidence to develop a preliminary grounded theory of how CBT/ERP for OCD may proceed (differently or not) when a high level of ‘primary’ shame is present. Twelve participants were interviewed, all of whom had experience of adapted or augmented CBT leading to increased wellbeing in people whose obsessions and/or compulsions were driven by feelings of shame. A model was developed which explored the ‘storyline’ of the therapeutic process, and the ways in which shame could block therapeutic processes, or be targeted in therapy.

The model was broadly in keeping with the existing literature around CBT/ERP for OCD. For example, it is often suggested (Bream et al., 2017; Whittal et al., 2010) that early stages of therapy should routinely include psychoeducation about the range of possible taboo intrusive thoughts which are understood as 'OCD'. The normalising effect of the therapist showing this proactive awareness was captured on the 'knowing<->not knowing' axis.

Similarly the judgement<->acceptance axis in the model mirrors Ong et al.'s recent (2022) research into the content of ERP therapy, which finds that "higher quality acceptance/tolerance procedures" is associated with positive outcomes for three out of four DOCS dimensions - specifically, the three dimensions which have been empirically linked with the presence of shame (responsibility for harm, unacceptable thoughts, and symmetry; Laving et al., 2022). It would be interesting to see the results of this study if data were analysed based on the emotional underpinnings of symptoms (e.g. shame), rather than superficial content of symptoms.

The emphasis on the therapeutic relationship in this model is somewhat in conflict with findings which have suggested that this is less necessary in ERP for OCD. Wheaton et al. (2016b) find that only practical engagement (such as agreement on goals) is predictive of ERP outcome, with no effect on outcomes for client ratings of the 'therapeutic bond'. However the measure they used to assess therapeutic bond (the WAI-SR; Munder et al., 2009) is focussed on a felt sense of care/liking, rather than the trust and safety which were central to this model.

Issues relating to 'concealment' (Newth & Rachman, 2001) are evident in the model (through the more data-near framing of 'unspeakability'). Clients may not disclose their experiences until a significant level of trust has been established - this was found to be an iterative process taking place over time, with most participants reporting that many months (or 10+ sessions) may pass before someone feels able to disclose. This in in keeping with findings that people may not disclose taboo

obsessions until a long way into therapy (Weidle et al., 2022), and may prove difficult under NICE guidelines (2005) for 'stepped care', where the initial course of ERP/CT treatment for OCD is a small number (<10) of group or guided self-help sessions - not tailored to the individual or focussed on the development of a therapeutic relationship. While the model does suggest that people may apply techniques learned from ERP in one area, to areas of difficulty which have not been disclosed ("disclosing details<->disclosing themes"), it is not clear that it is possible to generalise from ERP for anxiety-evoking stimuli, to ERP for shame-evoking stimuli. Participants expressed strong opinions that significant amendments are necessary to avoid the potential for iatrogenic harm when applying ERP techniques to shame-related stimuli.

People experiencing shame-based presentations of OCD would be unlikely to disclose or access effective interventions within the first 'step' of the NICE framework, and are likely to need the next 'step' of 10+ sessions of individual therapy. It is unclear how often this is available in practice, as it appears from this study that even high-intensity CBT within IAPT (as described by two of the therapist participants) may be limited to a six-session intervention, with a focus on quick formulation and goal-setting, which may counter-therapeutically encourage non-disclosure (Omylinska-Thurston et al., 2019). Furthermore, many of the client participants in this study seem to have accessed CBT which would not meet NICE (2005) standards for the treatment for OCD, perhaps in part due to a lack of "knowing" on the part of therapists who have treated shame-based concerns as anxious rumination, and prescribed thought challenging exercises which are contra-indicated in OCD (McKay et al., 2021) and indeed have the potential to become internalised as mental compulsions (McKay et al., 2019).

In another potential difference from NICE guidelines, this model suggests that when working with shame in particular it can be beneficial to integrate other types of therapy (trauma work, third-wave CBTs) with CBT/ERP, rather than offering these as standalone interventions. This is in keeping

with the ‘dual-focus’ which has been described as best practice for working with ‘trauma-related OCD’ (Dykshoorn, 2013) - though it may not be the case that trauma always needs to be worked with directly in treating OCD (Shavitt et al., 2010), and care should be taken that the necessary intensity of ERP is not undermined through the introduction of additional therapeutic elements (Law & Boisseau, 2019). Randomised controlled trials have confirmed that augmenting ERP with ACT (Twohig et al., 2018) or mindfulness (Strauss et al., 2018) does not reduce treatment efficacy - but neither has it been found to increase it. However these studies do not differentiate their participants based on symptom dimension, and it could be that improved efficacy for shame-related presentations (due to the factors identified in this study) and decreased efficacy for anxiety-related presentations (due to the dilution of core ERP treatment) may be hidden within the data. Evidence around CFT for OCD is at an earlier stage (Petrocchi et al., 2021), although it has been recommended for use in the context of shame by a mainstream treatment manual (Bream et al., 2017). Based on the practice-based-evidence (Barkham & Mellor-Clark, 2003) expressed by several therapists in this study, it seems that the augmentation of ERP with third-wave approaches, specifically for OCD characterised by a high level of shame, would be a fruitful area for further empirical research.

Another finding which resonates with existing literature is the idea of sociocultural variation in the development of shame (Rodriguez et al., 2016) and experiences of OCD (Nicolini et al., 2017). Processes by which people who have experienced social marginalisation are suggested to be more shame-prone is in keeping with the extension of the Minority Stress Model proposed by Cardona et al. (2022).

Strengths and Limitations of this Research

Compromises that were necessary for the purposes of recruitment may have reduced the scope of the study. The majority of participants were recruited through social media discussion about taboo

intrusive thoughts, although the information sheet and interview questions were more broadly focussed. Nonetheless participants do describe a wide range of OCD experiences as being underpinned by shame - not just taboo thoughts, but also "character indictment OCD", "false memory OCD", perfectionism/symmetry, and "relationship OCD".

Therapist participants varied in their level of experience working with shame in OCD, and this was a difficult concept to operationalise effectively. Although therapist participants were all asked to estimate how many clients they had offered therapy for OCD, and how many of those they considered to have experienced shame-related obsessions or compulsions, they often offered ranges or percentages, declining to offer exact estimates. As a result this data could not be meaningfully reported.

While early theorising, and theoretical sampling within later interviews, allowed for a certain amount of theoretical cohesion, categories and labels were nonetheless being refined and updated with each new interview. Conceptual depth was judged to be acceptable, but this study can only be said to constitute a preliminary grounded theory - further interviews may have yielded further complexities.

Implications

This study makes several novel contributions to the research and practice of CBT/ERP for OCD, particularly through the core concept of the "shame shield", and the "choosing <-> being sent" axis, which are explored further below. While other aspects of the model may be seen as less novel, due to their concordance with existing theory, this very concordance may still be seen as a contribution to the field. Grounded theorising is data-driven, with a wide range of possibility regarding the model which may ultimately prove most explanatory; it is therefore notable when a derived theory

matches existing theory so closely, as the a priori likelihood of this is relatively small. (Though it should be noted that participants and researcher can never be truly theory-naïve.)

Clinical Implications

This project identified some of the factors associated with effective interventions for shame-related OCD. Many of these are 'common factors' (Wampold, 2015), or aspects of treatment-as-usual for OCD (Nice, 2005). However, specific findings of interest to clinicians include the potential benefits of integrating ERP with other therapies (trauma therapies, or approaches which cultivate mindful awareness and/or compassion) - although further research would be needed to establish the efficacy of such approaches in comparison to shame-sensitive ERP.

In NHS settings, clients usually cannot choose their therapist, which is associated in this model ("choosing <-> being sent") with challenges to the development of trust and safety. NHS clinicians may need to attend more closely to the other two axes - knowledge and acceptance - in order to support the type of therapeutic milieu which has been identified as a necessary precursor of working with shame. This means that clinical education about the potential shame-based presentations of OCD is particularly vital, especially given the high level of misidentification (and ensuing mistreatment) which has been found amongst mental health professionals (Glazier et al., 2013), and which was evident in the accounts of several client participants in this study. If working in a non-diagnostic framework (e.g. Johnstone et al., 2018), clinicians may need to find other ways of allowing clients to access the benefits (identified in the model) of "coming to identify with OCD".

NHS staff are also likely to be working in time-limited settings, giving particular relevance to findings around the unspeakability/'concealment' and the iterative processes of disclosure - proactive awareness is needed that shame-related symptoms may be present, whatever the immediate presentation and therapy goals.

Research Implications

'Shame-related OCD' was not a viable construct for the purposes of participant recruitment. It is not clear whether this related to illegibility of the construct, the fact that early recruitment took place during the early months of the Covid-19 pandemic, or the fact that shame as a construct may be aversive. Nonetheless the model derived from the participants' accounts would seem to suggest that shame-related experiences in OCD had specific effects and required distinct approaches to treatment. Thus the legibility and potential usefulness of the 'shame-related OCD' construct would benefit from further research attention.

One area of urgent research interest raised by this study is the potential that shame-related presentations may be being overlooked in time-limited treatment settings. People with OCD symptoms may reach therapy goals set based on early disclosure (thus appearing to be a therapeutic 'success'), yet still be struggling with unspeakable distress. This may be captured in the high level of re-referral to IAPT services (NHS Digital, 2018), and would benefit from further exploration.

Longer-term, the suggestion that ERP is more effective in shame-related presentations of OCD when augmented by therapeutically "targeting the roots of shame" would need to be tested in large-scale randomised controlled trials.

Conclusion

This study drew on the insights of 12 people (five therapists and seven clients) with experience with CBTs for OCD to develop a grounded theory of how therapy may proceed when OCD presents with a high level of primary shame. The 'shame shield' was a core concept, illustrating how the presence of shame may interrupt or slow down necessary therapeutic processes such as the formation of a trusting relationship, disclosure of difficulties, and effective interventions. ERP was repeatedly reported to be helpful in working with shame, with several caveats. Findings were broadly

consistent with wider research, with potential additional research avenues suggested. Clinical implications were also explored, with therapists needing to show proactive awareness of the range of possible OCD presentations which may be driven by feelings of shame.

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Appendix A – Joanna Briggs Institute Checklist for Analytical Cross-Sectional Studies

CHECKLIST FOR ANALYTICAL CROSS SECTIONAL STUDIES

Critical Appraisal tools for use in JBI Systematic Reviews

INTRODUCTION

JBI is an JBI is an international research organisation based in the Faculty of Health and Medical Sciences at the University of Adelaide, South Australia. JBI develops and delivers unique evidence-based information, software, education and training designed to improve healthcare practice and health outcomes. With over 70 Collaborating Entities, servicing over 90 countries, JBI is a recognised global leader in evidence-based healthcare.

JBI Systematic Reviews

The core of evidence synthesis is the systematic review of literature of a particular intervention, condition or issue. The systematic review is essentially an analysis of the available literature (that is, evidence) and a judgment of the effectiveness or otherwise of a practice, involving a series of complex steps. JBI takes a particular view on what counts as evidence and the methods utilised to synthesise those different types of evidence. In line with this broader view of evidence, JBI has developed theories, methodologies and rigorous processes for the critical appraisal and synthesis of these diverse forms of evidence in order to aid in clinical decision-making in healthcare. There now exists JBI guidance for conducting reviews of effectiveness research, qualitative research, prevalence/incidence, etiology/risk, economic evaluations, text/opinion, diagnostic test accuracy, mixed-methods, umbrella reviews and scoping reviews. Further information regarding JBI systematic reviews can be found in the JBI Evidence Synthesis Manual.

JBI Critical Appraisal Tools

All systematic reviews incorporate a process of critique or appraisal of the research evidence. The purpose of this appraisal is to assess the methodological quality of a study and to determine the extent to which a study has addressed the possibility of bias in its design, conduct and analysis. All papers selected for inclusion in the systematic review (that is – those that meet the inclusion criteria described in the protocol) need to be subjected to rigorous appraisal by two critical appraisers. The results of this appraisal can then be used to inform synthesis and interpretation of the results of the study. JBI Critical appraisal tools have been developed by the JBI and collaborators and approved by the JBI Scientific Committee following extensive peer review. Although designed for use in systematic reviews, JBI critical appraisal tools can also be used when creating Critically Appraised Topics (CAT), in journal clubs and as an educational tool.

JBI CRITICAL APPRAISAL CHECKLIST FOR ANALYTICAL CROSS SECTIONAL STUDIES

Reviewer_____

Date_____

Author_____Year_____ Record Number_____

	Yes	No	Unclear	Not applicable
1. Were the criteria for inclusion in the sample clearly defined?	☐	☐	☐	☐
2. Were the study subjects and the setting described in detail?	☐	☐	☐	☐
3. Was the exposure measured in a valid and reliable way?	☐	☐	☐	☐
4. Were objective, standard criteria used for measurement of the condition?	☐	☐	☐	☐
5. Were confounding factors identified?	☐	☐	☐	☐
6. Were strategies to deal with confounding factors stated?	☐	☐	☐	☐
7. Were the outcomes measured in a valid and reliable way?	☐	☐	☐	☐
8. Was appropriate statistical analysis used?	☐	☐	☐	☐

Overall appraisal: Include ☐ Exclude ☐ Seek further info ☐

Comments (Including reason for exclusion)

_____

_____

_____

_____

EXPLANATION OF ANALYTICAL CROSS SECTIONAL STUDIES CRITICAL APPRAISAL

How to cite: Moola S, Munn Z, Tufanaru C, Aromataris E, Sears K, Sfetcu R, Currie M, Qureshi R, Mattis P, Lisy K, Mu P-F. Chapter 7: Systematic reviews of etiology and risk . In: Aromataris E, Munn Z (Editors). *JBI Manual for Evidence Synthesis.* JBI, 2020. Available from https://synthesismanual.jbi.global

Analytical cross sectional studies Critical Appraisal Tool

Answers: Yes, No, Unclear or Not/Applicable

1. Were the criteria for inclusion in the sample clearly defined?

The authors should provide clear inclusion and exclusion criteria that they developed prior to recruitment of the study participants. The inclusion/exclusion criteria should be specified (e.g., risk, stage of disease progression) with sufficient detail and all the necessary information critical to the study.

2. Were the study subjects and the setting described in detail?

The study sample should be described in sufficient detail so that other researchers can determine if it is comparable to the population of interest to them. The authors should provide a clear description of the population from which the study participants were selected or recruited, including demographics, location, and time period.

3. Was the exposure measured in a valid and reliable way?

The study should clearly describe the method of measurement of exposure. Assessing validity requires that a 'gold standard' is available to which the measure can be compared. The validity of exposure measurement usually relates to whether a current measure is appropriate or whether a measure of past exposure is needed.

Reliability refers to the processes included in an epidemiological study to check repeatability of measurements of the exposures. These usually include intra-observer reliability and inter-observer reliability.

4. Were objective, standard criteria used for measurement of the condition?

It is useful to determine if patients were included in the study based on either a specified diagnosis or definition. This is more likely to decrease the risk of bias. Characteristics are another useful approach to matching groups, and studies that did not use specified diagnostic methods or definitions should provide evidence on matching by key characteristics

5. Were confounding factors identified?

Confounding has occurred where the estimated intervention exposure effect is biased by the presence of some difference between the comparison groups (apart from the exposure investigated/of interest). Typical confounders include baseline characteristics, prognostic factors, or concomitant exposures (e.g. smoking). A confounder is a difference between the comparison groups and it influences the direction of the study results. A high quality study at the level of cohort design will identify the potential confounders and measure them (where possible). This is difficult for studies where behavioral, attitudinal or lifestyle factors may impact on the results.

6. Were strategies to deal with confounding factors stated?

Strategies to deal with effects of confounding factors may be dealt within the study design or in data analysis. By matching or stratifying sampling of participants, effects of confounding factors can be adjusted for. When dealing with adjustment in data analysis, assess the statistics used in the study. Most will be some form of multivariate regression analysis to account for the confounding factors measured.

7. Were the outcomes measured in a valid and reliable way?

Read the methods section of the paper. If for e.g. lung cancer is assessed based on existing definitions or diagnostic criteria, then the answer to this question is likely to be yes. If lung cancer is assessed using observer reported, or self-reported scales, the risk of over- or under-reporting is increased, and objectivity is compromised. Importantly, determine if the measurement tools used were validated instruments as this has a significant impact on outcome assessment validity.

Having established the objectivity of the outcome measurement (e.g. lung cancer) instrument, it's important to establish how the measurement was conducted. Were those involved in collecting data trained or educated in the use of the instrument/s? (e.g. radiographers). If there was more than one data collector, were they similar in terms of level of education, clinical or research experience, or level of responsibility in the piece of research being appraised?

8. Was appropriate statistical analysis used?

As with any consideration of statistical analysis, consideration should be given to whether there was a more appropriate alternate statistical method that could have been used. The methods section should be detailed enough for reviewers to identify which analytical techniques were used (in particular, regression or stratification) and how specific confounders were measured.

For studies utilizing regression analysis, it is useful to identify if the study identified which variables were included and how they related to the outcome. If stratification was the analytical approach used, were the strata of analysis defined by the specified variables? Additionally, it is also important to assess the appropriateness of the analytical strategy in terms of the assumptions associated with the approach as differing methods of analysis are based on differing assumptions about the data and how it will respond.

Appendix B – Salomons Institute Ethical Approval

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Appendix C – Information Sheet & Consent Form

Faculty of Social and Applied Sciences
Canterbury Christ Church University

Information about the research

12.09.2021 version 1.2

Working with shame in OCD

Hello. My name is Benny and I am a trainee clinical psychologist at Canterbury Christ Church University. I would like to invite you to take part in a research study. Before you decide whether to take part, it is important that you understand why the research is being done and what it would involve for you.

What is the purpose of the study?

Many people who have a diagnosis of obsessive-compulsive disorder (OCD) have difficulties with shame.

Research has suggested that some people experiencing obsessions or compulsions where shame is the main emotion benefit from interventions which target shame more than the traditional treatments, which target feelings of anxiety or disgust. There are lots of different ideas about how this might work. This study is about talking to clients and therapists about their experiences, to develop a theory about how treatment works (or does not work) for shame-related OCD.

Why have I been invited?

I wish to learn from people who have experience of cognitive-behavioural interventions working with shame in OCD. You have been invited because you have experience of therapy like CBT. ACT, or CFT, aiming to help alleviate obsessive and/or compulsive experiences which are driven by feelings of shame. I am interested in the experiences of people who offer and receive such therapy.

Do I have to take part?

It is up to you to decide whether to join the study. If you agree to take part, I will then ask you to sign a consent form. A minimum of 48 hours after you receive the information sheet should elapse before you sign the consent form. This is done to ensure you have time to think about whether you would like to take part. You are free to withdraw up to 7 days after the interview at any time, without giving a reason, and this will not affect your care.

What will happen to me if I take part?

You will be invited to a confidential online video interview using Zoom. The interview will take up to 60 minutes.

I will ask you about your personal experiences of receiving and/or delivering cognitive-behavioural interventions for shame-based OCD.

I will also ask for any ideas you have about how you think cognitive-behavioural interventions for shame-based OCD work (or don't work).

I will audio-record this interview and type it up (transcribe it) pseudonymously (using a different name to protect your privacy). I will use the things you have said to help me understand how this type of

therapy works in practice, and what specific actions on the part of the therapist can help to lead to meaningful change for the client. Anonymous quotations from your interview may be used to explain these things through publications in academic journals or at academic conferences.

With your permission, I would also like to contact you again towards the end of my research (in 2022), to check if my theory "rings true" for you, or if there are places where I have misunderstood things.

Expenses and payments

There is no payment for taking part. However, if you are not participating as part of a professional role, I can reimburse you £10 for lost wages.

What are the possible disadvantages and risks of taking part?

Taking part in this study is unlikely to cause you any disadvantages. However, shame is a powerful emotion, and it is possible that discussing this with a stranger in an interview could be difficult or even distressing. It is not my intent to cause distress, and my research study has been reviewed by a university ethics panel to ensure that it is unlikely to be harmful to participate. You will be offered breaks during the interview, and you do not have to answer any question that you do not want to. If you become too distressed during the interview, we will finish early. You are welcome to withdraw from the research up to 7 days after the interview takes place.

What are the possible benefits of taking part?

The research may not benefit you directly, however you may find it interesting to talk about your experiences. Information you provide will contribute to our understanding of shame-based OCD and may help improve the treatment of people with a diagnosis of OCD.

What will happen if I don't want to carry on with the study?

You can decide at any point that you no longer wish to continue with the study. If you notify me using the details below within 7 days of your contribution I will be able remove your data altogether; otherwise it will not be possible for your data to be removed from the analysis, so your anonymous contributions will form part of the "grounded theory", but I will not contact you again if that is your preference.

What if there is a problem?

If any part of this study feels wrong or is distressing to you, please let me know so that I can do things differently.

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be taken seriously and addressed by the research team.

If you have a concern about any aspect of this study, please contact me using the details below and I will do my best to address your concerns. If you remain dissatisfied and wish to complain formally, you can do this by contacting Dr Fergal Jones, Clinical Psychology Programme Research Director, Salomons Institute: fergal.jones@canterbury.ac.uk

Will information from or about me from taking part in the study be kept confidential?

All information which is collected from or about you during the course of the research will be kept strictly confidential, stored electronically on an encrypted and password-protected hard drive. You have the right to ask to see this data and correct any errors. The only time when I would be obliged to pass on information from you to a third party would be if, as a result of something jkuhyou told me, I were to become concerned about your safety or the safety of someone else. I will endeavour to speak to you about this first.

All data collected will be retained for 10 years as required by the Medical Research Council. Regulatory organisations may wish to look at your research data to check the accuracy of the research study. In this instance, the people who analyse the information will not be able to identify you and will not be able to find out your name or contact details. Only I will have access to data which includes your identity.

Your data will be analysed under a pseudonym (made-up name) so that you cannot be identified from the "grounded theory" or any publications that may follow from it. Your information will not be shared with anyone else apart from the researchers carrying out this study.

What will happen to the results of the research study?

Results from this research study may be shared in academic journals or at academic conferences. I will send you a summary of the findings.

Who is funding the research?

I am a Trainee Clinical Psychologist at the Salomons Institute, Canterbury Christ Church University. This project is supervised by Tamara Leeuwerik (tl227@canterbury.ac.uk) and Clara Strauss (c.y.strauss@sussex.ac.uk).

Who has reviewed the study?

All research at Canterbury Christ Church University is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and approved by The Salomons Ethics Panel, Salomons Institute for Applied Psychology, Canterbury Christ Church University.

Further information and contact details

If you would like to speak to me and find out more about the study or have questions about it answered, please email me at bl207@canterbury.ac.uk. Alternatively you can leave a message for me on a 24-hour voicemail phone line at 01227 927070. Please say that the message is for me Benny Lewis and leave a contact number so that I can get back to you.

Record of consent – Shame in OCD

	Please initial box
1. I confirm that I have read and understand the information sheet dated 12.09.2021 (version 1.2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason. I can decide to withdraw my data up to 7 days after any interview.	
3. I understand that pseudonymised data collected during the study may be looked at by the research supervisors, Tamara Leeuwerik and Clara Strauss. I give permission for these individuals to have access to my data.	
4. I agree that my interview can be audio-recorded and that anonymous quotes from my interview and other anonymous data may be used in published reports of the study findings	
5. I understand that data collected during the study may be looked at by regulatory authorities where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data.	

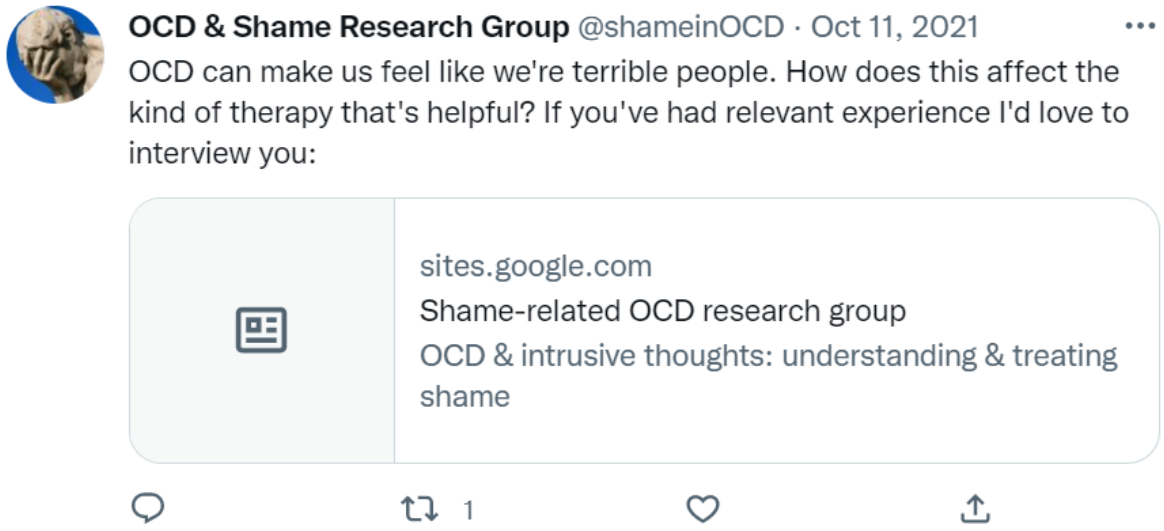
6. I understand that in the event that I disclose information which may indicate a risk to myself or others, the researcher will be obliged to follow university risk procedures that may require release of my personal data. I understand the researcher would speak to me about this first.

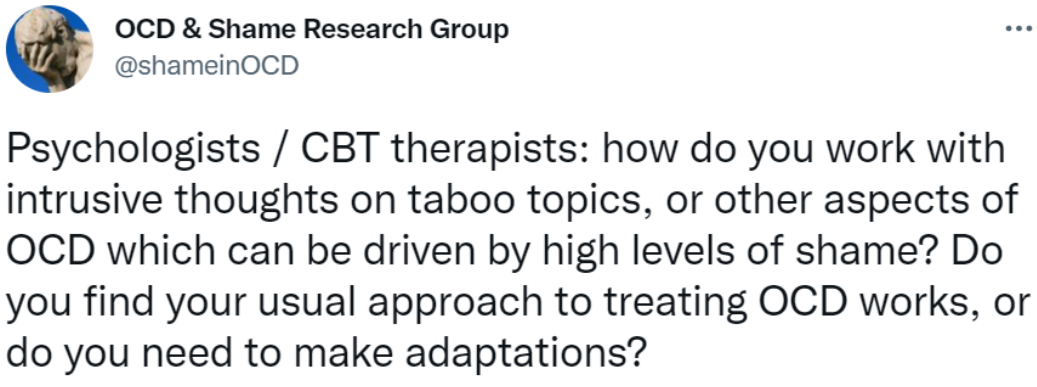
7. I agree for my pseudonymous data to be used in further, ethically approved research studies.

8. I agree to take part in the above study.

Name of Participant_____ Date_____ Signature _____

Appendix D – Examples of Research Publicity





OCD & intrusive thoughts: understanding & treating **shame**

OCD can make us feel like we're terrible people.

How can we measure this, and how can we help?

Intrusive thoughts and OCD are often understood as being about ***anxiety***.

But sometimes, ***shame*** is the driving force behind obsessions and compulsions.

We think it's important to understand this better so that we can offer the best treatment to people who are struggling with shame-related OCD.

If you have something to say about this we would like to invite you to take part in our research.

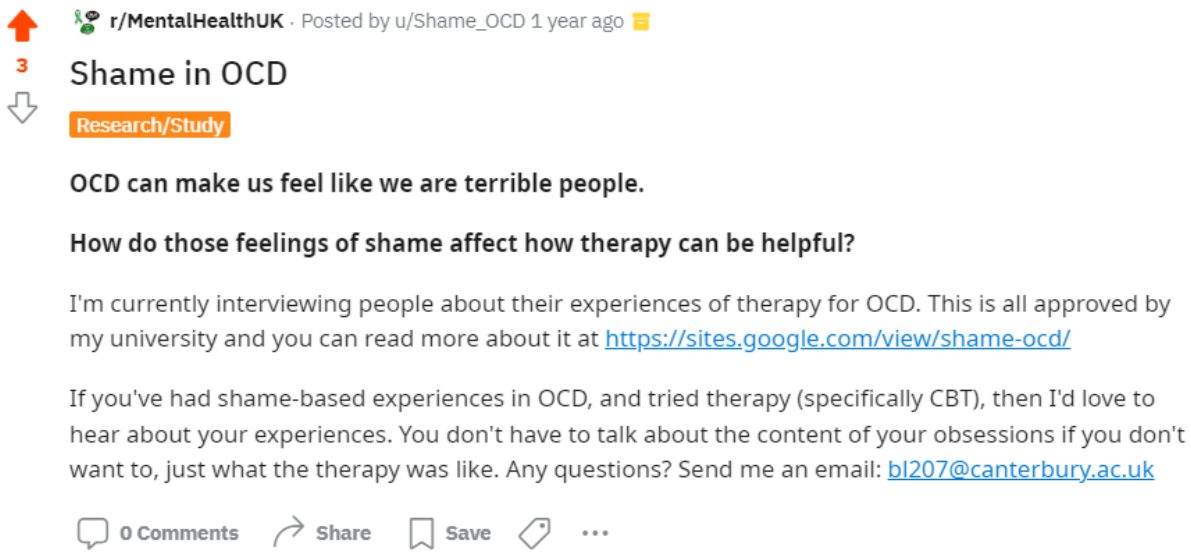
Alex is researching how we can measure shame in OCD.

Benny is researching people's experiences of therapy.

Click on the link in our pinned tweet / bio to find out more, or you can email us on:

Alex ac985@canterbury.ac.uk

Benny bl207@canterbury.ac.uk



Updated advert with focus on intrusive thoughts:

Appendix E – Interview Schedule - Clients

Thank you for agreeing to be interviewed. This is for a research study as part of my Doctorate in Clinical Psychology at Canterbury Christ Church University. I want to find out how therapy can be helpful when people have obsessive-compulsive experiences which are closely related to feelings of shame.

Our interview today will be typed up anonymously, so I can analyse it along with what other people have said in their interviews. This won't be connected to your name at all, and I will make sure that you can't be identified from any quotations that I might use when writing about the research.

You've seen the information sheet and emailed me back a consent form - thank you. Before we begin I wanted to check if you had any questions about what we're going to be doing today?

I don't expect the interview to take longer than an hour, and it's up to you how long we carry on for - you can choose to stop or take a break at any time. All of the questions I will ask are optional, it is always fine to say that you don't want to answer. I'll start with a few short questions that I need to ask everyone, and then open up the space for you to tell me what is important to you. Does that sound ok?

First of all I just need to ask a few background questions. These are optional, so you can just tell me if there are any you'd rather not answer.

- Which region are you currently living in?
- How would you describe your gender?
- And your ethnicity?
- *And your religion? (Added November 2021)*
- *Do you have any children? (Added November 2021)*
- *Would you describe yourself as having a disability? (Added November 2021)*
- *How would you describe your sexual orientation - that might be straight, gay, or some other way? (Added November 2021)*
- Is there anything else that it is important for me to understand about your background?
- Do you know any other people who have been diagnosed with OCD?
    - Are you active in any support groups or communities?
- What is your current age?
- At what age did you first experience difficulties which you would now understand as OCD?
- At what age did you first seek treatment for these difficulties?
- Please can you list all the different types of treatment that you have tried, and when you tried these? This could be anything that you thought might help, including self-help.

I would like to know more about the different psychological therapies that you have tried, particularly [identify anything CBT-based from their list]. I am interested in hearing about what helped, and what did not, and what you think made the difference. It's up to you how

much you would like to share, and you can take a break at any time. Please start at the beginning and tell me how it happened in your own words.

Use follow-up prompts to:

- Zoom in on shame.
- Zoom in on contexts and processes.
- Zoom in on why/how things are helpful/unhelpful.

Imagine that someone else tells you that they are struggling with shame-related OCD, similar to how you did. What advice would you give them about what treatment might help?

What advice would you give to a trainee counsellor/therapist about how they could best be helpful to someone experiencing shame-related OCD? (Added February 2022)

How has it been talking to me about this today?

Do you have any feedback for me about how I could make this a more comfortable experience for somebody else?

Appendix F – Interview Schedule - Therapists

Thank you for agreeing to be interviewed. This is for a research study as part of my Doctorate in Clinical Psychology at Canterbury Christ Church University. I want to find out how therapy can be helpful when people have obsessive-compulsive experiences which are closely related to feelings of shame.

Our interview today will be typed up anonymously, so I can analyse it along with what other people have said in their interviews. This won't be connected to your name at all, and I will make sure that you can't be identified from any quotations that I might use when writing about the research, including by my research supervisors within Salomons.

You've seen the information sheet and emailed me back a consent form - thank you. Before we begin I wanted to check if you had any questions about what we're going to be doing today?

I don't expect the interview to take longer than an hour, and it's up to you how long we carry on for - you can choose to stop or take a break at any time. All of the questions I will ask are optional, it is always fine to say that you don't want to answer. I'll start with a few short questions to contextualise your responses, and then open up the space for you to tell me what is important to you. Does that sound ok?

- Which region are you currently living in?
- How would you describe your gender?
- And your ethnicity?
- And your age?
- Is there anything else that it is important for me to understand about your background?
- How many years working in caring professions?
- What was your qualification route and when did you qualify as a [CBT therapist]?
- Roughly how many people with OCD would you estimate you have offered therapy to?
- Can you briefly tell me about your general professional experience of working with people who have a diagnosis of OCD?
    - How might you tend to understand or formulate their difficulties?
    - What therapeutic interventions might you be most likely to offer, and why?

In this study I'm particularly interested in how we offer therapy for people whose primary difficulties are driven by feelings of shame.

How many of your clients with OCD would you consider to have shame-related obsessions or compulsions as their primary difficulty?

Any noticeable demographic characteristics of this group? (Added May 2022)

- *age of presentation*

- *length of time with symptoms*
- *being a parent*
- *holding strong religious identities*

Please can you tell me the story of your work with someone in particular who you treated, who had experiences like this? I am interested in hearing about what helped, and what did not, and what you think made the difference. It's up to you how much you would like to share, and you can take a break at any time. Please start at the beginning and tell me how it happened in your own words.

Potential prompt questions:

- What types of presentation have you worked with where the emotion underlying your client's symptoms seemed more like shame, rather than anxiety?
- How (if it all) did this affect your formulation?
- How might your work with this client group differ from your work with other presentations of OCD?
- How (if at all) might you modify your usual interventions?
- How helpful have you found your way of working with shame-related intrusions, in comparison to people presenting with other forms of OCD?
- *Differences in prognosis / trajectory of treatment / time taken? (Added February 2022)*

Appendix G – Examples of Ad-Hoc Theoretical Sampling

Constantly comparing between experiences of different interviewees:

> **Therapist 5**: [suggests that they expect shame-based presentations in CAMHS to come from older adolescents]
>
> **Researcher:** "With your sense that it might be post pubescent, do you think that is about that being an *age of onset*, or that being an *age of presentation to services*? If you see the distinction… I'm wondering because with adults I have interviewed, there's been a sense of maybe it taking longer for shame based presentations to go from first onset to actually presenting to services, but maybe that's not the case with young people? Maybe it's a different sort of landscape?"

Following up on potential new themes the first time a participant introduces them:

> **Client 4: "**I think it's very difficult for the person to open up the first time, and if they didn't get any positive feedback … especially with culture diversity"
>
> **Researcher:** Do you think that was part of your experience with the self help things that you read - were they assuming a white British perspective, and you had to translate things to your own experience?

In later interviews, testing out tentative categories against client experiences:

> **Researcher:** "As you're talking, I'm wondering about those early sessions, when you were working out whether or not [therapist] was somebody who could work with, deciding how much to say and how much to hold back... I wondered if there's anything you remember from that time about how she showed you that she was somebody you could trust and feel safe with?" *[Trust & Safety concept]*

> **Client 7:** "it's not that she didn't know what my thoughts were at that point, but to actually write out a specific thought or say a specific thought to her was like something that just never seemed that it would ever be possible, and even after four months of seeing her, the day I did that I was.. literally I just cried the whole way through, like almost to the point of hyperventilating."

> **Researcher:** "it sounds like there was a really big step for you between "here's the general ballpark of the themes", or even talking about them in a not-literal way, versus actually saying – "here's the specific thought". Yeah, that was a really hard step for you to get over?" *[unspeakability concept]*

Appendix H – Debrief Email

Dear [participant name],

Thank you so much for taking the time to talk with me today. I really valued hearing about your experiences.

It is up to you whether or not I use the transcript of your interview in my research. Please let me know within seven days if you wish to withdraw, as after this I may not be able to fully remove your anonymous data.

I hope that you found it an interesting experience, but I know that some people can find that talking about their experiences of therapy brings up thoughts and feelings from the past. If you would like to talk to somebody then I can recommend OCD-UK 01332 588112 https://www.ocduk.org/contact-us/ or the Samaritans 116 123 https://www.samaritans.org/

Please let me know if you have any questions or concerns about the research study. As we discussed I'll keep your email on file and keep you posted as things develop with the project.

Very best wishes,

Benny

Appendix I – Example Research Journal Entries

December 17th 2020

Supervision meeting last Friday and a service user consultation yesterday. Starting to think that I'll be ready to open recruitment in the new year.

The lack of clarity around the construct of "shame-related OCD" was a thread running through both conversations. I'm trying to hold it conceptually distinct from "Pure O" and from "Intrusive Thoughts", both of which seemed more legible to my interlocutors, but maybe that's me being driven to overcomplicate? Certainly recruitment would be much easier if I just cleave closer to these widely-understood terms - less aversive than the word "shame", too. But my proposal and my rationale are clearly about shame!

September 21st 2021

Finally, an interview! Trying not to get too over-excited. As I listen back and start transcribing I notice my own prejudices being reinforced as the interviewee talks about how unhelpful psychodynamic psychotherapy was; I'm bringing my own preconceptions about this approach (that it's opaque, victim-blaming, allows therapists to take the 'expert position' regarding another person's unconscious life in a way which lands with me as unethical). I'll need to bracket off these extreme assumptions in my analysis, and look out for dynamic or attachment concepts being discussed in a positive light.

I see myself asking a follow-up question about the therapeutic relationship which seems transparently linked to my own prejudices about the 'blank slate', and then coding a section under "therapeutic relationship / blank slate" - perhaps I need to take this to supervision?

And there's a bizarre breakdown in empathy when the participant is saying "this was really sad" and I just don't .. acknowledge the emotion at all. But of course I'm only hearing audio & maybe I said things with my face? Still I must remember in future interviews that just because my interest is intellectual, my participants are still people!!

February 7th 2022

Having spent so long recruiting with minimal success, the sudden rush of people interested in participating feels like I must grab at it with both hands - this interest might not come again. But if I keep interviewing at this pace, I will be collecting data faster than I can possibly transcribe and analyse it. Through my own reflection and conversation in supervision I can still theoretically sample, particularly amending my interview questions based on things that stood out in previous interviews, even if I haven't properly analysed them in their entirety. This is not ideal GT practice, but I'm convinced it's a necessary compromise given the time-limited nature of the project (though I'm increasingly thinking that even if I do generate sufficient data, I won't have time to analyse it before April or even July - based on how long it is taking me to transcribe and code a single transcript, and how many other deadlines I have in the intervening time).

March 21st 2022

Another strong motivation I'm noticed in my coding, which could rise to the level of a bias, is that I'm interested in applicability to the practice of clinical psychology. While this is an appropriate focus for my ultimate MRP write-up, I should be careful that it does not skew my analysis towards simplistic utility, or cause me to draw too much on external knowledges which come from my immersion in CP culture over the last 5 years.

April 14th 2022

Having now fully transcribed and coded three interviews, I'm noticing how my client participants so far have tended to use the technical language of CBT to describe their experiences, but also that I have a tendency to impose it when it is not there (eg "exposure" was a used-language-adjacent code, but "behavioural activation" wasn't - so I changed the latter to the more data-near "changing what I'm doing".)

Worth noting that of my first three client participants, one is a qualified therapist and one volunteers on a phone helpline for people with OCD, so some significant "socialisation to the model" there beyond their own experiences of therapy.

Over the first three interviews I see my focus as an interviewer shifting towards disclosure - this was not in my original research questions but now this seems like an oversight, as if I'd assumed that full disclosure to a therapist was a given so all that mattered is "how we work with it now it is disclosed".

June 6th 2022

I'm still interviewing ahead of analysis, but I was particularly struck today by how well the interview I've just done (Therapist 5) resonates with emergent categories from the first 4/5 interviews. This feels like theoretical saturation, and not in a shallow way – looking at Nelson's conceptual depth criteria I do think an argument could be made that sufficient complexity and subtlety is present in the data for me to stop at 12 participants. Frustratingly I think I can't know for sure until I have properly coded a lot more interviews.

July 1st 2022

Talking to L who submitted a GT project for the April deadline and had a successful viva in June. She'd only had 9 participants, which I was surprised to hear was considered sufficient. She introduced me to the 'storyline method' for GT analysis, which was attractive to me as I'm drawn to narrative ideas in therapy and research – and it feels like an "if-then" process model has some important commonalities with a "beginning-middle-end" narrative model. I'm definitely going to apply this to my own data and see what emerges from the data being questioned in this way.

September 20th 2022

In therapy today I was talking about my particular horror of causing iatrogenic harm. Coming back to my coding afterwards, I am more aware of a potential bias in how I am thinking about the accounts of therapy given by my participants. Specifically, my mindset is pointing me towards "avoiding bad practice", while my research questions are around "characterising good/effective practice". This should not cause a problem for analysis as long I recognise when I am coding with a focus on negative processes – so for example, when sorting and grouping to think about themes I need to remember to search for "opposites", eg to notice when I'm coding about judgement and encourage myself to think about acceptance or other related opposites.

October 3rd 2022

As my other commitments at Salomons come to an end, I am moving into a phase where I can immerse myself in my data for multiple days each week. This feels sorely needed, as until now I have spent so much time on each study day re-orienting myself to my thinking.

I'm sure that this has led to a welcome depth of "data-nearness" in my theorising so far, but I need to start pushing through description and into theorising.

October 10th

As I compare my coding process now, to when I began, I notice myself doing a lot more "double-coding" – things can be more than one thing! Nvivo makes it easy to keep track of this without things getting complicated, I'm very glad that I picked an electronic analysis tool even if the screentime is giving me headaches! (Though it is frustrating that it is not possible to *uncode* something – though I suppose if I've changed perspective on something it is nice to hold onto the "both-and" of my past perspective, even if it does make some of my higher-level coding a bit frustrating at times!)

October 19th

Just finishing up coding Client 6's interview, and wondering if it's even appropriate to include at all when I got to this line: "So interestingly, your Twitter, like OCD Shame Twitter account popped under [therapist]. So when I followed accounts to follow so I looked and I was like, Oh my God, I've had a suspicion that my symptoms were because of shame all through these years and I wanted to go see a CFT therapist, and this would be super interesting. 'cause [my therapist] is more behavioural oriented, but this is a different way of looking at it." – this client has lots of experience of shaming, invalidating therapy – important contrasts for a process model – but arguably has not had experience of targeting shame in therapy. It feels like a very different situation to my other participants and I can't tell if that adds richness or puts this data out of scope for my research.

October 27th

After discussion in supervision, I have decided to keep Participant 6's interview in the dataset. I need to trust my inclusion criteria – the participant has a diagnosis of OCD, and therefore is within the remit of the study. Divergent experiences don't all need to be accounted for in the model, but I can still make good use of contrasts and edge cases.

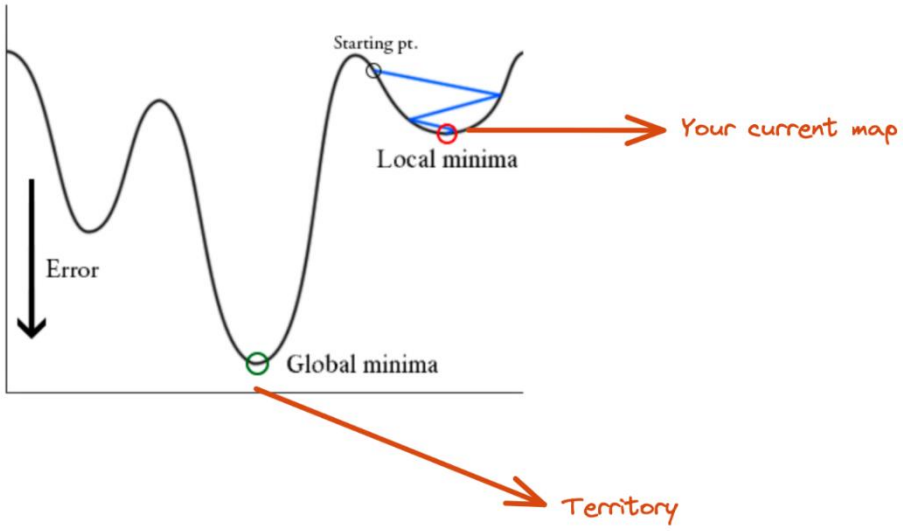
November 1st

I'm reviewing my first-pass coding, cross-checking and thinking about context. It definitely feels like things are coming together such that the later interviews fit in with my theorising about the earlier ones – I'm amending and refining the model, but not needing to drastically change it. For example I did have processes around "duration of therapy" under my "accessing therapy" context, but on reflection this has moved to the "processes of therapy" section – though it does connect to both, how long is allowed for therapy is a meta aspect of what is done in therapy more than how therapy is sought.

November 5th

Spent this morning talking through my data with A– it was really good to 'start from scratch' with someone who is not familiar with the research area. It helped me to reconnect with why grounded theory is a necessary choice here – theorising OCD symptom categorisation has happened based on taxonomical characteristics of symptoms, but my focus on the emotional underpinnings of those symptoms is distinct enough to require re-theorising.

This also helped me to go "back to the drawing board" with my theorising about how all the data fits together – I wasn't feeling confident enough that my working model was the best possible representation of the data. (I'm confident that it's a GOOD representation of the data – but I got a bit fixated on the concept of 'epistemic local minima' – what if I'm stuck in a 'gravity well' of knowledge construction that's keeping me from a more reality-near model?)



Having chosen to undertake critical realist grounded, theory, it felt important to test the theory that I was in a 'local minimum' – to try and knock myself out of any 'gravity wells', rather than just continue to refine a model based on my earliest theorising.

So while I talked about how different parts of the data seemed to connect to each other, A sketched out what they heard me talking about, generating a wide range of different possible models.

Following this conversation, I moved the entire "processes around accessing therapy" context into the "characteristics of the therapeutic relationship" context – they helped me to realise that the *timepoint* is a less important context than the pro-active normalising that exists in

both sections of the model – whether that happens on Instagram or two sessions into therapy actually seems less important than that it happens. Having done this it will be important to think about the implications for people who don't get to choose their therapist – essentially an NHS therapist may be starting on a back foot compared to someone who has been recommended by an OCD charity, or found via OCD social media, or otherwise been pre-emptively shown to be able to hold shameful things.

Appendix J – Coding Extracts

This has been removed from the electronic copy

Appendix K – Codebook Snapshot 01/11/2022

(grouped by relevant contexts to aid analytical thinking)

Name	Files	References
characteristics of the therapeutic relationship	6	15
acceptance	6	9
assumptions	1	1
blank slate	3	3
client trying to protect therapist	1	1
collaborative	5	9
inviting feedback	1	1
cultural competence	2	2
detatched clinical	2	2
doing what I'm told	2	3
easier to disclose to a same-gender therapist	2	2
equal	1	1
friendly	3	5
humility	3	8
judgement	8	13
knowledgeable	2	3
always understands, knows what to say	1	1
proactively showing awareness	2	3
modelling behaviour	1	1
not forcing disclosure	4	12
passively receiving help	2	2
remembering between sessions	3	3
safety	6	11
confidentiality	1	1
trusted figure outside family	1	1
seeming to care	2	2
shaming	1	3
slow to trust	4	5
therapist able to hold the shame	1	1
therapist not seeming to understand	1	1
therapist self-disclosure	5	7
normalising over-active shame appraisals	1	1
visibly shocked by disclosure	1	2
warmth	5	6
processes around accessing support	3	4
being sent to therapy	3	3
religious community facilitating access to therapy	1	2
blocks to referral	3	3
gatekeepers not understanding OCD	1	1
can't live like this any more	2	3
crossing CAMHS thresholds	1	2
duration of therapy	7	26
long slow build up to disclosure	1	2
space to talk about meaning of thoughts	1	1
time limits	3	10

Name	Files	References
expecting OCD to take longer	1	1
everything is CBT	2	2
fitting into boxes to access therapy	3	7
can't decide what modality to choose	1	1
going private	6	13
private therapy allowing privacy for NHS staff	2	2
less experienced therapist	1	2
masking leads to delayed therapy	1	1
peer support	2	3
believing that I'm the worst of everyone	1	1
normalising through peer experience	1	1
useful even when in remission	1	1
services embedded in school or uni	3	4
specialist therapist	4	10
don't know how to get specialist therapy on the NHS	1	1
generalists should not treat severe cases	1	1
lived experience	1	1
recommended by OCD peers	1	1
showing they can hold intrusions	2	3
starting therapy	2	2
therapist is online and far away	2	3
vague talking therapy in childhood	1	1
waiting lists	2	2
prioritising OCD within NHS CAMHS	1	1
processes around making sense of difficulties	4	7
aetiology of thoughts	5	11
drug-induced obsessions	1	1
emotions underpinning thoughts	2	2
OCD tendency pops up with different themes	3	6
appraisals of thoughts	5	9
learning to recognise ego-dystonic thoughts	1	1
shame appraisals instead of anxiety appraisals	2	4
avoidance exacerbating	1	3
can't make sense of difficulties	4	11
coming to identify with OCD	8	16
avoiding pop cultural appropriate of OCD	1	1
reformulating past experiences	3	7
contamination fears as expression of shame	1	4
physical contamination as expression of mental contamination	1	1
depth & complexity	5	11
discordance with values	3	4
disgust easier to recognise than shame	1	1
doubting OCD	2	2
doubting OCD as evidence of OCD	1	1
medical models	4	6
cognitive formulations	1	6
quantitative measures	2	6
misdiagnosis	3	5
more to you than the stories you tell about yourself	1	1
not 'stereotypical' OCD	9	15

Name	Files	References
differentiating from OCD with overt symptoms	4	5
guilt not shame	1	1
OCD as one part of broader neurodiversity	1	1
OCD as self regulation	2	11
alternative self-management strategies	1	2
OCD compensating for emotions	1	1
shame blanket	1	2
other-focussed shame	1	1
over valuing thoughts	4	9
learning not to over-value thoughts	1	1
perfectionism (countering shame)	3	11
being willing to be good enough	1	1
plausible beliefs and 'real' shame	2	2
covid impacts	1	1
'real' shame culturally normalised	7	15
collaborating with religious figures	1	1
family and religious expectations	1	6
teenage angst	1	2
social stigma	4	6
relapsing remitting patten feelings revert even if bhvr doesn't	1	1
relapsing remitting pattern allowing for denial	1	1
risk	4	5
self-diagnosing	1	1
shame-based OCD	8	26
can't JUST treat shame	1	1
delayed diagnosis	1	1
mental contamination	1	1
not trusting self	1	1
over correcting	1	4
rejection sensitivity	1	2
shame in relapsing	1	1
type of person	1	2
work on treating shame separately	1	2
unshared understandings	2	2
unspeakability	8	14
externalising themes	1	1
scoping level of shame by asking if friends know	1	2
speaking might make true	1	2
what kind of person am I	2	2
vicious flower	1	2
processes around therapeutic acts and outcomes	6	14
(guided) self-help	3	6
behavioural experiments	5	9
accompanying	1	1
ambiguity ERP	2	2
bhvrl exps as a kind of ERP	1	1
bhvrl experiments lead to cog restructuring	1	1
interoceptive experiments	1	2
tackling avoidance	3	3
behavioural interventions seen as excluding work with shame	1	3

Name	Files	References
changing what I'm doing	3	7
act in keeping with values	1	1
cognitive therapy	8	38
cognitive restructuring	4	8
thought records	5	14
thought records being found	1	1
concurrent therapies	4	5
disclosure as therapeutic	3	6
BUT therapy can proceed without disclosure	1	1
openness about OCD	1	1
stepped disclosure	1	1
going back to the core beliefs	1	3
habituation	3	4
high shame necessitates compassion focussed work	3	9
clients may reject compassion to begin with	1	1
inner critic work from CFT	1	3
integrating CFT with CBT	2	6
CFT is inherently part of CBT	1	1
incomplete recovery	6	9
learning to observe thoughts observer mind	6	10
prioritising	1	1
processes around exposure to shameful experiences	9	29
brings up feelings of shame	1	2
does not resolve feelings of shame	1	1
relief from managing to express to another	1	4
reassuring, but not pathological reassurance-seeking	1	1
E is therapeutic even without RP	1	2
ERP reduces compulsions	1	1
exposure inappropriate for children	1	1
flexible hierarchy	1	1
imaginal exposure	3	6
using compassionate image to normalise responses	1	4
worst case scenario	1	2
inibitory learning	1	1
making thoughts concrete	8	15
may need augmenting with gentler techniques	1	1
plus physical sensation	1	1
resisting mental compulsions	2	3
unmodified ERP	1	1
surveying, researching 'what's normal'	1	2
targetting traumatic roots of shame	4	5
rescripting shame memory of first intrusive thought	1	4
theory A theory B	3	8
therapeutic written materials	6	9
post-therapy 'leaflet' to use in tough times	1	1
understanding AS recovery	3	5
psychoeducation	7	12
coming to believe that OCD is treatable	1	1
explaining CBT model	1	1
unhelpful interventions	5	15

Name	Files	References
damaging interventions	6	13
analytic approaches experienced as harsh or making things worse	4	8
unwanted interpretations	1	3
over-directive	3	4
CBT being offered too formulaically	7	11
validation and normalisation	5	12
giving statistics about frequency of thoughts in population	1	1
normalising using CFT's three systems	1	1
seeming too jaded can invalidate pain instead of normalising intrusive thoughts	1	2
worksheets	3	5

Appendix L – Example Memos & Diagrams

Good & Bad reassurance?

When people talk about sharing their shame thoughts for the first time they often use a form of words like "reassuring – but not bad, OCD reassuring!". Is there something in this, or is it just indicative of how "reassurance-seeking" has been constructed as a pathology to recognise and resist?

"Knowing" someone has OCD

Today I've coded a section where a participant talks about coming to identify with the diagnosis of OCD as being inherently therapeutic / de-shaming. There's lots to think about here in terms of epistemology – just because I'm being "critical realist" doesn't mean I need to accept that "OCD" is a natural kind – do I need to look at the process of "believing in" OCD? Don't want to disappear down a social constructionist rabbit-hole however much that might be my natural inclination, I chose a critical realist approach for a reason! But also I'm having a hard time accepting that "OCD" is a real thing that exists in the world as opposed to a useful label for a family resemblance (I am *not* getting into Wittgenstein & conventionalism, this analysis needs to stay data-near!).

Starting to theorise

With six interviews now fully transcribed and coded, I'm holding a lot of ideas and associations in my mind about possible themes and processes. I've been too reticent to write things down until I feel I can substantiate them: but GT is pretty clear that I should be writing down as many thoughts as I can capture, and there's no saying what might be analytically

useful later on. (The perfectionist in me hates to write down something that will later be found inane, and discarded, but I need to get out of that headspace). So in the expectation that most of this will turn out to be nonsense, here are the preliminary thoughts coming to mind in response to my research questions as I look through my first tentative Nvivo codes:

How do people understand shame-based OCD?

I suppose the first thing to say is that a lot of people DON'T.

> **Client 2**: "most people who I've ever talked to about it haven't known what it is and so I've then ended up educating them … the first time I'd seen the GP, they didn't get it at all"

Lots of my participants value the connection to "stereotypical" OCD, in terms of making sense / family relation, but often this needs pointing out: people strongly self-ID as having OCD but only *after* the complexity is explained – (self-)psychoeducation is needed.

> **Client 1** – "OCD as a diagnosis makes much more sense as a lot of it was around uhm, ideas of being a bad person in some way, causing harm."

> **Client 2** – "I would read the examples in this book over and over and over and over and over again because it would be like "Mary is worried that she might hurt someone on the street" and so I would read this over and over again because that was my experience."

This kind of understanding is itself understood as therapeutic:

> **Therapist 1** – "people really find it helpful to be able to categorise "what the hell is wrong with me""

How to best treat it?

Facilitating disclosure.

> **Client 3** – "a big part of recovery was telling her that, because the shame was a lot a lot less once I'd got out in the open"

> **Therapist 1** – “I don't know how many people have held something back from me, but I'd be delusional if I thought they weren't a good proportion who had, who were frightened to tell me, which is why I probably spend so much time at start of therapy, really normalising”

> **Therapist 3** – “I had a sheet which would be sort of normalising intrusive thoughts, so I guess my focus was more on.. and it would say something like "these are the kind of intrusive thoughts" I think you must have seen that sheet. It's like a number of intrusive thoughts and really, really kind of ones which are kind of sometimes shocking and really kind of that you know difficult to even mention or say that we really do have those thoughts like that”

Modified ERP.

> **Therapist 1** – “if it's shame they ain't gonna habituate because all that's going to happen potentially is they're going to feel less and less like you have a clue what's going on for them less and less connected with you, and they're probably going to go and not come back and see you and you wouldn't blame them”

> **Client 1** – “a mixture of traditional exposure and response prevention type stuff and some more cognitive work, but also in parallel some direct trauma work”

It can be learned as a technique, and applied to obsessions too shaming to share:

> **Client 3** – “It's like I've learned from all the other exposures, and then those experiences filtered down to that one. So yeah, it probably wouldn't have gone away if I hadn't done exposures for like similar other things. I was able to apply it myself without her help I think.”

Therapists need to explore the roots of self-shaming tendencies WITHOUT reifying the contents of specific thoughts. (People talk about therapy not working or being harmful if either part of this dyad is missed – skipping the aetiology of thoughts OR over-focussing on the thoughts themselves.)

> <u>Attend to the personal context of self-shaming:</u>

Client 1: “So when we tried just doing trauma work without the ERP and more cognitive work also in parallel that was very difficult and I think I went backwards a little bit, but then having a pause on the trauma work, building myself back up again and then doing the work in tandem worked much better.”

Client 2: brilliant metaphor of thoughts as the little twigs coming from the big branches of shame – no point just pulling off little twigs, as they’ll keep growing back. “from my experience, the only way you can address that shame is by realizing that the shame is not only to do with the thoughts it's to do with the emotions”

Therapist 2: “ignore the cause and the symptoms will just arise in a different fashion - shame is exactly the same.”

Without over-valuing thoughts

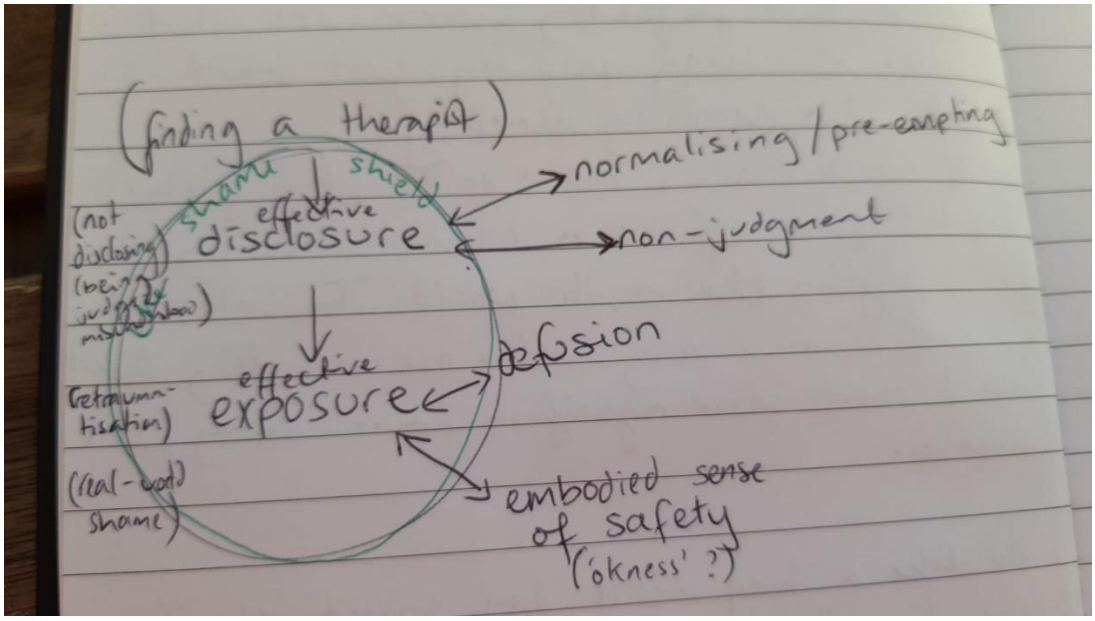
Client 2: (on being asked to keep a thought record) “I look back at that CBT exercise as something which had made things 10 times worse” … “CBT is not, currently, and I've never found it to be, tailored for OCD with intrusive thoughts, it's nowhere near because as we've said it places importance on the thoughts, and the thoughts - if you place importance on the thoughts, you are screwed because they're the most terrifying thing”

Therapist 1: “I think treatment can be very, very shaming if you're not careful, like you say: "here's a thought record".” … “there's always that risk, I think, with treatment that you can end up trying to persuade somebody that I don't know they're not a paedophile or they're not gay

Therapist 2: “we all have these intrusive thoughts and they don't mean anything and there is shame kind of involved in having that thought and being aware of it, but it doesn't need to be magnified in a traditional kind of CBT cycle fashion”

The Shame Shield

This just came out of my pen one day when I was scribbling in my physical research journal. Not yet sure if it’s meaningful, or just attractively poetic.



It's not a phrase drawn from the data, which should be ringing alarm bells – but rather my interpretation of how every process in the model can be complicated and/or slowed down by the presence of shame.

I'm aware that the diagram is "cute", with rhyming elements and metaphorical concepts. I need to watch my own tendency to mistake beauty/neatness with truth here – a more data-fitting model might be messier. "Defusion", also, comes from ACT terminology rather than from my data – the coding category is called "learning to observe thoughts" and maybe I need to stick closer to that.

[added later]

Therapist 4 talks about "the threshold of shame" in their interview, and I'm captivated! Is this really "the shield of shame" in the wild, immediately after I'd named it in my model?? Probably this would not have stood out to me as anything beyond a passing metaphor if I hadn't been "constantly comparing" against my tentative model – I need to talk in supervision about how to make sure that my method stays data-near, and not get carried away by confirmation bias.

[added later]

Participant client 6: “perfectionism is a seven-tonne shield to shield us against the feeling of shame.”

Which makes me wonder about my model – is it SHAME that is operating as the shield here, or is it AVOIDANCE OF SHAME? Which ties into the codes that I’ve gathered under the theme of “unspeakability” – does *EXPERIENCED SHAME* render things unspeakable, or is it *anticipated shame* - **not wanting to feel the shame of speaking**? So complicated when shame is in itself an emotion of anticipation, that expectation of being found out, of being expelled from the group. I also find myself wanting to bring in something about doubt/uncertainty here, which is so prevalent in how this participant is talking about their experiences of researching / double-checking everything – something like the question, “should I be ashamed?”.

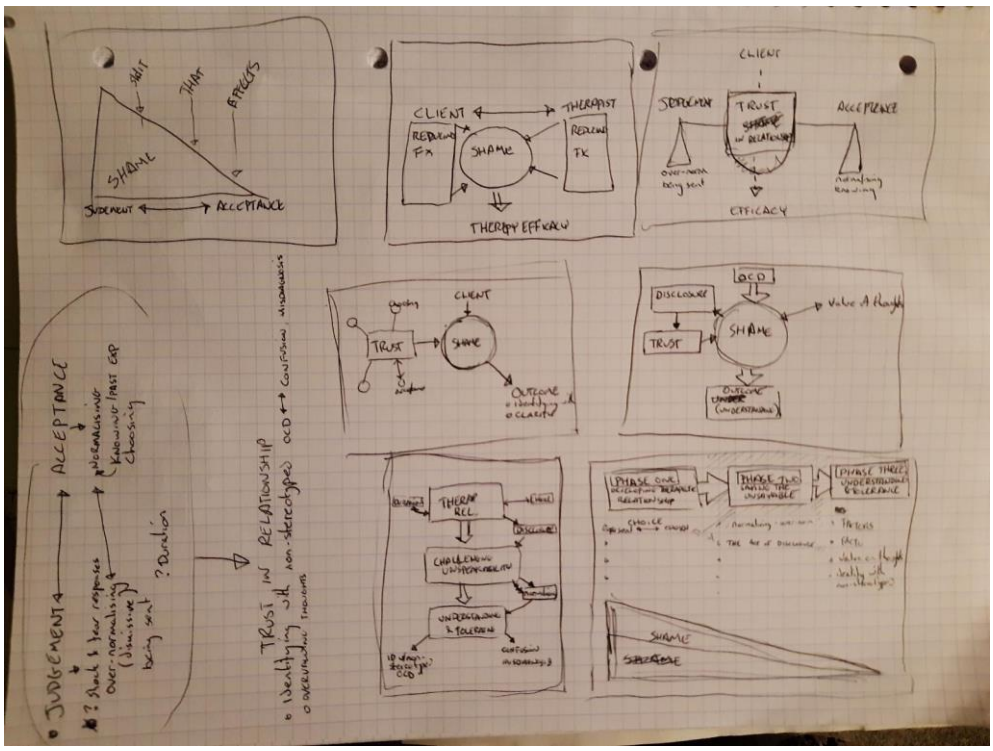
Also I’d carried out this interview some months before sketching out the draft model last week – so I guess “shame shield” had just sat outside my conscious awareness for all that time, waiting to be invited in?? The human mind is incredible.

This same participant also said “when you perfectly show yourself who you are, your authentic self, your true self, shame is kept at bay” which I’m so interested in – this participant struggled with perfectionism and “character indictment OCD” – feeling they didn’t know their true self, or couldn’t trust it – so can this concept of “speak the truth and the shame is gone” work in this context??

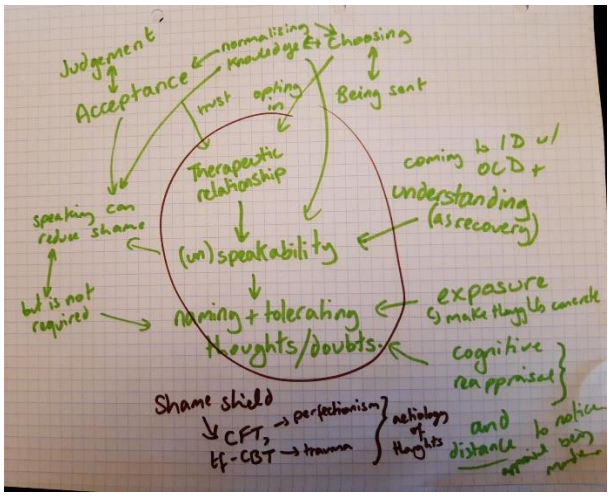
Getting Creative with A

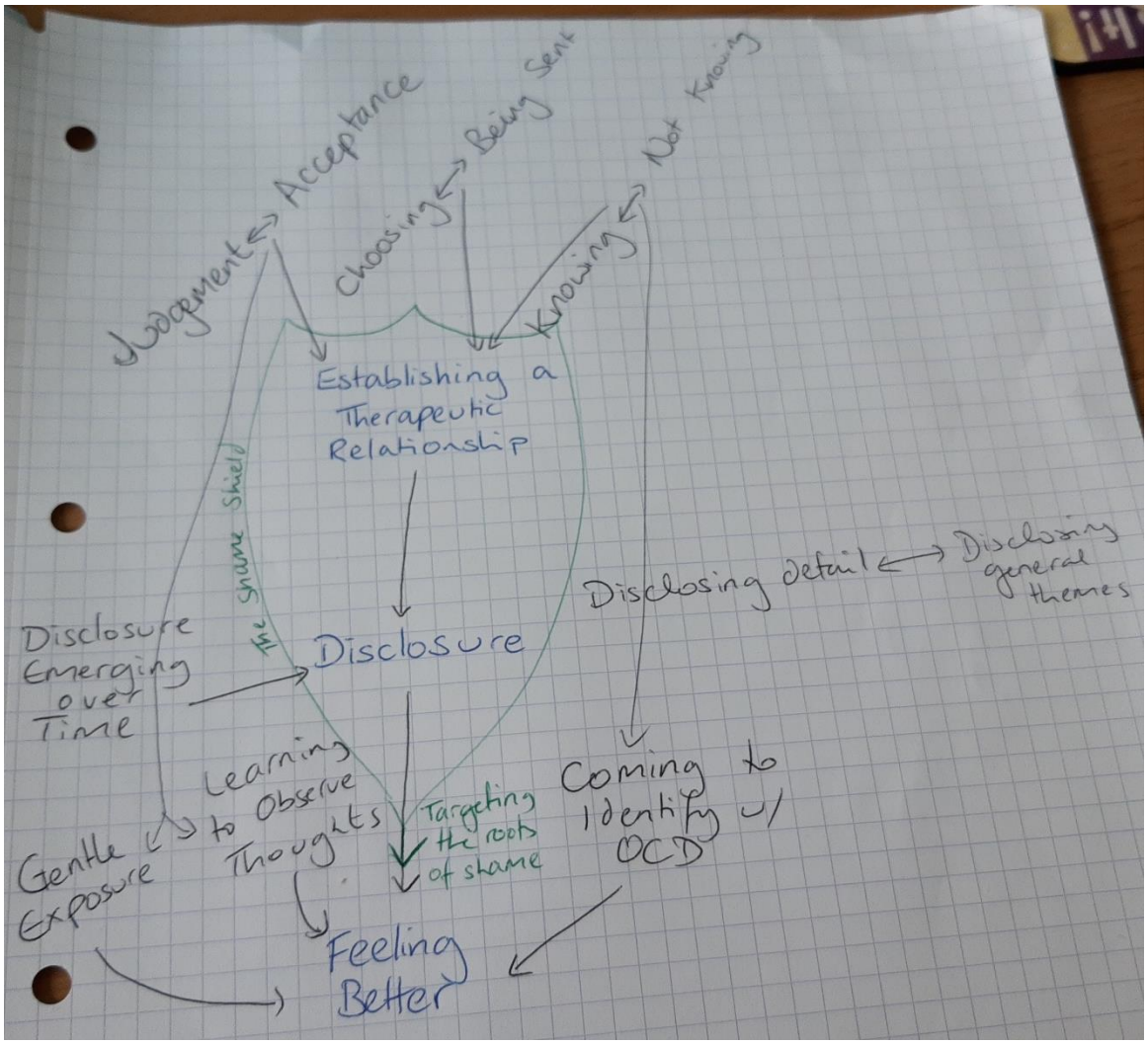
Corbin & Strauss are clear that I need to “connect with my creativity”, and certainly something needs to shake loose the stuckness and uncertainty that I’m feeling around this model. As I create best through performance, but my trainee colleague A is a visual artist,

I've arranged some teamwork – I talk through my ideas and concepts in a dramatic monologue, A scribbles down what I say in a visual form – lots of different visual forms, it turned out!



Through really considering each of A's diagrams, through discussion in supervision, it feels like something is starting to come together – it feels scary and like there's so much that's missing but I do believe in it – is this Corbin & Strauss' "leap of faith"?




Judgement ↔ Acceptance
Choosing ↔ Being Sent
Knowing ↔ Not Knowing
Establishing a Therapeutic Relationship
The Shame Shield
Disclosure
Disclosure Emerging over Time
Disclosing detail ↔ Disclosing general themes
Learning to Observe Thoughts
Targeting the roots of shame
Gentle Exposure
Coming to Identify w/ OCD
Feeling Better

Appendix M – Summary Email to Participants

Dear [Participant],

In [month, year] you kindly volunteered to be interviewed for my research into people's experiences of CBT therapies for shame-related OCD.

Your interview was combined with eleven others, and I analysed them all together. I was looking for common processes which describe and explain how CBT therapies might work when obsessions and/or compulsions are driven by high levels of shame.

I have attached to this email a brief summary of my model. It's still a "work-in-progress" at this point, so I would love to hear about which parts resonate with you, and which might feel less relevant to your experiences. Or is there something important which feels like it's missing?

In particular, I'm keen to check that you are comfortable with how your words have been quoted – that you don't feel misrepresented or identifiable, based on what I've included. Your quotes are attributed to [pseudonym].

If reading a document like this is not accessible to you, then I'd be happy to arrange a time to talk you through the model. You can send me any comments or questions by email, or we could arrange to speak again over Zoom on any day between Friday 25 and Tuesday 29 November (including evenings and weekends). I'm very sorry that this is such a short timescale.

Please note that this is **totally optional**. You've already been so generous in allowing me to interview you, and nothing else is needed or expected of you.

If it feels like thinking about this topic might be triggering at the moment, or you don't have time, then I hope you won't feel any obligation to engage further.

If this has raised anything that you'd like to talk about, please do email me your thoughts, or arrange a time to zoom. Or if you'd rather speak to someone else, I can recommend OCD-UK: 01332 588112.

Yours with gratitude and good wishes,

Benny

https://sites.google.com/view/shame-ocd/therapy-study

If you no longer wish to receive emails about this research, please let me know so I can remove your contact details from my records.

Appendix N – End of Study Summary for Ethics Panel

Re: Working with shame in cognitive-behavioural interventions for obsessive-compulsive disorder: developing a grounded theory.

I am writing with an update and summary of my Major Research Project, titled above, which you granted ethical approval in November 2020. The project has now been completed, broadly according to plan, although recruitment delays have extended the timescales.

Twelve participants consented to be interviewed, and to their data being incorporated into a grounded theory. This has now been written up for submission as **Overcoming the 'Shame Shield' - a preliminary grounded theory of how Cognitive-Behavioural Therapies may proceed in the presence of high levels of shame in OCD.**

Introduction: Experiences of shame have been associated with a variety of negative outcomes in OCD, including reduced access and response to psychological therapy. Much has been said about how therapy may need to change to account for the presence of shame, but little empirical research has been carried out. As a result, a grounded theory methodology was chosen to explore how CBT/ERP may proceed when OCD is characterised by high levels of shame.

Method: Twelve participants (5 therapists and 7 experts-by-experience) were recruited through social media activity and online adverts. Interviews took place online, lasting between 35 and 85 minutes. Theoretical sampling was used to develop the interview schedule over the course of the study – compared to the initial schedule, by the end there was a reduced focus on psychological formulation, and an increased focus on factors affecting clients ability to disclose shame-related experiences to their therapists. Data collection and analysis took place concurrently, guided by the grounded theory approach of Corbin & Strauss (2015).

Results: A preliminary grounded theory was developed, using the construct of "The Shame Shield" to show how the presence of shame may function as a context which interrupts or slows down three necessary therapeutic processes – "Establishing Trust and Safety", "Becoming Speakable", and "Effective Interventions". These processes may interact in different ways depending on the characteristics of the person and their therapist.

Discussion: Findings are discussed in terms of their relation to existing theory, research, and clinical practice. While they are in keeping with recent theorising and suggestions for clinical practice (e.g. Bream et al., 2017), there is a need for further empirical research exploring the efficacy of the therapeutic adaptations suggested for working with "The Shame Shield". Limitations and implications of this research are considered, in the hope that this study may appropriately inform future developments in relation to working therapeutically with shame in OCD.

Appendix O – Author Information for the Journal of Obsessive-Compulsive and Related Disorders

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