

**NIRVANA'S STORY: EXPLORING
OBSESSIVE COMPULSIVE DISORDER**

by

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I declare that **"NIRVANA'S STORY: EXPLORING OBSESSIVE COMPULSIVE DISORDER"**, is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

A handwritten signature in black ink, appearing to read 'R. Singh'.

RAAKHEE SINGH

AUGUST 2002

**There are those who think a story
is told only to reveal
what is known in this world.**

**But a good story
also reveals the unknown.**

(Griffin, 1992, p. 24)

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ABSTRACT

This exploratory study creates a post-modern narrative context for psychotherapy and extends these ideas to an individual living with a psychiatric disorder, namely obsessive-compulsive disorder. The present study explores OCD through the ecosystemic perspective and aims to obtain a holistic understanding of an individual's experience of living with OCD and to describe the recursive connections between OCD and the individual's ecological context. This investigation includes the re-authoring therapy of Michael White and David Epston and the application of their ideas to the individual's life story. A qualitative method within the naturalistic paradigm is employed focussing on the unique experience of the individual, which allows for an understanding of the individual's personal meaning. The dominant narratives, that emerged from the individual's life story, were deconstructed. Significant shifts in attribution of meaning took place.

KEY TERMS

Obsessive-compulsive disorder, ecosystemic epistemology, stories, narrative, deconstruction, dominant narrative, attribution of meaning, unique outcome, qualitative research, single case study method.

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CHAPTER ONE

I think about worrying, each day, everyday about different things,

Why am I so empty?

No answers, nothing!

Need to get answers

Need to know what I want to do when I am out there

Would like to change

I don't know

I don't know how to believe in anything

I'm just scared

I don't want to stay here

I don't want to go home

I don't know what everyone would say?

I don't like the long paragraphs

I have to study out of my mind

I'm scared I will do the wrong thing again

I'm not allowed to make mistakes.

It's bad to not know, and not make a decision.

I really want to do something to know who I am.

Everything's a mess!

Quote from Nirvana, 7/09/2001

General Introduction

Research with a person rather than research on a person is the participative process of inquiry of this research study. It is about inquiry as a means by which the research participant, Nirvana, engages, together with the researcher, to explore significant aspects of her life, to understand it better and to transform her action so as to meet her purposes in life more fully (Reason, 1994).

Nirvana is a young adult who has been diagnosed as suffering from obsessive-compulsive disorder (OCD). She was given an opportunity to tell her story around her understanding and world of experience surrounding OCD. Her story will be recounted by myself in the capacity of researcher. This research says as much about me as the researcher as it does about Nirvana whose story is recounted (Keeney, 1983). This research study attempts to explore obsessive-compulsive disorder from an ecosystemic perspective by means of narrating and discussing Nirvana's story as the only case.

Stories are habituations. The way that individuals make sense of events in life is through sharing stories. People live in and through stories. Everybody has a story to tell about his or her life and this is shared among people through language. People interact with each other by sharing stories. They conjure up worlds. Individuals do not know the world other than as a story world. Stories inform life. They hold people together and keep them apart (Howard, 1991).

It is stories rather than concepts that teach individuals what to feel and even how to feel it. Until emotions are embedded into a shared story, emotions are simply a reaction (Parry, 1998). If and when such emotions are allowed entrance into a story, shared by two or more individuals, they become a means for each person to reach across to others in the sharing of an experience. It is the binding force that describes a relationship. Storytelling conveys the reasons of the heart.

Rosen (1996) comments on the power of telling one's story. He advocates that everyone has a story to tell. Most stories are a mixture of pain, suffering, and frustration on the one extreme and happiness, pleasure, joys, satisfaction and pride

on the other extreme. Many stories contain secrets that individuals seek to conceal for fear of being rejected or being humiliated. Individuals who risk revealing their stories to others often find relief and sometimes even release from the mere telling of the stories. They may have been trapped in their respective stories and the simple act of telling these stories to others brings new meaning and perspective to these individuals' lives.

The meaning that individuals attribute to their experience which is constitutive of those individuals' lives, has encouraged social scientists to explore the nature of the frames that facilitate the interpretation of experience. Many social scientists propose that it is the narrative or story, which provides the primary frame for an interpretation for the activity of meaning making. It is through the narratives or the stories that individuals have about their own lives, and the lives of others that they make sense of their experience. These stories do not only determine the meaning that individuals give to experience. It is argued that these stories also largely determine which aspects of experience individuals select for expression. These stories determine real effects in terms of the shaping of individuals' lives (White, 1991). Nirvana tells her story in the context of obsessive-compulsive disorder, trying to make sense of her life.

With its origin in post-modern thinking that has gained wider acceptance in the social sciences and in western culture in the latter half of the 20th century, narrative therapy offers an understanding of human beings and an approach to psychotherapy that differs dramatically from classic psychodynamic and cognitive-behavioural models as well as the positivist and modernist approaches (Huntington, 2001). In this study Nirvana is engaged in narrative therapy. Within a narrative framework, problems are viewed as rising from and being maintained by negative stories, which dominate the narrator's life. Problems occur when the way in which individuals' lives are storied by themselves and others does not significantly fit with their lived experience. Significant aspects of their lived experience may contradict the dominant narrative in their lives. Developing therapeutic options to problems involves opening space for the authoring of alternative stories, the possibility of which has previously been marginalised by the dominant narrative, which maintains the problem. These alternative stories are preferred by individuals and do not contradict significant

aspects of lived experience and open up possibilities for individuals to take control of their lives. Narrative therapy rests on the assumption that narratives are not representations of reflections of identities and lives. Rather narratives constitute identities and lives (Bruner, 1991). According to this position, the process of therapeutic re-authoring of personal narratives changes lives and identities because personal narratives are constitutive of identity (Carr, 1998).

The languages of the ecosystemic epistemology and narrative approaches should not necessarily be seen as being in opposition with each other, since this study will illustrate the importance of seeing any narrative as existing in a wider ecology of narratives.

This study employs a qualitative research method within the naturalistic paradigm. In keeping with ecosystemic reasoning, this qualitative study does not seek the 'objective truth' about Nirvana, her psychiatric conditions and relationships. As Lincoln and Guba (1985) state the outcome of qualitative research is a reconstruction of the multiple constructions that various respondents have made. Consistent with the theoretical perspective of this study, which is based on an ecosystemic epistemology, the researcher cannot stand outside the system but is intrinsic to it and must be included in any description of it. As Keeney (1979, p. 124) postulates, "the therapeutic situation is therefore a whole system consisting of the simultaneous interactions of all parts. These simultaneous interactions self-referentially identify, define, and constitute the whole system". The research participant and researcher's relationship and interactions at a specific time in a particular context create the whole system. The description of my observations guides my behaviour and reflects the kind of epistemological lenses that are used to see Nirvana's behaviour. The distinctions drawn in this research reveal as much about myself as they do about Nirvana.

In this research project I view my role as follows:

I view myself as both the therapist and the researcher who is part of the system and is subjected to all the constraints and necessities of a particular relationship in which the therapist and researcher exists (Bateson, 1979). The therapist and researcher act on the participant simultaneously with the participant

recursively acting on the researcher. The therapy and research “is therefore a whole system consisting of the simultaneous interaction of all parts. These simultaneous interactions self-referentially identify, define, and constitute the whole system” (Keeney, 1979, p. 124).

My role as the researcher is that of “participant-facilitator” (Real, 1990, p. 259). My personal philosophical and theoretical perspective in which I view the world influences my way of viewing the participant's experience. With an ecosystemic lens I see myself as positioned not outside the system but in the system.

With myself as the researcher engaging in narrative therapy with Nirvana I also take on the role of a narrative therapist. The narrative therapist's position is described by White (1991) who draws on ideas from the French philosopher Derrida as being both a deconstructionist and a constitutionalist. A deconstructionist position consists of empowering individuals to defy psychiatric disorder definitions. A constitutionalist position means working from the assumption that lives and identities are constituted and shaped by three sets of factors namely:

- The meaning individuals give to their experiences or the stories they tell about themselves.
- The language practices that individuals are recruited into along with the type of words they use to story their lives.
- The positions individuals fill in social structures of which they are a part, and the power relations entailed by these.

The narrative therapist's task involves addressing these three sets of factors by deconstructing the stories that individuals tell about their lives, the language practices they use and the power relationships in which they find themselves. In deconstructing practices of power White (1991) draws on the work of the French philosopher Foucault. According to Foucault (1976) individuals move into the subjugation of their lives by power practices, which involve isolation, evaluation and comparison. Individuals internalise ludicrous societal standards yet at the same time believe that in doing so they are justifiably progressing to ideals of fulfilment. This

leads, for example, to extreme self-criticism or a sense of powerlessness in the face of threat or anxiety (Carr, 1998).

With narrative therapy there is openness about the therapist's working context, intentions, values and biases. The therapist is respectful for working at the participant's pace. The collaborative co-authoring position within narrative therapy is neither a one-up expert position nor a one-down strategic position. The therapist assumes that since social realities are constituted through language and organised through narratives, therapeutic conversations aim to explore multiple constructions of reality rather than tracking down the facts that constitute a single truth (Carr, 1998).

Exploring obsessive-compulsive disorder is not only of academic interest to me, but is also important to me in a very personal way. I began to realise why I had chosen this research topic once I had entered the process of *re-search*. When I first started out I had presented myself with all sorts of very reasonable explanations as to why this was the appropriate research to undertake. I had not really taken into account the emotional and psychological implications of conducting this research. I chose this topic because it reflected my growth and development as a therapist. I was able to find new ways of working in therapy with this client. This therapy pushed me as a therapist to be different in my approach to therapy because I had to employ an approach that was different to the positivist, modernist approach of the psychiatric team. Questions have been raised about my own self-worth and have made me look much more closely at 'who I am'. These deep inner questions of identity, relationship, of facing my own doubts, needs, uncertainties and resistances have helped me to experience a new understanding of myself and my thinking of others. This personal process in turn contributed to the research because of my increased awareness and sensitivity to the emotional and therapeutic needs of Nirvana.

Overview of Obsessive-Compulsive Disorder

According to the Diagnostic and Statistical Manual of Mental Disorders-IV-TR (DSM-IV-TR) (American Psychiatric Association, 2000) **obsessive compulsive disorder** can be defined as the presence of recurrent, persistent, and unwanted thoughts, impulses or images (obsessions) and/or the performance of repetitive,

ritualistic behaviours (compulsions). These obsessions and compulsions are often ego-dystonic, are often resisted by the individual at some point in the illness and interfere with the individual's daily functioning. These are characteristics that are clinically important in differentiating OCD from other diagnoses such as schizophrenia and phobic disorders.

Obsessions are persistent, repetitive thoughts which intrude upon an individual's mind and which may be either meaningless or frightening (American Psychiatric Association, 2000). They create doubts about whether harm has happened or will happen to oneself or to others. Even the most meaningless repetitive thoughts can cause anxiety, because it seems as if one's mind is out of control.

An obsessive thought enters an individual's mind gradually or suddenly. Initially the thought may be connected to an event that occurred, but later the thought may appear to be purposeless, and extreme, and it may sound bizarre to others. For some individuals obsessions take on different forms each time they happen. For others, obsessions come and go, either rapidly switching from one to another for no reason, or changing each time a new and more threatening thought comes along. It is these qualities that make obsessions different from ordinary worries and anxieties.

Obsessive thoughts may take the form of images such as of a child being killed that can occupy hours or entire days, or repeated thoughts of having sex with a dead person, which the obsessive person may find distressing yet is unable to dismiss the thought (Pato & Zohar, 2001). An important feature that is linked with obsessions is the feeling of doubt and uncertainty (Penzel, 2000). Doubts are a large part of what makes it so difficult and agonising for those with obsessions to function normally. Individuals who have excessive doubts tend to engage in compulsive questioning, checking and looking for reassurance about whether the thought is true or not.

Compulsions are acts performed to relieve the anxiety caused by obsessions. Compulsions are defined as repetitive, purposeful, and intentional behaviours that are performed in response to an obsession (American Psychiatric

Association, 2000). The behaviour is designed to neutralise or to prevent discomfort or a dreaded event or situation. They are meant to keep bad or unpleasant things from happening, to cancel out things that have already happened, or to relieve doubtfulness about such things. They can be either physical behaviours or thoughts and may or may not have to be carried out according to a set of very exact rules, over and over again. Individuals recognise that their behaviour is excessive or unreasonable, but they have the urge to perform them anyway. They perform them irrespective of how difficult it may be for them because they feel less anxious afterward. It is this rewarding escape from anxiety that gets individuals with OCD to establish these repetitive patterns of behaviour. They literally train themselves to do these things without realising what they are doing (Penzel, 2000).

Compulsive thinking activities are the urges to carry out some type of mental activity. This includes counting numbers in special patterns or repeatedly thinking of a word. Usually these acts are done in a special order, a perfect way or at a particular time. While driving, the thought that they may hit someone may come to mind, followed by the need to repeatedly return to a location to check, despite the virtual certainty that no accident occurred. These are different from obsessions because they are deliberately performed to relieve anxiety (Penzel, 2000).

Obsessive-compulsive disorder has a long history. Already in the seventeenth century, obsessions and hand-washing rituals were immortalised by Shakespeare in the guilt-ridden character of Lady Macbeth. Prior to that time, individuals with obsessive thoughts of a blasphemous or sexual nature were believed to be possessed by the devil. This view was consistent with the beliefs of that time. The treatment that was employed at that time was to remove the demons from the possessed soul. The treatment of choice was exorcism. The individual was subjected to torture in order to remove the evil in their mind (Jenike, Baer & Minichiello, 1998).

With time the explanation of the cause of obsessions and compulsions moved from a religious to a medical view. Esquirol first described obsessions and compulsions in psychiatric literature in 1838 and by the end of the nineteenth century, obsessions were generally regarded as manifestations of depression (Rachman & Hodgson, 1980).

By the beginning of the twentieth century, the view of obsessive-compulsive neurosis had shifted toward a psychological explanation. With Freud's publication in 1909 of the psychoanalysis of obsessional neurosis (*The Rat Man*), obsessions and compulsive actions were seen as the result of unconscious conflicts and of thoughts and actions being isolated from their emotional components (Freud, 1909). As a result of this shift in theory, treatment of OCD turned away from the symptoms and toward the unconscious conflicts that were assumed to underlie the symptoms. Although this shift identified that actions can be motivated by factors of which the individual is unaware, there was little improvement in the treatment outcomes for individuals who had suffered from obsessive-compulsive disorder.

With the rise of behaviour therapy in the 1950s, the learning theories that were useful in the conceptualisation and treatment of phobic disorders were applied to OCD symptoms. Although learning theories did not encompass all OCD symptoms, they did lead to the development of effective treatments for reducing compulsive rituals in the late 1960s and early 1970s (Jenike, Baer & Minichiello, 1998).

Today obsessive-compulsive disorder is again explained by the medical view. The past 15 years have seen a threefold increase in publications about obsessive-compulsive disorder. There has been a rapid growth in the understanding of the clinical features, pathophysiology and treatment of OCD. This reflects the growing interest in this disorder. Research has accelerated in areas across a spectrum of approaches as brain imaging, genetics, epidemiology, immunology, neuropsychology and treatment interventions including biological and psychotherapeutic modalities (Pato & Zohar, 2001).

Although there is an assumption that affective illness is at the core of OCD symptoms, the views of Rachman & Hodgson (1980) appear to have gained wide support. According to their view (1) biological predisposition, (2) psychological factors, (3) learning history, and (4) mood fluctuations can be crucial in the development and maintenance of OCD.

It is interesting to note that as the view of the causes of OCD changed over the centuries, the content of obsessions and rituals changed as well. Where once the

predominant fear was contracting the dreaded plague, this fear then gave way to obsessions and rituals to ward off syphilis. Recently, fears of cancer have been predominant (Rachman and Hodgson, 1980). Now, fear of acquired immunodeficiency syndrome (AIDS) has become predominant in obsessions and rituals.

Until recently obsessive-compulsive disorders were thought to be rare. It used to be thought that twice as many individuals suffered from schizophrenia as compared to the number of those with OCD. To the surprise of many health care professionals the National Epidemiological Catchment Area Survey (NECA) found that the opposite was true (Obsessive-Compulsive Foundation, 1999). What is striking about current incidence figures is that despite the fact that obsessive-compulsive disorders are so common, little is known or understood by society, health care professionals and the sufferers themselves. Some of the reasons for OCD being known as a rare disorder are:

- Misdiagnosis
- Sufferers of OCD keep their symptoms a secret
- Health care team members often fail to screen individuals for OCD even in the presence of prevalent warning signs.

According to the DSM-IV-TR (American Psychiatric Association, 2000) obsessive-compulsive disorder is categorised as an anxiety disorder because the central factors seem to be anxiety and discomfort, which are usually increased by the obsessions (thoughts) and decreased by the compulsions or rituals (actions). Although individuals with OCD frequently present with irrational or bizarre thoughts regarding their symptoms, they remain focused and are aware of reality in all other areas of their lives. Therefore, OCD cannot be considered to be a psychotic disorder (Jenike, Baer & Minichiello, 1998), and although it is considered to be an anxiety disorder, its pathophysiology and treatment varies considerably from that of the anxiety disorders.

The diagnosis of OCD is however not always easy or obvious. Many individuals do not seek psychiatric care for specific complaints of obsessive-

compulsive symptoms but rather for complaints of depression, phobic disorders and panic disorder all of which may occur concurrently with OCD. Many individuals feel embarrassed about their symptoms, and therefore they are very secretive about them. As a result these individuals usually fail to seek treatment (Penzel, 2000).

Due to the complex nature of obsessive-compulsive disorder, OCD attracts the attention of researchers in the fields of medicine and psychology. It is therefore a field suited for interdisciplinary treatment and research. The sexual and aggressive content of obsessive thoughts and the symbolism of rituals intrigue psychoanalysts. Behaviourists are interested in the way that behavioural rituals precisely fit into an anxiety-reduction model of learning. Psychopharmacologists noted that OCD is accompanied by depression, and OCD symptoms can be reduced or eliminated by medication. Neurologists have noted that specific lesions provide compulsive behaviours. To date, no single viewpoint provides a comprehensive explanation of OCD (Jenike, Baer & Minichiello, 1998). It is my hope that this investigation will make a contribution to the explanation of obsessive-compulsive disorder.

Aim and Rationale of the Study

Over twenty years ago, R. Julian Hafner in Adelaide and his colleagues wrote compellingly of the need for a family or systems approach in working with obsessive-compulsive disorder, rather than a client centred approach (1982). They published these articles at a time when behavioural approaches were hailed as the panacea for this disorder. Yet behavioural approaches were only achieving a 50% success rate (Perse, 1988), and clinicians were observing that patients often relapsed when returning home from hospital. Despite Hafner's ideas (1982) the dominant paradigm was clearly a client centred behavioural approach. Currently the preferred treatment modalities are drugs and cognitive-behavioural therapy. According to the literature the success rate is claimed to be 90% (Greist, 1990) with 'success' defined as a reduction of symptoms rather than clearing of symptoms. By exploring obsessive-compulsive disorder from the ecosystemic perspective and to gain understanding from that perspective will hopefully contribute to the existing body of knowledge.

By shifting from an emphasis on intrapsychic factors towards an understanding of contextual elements, this research aims to fill a gap in the research literature on obsessive-compulsive disorder. This gap between the addressed and the unaddressed is where White's (1991) and Epston and White's (1992) unique outcomes are to be found. The hope is that the door would be opened to more complex stories that would encompass both positive and negative components, in such a way to do justice to the notions of cybernetic complementarities (Keeney, 1983).

A review of the literature shows that extensive research has been conducted on OCD patients, specifically focusing on cognitive behaviour therapy (Warren & Thomas, 2001), multi-modal behaviour therapy (Hand, 1998); pharmacotherapy with psychoanalytic treatment (Greist, 1990), family therapy (Fine, 1973), multifamily group approach, post-traumatic OCD (Pitman, 1993), neurosurgical treatment and neurobiological treatment for OCD (Mindus, Rasmussen, Lindquist & Noren, 2001), role of imagery in the symptoms and treatment of OCD (Gapinski, 1999-2000), and yogic meditation techniques in the treatment of OCD (Shannahoff-Khalsa, 1997).

However, reviewing the contribution of systems theory in the understanding and treatment of obsessive-compulsive disorder (OCD) translates into examining a void in the professional literature. There is limited research conducted on OCD specifically from an ecosystemic perspective. This dissertation therefore attempts to explore OCD through the ecosystemic lens. The study seeks a more holistic understanding of the obsessive-compulsive disorder's experience, exploring how an individual's obsessions and the context in which they occur have evolved together to derive a fit that stabilises each other (Bloch, 1987). This 'fit' will have evolved out of the 'ecology of ideas' (Bateson, 1972) that has organised itself around the problem theme.

Reviews of research on OCD illustrate the invaluable contributions that have been made to the existing body of knowledge and understanding of the clinical features associated with OCD and their psychological and pharmacological treatments. However, the majority of these studies have adopted a positivistic and/or nomothetic approach that use primarily quantitative methods to investigate causal or

correlational relationships between different treatment groups and variables such as age, type and duration of OCD symptoms. Few OCD studies exemplify social psychological enquiry into the everyday lives of individual sufferers (O'Neill, 1999). It is my intention that this qualitative study may possibly contribute to a holistic exploration of OCD where the story of the OCD sufferer (research participant) is gathered.

Since symptoms are viewed as communications whose meaning is unique to the idiosyncratic interpersonal context of the problem, there is no focus on aetiology, cause and effect, truth or proof. What assumes importance in this research are the recursive connections between recurrent OCD and the research participant's life ecology, including her interpersonal relationships. Against this background, the study furnishes a descriptive account of the network of ideas and attributions of meaning that Nirvana and those individuals who recursively interact with her, including myself as the researcher attribute to the problem. Incorporated into this interlinked matrix of ideas are, among other conceptions, beliefs about the origin and perpetuation of the problem (Griffith, Griffith & Slovik, 1990) as well as perceptions about the effect of the symptoms on the OCD sufferer's interpersonal relationships.

This research does not focus on finding solutions or a 'cure' to OCD. This would be an expression of linear control and reductionist thinking. In this research it is assumed that the research participant and I view our worlds and make sense of our experiences in personal and idiosyncratic ways. Therefore, both Nirvana and I bring our own realities to the inquiry context. In becoming part of the problem system, I in the capacity of both therapist and researcher act on the research participant while the participant simultaneously acts on me. Through dialogue, the research participant and I actively collaborate to co-create the reality of the problem. The ideas that co-evolve from this recursive interaction result in what Maturana (1975) calls a 'consensual domain'. However, it must be remembered that just as realities are constructed in language, they can be de-constructed linguistically and new realities created (Fourie, 1996a). I have a different perspective to that of the research participant and may be able to introduce alternate constructions and meanings. In this study I investigate both the OCD context and ways to therapeutically intervene

into it. I attempt to perturb the existing ecology of ideas and help it "to evolve in a direction where the consensual definition of the problem is no longer central" (Fourie, 1996a, p.15). In this way, the problem may partially or completely take on a different meaning thereby facilitating different action possibilities for the OCD sufferer. This process is by no means certain and thus change is not guaranteed. Firstly, living systems are unpredictable and cannot be influenced directly since they are structure-determined. The system's response to any perturbation will be determined by the structure of that system, not by the perturbation. It is assumed that different perturbations will elicit different responses from a particular system. Secondly, an ecosystemic perspective does not conceptualise change in a finite, linear manner, but as part of an ongoing process (Wassenaar, 1987).

A qualitative research approach is coherent with an ecosystemic approach, which is the theoretical perspective of this study. The use of qualitative methods of collecting data promotes reflexivity, self-awareness and empowerment of participants involved in the research, by giving voice to a person to tell her story in her own words (Grafanaki, 1996).

The co-constructed story of the participant is told through my lenses. Nirvana tells her story in conversations that take place between her and me. This is consistent with the "idea that people make sense of and communicate their experience through stories" (McLoed and Balamoutsou, 1996). The emphasis is on how individuals construct meaning. The way that an individual constructs meaning is believed to be idiosyncratic to that individual. This is opposite to the positivistic perspective that "everyone shares the same meaning system" and experiences "the world in the same way" (Neuman, 1994, p. 63). The aim is to understand the subjective world of the participant. It is my view that this may be achieved through a qualitative research approach.

In this study a research participant was selected on the basis of purposive sampling (Lincoln & Guba, 1985). The selection of the participant took place with a specific purpose in mind to explore her experience of living with a diagnosis of obsessive-compulsive disorder. The selection of the participant was also made on the basis of convenience sampling. This study adopts a single case study method.

Therefore, the participant that is selected is one who can provide a rich description of living with a diagnosis of obsessive-compulsive disorder. Written permission was obtained from the participant.

The interviews, storytelling, letter writing and a single case study are the method used to collect the data. The case study method is employed as it is assumed to have the potential to provide a thick description of information within context. In presentation of a case study readers are provided with a description of a specific case. Readers are presented with an opportunity to draw distinctions on the basis of their own interpretations.

The participant in the study is called "Nirvana". The name of the participant has been changed to protect her privacy. She is 21 years old and is currently in her 2nd year of a Bachelor of Arts (Psychology) degree at a university. Nirvana was first diagnosed with OCD at the age of 20. Since that time she has received only drug therapy to treat her symptoms associated with stress and anxiety. With a recent admission to a psychiatric ward she receives drug therapy, occupational therapy and psychotherapy.

The following sequence will be followed to carry out the study:

- The participant is interviewed over a period of time. The interviews are audio-recorded.
- Thereafter, the recorded interviews are transcribed. The transcribed interviews are systematically analysed and interpreted using Strauss and Corbin's (1990) three-stage process of open, axial and selective coding.
- The researcher listens to the tapes whilst reading the transcript. The data from each tape is reduced to units of meanings. The researcher then formulates a summary from these natural-meaning units. Thus far the data analysis is mainly on a content level. Data analysis then moves to the interpretative level, the level of meaning.

- The summaries of all the interviews of the participant are summarised and form the participant's biography as recounted by myself. The participant's story is written about her experience of suffering from an obsessive-compulsive disorder.
- My narrative of the participant's story follows this. I carefully re-read the original transcriptions and elicit patterns and themes/descriptions/categories, which are relevant to the research context, to the story. Patterns and themes are to be identified and discussed.
- Finally, a comparative analysis is undertaken in order to integrate the findings from previous research with the themes that are articulated in this study.

Format of the Study

This study comprises both a literature survey and a practical component.

CHAPTER 2 is comprised of the literature review, which surveys the existing body of knowledge relating to obsessive-compulsive disorder as conceptualised according to medical, pharmacological and psychotherapeutic models. The gaps in previous research efforts are highlighted. In quantitative research generally one of the aims of a literature survey is to generate a hypothesis. The ecosystemic approach's aim of generating a hypothesis is deferred. Therefore, no hypothesis is generated. The literature survey represents an exploration of the existing body of knowledge on obsessive-compulsive disorder to give the reader a background to this study. This existing body of research is offered as an alternative voice to which the emerging themes can be compared.

CHAPTER 3 explains the theoretical foundation for this research namely ecosystemic epistemology, which guides my distinctions and assumptions in conducting the research.

CHAPTER 4 describes the method employed to conduct the research. This study is a qualitative research approach within a naturalistic paradigm. It includes a discussion of the qualitative methods used to collect the data as well as the qualitative method of analysis.

CHAPTER 5 entails the story of a single case description of an obsessive-compulsive disorder sufferer. A story is constructed about how Nirvana's OCD evolved within her own unique context. This leads to a discussion of what evolved from the conversations from Nirvana's perspective. A description of the psychiatrist's view of Nirvana's condition as well as my view as the researcher of Nirvana's life follows. The conversational practices used by me to intervene into Nirvana's OCD contexts are illustrated.

CHAPTER 6 highlights the dominant patterns, themes, narrative shifts and unique outcomes that Nirvana experienced. A meta-perspective of Nirvana's dominant discourse and the co-constructed shifts that occurred in her attributions of meaning is provided. This chapter also contains the comparative analysis between the emerging themes that were articulated in the study and the literature survey.

CHAPTER 7 is the concluding chapter. An overview of this research study is provided. This is followed by my reflections as a researcher on the research process. The research is evaluated according to the strengths and limitations of this study. The implications of an ecosystemic approach for the understanding and treatment of obsessive-compulsive disorder is discussed. Recommendations for future research are made.

CHAPTER 2

A LITERATURE REVIEW ON OBSESSIVE COMPULSIVE DISORDER

*Knowledge emerges as an ongoing self-referential construction,
knowledge emerges as a result of a recursion of descriptions
that generate other descriptions*

(Von Foerster, 1981)

Introduction

Obsessive-compulsive disorder (OCD) is one of the most debilitating of all psychiatric disorders. About 2/3 of the people who suffer from OCD also suffer from depression and they often attempt to commit suicide. OCD was once regarded as a rare disorder that was unresponsive to treatment, however it is now recognised as a common problem affecting between 2-3% of the general population. Based on these figures, it is estimated that there are over 100 million sufferers of OCD world-wide (Pato & Zohar, 2001).

According to the World Health Organisation OCD is rated in the top 10 for the most debilitating disorder. While these figures do not differentiate for the range in severity of the disorder, these results make OCD the fourth most common psychiatric disorder following phobias, substance abuse and major depressive disorder. Its prevalence is twice that of schizophrenia and panic disorder.

An obsessive-compulsive disorder is an emotionally painful and degrading experience for sufferers (Penzel, 2000). OCD sufferers are at the mercy of cleaning and checking rituals and obsessive thoughts (Jenike, Baer & Minichiello, 1998). Within the medical field OCD is generally referred to as the *hidden epidemic* because many OCD sufferers suffer in silence. They choose not to mention this disorder to significant family members or health care members because of their fear of being

judged as *crazy*. This disorder results in some sufferers isolating themselves, others to lose their ability to be spontaneous or take risks that are necessary for everyday functioning. OCD has the potential to handicap a sufferer's life.

Diagnostic Criteria for Obsessive-Compulsive Disorder

The DSM-IV-TR (APA, 2000, pp. 462-463) provides the following criteria for the diagnosis of obsessive-compulsive disorder:

"A. Either obsessions or compulsions:

Obsessions as defined by (1), (2), (3) and (4):

1. Recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate, and cause marked anxiety or distress.
2. The thoughts, impulses, or images are not simply excessive worries about real-life problems.
3. The person attempts to ignore or suppress such thoughts, impulses or images, or to neutralise them with some other thought or action.
4. The person recognises that the obsessional thoughts, impulses, or images are a product of his or her own mind.

Compulsions as defined by (1) and (2):

1. Repetitive behaviours (e.g., handwashing, ordering, checking) or mental acts (e.g. praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly.
 2. The behaviours or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviours or mental acts either are not connected in a realistic way with what they are designed to neutralise or prevent or are clearly excessive.
- A. At some point during the course of the disorder, the person has recognised that the obsessions or compulsions are excessive or unreasonable.
- B. The obsessions or compulsions cause marked distress, are time-consuming (take more than 1 hour a day), or significantly interfere with the person's:

normal routine, occupational functioning, or usual social activities or relationships.

- C. If another Axis I disorder is present, the content of the obsessions or compulsions is not restricted to it (e.g. preoccupation with food in the presence of an eating disorder, hair pulling)
- D. The disturbance is not due to the direct effects of a substance (e.g. a drug of abuse, a medication) or a general medication condition.

Specify if:

With Poor Insight: if, for most of the time during the current episode, the person does not recognise that the obsessions and compulsions are excessive or unreasonable."

Diagnostic Features of Obsessive-Compulsive Disorder (APA, 2000, pp. 464-465)

"The essential features of obsessive-compulsive disorder are recurrent obsessions or compulsions (Criterion A) that are severe enough to be time consuming (i.e., they take more than one hour a day) or cause marked distress or significant impairment (Criterion C). At some point during the course of the disorder, the person has recognised that the obsessions or compulsions are excessive or unreasonable (Criterion B). If another Axis I disorder is present, the content of the obsessions or compulsions is not restricted to it (Criterion D). The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (Criterion E)".

"*Obsessions* are persistent ideas, thoughts or images that are experienced as intrusive and inappropriate and that cause marked anxiety or distress. The intrusive and inappropriate quality of the obsessions has been referred to as 'ego-dystonic'. This refers to the individual's sense that the content of the obsession is alien, not within his or her own control, and not the kind of thought that he or she would expect to have. However, the individual is able to recognise that the obsessions are the product of his or her own mind and are not imposed from without (as in thought insertion)".

"The most common obsessions are repeated thoughts about contamination (e.g., becoming contaminated by shaking hands), repeated doubts (e.g., wondering whether one has performed some act such as having hurt someone in a traffic accident or having left a door unlocked), a need to have things in a particular order (e.g., intense distress when objects are disordered or asymmetrical), aggressive or horrific impulses (e.g., to hurt one's child or to shout an obscenity in church), and sexual imagery (e.g., a recurrent pornographic image). The thoughts, impulses or images are not simply excessive worries about real-life problems (e.g., concerns about current ongoing difficulties in life, such as financial, work, or school problems) and are unlikely to be related to a real-life problem".

"The individual with obsessions usually attempts to ignore or suppress such thoughts or impulses or to neutralise them with some other thought or action (i.e., a compulsion). For example, an individual plagued by doubts about having turned off the stove attempts to neutralise them by repeatedly checking to ensure that it is off".

"*Compulsions* are repetitive behaviours (e.g., hand washing, ordering, and checking) or mental acts (e.g., praying, counting, repeating words silently) the goal of which is to prevent or reduce anxiety or distress, not to provide pleasure or gratification. In most cases, the person feels driven to perform the compulsion to reduce the distress that accompanies an obsession or to prevent some dreaded event or situation. For example, individuals with obsessions about being contaminated may reduce their mental distress by washing their hands until their skin is raw; individuals distressed by obsessions about having left a door unlocked may be driven to check the lock every few minutes; individuals distressed by unwanted blasphemous thoughts may find relief in counting to ten backward and forward hundred times for each thought. In some cases individuals perform rigid or stereotyped acts according to idiosyncratically elaborated rules without being able to indicate why they are doing them. By definition, compulsions are either clearly excessive or are not connected in a realistic way with what they are designed to neutralise or prevent. The most common compulsions involve washing and cleaning, counting, checking, requesting or demanding assurances, repeating actions and ordering".

"By definition, adults with OCD have at some point recognised that the obsessions or compulsions are excessive or unreasonable. This requirement does not apply to children because they may lack sufficient cognitive awareness to make this judgement. However, even in adults there is a broad range of insight into the reasonableness of the obsessions or compulsions. Some individuals are uncertain about the reasonableness of their obsessions or compulsions, and any given individual's insight may vary across times and situations. For example, the person may recognise a contamination compulsion as unreasonable when discussing it in a "safe situation" (e.g., in the therapist's office), but not when forced to handle money. At those times when the individual recognises that the obsessions and compulsions are unreasonable, he or she may desire or attempt to resist them. When attempting to resist a compulsion, the individual may have a sense of mounting anxiety or tension that is often relieved by yielding to the compulsion. In the course of the disorder, after repeated failure to resist the obsessions or compulsions, the individual may give in to them, no longer experience a desire to resist them, and may incorporate the compulsions into his or her daily routines".

"The obsessions or compulsions must cause marked distress, be time consuming (take more than one hour per day), or significantly interfere with the individual's normal routine, occupational functioning, or usual social activities or relationships with others. Obsessions or compulsions can displace useful and satisfying behaviour and can be highly disruptive to overall functioning. Because obsessive intrusions can be distracting, they frequently result in inefficient performance of cognitive tasks that require concentration, such as reading or computation. In addition, many individuals avoid objects or situations that provoke obsessions or compulsions. Such avoidance can become extensive and can severely restrict general functioning."

Associated Features of Obsessive-Compulsive Disorder

In the following sections I will discuss associated features of obsessive-compulsive disorder, namely the course of obsessive-compulsive disorder, the age of onset of the disorder, whether obsessive-compulsive disorder exists in a specific

culture, age and gender and the precipitating factors that lead to the onset of obsessive-compulsive disorder.

Course

According to Pato and Zohar (2001) the course of OCD is variable. It is not uncommon to find patients who have experienced episodes of varying length that remit before the disorder becomes chronic. In three studies summarised by Black (1974), the initial course of OCD was static or steadily worsening in 57% of subjects, phasic in 13% of subjects, and fluctuating in 30%. More recently, Gojer, Khannu and Channabasavanna (1987) as cited in Marks (1987) reported that after discharge, 66% of patients showed a deteriorating course, 17% fluctuated, 11% remained the same, and only 2% improved. After remission, relapse may be precipitated by a number of factors, namely fatigue, depression, any cause of anxiety, and recurrence of conditions that initially triggered the problem (Marks, 1987).

OCD usually begins in adolescence or early adulthood, although it may also begin in childhood. The modal age of onset is earlier in males (between the ages 6 and 15 years) than in females (between the ages 20 and 29 years). For the majority of individuals diagnosed with OCD the onset is gradual, but acute onset has been documented in some cases. The majority of individuals have a chronic waxing and waning course, with an exacerbation of symptoms that may be related to stress. About 15% of OCD sufferers show progressive deterioration in occupational and social functioning, and about 5% of OCD sufferers have an episodic course with minimal or no symptoms between episodes (APA, 2000).

Age of Onset

According to Pato and Zohar (2001) the age of onset in OCD is variable. It is likely that most cases first occur in late adolescence or in the early twenties. There is evidence to suggest the presence of an early onset group who are predominantly male. It is possible that several adolescent onset cases could be placed in this category, due to the fact that some patients are simply able to conceal the symptoms throughout their childhood. Swedo and Rapoport (1989) suggest that early onset symptoms may be present in children between four to six months before their parents

become aware of the problem. The average time that can elapse between the onset and first clinical presentation of OCD is approximately seven to eight years, which underscores the severe embarrassment suffered by these individuals.

Specific Culture, Age and Gender Features

Ritualistic behaviour that is culturally prescribed is not in itself indicative of OCD unless it exceeds the defined cultural norms, and occurs at times and places that are judged inappropriate by other members of the same culture, and interferes with social role functioning. Individuals experiencing important life transitions or mourning losses may engage in an intensive ritual behaviour that may appear to be an obsession to a member of the health care profession that is not familiar with the cultural context.

Presentations of OCD in children are similar to those in adulthood. Washing, checking and ordering rituals are particularly common in children. Children generally do not request help, and the symptoms may not be ego-dystonic. Often the parents, who bring the child in for treatment, identify the problem. Gradual declines in schoolwork following an impaired ability to concentrate have been reported in children. Like adults, children are more prone to engage in rituals at home than in front of peers, teachers, or strangers. This disorder is equally common in males and females (APA, 2000).

Precipitating Factors

Research into the precipitating factors of OCD has yielded mixed results. Some studies have found that in 30% to 50% of cases no precipitating factors are reported (Black, 1974). Other researchers suggest that between 50% to 90% of patients with OCD can recall a precipitant (Rasmussen & Eisen, 1992).

According to Pato and Zohar (2001) precipitating factors usually take the form of some kind of emotional stress in the domestic or work environment, although any life change resulting in increased levels of responsibility may also be significant. OCD subjects were found to experience a significant excess of life events in the six months

prior to their illness, particularly undesirable, uncontrolled events in the areas of health and bereavement.

An acute onset is typically more marked in women for example during pregnancy, after a termination or after the birth of a first child (Rasmussen and Eisen, 1992). Individuals with predominantly cleaning compulsions are more likely to report a precipitating event than those with predominantly checking compulsions, which are associated with a more gradual onset (Rachman & Hodgson, 1980).

Is Obsessive Compulsive Disorder Inherited?

The Obsessive-Compulsive Foundation (OCF) has investigated the possibility that OCD could have a genetic basis. According to their investigation, no specific genes for OCD have yet been identified. However, research suggests that genes do play a role in the development of the disorder in some cases. The onset of OCD in childhood tends to run in families (sometimes in association with tic disorders). When a parent has OCD, there is an increased risk that a child will develop OCD, although the risk is still low. When OCD runs in families, it is the general *nature* of OCD that seems to be inherited, not *specific symptoms*. Therefore, a child may engage in checking rituals, while the child's mother washes compulsively. If the development of OCD were completely determined by genetics, the pairs of identical twins would always both have the disorder, or both not have it. For example, eye colour is entirely determined by genes and identical twins always have the same colour eyes. However, in the case of OCD, if one identical twin has the disorder, there is a 13% chance that the other twin will not be affected. This supports the idea that genes are only part of the cause of OCD, and that other factors are also important. At this stage, it is not clear what the other factors might be, although some researchers have suggested that it may be a viral infection that occurs at a critical point in a child's development, or possibly an exposure to an environmental toxin (OCF, 1999).

Research suggests that there may be different types of OCD, and that some types are inherited while other types are not. Although the findings are preliminary, there is evidence that OCD that begins in childhood may be different to OCD that begins in adulthood. Individuals with the onset of OCD in their childhood appear more

likely to have relatives that are affected with the disorder than are those whose OCD first appears when they are adults (OCF, 1999).

The OCF (1999) has established that if a parent is diagnosed with OCD it is likely that their child will also have the disorder. If one parent has OCD, the likelihood that the child will be affected is about 2 - 8%. It is important to consider this statistic as an approximation, and several factors should be considered when attempting to estimate the risk of a child developing OCD. One factor is whether or not the parents themselves have a family history of OCD. For example, if a parent that is living with OCD also has relatives with the disorder, the risk for the child increases. Conversely, if a parent has OCD but none of his or her relatives are affected, then the risk decreases. Another factor is whether the parent has OCD that began when he/she was a child. If the parent's OCD did not start until adulthood, there is probably a decreased likelihood that his or her child will be affected. Conversely, if the parent's OCD is the variety that starts in childhood, the chances of passing the disorder on are increased.

Other Problems that are Sometimes Confused with Obsessive-Compulsive Disorder

There are some disorders that closely resemble OCD and which may respond to some of the same treatments of OCD. These disorders are Trichotillomania (compulsive hair pulling), body dysmorphic disorder (imagined ugliness), and habit disorders, such as nail biting or skin picking. While these disorders share superficial similarities, impulse control problems, such as substance abuse, pathological gambling, or compulsive sexual activity, are probably not related to OCD in any substantial way (Obsessive Compulsive Foundation, 1998).

The most common disorders that resemble OCD are the tic disorders (Tourette's disorder and other motor and vocal tic disorders). *Tics* are involuntary motor behaviours (such as facial grimacing) or vocal behaviours (such as snorting) that often occur in response to a feeling of discomfort. More complex tics, like touching or tapping tics, may closely resemble compulsions. Tics and OCD occur together much more often when the OCD or tics begin during childhood (OCF, 1998).

Depression and OCD often occur simultaneously in adults, and less commonly in children and adolescents. However, if depression is not present, people with OCD are not generally sad or lacking in pleasure. People who are depressed, but do not have OCD, rarely have the kinds of intrusive thoughts that are characteristic of OCD (Pato & Zohar, 2001).

Although stress can make OCD worse, most people with OCD report that the symptoms can come and go on their own. OCD is easy to distinguish from posttraumatic stress disorder, because OCD is not caused by or related to a traumatic event (Pitman, 1993).

Schizophrenia, delusional disorders, and other psychotic conditions are usually easy to distinguish from OCD. Unlike psychotic individuals, people with OCD continue to have a clear idea of what is real and what is not. People with OCD are aware of their reality and are not in a state of psychosis.

In children and adolescents, OCD may worsen or cause disruptive behaviours, exaggerate a pre-existing learning disorder, cause problems with attention and concentration, or interfere with learning at school. In many children with OCD, these disruptive behaviours are related to OCD and will go away when OCD is successfully treated.

Individuals with OCD may have substance-abuse problems, sometimes as a result of attempts to self-medicate. Specific treatment for the substance abuse is usually also needed (Hoffman, 1993).

Children and adults with pervasive developmental disorders (autism, Asperger's Disorder) are extremely rigid and compulsive, with stereotyped behaviours that somewhat resemble very severe OCD. However, those with pervasive developmental disorders have extremely severe problems relating to and communicating with other people, which do not occur in OCD (Owens & Piacentini, 1998).

Only a small number of individuals living with OCD have the collection of personality traits called Obsessive Compulsive Personality Disorder (OCPD). Despite its similar name, OCPD does not involve obsessions and compulsions, but rather is a personality pattern that involves a preoccupation with rules, schedules and lists; perfectionism; an excessive devotion to work; rigidity; and inflexibility. However, when people have both OCPD and OCD, the successful treatment of the OCD often causes a favourable change in the person's personality (OCF, 1998).

Obsessive Compulsive Disorder and Alcohol

According to Eisen and Rasmussen (1993) alcoholism and obsessive compulsive disorder are common problems, causing significant suffering and impairment of functioning for patients with a major impact on the affected families. Estimates of the prevalence are that 4-7 million American people have a major alcohol related disorder. However, little is known about how often these two problems (OCD and alcohol) co-occur in the individual. Although it is conventional wisdom that alcohol is sometimes used to 'self-medicate' anxiety, the prevalence of combined OCD and alcohol abuse/dependence has probably been underestimated.

Research which examined the frequency of anxiety disorders in alcoholics, found patients with panic disorder, agoraphobia, social phobia and post-traumatic stress disorder but not with OCD (Eisen & Rasmussen, 1993). There may be several reasons for this. Clinicians do not always ask questions about obsessions and compulsions when interviewing patients who present with alcohol problems. Many patients who come for medical attention regarding another problem are hesitant to reveal their OCD symptoms. Eisen and Rasmussen (1993) have found that the average time between the age of onset of significant OCD symptoms and the time of seeking treatment is 7,6 years. This correlates strongly with the observations and findings of Swedo and Rapoport (1989). When Eisen and Rasmussen (1993) asked people, who were in treatment for OCD, about substance abuse, some patients reported the use of excessive amounts of alcohol as a way of coping with their intrusive thoughts. It became clear that for those patients, alcohol abuse had become a major problem leading to increased anxiety as well as a host of difficulties connected with alcohol.

To look at this question systematically, Eisen and Rasmussen (1993) screened fifty people admitted to an alcohol program for possible obsessions and compulsions and found 6% met the criteria for OCD. Two of those patients identified at screening would not have admitted to having obsessions and compulsions unless they had specifically been asked to report on their self-consciousness about their OCD symptoms.

Obsessive Compulsive Disorder and Substance Abuse

Studies examining the question of OCD in conjunction with substance abuse have been few, but it seems that having both of these problems is more frequent than has been previously thought. Due to the limited research outputs for OCD and substance abuse the literature on OCD is almost two decades old. Nevertheless, in the light of not having more recent information I decided to include this section since a review of the literature on OCD would be seen as incomplete without it.

The following signs can identify individuals having a problem with substance abuse:

- "Using a substance to alleviate feelings such as anxiety or depression or to control obsessions and compulsions (self-medication).
- Using increasing amounts of a substance over time (developing tolerance).
- Experiencing withdrawal symptoms such as tremors, flu-like symptoms, anxiety and irritability if the individual tries to stop.
- Having arguments with friends, family or co-workers about the amount of a substance the individual is using.
- Trying to hide or minimise the degree to which an individual uses a substance.
- Repeated unsuccessful attempts to stop using preferred substance or substituting one substance for another" (Hoffman, 1993, p. 2).

Substance abuse may provide temporary reduction in anxiety as well as transient relief of obsessive-compulsive disorder symptoms. However in the long run substance abuse worsens the OCD symptoms. Moreover they exacerbate related problems such as anxiety and depression. This is true for alcohol, illegal drugs and

abused prescription medications. It has been suggested that marijuana abuse exacerbates OCD by lowering serotonin levels (Jenike, Baer and Minichiello, 1998).

According to Penzel (2000) cocaine and other drugs that stimulate the central nervous system have been known to cause repetition or stereotypical behaviours that resemble classic OCD. Penzel (2000) is of the opinion that there have been a number of individual case studies that speculate about the association between the use of certain drugs and the onset of OCD. One larger scale study by Crum and Anthony (1993) as cited in Penzel (2000) found a greater than expected risk of OCD among adult users of both cocaine and marijuana, as compared with adults who were not illegal drug users.

The major difference between the *compulsive* use of a substance from regular compulsion is that regular substance abuse provides pleasure initially while obsessive compulsions are not pleasurable. Another difference between compulsive use of a substance and regular use is that people do not perceive their substance abuse as irrational. In contrast, individuals with OCD tend to regard their symptoms as senseless (Hoffman, 1993).

Obsessive Compulsive Disorder in South Africa

The incidence of OCD in the general population has been undervalued for many years due to both the closet nature of the disorder (patients recognise the irrationality of their actions and thoughts and tend to hide them from others) and to the failure of researchers to look for it (Welfare, 1993). With regards to the prevalence of OCD in South Africa, research is not taken seriously. According to Professor D. Steyn from the Medical Research Unit, Cape Town (personal communication, 09 January 2002) between 2% - 3% (~700 000) of the South African population are diagnosed with OCD. This figure is a representation of only those individuals that reach out and seek help. According to Locker from the Mental Health Information Centre (personal communication, 06 March 2002) OCD is known as a secretive disorder. Many of those that suffer from OCD are highly functioning, professional individuals who prefer to keep quiet about the disorder and try to cope with it.

In South Africa up to now there is only one organisation or resource for obsessive-compulsives called the Obsessive-Compulsive Disorder Association of South Africa. The founder of the organisation is an obsessive-compulsive person himself and the organisation is established by other OCD individuals to help themselves.

OCD has only recently been recognised as a common disorder, because OCD patients are generally secretive about their obsessive-compulsive symptoms and attempt to hide them rather than seek help. In many cases, the content of the obsessions concerns harming others, which makes it even harder to disclose.

Obsessive-compulsive symptoms are usually ego-dystonic, which means that the patient recognises them as senseless or exaggerated, and he/she is therefore ashamed. Sufferers of OCD are aware of their abnormal behaviour, since they are well aware of the irrationality of their compulsions. This awareness creates a sense of fear that other people may think of them as *mad* and makes them secretive about their symptoms. This contributes to their reluctance to seek treatment.

The majority of patients with OCD exhibit both obsessive and compulsive symptoms, while a few show only either obsessions or compulsions.

The cause of OCD was believed to be a disease of psychological origin related to attitudes ingrained in early childhood, such as an overemphasis on cleanliness. However, recent evidence has brought to light that patients with OCD respond to a particular group of drugs, which provides us with an indication that this disease may have a neurobiological cause. The neurotransmitter, serotonin, a naturally-occurring compound in the brain involved in the transmission of nerve impulses, is thought to be the key factor in this disease. Recent studies using a technique that measures how the brain functions have demonstrated that patients with OCD have different patterns of brain activity from normal individuals and those with other psychiatric disorders, thus adding more evidence to the theory of a biological cause for OCD.

The most effective and dominant treatment for OCD in South Africa seems to be a combination of anti-depressants and cognitive behavioural therapy. There is evidence from recent research in which this combination has proved successful in most cases.

The question of in which gender is OCD more prevalent, and how is OCD interpreted in South Africa within the different cultural groups needs to be researched, which can add to the limited research that has been conducted and documented on OCD in South Africa.

Different Approaches to Understanding and Treating Obsessive Compulsive Disorder

Obsessive-compulsive disorders have been treated more or less successfully by drug therapy, psychodynamic therapy, behavioural therapy, cognitive therapy and systems interventions. A combination of approaches such as drug therapy and cognitive-behavioural therapy has been tried and considered to be most successful (Pato & Zohar, 2001).

The Serotonergic Theory of Obsessive-Compulsive Disorder

According to an old Chinese proverb, *Medicine can only cure curable diseases* Penzel (2000) considers the serotonergic theory as the most widely accepted and most durable hypothesis about the actual mechanism behind OCD. Neurotransmitters are chemicals that help transmit electrical impulses between nerve cells (neurons). Normally serotonin is stored in chambers known as vesicles near the endings of certain neurons. When the neuron is stimulated by an electrical nerve impulse, the vesicles release their serotonin into the gap that typically exists between neuronal fibers. This gap is known as the synaptic cleft. The serotonin then travels across the synaptic cleft and fits into receptors on the other side, on the ends of the fibers of the neighbouring neuron, much like keys being inserted into their locks. This allows the electrical nerve impulse to cross the synaptic cleft and continue on its travel through the brain to its final destination. When the impulse has jumped the gap, the serotonin is then taken back into the vesicles to await the next impulse, and for

the cycle to begin again. This last activity is known as *reuptake*. The serotonergic theory holds that in OCD the serotonin is released into the synaptic cleft, but before the nerve impulse can properly jump this gap, reuptake happens prematurely and a proper electrical transmission between nerve cells does not take place. When this takes place simultaneously at multiple nerve cell junctions, there is a brain dysfunction.

According to the Obsessive-Compulsive Foundation (1998) research clearly shows that the serotonin reuptake inhibitors (SRIs) are uniquely effective treatments for OCD. Medications that increase the concentration of serotonin are Clomipramine, Fluoxetine, Fluvoxamine, Paroxetine, Sertraline and Citalopram.

Fluoxetine, fluvoxamine, paroxetine, citalopram and sertraline are called selective serotonin reuptake inhibitors (SSRIs) because they primarily affect only serotonin. Clomipramine is a nonselective SRI, which means that it affects many other neurotransmitters besides serotonin. This means that clomipramine has a more complicated set of side effects than the SSRIs. For this reason, the SSRIs are usually tried first since they are usually easier for people to tolerate (Pato & Zohar, 2001).

The SSRIs each have potent effects on brain serotonin. Potent effects on brain serotonin are necessary, but not sufficient, to produce improvement in OCD. Serotonin is one of several neurotransmitter chemicals that nerve cells in the brain use in communicating with one another. Unlike other neurotransmitters, its receptors are not localised in a few specific areas of the brain. Therefore, its uptake and release affects mental health, including OCD and depression.

Neurotransmitters such as serotonin are active when they are present in the gap (synaptic cleft) between nerve cells, and the neurotransmitter activity is ended by a process by which the chemicals are taken back up into the transmitting cell. The SRIs work by slowing the reuptake of serotonin, thus making it more available to the receiving cell, and prolonging its effect on the brain. It is hypothesised that this increased serotonin produces change, over a period of a few weeks, in the receptors in some of the nerve membranes. It is also hypothesised that these receptors may be abnormal in patients with OCD, and that the changes that occur in them due to these

medications at least partly reverse the OCD symptoms (OCF, 1999). According to the OCF (1999) patients report marked improvement after 8-10 weeks on a serotonin reuptake inhibitor (SRIs). Unfortunately, fewer than 20% of those treated with medication alone end up with no OCD symptoms. Therefore, medication is often combined with psychotherapy to achieve better results. Psychotherapy may play a significant role in teaching coping skills, addressing co-morbid diagnoses and family issues, treating the accompanying anxiety and depressive symptoms of OCD, and helping improve family relationships (Penn & Leonard, 2001).

The Psychodynamic Approach to Obsessive-Compulsive Disorder

Psychoanalytic theories of OCD attribute symptoms to a disturbance in the anal-sadistic phase of development. A conflict such as the oedipal-genital impulse may lead to regression to use of earlier defenses, including isolation, undoing, displacement, and reaction formation, resulting in ambivalence and magical thinking (Penzel, 2000).

A key feature of psychoanalytic theory is *defence* pertaining to unconscious impulses (Tallis, 1995). The defensive reaction or process occurs in response to a forbidden wish or impulse. In the context of OCD, this is usually of an aggressive or hostile nature. Defence mechanisms have a specific function: to keep unacceptable cognition out of awareness. The purpose of this is to protect the individual from painful emotions, principally anxiety and guilt. However, because defence mechanisms are imperfect, the affect associated with unacceptable thought content may still be experienced. When this happens, further defensive mechanisms may come into operation. It has been suggested that the principal defence mechanism is repression, and it is only in response to its failure that other defence mechanisms are required.

Several secondary defences have been implicated in OCD; however 'undoing' is perhaps the one that is most closely associated with the central feature of 'neutralising'. Undoing refers to an act that is undertaken in order to prevent, or undo, the feared consequence of an obsessional thought or impulse. For example, an individual who experiences the obsessional thought 'My father will die' when turning

off a light, will then feel compelled to switch the light back on as a reparative gesture. Such superstitious behaviour is no doubt reinforced by the apparent efficacy of such measures. Given that it is unlikely that the events anticipated by individuals with obsessional illness will actually happen, reparative measures are proved to be effective on a daily basis, confirming and strengthening underlying superstitious beliefs while disconfirmatory evidence is rarely sought (Tallis, 1995).

Psychoanalytic theory attempts to account for why superstitious thinking arises by suggesting that the psychic apparatus has regressed to an earlier stage of development, characterised by feelings of omnipotence. According to Freud (1909, p. 113) the "overestimation of personal power is a relic of the old megalomania of infancy". The connection between magical thinking and infant cognition is strengthened by the reflections of Freud's most famous obsessional case, the rat man, who suggested that his obsessional illness began in early childhood. At this time, he felt that the occurrence of unacceptable thoughts (e.g. naked girls) would cause his father's death and that he "must do all sorts of things to prevent it" (Freud, 1909, p. 43). Superstitious thinking in the adult is caused by a regression to an earlier stage of development. However where early onset OCD persists into adulthood, magical thinking might be more parsimoniously explained by invoking the more contemporary concept of a developmental delay. Irrespective of the preferred discourse, the overestimation of personal influence causes the individual to believe that by merely thinking something, it will actually happen. If a thought is associated with unacceptable consequences the same inflated personal influence can be employed to 'undo' those consequences (Tallis, 1995).

A further defence mechanism worthy of brief consideration in the context of OCD is that of reaction formation. Overt behaviour patterns and attitudes are formed in exact opposition to underlying impulses. Therefore, the hostile intentions considered fundamental to obsessional illness are 'contained' by the adoption of an excessively non-violent persona.

A critique to the psychodynamic view is that OCD was thought to originate strictly due to a result of a psychological problem. Psychoanalysts believed that obsessions were a type of neurotic defense against unconscious impulses.

Compulsions were thought to be an unconscious way of defending oneself against unacceptable aggressive impulses towards one's parents. This aggression that had to be controlled was supposedly the result of early experiences related to one's toilet training. This theory defies common sense and logic and merely represents pure speculation by Sigmund Freud (Penzel, 2000).

Another critique is that it is debatable whether specific OCD symptoms represent specific intrapsychic conflicts. Esman (1990) described how OCD could be understood as having both biologic and psychodynamic components. The psychodynamic view has not led to an appropriate understanding of the problem of OCD, nor has it produced a viable treatment of OCD. It is the opinion of Penzel (2000) that this theory has led to many sufferers and their families feeling as if they were somehow to blame. Psychodynamic psychotherapy may play a limited role in overall treatment because it has generally not been an effective treatment for younger or older patients with OCD (Hollingsworth, Tanguay & Grossman, 1980). Therefore psychodynamic therapy probably would no longer be considered as first treatment of choice. Also, therapists need to be cautious when psychodynamically treating OCD individuals as a searching, interpretive, in depth approach may exacerbate obsessional thinking (Pato & Zohar, 2001).

The Behavioural Approach to Obsessive-Compulsive Disorder

The behavioural/learning account of OCD is based on Mowrer's (1960) two-factor theory of learning. The preoccupation of OCD individuals according to this approach concerns feared stimuli that have acquired anxiety-producing properties by a process of classical conditioning. The behavioural/learning account suggests that the compulsions provoked by these feared stimuli are escape or avoidance behaviour. According to this account, this behaviour reduces or prevents anxiety and is thus reinforced by a process of instrumental conditioning. De Silva (1987) suggests that the model is essentially one of learned anxiety reduction. In the case of OCD the avoidance behaviour may be passive, for example, not approaching objects that are thought to be contaminated or active, for example, checking for contamination (Pato & Zohar, 2001). An example of OCD escape behaviour is cleaning to remove what is thought to be some contamination.

The model is not altered by the recognition that it is not only anxiety but also other forms of mood disturbance, subsumed under the term 'discomfort', that is reported by some OCD individuals (Rachman & Hodgson, 1980). The maintenance of compulsions is attributed to learned discomfort reduction (De Silva, 1987). Consistent with this, Rachman and Hodgson (1980) have shown that compulsions are often provoked by environmental cues and when OCD patients are exposed to these cues they experience an increase in anxiety or discomfort. It has also become apparent that when these individuals carry out their compulsive behaviour, they often experience a reduction in discomfort.

Behavioural treatment involves the two components of exposure and response prevention. Exposure is based on the assumption that anxiety usually diminishes after long enough contact with something feared (OCF, 1998). The individual is encouraged to enter feared situations, or undertake activities that evoke anxiety, while refraining from the compulsive activities that are usually employed as a means of reducing anxiety. In the absence of anxiety-reduction rituals, the individual is forced to experience and tolerate discomfort, which follows a course of increasing and decreasing intensity. Repetition of this procedure results in habituation of the anxiety response (Rachman & Hodgson, 1980). Habituation is a property of the nervous system, associated with the gradual loss of a reflexive behaviour after repeated presentations of an evoking stimulus. After anxiety has habituated, anxiety reduction rituals become redundant. Any subsequent performance of compulsive behaviour will not be negatively reinforced, leading to extinction of the compulsive behaviour.

The Cognitive Approach to Obsessive-Compulsive Disorder

According to Pato and Zohar (2001) the cognitive approach attempts to change thinking and beliefs directly. Treatment usually involves the identification of inaccurate thoughts, or a particular thinking style, and the demonstration of links between thinking, affect and behaviour. Individuals are encouraged to challenge their inaccurate thoughts, and replace them with more accurate thoughts.

Cognitive therapy strategies can be used in two ways. First, as a means of facilitating traditional behavioural therapy in the form of exposure and response prevention, and second as a means of modifying beliefs that may be central to the maintenance of an obsessional problem.

There are few descriptions of specific cognitive techniques aimed at modifying the appraisals and beliefs that subserve obsessional behaviour. One is by Van Oppen and Arntz (1994) who have provided a concise account of how cognitive therapy might be practised with individuals suffering from OCD.

Van Oppen and Arntz (1994) suggest that a principal focus of cognitive therapy should be the modification of abnormal risk assessment. They recommend a technique described by Hoekstra for the modification of abnormal risk assessments. This is undertaken by first assessing the degree to which the *probability* of danger is overestimated, and second, the degree to which the *consequences* of danger are overestimated. This involves comparing probability estimates of feared catastrophes with probability estimates based on the analysis of event sequences leading to feared catastrophes. The efficacy of Hoekstra's technique is most probably subserved by providing individuals with a *corrective* framework within which to examine the validity of their risk assessments. When the technique is effective, individuals often spontaneously exclaim *you know I never thought about it like this before*. A realisation of this nature is usually accompanied by a concomitant reduction in anxiety.

Van Oppen and Arntz (1994) suggest that although OCD patients may recognise that the probability of a feared event is low, they may still wish to perform neutralising rituals. For many patients with OCD, the fact that an event can happen is sufficient to engender anxiety, irrespective of its low probability. It is therefore necessary for the therapist to focus not only on abnormal risk estimates, but also on what makes the consequences of feared events so unacceptable to the individual. For Van Oppen and Arntz, the issue of perceived responsibility is of central importance.

O'Connor and Robillard (1999) provide a different view to the treatment of OCD. They argue that OCD with overt compulsions, where there is overvalued ideation, is primarily a disorder of the imagination and hence, by implication, psychotherapy should principally address the client's imagination, rather than other cognitive processes. According to this model, the OCD client imagines a state of affairs which is then taken 'as if' it were a reality and does so because of the persuasive influence of an imaginary narrative fiction. This narrative is replayed, often in condensed form, in the OCD context and leads the client into a chain of maladaptive inferences about a possible state of affairs. The client then acts in accordance with what might be present rather than what is actually present. They recommend an inference-based approach that directly addresses and challenges the imaginary narrative of the client. This approach complements other cognitive-behavioural therapy (CBT) and can be used in conjunction with existing CBT methods which focus more on modifying the interpretations and secondary appraisals subsequent to primary inferences.

The Systems Approach to Obsessive-Compulsive Disorder

Systems theory is an approach to knowledge in which a unit is seen as being a subsystem of a larger and more comprehensive system and also seen as being composed of various and smaller subsystems. The person-environment context contains various system levels, such as an individual as part of the family, the family as part of the community, church, school, work and culture. The individual is composed of biological and mental subsystems (Bateson, 1980). There is constant exchange of information between the subsystems and systems. This mutual influencing, moulding and reactions between systems and subsystem is called cybernetics. The feedback may be positive, promoting growth or change or negative, that is, promoting stability. These positive and negative feedback loops work together to maintain the integrity of the system. A unit cannot be studied with having no understanding of how that unit (individual) fits into other larger and smaller systems. This embraces the principle of ecology or the importance of context. One may not understand a problem until one sees it in the context in which it functions (O'Conner & Lubin, 1984).

If an obsessive-compulsive person, for example a housewife who engages in excessive handwashing should consult a systemic therapist, the therapist would immediately contextualise her problem. The therapist may bring into the therapeutic relationship the obsessive-compulsive's husband, children or any significant others that the therapist assumes could influence the symptomatic behaviour. Systemic theory does not disregard the intrapsychic, but from a systems perspective, analysing the individual provides little information about how the individual behaves in different situations. When the therapist speaks and interacts with the individual's significant others he/she would gain an understanding of how the individual is influenced by others, and how other's behaviour influences that individual. The therapist may find that the woman is married to a domineering man, who controls every minute aspect of her life. By engaging in excessive handwashing, she sabotages his control over her and thus gains some control for herself, but without acknowledging this. By behaving symptomatically she is protecting herself, as well as her husband from facing difficulties in their relationship. One may find that this woman's recovery may be accompanied by her husband's eruption into symptoms, or he may even attempt to sabotage her recovery (Haley, 1963).

Systemic therapists comment as they understand the script that is being unfolded in a family with a symptomatic member. It becomes increasingly difficult to discern just who the real symptom bearer is, as everyone's behaviour seems to maintain the symptoms. From the systemic approach the origin of problems is not seen in one person, but in a pattern of interaction maintained by the whole system. Systems theory rejects the linear cause and effect understanding of symptoms as espoused by psychoanalysis, whereby one event (past experience), causes another event (present difficulties). Instead the therapist contextualises the problem and acknowledges everyone's contribution to the state of the symptoms which are embedded in a context of circular causality. In circular causality one cannot discern where the problem started (Selvini-Palazzoli, Boscolo, Cecchin and Prata, 1980). There are complex actions and reactions in a system. Even when individuals gain insight into their problem, they still have to work at a solution that will affect those around them. Their long-standing symptomatic behaviour has led to certain patterns of interaction which they would have to change now, in co-operation with significant others (Haley, 1963).

Symptoms are regarded not as signs of *sickness* but as forms of communication. The child's acting out behaviour may be a masked depression, or it may signal the child's distress at the marital difficulties of his parents. Symptoms may also serve a function in a system. The acting out child deflects attention onto himself and away from the real problem (i.e. the marital difficulties of the child's parents).

The various forms of systemic therapies generally approach therapeutic change on two levels, 1) the different members of the system define the problem along the way and 2) different members of the system define their behaviour especially in relation to each other. The emphasis in systemic therapy is on gaining a new understanding of their individual and social functioning as well as gaining behaviours that do not include symptomatic interaction (Barker, 1992).

A systemic therapist may prescribe a ritual to the family that disrupts the usual patterns of interaction, or the therapist may address the identified patient in a manner that conveys respect and a belief in his or her authenticity as a person. This disrupts not only the usual beliefs about the person who is also the scapegoat in the family, but also models a new way of dealing with this person. By introducing the family to new meanings and behaviours the family gains access to alternative solutions. They are faced with a new epistemology regarding themselves and their functioning as a unit. Whether they have gained insight or not, is not a goal in itself. The rationale is that the changed understanding of their problem and their newer ways of interacting with one another, is more relevant than their past experience or their current insight into their problems (Haley, 1963).

Family Therapy

Impact of Obsessive-Compulsive Disorder on Family and Marital Relationships

OCD can have an adverse effect on family member's quality of life and interactions. Many families become dysfunctional as a result of a member's OCD and the family's involvement in his/her symptoms. Due to families affecting and being affected by OCD, family members often need assistance and direction in how to effectively participate in combination of psychological and drug treatments. Specific

family or marital therapy would be necessary to get family or spouse co-operation so as not to impede treatment of the OCD member (Penn & Leonard, 2001).

The few studies on the effects of OCD on family relationships and family members have methodological limitations, but all suggest a substantial adverse effect.

OCD diminishes the quality of family relationships. Individuals with OCD may ask their family members for example, to avoid being exposed to *contaminated* objects or areas or to wash themselves thoroughly after being exposed, to help in checking stoves or locks for potential dangers, and also ask family members to provide repeated reassurances. Family members may be forbidden by the OCD member to use a certain bathroom or may find most of the house out of bounds because it is filled with hoarded items according to the OCD member. Failure to comply with the OCD sufferer's demands can lead to angry outburst and verbal abuse from the OCD member. Family members, especially parents of individuals with OCD may blame themselves for the presence of the disorder or feel guilty for increasing the OCD sufferer's anxiety or depression.

A study of 19 families with an adult OCD member provides more detail but must be viewed cautiously because of the small sample size of just 19. In a study conducted by Black, Gaffney and Schlosser (1998) more than half the spouses complained of disrupted family and social life, and nearly half cited anger and frustration, family conflicts, and the OCD subject's depression and marital difficulties as problems.

Magliano, Tosini and Guarneri (1996) used structured interview instruments to research burdens experienced by family members among 32 relatives of 32 adult patients with OCD. More than one third of the relatives reported experiencing a moderate or severe burden, including difficulty taking trips or holidays, poor social relationships, and neglect of hobbies. More than half endorsed items such as:

- Feelings of having given up leading one's life as wanted (58%),
- Feelings of not being able to stand the situation any longer (68%)

- Crying or depressive feelings (84%).

The study concluded that the family burden of OCD is not substantially different from that of major depression or schizophrenia.

The Epidemiological Catchment Area (ECA) survey reported that individuals with OCD are more likely to be divorced or separated than individuals without OCD. Whether married individuals with OCD have milder forms than unmarried sufferers has not been determined. At least two studies have reported marital maladjustment or dissatisfaction in nearly half of married OCD sufferers (Koran, 2000).

Hafner (1982) describes the interconnectedness between the symptomatology of 5 women suffering from OCD and their marital interactions. All women became symptom free while hospitalised but relapsed on returning home. While Hafner (1982) was able to identify these interactions, he was unable to shift them due to their extreme rigidity. He defined and clarified the *husband's contribution to the system maintenance* as:

1. *Shifting the Focus of Dissatisfaction Within the Marriage*

In all 5 cases the sexual relationship had been unsatisfactory from the beginning and Hafner (1982) considered that the husbands were unable to acknowledge their contribution to this. The wife's symptomatology rescued the couple from focusing on this.

2. *Role Conflict and Take Over*

From early in the marriage, the husband's mother competed for the wife's role. Later daughters may take this position. This set up a vicious cycle whereby the only role for the wife was as patient (Hafner, 1982).

3. *Husband's Denial of Personal Problems*

Three of the husbands were markedly socially phobic and withdrawn. One husband had unresolved feelings from his mother's death. Four husbands had "abnormal, ambivalent dependency on their mothers" (Hafner, 1982, p. 176).

4. *Compulsory Marriage*

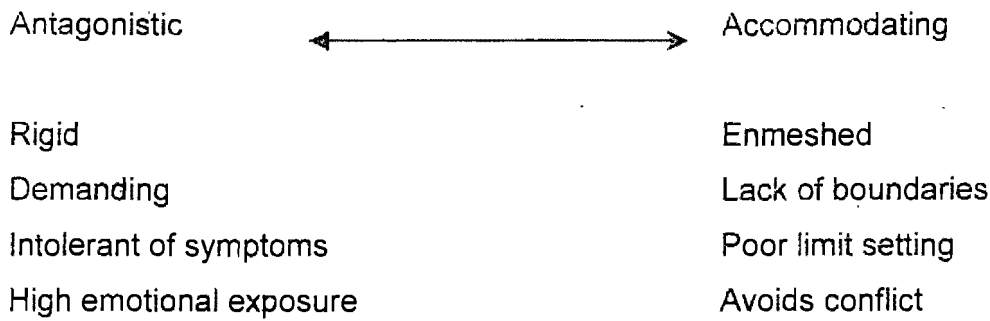
All 5 husbands had threatened to leave their wives but did not do so because they believed their wives would not survive without them. The wives shared this view and feared their husbands might leave them if the obsessive-compulsive symptoms were not present.

These marital systems are so rigid and fixed that Hafner (1982) believes it is impossible to intervene directly to change them. The couples are caught in a bind such that to remove the symptomatology would be to threaten their marriage. Consequently Hafner (1982) has developed *spouse-aided therapy* whereby the spouse is invited to attend the patient's therapy as a co-therapist. "This helps protect the spouse from feeling that she/he is under attack, reduces his/her sense of helplessness in relation to the patient's symptoms and increases the likelihood of constructive involvement in therapy" (Hafner, 1982, p.177). Once the couple is engaged in therapy, their patterns of interaction can be challenged.

Hafner's (1982) paper needs to be viewed in its context of over two decades ago. It could be argued today that he is blaming the spouse and not equally viewing the spouse's stuckness in the system. However, this was a general criticism of family therapy as it was twenty years ago. What is relevant today about his work is his identification of these rigid dependency cycles of interaction that become established around the symptomatic behaviour, similar in some aspects to the vicious cycles that occur with adolescents and their families.

Family Response Patterns

The manner in which members of a family reacts and responds to a family member who has OCD is a reflection of the effect of the impact of the OCD on the family. Family responses to obsessive-compulsive symptoms fall along a continuum of behavioural interactional patterns. This spectrum can be visualised as having two polar opposites of either totally giving in to, and even assisting in the symptomatic behaviour or opposing the behaviour. The extreme positions can be shown as:



A third type of response pattern that is commonly seen is a split family. The family members (usually parents) are divided in their reactions to the symptoms, with one family member at the antagonistic end and one at the enmeshed, accommodating end of the response continuum. A common scenario occurs when family members oscillate in their responses, swinging from one end of the spectrum to the other as frustration and anger toward the OCD sufferer and his or her symptoms escalate. Family members, usually out of frustration that *nothing seems to work*, become inconsistent by trying to participate in the rituals and then trying to cut them off. Most families lie somewhere in the middle of the continuum. Regardless of the family response pattern, both patients and their families often feel confused, angry and anxious (Van Noppen & Steketee, 2001).

Relatives are often uncertain whether the prolonged rituals and constant need for reassurance are really part of an illness or are wilful rebelliousness and demands for attention and control. Such perceptions may influence the ways in which family members respond to or try to cope with the symptoms of OCD. A transactional coping process unfolds in which family responses may facilitate or extinguish obsessive-compulsive symptoms, thereby affecting the patient's functioning. Preoccupation with the needs of the patient and feeling blamed and burdened, family members may pull away from their usual social contacts or work commitments and become increasingly socially isolated themselves. Sufferers of OCD may become impaired if it seems that less is expected of them, but hostile criticism and unrealistic expectations from relatives can also cause undue anxiety (Van Noppen & Steketee, 2001).

Expressed Emotion

Another area of interest in family therapy that links to understanding transactional coping processes in OCD families is the concept of expressed emotion (Van Noppen & Steketee, 2001). Expressed emotion is applicable to the understanding of and treatment approach with OCD sufferers and their families. Based on studies conducted in Britain of families coping with a member diagnosed with a psychiatric disorder, expressed emotion refers to the family relatives criticisms, hostile or over involved attitudes toward the diagnosed sufferer. Conclusion drawn from these studies is that high expressed emotion is significantly correlated with high rates of relapse. Expressed emotion has been found to predict outcome independent of the severity of the disorder which supports the notion that criticism and emotional over involvement are not merely responses to severe symptoms in sufferers (Hooley, Orley & Teasdale, 1986). There is limited research regarding expressed emotion in OCD. In a study conducted by Hibbs (1991) it was found that high expressed emotion was more frequent among parents of children with OCD than among the control sample. Leonard (1993) reported a 2-7 year follow-up study of 54 children and adolescents with OCD in which high parental expressed emotion was the second strongest predictor of long-term global functioning. A study with similar findings was reported by Steketee (1993) who found that negative family interactions such as anger, criticism and relatives' beliefs that the patient with OCD was malingering predicted relapses at follow up.

Family Therapy with Obsessive Compulsive Disorder Sufferers

Hafner, Gilchrist, Bowling and Kalucy (1981) outlined two case studies of adolescents with OCD. Both adolescents had chronic and severe OCD, which had necessitated prolonged hospitalisation and had not responded to a broad range of treatment options that were behavioural. They and their families were engaged in therapy, as it was the last therapeutic attempt before leucotomy. Yet within only a few weeks of family therapy, symptomatic improvement occurred and was sustained during lengthy follow up. Both adolescents resumed a 'normal' and productive life (Hafner et al., 1981). The type of family therapy that was used appeared to be a communication approach. Unexpressed anger between parents was made overt,

which was a frightening and somewhat disintegrative experience for family members. Hafner et al. (1981) noted "there was a direct relationship during therapy between levels of suppressed parental emotion and conflict and the patients' rituals" (p. 150).

Hoover and Insel (1984) studied the families of 10 severe OCD patients. For all their patients the OCD was so debilitating that they were unable to attend work or live away from a care-taking family. They interviewed families, parents of the patient and selected individual members over a period of months. They aimed to look for similarities in interaction styles among these families and contrasted them to the interaction styles of families with a schizophrenic member.

Hoover and Insel's (1984) findings highlighted a dominant grandparent (dead or alive) who was a frequent feature in these families. The grandparents also tended to be substitutes for adequate contemporary social relationships. These isolated family cultures emphasised cleanliness and perfection. They noted severe conflicts within the nuclear family regarding intimacy and closeness. Relationships between parents were described as unfulfilled, disappointing, strained or distant, and unsatisfactory yearnings for closeness tended to be focussed on a child rather than upon the marital partner. Generally one of the parents sought an especially intense involvement with their child (in at least half of these patients, this parent was the father).

Hoover and Insel (1984) also noted striking differences between parents of children with OCD and parents of children suffering from schizophrenia: "Unlike the parents of schizophrenics, who tend to deny their part in their child's illness, the fathers and mothers of our obsessive patients regarded themselves as hopelessly bad parents who had done all the wrong things" (p. 213). They recommended that the OCD patient be given medication, a behavioural regime and family therapy. They believed that the patient must be assisted to leave home and that it was imperative for the parents to receive support during this phase.

Welfare (1993) describes a strategic and systemic approach with a 19-year-old male. Strategic approach is a systems orientated therapy with an exclusive focus on the role of interpersonal communications in the construction of symptoms (Haley,

1963). Strategic approach includes using a plan, or a strategy, for example, humour, and paradox, telling stories or reframing a problem. The use of a strategy often shows the ridiculousness of a symptom and it is assumed to bring about change, or provide new information surrounding the problem (Barker, 1992).

This patient suffered from chronic and severe OCD and had undergone and failed a full range of treatment options with eight different therapists over a period of three years. He was different from the men that Hafner et al. (1981) had described. He had minimal symptoms unless he ventured into studying, in working at a job, or engaging in social interactions. He and his family were clearly entrapped in the rigid dependence cycle of a mentally ill child.

The impetus for therapy came from the father who was about to retire. He was pushing his son to become independent in order to free the parents to live the father's retirement dreams, which is to travel and to live in the country and run a farm. The mother felt she was in a bind. She did not share her husband's dreams but yearned for her own release from the shackles of motherhood. She feared replacing this with the shackles of her husband's dreams. She required her son to be independent in order to regain her own freedom and also required him to be dependent in order not to be engulfed by her husband's vision. The son believed that it was crucial for him to remain at home with his parents, because he feared catastrophic fighting between his parents (who never expressed anger) if he abandoned them. Consequently, any direct attempts by the parents to help the son to get on with his life were met with covert rebelliousness and failure from the son.

Welfare (1993) approached this case by working both individually with the son (focussing on the broader contextual issues) and with the family. The therapy could be classified into 4 main stages that were each important transition points in the process of change:

1. Engagement Issues (the Context of Therapy)

The therapist deemed it important to understand the transactional pattern for engaging in and redefining the context of therapy. When the adolescent son was questioned he was quite open in acknowledging his perception that the therapist was

his father's agent. The son perceived the therapist as attempting to change him in a way that he was initially not willing to change. When the therapist could manoeuvre into a neutral position for change, and reject the role of the father's agent, the engagement could occur between the son and the therapist to create a therapeutic context. The previous therapies had failed at this point.

2. Individuation and Lifestyle Choices (The context of the Son in the Family)

This involved identifying the importance of the son's role in his parents' relationship- 'the intimacy moderator' (Welfare, 1996, p. 142) and neutrally exploring the options of continuing with this role or living with other options. The son's loyalty to his parents was extremely constraining for him to be able to choose other options. The therapist eventually utilised imaginary team members to argue for no change. Ultimately he chose to lead his own life and return to his studies. This actually freed his parents to begin fighting and they were able to clarify their own options.

3. Individuation of Belief Systems (The Individual in Therapy)

The adolescent, while now outwardly individuated was inwardly in a rigid and unbending manner still upholding the ideas and adhering to the values and beliefs of his family. These required challenging and changing before he could be free of his obsessional thinking.

4. Termination

Therapy was long-term covering 3 years (Stage 3 lasting 2,5 years). Consequently termination was a major stage.

The application of systems theory was crucial in freeing this adolescent male from OCD. This is because the previous therapies had failed before they began, owing to their symptom focus (e.g. perception of the illness being a lifelong disorder) and blindness to the important broader contextual issues (e.g. the role of the parents in creating a context for the adolescent son to exhibit OCD symptoms). Stage three could be justifiably labelled by behaviourists as cognitive restructuring and it also involved medication with clomipramine. However, in this case the son was totally incapable to engage in such work until the preceding two stages had been completed.

Mehta (1990) reported that involving family members in psychological treatment for 30 patients in India led to significantly greater gains in OCD symptoms, mood state, and social and occupational functioning compared with unassisted treatment. At follow-up, family treatment patients showed continued improvement, whereas patients treated individually lost some gains. Patients with family members who were not anxious and who were firm were more successful than patients who had anxious and inconsistent family members, especially those that engaged in argument and ridicule.

Group Therapy with Obsessive-Compulsive Disorder Sufferers

Group treatments have proven effective for several patient populations with anxiety disorders. However only a few studies have investigated group treatments for OCD (Epsie & Michelson, 1996). This treatment may hold interest because the group context may offer added benefits for patients with OCD who experience stigma and social isolation or who need the motivational boost of a supportive treatment group.

Social Aspects of Obsessive-Compulsive Disorder

The chronicity of OCD coupled with the intrusive, ego-dystonic nature of its primary symptoms can lead to severe social impairment. Although there has been relatively little systematic research into the social adjustment of patients with OCD, it is clear from clinical experience that it can cause severe distress in the personal and family life of sufferers (Burrows, Norman, Judd, Cornwell, Moore & Tiller, 1991).

Employment prospects may be adversely affected. While traits such as neatness and cleanliness are desirable in most occupations, they can be handicaps if carried to the extreme. Hafner (1988) conducted a survey of 93 patients with OCD showing that employment may have a beneficial effect on symptoms. This study indicated that among women, the 36% in employment scored significantly lower on the Padua Inventory of Obsessions and Compulsions than those not employed. In married women, employment outside the home may have a protective effect on their mental health (Tennant, Bebbington & Hurry, 1982). Rituals may cause employment problems because the inordinate amount of time taken to perform them can lead to

habitual late arrival or slow performance of work-related tasks: washers and checkers are known to have particular difficulties (Khanna, Rajendra & Channabasavanna, 1988).

In some cases the family of some OCD sufferers is unaffected but severely disrupted in others, due to the patient's loss of job, income and social life (Marks, 1987). Rituals may be so severe as to prevent patients contributing to the running of the home. The fear of contamination may force the patient and the family to move house regularly. In less severe cases it may lead to social isolation, because visitors are barred from the home for fear of contamination.

Relatives may also become involved in the patient's ritual. Marks (1987) cite the example of an 18-year-old girl who involved her parents in her bedtime rituals to check that she performed them properly. In other extreme cases children may be forced to remove all their clothing before entering the house for fear of contamination by germs. The consequences of such behaviour for family life can be quite disastrous. The family may refuse to participate in rituals, leading to a constant atmosphere of disharmony and discord. Marital breakdown may ensue as the non-affected partner decides that enough is enough. Children may go uncared for as the patient ceases to look after them, though most children who grow up in such abnormal environments have surprisingly few problems themselves. According to Hafner (1988) a survey of OCD sufferers found that they were significantly more protective than normal parents. This finding is in agreement with another study conducted by Parker, Tupling and Brown (1979) in which social phobics scored significantly higher than normal on both maternal and paternal care.

Cultural Aspects of Obsessive-Compulsive Disorder

Does the prevalence of OCD vary between cultures, and what is the significance of such findings? Writings of early psychoanalysts on the link between toilet training and the development of an obsessive-compulsive character influenced the attitudes of early psychiatric anthropologists. Weston LaBarre's (1946) opinion of the Chinese is that they are as free from compulsiveness about time and performance as they are unobsessive in all the other spheres of their life. He

concluded that OCD is uncommon in China, but more common in the west, where toilet training was more rigid. These speculations are refuted by the Taiwan Psychiatric Epidemiological Project, including 11 000 subjects in Taipei city and local towns and villages, finding a lifetime prevalence rate of OCD between 0.3% and 0.9%.

Berkeley-Hill (1921) described what he termed the anal-erotic factor in the religion, philosophy and character of the Hindus. By anal-erotic factor he means the anus is an erogenous zone. Anal eroticism, according to the psychodynamic view, is about control and retention. Chackraborty (1975) described a normative Indian ritual based on a fear of contamination and a desire to remain clean, known as *Suchi-bai*. Both authors noted the central role of washing and purity in Indian life and considered some normative states to include many sufferers from OCD.

Khanna, Kaliaperumal and Channabasavanna (1990) described OCD as having form and content. Form is the structure of the phenomena, such as fears, thoughts, doubts, urges, convictions, images, repeating, rituals, checking and avoiding. Washing is not included as an independent form, but is included under content, as a version of repeating compulsions. Khanna et al. (1990) define OCD rituals as behaviours performed in a set, precise manner, often felt to have a symbolic significance. Khanna et al's (1990) research focused on whether OCD rituals are more likely to exist in a society with more rituals or does a stable society provide a normative framework for such inclinations? If a culture emphasises exactness, does this encourage pathological expression or alternatively institutionalise and thereby normalise checking and repeating?

Historical accounts provide a view of the interplay between culture, religious ritual and the form of OCD. Roman Catholicism has two sacraments that must be repeated frequently. One is confession, which features, repeatedly in both historical and recent accounts of OCD.

Historical accounts and recent case reports of OCD give the impression that there is a link between normative religious ritual and the form of OCD. Catholics influenced by the ritual of confession have a tendency to compulsive behaviours of

repeating rituals and checking, related to the confession of sins, while Protestants with OCD are less encumbered by rituals and contend with blasphemous urges at prayer time. Both feel guilty about their sins (Greenburg & Witztum, 1994).

Freud (1909) was the first to comment on the parallels that can be drawn between religious ceremony and obsessional rituals. Both can reduce anxiety associated with subjectively perceived moral transgressions, and both serve to ward off catastrophes.

Gaitonde (1958) conducted a study in Bombay and found that all his obsessional subjects were Catholics. Similar findings have been found in Jewish communities. Greenberg (1984) found that half of the obsessional patients attending a psychiatric clinic in an orthodox area of Jerusalem reported experiencing OCD problems related to the practice of Judaism at some time in their lives. With the exception of one patient in this group, the onset of OCD was reliably triggered by increased religious commitment.

Steketee, Quay and White (1991) did not find any specific association between religious denomination and OCD. Obsessional patients were not found to be more religious or guilty than anxious controls. However, the severity of OCD symptoms was positively correlated with religiosity and guilt. Greater religious devotion was associated with more guilt in OCD, but not with other anxiety disorders.

Greenberg and Witztum (1994) are of the opinion that anthropologists and biologically oriented psychiatrists tend to agree that the environment influences the content of a psychiatric disorder. Time and place also alter the content of psychopathology. A conclusion drawn regarding research findings in OCD across cultures (Greenberg and Witztum, 1994) is that dirt and contamination are the commonest topic in all but the Moslem countries. Religion is more common in the Moslem and Jewish populations. Religious topics are more common and cleanliness less common in OCD in Moslem countries.

A study conducted by Okasha, Saad, Khalil, Dawla and Yehia (1994) as cited in Greenberg and Witztum (1994) where the main symptoms among 90 cases of

OCD in Egypt were an exaggeration of the normative ritual of *Al Wodo* in which the five orifices of the body are cleaned three times after using the toilet or after intercourse and before the five-times daily prayer. Pfeifer (1982) has described a normative condition in Islamic communities known as *Waswas* in which preprayer washings continue because the person does not feel clean enough, the opening words and movements of the prayers are repeated because the person does not feel that his concentration is adequate, and at the close of the prayer the person fears he has left words out and must start afresh. The term *Waswas* is taken from a verse in the Koran, referring to the mind being preoccupied with evil thoughts or doubts preventing religious practice. It seems that these behaviours are subsumed under the rubric of *religious topics*, yet they abound with issues of contamination and cleanliness.

Greenberg and Witztum (1994) describe the religious context of symptoms and the content of religious symptoms in a study conducted in Jerusalem. All 34 patients were Jewish, yet they were far from having one cultural identity. Fifty percent of the population of the catchment area were ultra-orthodox Jews and the normative beliefs and practices of this group are described in order to understand the symptoms that they developed.

Greenberg and Witztum's (1994) opinion of the ultra-orthodox Jewish population in Israel is that it is in many ways a culture distinct from the other cultures. Its members guide their lives according to a text known as the Code of Jewish Law (in Hebrew, *Shulkan Arukh*). Their clothing is distinctive, they avoid social contact with people from other cultures, they have minimal secular education and often they do not work but instead spend every day of their lives in the study of Talmud (religious writings). The features of this population that make it valuable for a study of the effects of culture on OCD are the avoidance of contact with secular society and values, the primacy of religious values and rituals, the judgement of failure to comply with normative demands as wrong or sinful, and the penetration of ultra-orthodox religious rituals into the smallest details of daily life.

Of the 34 referrals, 15 were not ultra-orthodox and 19 were ultra-orthodox. Of the 19 ultra-orthodox cases of OCD, six had obsessive-compulsive symptoms only of

a non-religious nature, eight had both religious and non-religious symptoms, while five had only religious symptoms. Considering the exclusion of secular values from daily life and study, it is surprising that there were so many non-religious symptoms.

Of the 13 cases with religious symptoms, prayer was the topic in seven cases, dietary laws in two cases, menstrual laws in two cases and cleanliness before prayer in five cases. There were no other religious topics in this sample, although Greenberg and Witztum (1994) encountered single cases elsewhere of a compulsion for a ceremony to counteract dreams and for a ceremony to annul vows. The compulsive behaviours noted in the 13 cases of religious symptoms were cleaning (seven cases), repeating (six cases), and checking (1 case) and slowness (two cases).

In keeping with the accounts of normative religious behaviour in Islam (Al Woodo and Waswas) and Hinduism (Suchi-bai), the Jewish laws are in each case very stringent in their demands. Nevertheless, most ultra-orthodox Jews will care about precise performance, but will not repeat, and these repetitions will not be at the expense of other observances. The areas of ritual behaviour that were the focus of obsessive-compulsive symptomatology in patients are not central to Jewish ritual practice. They are however, typical of obsessive-compulsive disorder. If the religious context of the symptoms of the patients is ignored, all 13 cases of religious symptoms can be reclassified as concerning dirt and contamination (eight cases), orderliness (six), aggression, including blasphemy (two) and sex (one). It is as if the patients with OCD go through a directory of ultra-orthodox religious practices and 'get stuck' only at the rituals typical of OCD. This is similar to the finding of Leonard, Goldberger, Rapoport, Cheslow and Swedo (1990) that children who go on to develop OCD do not have more pronounced performance of childhood rituals, except in the behaviours of their future symptoms.

The overall impression is that obsessive-compulsive symptomatology does not appear in all areas of religious ritual life, but selects areas typical of OCD in other less ritualised cultures. If the religious setting is ignored, the obsessive concerns of dirt, orderliness, aggression, and sex and the compulsive behaviours of washing, repeating, checking and slowness are typical of OCD.

In conclusion OCD has been found in all cultures that have been the subject of epidemiological study. Obsessions of OCD appear to mirror the prevalent habits and values of a culture. Religious symptoms are common in OCD in cultures in which religious practice and ritual are important. Variations have been noted in the prevalence rate between cultures, although most of these studies have not noted ethnic, religious and urban/rural variations within their samples. The content of OCD does vary according to culture. These observations can be verified only if future samples permit examination of the presentation of cultural subgroups within samples. Then it may be possible to approach definitive answers to the above questions and gain greater understanding of the factors influencing the prevalence, form and content of OCD (Greenberg & Witztum, 1994).

Relationships between Obsessive-Compulsive Disorder and Quality of Life

Attempts to measure quality of life have forced the acknowledgement that the concept is multifaceted and culturally bound. After years of study the World Health Organisation has organised its assessment questionnaire into six broad domains that can be examined cross-culturally: (1) physical, (2) psychological, (3) level of independence, (4) social relationships, (5) environment and (6) spirituality, religion and personal beliefs. Therefore in assessing quality of life a focus should be chosen from global quality of life to one or more domains within one or more dimensions (Skevington, Bradshaw & Saxena, 1999).

Koran (2000) focused on health-related quality of life (HRQL) in adult patients with obsessive-compulsive disorder. Included within this concept are the relationships of health to family, social and vocational functioning, sense of emotional and physical well-being and global quality of life. Stein, Roberts and Hollander (1996) surveyed 200 members of the OCD Association of South Africa with a detailed self-report questionnaire. Of the 75 questionnaires returned, 39 reported OCD symptoms. OCD apparently impaired HRQL in many domains. 55% of respondents reported moderate or severe interference with socialising, family relationships and ability to study, 30% reported moderate or severe interference with ability to work. 40% reported moderate or severe distress from their current obsessions and compulsions. 75% reported a decrease in self-esteem and 50% reported suicidal ideation.

In 1994-1995 Hollander, Stein and Kwon (1997) conducted a questionnaire survey of every fourth member of the Obsessive Compulsive Foundation, which is a US patient advocacy and informational organisation. Responses were received from 701 of the 2670 (30%) members surveyed. Average age of respondents was 37 years, with 55% being women, and 95% were white. Parents, guardians or close relatives completed young children's questionnaires. A similar pattern of impairment of HRQL domains was found. 55% of respondents reported interference with socialising or making friends. For example, 70% noted that OCD caused difficulties in family relationships. Among the respondents who were previously employed, approximately 40% had been unable to work for a time because of OCD symptoms, 38% for more than a year. During periods of unemployment, approximately one fifth of the respondents received disability income payments. The respondents' average career achievement level was below their educational attainment, suggesting impaired vocational functioning. This impairment was evidenced by the disparity between their educational attainment and their income. In the HRQL domain of well-being, 59% reported moderate to severe distress from obsessions and 51% from compulsions. 90% reported lowered self-esteem, half had suicidal ideation. Another indicator of reduced well being was self-reported abuse of alcohol and of other drugs.

Koran, Thienemann and Davenport (1996) conducted an HRQL study of 60 medication-free outpatients with moderate to severe OCD who were enrolling in a medication trial. HRQL was assessed with the Medical Outcomes Study 36-item Short-Form Health Survey, a self-report questionnaire. This questionnaire generates measures of physical domains of HRQL (e.g. physical functioning and role limitations caused by physical health and bodily pain), mental health domains (e.g. mental health [reflecting primarily anxiety and depression], role limitations caused by emotional symptoms and social functioning, and measures of general health and vitality. The researchers hypothesised that OCD would most affect social relationships and instrumental role functioning (e.g., functioning in work, school and homemaking). The hypothesis was confirmed: the subjects' scores for the domains of role limitations caused by emotional problems, social functioning, and mental health were below the norm. The more severe the subject's OCD, the poorer their HRQL in the domain of social functioning, but severity of OCD was unrelated to role limitations caused by emotional problems, even after controlling for baseline severity of

depression. The subjects with OCD had higher scores than did patients with type II diabetes.

Although many treatments are effective in relieving the symptoms of OCD, little is known about the effects of treatment on HRQL. In one study that addresses this question, Bystritsky, Saxena and Maidment (1999) studied change in HRQL in a group of 30 consecutive, treatment-resistant OCD patients treated for 6 weeks in a partial hospitalisation program. The patients were interviewed to complete Lehman's Quality of Life Scale, which was developed to measure HRQL in-patients with schizophrenia. The scale provides objective and subjective (that is, patient satisfaction) measures of activities; health; safety; living situation and functioning related to family, social roles, work and finances. Treatment was associated with significant changes in the objective measures of activities, health and social functioning. The changes in quality of life were only weakly correlated, suggesting independence in these measures of treatment outcome.

Conclusion

An attempt has been made within this literature review to highlight the central tenets of physical, psychological, family systems and other theories regarding OCD. Research findings suggest that many possible factors may contribute to the emergence of OCD and that the aetiology thereof, is multi-determined. Possible etiologic models include parental teachings and modelling; biologic sources, cultural factors, historical experiences, religious teachings, cognitive beliefs and appraisals. Certain common influences with regard to the psychodynamic approach, the cognitive behavioural approach and family systems approach have been delineated. However, it is the view of many researchers and clinicians within the field, that the exact aetiological processes or optimal treatment is a combination of drug therapy and psychotherapy, specifically cognitive-behavioural therapy (Penzel, 2000). Treatment approaches should maintain a balance between the different systems, as opposed to relying exclusively on one approach only.

Given the apparent multi-determined nature of the illness Penzel (2000) states that it is helpful to conceptualise the illness in terms of its predisposition, precipitating

and perpetuating factors. *Predisposing* factors would include the contexts (e.g. the psychiatric history of the family, the structure and power of the family system and cultural rituals) as well as individual factors (e.g. personality and cognitive factors, ego deficits, maturation fears and genetic factors), which lay the ground for the potential emergence of the disorder. *Precipitating* factors include the trigger episode (e.g. puberty, separation, or family tensions) that initiate the disorder within the context of predisposing factors. *Perpetuating* factors include events and situations, which maintain the illness (e.g. the secondary gains of compulsions, or the physical sequelae of obsessions such as, increased preoccupation with feelings of guilt, and decreased self-esteem due to impaired cognitive and interpersonal functioning).

Such a multi-dimensional conceptualisation facilitates a cybernetic approach, in which the patterns and connections between the predisposing, precipitating and perpetuating factors could be taken into account. A multi-dimensional conceptualisation of OCD implies a multidimensional approach to treatment. Conceptual and treatment approaches should take into account the specific factors, which appear to be pivotal in the onset and maintenance of an OCD patient. With regard to the current *state of knowledge* regarding OCD, a vast amount of theoretical and clinical knowledge has been accumulated regarding potential aetiological factors. Further empirical research is however needed regarding the efficacy of combining of different treatment approaches. The effects of OCD on relationships between members of a family and their role functioning may be detrimental to them as well as on the course of the illness. Impaired relationships and functioning may adversely affect the OCD sufferers' rates of seeking help, compliance with treatment and response of treatment. Conversely, when the family is educated about the symptoms and characteristics of OCD, and when the family provides support by participating in treatment programs there may be favourable outcomes (Koran, 2000).

Difficulties in social and family relationships in OCD highlight the need for continuing research into the disorder and its treatment and the need for relatives to be involved in the therapeutic process (Burrows et al., (1991). According to Greenberg and Witztum (1994) it appears that wherever surveys are carried out, OCD is found in at least 0.3% of the adult population. The variation in prevalence rates between different countries and between urban and village populations suggest

that further research could provide important information on factors influencing the prevalence and possibly the development of OCD.

The next chapter is a description of the epistemology that forms the basis of this research. An ecosystemic epistemology guides the researcher in drawing the distinctions around the meanings that the participant of the study attributes to OCD and how this informs her behaviour.

CHAPTER THREE

EPISTEMOLOGY

"Epistemology is always and inevitably personal.

The point of the probe is always at the heart of the explorer.

What is my answer to the question of the nature of knowing?

I surrender to the belief that my knowing is a small part of a wider integrated knowing that knits the entire biosphere of creation."

(Gregory Bateson, 1977, p. 84)

Introduction

Over the past decades there have been growing criticisms levelled at Newtonian, positivistic epistemology for its limitations and impediments (Bateson, 1972; Capra, 1983). Scientists found that they could no longer use their traditional basic concepts, language and way of thinking, which is based on a Newtonian linear-causal, reductionist and objective stance to describe life events. Therefore, theoretical change and movement was inevitable. This resulted in a major shift in *outlook*, a perspective that encompasses a holistic and ecological outlook (Capra, 1983). Capra calls this shift a *paradigm shift* towards an ecological perspective, which is used to describe the world.

A Newtonian linear-causal perspective on the diagnosis and treatment of obsessive-compulsive disorder (OCD) is based on the assumption that any deviation from normal behaviour indicates a disorder. A disorder may be due to known and natural causes and that elimination of these causes results in cure or improvement in the individual (Engel, 1977). The biomedical model, which follows a Newtonian linear epistemology, is reductionist, and anti-contextual. It requires that the disorder be dealt with as an entity, which is independent of social behaviour or relational context.

It states that behaviour aberrations be explained only on the basis of disordered somatic processes (Engel, 1977).

A psychiatric diagnosis from the biomedical model within the Newtonian linear-causal perspective results in the process of ascribing a label to an individual in order to signify the particular pathology and class of symptoms exhibited. This perspective views the individual as the receptor of lineal causal effects and hence the site of pathology (Keeney, 1983). The ecosystemic, post-modern way of thinking not only challenges traditional, scientific Newtonian thinking where discussion of concepts such as *facts*, *neutral observers*, *linear causality*, and *objectivity* have determined the method and style of research, but it also offers a different way of viewing the world.

A description of how the ecosystemic epistemology informed my perceptions and distinctions in defining the focus and aims of this study, in designing the method, and in describing the research participant, will be provided. The tools of an epistemological framework from which to understand and create reality will be outlined. This is followed by the narrative approach because I actualise my epistemology through the utilisation of a narrative approach to therapy.

What is an Epistemology?

Keeney (1982) refers to the term *epistemology* as being used more and more by family therapists. Gregory Bateson referred to his work as epistemology and he often called himself an epistemologist. He is responsible for bringing the term epistemology to family therapy as well as to the other disciplines of biology and the social sciences.

Auerswald (1985, p.1) defines epistemology as "a set of imminent rules used in thought by large groups of people to define reality", or "thinking about thinking". Keeney's (1979) explanation is that one's epistemology leads to particular ways of knowing or arranging data. Furthermore, one's descriptions and maps of problematic situations contain an implicit epistemology. Epistemology is also used in this sense to signify how particular organisms think and know problematic situations (Bateson, 1979).

No model of clinical intervention exists in a theoretical vacuum (Benjamin, 1982). Rather, the clinical intervention is embedded in an epistemology. The epistemology reflects the rules that individuals use for making sense out of their world (Hoffman, 1981). Some body of theory must be drawn on to rationalise how change and learning occurs. As Bateson (1977, p. 84) explains: "all descriptions are based on theories of how to make descriptions. You cannot claim to have no epistemology. Those who so claim have nothing but a bad epistemology. Every description is based upon, or contains implicitly, a theory of how to describe."

Bateson (1972) emphasised that it is important for individuals to be conscious of the frameworks they use, the assumptions on which they are based, and the possibility of logical inconsistency, or what Bateson (1972) calls *pathologies of epistemology*. This is echoed by Apthekar (1989) who says the therapist has a responsibility to be aware of his or her own epistemological premises and to be truly part of the therapeutic process. "We have to believe in the value of our own experiences and in the value of our ways of knowing, our ways of doing things" (Apthekar, 1989, p. 254). It is thus important to examine one's personal framework and personal set of assumptions about reality.

It is important to explore the language and concepts which are used in this chapter and in the interpretation of descriptions. It is through language that social interaction is mediated, and it is through social interaction that meanings are developed. It is also through language that distinctions are drawn, the flow of events are punctuated and stories are told which shape our world and thereby give it meaning (Anderson & Goolishian, 1987). Also, basic to understanding epistemology is the idea that what one perceives and knows is shaped largely by the distinctions that one draws. The concepts described below, reflect my framework and epistemology and serve as markers for those reading this text as to how this research is punctuated.

Principles of an Ecosystemic Epistemology

According to Keeney and Sprenkle (1982, p. 6) "ecosystemic epistemology attempts a nondualistic conceptualisation of cybernetics that recognises complete

circuits or whole systems, rather than isolated parts. This perspective avoids any over-emphasis upon dualisms between individual and family, identified patient and therapist, symptom and context, behaviour and interactional pattern, lineal and cybernetic, pragmatic and aesthetic that may overshadow the connectivity of whole systems". A therapist is always viewed as part and parcel of the unit of treatment; both are connected as parts of a complete cybernetic circuit.

Ecosystemic epistemology is based on systems theory, cybernetics and ecology which implies that it is attuned to holism, relationship, complexity and contextual interconnectedness (Keeney & Sprenkle, 1982). It involves seeing patterns of relationships in which parts are embedded within the whole rather than dividing the world into dualisms. It prescribes a way of seeing events as organised by recursive feedback processes and is a way of seeing and describing the patterns that organise events (Keeney, 1983).

Keeney (1983) identifies the most basic tools of epistemology. The first of these tools is the drawing of a distinction. The process of drawing distinctions involves making observations and from these observations individuals draw further distinctions in an effort to describe what they have observed. This leads to the concept of recursion, which is the second epistemological tool. The other tools of epistemology are to create news of difference, to be self-reflective and to process feedback.

Drawing Distinctions

The fundamental act of an epistemology, of how one comes to know what one knows, is by drawing a distinction. The purpose of drawing a distinction is to distinguish the *it* from the *background* that is *not it*, or distinguishing a thing from its background (Keeney, 1982). In the process of distinguishing a thing from that which it is not, one creates a difference, and it is this difference that gives useful information about the nature of that which one seeks to describe.

In ecosystemic theory, what one perceives and knows about the world always follows from drawing a distinction. This is a recursive process meaning that what one

draws, one observes, and vice versa (Keeney, 1982). Therefore, reality as a realm of things, is brought forth by an observer who makes distinctions in language (Maturana, 1988). Thus, reality is not singular but comprises multiple versions. The implication of this for therapy and research is that therapists and their clients/participants mutually construct a shared reality through the distinctions or punctuations they carve (Keeney, 1983).

Events can be patterned or organised in countless ways depending on how the observer chooses to see them. This implies that by drawing distinctions, dualisms/polarities, or relationships are created. By looking from the both/and perspective, ecosystemic epistemology represents seeing the complementarity of things, which is a nondualistic perspective of dualistic, individual, group and other phenomena.

News of Difference

Bateson (1979) states that distinctions imply a relationship, a difference or change, to which the observer responds. The sensory and the mental system only operate with events that imply difference. The mind can only receive news of difference. In the therapeutic context new meanings are generated when new information becomes part of the interaction between the therapist and client (Keeney, 1983). News of difference according to Bateson (1972) is only meaningful if it fits within the relationship context. If the information fits within this context the therapeutic system is able to perturb the meaning system in order for new meanings to be generated. New information has the capacity to perturb the system while new meanings bring change to the therapeutic process which give new meaning to the meaning of the problem as well as the previously tried solutions. Keeney (1983) calls the adding of new meaningful elements in the therapeutic process, the adding of meaningful noise. These new meaningful elements can arise from the client or the therapist's world or the one that they have created together.

Objectivity in Parentheses

The term *objectivity in parentheses* as described by Maturana and Varela (1987) indicates that no objective reality exists. Multiple realities is a reality available to us. Different people view reality differently. The therapist and client and the client's family members do not view the impact of OCD in the same manner. Objectivity is put in parentheses by Maturana and Varela (1987) since there is no objective way to view obsessive-compulsive disorder. A multi-verse as opposed to a uni-verse is then described as different ways of a described reality. One statement is not more valid or true than the next and one description of the drawing is not more valid than the next. Each person who observes and experiences will see and feel something different from the next and will punctuate experiences in different ways.

Recursion

For Keeney (1983) the concept of recursion is used to denote "repetition, recurrence, circularity, cybernetics, redundancy and pattern" (p.58). Recursive descriptions define an item in terms of its relationship with other items. Implications of recursive processes are that the therapist can no longer be seen as unidirectionally *impacting* on the client or family through techniques. The therapist becomes neither the agent of change nor is the client a subject. Both are part of a larger field in which the therapist, family and any number of other connected elements reciprocally interact upon each other.

Self-Reference

Ecosystemic epistemology points to the observer's inclusion in that which is observed, thus emphasising the self-referential nature of any and all descriptions. It thus follows that the therapist/researcher is seen as part of the therapeutic/research system. The ecosystemic perspective provides us with a view of self-reference for how we participate in the construction and maintenance of our experiential universe. Taking on a position of self-reference is a higher order process in which the therapist does not throw away the pragmatic advantages gained by a first-order view. Instead,

the pragmatics of simple cybernetics is contextualised by a perspective that brings the therapist fully into therapy (Watzlawick, Beavan & Jackson, 1967).

What we perceive is largely due to the distinctions we draw (Bateson, 1979; Keeney, 1983). The descriptions of these distinctions reveal as much of our properties as those of the observed (Keeney, 1983). This interpretation implies that therapists can neither assume an expert position nor have unilateral control over the system they are observing. Boscolo et al. (1987) refer to this as the observing system rather than the observed system. For Von Foerster (1981) there is an inextricable link between the observer and that which is observed. He argues that it would be impossible to make any descriptions if the observer were not to have properties that allow him to generate such descriptions.

Semantics and Politics

How do the *meanings* that people attribute to lived experience inform their behaviours? Bateson's (1979) idea is that the behaviour of each individual is in some way consistent with the behaviour of every other individual in the system. "The ideas of each family member lead him to behave in ways that confirm or support the ideas of every other family member" (Bogdan, 1984, p. 376). People's behaviours are consistent with the ideas or meanings they attribute to events. According to Keeney and Ross, (1992) all kinds of human communication address both the semantic and the political frame of reference. They define a political frame of reference as a sequential pattern of behaviour whereas the semantic frame of reference refers to the meanings given to the sequential patterns of behaviours (Keeney & Ross, 1992). Keeney and Ross see the relation between the semantic and the political frames of reference as recursive, which means that each frame can be seen as a part of the other frame. Therefore, the semantics (meanings) cannot be addressed without also looking at the patterns of behaviour (politics).

In this regard I, in the capacity as both the researcher and the therapist together with the participant will co-construct the meanings attributed to OCD, and the patterns of behaviour that are consistent with these meanings.

Feedback

Central to the interweaving of Nirvana's story within this study are the notions of feedback and co-construction. Keeney (1983) defines *feedback* as the method of regulating a system's operations, by means of reinserting into it the results of its last action or performance. Feedback may be seen to operate, to stabilise, regulate, and keep a system's behaviour within certain acceptable parameters (Keeney, 1983). Bateson (1972) noted that corrective action is activated by difference between the current state and the preferred state of the system. Therefore, those behaviours that fall outside the acceptable limits may be corrected through feedback. Such systems endure because of their ability to self-correct (Keeney, 1983).

There is more than one level of feedback. The process described above is often referred to as simple feedback. There is then by implication, a feedback of feedback which controls or governs feedback loops between systems (Keeney, 1983). "All simple and complex regulation as well as learning involves feedback", (Keeney, 1973, p. 67). The different contexts of learning and change are principally concerned with altering or establishing feedback. Therapy requires the creation of alternate forms of feedback, which will provide an avenue for appropriate change. The aim of therapy, for Keeney (1973) is the attempt at creating alternative forms of feedback, which provide suitable paths to change.

Structural Coupling

Two systems are considered to be unable to influence one another directly. However, in the process of interacting together they are considered to couple structurally, forming a larger self-regulated system in the process (Fourie, 1996b). In other words, by coupling structurally, systems are able to mutually co-exist. Becvar and Becvar (1996) explain that organisms generally survive by correctly fitting with one another and with other aspects of their context, and will probably die if that fit is insufficient or inappropriate.

Although systems couple structurally they remain organisationally closed from one another (Fourie, 1996b) and thus their interactions continue to be determined by

their individual structures (Becvar & Becvar, 1996). As long as systems fit or couple, their reciprocal perturbations trigger structural changes in one another (Maturana and Varela, 1987) such that they may each begin to think and behave differently. These ideas are coherent with Bateson's (1979) contention that "information consists of differences that make a difference" (p. 109).

The process of structural coupling occurs when individuals become structurally coupled through sharing ideas (that is, verbal and non-verbal communication) (Anderson & Goolishian, 1987). Each system attributes meaning to the words and behaviour of the other system, meanings which are determined by the perceiving system's structure (Fourie, 1996b). The meanings attributed by the recipient may or may not be what the communicator intended to convey.

The notion of structural coupling prevents constructivism from being mistaken for a solipsist *anything goes* approach whereby all (constructed) realities are considered to be equally valid (Fourie, 1996a). Von Foerster (1981) points out that reality is a frame of reference that can be consistent for at least two observers. Even though each individual creates a slightly different reality according to his or her own unique biological makeup, such as experiences, and attitudes (Becvar & Becvar, 1996), our ideas about the world are largely shared ideas, shaped by culture and language (Hoffman, 1985). This means that the validity of a particular reality is determined by the way it fits with the beliefs, attributions, and presuppositions of the people participating in its co-creation (Fourie, 1996a). Bogdan (1984) says that a process of confirmation facilitates the fit of one person's ideas to those of another person. Therefore, when we believe something to be true, any event that is interpreted as compatible with that belief tends to strengthen our conviction of its truth (Bogdan, 1984).

When the above ideas are extended to the domain of therapy and research, one realises that the therapist and researcher is unable to describe any therapeutic and research situation without including themselves in the description, and that "different couplings cause different, but compatible, worlds to emerge" (Elkaim, 1990, p. 69). Therefore, if the constructions co-created by members of the therapeutic system present a solution to a problem, it means that they happened to fit with the

ideas and meaning systems of those members. This means that consensus was co-created (Elkaim, 1990).

Language and the Construction of Meaning

For Maturana (1975) language is not to be found in the brain but rather in the interactions through structural coupling with other structural beings in the environment. He defines a linguistic domain as "a domain of consensual behaviour ontogenically established between at least two structurally plastic organisms" (Maturana, 1975, p. 320).

Language arises simultaneously through (a) a complex and structurally closed nervous system that allows for recursive interactions, (b) internal and external nervous system perturbations, and (c) a social domain, which simultaneously perturbs the nervous system. It is through the relationship between the social domain and the nervous system that language emerges.

Maturana (1975) further argues that language, as a biological phenomenon does not take place primarily in the head, but rather in the community. It requires the intimate communal contact that permits complex patterns of living to evolve and to be passed on from generation to generation. Language also creates the illusion that things really do exist without our inventing or making them. It creates the illusion that we can stand outside ourselves and observe. Thus language also creates the illusion of the observer (Efran, Lukens & Lukens, 1988).

Reality (meaning) is constructed through the distinctions we make in language, and it does not exist prior to language (Dell, 1985). However, language (verbal and non-verbal communication) not only enables us to make distinctions, but also to take action based on these distinctions, such as to describe or interpret our constructions (Anderson & Goolishian, 1987). In this regard, Maturana (1975) argues that language is based on human action, namely, "the co-ordination of co-ordination of behaviour" (Loos & Epstein, 1989, p.154). Another way of explaining it is that language arises from the reciprocal structural coupling of members of a system (Dell, 1985) who evolve a consensual domain through an ongoing process of mutual

perturbation of one another's ideas and behaviours (Maturana, 1975). In this sense, language both modifies and is modified by experience (Anderson & Goolishian, 1987). It is important to note that although consensual domains denote consensus about certain matters, agreement is not necessarily forthcoming; nor are consensual domains static, since ideas and actions are continually evolving through ongoing reciprocal perturbations. These ideas suggest that meaning is dialogically constructed and intersubjective and always changing (Anderson & Goolishian, 1987).

This perspective is shared by Bateson (1972) and expressed in his related concepts of *mind* and ecology of ideas. Bateson (1979, p. 101) defines mind as "an aggregate of interacting parts" which is triggered by difference, resulting in transformations of the preceding events/experiences which are also referred to as *ecologies of ideas* (Anderson, Goolishian & Windermant, 1986). Mind is found in communication networks, it is a process and not something inside a person's skull (Loos & Epstein, 1989). Ecologies of ideas are the shared linguistic discourses through which our actions are co-ordinated to derive co-created realities and thus meaning (Anderson et al., 1986).

The Importance of Being in Language

Maturana (1988) attributes to language processes all those qualities considered most human about people. For instance, language makes possible a sense of self and the phenomenon of self-awareness. It permits all of us to distinguish a world of separate things and events. As human beings operating in language we are able to become observers of our own evolving circumstances and can engage in the sorts of self-examination processes that characterise psychotherapy (Efran & Fauber, 1995). Explanatory schemes, comparisons, meanings, and future plans are all constructed in language along with the perspective of time and the lineal concept of cause and effect. Without language there is only the silent here and now of our immediate experience (Efran & Greene, 1996).

In the light of this information, the research participant's idea about her experience of OCD will be dialogically co-created in this study through the epistemological lenses of both the participant and myself.

An exposition of the narrative approach to therapy will be provided next, and the way in which the epistemology is actualised through the utilisation of a narrative approach to therapy will be described. I played an active part in the co-creation of narratives, by intervening and attempting to re-direct processes.

A Narrative Approach to Therapy

Stories serve to organise experience by bringing together episodes, actions, accounts of actions, time and place, and thus providing a sense of connectedness or coherence and temporality (Sarbin, 1983). Stories have a beginning, middle, and an end. Although these are not necessarily discrete stages they need to link accounts of events or actions in a sequence that is meaningful to another through time (Gergen & Gergen, 1983).

Michael White's narrative approach holds several ideas about problems and how people experience and solve them that are unique in post-modern theory. White (1991) believes that the narratives we live by are not neutral, as they come from a dominant culture. Stories are never a-contextual, culture or value free. However, stories are always historically negotiated and constructed within the context of the social structures and institutions, which surround the participants (Epston & White, 1992). Narratives have specific effects on individuals and influence the way that they lead their lives. This does not mean that there are good and bad narratives. However, for some people dominant cultural stories have restrictive effects on their lives and interactions. Cultural stories are never neutral, and there is a strong canonical dimension to them in that they are co-authored by members of the community. These dominant cultural knowledges act to influence what is deemed acceptable or not, and to sustain a particular worldview (Hare-Mustin, 1994). These cultural stories "lead to constructions of a normative view, reflecting the dominant culture's specifications, from which people know themselves and against which people compare themselves" (Zimmerman & Dickerson, 1994, p. 235). Through their interactions with the culture, their stories of who they are become rigid, with the cultural story often determining how they should be as well. These stories are formed in conjunction with others through social interaction, and the individual's sense of self arises through discourse with others. It is the others who help the individual develop any alternative new story

through continual renegotiations and therefore become a member of the individual's "community of co-authors" (White, 1995). In this study, I, as therapist and researcher, am one of these others who helps Nirvana to develop an alternative story. By continual renegotiation I am becoming a member of Nirvana's co-authors.

In therapy, clients have always been encouraged to tell their stories. Therapists have relied on client narratives. Psychoanalysts treat narratives as the "materials" of analysis to be examined for clues to unconscious conflict, which the analyst would interpret for the client. Cognitive therapists listen to narratives to identify and point out logical errors to the client. Behavioural therapists look for evidence in narratives of why planned reinforcement programs fail to produce expected consequences. Modernist therapists armed with "expert knowledge" comment on the client's inadequacies and replace the client's story with what is taken to be a more accurate representation of reality but may well be the therapist's own story (McNamee & Gergen, 1992). Often the client's telling of his or her story is considered a necessary precursor to therapy.

It is only recently that the telling of the story per se has been recognised as having therapeutic value in and of itself. Constructive and narrative therapies rely on the "narratory principle" (Sarbin, 1983), that "humans think, perceive, imagine and make moral choices according to narrative structures" (p. 8). Constructive therapists recognise that individuals shape experience through narrative meaning (Polkinghorne, 1991). Individuals know themselves and their world through the stories that they tell (Neimeyer, 1995). "The individual is simultaneously the writer, the written, and the literary critic" (Goncalves, 1995, p. 197). One's stories confer meaning on one's past and give direction to one's future (Polkinghorne, 1991).

Narrative work relies on language. Riikonen and Smith (1997) wrote extensively about the significance of words in narrative practice. "Each word is like a railway station, from which many places can be reached. Many things can be reacted to, many paths can be chosen" (Riikonen & Smith, 1997, p. 19).

Narratives of many different sorts provide the content or data of this study. This is coherent with the shift in focus from behaviour and structural systems to

meaning systems. According to Bruner (1986) the key elements of a narrative, could be viewed as a *story* (the systematically related sequence of events), a *discourse* (the medium such as conversation, in which the story is manifested, and a *telling* (the action, the communicative process that produces the story in discourse). Narratives are never isolated or static but are always in process and represent conversational consensual domains and language for making the self intelligible, for specifying relationships with others and for co-ordinating social practices.

Narrative therapists adopt a narrative approach to organise and describe the work that they do (Hoffman, 1993). They adopt a post-modern worldview to better reflect their understanding that knowledge is multiple and context-dependent (Hare-Mustin, 1994). For Sluzki (1992) the practice of therapy represents a special case of the narrative form. Sluzki considers the complex ecology of narrative that constitutes the social world to be an important, core concept of the second-order, constructionist approach to therapy.

According to Weingarten (1998, p. 4) a "narrative approach provides a context for listening at the level of the word to the possibilities for a story to pivot at any point. From a narrative perspective, it is the participant's knowledge that must be brought forward, illuminated and amplified". The narrative approach of *thought* focuses on the particulars of lived experience. Lived experience is the *vital* consideration, and the links between different aspects of lived experience are the generators of meaning (White & Epston, 1990).

In the course of telling and re-telling one's story, in the course of listening and being listened to, in the course of responding and being responded to with thoughtfulness, care and compassion, the narrative assumes alternatives to the troubling story, and the problem-saturated story is deconstructed (White & Epston, 1990). The narrative approach, is acutely attuned to the plotting and unfolding of events through time, and acknowledges the contextual embeddedness of co-created meanings. Within specific contexts there is a beginning and an end to a story, which implies the passage of time.

The narrative approach views an individual as a protagonist or participant in his/her world. There is a world of interpretative acts, a world in which every retelling of a story is a new telling, a world in which individuals participate with others in the *re-authoring* and thus in the shaping of their lives and relationships (White & Epston, 1990). The narrative approach redefines the relationship between the observer and the client. Both *observer* and *client* are placed in the *scientific* story, in which the observer has been accorded the role of the privileged author in its construction (White & Epston, 1990).

Russell and Van den Broek (1992) have presented a three-dimensional model of narrative structure, emphasising (1) the structural connectedness of narratives, (2) the representation of subjectivity in narratives and (3) the elaboration/complexity of narratives. These three dimensions have characteristics of narrative structure that produce information about an individual's experience. For example, the way in which individuals employ and interconnect events through devices as the definition of event categories and of causal and temporal relationships, provides information about the interrelationships between events, and suggests how the events impact and influence the individuals psychologically to provide a coherent understanding of their lives.

"There are two main classes of structural variables (the first dimension of the model): *first*, abstract event categories (for example, setting, initiating event, internal responses, attempt, consequence and reaction) that employ the content of the narrative, and *second*, abstract sets of relations, such as temporal and causal ones, that connect the events in the different categories" (Russell & Wandrei, 1996, p. 323).

Subjectivity which is the second dimension of the model, has been called "the landscape of consciousness" by Bruner (1987, p. 20). This dimension is about the way in which individuals construct and qualify their psychological relation to the events being talked about. Linguistic markers of subjectivity in a narrative provide information about the individual's intention. This information is important to the therapist who is assessing how individuals portray their relationship to concrete events and episodes in their life, and the level of reflective awareness that people can attain in understanding their own activity.

The third dimension is about the type and level of language that individuals use in constructing their narratives. When attention is directed to the third dimension the questions that should be asked, are if the narratives are multi-episodic or restricted to single episodes. This dimension provides information about the complexity or poverty of individuals' experiences, and their level of knowledge about their dominant narratives (Russell & Wandrei, 1996).

It is important at this point to make the distinction, however subtle it may seem, between *narrative* and *discourse* since they are used almost interchangeably. According to Hare-Mustin (1994) the term *discourse* refers to those practices which serve to sustain a particular worldview. Discourses constitute or produce social interaction but are also constituted and produced through social interaction, and influence what can be said, thought and done (White, 1991). They specify what is said as well as *how* it is said, and importantly what remains unsaid. The *how* is achieved through the influence on the type of languaging as well as the acceptable use of language. *Discourse* places emphasis on the non-linguistic or non-verbal aspects of communication (Hare-Mustin, 1994).

There is a strong link between the notion of established societal myth and dominant discourse/narrative. For the purposes of this study the myths that surround an obsessive-compulsive individual have been approached in this way. Myths can possibly be seen as dominant narratives which serve to shape the way that Nirvana has come to experience herself as an individual who suffers from obsessive-compulsive disorder.

The deconstruction of these dominant narratives is one of the aims of this study. Discourses and narratives co-exist in a landscape of competing narratives and there may be narratives that are silenced or limited and constrained in their degree of expression (Hare-Mustin, 1994). According to Hoffman (1990) these stories remain unsaid and unexpressed. For example, the narrative that dominates public perception concerning OCD sufferers is that these individuals have a mental problem, or a chemical imbalance. This perception does not allow for the expression of their story.

According to Foucault (1976, p. 216) discourses exercise their influence in society to “avert its powers and its dangers, to cope with chance events, and to evade its ponderous awesome reality”. He argues that individuals experience the positive effects of power by generating knowledge practices that define their world, and which have improved and eased the burden of living. It avoids the negative aspects of control, but that individuals are nonetheless subject to the influence of this power through its normalisation of truths that shape our reality (Foucault, 1976).

Power and knowledge are inseparable according to Foucault (1976) since it is an endeavour through which people’s lives are shaped. In most cases, this is achieved by laying claim to objective truths and by the accessing of a singular reality. The truths of which Foucault speaks are not positivistic, tangible realities, but rather those constructions and stories that are accorded truth status through co-created claims of global truth. These are then internalised and accepted as part of their storying process (Epston & White, 1992). People are isolated in their experience of this subjugation to the dominant discourses, and exercising of power (White, 1991).

According to Foucault (1976) discourses operate on the principle of exclusion, eliminating contradictory or troublesome descriptions, and subjugating those discourses that do not fit the frame of the dominant discourses. If the point of intervention in subverting these dominant narratives, and allowing the expression of all narratives, without prejudice at the level of taken for granted realities and assumptions, then that indicates a deconstruction of dominant narratives. It is the very realisation that the individual’s dominant narrative does not account for the entirety of lived experience that brings him/her to therapy (White, 1991).

The process of therapy is involved in the eliciting of those stories, which are not given a voice. Meanings are deconstructed and explored to find alternative feedback paths or unique outcomes which facilitate change (Keeney, 1983). Change entails the shifts in attribution of meaning, which people might undergo through altering feedback loops, and which alter the way in which they experience their world.

This study has set out to facilitate this shift in meanings within Nirvana by questioning the process of storying or meaning generation, which has left her feeling

depressed. By highlighting incidents where the dominant narratives were seemingly silenced, and by creating contexts in which this can happen again, meanings were altered in a way which proved all the more effective because this happened in a context where it could be commented on.

Letter writing

We are all storytellers, and the story that consumes us the most is the one we tell ourselves about our own lives. Therapeutic letter writing can change the inner dialogues that underlies the unspoken dramas that we act in our minds and help us negotiate a new relationship with the other and with ourselves.

(Penn, 1991. p. 45)

Australian family therapist Michael White and New Zealand family therapist David Epston have pioneered in the therapeutic use of letters to help clients through the process of re-storying or re-authoring their dominant narratives. According to White and Epston (1990, p.125) "letters constitute a medium rather than a particular genre and as such can be employed for any number of purposes". In a therapy involving the use of storytelling, letters are used primarily for the purpose of rendering lived experience into a narrative or *story*, one that makes sense according to the criteria of coherence. In a storied therapy, letters become a version of the co-constructed reality in therapy. Letters can therefore be substituted for case records.

According to White and Epston (1990, p. 107) "written means to therapeutic ends need not always be extensive. Short letters can be invaluable to persons in their struggle to take their lives and relationships away from the problems they find so troublesome". In the light of the above I also engaged in letter writing to Nirvana. Nirvana, is socially relatively isolated. She has difficulty identifying her sense of self, and constantly questions her existence. Her existence as a person of worth is rarely recognised by others. For her, receiving mail addressed to her by name constitutes a major acknowledgement of her presence in the world.

Deconstructing the Domestic Story

When a client identifies with a narrative about questioning his/her identity and loses sight of alternative descriptions of self, then the client comes to take ownership of the narrative. This process of taking ownership is supported by the narrative culture. To separate clients from problems, White (1989) has developed a procedure he calls "externalising of the problem" for it is "not the person who is, or the relationship that is, the problem. Rather, it is the problem that is the problem" (p. 6). Through *externalisation*, clients are enabled to name their problems and attain some distance from them in order to examine how the problems influence them and how they influence the problems.

According to White (1991) the process of *deconstruction* involves exoticising their domestic story. That means objectifying the familiar story to facilitate the reappropriation of the self by externalising conversations rather than internalising them. By entering into an external dialogic space in which the relationship between the client and the personal and cultural stories is mapped, the client is placed in relationship to these stories. This is done by mapping the influence these problematic stories have on the clients' lives in real terms, since they are not abstractions, but influence life decisions. It involves exploring how these stories have influenced their view or perception of themselves and their relationships. The way in which the client was recruited into policing herself and adopting these problematic stories is also discussed. Once the client is no longer captured by the problem, the client becomes an observer of the process. The client may be able to describe, examine and comment on the unfolding narrative and not be affected by it as he/she usually is. The client can give a name to the narrative such as, "obsessive-compulsive girl". The client enters another discourse from the problematic narrative to view the latter more clearly. The client can then begin to identify unique outcomes, times when the problem is not present and preferred thoughts, feelings and behaviours, ones that she can examine without attachment. Based on these exceptions to the problem, further alternative discourses can be developed and named. The client is then oriented to those stories which contradict the dominant narrative, and which allow for exploration of unique outcomes (nodal points which allow for re-authoring) and shifts in meaning (Epston & White, 1990).

These *unique outcomes* are the gateway to alternative stories and meanings (Epston & White, 1990) and provide the individual with alternatives to the pathologised stories, which shape experiences. The clients allow for the meanings by which they have lived their lives and occupied roles, to be altered in a way, which allows more relevant meanings to be generated. These unique outcomes, or points of meaning shifts, are necessary if the influence of these dominant narratives is to be altered, and other stories allowed a voice.

As White has described, clients can use these narratives to resist the overwhelming pull of the problematic story. When a client is describing or engaged in a unique outcome, the old problematic story is absent and the new story helps the client resist the pull to restore the old one. Soon the new one becomes the familiar narrative, supplanting the old one, giving the client a fuller range of experiences.

Goal of Therapy

According to Romanoff (2001) narrative approaches view the therapeutic process as a facilitated journey wherein the telling and mutual understanding of the client's story will enable a new co-constructed story to emerge. Although the outcome or goal of therapy is not known at the outset, the expectation of change is an explicit part of the therapeutic contract. Narrative is the vehicle for change.

The Role of the Therapist

According to Weingarten (1998) the narrative therapist does not take an expert position. He/She is no longer the expert who knows how families can, or should solve their problems. While the therapist does possess expertise, that expertise is not used to put the therapist in a one-up position in relation to the client. Instead, the therapist is a fellow traveller, dedicated to listening as carefully as possible to the stories clients tell about their lives. The therapist thus enters the conversation attending to the client's words and stories about his/her experience. "If the therapist takes an objective role at all, it is as a literary critic deconstructing the text, articulating the thematic subtext, or promoting development" (Goncalves, 1995, p. 247). The healing is in the intersubjective re-authoring of the story (Neimeyer, 1995).

For a narrative therapist, there are no *true* stories, no fixed *truths*, no master narratives (Freedman & Combs, 1996). A narrative therapist is generally uninterested in conversation that tries to flesh out the causes of problems. Instead, the narrative therapist is interested in conversations that generate many possible ways to move forward once a problem is defined. Narrative therapists and clients co-construct preferred narratives that fit the individuals' lived experience. Finally a narrative therapist is present in the interview in a very different way, in a way that allows the therapist to consistently share her thinking about what she is thinking (Weingarten, 1992).

Consistent with a side-by-side relationship the therapist has to find ways to comment and acknowledge clients' abilities. Clients are steered in therapy to become aware and realise their possible choices and solutions out of their own experience (Weingarten, 1998).

According to Anderson and Goolishian (1990) people live and understand their living, through socially constructed narrative realities that give meaning and organisation to their experience. It is a world of human language and discourse. Anderson and Goolishian (1990) explain this narrative position according to the following:

- Human systems are language generating and meaning generating systems. Communication and discourse define social organisation, thus a social-cultural system is the product of social communication. Human systems are linguistic systems and are best described by those participating in them. The therapeutic system is such a linguistic system.
- Meaning and understanding are socially constructed. One does not have meaning and understanding until one takes communicative action, thus engaging in some meaning generating dialogue within the system for which the communication has relevance. A therapeutic system is a system for which the communication has a relevance specific to its dialogue exchange.
- In therapy any system is one that has dialogued around some problem. The system will be involved in evolving language and meaning specific to itself, to its organisations, and to its dis-solution around the problem. The therapeutic system is a system that is distinguished by the evolving co-created meaning,

the problem, rather than an arbitrary social structure, such as a family. The therapeutic system is a problem organising, problem dis-solving system.

- A therapeutic conversation is seen as a linguistic event that takes place in therapy. This conversation is a mutual search through dialogue in which new meanings are continually evolving towards the dis-solving of problems, and thus, the dis-solving of the therapy system and hence the problem-organising problem-dis-solving system.
- The therapist is seen as a conversational artist of the dialogical process. The therapist is a participant-observer and a participant-facilitator of the therapeutic conversation.
- The therapeutic art is exercised through the use of conversational or therapeutic questions. This question is the instrument to facilitate the development of conversational space and the dialogical process. The therapist uses expertise in asking questions from a position of *not knowing* rather than asking questions that are informed by method and that demand specific answers.
- Problems that are dealt with in therapy are actions that express human narratives in such a way that they diminish our sense of action and personal liberation. Thus, problems exist in language and problems are unique to the narrative context from which they derive their meaning.
- Change is caused by the dialogical creation of new narrative, and therefore the opening of opportunity for new action. The strength of narrative lies in its capacity to re-relate the events of our lives in the context of new meaning. People live in and through the narrative identities that they develop in conversation with one another.

Thus human action takes place in a reality of understanding that is created through social construction and dialogue. These socially constructed narrative realities give meaning and organisation to ones experience (Gergen, 1982). This social constructionist approach assists the client to move from being influenced by problem dominated narratives to preferred narratives (Zimmerman & Dickerson, 1994). In using the narrative metaphor the focus is on a story and conversation in general to generate specific questions in order to create a re-authoring context

(Epston and White, 1992). A narrative metaphor uses experience as a primary variable. Thus there is a shift from people's relationships as the object of therapy to their stories about their relationships as the object of therapy stories (Zimmerman & Dickerson, 1994).

The Ecosystemic Link to a Narrative Approach

In striving to make sense of life, individuals face the task of arranging their experiences of events in sequences across time in such a way as to arrive at a coherent account of themselves and the world around them. Specific experiences of events of the past and present and those that are predicted to occur in the future must be connected in a lineal sequence to develop this account. This account can be referred to as a story or self-narrative (Gergen & Gergen, 1983). Bateson (1979) argues that all information is necessarily *news of difference*. This means that it is the perception of difference that triggers all new responses in living systems. He also demonstrated how the mapping of events through time is essential for the perception of difference, and for the detection of change. The success of this storying of experience provides individuals with a sense of continuity and meaning in their lives, and this is relied upon for the ordering of daily lives and for the interpretation of further experiences.

A number of focuses of narrative therapy are central to the theory of ecosystemic theory. *First* is the observation that patterns of interaction within the family and the wider social network may predispose family members to have problems or maintain these problems once they occur. *Second* is the observation that family life cycle transitions and crises may precipitate the onset of problems for individual family members. *Third* is the observation that therapy which involves both the individual with the problem and significant members of the family and social network is an effective approach to ameliorating many difficulties. *Fourth* is the notion that therapy is not haphazard but is guided by certain hypotheses about the most useful way to proceed. A challenge for narrative therapy is to incorporate these into its practice (Carr, 1998).

Criticisms of the Narrative Approach

One of the pitfalls of the narrative approach is that a narrative can never encompass the full richness of our lived experience:

"Life experience is richer than discourse. Narrative structures organise and give meaning to experience, but there are always feelings and lived experience not fully encompassed by the dominant story," (Bruner, 1986, p. 143).

The structuring of a narrative requires recourse to a selective process in which clients' experience feeling hurt, from their experience, those events that do not fit with the dominant evolving stories that they and others have about them. Therefore, over time and of necessity, much of their stock of lived experience goes un-storied and is never *told* or expressed (White & Epston, 1990).

However, some of the advantages of engaging in narrative therapy are:

Firstly, an individual's experience is situated in the flow of time which can reflect change.

Secondly, various interpretations and different meanings of the complexity and richness of stories can be accommodated. Stories tend to be inclusive and as a result enrich events in individuals' lives. "Narratives allow for lived experience to be construed in lived time and rendered eventful by being plotted into a story" (White & Epston, 1990, p. 126).

Conclusion

The ecosystemic approach is very challenging and requires a lot of insight into my own values and ideologies. It requires me as a researcher to be aware of myself as far as I can be aware of my own ways of doing, seeing and believing. This approach requires me to be constantly consciously aware of myself (Becvar & Becvar, 1996). It is not easy to understand that people do what they can do according to their own structure, to the extent of being so perfect and logical within their context. The ecosystemic approach "challenges beliefs and practices in traditional mental health practices and research" (Becvar & Becvar, 1996, p. 346).

The framework presented in this chapter exemplifies a collaborative and respectful therapy, in which I co-constructed and co-authored alternative narratives that open opportunities for change and growth. The epistemology that was discussed is representative of critical shifts that are now occurring more generally in the context of psychotherapy (Friedman, 1993). These current transformations in thinking emphasise my role as researcher, as a co-participant in a meaning-generating process that is both hopeful and empowering. This means that the ecosystemic therapist prescribes to the following:

- Believes in a socially constructed reality
- Emphasises the reflexive nature of therapeutic relationships in which researcher and participant co-construct meanings in dialogue or conversation.
- Co-constructs goals and negotiates direction in therapy, placing the participant back in the driver's seat as an expert in his/her own life.
- Maintains a belief in the power of therapeutic conversation to liberate previously unacknowledged voices or stories.
- Searches for the participant's strengths and resources and avoids pointing to pathology or focusing on rigid diagnostic distinctions (Friedman, 1996).

In this chapter the epistemology and theory that guides my actions as a researcher and the constructions of ideas around OCD were described. This chapter has set the stage for the link between theory and method. The next chapter is a description of the method that I employed to describe Nirvana's system within the context of her life.

CHAPTER 4

METHOD

*How can we create ways of relating research stories
that allow the tellers (us) and our constructing processes
not to be eliminated from the tale?*

(Steier, 1991, p. 164)

Introduction

The process that I shall follow to create ways of relating research stories without eliminating myself and my constructing processes from the tale, consists of qualitative research within a naturalistic paradigm. The method I chose for this study is one that is consistent with the underpinning of ecosystemic epistemology, which forms the basis of this research. Qualitative research generally makes different assumptions about the nature of reality and it has different research objectives. Qualitative research is usually equated with a new way of thinking about the world. This new way of thinking about the way that individuals make sense of their world is consistent with the ecosystemic epistemology. According to Moon, Dillon and Sprenkle (1990, p. 358) qualitative research reflects a phenomenological perspective and researchers "attempt to understand the meaning of complex events, actions and interactions in context from the point of view of the participant involved", and to understand phenomena in a holistic way. This study therefore aims to explore Nirvana's experience of living with a diagnosis of obsessive-compulsive disorder, which will be presented as a story. The exploring will be reflected in Nirvana's story by using a qualitative research method, since it provides a rich source for the process of data collection.

Method of Data Collection

*Qualitative research can be seen as a process of systematic inquiry
into the meanings which people employ
to make sense of and guide their actions.*

(McLoed, 1994, p. 50)

For this study interviewing Nirvana, and recording her story were the methods for collecting the data. By using qualitative methods of collecting the data reflexivity, self-awareness and empowerment of both the participant and the researcher are promoted. By involving both the participant and the researcher in the study, a voice is given to the participant to tell her story in her own words (Grafanaki, 1996). Nirvana perceives herself as an individual with an obsessive-compulsive disorder (OCD), and she will be given an opportunity to tell her story surrounding her understanding and experience of her disorder. Nirvana's story will be recounted by myself as the researcher through Nirvana's eyes.

The qualitative approach is selected as it is particularly insightful when inquiring about people's experiences (Maione, 1997). Qualitative research is essentially different to traditional quantitative research, especially with regard to the conceptualisation of constructs such as reality, truth, knowledge and objectivity. From this perspective there is no single reality existing autonomously *out there* (Moon, Dillon & Sprenkle, 1990). Instead, reality is regarded as co-created, and it is considered to exist in multiple forms within people's minds. Furthermore, reality is regarded as something that continuously changes from moment to moment and thus cannot be regarded as a static entity. Within the qualitative paradigm, it is understood that multiple kinds of knowledge can be obtained through a variety of methods (Gergen, 1985).

An aspect that is characteristic of qualitative research is the emergent and unpredictable nature of the research process and the research results. The research process therefore evolves as the therapeutic process evolves. The qualitative research design has an impact on both the researcher/therapist and on the

participant because of its dynamic and changing nature (Munhall, 1988). Therefore, the focus of this type of research is on the process of interaction between the researcher/therapist and the participant.

"Like systems theory, qualitative research emphasises social context, multiple perspectives, complexity, individual differences, circular causality, recursion and holism. Qualitative methods provide an avenue for examining the experience of therapy from the perspective of the participant rather than from the more typical research perspectives of the therapist and/or researcher" (Moon, Dillon & Sprenkle, 1990, p. 364). The qualitative method is thus the preferred method for investigating Nirvana's obsessive-compulsive disorder and her experience from her perspective and within her domain rather than from my perspective as the researcher.

This type of research also includes self-reflexivity. Self-reflexivity is an essential activity by both researcher/therapist as well as the participant. The researcher and the research material can therefore never be separated and the relationship between the researcher and the participant needs to be described. Hammersley and Atkinson (1983) concur that there is no possible separation of the researcher from the material researched. One of the underlying focal points of this study is to explore and understand the reciprocal effects of the researcher's participation in the ecology of therapy. This study is also based on the premise that social inquiry is reflexive and is founded on the human capacity for participant observation.

A Naturalistic Research Paradigm

"We can only do research *with* a person, if we engage with them as a person" (Reason, 1994, p. 10). In this study the researcher therefore intends to do research with a person. Subjects in this research paradigm are called 'participants' (Moon, Dillon & Sprenkle, 1990) because of the active and egalitarian roles they play in the research process. It therefore follows that research in this paradigm "acknowledges the self-referential nature of the research process and outcome" (p.360). In line with the naturalistic paradigm, the researcher refers to the person with whom she does research as a *participant*.

A qualitative researcher in psychotherapy is part of the process and not just an external observer. A researcher thereby affects and is affected by the interaction. Therefore qualitative research is best understood as an active process and cannot be seen in isolation from the culture, the context and the participants involved (Hutchinson & Wilson, 1994). One cannot observe without participating. According to Keeney (in O'Connor & Lubin, 1984, p. 30) "Heisenberg's famous Uncertainty Principle states that the observer constantly alters what he/she observes by the obtrusive act of observation." Furthermore, in a world of multiple co-constructed realities, where there is no absolute truth, we are continuously engaged in negotiating and re-negotiating our realities. This does not preclude the researcher, but rather, highlights her ethical responsibility to explicitly set out her subjectivity during the design and throughout the implementation of the research. Even as the research unfolds, so too may the subjectivity of the researcher. The researcher is engaged in an ongoing process of explicitly readjusting the setting out of her subjectivity.

Nirvana and myself are the primary data-gathering instrument. The reason for this being that the human instrument is able to adapt to the multiple realities being constructed in the research process, and the human instrument is also capable of grasping and evaluating the meaning of each interaction (Lincoln & Guba, 1985). It is therefore imperative that my role as researcher is clear, and that all my assumptions (ways of punctuating) and biases are made explicit when reporting the qualitative findings (Moon et al., 1990).

Lincoln and Guba (1985) comment that the human instrument is preferred as opposed to open-ended questionnaires and other 'artificial' instruments. It would be impossible to devise a priori, a non-human instrument with sufficient adaptability to encompass and adjust to the variety of realities that will be encountered. Although all instruments interact inherently with participants, it is only the human instrument that is capable of grasping and evaluating the finer meaning of interaction. The intrusion of instruments intervenes in the mutual shaping of other elements, and that shaping can be appreciated and evaluated only by a human being that is flexible. All instruments are value-based and interact with local values but only the human instrument is in a position to identify and take into account those resulting biases (Reason & Rowan, 1981).

Within this paradigm the existence of multiple constructed realities is acknowledged. For the nuances in these realities to be appreciated the researcher needs to draw upon her intuition, tacit knowledge and the use of self-dialogue. It is then very important to remain aware of one's own internal frame of reference in as much as it influences one's way of knowing and understanding the nature, meanings and essences of human experience.

Lincoln and Guba (1985) describe tacit knowledge as "all that is remembered somehow, minus that which is remembered in the form of words, symbols or other rhetorical forms. It is that which permits us to recognise faces, to comprehend metaphors and to know ourselves" (p. 208). It is knowledge that we cannot verbalise. Wynne (1988) comments that implicit beliefs will guide what the researcher attends to in particular situations and the conclusions that she will draw. I am therefore using tacit knowledge to guide me through the research process. I am also going to use my intuition as to what is going on, and what further questions should be asked. Thus, the use of my tacit and propositional knowledge, as well as being aware of my own values, together with the reflexive nature of the research process, makes this combination an indispensable part of the research process.

Propositional knowledge is knowledge gained through past experience that can be stated verbally or in propositional form (Lincoln & Guba, 1985). Thus, any information that we can bring into awareness, information that can be made explicit, is referred to as propositional knowledge.

My values will therefore intrude into the arena of tacit knowledge. Values refer to a criterion that one brings into play, implicitly or explicitly, in making choices or designating preferences, and includes both personal and social or cultural norms (Reason, 1994). It is therefore important that I as the researcher am aware of my values, so that the manner in which they may influence the research process can be made explicit.

It is also important for me to be aware of the reflexive nature of my questioning. Within the research process, both the researcher and participant mutually influence each other. It is in this process that their respective values, beliefs,

attitudes, morals and tacit knowledge come into play, since they become salient, whether implicit or explicit, within an interaction.

Reflexivity refers to a questioning of one's own thoughts and ideas, an application of one's own concepts to oneself. It is a process whereby one becomes aware of one's own response to another, where one is cognisant of the reciprocity between oneself and the other. The researcher needs to apply her own theory to herself, to understand how she may influence the participant and how the participant may be influencing her in turn (Lincoln & Guba, 1985). This fits well with the ecosystemic paradigm's understanding of how the researcher's own punctuation, her constructed realities and 'subjectivity' would influence any enquiry, and it demands that the researcher reports her interpretations of self-referentiality.

The above process will help to create a story, which will portray the qualities, meanings and essences of the unique experiences of Nirvana. Descriptions of the experience of OCD will be sought, along with an ability to see and understand it in a different way. This research allows the researcher to reach deeper regions of the human experience of OCD and come to know or understand its underlying dynamics more fully. The researcher proposes to look for, and lift out, the essential meanings of the experience for the participant.

The above process will require me to recognise my self-awareness, value my own experiences, rely on my resources and accept whatever opens channels for clarification on the topic. Fitting in with the requirements of ecosystemic self-referentiality, I also need to indicate my contributions to the study findings in terms of thoroughly describing the process of selecting and formulating the research question, describing the data collection methods, implementing the analytic techniques and effecting the writing (Kaniki, 1999).

Qualitative methods rather than objective measuring devices are appropriate to humanly implemented cues such as speaking, listening, observing, interviewing, and observing non-verbal communications. The research process consists of successive and recursive repetition of four elements, namely, purposive sampling, inductive analysis of information obtained from the sample, development of grounded

theory and a projection of the next steps in a constantly emergent design (Lincoln & Guba, 1985).

In naturalist investigations, the purpose of sampling is to include as much information as possible, with the focus on detailing the many aspects that give a context its unique characteristics (Lincoln & Guba, 1985). A second purpose of sampling would be to generate the information upon which the emergent design and grounded theory can be based and the research focus then be addressed (Lincoln & Guba, 1985).

Grounded theory, that is, theory that follows from the contextualised findings, is a necessary consequence of the naturalist paradigm. In addition, the naturalist paradigm incorporates the idea of using theory that is applicable at a specific time for a specific research context. This viewpoint enables multiple realities to be posited. An *a priori* theory would not be able to predict the many realities that the researcher may encounter when carrying out the research, nor would it be able to take into account the various factors that could impact at a local level (Lincoln & Guba, 1985).

Qualitative research designs are fluid and require the researcher to make choices throughout the process (Polkinghorne, 1991). From this perspective, it is evident that the *design* of this research is an evolving one that emerges from the interactions between the researcher and the participant within a particular context. These interactions are not predictable beforehand, as the results of a mutual interaction cannot be predicted until they actually occur. All of these features together point to the indeterminacy of research in the naturalistic paradigm, such that research becomes an unfolding process, co-evolved between researcher and participant (Lincoln & Guba, 1985).

When the process has unfolded, the outcome of the research is negotiated with Nirvana. I am liable for checking that I understand her correctly and/or that both Nirvana and myself have a similar understanding of the research outcomes. The reason for this is that there will be no misinterpretation or incorrect assumptions made.

Legitimisation of Knowledge in a Naturalistic Research

According to Atkinson and Heath (1987), those who read this research will establish whether my findings are credible. It is actually the "community of consumers of research" according to Atkinson, Heath and Chenail (1991, p. 163) who establish the trustworthiness of the study by deciding whether they understand the reasoning that leads to the researcher's constructions, establishing whether these are feasible against their own perceptions of *reality*. Lincoln and Guba (1985) and Atkinson and Heath (1987) agree that the legitimisation of knowledge is the responsibility of the consumers of the research, and they propose that the readers of the study be given full access to the process of research so that ethicality can be maintained. In this study the consumers or 'stakeholders' may include the supervisor, collaborators, colleagues, readers and examiners.

Reason and Rowan (1981) maintain that "the validity of research is much enhanced by the systematic use of feedback loops, and by going round the research cycle several times" (p. 247). The paradigm axiom of negotiated and collaborative inquiry also implies that the researcher's own activities are as much open to observation as those of the participant. Furthermore the structure and variables of the research are defined and may be altered by dialogue between researcher and participant (Guba & Lincoln, 1988).

Establishing Credibility

In this study credibility will be enhanced by the employment of several measures. The first step that is taken to enhance credibility is the examining and acknowledging of personal biases and preconceptions regarding the research. This is done by outlining my theoretical and epistemological frame of reference with regard to the research process and research material. This is regarded as relevant because I as a qualitative researcher view bias as unavoidable and therefore as something that needs to be admitted instead of avoided (Maoine, 1997).

Credibility is further enhanced by what Lincoln and Guba (1985, p. 313) call "referential adequacy". This involves obtained data being made accessible to the

reader in the form of transcribed audiotape recordings and process notes. Actual transcripts are available upon request.

Member checks, which are regarded by Lincoln and Guba (1985, p. 314) as "the most crucial technique for establishing credibility", are also employed in the course of this study. This is done by verifying the obtained data, analytic themes, interpretations and conclusions with the participant. The process by which Nirvana checks the data occurs continuously throughout the course of this study, while checking the analytic themes, interpretation and conclusions occur continuously towards the end of the research process.

Accountability

By engaging in qualitative research, the researcher realises that she is accountable to the participant to which the research results will be presented. The researcher also has the responsibility of following certain procedures, which will make it likely that the readers will be able to assess whether her findings are legitimate. The researcher needs to state how her constructions will be co-created (Keeney & Morris, 1985). This implies that qualitative researchers retrace the distinctions they created in co-constructing a *reality* so that the reader can understand how the researcher arrived at her conclusions (Atkinson & Heath, 1987). Keeney (1983) agrees with this by stating "to understand any realm of phenomena, we should begin by noting how it was organised, what distinctions underlie its creation" (p. 21).

Focussing on collaborative research provides a rationale for feedback according to Guba and Lincoln (1988), for when the research is carried out independently of the participants' constructions it seems to generate alienated half-truths, exploits the persons it studies and the value agenda in the inquiry remains unchecked. For ethical reasons the researcher therefore bears equal responsibility to the participant, who should be given back their co-created notions and not be treated like subjects.

Linking Qualitative Research and Ecosystemic Epistemology

According to Wassenaar (1987) epistemology is concerned with the cognitive operations involved in acquiring knowledge. Therefore, an epistemology underlies every research approach that is used in an investigation.

Ecosystemic epistemology specifies that observers actively participate in constructing their observations and that the act of observing influences what is observed (Atkinson & Heath, 1987; Hoffman, 1990; Keeney & Morris, 1985). Observation is always theory-laden and self-referential, and according to Keeney and Morris (1985, p. 549) qualitative approaches represent "a shift from a monological paradigm in which the observer is not allowed to enter his descriptions, to a dialogical paradigm in which descriptions reveal the nature of the observer". Consistent therefore with the constructivist view that all observations are self-verifying, qualitative research sets out to generate new theoretical principles (Keeney & Morris, 1985).

The coherence between qualitative research and ecosystemic epistemology is evident in their emphases on social context, recursion, self-reference, whole systems and multiple realities (Atkinson & Heath, 1987; Sells, Smith & Sprenkle, 1995). In descriptive and qualitative research, the whole self-referential system includes the researcher, the research participant, and the research problem in simultaneous recursive interaction (Keeney, 1979). From an ecosystemic view, the two separate systems comprising the researcher and research participant come together to form a new and larger composite system.

In qualitative research, open-ended exploratory interviews are used with the intention of generating rich descriptions and emergent themes (Sells, et al., 1995). Research results are not 'facts' representing a fixed reality. Consistent with an ecosystemic perspective, they are social constructions co-created by both the researcher and the participant in the flow of an evolving conversation in a particular social context (Hammersley & Atkinson, 1983).

Because I, as the researcher am working within the frame of a narrative approach to therapy, it is important to show the link between research and narrative therapy.

Linking Qualitative Research and Narrative Therapy

Kvale (1992) says when emphasising knowledge and the creation of meaning over the *discovery* of broad generalisable truths that exist in an observable reality, the lines between research and therapy are blurred as both come to rely on narrative methods as an important source of data (Polkinghorne, 1992). However, narratives are not only important and fruitful sources of information, but they are also powerful agents of change in both psychotherapy and perhaps in research endeavours (Romanoff, 2001).

Narrative methods are increasingly recognised as valid research tools and sources of data in the human sciences (Romanoff, 2001). It is therefore useful to compare the functions of the narrative in research and therapy settings. In both contexts, a narrator tells his/her story to a listener. Narrative refers to both the products (the story that is told) and the process (the act of telling).

All narratives are socially constructed, and the story that is told is a “co-constructed product of the interaction between person, the subjectivity of the person serving as the object of inquiry, and the subjectivity of the researcher and therapist are intertwined” (Rennie & Toukmanian, 1992, p. 241). Both research and therapy involve a mutual engagement of the other, linked by the narrative. The stories that interest social scientists are often narratives about the self, in which the interaction between the participants is often intense and laden with emotion.

There is much similarity and overlap between the narratives generated in research and therapy. However, the goals of narrative research and narrative therapy are fundamentally different. The goal of narrative therapy is to “enlarge the domain of experience” (Neimeyer, 1995), to help the client to a “different place from where she began” (Efran & Clarfield, 1992, p. 202). However conceptualised, the goal of therapy is change. At some point in the encounter the therapist interacts *orthogonally* to the

client's frame, *changing the rules* and thereby opening up the system to new possibilities (Efran & Clarfield, 1992).

In research, the goal is not change but understanding human behaviour and finding meaning. Research participants are asked to educate the researcher about their lives. The researcher as interviewer enters the participant's life in order to understand the participant's constructions of experience. Intrusions are not planned for therapeutic effect. The researcher asks broad, unstructured questions so as not to impose her own constructions on the interviewee's experiences. Where constructions differ, meaning is negotiated. The researcher empowers the participant to tell her story with minimal constraint, by inviting her into the research as a collaborator, and allowing her narrative to unfold. The researcher believes that data collected in this manner best represents the participant's truths (Mishler, 1986).

Change is implicit in the research process in other ways as well. Even the agreement to participate in this research demonstrates therapeutic change, as the participant agreed to a line of questioning because she wanted to help other people in a similar position. The telling of her story then becomes a means of healing with an altruistic goal.

The form of the research interview resembles the therapeutic stance in narrative therapy where co-researchers explore in order to find meaning in the text of a life. Although the purposes of the processes differ and should be clearly stated, in practice narrative therapy is investigative research and interview research is often therapeutic (Romanoff, 2001). To conclude this discussion of the link between research and therapy, by conducting narrative research, the lines between therapy and research blur. The process of answering my questions changes the answer as Nirvana constructs her story. The process also changes the research question, since I, as the researcher and Nirvana, as the participant co-create new meanings.

The Role of the Researcher

A story that is told in a research interview is a co-constructed product of the interaction, as it is in therapy. According to Romanoff (2001) researchers therefore need to be acutely sensitive to their role in shaping the telling and in shaping the story that is told. The researcher should be a skilful listener, a "master of the art of conversation" (Goolishian, as cited in Lax, 1992, p. 74), using herself as a tool to direct the flow of the interview in the face of strong affect (Marshall & Rossman, 1995). The researcher must listen beyond the words for the meaning and recognise that which is unspoken (Romanoff, 2001).

Sampling and Selection

The Research Participant

Nirvana's participatory and reflexive characteristics of her involvement in the study were carefully explained to her (e.g. she would be asked to describe as fully as possible her experiences and to reflect on and discuss her reactions to these experiences both at the time they occurred and at the present time). Nirvana was informed that the interviews and therapy sessions were also for research purposes. She agreed to participate and granted permission for the interviews to be audiotape recorded and transcribed. Confidentiality was assured in that her identity and actual contributions in the form of interviews and letter writing will remain anonymous. Only I, as the researcher will work with the raw data of the study.

Each interview lasted approximately 1 hour. Full verbatim transcriptions are produced from the audiotape recordings of the interviews and the relevant comments will be included in the discussion section.

The interviews are conducted in such a manner that they resemble a conversation rather than a formal questioning session. This is done in order to facilitate collaboration between Nirvana and myself. Interviews are thus flexible and informal and are allowed to progress spontaneously in order for rich descriptions and emergent themes to be generated (Sells, Smith & Sprenkle, 1995). Conversations

are then listened to and transcribed. These transcriptions are studied for emerging themes upon which follow up sessions with Nirvana are conducted. The purpose of the follow up sessions is to clarify certain aspects of the related experiences and to further enhance collaboration between Nirvana and myself. Nirvana and I thus co-create a "shared domain of meaning" (Anderson & Goolishian, 1990, p. 162) through the various epistemological distinctions drawn by both of us (Keeney, 1982).

Data Collection

Single Case Study Method

Pugh (1998, p. 259) states that the "case study method is particularly well suited to making sense of the process of change in therapy. It facilitates the detailed examination of the complexity of problems that an individual presents in therapy and of the nature of change resulting from interaction and communication between client and therapist". A two-fold emphasis is maintained. Firstly, the emphasis is on myself, as the therapist, working with Nirvana the patient as a unique individual in such a way that would facilitate personal growth and the development of her potential. Secondly, the emphasis is on myself as the researcher, trying to capture the process of how change occurs in therapy for Nirvana, who is one particular client, as well as for myself as therapist. I therefore take on the dual role of therapist and researcher in order to examine the process of change in therapy.

The case study method is preferred, as it is believed to be more accommodating to a description of the multiple aspects of reality of Nirvana and myself. This method provides an opportunity to present the data by means of the constructions that are used by Nirvana. In other words, attempts are being made to provide readers with a glimpse of Nirvana's world through her own eyes. This is done by providing information through the use of her own language. According to Lincoln and Guba (1985) the uniqueness of the ecology of a specific individual can only be captured satisfactorily through the use of the case study method.

Furthermore, the case study method is preferred, as it is believed to have the potential to provide a thorough description of contextual information (Lincoln & Guba,

1985). The case study can therefore be an effective tool for portraying the specific nature of the interaction between Nirvana and myself. By providing readers with a vivid, lifelike description of a specific case, they are provided with an opportunity to draw distinctions on the basis of their own interpretations, which permit an assessment of transferability. As Lincoln and Guba (1985, p. 359) state: "The reader has an opportunity to judge the extent of bias of the inquirer, whether for or against the respondents and their society or culture." The case study method can also be particularly useful in uncovering the variety of mutually shaping factors imbedded in the research process (Lincoln & Guba, 1985).

Clarkson (1995) suggests that therapy research should become a way of working with every client and he advocates that therapy and research should be conducted as a simultaneous and ongoing process. This therapy/research is carried out by myself only, and therapy and research are occurring simultaneously.

Storytelling

Storytelling is an ageless art. People have told stories for centuries to entertain, to preserve history, and cultural values, and to teach. Many have also used stories to promote change (Gordon, 1978). In this case Nirvana's story will hopefully promote change for Nirvana and provide me with an understanding of herself.

Psychotherapy also promotes change, and consequently many therapists use stories in therapy. Thomas (1995) believes it is easier for clients to access their internal, untapped resources indirectly rather than through direct intervention by a therapist. Rosen (1982) viewed therapeutic stories as ways of teaching clients values and self-discipline and of helping them to learn by experience. Many therapists tell stories to indirectly induce change in their clients.

The field of family therapy has recently re-discovered the use of stories with its interest in post-modern thought. With the shift from action to meaning, language has become a more central focus for many therapists. Anderson and Goolishian (1988) suggest that co-created *therapeutic conversations* with clients dissolve their dilemmas by shifting the meanings of these dilemmas. Similarly, White and Epston

(1990) propose that changing the meaning of life events changes a client's behaviour. They assume that clients live their *dominant narratives* (stories). White and Epston (1990) help clients re-discover alternate, subjugated stories that have been suppressed by the dominant story. When the therapist helps an alternate narrative to emerge, clients change their behaviour accordingly. This *re-authoring* process according to White and Epston (1990) is started through the editing of the internal stories that guide client's lives.

Case studies are in essence narratives or stories that have been constructed in the therapeutic process. Freeman (1993) states that stories are shaped by what the author edits out of the story. According to Zimmerman and Dickerson (1994) in the process of creating stories, people look backwards for memories and information that support the dominant story.

Conducting Interviews

Interviewing is a flexible way of gathering qualitative data that is detailed and personal (McLoed, 1994). By conducting interviews as the main source of data collection, I had an opportunity to interact with Nirvana at a personal level. Face to face interviews promoted the building of a *research alliance* between Nirvana and myself. During the research interviews I needed to be fully present and engaged in what Nirvana was sharing with me.

As McLoed (1994) had stated, I quickly learnt that qualities like active listening, accurate understanding, warmth, acceptance and genuineness are of major importance in encouraging and promoting a good rapport between Nirvana and myself.

According to Grafanaki (1996) the researcher's degree of sensitivity and respect towards the research participant affects the depth and the quality of the interview and the material shared. This sensitivity is portrayed both in the manner and in the content of the questions the researcher asks, as well as in the way the researcher reacts and responds to the answers.

When soliciting information during the interviews, two important Batesonian principles were kept in mind (Bateson, 1979). These are:

- a) Information is a difference and
- b) Difference is a relationship (or a change in a relationship)

Information about relationships and organisation is gained through a process of *circular questioning*, which was described by Penn (1982) and Selvini Palazzoli, Cecchin, Prata and Boscolo (1980). The method of circular questioning seems to “augment powerfully the amount and quality of information that comes out in an interview” (Hoffman, 1981, p. 301).

Hoffman (1981) points out implications of this method: first of all, such questions make people stop and think, rather than react in a stereotypical way. Secondly, these questions seem to trigger more of the same kind of *difference* thinking which is essentially circular because it introduces the idea of links made up of shifting perspectives.

The process of the interview itself also reflects circular thinking when the technique of circular questioning is employed. In this way, the underlying philosophy and technique is congruent.

During the interviews information on the participant's ecology, support system, her relationships with family and friends were obtained. The context in which the participant experienced the obsessions was also explored.

Alternative meanings were offered whilst I was in dialogue with Nirvana. Nirvana and myself were both actively involved in co-creating alternative realities.

Data Analysis

According to Marshall and Rossman (1995), *data analysis* is defined as the process whereby order, structure and meaning is imposed on the mass of data that is collected in a qualitative research study. It is described as a “messy, ambiguous,

time-consuming, creative and fascinating process" (Marshall & Rossman, 1995, p.111).

The interviews will be transcribed and systematically analysed and interpreted using Strauss and Corbin's (1990) three-stage process of open, axial and selective coding.

Open Ended Coding

The process of open coding (Strauss & Corbin, 1990) involves breaking down the transcripts into 'units of meaning'. The open coded categories comprise concepts that represent distinct clusters of meaning. In order to encompass the complexity and richness of the meaning emerging from the data, it may be necessary to create sub-categories within each of the main categories.

Axial Coding

The second stage of grounded theory analysis is axial coding. This is designed to process the data at a meta-level. The open-coded categories and sub-categories are surveyed to discern relationships between them. The data is then re-appraised for relational issues of context, causal conditions and inter-relationships (Strauss & Corbin, 1990). Open-ended categories and sub-categories are considered to represent a descriptive *still* of all the meaning in the data, and when subsumed into axial categories, the dynamic interrelationships may emerge.

Selective Coding

The final stage of coding is the systematic process of selecting a core category and grounding it in the former two stages of the coding as well as in the quotes from the participant. Strauss and Corbin (1990) advocate that the first stage of this final process is for the researcher to construct a story line that represents a descriptive narrative about the central phenomena of the study.

After the data is analysed, an interpretative approach is selected. Interpretative science is defined as emphasising the human experiences of understanding and interpretation and is presented as people's detailed stories (*thick description*), which serve as exemplars and paradigm cases of everyday practices and lived experiences (Hutchinson & Wilson, 1994). These everyday practices and experiences are identified, described and interpreted within their given contexts.

Conclusion

This chapter has provided an outline on the qualitative research method that is used for this investigation within the confines of the naturalistic research paradigm. The qualitative research approach is coherent with the ecosystemic approach which is the theoretical perspective of this study. The underlying assumptions of naturalistic research and a description of how the information that was gathered during the investigation will be legitimised were laid out. The process of establishing credibility was also provided. The research being qualitative in nature employs the single case study method which depicts Nirvana's story, together with the co-creations and the retelling of Nirvana's dominant narrative in the hope of effecting some change for her. Her story is told in chapter 5.

CHAPTER FIVE

NIRVANA'S STORY

*"When someone tells us his or her story,
we come to understand how they see their own life."*

(Penn, 1991, p. 43)

Biographical Background

Nirvana was born on 20 July 1981 in Vredendal, near Cape Town. She could not provide other information about herself as a child because she claimed that she could not remember anything from her childhood. She is very frustrated with herself for not being able to remember her childhood memories. Nirvana has an interest in finding out about her childhood. She tried to gather information from her conversations with her parents but they are not willing to enter into a conversation with her around her childhood. Nirvana gave up the attempt because she felt as if she would be upsetting her parents if she pursued the issue.

Nirvana belongs to a family of five members, namely her parents, an elder sister of 24 years and a younger brother of 15 years who is currently in grade 11 and lives at home with his parents in Durban. Her sister moves back and forth to her parents' home. Her sister first moved out of the house four years ago. She was engaged to be married and lived with her fiancée. They broke their engagement after a year and then she moved back home. Now her sister is working and living away from her parents' home. Nirvana mentioned her maternal grandmother whom she seeks out especially when wanting some form of emotional and financial support.

Nirvana's support system is comprised of a friend from Rand Afrikaans University. He used to visit her several times a week in hospital. She does not have any friends in Durban from school or from her church.

Nirvana belongs to a culture of Afrikanerdom. The language that she uses to communicate with other members of her community is Afrikaans. The religion that Nirvana and her family follows is Christian.

Nirvana did not attend kindergarten like her other siblings. She cannot remember why and assumes that her mother probably looked after her at home. She was schooled in Cape Town from Grade 1 to Grade 3. When she was in Grade 4 her family moved to Queensburg, Durban. She then attended both Primary and Secondary schools in the Bluff, Durban. She remembers not being selected as a prefect, yet her best friend was. She remembers that she cried often at school. Nirvana matriculated in 1999 with a matric exemption.

On applying to university for first year Nirvana only chose to apply to Rand Afrikaans University (RAU) in Johannesburg. Her father did not approve of her applying to universities in Durban. It was his opinion that she would receive better education at RAU. She registered as a full time student for the degree Bachelor of Arts (majors: Psychology, Industrial Psychology) at Rand Afrikaans University, Johannesburg during the year 2000-2001. Her career intention was to be a child psychologist. She passed all her first year courses as well as her second year (first semester courses). When Nirvana was admitted to 1 Military Hospital she was currently registered for four-second year semester courses. However, due to her being hospitalised for four weeks she did not meet the requirements for the second term courses that were comprised of writing tests, which would allow her to write the examinations at the end of the year. Due to her not being able to write the tests, she chose not to return to university during that year.

In order to attend RAU in Johannesburg she had to move away from her parents' home in Durban and live at a university residence. She did not share her room with anyone. She hardly ever travelled to Durban, except during the holidays.

Nirvana describes her father as having skin cancer in his face for the last 5-6 years. She described her mother as suffering from depression. For the past few years her mother's depression has been controlled by medication. Nirvana mentioned that her sister had attempted suicide two years ago by drinking pills that

she found in the medicine cabinet. Nirvana claimed that when they lived in Vredendal her sister was molested by another man when she was a child. She thinks that her mother was aware of this and knew who this man was but did not do anything about it. Nirvana's story will now be told from her perspective, in which she herself is speaking.

Nirvana's Voice

I don't know, what must I tell you, I have been diagnosed with OCD by the psychiatrists. I don't really understand it, or what it means when they say that I have OCD.

I am confused a lot of the times. I am confused in all aspects of my life with regards to my role as a daughter and sister, with regards to my parents' expectations of me and my expectations of myself. I do not really know what to do, and when I am doing something I do not know if it is the right thing. I am not sure whether I must do what my parents want me to do? Or must I do what I want to do, but I do not know what it is that I really want.

I obsess about everything. I have obsessive thoughts about worrying and attempting suicide. I worry about everything. I worry a lot about my family, my father who is away a lot of the times from home, my mother who is depressed most of the time. I think about them all the time. When my father is away I am stuck with my mother, sister and brother. My mother and I do not connect the way that she and my sister do. So she is ruled out. My brother and I, well he is in standard 9, he has his own friends and does what he likes. So he is also ruled out. My sister thinks that I am a 'donderse dooie lyk'. So she is also ruled out. Our relationships between family members at home are not good.

I often feel that my family does not really care for me. I constantly receive mixed messages from my parents who say that they love me but act contrary to this. I feel as if I do not really belong at home. I sometimes feel as if they abandoned me and wish that I was not around. If they would phone me everyday then I would know that they care for me, but if they do not phone, it is fine. I will phone because I need

to speak to them. They do not understand me when I speak and they do not understand the things that I do. I cannot make sense of this because I am not a difficult child. I will just do what they ask of me. If they say stop studying now, I would love to go back home and stop studying. If they say carry on with the studying, then I will try to go on.

I constantly think and become frustrated with myself about why I cannot remember anything from when I was growing up. As hard as I try, I can never remember what I did as a child, the games that I played, the toys that I played with, the children with whom I played with at school. I do not have many or any memories of my childhood, except there is this one photo of me in standard 4 where my father is standing in the back of me with his arms around me, like my father loved me and that he played with me.

I guess I am growing up in the wrong time slot. Why do you ask, because I do not like to do the same things that other children (young people) my age like to do. And my mother does hammer me on it!! I hate pubs because I hate drunken people. They never know what they are doing or saying. I hate alcohol. Nothing needs to be said further. I would much rather have family picnics by a waterfall or somewhere peaceful. Play baseball or cricket with a bunch of friends. All my family wants to do is make me drunk. I will never get drunk. I do not like the taste of alcohol and I would never get so out of control that I myself do not know what I am doing. Nobody knows this but I have a great fear of throwing up. I cannot take that.

For most of my life I remember experiencing fluctuating emotions. I cry a lot. I feel sad most of the time. I have hardly ever smiled during the last few years. I am mostly in a low mood and lack motivation in everything. I rarely feel happy. I do not know what would make me happy? I think so, but I do not know if there were ever times that I was happy? I do not know how I express my happiness? I do not know. I think so that there is someone in my home who shares in my happiness? O.K. if I were happy at home, why can't I remember what it is about being at home that makes me happy? Well, maybe it is because I do not feel that way at home. So where is it that I feel happy? I do not know why I feel this way. I feel I cannot do anything. No, I am thinking about happiness, I have to focus on happiness. When

were the times that I was happy? I cannot say, I am not able to say. I cannot say why but I cannot remember when and why.

I feel sad that my father has to travel a lot. However, I do get excited upon his return home. I feel ashamed of not being able to do the simple things that other people can. I feel bad for letting my parents down and disappointing them by making the wrong choices in life. I often experience guilty feelings and feelings of blame for everything that goes wrong in my life and the life of my family members and even when it is not my fault such as when I witnessed a horror event. The neighbour's two dogs ripped a cat apart and I could not do anything. It was horrible. I cannot help feeling guilty, as if it is my fault that the cat died. I'm sorry.

I experience difficulty in making important decisions such as I cannot make decisions regarding my studies, and my career. Next year I will be 21 years old, and I know that I will be a 'big' girl but it does not mean that I will know what to do in all situations. I cannot choose what I want to do with my life because I myself do not know what I really want to do. My father is the only one in my family that I can discuss my career options with. However, he will only return home in a few months time and then it will be too late in the year to apply for admissions to universities. I do not think that I have any options. According to my mother I have to work. She nags me to get a job, but I cannot find anything. I am scared that if I start studying again that I would not be able to cope. I just pray that I am not making another mistake again!! Dear God, if I make a mistake and do not make a success of this, then I am really giving up. Then you can lock me up and throw away the key.

I would like to study (I think). I just do not know what exactly. I was thinking about continuing with Psychology and maybe just finishing it, and carry on from there. Or find out what biomedical technology is all about and go for that. On the other hand I am not so sure if my parents will pay for me to go study again. Yes, I'm sure they said they will pay for me again, but maybe I misunderstood them. The only reason I left RAU in Johannesburg was because I thought that I could go back and study in Durban, but I am wrong. My parents have changed their stories. I am forced by my mother to visit funny places like Intec, Varsity College, UNISA, and to go and find out what they offer. I am not going to get into the new tricks my mother is pulling. I get so

angry with her and we cannot talk about it. Why not? Your mother is supposed to be your best friend, but I do not have a best friend. She hates me. And I cannot do anything right. And my father is very mellow (in between). I do not know what may happen, I may never go back to university.

I consulted a psychologist at RAU for assistance with career counselling. The feedback that I received was that I have no strong points and that my career options are all the same. I feel that the consulting psychologist did not help me very much. This feedback made me think very poorly of myself. I do not think that I am clever enough to finish my studies. Every time before an examination I become very afraid to such an extent that I cannot eat, or sleep. How am I going to get anywhere in life? I feel like a failure. I think the best thing to do is to do away with myself.

The first time that I remember being hospitalised there were very disturbing information discussed. All the information was written and placed in a file. I forgot about the file and left the file at university. The disturbing things are like rejection from school time, all sorts of hurt that stayed with me, my sister's suicide attempt. These things would bother me over and over. That's how the psychiatrists came to the conclusion that I'm suffering from OCD. My compulsive behaviour was calling other people, sending short messages until those people would hate me and I would feel more rejected afterwards. I'm still engaging in this behaviour when I feel bad about myself. I need help to get myself to stop doing this. People say that they cannot really help me until I help myself. Other people have said that time will bring answers. The only thing that time has brought for me is more confusion and trouble.

Being hospitalised during this time was also the first time that I made contact with a psychologist at Rand Afrikaans University in September 2000. Whilst attempting suicide by drinking pain medication, I phoned the psychologist to inform her of my intention to kill myself. The psychologist immediately called one of the girls that live in my hostel to help me. I regret being saved. It is because I did not feel like there is something to live for anymore. I feel I have to kill myself to make things better for me. I was admitted to hospital where I received therapy from the psychologist and the Chaplain from RAU. Since this first suicide attempt I have thought about attempting suicide again many times but I have not as yet acted upon my thoughts.

After my first time in the hospital I feel as if something in me has changed. When it came time to write tests I would behave like the way I did before I went to the hospital for the second time. I find it difficult to focus my attention on daily tasks and have a low concentration level. Is it my stress? A worst kind of stress if you ask me. I am scared. I do not know if I'm doing the right thing. I have no confidence any more to think that I can pass any test. I think of myself as a dump. I want to become somebody, but with this little confidence in myself I would not get anywhere. That is why I need to find some help.

The second time I went to the hospital was very different for me. This time it was all about me not knowing, not knowing anything. Something in me is missing. I am not like I used to be. Thinking about this still turns my stomach upside down. My life existed out of I don't know. And it still does. I did not know and was very unsure of where my life was heading, which put me in a state where I could not study. Nothing made sense to me. I could not get any information into my head. I could neither eat nor sleep. I became scared because my semester tests were around the corner. I felt scared every time my thoughts focused on the semester exams which were nearing. The best thing that was left to do was doing away with myself. I lost my tongue, could not really speak and went back to hospital.

I consulted a psychiatrist at 1 Military hospital as an outpatient in April 2001. According to the psychiatrist I could be described as having long standing psychiatric problems. I was diagnosed firstly with Obsessive Compulsive Disorder and secondly with Major Depression. I experience constant headaches as well as insomnia. I know that I am taking a tablet called Zoloft. However I cannot remember when I started taking it and for what period of time I am now taking the tablet. The psychiatrist also suspected me suffering from temporal lobe epilepsy. This was ruled out as a result of a normal electroencephalogram (EEG) and a normal CT scan. However, excessive Beta waves indicated the possibility of me experiencing severe anxiety.

The next time that I consulted with the psychiatrist was in May 2001 just weeks before my father had to leave to go to the Congo for the next few months. I was not showing signs of improvement even after taking the medication for the previous weeks. I was eating and sleeping poorly. I still had signs of depression and

was very tired. I often thought about death and dying. My obsessive thoughts were about various problems in my life and I was very anxious. I had a low attention and concentration level and I was barely managing to function efficiently, study and write examinations.

In the first week of June 2001 I was admitted to 1 Military Hospital, Psychiatric ward. I do not like being in hospital, but I am scared if I go out it will happen again. Whilst I was an inpatient, I remember that my feelings were not always congruent with my mood and my actions. I became very suspicious of everything and everyone. I was not delusional. I constantly worried about what people thought about me being admitted to hospital and of being a failure. I obsessed tirelessly about what other people thought about me. I became very negative towards myself and of other people. I have a low self-esteem. I have no concept of myself. I have a negative image of other people. I feel that everyone was disadvantaging me. I was so wrapped up in my thoughts that I became unaware of other people's emotions. I was completely unaware of my effect on other people. I was very lonely and my parents did not contact me often in hospital. I would love my parents to be here with me but why, because they cannot do anything. I just wish I had more support from my family, but I guess that I let them down once, therefore I cannot expect them to help.

With the continuous taking of the medication Zoloft I began experiencing nausea and dizziness. I sometimes think that it is the medicine that makes me feel so bad. My medication then changed to Aropax 20 mg three times a day. Towards the third week of June the dosage of Aropax increased to 60mg. I started to feel better and was less anxious. Towards the end of June I felt as if my self-esteem started to improve. I realised that I must take care of myself to get better. I remember being less anxious than before. I was beginning to socialise better. My obsessions were still around but they were not as restricting on my functioning on daily activities.

For my follow-up in July 2001, I was appointed to a different psychiatrist. I remember being told that I was now having recurrent obsessive doubt (whatever that means). I was lethargic and drowsy for most hours of the day. This led to me having poor focus levels and decreased concentration. I was unable to study because I constantly fell asleep. I also remember questioning myself in terms of being

emotionally labile (something that I read about), depressed, having low hopes and low energy levels. At this point I was considering switching psychotherapists at RAU because I felt that I was getting nowhere in the therapy. I had extreme doubt concerning multiple aspects of my life such as my present studies and my future career and my fear of my father's safety with him being deployed away from home to the Congo for the next eight months.

My understanding of my problems in life and of my diagnosis of OCD and my understanding of why I was admitted to hospital is I think because of the fact that my sister wanted to kill herself. Since then I was very quiet at home. I only just did my homework and did it good so that no one would recognise that things was not all together. I never knew why my sister did it. I thought it were my fault. It was my fault. I always ran to my books so that I would not know what was going on. I never talked to anybody at home. I thought that if I stayed quiet then nobody would recognise that something was wrong. Maybe I just wanted some attention. My sister got all the attention. The teacher I liked only talked to her. She did not even like me. Nobody ever liked me. I did not have a friend with which I could talk. I was the good kid that was always as an example for the others. Why did I want attention? What was the real fault? I never knew. I still don't know.

All I can think of myself is that I am a very confused individual with nobody around to talk to. I must write on paper how I feel and hide it in my cupboard. I just really need to talk to someone, but no one listens. I cannot talk to my mother, because she never understands, always turns my words around and starts a fight. My sister is almost the same. My brother does not even know what is going on. I have no friends and cannot talk to the family that brings me more trouble. I cannot even keep a conversation going. I cannot talk. I never really know what to say. It is like I do not have anything to talk about. Why can't I just talk about anything that I read about?

Inspite of all the turmoil in my head and in my heart and in my life I have a few goals in life that I would like to achieve to meet my needs such as:

- To find out who I am, what my strengths are, my weaknesses and my characteristics as a person. What I would want out of life, and I would like to get a positive sense of self

- To take responsibility for making important decisions in my relationships with my family, as well as my career
- To control and handle stress in my daily activities so that I can function efficiently
- To find answers to the many questions that I have regarding my childhood

This is my story and this is how I feel so can you help me:

So leeg...

Met 'n vraagteken kleur ons die lewe

Dit...bring ons vrede

Maar nie veel...

Antwoorde lê gestrooi

Tog so mooi

Oop en bloot

Vaag en groot...

Wat se een te kies

Dit maak my so vies

Alles so gou

Dit maak my blou

Wat is dit?

Ek vang sommer 'n fit

Die son begin weer skyn

En ek skryf dat dit rym

Al die seisoene in een

Ek voel so verskriklik alleen

Translated into English:

So empty
With a question mark we colour life
It brings us peace
But not much

Answers lie scattered
O so pretty
Open and exposed
Vague and big
Which one to choose
It makes me so annoyed
Everything is so fast
It makes me blue

What is it?
I'll catch a fit

The sun begins to shine again
And I write so that it rhymes
All the seasons in one
I feel so terribly alone

THE END

Following Nirvana's Voice entails a description of the psychiatrist's view of Nirvana's condition as well as my view as the researcher of Nirvana's life. The different views of Nirvana are based on the interaction between Nirvana and the psychiatrist as well as Nirvana and myself. The distinctions that I have drawn from an ecosystemic epistemology are intersubjective which reflect a reality that is co-created between Nirvana and myself in interaction. I shall begin with a description of the psychiatrist's view of Nirvana based on his managing her treatment since April 2001.

The Psychiatrist's View of Nirvana's Condition

The first time the psychiatrist met Nirvana was in April 2001. During this period she showed symptoms of being emotionally labile and not being in contact with reality (psychotic features such as delusions or depressive stupor which are generally mood congruent and which involved themes of personal inadequacy and guilt). There were indications of mood disturbance, such as normal depression and symptoms of depression for example low self-esteem, poor concentration and difficulty making decisions and loss of interest in daily activities. However, her affect, mannerisms and speech tempo was very histrionic (a personality disorder) such as attention seeking and manipulative.

When Nirvana was questioned about her psychiatric history she mentioned that she had consulted with several psychologists and psychiatrists, but she was unsure of their diagnosis regarding her condition. She was administered Zoloft, 50 mg, to take one tablet at night according to the psychiatrist's prescription. Zoloft is a selective serotonin reuptake inhibitor (SSRI), which blocks serotonin reuptake at the synapse.

The psychiatrist described his interviews with Nirvana as very difficult. His reason was that Nirvana found it difficult to express herself, and she could not clearly define herself and her problem. The psychiatrist described her as finding it difficult to focus on the problem, and he said that she did not easily get to the root of the problem.

The psychiatrist received a report from Nirvana's private psychologist at RAU, which stated that Nirvana had obsessive thoughts about her mother dying. She would continually follow her mother around the house in Durban. There upon he administered another medication, Pasrin 10 mg, to be taken twice daily in addition to Zoloft 50 mg, to be taken at night. Pasrin is an anxiolytic, a mood stabiliser that helps to reduce anxiety. According to the psychiatrist he diagnosed her as follows:

- Axis I - Obsessive Compulsive Disorder with Major Depression
- Axis II - Cluster B, Histrionic Traits
- Axis III - No epilepsy

Nirvana's past schoolteacher called the psychiatrist to inform him that whilst Nirvana was on holiday with her parents in Durban, Nirvana called her in a state of hysteria. Her schoolteacher was very worried about her and suggested to the psychiatrist that Nirvana be admitted to hospital. Due to the psychiatrist receiving collateral information from Nirvana's other therapists, he decided that this behaviour is typically repetitive and that the current hysteria was not a new situation that justified her admittance to hospital.

In the first week in June 2001 Nirvana was admitted to I Military Hospital, Psychiatric Ward. The psychologist from RAU telephoned the psychiatrist at I Military Hospital. The information that they provided was that Nirvana would make appointments with them and not follow through. They felt that she is very suspicious throughout the therapy process, and of the therapy process itself. She constantly phoned them and sent short messages via cellular phone to them at least 15 times a day. She was constantly in a state of crisis, but did not follow the suggestions of the psychologists. Nirvana showed no insight into her anxiety. The object and nature of her anxiety is not known. She has a helpless feeling about herself and she felt that her doctor (psychiatrist) also thinks so. At this point the psychiatrist considered whether she has social phobia, or anxiety.

Nirvana attended occupational therapy whilst being admitted to the psychiatric ward and she realised that she is ambivalent over everything. She exhibited an external locus of control.

A psychometric evaluation was conducted. Results of the evaluation showed a possibility that Nirvana displays obsessive-compulsive aspects. At this point she was not psychotic, but she displayed pre-psychotic aspects. No delusions or hallucinations were present. There was non-integration of her ego strength. The dosage of Zoloft was increased to 150mg per day. She was also administered Risperdal 2mg to be taken one tablet per day and Urbanol 10mg one tablet to be taken three times a day.

Nirvana underwent cognitive behavioural therapy which was conducted by the psychiatrist. On a cognitive level Nirvana and the psychiatrist had concentrated on

the identification of the obsessions as ego disintegration. They together began to work on the analysis of the obsessions. The underlying obsession was *"if I do something wrong then something terrible is going to happen."* They worked on identifying what is the something wrong, and what is going to happen, and why it is going to be so terrible if it happens. The compulsion then was to worry and to actually plan for this 'thing' that is to happen. The psychiatrist at this point noted that it became evident to him that Nirvana was *sicker* than what he thought she was previously. At this stage she was on Aropax 40 mg three times a day. Towards the third week of June the dosage of Aropax had been increased to 60mg. She started to feel better and was less anxious. The psychiatrist then experienced her as being easier to make contact with.

Towards the end of June Nirvana's self esteem improved. She started showing insight into her problems. Nirvana realised that she must take care of herself to get better. She was less anxious than before. She socialised better. Her obsessions were still present but not as restrictive on her functioning. Her thought processes were better. The cognitive behavioural therapy was working well for her. She began identifying the obsessions, started to evaluate them and was more self-confident. She was discharged and wanted to go on holiday with her family. Her follow up appointment was in five weeks (beginning of August). She was referred to a psychologist, whom she consulted with at RAU. It seems that after she was discharged her condition deteriorated. She consulted the psychiatrist again in July 2001. I was part of the psychiatric team when she was readmitted, which is the time when Nirvana and I met for the first time.

My View as the Researcher of Nirvana's Life

Setting the Therapeutic Stage

Enter the Researcher

I was serving a clinical psychology internship at 1 Military Hospital during the year 2001. I worked at two service points, from January to June in the Neurology and Neurosurgery wards and from July to December in the Psychiatric ward. In the

Psychiatric Ward I was on call once a week (attending to patients during crises). It was during the period when I was on call that I came into contact with Nirvana for the first time, as a referral handed over from the psychiatrist on call. The psychiatrist informed me that Nirvana had been admitted to the psychiatric unit the previous day, and introduced her to me by briefing me in connection with Nirvana's history. The briefing also included a warning about the challenge that I may experience when working with "this sort of patient".

Enter the Psychiatric Team

It was hospital procedure that every patient that was admitted to the Psychiatric Ward would be presented on panel (ward rounds) to be assessed by the psychiatric team. The psychiatric team consisted of psychiatrists, psychiatric nurses, occupational therapists, a social worker, a psychologist and two intern psychologists. I as the researcher functioned in the role of an intern psychologist and a collaborator on the panel.

The panel presentation included the psychiatrist's assessment of Nirvana upon admission, along with input from the other members of the team. Nirvana received the primary diagnosis of Obsessive Compulsive Disorder, with a secondary diagnosis of Depression. Since the psychiatric team understood her symptoms within the Medical model, the treatment that followed included medication together with psychotherapy.

For purposes of understanding and tracking my interactions with Nirvana as the intern psychologist, I decided to structure this description according to weeks, ranging from week 1 to week four.

Week I

Psychiatric Diagnosis

According to the use and language of the Medical model the psychiatric team diagnosed Nirvana with obsessive compulsive disorder (OCD) fitting with the

Diagnostic and Statistical Manual IV (DSM IV-TR) (APA, 2000) criteria (described in chapter 2). Their treatment strategy for Nirvana was that she be administered medication in order to alleviate her symptoms of OCD.

Therapeutic Interventions

Myself, as therapist and researcher, together with colleagues, collaborated on working according to a different approach. I scheduled four sessions with Nirvana that week, in order to get a holistic picture. The tools that I used to provide this picture were a mental status exam and a genogram. The mental status exam is a systematic method for gathering behavioural and psychological data of a patient. Appearance, level of consciousness, psychomotor activity, behaviour and general mood state are observed before and also throughout the interview. Speech, thought content and form, orientation and memory are appraised throughout the interview. Insight and judgement are "usually determined towards the end of the interview" (Yates, Kathol and Carter, 1994, p. 25).

A genogram as described by Kippling (in Lieberman, 1979, p. 68) is, "a visual diagram of family relatedness, structure and history". A genogram graphically represents the skeletal relationship structure of two or more generations of a family, upon which the coalitions, patterns, bonds and the transgenerational passage of their culture may be superimposed. It also serves to depict important relationships, both in the past and the present (Lieberman, 1979). A genogram described by Estrada and Haney (1998) provides a gestalt of complex family patterns, stimulate clinical hypotheses linking the clinical problem to the family context. By working ecosystemically, I introduced 'news of difference' to broaden the scope of the problem definition.

Psychometric testing was administered in three out of the four sessions, and took place in the wardroom. For the fourth session of that week I intervened by changing the physical context of that session by going outside of the hospital for therapy. As Friedman (1996) noted, I, the researcher as a facilitator of the therapeutic conversation was in a position to open a space for Nirvana in which she was able to

notice and acknowledge the positive steps that were taken toward her preferred outcome.

Goal of Therapy

Therapy from an ecosystemic perspective is a collaborative conversational process. It is a structured dialogue that engenders new perspectives and new possibilities for action (Friedman, 1993). Since the first few sessions consisted of conducting psychological tests, a relationship of tester and testee was established between Nirvana and myself. Thereafter, one of my goals was to establish a relationship that was more conducive to therapy. There needed to be a nurturing within the relationship, which would keep me as the therapist attuned to Nirvana's needs.

Week 2

Psychiatric Diagnosis

During the second week, I became very concerned about Nirvana's poor memory. This was evidenced when Nirvana was not able to remember the contents of the previous therapy sessions on a day to day basis. Her poor memory was addressed and discussed by the panel. A decision was taken by the psychiatric team that Nirvana needed to be cognitively tested and assessed by the Senior South African Intelligence Scale - Revised (SSAIS-R), together with a battery of neuropsychological sub-tests.

Memory testing assesses the ability to retrieve and recite information previously stored (retrograde memory) and to form new memories (anterograde memory). Remote memory (usually retrograde) involves remembering events that occurred many years ago, such as the name of a school attended. Recent past memory (retrograde and/or anterograde) involves remembering events that occurred months ago and may be assessed as the patient provides "believable and/or confirmed details of the present illness or events leading up to the assessment" in the present time (Yates, Kathol & Carter, 1994, p. 32). Impairment of immediate recall,

especially with repeated attempts, suggests an attention deficit that precludes further anterograde memory testing. Intact immediate recall with impaired recall after 5 minutes suggests impairment of short-term memory.

The SSAIS-R assesses general intelligence ability, provides a differential of high and low abilities, and also highlights strengths and weaknesses of cognitive abilities, and points to IQ scores. The neuropsychological sub-tests are sensitive to neurological damage. Also, for the psychiatric team to get a clearer understanding of Nirvana, a request was made for administering the Minnesota Multiphasic Personality Inventory (MMPI) test, which could indicate possible pathology in personality make-up.

The SSAIS-R consists of 11 sub-tests. There are 6 verbal tests measuring verbal ability and 5 non-verbal tests measuring non-verbal ability. The sub-tests are tests of:

1) Vocabulary, 2) comprehension, 3) similarities, 4) number problems, 5) story memory, 6) pattern completion, 7) block designs, 8) missing parts, 9) form-board, 10) memory for digits and 11) coding.

The battery of neuropsychological sub-tests included:

- Tests for orientation to place, person and time
- Rey Auditory Verbal Learning Test and Delayed Recall testing for verbal memory
- Rey Complex Figure and Delayed recall testing for visual memory
- Halstead Reiten Trail Making Test A and B

The Minnesota Multiphasic Personality Inventory represents one of the most widely used and most widely researched psychological tests. It is recognised as one of the most broadly useful diagnostic tests for the assessment of psychopathology. The test consists of 550 affirmative statements measuring an individual's behaviour on ten clinical scales. The scales are:

1. *"Hypochondriasis* – a neurotic pattern characterised by extreme concern for health and bodily functions
2. *Depression* – an affective disorder usually characterised by sadness, feelings of lack of worth, loss of energy and interest
3. *Hysteria* – a neurotic condition in which physical symptoms are used to avoid or solve conflicts and to avoid responsibilities
4. *Psychopathic Deviate* – a personality disorder characterised by an extreme and flagrant disregard for social and moral norms
5. *Masculine-Feminine* – the extent to which the respondent accepts extreme, stereotypic sex roles
6. *Paranoia* – delusions of reference, influence, grandeur, persecution
7. *Psychasthenia* – obsessive-compulsive behaviour or thought patterns
Schizophrenia – a disorder characterised by a lack of connection between affect and cognition
8. *Hypomania* – a disorder characterised by over-activity, flight of ideas, emotional excitement
9. *Social Introversion* – a disorder characterised by withdrawal, avoidance of social contact" (Murphy & Davidshofer, 1994, p. 427).

Therapeutic Interventions

I questioned, challenged, and pushed Nirvana in order to explore rich descriptions of Nirvana's understanding of herself and her world. The more I pushed Nirvana, the more she replied, "I don't know, I don't know". Initially, I interpreted Nirvana's constant replies of "I don't know" as reflective of her state of confusion. This then shifted to being seen as a hindrance to therapy. Upon exploration of her "I don't knows", both Nirvana and myself became aware of how the not knowing or not being able to provide answers was frustrating for Nirvana. Nirvana and I then found an alternate way of being in therapy: by way of letter writing. By communicating via letter writing, I was in a unique position to engage in conversations that built on Nirvana's resources, and utilised her strengths in ways that offered hope for change.

Letter writing

Nirvana's letters to me helped me to understand her background, her strengths, her weaknesses, her interests, and her sense of self. They also indicated another way that she could communicate with other people, reach out to others and be responded to.

This therapeutic intervention of letter writing allowed Nirvana to find an expression for feelings that she did not normally express easily. The following are a few statements quoted from Nirvana's letters which reflect her ability to find words more comfortably in writing than when spoken to:

"Do not say to my parents that they reject me, because they are not!!

"Everything is just tight with the money!!"

"Money is evil, I hate money"

"They are going to be angry if I can't make choices"

"They are going to be angry if I am so irritated at home as I am now".

Goal of Therapy

Two goals were set for the second week of therapy. The first goal entailed the following: to determine the results of the neuro-battery. Depending on the results neurological damage would be either ruled out or not. The second goal entailed the exploration of alternate and more effective ways of communication between Nirvana and others. I attempted to achieve this goal by doing what White (1991) suggests, which is to act as a consultant who works to deconstruct totalising descriptions of Nirvana's life in ways that would enable previously unnoticed options to emerge.

The test results were as follows:

Scores of the SSAIS-R reflected an average performance on the intelligence tests. This average performance must be interpreted in the light of her low mood, lack of motivation, anxiousness and her fluctuating attention and concentration. Initially she would attend and respond, then it seemed as if she became bored, lost interest and concentration. She performed better on non-verbal subtests than verbal subtests. This could be due to her being very creative with her hands. A reason for

her poor performance on verbal subtests could be as a result of her poor social interpersonal skills.

The Rey Auditory Verbal Learning test (RAVLT) measures immediate memory span. It shows interference tendencies and tendencies to confuse or confabulate on memory tasks. It measures both short term and long-term retention. Interpretation of the RAVLT scores shows that learning of information does take place. She showed a positive learning curve. She showed her strategy of learning, grouping information into categories. There was a proactive inhibition effect (what was just learnt has interfered with the acquisition of new information), and Nirvana showed an inability to shift between tasks and do double mental tracking. However, she showed slow information processing. Nirvana needs time to store information and then process that information. She is able to retrieve information once encoding has taken place and time has passed.

Due to Nirvana obsessing on certain thoughts, she showed a lack of concentration, and this resulted in her poor memory and at times having no memory at all. This could be due to her inability to focus and pay attention. Without paying attention she is unable to store information and is therefore lacking in memory recall.

With regards to the MMPI, the clinical scales that had elevated scores were Depression, Hypochondriasis, and Social Introversion.

These tests are sensitive to neurological damage, and her performance would be significantly lower in the presence of neurological damage. Based on these test results the psychiatric team ruled out neurological damage. Overall, Nirvana has the ability to take in information, although she is slow in processing information. It was the opinion of the psychiatric team that due to her psychological and social problems, such as the depression and lack of motivation, her memory could be affected to some extent. The psychiatric team also suggested possible signs of pseudodementia (her cognitive problems are due to severe depression, and there is no neurological damage) or psychogenic amnesia (Nirvana showed a positive learning curve and has the ability to learn, but forgets information).

Week 3Psychiatric Diagnosis

By now, Nirvana has been in the psychiatric ward for three weeks. According to her and the psychiatric team, her psychiatrist had not consulted with her for the past two weeks. In my opinion the psychiatrist (who is trained and works according to the medical model) believed that Nirvana's condition would not change and was therefore ready to discharge her after the second week. However, since she was receiving both occupational therapy and psychotherapy the psychiatrist was unable to physically discharge her.

Therapeutic Interventions

Nirvana's goal of wanting to find answers to the many questions she had, prompted me to continue to create contexts within a safe therapeutic environment in which I tried to challenge and push her with sensitivity towards her goal. During this week Nirvana's languaging about herself was different to that of previous sessions. Her excited exclamation of "I've found my tongue" allowed her the opportunity to mention words, to speak full and complete sentences, and she was able to think differently about herself. This helped the therapy, and in turn the therapy then helped her.

I then suggested Nirvana undergo a career assessment to meet her needs of uncertainty, regarding her future studies and career. I administered the following tests: the Jung Personality Questionnaire (JPQ) and the 19 Field Interest Inventory (19FII). The JPQ is concerned with the way people utilise their personality resources. This is important when determining a career choice.

The JPQ indicated a possible personality profile of Introversion, Sensing, Thinking and Judging (ISTJ). The following is a short description of the ISTJ personality profile:

I prefer to focus on the inner world of ideas and impressions

S tend to focus on the present and on concrete information gained from senses

T tend to base decisions on logic and on objective analysis of cause and effect
 J likes a planned and organised approach to life and prefers to have things settled,
 (Human Science Research Council, 1992).

Nirvana understood the above information in terms of being thorough, reliable, reserved, systematic, and orderly. She considered her strengths as knowing the rules, to follow guidelines, likes structure, and puts work before play. She prefers to plan her work and then follow the plan, likes goals and projects to be detailed, expects all aspects of work to be orderly and prefers a task-oriented, quiet environment.

The 19 Field Interest Inventory indicates interest, and therefore, motivational factors, which influence the direction in which cognitive abilities, are mobilised when career decisions are made. The profile can indicate both high and low interests and is used to support other data regarding personality profiles (Human Science Research Council, 1997).

Upon interpretation of the 19FIII Nirvana showed a more prominent interest in science and practical related careers. This includes an interest in the physical and biological sciences. This also refers to the mechanical and technical field and includes interest in practical execution of a task. She also showed great interest in numerical aspects (measures the person's interest in the use of numbers and other mathematical systems for the execution of calculations) as well as clerical aspects (includes interest in routine work usually performed by clerks).

These test scores should be considered in conjunction with other tests as well as her background information. The scores may indicate her academic potential and scholastic achievement. The scores may therefore act as a guide to choices for career development in the areas of tertiary development.

Painting

As part of the occupational therapy Nirvana attended painting classes. According to her, she painted because *"I was bored"*, and *"I have a lot of questions*

and time". *"The many different bright colours that I use in this painting show my confusion and many questions that I don't have answers for"*. Painting proved to be another non-verbal way through which Nirvana could articulate her feelings.

Goal of Therapy

From the perspective of the medical model, and according to the psychiatric team, there is no hope for individuals who suffer from OCD. The psychiatric team therefore wanted to terminate Nirvana's therapy sessions. However, my assumptions for understanding and treating OCD are different to those of the medical model, and since I worked from the perspective of the ecosystemic approach I was in favour of Nirvana continuing with therapy.

Having gained two more weeks for Nirvana to attend therapy, the time constraints were then explained to Nirvana. The first two weeks were spent conducting tests and doing assessments. All the tests were used as tools to gather information and provided a way for building a relationship. Therefore, the goal for week three was to reassess the therapy to date, and then to address Nirvana's needs in therapy.

Week 4

Psychiatric Diagnosis

The psychiatric team decided that Nirvana would be discharged at the end of week four. She would return to her parents' home in Durban. Her medication was reviewed and she would be referred to a psychiatrist in Durban for follow-up sessions.

Therapeutic Interventions

To explore and understand Nirvana's impressions of her future, Nirvana and I constructed an ecological map or genogram. Bowen's (1976) development of the

genogram reflects his theoretical assumptions that family problems derive normative and emotional meaning in relation to their *historical* context.

Whilst the genogram is a relatively new instrument in the field of family research and therapy, it can be a useful instrument in this type of research. It is consistent with the underpinnings of ecosystemic epistemology in that it acknowledges the primacy of context, in this instance different contexts over time. It also acknowledges the participative role of the family in exploring their own history, culture, values and beliefs. Furthermore, meanings can be explored relatively easily with the family's historical backgrounds already in place (Estrada & Haney, 1998).

According to Roberto (1992) a genogram also stimulates the researcher and participant to think about extended family patterns over time, thus contributing to the formation of systemic hypotheses about behaviour, beliefs and values.

In this study, the genogram was used to generate information about the following:

- The family tree network, with special focus on those who suffer from an illness.
- A description of the relationship patterns between all the members of the family
- An exploration of the patterns of behaviour and how these organise the behaviour of others.
- Through my interpretation, a co-construction of the meanings that Nirvana attaches to the disorder, and how this is recursively connected to others.

The dominant themes that emerged from her ecological map are reflected in the following quotes.

"I need love from my family circle"

"Sports that I did play but not anymore".

"Friends/lack of friends"

"The stronger boundaries between Nirvana and her father, than between Nirvana and her mother".

"My need for future goals"

Goal of Therapy

Since this was the final week of therapy before Nirvana was discharged Nirvana and I defined the goals for the fourth week. One of the goals was to reflect on the themes that had arisen from the previous week's therapies. To reflect on:

- herself as an individual,
- her relationship with her family members,
- her support systems,
- her future,
- her pattern of communicating and relating to people.

Another goal was to obtain Nirvana's understanding of the change process, whether she had experienced change and in what way. Words and descriptions have the power to saturate thinking, and to colour perspectives. In this way conversations with Nirvana could according to Friedman (1996) serve to open options, create a context for possibilities, and generate a variety of alternate views and ideas.

Penn (1985) describes the term *feed-forward*, which is based on the client's consideration of how the pattern of her relationships will continue in the future. Since the maps for the future are not yet set, the client is free to construct or imagine a different set of alternatives to her problem. The consideration of these future maps places her in a metaposition to her own view of her problem and the system increases its view of its own evolutionary potential.

One of the most important propositions of Milan systemic therapy is the use of *positive connotation*, a technique that describes the current organisation of the system in a positive way (Selvini, et al., (1978). Blaming in any form is omitted, and instead a perception is offered that defines her problem in a positive way, regards it as context-bound, and implies that contexts themselves are relative and changeable. The positive connotation creates a place where one may stand meta to the system itself. Through the use of *positive connotation*, Nirvana can achieve a view of her experiences as context-bound, since by standing outside her own context its meanings are altered.

Future questions in combination with *positive connotation*, promote the rehearsal of new solutions, suggest alternative actions, foster learning and address the system's specific change model. For example, "if your sister was successful in her suicide attempt, how would your role in the family change?" In this way new information about the future is introduced into the system. According to Penn (1985) these questions elicit relationship information and introduce ideas into the system about the stability, and endurance or change in its patterns over time.

According to Selvini-Palazzoli, Cecchin, Prata and Boscolo (1978) future questions break the pervasive rules that govern communication in the family. Since the future is often indicated but not 'set' no one is bound by formal contextual rules, and a different pattern may be imagined. For example, to ask the client a hypothetical question regarding future events, because the event is only being considered now, the system is free to create a new map. Then the communication of these new ideas about the future becomes important information introduced back into the present 'time' of the system. They include opinions and hope, all a part of the ongoing system, and now unexpectedly called into play as part of the family's expressed interactions. Repeated hypothetical questioning of an outcome will give her a sense of her own potential to imagine new solutions. At this moment she is in a process of feed-forward.

A second goal of therapy for the fourth week was to engage in a discussion of (1) the shifts in behaviour or attribution of meaning which had taken place during the interviews as co-constructed by Nirvana and myself in the final session, (2) what was helpful/unhelpful from Nirvana's perspective.

The following excerpt taken from a letter, which Nirvana wrote to me illustrates how helpful the interviews were according to Nirvana.

"We know each other for 4 weeks and you know me better than I know myself. These last few weeks you've helped me through a lot. Thank you for assisting me through this time of uncertainty. We've worked hard on bringing change in my sense of self and I appreciate all the confidence you have in me to get myself out of this state. Our times together were sufficiently spent and although I can't remember all of

it, I learned a lot about myself. I am going to miss our time that we spent together just talking.”

Nirvana's Discharge

Since Nirvana was discharged from the hospital, we continued to have both verbal and non-verbal contact with each other. This was achieved by follow up telephone calls, receiving short messages via cellular phone, and letter writing. I, however only responded to her written letters.

Conclusion

This chapter has provided Nirvana's story, a description of the psychiatrist's view of Nirvana based on his treatment of her as well as my view as researcher and intern psychologist to Nirvana based on our interactions within a therapeutic setting. The next chapter is a description of my interpretation of the dominant narratives, themes and patterns that emerged through my interaction with Nirvana. Frugerri (1992) notes “there are no descriptions that are more exact or more accurate, the researchers' descriptions are linked to their ways and researchers will see what their viewpoints allow them to see” (p. 44). Linking to Frugerri's (1992) words it is important to note that the patterns and themes that I draw are the distinctions that emerged from my interaction with Nirvana and are therefore intersubjectively created.

CHAPTER SIX

THE RESEACHER'S NARRATIVE OF CO-CONSTRUCTED THEMES

Introduction

It is impossible for us to have an objective reality according to Bateson (1972). By referring to Korzybski's maxim, *the map is not the territory*, he proposes that the understanding we have of, or the meaning we attach to any event is determined and restrained by the receiving context for the event, that is, by the network of premises and presuppositions that make up our maps of the world. Linking these maps to patterns, the interpretation of any event, is determined by how it fits with known patterns of events, and he calls this *part for whole coding* (Bateson, 1972).

Following Nirvana's story, a meta-perspective of her dominant discourse and narratives will now be explored. This chapter will highlight the dominant patterns, themes, narrative shifts and unique outcomes which Nirvana experienced. These thematic punctuations place emphasis on creating a *rich* description of the *making sense* process of being diagnosed with OCD. A comparative analysis between the themes associated with obsessive-compulsive disorder, which emerged from this study, and the literature on obsessive-compulsive disorder will follow. These co-constructed emergent themes will be discussed in terms of the literature review. The distinctions are intersubjective, bringing forth a reality that is co-created from my point of reference as therapist and researcher. According to Keeney and Ross (1992) an individual's distinctions and perceptions are a consequence of how that individual participates in perceiving, which in turn is a consequence of the individual's social context, the individual's values, experience and time. Listening to what researchers and therapists claim to perceive tells as much about them as about the participant under observation. In the descriptions that follow I acknowledge that the analysis that I make of Nirvana's story cannot be considered to be an objective description. All the descriptions will be self-referential, reflecting my dual perspective based on an ecosystemic epistemology.

When interpreting Nirvana's story I kept in mind that "all behaviour in an interactional situation has message value, that is, communication" (Watzlawick, Beavan & Jackson, 1967, p. 48). This leads to the assumption that no matter how hard one may try, one cannot not communicate. Activity or inactivity, words or silence all have message value: they influence others and these others, in turn, cannot not respond to these communications and are thus themselves communicating. Every communication has a content and relationship aspect such that "the latter classifies the former and is therefore a metacommunication" (Watzlawick, et al. 1967, p. 54).

Bateson's theory of communication dealt with the process of the classification of messages (Bateson, 1979; Bateson, Jackson, Haley & Weakland, 1956). Bateson et al. (1956) classified (categorised) two levels of messages in communication, that is, verbal and non-verbal. This classification emphasised that the context (for example, non-verbal behaviour) is important in understanding interactions. Bateson (1979) named two categories of interaction, namely complementary interactions and symmetrical interactions. Categories of interactions represent a kind of choreography for the participants in the relationship (Keeney, 1983). Bateson postulated that descriptions of the choreography of interactions are of a higher logical type than simple descriptions of behaviour (for example, feeling guilty).

Describing interactions entails identifying how interactional patterns (complementary and symmetrical) are patterned, connected and sequenced (Keeney, 1983). Behaviour can thus be defined as complimentary or symmetrical based on the connecting behaviours that precede or follow it (Keeney, 1983). Complementary interactions would be those characterised by a mutual fit, for example, dominance-submission; dependence-nurturance; *one-up* and *one-down* interactions (Keeney, 1983). Symmetrical relationships would, for example, be interactions characterised by competition, rivalry, struggles for control, and mutual emulation (Keeney, 1983). According to Bateson (1979) either of these two patterns (complimentarity and symmetry) can potentially lead to schismogenesis (an escalating pattern leading to intolerable stress and dissolution of the relationship). Schismogenesis results from the progressive change (escalation) inherent in cumulative symmetrical or complementary interactions (Watzlawick, et al. 1967). A balance in mutual interactions between dependence and nurturance is the only

interaction that does not lead to progressive change resulting in stress and dissolution of the relationship

According to my epistemological assumptions I recognise that it is not possible for individuals to have one true knowledge of the world. An objective description of the world may not be possible, and that "no-one has a privileged access to the naming of reality, whatever that reality is" (Epston & White, 1992, p. 78). Epston and White (1992) assume that what individuals understand of the world, they become aware of through their experience of it. Individuals learn about the world through their own experiences of seeing, hearing, feeling and touching, through listening to the experiences of others, by looking at or observing the experiences of others and by achieving consensus with others about the co-constructed meaning of their experiences. One person cannot know another person's experience of the world. Individuals can try to interpret the experience of others, that is, "the expressions of their experience as they go about interpreting it for themselves" (Epston & White, 1992, p. 79). To interpret the expressions of the experiences of others, individuals may need to rely upon their own lived experience and imagination. This is the assumption that I have built upon in interpreting Nirvana's experience of living with obsessive-compulsive disorder. The themes that emerged from Nirvana's story flowed out of my idiosyncratic way of drawing distinctions during the research process. The co-constructed themes that emerged from Nirvana's story are:

- theme of confusion and not knowing
- theme of feeling abandoned and seeking to belong
- theme of attributing positive meaning to her life
- theme of identifying personal needs and the needs of others
- theme of not confronting issues
- theme of failing to meet expectations
- theme of low self esteem/ lack of identity
- theme of not taking responsibility for herself

The above themes will be explored later in this chapter.

Pattern

The ideas about pattern are well established in Batesonian theory and in most systems theory thinking and writing. Zimmerman and Dickerson (1996) also find it useful to pay attention to pattern by bringing an alternate theoretical understanding to patterning, based on social constructionism and narrative. This does not mean they believe any specific pattern *exists* in families, but that various patterns can be constructed by the researcher in a way that helps those individuals *caught* in them to notice them. For example, I as the researcher am interested in the way in which Nirvana's behaviour may affect the members in her ecological context, and in what way her ecological context affects her by the way she creates meaning around it. What patterns exist in Nirvana's story and in her relatedness to her ecological context?

Narrating the history of Nirvana's illness suggests a tendency towards interactional symmetrical (competitive) processes in the daughter-parent relationship. This is reflected in the sequential nature of the parent-daughter depression-worrying relationship. The sequential nature of the parent-daughter depression/worrying reflects a symmetrical dance within this relationship. Were such processes connected to the beginning of the worrying process and the escalation of worrying? From an ecosystemic point of view, these processes are considered in terms of the systemic and cybernetic aspects of family functioning.

Nirvana's Dominant Narrative

Nirvana's dominant narrative over time reflects a change. Initially Nirvana's dominant narrative of herself, can be depicted in the following quote: "I don't know, I don't know, I have got no memory, I don't know". This was characterised by her intense feelings of guilt and feelings of blame for everything that goes wrong in her life and the life of her family members. The idea of letting her family down and not being loved by them dominates her life. The dominant theme in her story is around disappointing the significant people in her life and not deserving their love. This has recursively impacted on her behaviour. Through the process of therapy her dominant

narrative then changed or shifted through therapeutic conversations to seeking positive meaning in her life.

Externalising the Problem

Externalising the problem is the central therapeutic technique used by Michael White to help clients begin to define their problems as separate from their identities. The focus is to assist clients to begin to view their problems as separate from themselves (White, 1995).

Nirvana's dominant narrative was deconstructed at many levels. The dominant narrative, which shaped the way Nirvana perceived her own family appears to have been influenced by a dominant perception of having been abandoned by her family. It was through an intervention such as constructing a genogram or ecological map that the problem was now externalised and Nirvana became aware of the problem. By engaging Nirvana in *writing* her narrative gave her the opportunity to examine her way of punctuating events in her life in a way that was both concrete and creative. The effect of having her write her story may have hastened the discovery of her new voices (Penn & Frankfurt, 1994). The involvement of different narrative frames through the writing process allowed the narrative discourse to continue to multiply and expand (Penn & Frankfurt, 1994).

Now that we have been introduced to the dominant narrative in Nirvana's story and to the patterns that exist within her story through the process of externalisation, a discussion of the co-constructed themes that emerged from Nirvana's story follows.

Emerging Themes

Confusion and not knowing

The theme of confusion and not knowing has been a very prominent theme for Nirvana throughout her story as well as through the therapeutic process. When I met Nirvana for the first time she appeared to be very fragile, thin, weak and confused. She cried constantly mumbling her confused thoughts. Nirvana was hospitalised in a

psychiatric ward and received no support from her family or friends, since her family was living in Durban. Nirvana could neither provide answers to my questions nor to herself. She panicked about her performance on tests, and not coping at university. According to Penn and Leonard (2001) strong indicators of OCD as experienced by Nirvana were unproductive hours spent on homework, retracing over letters or words, exaggerated requests for reassurance, and a preoccupying fear of harm coming to self or others.

This thread of confusion spans across all aspects of her life such as her role as a daughter and sister, her parents' expectations of her, and her expectations of herself regarding her career. Nirvana expressed confusion with regards to all spheres of her life, but more especially she was confused about not knowing herself. She was not able to describe to herself her strengths, her weaknesses, or her personality characteristics. Other people knew Nirvana as the obsessive-compulsive girl, and with her not taking up the label as an obsessive-compulsive individual, she claimed that she did not know who she was, and that she had no identity. With Nirvana's primary diagnosis being OCD the differential diagnosis included depressive and anxiety disorders (e.g. separation anxiety, social phobia, panic disorder and generalised anxiety) with obsessional features (Penn & Leonard, 2001).

A reason that could account for her states of confusion and not knowing could be due to her poor ability to recall from memory. Depression is the most common complication of OCD (Rapoport, 1991). According to Dohr, Rush and Bernstein (1989) individuals who experience depression suffer from dysfunctional cognitive patterns (i.e. difficulty in thinking, concentrating or making decisions). The way in which depression affects cognition influences how the depressed person perceives him or herself, his or her world, and his or her future. Cognition in turn affects the behaviour of individuals in a way that results in their experiencing anhedonia (losing interest in the activities that previously provided pleasure) and psychomotor retardation.

Nirvana constantly experienced feelings of guilt especially when she assumed that she was responsible for the things that go wrong in other people's lives. Nirvana strongly believed that if she thought negatively about someone then "*something bad*

would happen to that person". Tallis (1995) states that the overestimation of personal influence causes a person to believe that by merely thinking something, it will actually happen.

Feeling abandoned and seeking to belong

Nirvana felt that her family does not really care for her. She believed that her parents did not love her the way that she expected, and she has a constant yearning to receive affection from her parents. Nirvana received mixed messages from her parents who cared about her but at the same time did not care. She feels as if they do not understand her when she speaks and they do not understand her in her actions. The feeling of not being heard was linked to the theme of feeling abandoned. Not being heard isolated and alienated her as a person, and this resulted in her feeling abandoned. She felt that she did not identify with any community, nor belong to any community at home and at university. She did not experience the benefits of a close parent-child relationship nor of a close relationship with any of her friends. Nirvana's inability to have a close relationship with her parents links with Hoover and Insel's (1984) findings. They studied the families of 10 severe OCD patients and found that there exist severe conflicts within family members regarding intimacy and closeness. Relationships between parents and siblings are described as unfulfilled, disappointing and distant. There was a constant yearning for closeness on the part of the child.

Nirvana's failure to experience attachment during her childhood seems to have hampered her ability to develop relationships and build her support system (Sarason, Sarason & Pierce, 1990). The importance of early attachment experiences in childhood is highlighted by Sarason, Sarason and Pierce (1990). This together with Nirvana's depressed emotional state seems to have disrupted her social functioning, which probably led to her experiencing stress within herself and in everyday situations. Burrows, Norman, Judd, Cornwell, Moore and Tiller (1991) have found that the chronic effect of OCD leads to severe social impairment which causes distress in the personal and family life of sufferers. This is a vicious, reflexive cycle that Nirvana was caught in because although OCD is characterised by a waxing and

waning course, the OCD becomes worse as a result of psychosocial stress (Pato & Zohar, 2001).

The OCD became an expression of Nirvana's emotional need, which is responded to in different ways by members of her family and friends. Her family now responds by taking an interest in her health. Her family responding only to her illness reflects the poor relatedness and lack of connection between her and her family. Van Noppen and Steketee (2001) suggest that the family support system often plays a critical role in the prognosis and outcome of treatment. In case studies conducted by Hoover and Insel (1984) OCD sufferers showed improvement with parental involvement in the behavioural treatment of children, adolescents and adults. However, Calvocoressi, Lewis and Harris (1995) found that the OCD sufferer's symptoms could engender extensive family involvement and have adverse effects on family functioning. Calvocoressi et al. (1995) reported that 88% of family members participated in some way in OCD symptoms and that greater family participation in symptoms was significantly correlated with family dysfunction and negative attitudes toward the OCD sufferer. Intervention to address these difficulties might be helpful in recovery. However, most of the research reported on family treatment for OCD has not directly addressed family involvement in symptoms or family stress.

One of the associated accompanied disorders of obsessive-compulsive disorder is depression. Nirvana often experienced a measure of depressed emotions. When she was in this depressed state one of her most dominating feelings was that she often felt a sense of loss. A feeling of loss was evident in her story. Her level of depression seemed to have robbed her of taking an interest in almost all aspects of her life.

With her constant feelings of loss and not feeling loved by her family, Nirvana was seeking to belong in different and dangerous ways. She continuously questioned herself in terms of how does she belong, where and with whom does she find belonging. Therefore, one of the co-constructed goals was to shift her from a position of feeling abandoned to creating a space for her to belong to her family and her community in a way that was comfortable for her. The notion of seeking to belong

reflects Nirvana's proactive behaviour by recognising her needs and trying to meet those needs.

Nirvana engages in limited social contact with friends and acquaintances. Her explanation for this is that she experiences anxiety around building relationships, and making contact with people. Nirvana entered adulthood without having adequately acquired interpersonal skills to cope with in social contexts. This resulted in her social functioning being disrupted thereby causing her to experience stress within herself. Gotlib and Hammen (1992) postulate that when an individual fails to acquire the necessary coping skills and resources and problem-solving strategies to cope with stress, they are not equipped to deal with life's demands on them (i.e., in situations of stressful jobs and social relationships).

Attributing positive meaning to her life

Nirvana continuously expressed a need to find meaning in her life, in the actions that she engaged in and more importantly in her thoughts. She constantly searched for meaning from significant others such as her family and her lecturers at university. By searching for meaning Nirvana means searching for happiness, peacefulness, searching to be loved, and to find positive meaning in the things she does. She acknowledged that she already has meaning attached to the events in her life, except that the meaning that she has attached is negative and unproductive for her. This led to her questioning herself in terms of "why do I, Nirvana attach negative meaning to events, and why do I have to search for receiving love in my life?" Saari's (1996) ideas on influences on an individual's capacity to create meaning in life are that creating meaning is a similar process to forming an identity in life. Both are constantly created and modified throughout an individual's life. The process of meaning making is viewed as an interpersonal negotiation where it is created in the interaction between at least two people. Factors that influence an individual's ability to create meaning in life are:

- An individual's internal state must be experienced as stable. There must not be so much conflict that it debilitates the person. However, some degree of conflict can motivate the person to create meaning in order to solve the

problems involved. The person's physical environment must be experienced as emotionally safe.

- The specific content of the individual's picture of self and of the world, for example, whether these are seen as good, bad, or helpful will either encourage or depress the capacity to create meaning.
- A history of reasonably attuned human relationships will make the person likely to be able to engage productively in meaning-making, because the individual's capacity to create meaning develops over time and once developed can endure some adverse conditions.
- A cultural environment that is understood and that is expected to understand will facilitate the creation of meaning (Saari, 1996).

In Nirvana's self-description (the meaning she gives to herself) she sees herself as weak because she suffers from obsessive-compulsive disorder. She describes herself as weak, unproductive and unable to function effectively. In considering the meaning that Nirvana gives to herself as an OCD sufferer, one needs to look at how the DSM-IV-TR (APA, 2000) describes OCD sufferers, in what way I, as researcher and therapist, see her from an ecosystemic perspective, in what way the psychiatric team sees her, and how the significant people in her life see her. Her meaning of weakness has recursively impacted on her behaviour and her family's behaviour towards her (e.g., Nirvana walks very droopily, low body tone, does not take an interest in her dressing and she is not as adventurous as she would want to be).

Nirvana's ideas around the meaning she has given to herself as an OCD sufferer is influenced by the views and socio-cultural practices of a particular time in her life. Gergen (1985, p. 15) states, "the terms in which the world is understood are social artefacts and products of historically situated interchanges among people". This links strongly with Bateson (1979) that context gives meaning and understanding to words and actions. Nirvana's ideas around people suffering from OCD are shaped by her experiences as a child raised in a home where there was a shared ecology of ideas around family members' feeling neglected, not being loved, and its recursive impact on an illness.

Nirvana's experience of feeling discomfort and being in therapy could be due to her being confronted with negative aspects of herself and her relationships. She consequently felt challenged to take on the responsibility to modify her negative behaviours. These challenges were experienced in response to my deconstruction of her dominant story. Deconstructing her dominant story externalised the absurdity of Nirvana's behaviour and left her with a choice of changing these behaviours. The challenge experienced by Nirvana is in accordance with the aim of narrative therapy as described by White and Epston (1990) namely to deconstruct the problem story through externalising conversations where significant shifts in meaning take place that bring about new behaviour. This is a recursive process. Farrelly and Brandsma (1974) similarly believe that the task of the therapist is to challenge clients to engage in reality testing and risk-taking behaviours in order to react appropriately in relation to their context.

News of difference appears when Nirvana claims to have gained new insights as a result of her participation in therapy (Bateson, 1972). Nirvana indicated that she came to see herself and her behaviours in a new light as she progressed through the therapeutic process. This newly obtained insight was brought about by Nirvana confronting herself, to such an extent that she could no longer avoid or deny her own behaviour and role. As a result of the news of difference, Nirvana admitted to beginning to view the circumstances of her problems differently. This brought her to a point where she started realising the importance of taking responsibility for her own actions. Exploring her roles provoked her into reconsidering hidden aspects of her different roles. Andolfi et al. (1989) are of the opinion that experiences such as news of difference within a therapeutic context can also be regarded as an experience of support.

Identifying personal needs and the needs of others

This theme, according to which Nirvana identifies and satisfies the needs of others before her own needs are met, becomes evident in her loyalty towards others. This is consistent with the findings of Welfare (1993) in which he found that individuals suffering from OCD are engaged in a constant internal battle of being loyal to others before being loyal to themselves. Nirvana was more sensitive to the

needs of others and always put the needs of others before her own needs. She always placed her family and significant others' loyalty above being loyal to herself. However, her loyalty to other people was at the expense of herself. This made her vulnerable to hurt from others when they failed to meet her needs and she perceived other people as taking advantage of her. Since Nirvana's emotional needs were not being met she was experiencing feelings of depression and a loss of self. She only deemed it important to accomplish and achieve tasks so that she would receive the acknowledgement and admiration from her significant others.

However when Nirvana was discharged from hospital and went back to her family it seems that she was able to identify and differentiate her needs as a daughter and a sister. She describes situations after having identified her needs that she was able to assume responsibility for trying to meet those needs. She was able to identify the needs of others by engaging in conversation. She was able to draw boundaries around herself in terms of not engaging in activities that she perceived as harmful to herself or that would require sacrificing herself.

Not confronting issues

The theme of not confronting issues was prevalent in Nirvana's life with regard to her avoidance to deal with issues whereby she consciously chose to be passive and silent. Nirvana describes her family as unable to openly share their emotional needs and issues with each other. This is seen in her sister's suicide attempt and in her mother's diagnosis of major depression. The family never addressed her sister's suicide attempt, and Nirvana thought it was her fault and accepted the blame for that situation. She consciously chose to be silent, to be voiceless. The collusion of silence was also maintained because of her belief that if the problems were not acknowledged, then her family problems did not exist.

Nirvana tended to avoid dealing with issues that confronted her and her family, as her previous attempts to confront their problems were met with misunderstanding, miscommunication or silence. This miscommunication was also evident in my attempts to communicate with Nirvana's parents as well as between Nirvana and the psychiatrist.

Nirvana's inability to handle stress in relation to her study material led to her experiencing anxiety symptoms. She also experienced severe stress whilst living at her parent's home. Her attempts to confront the issues at her home failed. Nirvana feared that her mother would become depressed again, and therefore decided to approach the issues at home by remaining silent.

Until Nirvana began therapy she had found a way of coping with the pressures of life by avoiding issues or problems. The issues that she needed to deal with were relationship issues linked to her feelings of depression. She had a lot of pent up anger towards her family members. She did not express her anger to them for fear of being rejected by them. However, when she left the hospital and went back home, her pattern of dealing with problems changed from being silent to addressing issues. This paved a way for honest communication between herself and her family. Hafner, Gilchrist, Bowling and Kalucy (1981) found that once unexpressed anger between family members was made overt communication with each other increased.

Nirvana took the initiative and responsibility to engage in another form of communication, namely the process of letter writing. According to Bennion (1998) letter writing is deeper, more emotionally involved, self-descriptive and exploratory than spoken therapeutic intervention. Written narratives are more expressive and coherent than spoken narratives and by being fully heard, clients are enabled to transform their stories. This study has shown that Nirvana's experience of and relationship to her problems was also transformed through her continuous letter writing to me.

Failing to meet expectations

Nirvana experienced an inability to meet the expectations of herself as well as the expectations of others. Her perception was that she constantly failed to meet her own expectations, the expectations of her family as well as my expectations of her during therapy. With regard to her expectations of herself, her explanation was not knowing herself well enough to really know what to expect. With regard to her family's expectations of her, she was not aware of their expectations of her because she felt that they often gave her mixed messages. Nirvana could not really grasp

what they really wanted her to do or achieve. This resulted in her only disappointing them. With regard to Nirvana's expectations during therapy, she constantly checked with me if she was saying or doing the right thing. Nirvana was very unsure of herself. She described this being unsure of herself and not knowing what was expected of her during therapy, as a result of her poor memory. Van Noppen and Steketee (2001) have found that the most dominant characteristics of OCD are experiencing uncertainty, a strong need for feeling certain, overestimation of harm, ideas of being perfectly competent, and that failure to achieve these aims should be punished.

In speaking about her failing to meet the expectations of herself and of her family she expressed her fears of failing and of being afraid of this process of letting everyone down. In a study conducted by Notman (1989) it was found that individuals, who have a fear of failing were often found to experience failure and low self-esteem.

Due to an inability to meet her own expectations Nirvana experiences a poor quality of life, in which she has difficulty socialising, building relationships with significant family members, has difficulty studying, and focusing or concentrating on work. This is consistent with Koran's (2000) findings that most individuals suffering from OCD experience poor quality of life across the different domains of their life.

Low self-esteem/lack of identity

Nirvana felt helpless, hopeless and stuck in her life because she did not know what career direction to take. This resulted in her experiencing feelings of stuckness. She would have liked the chance to make a fresh start but her feelings of helplessness immobilised her. According to Nolen-Hoeksema (1987) women feel helpless because they believe that they are powerless to bring about change. Her intentions remained stuck as ideas, and the ideas were unable to be transformed into action. Low self-esteem, low self-efficacy, dependency, self-criticism, perfectionism and introversion are personal characteristics that are involved in the aetiology of individuals suffering from depression (Nirvana's secondary diagnosis). Adverse childhood experiences lead to the development of negative self-images that are characterised by low self-worth and expectations that others would respond negatively to them. This results in individuals, who suffer from low self-esteem, to

depend on others in order to maintain their self-esteem. If their needs are frustrated, they demand support or alternately develop obsessive, perfectionistic tendencies (Gottlib & Hammen, 1992). Nirvana developed both perfectionism and obsessive thoughts. Blatt (1995) refers to qualities of perfectionism developing in individuals as resulting from adverse childhood experiences, whereby the child's dependency needs are frustrated, and the child develops perfectionistic tendencies.

Nirvana was very critical of herself with regard to all the domains in her life, such as the interpersonal domain, and the academic domain. Nirvana suffered from low self-esteem, was self-critical and self-condemnatory. Her low self-esteem centred on the belief that she had not accomplished anything worthwhile in her life. She constantly experienced feelings of incompetence as a result of the remarks made by those around her. Her inability to cope with the pressures of life tied in with her belief that she was not in control of her life. Many times this brought her to breaking point as she perceived that her life seemed to be falling apart and going from bad to worse.

According to Kaplan (1986), low self-esteem is related to experiences of loss, inhibition of action, and inhibition of anger and aggression. Low self-esteem also refers to "pervasive feelings of worthlessness and extreme inadequacy" (Kaplan, 1986, p. 236). Conducting relationships is important for women to attain self-esteem. In their relationships women can "feel powerful and effective" (Notman, 1989, p. 226). Therefore, women's sense of self worth rests heavily on their sense of their ability to make and build relationships" (Kaplan, 1986, p. 238). Women who experience feelings of depression experience low self-esteem as a result of early and continuing emotional disconnection from others. They take personal responsibility for their failure to connect emotionally, and this serves to further increase their low self-esteem. In their relationships, women sacrifice and silence themselves. The aspect of loss experienced by these women is the loss of self in order to preserve peace and harmony in their relationships by silencing themselves through failing to voice their needs in order to please others. There is also the loss of self-esteem that accompanies the awareness of self-betrayal (Jack, 1991).

Nirvana continuously spoke of having no identity or lacking an identity. Identity is defined as a personal meaning system that is created over the course of an

individual's experience with the world and is organised in narrative form (Bruner, 1991). Identity is the content of the stories told to others and self. From my perspective, identity may also be seen as an individual's personal theory about himself or herself, about the world, and about his or her relationship with the world. It is through this personal theory that the individual organises past experiences and plans future actions (Epstein, 1973).

Personal identity can therefore be seen as a meaning system constituted with other people through processes of dialogue. Maranhao (1990, p. 18) explains that the "traits of identity do not precede dialogue, they are bestowed upon the person as he/she speaks and listens. An individual comes into being together with dialogue and is as much a meaning content as are the things talked about". According to Saari (1996) identity does not exist inside the isolated individual, waiting to be uncovered through an exploration of the layers of the unconscious, but it seems to be a meaning system created through dialogue with others. Furthermore, personal identity does not form in an early developmental stage and then remain the same throughout life. It is constantly modified, created and recreated, in negotiations with interacting individuals throughout a person's entire life. This process that Nirvana underwent with regard to knowing her personal identity, brought her to the point where she believed she had no identity due to an absence of relationships, dialogue and negotiations.

Not taking responsibility for herself

Nirvana's feeling of helplessness that was linked to an external locus of control was prominent. She believed there was nothing that she could do to change her position because she was at the mercy of external factors that control her life and that nothing she can do will make any difference to her unfortunate circumstances. The consequence of this led to her taking on a passive approach and she took no responsibility to do anything about her situation. Nirvana's behaviour of avoiding responsibility was obvious since she expected others to assume responsibility for changing her situation. She passively expected or wished that things would happen to her that would change her situation.

Nirvana stated that she expected me to point out her mistakes and provide her with advice and solutions. Instead, she found that I was merely provoking her in order to bring forth her underlying issues (Andolfi, Angelo, Menghi and Nicolo-Corigliano, 1983). She realised that neither I nor anyone else would take responsibility for directly changing her behaviour except herself. She stated that she was surprised by the fact that I as the therapist made her see what her problems were while placing the responsibility for finding answers solely in her hands.

Nirvana talks about OCD in a way that reflects her as having no control over the disorder. When Nirvana consulted with health care members she felt powerless because they too had no control over the disorder, which was seen in their talking about OCD as a chronic and lifelong disorder. This left Nirvana with feelings of being unable to cope and therefore having no power and control over the effects of the disorder on her life.

It seems that Nirvana was unable to assume responsibility because she perhaps did not acquire the skills needed to assume responsibility. She believes that she did not learn and was not even taught by her parents about taking responsibility. This became evident after Nirvana went through a process of engaging in dialogue around personal responsibility, when there was a shift in her thinking and in the actions that she undertook around taking responsibility for her emotional self, her career needs, and her position in her family.

Nirvana's story is an example of conflicting relationships identified by Luborsky and Crits-Christopher (1990). One of Nirvana's goals in therapy and in life was to express her feelings, but her anticipated *reaction of others* was rejection, which would result in a *reaction of* discomfort for herself. Her discomfort was linked to speaking about the unspoken. Bringing forth hidden or unspoken issues through the use of deconstruction and feedback made her uncomfortable with herself as she had previously decided not to address unspoken issues, and to be silent. This links with the emphasis that Andolfi, Angelo and De Nichilo (1989) place on the concept of provocation within a system. According to this concept, the therapist takes on a role to provoke individuals in therapy to enhance the therapeutic process. These provocations are sometimes experienced as extremely challenging.

Nirvana also experienced a sense of discomfort that was linked to her need for affirmation. The continuous over-emphasising of the negative and the dark side of events during the therapeutic process discouraged her at times. This strengthened her need for affirmation from me. She indicated that she needed me to believe in her. She therefore expressed a desire to be acknowledged for her achievements in therapy. With Nirvana seeking the acknowledgment for her achievements in therapy it became a pivotal point in the therapeutic process for both of us. It highlighted her insight into her position with regard to her approach to therapy, her insight into the therapeutic goals that she set for herself, her awareness into what her needs in life are, and with identifying and knowing what her needs were, she was able to bring about changes so that her therapeutic and emotional needs could be met. She expressed desire, enthusiasm and energy to fulfil her needs.

Unique Outcome

To help clients internalise personal agency and develop a self-narrative in which they view themselves differently, White has developed an interviewing technique to elicit unique outcomes (White, 1995). Unique outcome is a term coined by Goffman (1986) and consists of experiences or events that would not be predicted by the problem saturated story or narrative that has governed the client's life and identity. Unique outcomes include exceptions to the routine pattern within which some aspect of the problem normally occurs. The therapist and client engage in dialogue about particular instances in which the client prevents the problem from having a major negative influence in his/her life (Carr, 1998).

The unique outcome identified in Nirvana's story did not appear to require the substitution of the active story, but rather a story which questioned the assumptions of the way in which meaning was attached (Gergen & Kaye, 1992). To construct a story in which this was countered would have been to exchange one extreme for another, and thus maintain the dominant story, for example, "I feel that I am to blame for doing everything wrong. I worry about disappointing everyone that I love. Therefore I do not deserve their love". It was necessary to find a new story that did not rely on an either/or dichotomy, but which opened up alternatives. A unique outcome emerged with Nirvana having a strong voice.

Follow-up months later revealed that although it had not been easy for Nirvana, she still took responsibility for bringing about positive change for herself. Her inclusion in the family appears to have been given a new positive meaning. Her emphasis is not on her position in the family, and who is close to her. It has shifted to a position of ease with which she can move between relationships with members of her family. After Nirvana confronted her family she says that the family are now *talking about it, rather than not addressing it at all*. This implies that that which had remained unsaid for so long, was now being said (Hoffman, 1992).

In some ways the notion of deconstruction aligns itself closely with Bateson's (1972) notion of distinctions between levels of learning, that is from replacing one story with another to learning new ways of telling the stories to challenge and change the underlying assumptions that underpin storytelling habits. Nirvana's definition of herself changed from being weak, to one in which she had developed a greater sense of self. She took on a new role, and a new meaning of self had been established. Nirvana was able to stay in uncertainty, be comfortable with herself about making decisions, and take responsibility for herself without having feelings of guilt. Nirvana began to sense that once the assumptions underlying her dominant narrative were under discussion, her story about herself began to change and she realised that new meaning was being attributed in her life.

With regard to Nirvana's problem of having a poor memory problem her emphasis shifted. Allen and Allen (1995) point out that memories are created in the present, and projected back into the past or forward into the future. The secret of history is therefore lost, since individual memories are reconstructions in the present time and thus influenced, shaped and constrained by the currently dominant narratives. Nirvana did not worry excessively about her poor ability to recall from her memory. She came to realise that not having a history is not as important as having the ability to create history and new memories.

A reframe was introduced into therapy which brought about another unique outcome for Nirvana. Reframing involves conceptualising a viewpoint, situation or problem differently but in such a way that the new explanation fits the 'facts' as well or better than the old one (Watzlawick, Weakland & Fisch, 1974). Hence a reframe,

or a redefinition of the problem/event (Andolfi, Angelo, Menghi & Nicolo-Corgliano, 1983) alters the meaning of the existing explanation. I was always aware of Nirvana's diagnosis of OCD. However, I did not refer to Nirvana or think of her as an obsessive-compulsive person, neither did I mention the diagnosis often. I did not identify Nirvana as a sick person. In contrast to a linear epistemology, which defines a system as a particular social structure characterised by certain structural norms and roles, ecosystemic epistemology looks beyond the boundaries imposed by social norms, to consider the network of meanings and intersubjective processes that organises the problem (Keeney, 1983). In following this epistemology, a shift was made from considering clinical diagnoses as a process of ascribing a label to an individual so as to signify a particular pathology, to considering the network of complexly intertwined relationships around OCD. Nirvana commented on this during the last session. We then explored the impact that this reframing had on Nirvana. Nirvana shared with me that by my not constantly referring to the diagnosis, it seemed as if the disorder is not really a problem to such an extent where she cannot function effectively. When other people refer to the disorder or refer to Nirvana as being ill, she can easily take on that role and play that part. However within the context of therapy where Nirvana was not identified as a sick person she was able to be and exist differently from her sick self within a therapeutic relationship.

Conclusion

For change to occur, it is essential that the problems be resolved by the deconstruction of the problematic language (Anderson & Goolishian, 1988). It might be argued then that by changing the way individuals language or story about problems or problematic situations they are, in essence freeing themSELVES from the grip of dominant narratives which have served to hinder other ways of attaching meaning (Allen & Allen, 1995). At the end of the therapy Nirvana exclaimed that "the way that I saw my situation was a problem. Now I see and understand it differently, and it is not a problem any more." To me as a researcher and therapist the reality of the first order has remained unchanged (first-order reality being Nirvana's life situation), but Nirvana's second-order reality (second-order reality being the meaning that Nirvana attributed to her life story) is now different and bearable for her (Watzlawick, 1996).

CHAPTER SEVEN

CONCLUSION

*To a large extent, our lives are lived according to a story,
and just as a scriptwriter can change the reactions of the hero and the themes
within a tale, so too can the disclosure of an individual's life to others
change her own lived story.*

(Stones, 1996, p. 3)

Introduction

By Nirvana disclosing and sharing her story with me, Nirvana experienced change on different levels in her lived story. She experienced change in herself, in her perceptions of others in interaction with herself, in the meaning that she attributes to herself, and in the meaning that she attributes to her life. Sharing her life story also influenced the way she views her world, and her relationship with significant others. This links with Dunne's (1973) assumption that there is a profound link between the story of an individual's life and the story of his/her world.

In this concluding chapter, an overview of this investigation will be provided. This is followed by my reflections as a researcher on the research process. The study will be evaluated in terms of its strengths and limitations. The implications of the findings of this study will also be highlighted. Recommendations for future research will then be proposed.

Overview of this Investigation

The aims of this study were as follows: seeking a holistic understanding of Nirvana's experience of living with OCD, and providing a descriptive account of the recursive connections between OCD and Nirvana's ecological context. Both aims

were achieved. The usefulness of using deconstructive techniques within narrative therapy when approaching dominant narratives of an individual with OCD were illustrated by Nirvana's story. Important and significant shifts in meaning took place that allowed Nirvana to open the door to multiple and new meanings and different voices in her life. The deconstruction of dominant narratives, which were constructed through social interaction, without replacing one dominant narrative with another, was another aim that was achieved. And finally, the findings of an ecosystemic exploration of OCD, was linked to the existing literature.

Since "life cannot be relived but can only be retold" (Steele, 1982, p. 372), the reality of our lives is to a large extent, inextricably linked with the stories we tell others and ourselves about our own life history. Stories also provide a relatively comfortable way for an individual to relate his/her experience, therefore this investigation used the process of storytelling. Epston et al. (1992) believes that stories play a vital role in organising one's experience and it is in these stories that we give meaning to our experience. Similarly, through the application of storytelling the aim of arriving at the meanings that Nirvana has constructed around OCD was achieved.

According to Blake (1989, p. 425) the quantitative approach has "limited ability" to identify and study the extremely complex, psychological, social and cultural contexts in which events and associations unfold. With regard to generalisations the quantitative approach assumes that there is a single reality that is independent of context. Qualitative research however focuses on revealing and describing context and illuminating meaning. Notions such as recursion, connectedness, complementarity and feedback are examples of the ecosystemic epistemology used in this investigation. The ecosystemic approach has allowed for an understanding of the unique meaning of the experience of living with OCD, together with the meanings of the associated issues that were explored. Also, by employing the qualitative approach in this investigation it became possible to focus on Nirvana's personal and unique experience.

I chose the case study not as a methodological choice, but as a choice of a particular case to be studied (Denzin & Lincoln, 2000). I chose to study a case of OCD. OCD symptoms can be viewed and described both qualitatively and

quantitatively. However, my emphasis and method of documenting Nirvana's case of OCD is qualitative.

For carrying out this investigation I used a narrative approach to therapy. My choice for working narratively is reflected in White's words (1995, p. 21) "I'm really interested in people's accounts of their experience. I really want to understand what life has been for them". Since the ecosystemic epistemology emphasises description (Keeney, 1983), a narrative approach to therapy seemed to be the most logical choice for Nirvana's story of living with OCD.

By deconstructing Nirvana's dominant story the following themes were illuminated:

- confusion and not knowing
- feeling abandoned and seeking to belong
- attributing positive meaning to her life
- identifying personal needs and the needs of others
- not confronting issues
- failing to meet expectations
- low self-esteem/lack of identity
- not taking responsibility for herself

Through the externalisation of the problem as defined and understood by Nirvana, and the way that she spoke about the problem, seems to have dissolved the problem (White, 1991). Nirvana's dominant narratives were deconstructed, and by the process of deconstruction the meaning that Nirvana attached to her dominant narratives shifted. Bruner (1991) calls this phenomenon the exoticising of the domestic. Within the post-modern frame, it seems that the three stages of narrative change as outlined by Allen and Allen (1995) may be applied to the process of this investigation:

- Deconstruction of a life story or a dominant story and a related sense of self, or group of selves that have been attributed meanings by that story.
- Co-authoring a new story with a new sense of selves with new possibilities

- Reintegration of these new selves into a community of meaningful narratives.

One of Nirvana's most important needs in life and her main goal of therapy was to create a new identity, to achieve a positive sense of self and to attribute positive meaning to the different domains of her life. Identity is created, recreated and modified throughout one's life in a similar way that the capacity to create meaning in one's life may be developed. Also, the process of creating identity is similar to the creation of meaning in that it is not a static entity. It fluctuates within specific contexts and the contextual element that most influences an individual's capacity to create meaning is the relationship to other people. According to Saari (1996) children who are raised with little contact with other people fail to develop a good command of language. Creating meaning is interpersonally based, and it can be expected to develop less well in children who have little access to empathic communicative interaction with other people. Despite, Nirvana's upbringing which provided her with limited verbal communication and interaction with the members of her family, she was able to participate with individuals (psychiatrists, psychologists, health care members) to recount her experiences, and this recounting enabled her to maintain an identity. Nirvana realised that whatever her experiences were, it was only through her relationship with others that her own life experience became clarified and meaningful. Her constructions around events and relationships in her life and their associated meanings are not necessarily static and often tend to change over time, as adaptations do, or as a result of new experiences. Changes occur rapidly and spontaneously as a result of immediate input from external sources, during which Nirvana underwent internal changes with resultant shifts in the original meanings that she had attached.

With Nirvana's previous admissions to hospital she became symptom free while hospitalised but relapsed on returning home. From her description of her experience with the psychiatrist, it seems that the focus of treatment was directed towards her symptoms and medication. Her severe anxiety, the psychological and social content and context of her life, and her personal attribution of meaning were not explored or taken into account. According to Hafner (1982) there was an interconnectedness between the symptomatology of women suffering from OCD and their family relationships. Hafner, (1982) who worked individually with the OCD

individual was unable to shift the rigid family patterns of interaction between the OCD individual and the rest of his/her family members. Therefore the OCD individual upon arrival at home relapsed. Nirvana's last admission to hospital consisted of psychotherapeutic treatment, which involved an ecosystemic exploration of herself and her ecological context. This was different to the previous times she was treated. An ecosystemic epistemology involves seeing the patterns of relationships which looks beyond the boundaries to consider the network of meanings and intersubjective processes that organise the problem (Keeney, 1983). This could account for the fact that Nirvana did not experience a relapse upon returning home, and reflects the results of a different outcome or treatment response through working ecosystemically. There needs to be a shift from placing the emphasis on the patient, the psychiatric disorder and the symptoms with the associated symptomatic treatment, to a more holistic and ecosystemically oriented approach towards the individual and his/her context which is inclusive of his/her psychological pain, thoughts, emotions and attribution of meaning (Bloch, 1987).

Nirvana's opinion of her not expressing herself well often hindered her communication with others and her ability to form relationships with others. She viewed this as a negative aspect of herself. She therefore chose to write to counter this negative part of herself and to communicate with others. She wrote letters as a way of finding out about herself and her relationship to OCD. For her, writing became a way of "knowing", a way of discovering and analysing herself (Richardson, 2000).

It seems therefore that the most important aspect of telling one's life story as Nirvana did, "is its creation" (Stones, 1996, p. 6). One lives a story that is narrated without necessarily speaking and giving voice to it. It unfolds by living and even through concealment it is being told while at the same time the teller of the story is brought into existence.

My Reflections on the Research Process

Once a researcher/therapist recognises that there are many stories that may fit an individual's life, the researcher/therapist is freed from having to discover the ultimate truth about that individual's life. This recognition enables the researcher/therapist to make use of a therapeutic resource that is already in front of them, namely the client.

(Penn, 1991, p. 43)

My relationship with Nirvana

There was a rapport between Nirvana and myself that allowed me to establish a working relationship with Nirvana. I engaged in self-disclosure for the purpose of connecting with Nirvana, and establishing an "ethic of participation" (Kogan & Gale, 1997, p. 112). I tried to connect with Nirvana on many levels. As one who listened and understood Nirvana, as one who spoke to her in a way that her sense of self would grow, as one who spoke to her that she could believe in herself and take responsibility to make decisions for herself. Nirvana was eager to constantly engage in conversation with me when she realised the sense of support she received from me.

Listening to the story Nirvana told me allowed me to learn about her life. This made it easier for me to be connected with Nirvana's feelings. The deep engagement between us helped me to deepen my understanding and to become more sensitive to Nirvana's therapeutic needs and her life experiences. The communication and contact between Nirvana and myself after each session and during the interviews gave me the opportunity to know her better and start considering her as a collaborator in this research. Stiles (1993) suggests that this sort of "engagement fosters an internal view of human experience. It deepens understanding aesthetically and emotionally, as well as cognitively" (p. 605).

Clients are meant to experience support when they are allowed to get in touch with their own level of suffering and fears of inadequacy. At one stage Nirvana indicated that she experienced the therapeutic context as a learning context. She

indicated that she realised that I was supporting her throughout the therapy process. Nirvana experienced me as always listening to her and that I acknowledged her as a person by conveying the message to her that her issues were real and worth talking about. Minuchin (1974) describes this type of support as expressed through the therapist's explicit showing of appreciation for the client's perceived strengths and achievements. The experience of being supported by the therapist has often been enhanced by an experience of being understood.

The one word that can be used to describe the relationship that existed between Nirvana and myself as the researcher is one of *dependency*. It is my opinion that Nirvana was dependent on me for emotional support, approval of herself in terms of her behaviour as a person, and acknowledgement of herself as an individual, a daughter, and a student.

Reflecting on my role as Researcher

Upon reflection I realised that my ability to maintain a non-judgemental attitude towards Nirvana was a key factor in eliciting information (Grafanaki, 1996). I am of the opinion that my non-judgemental attitude towards Nirvana helped me to have a more balanced outlook towards her. This prevented me from being locked into focusing only on Nirvana as an individual suffering from OCD. It also helped to introduce a difference into a system that was characterised by criticism and judgementalism.

Nirvana and I continued the therapeutic relationship after she was discharged from the hospital. Both of us realised that I formed an important and integral part of her support system. We both decided that I would continue to play this role until Nirvana would return to her family, and become integrated into her family in such a way that she was comfortable with herself and with others, and until she would have built up her support network from within her family circle and her friends.

My experience of being in dialogue with Nirvana is one of confusion. I constantly felt the pull and the push to respond in a way Nirvana wanted me to which was to be an affectionate mother. My experience of therapy with Nirvana was a bit

tedious, with her often having no memory, and giving the message that she did not wish to continue.

Flexibility

Conducting research with Nirvana required me to possess a degree of flexibility. This flexibility is expressed in the ability to be open to new experiences, and the willingness to change. For me, as researcher, it became easier to enjoy the research process and learn from it. This led to my becoming more able to let the process unfold, instead of trying to guide it in directions intended to prove my theoretical assumptions. The more I trusted the research process, the easier it became for me to stop imposing unnecessary structure onto the process of research (Grafanaki, 1996).

Perceiving and treating Nirvana as a co-researcher and collaborator made it easier for me to relax and enjoy the research process, and at the same time gain more co-operation from her (Hill, 1984). I continuously asked for feedback from Nirvana about the therapeutic interaction. Her perception of the research process provided me with valuable insight. This feedback increased my awareness and flexibility and reduced my tendency to seek unnecessary structure and control over the research process.

My flexibility can also be expressed in the willingness to share with Nirvana what I understand from my perspective, and in providing her with the opportunity to comment on or provide feedback on my interpretation (Stiles, 1993).

During the research interviews, I constantly tried to reflect and summarise what Nirvana had shared with me, giving her the chance and the opportunity to correct any misunderstanding or misinterpretation. Throughout the interviews, I took on a position of allowing her to *teach* me how to *retell* her story in a way that was closer to her experiential world. As May (1989) had indicated, the process of asking, listening, understanding and retelling was an exciting, interesting and exhausting experience for me.

Ethical decision-making

The main ethical dilemmas I struggled with consisted of my dual roles as researcher and therapist, and maintaining role boundaries. Dual roles and role boundaries can also create tension between my role as researcher and my role as therapist. Although the researcher may provide information, reassurance and emotional support to the participant at some point during the research process, the major role is that of an investigator rather than a therapist especially when highly emotionally charged material is shared, and unresolved issues are revealed (Hutchinson & Wilson, 1994). However, the calling for me to be a therapist was stronger, and I therefore needed to constantly reflect on my role boundaries.

According to Patton (1990) the researcher needs to adopt a stance of *empathic neutrality* that is, empathic engagement, connection and understanding with the story the participant shares, but neutrality regarding the specific content of the material that is being generated. I was in a constant battle of trying to maintain a balance that is suggested by May (1989, p. 181) "qualitative research requires balance between flexibility and consistency, depth and breadth, and ability to get the story and attend to the needs of the story-tellers themselves".

Using other people's life stories to gain a higher degree for the researcher constitutes an ethical issue according to Etherington (1996). Most people are in some way recompensed for the work they do, by the payment of money, the conferring of a degree, or some other form of reciprocation including personal satisfaction. The same is true for people who allow their stories to be used for research. Towards the end of the therapeutic process Nirvana admitted that she was there for her own benefit, and that this process of telling her story felt entirely right for her. I as a researcher and therapist do not feel guilty for using an individual's life story to gain a higher degree because of my belief or assumption that through sharing a life story there can be healing.

My challenges as a researcher

The first challenge that I faced in the role of Nirvana's researcher and therapist was the fact that she did not come for therapy of her own accord. Yes, she did agree to be admitted to the psychiatric ward, but she did not choose to attend psychotherapy. Her psychiatrist had suggested that she consult the psychologist. Nirvana's reason for coming to therapy is "just following instructions and she wants to do the right thing". She however failed to see that she had a choice to attend therapy. The first challenge that I therefore experienced was Nirvana's overt resistance to the therapy process. The second challenge that I quickly detected was Nirvana's indecisive nature. She could not make a decision, and decided to attend psychotherapy just to please the doctor.

I was aware of my need to respond to Nirvana, as if Nirvana was a lost child that could be saved by her responsible mother. I felt like a mother to Nirvana who had to teach her child values, family rules and discipline. As the researcher I was aware of my responsibility for helping Nirvana with her career decisions. I felt the need to please Nirvana by showering her with statements of proudness and to be in conversation with her only about incidents or events in her life that would put a smile on her face. I felt her urgency to only have conversations centred on happy times and good memories. The challenge for me was to remember the role of the therapist addressing Nirvana's goals of therapy. To reach these goals meant I was constantly challenged to create contexts for addressing the unspoken words from Nirvana's past, such as the non-existent relationship between Nirvana and her mother. My challenge as the researcher was to create a holding and safe enough context for Nirvana to confront herself. The challenge was to *stay with* Nirvana while she was facing her dark side.

Relationship boundaries

As I listened to Nirvana's story with my *researcher* ears, I became uncomfortable with myself when I realised that I was thinking at one stage that this is really good information. I am aware that this is something I would not have thought in my capacity as therapist. I appreciated the useful research material that was

unfolding before me, as the researcher. However, upon reflection, I, as the therapist, was shocked to realise that I had lost my therapeutic sensitivity for one moment.

Impact of the research on myself as the researcher

Qualitative researchers often study concepts that are important to them at a personal level. This leads to researchers being involved in self-examination, personal learning and change. The researcher's interpretations evolve, transform, and change, as the researcher becomes infused with the observations (Stiles, 1993). Upon reflecting on the experience of conducting this qualitative investigation, I believe that the research has changed me both on a personal and professional level. My learning involved development of self and development as a therapist. This change has been facilitated by my close engagement in the commitment to the research. The passionate interest and commitment in what I was doing kept me going in moments when the process was tiring and draining. My experience taught me to be more flexible and able to cope with changes in a more productive way. The intensive research interviews encouraged reflexivity and self-exploration, and increased my awareness of my assumptions and biases.

Evaluation of the Research

Strengths of the Research

One of the aims of this investigation was to hear Nirvana's life story of OCD, and since stories are the closest that individuals can come to experience as they and others tell of their experience, the information generated in this investigation may be valuable to those individuals working with obsessive-compulsive people or to individuals whose family member is an obsessive-compulsive person (Stake, 2000).

Another strength of this research was choosing to work from a qualitative research paradigm. Conducting qualitative research proved to be an appropriate way to gain information that was personal and sensitive. The qualitative design is holistic, looking at relationships within a system and beginning with a search for understanding the whole picture that paved a way for meeting the aims of this

investigation (Janesick, 2000). If a quantitative approach had been adopted and the participant had been administered a questionnaire, the answers to which would then have been statistically analysed and presented, the findings discussed in the research would have been notably different to what has been presented. Personal, unique attributions of meaning may have arisen but would have been tabulated into categories and given statistical importance, that is, significance or non-significance, rather than being understood and utilised from an ecosystemic perspective. Within the application of the traditional medical model to patients the aspect of the patient's individual way of integrating, perceiving and understanding his/her diagnosis with the resultant attributions of meaning may have possibly been disregarded.

This investigation used only a single case study, which does not represent a population of OCD cases and provides no ground for making a generalisation. However, a single case study in spite of being a poor sample can establish limits to grand generalisations (Stake, 2000). A single case study of an individual's experience of living with OCD may be of value in refining theory and suggesting areas for further investigation, as well as helping to establish the limits of generalisability.

Limitations of the Research

One of the major limitations of this study could be the use of a single case study. A limited sample of one participant was used. This limitation could have been avoided if the sample size of the study was increased and more descriptions upon descriptions were obtained from other participants. Therefore the meanings, themes and patterns described cannot be generalisable across time and context. No generalisations can be made with regard to obtaining just one description of an experience of living with obsessive-compulsive disorder although it may be a rich, in-depth description. For this investigation to be carried out a qualitative method was selected where the research findings cannot either be proven or verified by replication. Nirvana's story and description of her experience of obsessive-compulsive disorder is unique to herself, therefore once again, no generalisations can be extrapolated from this research.

One of the limitations of qualitative research is that the researcher may tend to select data that links with his/her working assumptions and impressions (Moon et al., 1990). The implication of this is that the themes and meanings generated by myself as the researcher are not the only distinctions that could have been made. The meanings identified during this study are representative of both Nirvana's and my co-constructed understanding of Nirvana's experience of obsessive-compulsive disorder. They should be regarded as context bound. Another researcher may have drawn completely different distinctions and punctuated significant events differently.

A researcher's description of another person's meaning system is a secondary account, which could be regarded as a limitation of this study. I was not able to provide the entire transcript of Nirvana and because certain data was selected, it failed to "capture the full experience of a living text or live narrative" (Hoshmand, 1989, p. 21). However, selected excerpts from the interview texts were provided which were linked to the themes that were articulated.

Implications for Treatment

A psychiatric disorder is identified by a number of distinct sociomedical and psychological characteristics. First, OCD may be a long-term disorder, second, OCD usually involves maintenance of and adjustment to the disorder rather than cure, third, OCD has multidimensional effects on an individual's life and recursively impacts on family members, which requires major modifications in the lifestyle of OCD sufferers and frequently of their families, fourth, OCD frequently deprives OCD sufferers of their familiar and identity-related roles, and requires the development of a new life style. Finally, OCD may require long-term adaptation to special medical and psychological regimens.

Due to this combination of factors, which are psychological or behavioural, an exclusively biomedical approach is insufficient and inappropriate for the understanding of OCD patients. Many of the issues that confront OCD individuals and their families are psychological or philosophical in nature, rather than being only organic. Adhering to an ecosystemic epistemology has the advantage of considering the relational context, which may create wider possibilities to work with OCD

sufferers in therapy (Keeney, 1983). I therefore, suggest and stress the importance of understanding, treating or managing the individual living with OCD from an ecosystemic perspective.

In contrast to a linear epistemology, which sees events as being connected by a linear cause and effect link, ecosystemic epistemology acknowledges the recursive connection between events. According to Keeney (1983, p. 58) recursion denotes "repetition, recurrence and circularity", implying that any item or object can be described in terms of its relationship with other items. With this manner of perceiving things there may be a shift from blaming the OCD sufferer or symptom bearer as the cause of pathology within the family. A non-blaming stance may enable members of the system to consider their part, such as their patterns of behaviour and attributions of meanings in maintaining the symptoms of the OCD sufferer.

Recommendations for Future Research

Although this study has made a contribution towards the existing body of knowledge with regard to experiences of an obsessive-compulsive disorder sufferer the following recommendations are made for future research:

- There is a need for more research on obsessive-compulsive disorder in South Africa.
- Research into Indian, Coloured and Black communities in terms of statistics regarding prevalence, onset of OCD and maintenance of the disorder.
- Research into the conceptualisation and understanding of OCD by the different cultural denominations.
- Research into establishing and setting up more support groups for sufferers of OCD in all provinces in South Africa.
- Qualitative research into the ecology of an OCD individual with focus on the members of that ecology and not only on the OCD sufferer. The lack of qualitative knowledge possibly affects the quality of patient care.

- Future study specifically focusing on the personal trauma experienced by an OCD sufferer such as the impact of the disorder on their personal identity, or self-esteem.

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