

**OCD within the therapy room: An exploration of person-centred
therapy**

By

Luke Madden

Submitted in partial fulfilment of the requirements of the Higher Diploma in

Counselling and Psychotherapy,

Dublin Business School, School of Arts, Dublin

Supervisor: Dermot Ronaldson

May 2025

Department of Psychotherapy

Dublin Business School

Declaration

I hereby certify that this thesis is entirely my own work and has not been submitted as an exercise for a degree at any other university. I agree that the library may lend or copy the thesis request

Signed

Luke Madden

Abstract

This study sets out to explore the application of person-centred therapy (PCT) in addressing obsessive-compulsive disorder, a disorder that affects between 1-3% of the global population. OCD is characterised by core components including obsessions and compulsions that impair quality of life (QoL) including social functioning and a sense of wellbeing. OCD leads to distress and anxiety which reduces autonomy and creates a false sense of identity, whilst invoking feelings of guilt and shame. PCT's humanistic framework uses empathy, congruence and unconditional positive regard to promote self-acceptance and autonomy. Examining OCD and its subtypes, this study finds that PCT counters the fragmented self-identity commonly reported in individuals with OCD, whilst fostering self-actualising tendencies.

Acknowledgements

Firstly, I would like to thank my Mam for her continued support over the past two years. She has shown a true belief in me, and I will be forever grateful for her support. I would also like to thank my sister for her support and the home cooked meals she has provided me with when I didn't have time to cook.

A special thank you to my supervisor Dermot, who provided invaluable feedback to me throughout this dissertation process.

Table of Contents

Chapter 1 – Introduction.....	1
1.1 Overview	1
1.2 Aims and Objectives.....	3
1.3 Prevalence of OCD	4
Chapter 2 - Understanding OCD	5
2.1 Obsessions: Ego Dystonic	5
2.2 Compulsions: Ritualised Behaviour.....	6
2.3 OCD and its subtypes	7
2.4 Psychological and emotional consequences of OCD.....	9
Chapter 3 - The person vs the problem	12
3.1 Discovering Self Through Core Conditions.....	12
3.2 Conditions of Worth: Locus of Evaluation	15
3.3 The Fragmented and False Self	17
3.4 Self-Actualisation and OCD.....	18
Chapter 4 – Discussion & Conclusion	20
References	25

Samuel Johnson (1709-1784): “The chains of habit are too weak to be felt until they are too strong to be broken”.

Chapter 1 – Introduction

1.1 Overview

We all have an intuitive understanding of what it is to be human, to feel free and alive whilst embarking on a journey of autonomy and personal growth. Autonomy plays a fundamental role in shaping wellbeing, positively impacting life satisfaction and emotional balance (Steckermeier, 2020). Within today’s society, many individuals maintain autonomy and navigate the complexities of their human experience with a level of congruent consciousness, and without an overwhelming sense of obsessions or compulsions. While human existence is often characterised by the ability to be self-aware, to explore emotional depth, and to pursue the meaning of life, individuals with obsessive compulsive disorder (OCD) often struggle with obsessions, intrusive thoughts and compulsions which inhibit their ability to live an autonomous and fulfilling life (Kaufman, 2018)

OCD is a clinical diagnosis that infiltrates this sense of conscious congruence and can have profound implications on an individual's quality of life (QoL), affecting personal relationships, life aspirations and their overall wellbeing (de Haan et al., 2013). The impairment of QoL within the context of OCD encompasses domains including social functioning, a sense of wellbeing and an ability to enjoy leisure activities (Schwartzman et al., 2017). OCD is a heterogenous disorder that is often referred to as

a phenomenon (Fukuda et al., 2023; Pitman, 1987; Rasmussen, 1994) and overpowers an individual's sense of autonomy and significantly reduces their sense of freedom (Stein et al., 2019). This lack of autonomy and reduced sense of freedom results in a diminished QoL (de Haan et al., 2013). According to Singh et al. (2023) OCD places rigid constraints on human thoughts, behaviours and interactions by fixating on recurrent thoughts or compulsive activities that impede on an individual feeling psychological wholeness, personal growth or achieving self-actualisation. Although OCD has been extensively researched over the years, it has been done so from a clinical perspective, with a large proportion of research focussing on cognitive behavioural therapy (CBT) (Fineberg, 2020; Koran et al. 2007; Stein et al. 2019) and exposure and response prevention therapy (ERP) (Foa & McLean, 2016; Hezel & Simpson, 2019).

In addressing the debilitating symptoms that accompany an OCD diagnosis from a clinical perspective, it is important to understand the impact that OCD can have on an individual on a human level, and the implications involved in treating a client from a humanistic perspective. Roger's (1951) person centred therapy (PCT) is underpinned in humanistic principles and aims to focus on the subjective lived experience of the client whilst building quality personal relationships (Narknisorn, 2012). PCT leads from a non-directive and non-judgemental perspective with a belief that individuals possess an innate tendency to grow towards self-actualisation (Cain et al., 2016). In addressing OCD as a disorder and understanding the serious implications that it can have on the QoL of an individual, having a distinct understanding of the core concepts

that underpin OCD is required. Developing an understanding of the core concepts that underpin OCD will allow this study to apply a humanistic and person-centred therapeutic approach to understanding and working with OCD.

When exploring OCD through the lens of humanism and person-centred therapy (PCT), it is essential to understand the core concepts of OCD including obsessions, compulsions and the subtypes related to the phenomenon. The core conditions that will be explored within this study are empathy, congruence and unconditional positive regard. Once explored, from a theoretical based perspective using previous literature, this study will explore PCT as a therapeutic modality grounded in the core humanistic values of personal growth, autonomy and the actualising tendency.

1.2 Aims and Objectives

Aim: To explore how person-centred therapy influences the treatments and lived experience of individuals with obsessive-compulsive disorder.

Objectives:

- To examine the psychological impact of OCD and its implications for an individual's quality of life.
- To explore person centred therapy as a therapeutic modality when working with OCD.

1.3 Prevalence of OCD

As an introduction to the topic and to provide further understanding to the disorder, this study will provide additional context to highlight the impact of the disorder worldwide and will also provide a specific definition of OCD from the American Psychiatric Association. To contextualise the severity and global significance of OCD, it is essential to consider its prevalence and diagnostic complexity. OCD has been highlighted as one of the ten most debilitating mental health conditions by the World Health Organisation (WHO, 2021) and it is estimated to affect between 1-3% of the overall general population (Roswell & Francis, 2015). Due to its complex and often misunderstood nature, OCD frequently is misdiagnosed or goes undetected, leading to delays in treatment. Research indicates that it can take an average of ten to seventeen years for individuals to receive an accurate diagnosis and appropriate support (Fineberg et al., 2019), increasing distress and severity of the symptoms over time.

The American Psychiatric Association (APA) (2013) defines OCD as: *“a disorder characterized by recurrent intrusive thoughts (obsessions) that prompt the performance of neutralizing rituals (compulsions). Typical obsessions involve themes of contamination, dirt, or illness and doubts about the performance of certain actions (e.g., being preoccupied with whether or not you turned off the oven before leaving the house). Common compulsive behaviors include repetitive cleaning or washing, checking, ordering, repeating, and hoarding”* (American Psychiatric Association, 2013).

Chapter 2 - Understanding OCD

OCD symptoms are frequently persistent, irrational, and ego-dystonic with an inconsistency to the individual's self-concept (Davey, 2008) and tend to evolve over time (Abramowitz et al., 2009). This level of inconsistency can seriously impair daily functioning and emotional well-being (Nakao et al., 2014) disrupting everyday life (Singh et al., 2023). Semeniuc et al. (2023) describes OCD as a complex and nuanced disorder that poses challenges for therapists due to its fluctuating presentation and subjective manifestations. In order to understand OCD from a person-centred perspective, this chapter will firstly, provide an understanding of the core concepts that underpin OCD. These core concepts include obsessions and compulsions which provoke symptoms of chronic anxiety (APA, 2013) cognitive distortions, and have serious psychological consequences on an individual (Abramowitz et al., 2009). Additionally, this chapter will outline four of the common subtypes of OCD including harm, sexual, contamination, and symmetry to gain a deeper insight into the OCD phenomenon. Only then can this study fully understand the implications of a person-centred therapeutic approach when dealing with an individual with OCD.

2.1 Obsessions: Ego Dystonic

At the core of OCD are obsessions, which are often ego-dystonic and come in the form of intrusive and recurring thoughts, images or impulses that trigger anxiety and discomfort which individuals find overwhelming and disturbing (Kring & Johnson, 2017). Obsessions are irrational and persistent and the individual experiences this as their consciousness being invaded by senseless thoughts (Fukuda, 2023) impairing

functionality and an individual's QoL (Singh et al., 2023). The obsessions are somewhat paradoxical as the more an individual attempts to resist the thoughts or obsessions, the more obsessed and distressing they become (Fukuda, 2023).

Although obsessions occur recurrently and are incongruent to the values held by an individual, they result in severe distress and a depleted sense of freedom (Elsouri et al., 2024). This can negatively impact an individual's sense of self and creates an inability for unconditional self-acceptance. Laving et al. (2022) argue that individuals living with OCD encounter high levels of self-doubt, shame, and compulsive attempts to neutralise perceived threats. Living with high levels of self-deprecation and a lack of internalised value due to these obsessions may hinder an individual's capacity to self-actualise and express an authentic identity (Ponzini & Steinman, 2022).

Individuals are often driven to perform some form of compulsion to appease the irrational and distressing obsession (Ponzini & Steinman, 2022).

2.2 Compulsions: Ritualised Behaviour

Compulsions are the behavioural or mental acts that an individual performs in response to obsessions to appease the anxiety or prevent a feared outcome. They are often repetitive or ritualised in nature and take many forms including excessive cleaning, checking, repeating, counting, praying or seeking assurance (National Institute of Mental Health, 2023). Many compulsions are of a visible nature, but they can also occur entirely mentally and are equally as debilitating (Heyman et al., 2006).

Although compulsions provide temporary relief for an individual, they ultimately reinforce the cyclical nature of OCD as they validate the irrational fear. The expectation is that performing the compulsion to appease the obsession will prevent any negative outcomes associated with them (Weiss, 2024,); however, this results in individuals becoming stuck in a feedback loop and feeling obligated to succumb to the compulsive tendency. Laving et al. (2022) argues that this sense of obligation operates from a place of fear and restricts an individual from their sense of freedom and autonomy, which is central to their psychological wellbeing. OCD's diverse manifestations are categorised into subtypes, each with their own unique psychological impacts.

2.3 OCD and its subtypes

OCD is a complex disorder and manifests in a variety of different forms that are often categorised into different subsets based on the predominant obsessions or compulsions (Schwartzman et al., 2017). Due to OCDs complex and heterogenous nature, the specific subtypes of OCD; harm, sexual, contamination, and symmetry, can have distinct psychological and emotional implications that can disrupt an individual's daily life. Harm related OCD can present in a variety of different ways and is often misidentified in comparison to other prototypical OCD subtypes (Lahey et al., 2024). This subtype can be violent in nature, and results in recurring intrusive thoughts about causing harm to oneself or others (Wu & Storch, 2016). Furthermore, they purport that although ego-dystonic and continuously rejected by an individual, it may result in an individual believing that they are a threat, which leads to compulsive checking,

seeking reassurance or avoiding social situations. This can restrict daily functioning and result in individuals restricting themselves from social situations due to fearing that they may harm others (Lahey et al., 2024).

Intrusive thoughts may also come in the form of unwanted sexual thoughts that can include taboo themes, provoking an intense sense of shame and a distinct fear of social rejection due to their stigmatising nature (Cathey & Wetterneck, 2013). Wetterneck et al. (2015) argue that sexual intrusive thoughts are quite common in individuals with OCD and differ meaningfully from other types of unacceptable thoughts. They suggest that such obsessional thoughts result in covert rituals that may cause significant distress. Allely and Pickard (2024) conducted a systematic review and support this, finding that these sexual obsessions are distressing in nature and result in constant reassurance seeking to reject the sexual obsession. These everyday manifestations of taboo intrusive thoughts including harm and sexual obsessions can be debilitating for an individual and lead to a fractured sense of identity (Rachman, 2007).

The everyday manifestations of contamination or symmetry subtypes can severely disrupt day to day routines and reinforce negative self-perceptions (Jalal et al., 2022; Radomsky & Rachman, 2004). Contamination is often associated with a fear of germs or illness and result in excessive compulsions such as washing or cleaning that can become dominating within an individual's life (Jalal et al., 2022). Symmetry OCD can also become a dominating presence within an individual's life and involves a

compulsive need to repeat actions or rearrange items to appease the fear of perceived danger (Radomsky & Rachman, 2004). Moreover, repetitive behaviours related to symmetry may come in the form of ordering arranging, repeating or counting and are common symptoms reports amongst OCD sufferers. These specific subtypes all share a common thread; infiltrating everyday existence causing negative psychological consequences (Radomsky & Rachman, 2004). These psychological consequences negatively impact the overall wellbeing of an individual and hinder their QoL (Jalal et al., 2022).

2.4 Psychological and emotional consequences of OCD

The psychological and emotional consequences of OCD are often profound, with individuals reporting impaired daily functioning whilst experiencing high levels of anxiety, distress, and overwhelm due to the regular intrusion of their obsessions and time-consuming compulsions (Sahoo et al., 2017; Zisler et al., 2024). Although the defining symptoms of OCD are obsessions and compulsions, these symptoms permeate into every aspect of an individual's life and impact their psychological and emotional wellbeing as well as their social existence. Each of the different subtypes result in excessive preoccupations and obsessive or compulsive preferences that reduce human autonomy and result in individuals feeling controlled and often exhausted with a reduced sense of life satisfaction (Subramaniam et al., 2013). The constant intrusion of intrusive thoughts and compulsive behaviours often leads to feelings of hopelessness, despair and a distorted sense of self (Vellozo et al., 2021).

A strong emotional consequence of OCD is the internalisation of guilt, and it plays a significant role in the conceptualisation of OCD (Giacomantonio et al., 2024). Research suggests that obsessions and compulsions characterised by OCD are intending to minimise the overwhelming sense of guilt that can at times feel inescapable (Mancini & Mancini, 2015). Laving et al (2022) suggest that guilt associated to OCD is unlike regular guilt that is based on an action committed, and it is often anticipatory, imagined or symbolic which becomes interlinked to one's identity. Furthermore, individuals may feel immoral or dangerous based on these imagined thoughts, fearing that they may act upon them and cause harm. This level of distress can amplify compulsions in order to negate the distressing thoughts which may result in checking or reassurance seeking to appease the guilt (Giacomantonio et al., 2024). This continuous cyclical nature of OCD may over time become deeply rooted within an individual and severely impact their sense of self with an inability to accept themselves unconditionally (Giacomantonio et al., 2024)

Guilt and shame are closely interlinked in the experience of OCD due to their morality-based nature and can negatively impact an individual's self-esteem and self-acceptance. Laving et al. (2022) highlight shame as a common emotion experienced by individuals suffering from OCD, and due to the complexity of the disorder, it can become overbearing to one's entire being. These feelings are particularly present in individuals suffering from obsessions focussed on harm or sex with a fear that they may act on these obsessions provoking a sense of distress, shame and internalised stigma (Wetterneck et al., 2015). Wolf et al (2010) argue that shame is viewed as a

morality-based construct that involves self-reflection and evaluation in accordance with social norms. Due to the ego-dystonic nature of OCD, it can prove difficult to assimilate these thoughts, feelings and emotions due to the misalignment to one's own true values and beliefs leading to a rise in feeling shame and morally flawed. The internalisation of shame can result in the implementation of maladaptive coping strategies including withdrawal from social engagement and isolation.

It is argued that OCD can significantly impact an individual's subjective perception of life and affects their psychological wellbeing, social relationships and physical health (Subramaniam et al., 2013). Individuals may withdraw from their friendships, romantic relationships, family life and their professional life due to a fear of being judged based on their distorted sense of self (Wetterneck et al., 2015). This distorted sense can result in psychological implications including self-stereotyping and self-discrimination (Ociskova et al., 2013) whilst also carrying heightened levels of fear and embarrassment (Schwartzman et al., 2017). The disorder can have a detrimental impact on a person's psychological development, particularly in the form of self-worth and identity formation. OCD can distort an individual's sense of self by creating a fragmented self-image (Wetterneck et al., 2015).

Chapter 3 - The person vs the problem

Person-Centred Therapy, pioneered by Carl Rogers (1951; 1957), provides a humanistic framework with a belief that every client is inherently driven towards personal growth and has the capacity for self-actualisation (Yao & Kabir, 2023).

Within this humanistic framework, experiencing is central, and the client's subjective experience is prioritised whilst fostering autonomy, self-acceptance and psychological growth (Rogers, 1951). PCT differs from traditional clinical therapeutic modalities such as ERP or CBT, which often take a directive approach focussed on symptom reduction and emphasises the importance of a non-directive therapeutic relationship to reconnect individuals with their true selves (Cooper et al., 2013). PCT, rooted in three core conditions; empathy, congruence, and unconditional positive regard (Rogers, 1951), emphasises that irrespective of the human condition, an individual should be treated empathetically and always valued equally (Rogers, 1957). This chapter will explore how PCT, incorporating Rogers' three core conditions and the concept of locus of evaluation (1951; 1957), can facilitate psychological recovery and improve the QoL of an individual's living with OCD.

3.1 Discovering Self Through Core Conditions

PCT places a primary focus on three core therapeutic conditions; empathy, congruence and unconditional positive regard, which are proposed as sufficient for therapeutic change (Rogers, 1957). For individuals living with OCD, whose self-acceptance and psychological growth is fragmented by ego-dystonic obsessions and compulsive and ritualistic behaviour, PCT provides an approach that is non-judgemental with a

primary focus on restoring self-acceptance and an individual's sense of autonomy (Rogers, 1957). Bohart and Greenberg (1997) argue that empathy is imperative when establishing a therapeutic relationship as it creates an accepting environment and allows an individual to feel more comfortable when divulging their concerns. Within the therapeutic space, empathy involves the therapist deeply understanding the client's thoughts, feelings, and struggles whilst reflecting the client's internal world in a compassionate and sensitive manner (Elliott et al., 2018; Rogers, 1980). Furthermore, empathy provides emotional validation which contributes to an improvement in self-esteem and emotional wellbeing alleviating self-criticism and fostering self-acceptance (Irrázaval & Kalawski, 2022).

For individuals with OCD, ego-dystonic obsessions often provoke a sense of fear, guilt and shame, resulting in an overwhelming sense of self-criticism whilst negatively impacting self-acceptance (Clark, 2020). Moreover, individuals may experience fear of rejection due to the specific nature of their thoughts with a reluctance to express their thoughts, feelings or emotions (Friedman-Ezra et al., 2024). From a PCT perspective, empathy provides a space where the client may feel understood and validated, fostering a sense of emotional safety when exploring explicit OCD subtypes such as sexual or harm (Wetterneck et al., 2015). In comparison to clinical based interventions such as CBT or ERP, empathy allows the therapist to connect with the client's subjective experience and deeply explore the disturbing emotional schemes connected to their obsessive thoughts (Irrázaval & Kalawski, 2022). Elliot et al., (2018) conducted a meta-analysis on empathy within the therapy process and found

that empathy was positively correlated to symptom reduction and increased client satisfaction. Furthermore, they suggest that empathy within the therapeutic space allows for the development of self-empathy, which may facilitate an internalised acceptance of oneself and allow an individual to reconnect with a more integrated, congruent, and compassionate sense of self.

Within the PCT framework, congruence ensures that the internal experience of the therapist is expressed to the client with an emphasis on the therapist remaining authentic (Rogers, 1957). This modelling of genuineness and authentic emotions from the therapist's perspective can assist with clients reclaiming their sense of identity and reconnecting with their authentic selves (Ray et al., 2014). Moreover, they suggest that congruence within the therapeutic space encourages trust, fostering a sense of belonging and reducing the isolation reported by clients with OCD. This level of authenticity invites clients to explore deeper emotional material and may provide them with the confidence to discuss their distressing compulsive rituals such as checking or symmetry without it being minimised (Cooper, 2007).

Empathy and congruence are critical conditions within the therapeutic space as they provide full empathic understanding from a genuine perspective; however, Rubin and Humphreys (2016) suggest that they must be accompanied with unconditional positive regard to be completely effective. Furthermore, it is a combination of these three core conditions that provides a safe and supportive environment for an individual which is

underpinned in trust and authenticity. Rogers (1959) described unconditional positive regard as valuing “the person, irrespective of the differential values one might place on his specific behaviors” (p.208). Clients are accepted as inherently worthy, countering the morality-based constructs such as guilt and shame prevalent in OCD (Giacomantonio et al., 2024). Irrázaval & Kalawski (2022) argue that unconditional positive regard may negate the negative self-perception of oneself commonly reported in cases of OCD, resulting in disentangling themselves from their obsessions and reclaiming a sense of autonomy, identity and internalised self-worth.

3.2 Conditions of Worth: Locus of Evaluation

Rogers (1951) argued that individuals have an innate capacity for self-actualisation and personal growth, however, he stated that the external environment, societal expectations, and judgements can negatively impact this process. Rogers (1951) referred to this as the conditions of worth incorporating the concept of locus of evaluation. The concept of locus of evaluation is an integral component of psychological growth and self-actualisation, depending on whether an individual's locus of evaluation is primarily fixed to internal or external values (Feltham & Dryden, 1993). Furthermore, they purported that locus of evaluation is the sense that people refer to when making judgements about themselves, others or the world. An internal locus of evaluation refers to an individual having the capabilities to rely on their own judgements and operate from a self-directed values perspective (Rogers, 1951). However, an external locus of evaluation refers to an individual relying on external sources such as societal expectations, judgements or another individuals'

opinions or advice. Mearns et al. (2013) suggests that the restoration of an internal locus of evaluation allows for an individual to operate from a place of autonomy and self-acceptance, indicating that an internal locus of evaluation may improve the psychological functioning and QoL of an individual.

Wetterneck et al. (2015) argue that conditions of worth can negatively impact QoL including the psychological welfare and social functioning of an individual with OCD. Due to the ego-dystonic nature of OCD and the misalignment with their internal value system, it is common for individuals with OCD to externalise their self-worth resulting in a distortion of self-perception (Schwartzman et al., 2017). Moreover, Ponzini and Steinman (2022) argue that although individuals self-stigmatise due to their obsessions and compulsions, societal stigma results in the externalisation of these value-based judgements due to fears of being labelled dangerous or immoral. This external locus of evaluation carries negative implications and may lead to a reduced QoL including withdrawing from social interactions, sense of wellbeing or the ability to enjoy leisure activities (Kugler et al., 2013). Clark (2020) supports this and suggests that individuals with OCD experience heightened states of self-deprecation due to a perceived fear based on an inability to meet societal expectations. The lack of internal compass and an inability to connect to an internal sense of self is primarily rooted in doubt, guilt, shame and a compulsive need for certainty (Joseph & Murphy, 2013). This externalisation of self, which is particularly evident in sexual or harm-based subtypes, may lead to perfectionist traits, control or the desire for moral purity (Wetterneck et al., 2015).

Rogers (1959) argued that movement towards an internal locus of evaluation is a key principle of PCT, embedding the individual's self-worth within their own subjective organismic experiences. Furthermore, PCT aims to provide support to an individual to recognise their own feelings, emotions and perceptions, whilst navigating dependency from external validation to internal acceptance. A trusted internal locus of evaluation signifies an individual that has an unconditional self-acceptance allowing them to develop a healthier sense of self and express an authentic identity (Feltham & Dryden, 1993). This internal self-worth contrasts with relying on external approval or validation which is apparent in the external locus of evaluation. Although PCT highlights the importance of an internal locus of evaluation, Foa McLean (2016) argue that non-directive approaches may be time consuming and pose difficulties for OCD symptoms, resulting in a continued sense of fragmented self or false self.

3.3 The Fragmented and False Self

From a person-centred perspective, a fragmented or false sense of self results in psychological distress and undermines QoL (Mearns et al., 2013). The conditions of worth, shaped from societal expectations result in a discrepancy between one's subjective organismic experience and their concept of self, leading to a sense of incongruence (Rogers, 1951). Ponzini and Steinman (2022) argue that OCD results in the fragmentation of identity as individuals struggle to accept their ego-dystonic obsessions with their own authentic identity. Furthermore, they purport that these internalised beliefs, based on their intrusive thoughts, may diminish their sense of self-worth and result in guilt, shame and self-rejection. This false sense of self based upon

the externalised conditions of worth may erode self-esteem and impact levels of social engagement (Ocisková et al., 2013; Wolf et al., 2010).

Incongruence fosters psychological fragmentation with individuals adopting a false self as a coping mechanism to neutralise the distress caused by their obsessions (Laving et al., 2022). This results in compulsive behaviours including reassurance seeking, symmetry and checking (Purdon & Clark, 2002). Moreover, these compulsive tendencies tend to alleviate the distressing and anxiety provoking obsessions encountered by an individual with OCD (Laving et al., 2022). Irarrázaval & Kalawski (2022) suggest that these compulsions reflect an attempt to assert control and moral purity to combat the internal doubt, reinforcing the fragmented self-structure delineated by Rogers (1951, 1957). PCT aims to counter this internal fragmentation, facilitating a non-judgemental space and incorporating empathy and congruence to support the client's authentic self and achieve self-actualisation (Rogers, 1957).

3.4 Self-Actualisation and OCD

Rogers (1951) proposed the actualising tendency as an innate drive towards growth, wholeness and fulfilment and the realisation of one's potential. Although self-actualisation can be impacted by conditions of worth and external evaluations, Rogers (1957) argues that the ability to actualise remains present in all individuals even those experiencing severe psychological distress. Laving et al (2022) suggests that OCD obstructs actualising tendencies and limits autonomy through excessive forms of

obsessions and compulsions. Compulsions including checking in sexual OCD or washing or cleaning in contamination OCD can often become excessive and impede on the personal growth of an individual (Weiss et al., 2024). This can often become debilitating for an individual and negatively impacts social, occupational and family functioning, whilst also impeding on their sense of well-being (Weiss et al., 2024). Moreover, Ryan and Deci (2000) argue that autonomy is restricted for individuals living with OCD which negatively impacts their capacity for self-actualisation.

The pervasive nature of OCD disrupts the self-actualisation process as clients often feel controlled by their obsessions and compulsions resulting in a distorted self-perception (Vellozo et al., 2021). Furthermore, this distorted self-perception inhibits an ability to trust internal experiences and obstructs the actualising tendency through fear, control and self-doubt (Vellozo et al., 2021). PCT fosters self-actualisation and empowers individuals to begin to trust their locus of evaluation by incorporating empathy, congruence and unconditional positive regard into the therapeutic space (Cooper et al., 2013). Contrary to a clinical approach such as CBT or ERP, which aim to treat the symptoms or the problem, PCT focusses on the whole person by affirming their subjective experience and reintegrating their authentic self (Rogers, 1951).

Chapter 4 – Discussion & Conclusion

This study set out to explore how person-centred therapy influences the treatments and lived experience of individuals with obsessive-compulsive disorder. To achieve this, it had two primary objectives: firstly, to examine the psychological impact of OCD and its implications on an individual's quality of life, and secondly, to explore person centred therapy as a therapeutic modality when working with OCD. By addressing the aim and objectives, the research sought to address the gap in humanistic approaches to OCD treatment, which has primarily been studied through clinical based therapeutic modalities including CBT and ERP.

The findings of this research study suggest that OCD, a disorder encapsulated by core components including obsessions and compulsions, have a profound impact on an individual's QoL including psychological and social functioning, as well as negatively impacting a sense of wellbeing. It found that OCD has psychological and emotional consequences including guilt, shame and a lack of autonomy, which were identified in each of the four subtypes (Giacomantonio et al., 2024; Irarrázaval & Kalawski, 2022; Laving et al., 2022). Subtypes including harm, sexual, contamination and symmetry were found to have negative implications on the sense of self, which contributed to a fragmented sense of self and a reduced QoL. Harm and sexual subtypes were found to have more severe implications on self-identity and self-perception, resulting in individuals disengaging from social engagements and becoming more isolated.

PCT, which is underpinned by a humanistic framework, was found to offer a non-judgemental therapeutic approach rooted in three core conditions: empathy, congruence and unconditional positive regard (Rogers, 1951). This study found that these core conditions facilitate a therapeutic environment that is safe, supportive, and accepting, which counters self-stigmatisation and promotes self-actualisation (Pinzini & Steinman, 2022). As PCT focusses on the whole person by affirming their subjective experience and reintegrating their authentic self, it found that PCT may be a useful therapeutic modality in treating OCD.

The findings of this study align with previous research emphasising the debilitating nature of OCD and its implications on QoL, particularly in relation to the impact on autonomy, self-concept and self-perception (de Haan et al., 2013; Singh et al., 2023; Vellozo et al., 2021). The identification of guilt and shame as morality-based constructs linked to the psychological burden of OCD (Giacomantonio et al., 2024; Wetterneck et al., 2015; Wolf et al., 2010) supporting the idea that OCD diminishes psychological wholeness (Singh et al., 2023). This alignment occurs as previous study's analysis on OCD subtypes identified the impact of ego-dystonic obsessions and how they provoke morality-based implications including distress and anxiety.

These emotional barriers correlate with an inability to connect to self, obstructing the capacity for self-actualisation (Rogers, 1951). This study extends these findings by incorporating Roger's (1951) PCT framework, suggesting that empathy and

unconditional positive regard can mitigate guilt and shame, whilst fostering an internal locus of evaluation. These findings support Roger's theory that suggests that providing a non-directive therapeutic space can facilitate psychological growth and actualising tendencies, further supporting the idea that every individual has the capacity for self-actualisation. As PCT prioritises subjective experience, this study challenges Fineberg et al.'s (2020) emphasis on CBT symptom focussed efficacy and its emphasis on behavioural outcomes. The findings of this study divert from previous studies finding which questioned non-directive therapeutic modalities for treating OCD (Foa & McLean, 2016; Hezel & Simpson, 2019). These studies argue that due to the severity of OCD symptoms, including intense obsessions and compulsions within subtypes, OCD requires direct therapeutic interventions to disrupt the psychical nature of OCD. This suggests that the non-directive nature of OCD could be time-insensitive and less effective for acute OCD cases. However, this study highlights that although ERP and CBT may rapidly reduce compulsions through exposure-based therapies, they may divert from the identity fragmentation observed in individuals with OCD (Singh et al., 2023).

The inconsistency between clinical based interventions and humanistic interventions is apparent as this study highlighted emotional validation through PCT, which can be absent from CBT and ERP based interventions (Bohart and Greenberg, 1997).

Through a humanistic lens, this study highlighted emotional validation as critical for addressing the anxieties, which are often provoked in individuals living with OCD (Stein et al., 2019). Therefore, this study argues that there is a limitation in current

research on clinical based interventions as they may undervalue the importance of the subjective organismic experience of OCD. This study's findings suggest that Rogers (1951) theory could be expanded to include OCD-specific applications including the core conditions for moral obsessions.

The theoretical nature of this study is the primary limitation of this study as it relied on previously conducted research and lacks empirical data. This restricts the ability to validate the effectiveness of PCT when working with OCD. The study may have also overlooked the potential benefits of integrating humanistic and clinical based interventions to meet the needs of all clients, particularly those requiring directive interventions (Foa & McLean, 2016). However, research conducted by Koran et al. (2007) indicate a limitation within this study based on its theoretical nature as it lacks empirical rigor, which restricts its ability to challenge CBT and ERP validated outcomes.

A review of the literature through PsycINFO, PsycARTICLES and PEP Archive found no studies that have explored PCT within the context of OCD. Therefore, the strength of this study lies in its novel exploration of PCT within the context of OCD, which addresses a significant gap within the literature. The comprehensive review of OCDs psychological impact on provide a foundational framework for understanding the complexity of OCD and highlight future approaches that may be considered.

Future research should empirically test the effectiveness of PCT for OCD using qualitative studies to explore the experiences of clients. It may also be of use to include a mixed methods approach to measure the change in QoL and symptom severity. Additionally, comparative studies examining the PCT alongside CBT and ERP should be investigated to clarify the possibility of these modalities complementing each other. As the findings of this study suggest that PCT can enhance OCD treatment by fostering autonomy and self-acceptance, it may be possible to compliment clinical approaches and promote safe and non-judgemental spaces for clients to explore their ego-dystonic obsessions (Wetternceck et al., 2015).

In conclusion, this study highlights that PCT offers a valuable approach to the treatment of OCD, whilst addressing its psychological and emotion consequences through empathy, congruence and unconditional positive regard. By fostering a self-acceptance and autonomy within the therapeutic space, PCT counters the external locus of evaluation and fragmented self, which is apparent in OCD. Despite the study's limitations, it highlights a need for humanistic interventions when treating OCD, and for humanistic perspectives in OCD research. This research advocates for a PCT approach that prioritises the client's subjective experience, which may navigate clients towards self-actualisation and improved QoL.

References

Abramowitz, J. S., Taylor, S., & McKay, D. (2009). Obsessive-compulsive disorder. *The Lancet*, 374(9688), 491–499. [https://doi.org/10.1016/s0140-6736\(09\)60240-3](https://doi.org/10.1016/s0140-6736(09)60240-3)

Allely, C. S., & Pickard, M. (2024). A systematic scoping review of the literature on sexual orientation obsessive compulsive disorder (SO OCD): Important clinical considerations and recommendations. *Psychiatry Research*, 342, 116198. <https://doi.org/10.1016/j.psychres.2024.116198>

American Psychiatric Association, DSM-5 Task Force. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5™* (5th ed.). American Psychiatric Publishing, Inc.. <https://doi.org/10.1176/appi.books.9780890425596>

Cain, D. J., Keenan, K., & Rubin, S. (Eds.). (2016). *Humanistic psychotherapies: Handbook of research and practice* (2nd ed.). American Psychological Association.

Cathey, A. J., & Wetterneck, C. T. (2013). Stigma and disclosure of intrusive thoughts about sexual themes. *Journal of Obsessive-Compulsive and Related Disorders*, 2(4), 439–443. <https://doi.org/10.1016/j.jocrd.2013.09.001>

Clark, D. A. (2020). *Cognitive-behavioral therapy for OCD and its subtypes: Second edition*. Guilford Press.

Cooper, M., Schmid, P. F., O'Hara, M. & Bohart, A. C. (2013). *The Handbook of Person-Centred Psychotherapy and Counselling* (2nd ed.). Basingstoke: Palgrave.

- Cooper, M. (2007). *Person-centred therapy: A pluralistic perspective*. SAGE Publications.
- Davey, G. (2008). *Psychopathology: research, assessment and treatment in clinical psychology*. Bps Blackwell.
- de Haan, S., Rietveld, E., Stokhof, M., & Denys, D. (2013). The phenomenology of deep brain stimulation-induced changes in OCD: an enactive affordance-based model. *Frontiers in Human Neuroscience*, 7. <https://doi.org/10.3389/fnhum.2013.00653>
- Elliott, R., Bohart, A. C., Watson, J. C., & Murphy, D. (2018). Therapist empathy and client outcome: An updated meta-analysis. *Psychotherapy*, 55(4), 399–410. <https://doi.org/10.1037/pst0000175>
- Elsouri, K. N., Heiser, S. E., Cabrera, D., Alqurneh, S., Hawat, J., & Demory, M. L. (2024). Management and treatment of obsessive-compulsive disorder (OCD): A literature review. *Cureus*, 16(5), e60496. <https://doi.org/10.7759/cureus.60496>
- Feltham, C., & Dryden, W. (1993). *Dictionary of counselling*. Whurr Publishers.
- Fineberg, N. A., Hollander, E., Pallanti, S., Walitza, S., Grünblatt, E., Dell’Osso, B. M., Albert, U., Geller, D. A., Brakoulias, V., Reddy, Y. J., Arumugham, S. S., Shavitt, R. G., Drummond, L., Grancini, B., De Carlo, V., Cinosi, E., Chamberlain, S. R., Ioannidis, K., Rodriguez, C. I., Menchon, J. M. (2020). Clinical advances in obsessive-compulsive disorder: a position statement by the International College of Obsessive-Compulsive Spectrum Disorders. *International Clinical Psychopharmacology*, 35(4), 173–193. <https://doi.org/10.1097/yic.0000000000000314>

Friedman-Ezra, A., Keydar-Cohen, K., Van Oppen, P., Eikelenboom, M., Schruers, K., & Anholt, G. E. (2024). Loneliness in OCD and its determinants. *Psychiatry Research*, *337*, 115963. <https://doi.org/10.1016/j.psychres.2024.115963>

Foa, E. B., & McLean, C. P. (2016). The Efficacy of Exposure Therapy for Anxiety-Related Disorders and Its Underlying Mechanisms: The Case of OCD and PTSD. *Annual review of clinical psychology*, *12*, 1–28. <https://doi.org/10.1146/annurev-clinpsy-021815-093533>

Giacomantonio, M., De Cristofaro, V., & Mancini, F. (2024). In/stability of moral sense of self and OCD. *Journal of Obsessive-Compulsive and Related Disorders*, *40*, 100857. <https://doi.org/10.1016/j.jocrd.2024.100857>

Heyman, I., Mataix-Cols, D., & Fineberg, N. A. (2006). Obsessive-compulsive disorder. *BMJ*, *333*(7565), 424–429. <https://doi.org/10.1136/bmj.333.7565.424>

Hezel, D. M., & Simpson, H. B. (2019). Exposure and response prevention for obsessive-compulsive disorder: A review and new directions. *Indian journal of psychiatry*, *61*(Suppl 1), S85–S92.

https://doi.org/10.4103/psychiatry.IndianJPsychiatry_516_18

Irrázaval, L., & Kalawski, J. P. (2022). Phenomenological considerations on empathy and emotions in psychotherapy. *Frontiers in psychology*, *13*, 1000059. <https://doi.org/10.3389/fpsyg.2022.1000059>

Jalal, B., Chamberlain, S. R., Robbins, T. W., & Sahakian, B. J. (2022). Obsessive-compulsive disorder-contamination fears, features, and treatment: novel smartphone

therapies in light of global mental health and pandemics (COVID-19). *CNS spectrums*, 27(2), 136–144. <https://doi.org/10.1017/S1092852920001947>

Joseph, S., & Murphy, D. (2013). Person-centered approach, positive psychology, and relational helping: Building bridges. *Journal of Humanistic Psychology*, 53(1), 26–51. <https://doi.org/10.1177/0022167812436426>

Kaufman, S. B. (2018). Self-Actualizing People in the 21st Century: Integration With Contemporary Theory and Research on Personality and Well-Being. *Journal of Humanistic Psychology*, 63(1). <https://doi.org/10.1177/0022167818809187>

Koran, L. M., Hanna, G. L., Hollander, E., Nestadt, G., & Simpson, H. (2007). Practice Guideline for the Treatment of Patients with Obsessive–Compulsive Disorder. *The American journal of psychiatry*. 164. 5-53.

Kring, A. M., & Johnson, S. L. (2017). *Abnormal psychology* (14th ed.). John Wiley & Sons, Inc.

Kugler, B. B., Lewin, A. B., Phares, V., Geffken, G. R., Murphy, T. K., & Storch, E. A. (2013). Quality of life in obsessive-compulsive disorder: the role of mediating variables. *Psychiatry research*, 206(1), 43–49. <https://doi.org/10.1016/j.psychres.2012.10.006>

Lahey, C. A., Fawcett, E. J., Garland, S., & Fawcett, J. M. (2024). Professional and student understanding of harm obsessive–compulsive disorder: A vignette study. *Canadian Journal of Behavioural Science/Revue Canadienne Des Sciences Du Comportement*. <https://doi.org/10.1037/cbs0000425>

Laving, M., Foroni, F., Ferrari, M., Turner, C., & Yap, K. (2022). The association between OCD and Shame: A systematic review and meta-analysis. *British Journal of Clinical Psychology*, 62(1), 28–52. <https://doi.org/10.1111/bjc.12392>

Lívia Emy Fukuda, Melissa Garcia Tamelini, & Guilherme Messas. (2023). Obsessive–compulsive existential type: a dialectical-phenomenological approach. *Frontiers in Psychology*, 14. <https://doi.org/10.3389/fpsyg.2023.1211598>

Mancini, A., & Mancini, F. (2015). Do not play God: contrasting effects of deontological guilt and pride on decision-making. *Frontiers in Psychology*, 6. <https://doi.org/10.3389/fpsyg.2015.01251>

Mearns, D., McLeod, J., & Thorne, B. (2013). Person-centred counselling in action.

Nakao, T., Okada, K., & Kanba, S. (2014). Neurobiological model of obsessive-compulsive disorder: Evidence from recent neuropsychological and neuroimaging findings. *Psychiatry and Clinical Neurosciences*, 68(8), 587–605.

<https://doi.org/10.1111/pcn.12195>

Narknisorn, B. (2012). Person-Centered Therapy and Personal Growth. *Journal of Social and Development Sciences*, 3(9), 322–330.

<https://doi.org/10.22610/jsds.v3i9.716>

National Institute of Mental Health. (2023). *Obsessive-Compulsive Disorder: When Unwanted Thoughts or Repetitive Behaviors Take Over*. National Institute of Mental Health (NIMH). <https://www.nimh.nih.gov/health/publications/obsessive-compulsive-disorder-when-unwanted-thoughts-or-repetitive-behaviors-take-over>

Ocisková, M., Praško, J., Černá, M., Jelenová, D., Kamaradová, D., Látalová, K., & Sedláčková, Z. (2013). Obsessive compulsive disorder and stigmatization. *Activitas Nervosa Superior Rediviva*, 55(1–2), 19–26.

Pitman, R. K. (1987). Pierre Janet on Obsessive–Compulsive Disorder (1903). *Archives of General Psychiatry*, 44(3), 226.

<https://doi.org/10.1001/archpsyc.1987.01800150032005>

Ponzini, G. T., & Steinman, S. A. (2021). A systematic review of public stigma attributes and obsessive–compulsive disorder symptom subtypes. *Stigma and Health*, 7(1), 14–26. <https://doi.org/10.1037/sah0000310>

Purdon, C., & Clark, D. A. (2002). The need to control thoughts. In R. O. Frost & G. Steketee (Eds.), *Cognitive approaches to obsessions and compulsions: Theory, assessment, and treatment* (pp. 29–43). Pergamon/Elsevier Science Inc.

<https://doi.org/10.1016/B978-008043410-0/50004-0>

Rachman, S. (2007). Unwanted intrusive images in obsessive compulsive disorders. *Journal of Behavior Therapy and Experimental Psychiatry*, 38(4), 402–410.

<https://doi.org/10.1016/j.jbtep.2007.10.008>

Radomsky, A. S., & Rachman, S. (2004). Symmetry, ordering and arranging compulsive behaviour. *Behaviour Research and Therapy*, 42(8), 893–913.

<https://doi.org/10.1016/j.brat.2003.07.001>

Rasmussen, S. A., & Eisen, J. L. (1994). The epidemiology and differential diagnosis of obsessive compulsive disorder. *The Journal of clinical psychiatry*, 55 Suppl, 5–14.

Ray, D. C., Jayne, K. M., & Stulmaker, H. L. (2014). A way of being in the playroom: Experience-expression congruence model (EECM). *International Journal of Play Therapy*, 23(1), 18–30. <https://doi.org/10.1037/a0035512>

Rogers, C.R. (1951). *Client-centered therapy*. Houghton Mifflin.

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

Journal of Consulting Psychology, 21(2), 95–103. <https://doi.org/10.1037/h0045357>

Rogers, C. R. (1959). A theory of therapy, personality, and interpersonal relationships, as developed in the client-centered framework. In S. Koch (Ed.), *Psychology: A study of a science* (Vol. 3, pp.184–256). McGraw-Hill.

(PDF) Therapists' perspectives on positive regard. Available from:

https://www.researchgate.net/publication/362403232_Therapists'_perspectives_on_positive_regard [accessed May 01 2025].

Rogers, C. R. (1980). *A way of being*. Boston: Houghton Mifflin.

Rowell, M., & Francis, S. E. (2015). OCD subtypes: Which, if any, are valid?

Clinical Psychology Science and Practice, 22(4), 414–435.

<https://doi.org/10.1111/cpsp.12130>

Ryan R. M., Deci E. L. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist*, 55, 68-78.

Sahoo, P., Sethy, R., & Ram, D. (2017). Functional impairment and quality of life in patients with obsessive compulsive disorder. *Indian Journal of Psychological Medicine*, 39(6), 760. https://doi.org/10.4103/ijpsym.ijpsym_53_17

Schwartzman, C. M., Boisseau, C. L., Sibrava, N. J., Mancebo, M. C., Eisen, J. L., & Rasmussen, S. A. (2017). Symptom subtype and quality of life in obsessive-compulsive disorder. *Psychiatry Research*, 249, 307–310. <https://doi.org/10.1016/j.psychres.2017.01.025>

Semeniuc, S., Sterie, M. C., Soponaru, C., Butnaru, S., & Gavrilovici, O. (2023). Therapists' problematic experiences when working with obsessive-compulsive disorder: a qualitative investigation of schema modes, mode cycles, and strategies to return to healthy adult mode. *Frontiers in Psychiatry*, 14. <https://doi.org/10.3389/fpsy.2023.1157553>

Singh, A., Anjankar, V. P., & Sapkale, B. (2023). Obsessive-Compulsive Disorder (OCD): A Comprehensive Review of Diagnosis, Comorbidities, and Treatment Approaches. *Cureus*, 15(11), e48960. <https://doi.org/10.7759/cureus.48960>

Steckermeier, L. C. (2020). The Value of Autonomy for the Good Life. An Empirical Investigation of Autonomy and Life Satisfaction in Europe. *Social Indicators Research*, 154. <https://doi.org/10.1007/s11205-020-02565-8>

Stein, D. J., Costa, D. L. C., Lochner, C., Miguel, E. C., Reddy, Y. C. J., Shavitt, R. G., van den Heuvel, O. A., & Simpson, H. B. (2019). Obsessive-compulsive disorder. *Nature Reviews Disease Primers*, 5(1), 52. <https://doi.org/10.1038/s41572-019-0102-3>

Subramaniam, M., Soh, P., Vaingankar, J. A., Picco, L., & Chong, S. A. (2013). Quality of life in obsessive-compulsive disorder: impact of the disorder and of treatment. *CNS drugs*, 27(5), 367–383. <https://doi.org/10.1007/s40263-013-0056-z>

Vellozo, A. P., Fontenelle, L. F., Torresan, R. C., Shavitt, R. G., Ferrão, Y. A., Rosário, M. C., Miguel, E. C., & Torres, A. R. (2021). Symmetry Dimension in Obsessive-Compulsive Disorder: Prevalence, Severity and Clinical Correlates. *Journal of clinical medicine*, 10(2), 274. <https://doi.org/10.3390/jcm10020274>

Weiss, F., Schwarz, K., & Endrass, T. (2024). Exploring the relationship between context and obsessions in individuals with obsessive-compulsive disorder symptoms: a narrative review. *Frontiers in Psychiatry*, 15. <https://doi.org/10.3389/fpsyt.2024.1353962>

Wetterneck, C. T., Siev, J., Adams, T. G., Slimowicz, J. C., & Smith, A. H. (2015). Assessing Sexually Intrusive Thoughts: Parsing Unacceptable Thoughts on the Dimensional Obsessive-Compulsive Scale. *Behavior therapy*, 46(4), 544–556. <https://doi.org/10.1016/j.beth.2015.05.006>

Wolf, S. T., Cohen, T. R., Panter, A. T., & Insko, C. A. (2010). Shame Proneness and Guilt Proneness: Toward the Further Understanding of Reactions to Public and Private Transgressions. *Self and Identity*, 9(4), 337–362. <https://doi.org/10.1080/15298860903106843>

World Health Organization. (2021). Mental Health Atlas 2020. World Health Organization.

Wu, M. S., & Storch, E. A. (2016). A Case Report of Harm-Related Obsessions in Pediatric Obsessive-Compulsive Disorder. *Journal of Clinical Psychology, 72*(11), 1120–1128. <https://doi.org/10.1002/jclp.22392>

Yao, L., & Kabir, R. (2023). *Person-Centered Therapy (Rogerian Therapy)*. PubMed; StatPearls Publishing. <https://www.ncbi.nlm.nih.gov/books/NBK589708/>

Zisler, E. M., Meule, A., Koch, S., Schennach, R., & Ulrich Voderholzer. (2024). Duration of Daily Life Activities in Persons with and without Obsessive–compulsive Disorder. *Journal of Psychiatric Research, 173*.
<https://doi.org/10.1016/j.jpsychires.2024.02.052>