“What are the similarities and differences in the experience of unwanted, intrusive thoughts between clinical and non-clinical participants, as explored through a Framework Analysis?”

By Nadia Sampson

Portfolio submitted in fulfilment of the requirements for the Professional Doctorate in Counselling Psychology (DPsych)

City, University of London

Department of Psychology

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Preface

What is a preface but the introduction to a story, about to be told? The significance and power of the stories we tell both others and perhaps, more importantly, the ones which we tell ourselves, is the theme that runs throughout this portfolio. In truth, I was not entirely sure what the connecting theme would be when I began writing this portfolio of work but like all good stories, it eventually wrote itself.

"It's like everyone tells a story about themselves inside their own head. Always. All the time. That story makes you what you are. We build ourselves out of that story."

(Patrick Rothfuss, author of 'The Name of the Wind' and 'The Wise Man's Fear')

Each and every day, all of us are writing our own stories inside our heads. Perhaps we are revisiting the story of yesterday, which depending on the day we had, may contain details of great joy or maybe of real misery. Maybe the story we are constructing is not one of reflection but rather one of anticipation; this may be excitement for what we think the day will bring or it may be filled with anxiety, fear and dread about what we believe lies ahead. Perhaps the more important stories we are constructing each day are the ones that we continue to build and develop throughout the course of our lives; the ideas and pictures we paint of ourselves, eventually we build a story about the kind of person we think we are, we decide our strengths but also our limitations and whilst many of us fear external judgement, there rarely exists a harsher critic than the one that lives inside our own head.

This portfolio, therefore, consists of three separate but connected parts. Part One is the research project which explores two different participant groups' experiences of the cognitive phenomenon of unwanted intrusive thoughts. The introduction to the study opens with a quote from a famous philosopher reminding us that our happiness depends largely upon what thoughts we choose to focus upon. Whilst reviewing the literature, a common theory and

finding regarded '*appraisals'* – the suggestion being that what might really distinguish unwanted intrusive thoughts in clinical and non-clinical populations had little to do with the content of their thoughts but rather how they appraised them. This issue is then explored in several of the themes and categories in both the analysis and the discussion chapter and became a central issue in the research. Arguably, when we appraise something or someone, including ourselves, what we are doing is telling ourselves a story based on our perception at the time. These stories are often formed quickly and without a lot of information. We make judgements based on feelings, body language, prejudices – cognitions of which we ourselves, are often unaware of. Differences between participant stories were very interesting to observe – they were all, arguably, observing the same phenomenon but describing it entirely differently. This highlighted the power of the stories we tell ourselves about who we think we are and what we believe we are capable of. What we think we can control and who or what we believe controls us. These stories can determine our success and happiness in life which begs the question – why do so many of us tell ourselves such limiting and depressing stories? One answer may be a lack of awareness. This study utilised semi-structured diaries as one of its methods of data collection, asking participants to record the unwanted intrusive thoughts for one week. This activity ended up creating a story of its own and one which reflected back to each participant some of the daily stories they had been telling themselves, revealing that we all may not know our own thoughts as much as we might think that we do. Maybe we should all be writing down our thoughts, just to check that we are happy with the stories we are telling ourselves.

PARAGRAPH REDACTED FOR CONFIDENTIALITY REASONS

also the aim of the narrative work described in the combined case study and process report that forms the third and last part of this portfolio. Both in this report and whilst writing up my research, I note my own struggles at the word count limiting how much I can tell of my client and the participants' stories. Such rich and powerful stories, cut down to fit into a word limit.

These stories then had to be cut down further, to form part of the much tighter word limit in the publishable paper, that forms the second part of this portfolio. I can only hope that the words that remain still do justice to all these amazing stories and that whoever reads this learns something from them.

PART I: DOCTORAL RESEARCH

"What are the similarities and differences in the experience of unwanted, intrusive thoughts between clinical and non-clinical participants, as explored through a Framework Analysis?"

Nadia Sampson

Supervised by Dr Jacqui Farrants

Abstract:

Our thoughts do not always follow our intended path, they do not always stay on task and they are not always reasonable. In fact, our thoughts are often interrupted by unwanted cognitive activity, which can hinder our productivity (Clark & Rhyno, 2005). Examples of such mental processes which can cause cognitive interference include daydreaming, worry, rumination, distractions and obsessive thoughts (Klinger, 1996). Thoughts which can all come under the

umbrella of intrusive thoughts. The aim of the present research will focus on intrusive thoughts which are unwanted, which can not only interfere with intellectual pursuits, social activity or task performance, but can often form a substantial part of a number of psychological disorders (Pierce & Sarason, 1996). Through the use of semi-structured diaries and interviews, data was collected from four non-clinical and four clinical participants and was analysed through the five stages of Framework Analysis (Ritchie and Spencer, 1994). This uncovered the following themes: Interference with Daily Life, Triggers, Appraisal of Self and UITs and Response to Completing the Diary, with each theme also offering a case analysis, comparing the accounts of both the clinical and non-clinical participants. These findings are discussed in the light of the current literature on unwanted intrusive thoughts and its potential implications for clinical practice.

1. Introduction:

"The happiness of your life depends upon the quality of your thoughts, therefore guard accordingly…"

Marcus Aurelius Antoninus (121 AD -180 AD)

1.1 Chapter Overview:

The beginning of this chapter will introduce the focus of this current study, exploring some of the many definitions that have been provided for the cognitive phenomenon of unwanted intrusive thoughts, the different types of thoughts this can include and exactly which thoughts will be explored in this present study. This will then be followed by a discussion of the four main areas of research on the topic of unwanted intrusive thoughts: their content; possible triggers; how people appraise such thoughts and finally, how people may respond to these thoughts. The end of this chapter will look at the rationale for the present study, as well as a discussion of what the researcher hopes to contribute towards the field of Counselling Psychology.

1.2 Delineating the Focus:

Our thoughts do not always follow our intended path, they do not always stay on task and they are not always reasonable. In fact, our thoughts are often interrupted by unwanted cognitive activity, which can hinder our productivity (Clark & Rhyno, 2005). Examples of such mental processes which can cause cognitive interference include daydreaming, worry, rumination, distractions and obsessive thoughts (Klinger, 1996). Thoughts which can all come under the umbrella of intrusive thoughts. The aim of the present research will focus on intrusive thoughts which are unwanted, which can not only interfere with intellectual pursuits, social activity or task performance, but can often form a substantial part of a number of psychological disorders (Pierce & Sarason, 1996).

To differentiate this phenomenon from a variety of more *wanted* cognitive intrusions, such as fantasy, pleasant daydreams or sudden inspirational thoughts, a critical aspect of this mental phenomenon is that the person views such thoughts as being unwanted or unacceptable (Rachman, 1981). Clark (2005) has defined unwanted intrusive thoughts (UITs) to include

images and impulses, which are difficult to control, are non-volitional or unintended, are associated with negative affect and which interrupts the flow of thought. Many researchers and psychologists cite a key aspect of this mental intrusion to be its apparent spontaneous and uncontrollable nature. Rachman (1981) refers to such thoughts as having a 'wilful independence' whilst Klinger (1996) describes the occurrence of such intrusive thoughts to be without any intended purpose. As Clark and Rhyno (2005) note, such cognitions are not neutral in their nature but come with an "emotional bite" (p.137). In clinical states, such unwanted intrusive thoughts can seriously affect the person's mood and concentration, making even the most straight forward tasks difficult to complete – despite frequently making huge efforts to control these thoughts (Purdon, 2005). Numerous researchers have offered up a variety of definitions for UITs but for the purpose of clarity, this study has been working with the definition offered by Rachman (1981) - a sudden, quick, thought that sometimes occurs repeatedly, that is unacceptable and/or unwanted.

Some researchers have separated Negative Automatic Thoughts (NATs) and worry from their definition of UITs. This may make sense in the context that most of the research on UITs has predominantly focused upon UIT's role in obsessive compulsive disorder (OCD) and UITs in OCD tend to focus on obsessional themes, such as dirt and contamination (Turner, Beidel & Stanley, 1992; Fineberg et al., 2020). However, as this research wishes to focus on the broader role of UITs in all psychological conditions, the researcher will be examining all UITs, including worry and NATs. NATs, for example, both fits the definition offered above by Rachman (1981) and forms the main UITs experienced by people with depression. Worry is a UIT that also fits the definition given by Rachman (1981) for a UIT and is central in all psychological disorders, especially in anxiety disorders. Moreover, as Wells and Morrison (1994) point out in their study, "*worrying may be involved in the transformation of normal obsessions into obsessional problems. Worry could underlie compulsive activity associated*

with obsessions and worrying may be involved in the transformation of normal obsessions into obsessional problems. Worrying about obsessions and also worry about worry … may be a pathologising factor" (p.870).

When the researcher first began exploring this topic, their initial search of UITs (when put into the City University online library search engine) returned over 10,000 hits. Nearly 8,000 of those stemming from journal articles and the majority of those being from Psychology and Medical journals. During the years 2016 – 2024, the researcher would search some of the following terms; 'unwanted intrusive thoughts', 'intrusive thoughts', 'unwanted thoughts', 'diaries and unwanted thoughts', 'unwanted intrusive thoughts and clinical disorders', every few months, to keep up to date on any possible new research. Currently (February 2024) a broad search on City University's online Library of 'unwanted intrusive thoughts' still returns a very similar number of studies, in total (11,023 total results), the majority still resulting from within the field of psychology. Throughout this process the researcher has kept their focus upon academic sources only – such as journal articles, book chapters and thesis publications, excluding less academic sources, such as newsletters and newspaper articles. They also focused on journals and books most closely aligned with counselling psychology, such as clinical and cognitive psychology and excluding purely medical based journals. This helped the researcher to both reduce the research to a more manageable quantity, as well as a more focused and relevant one.

Psychology's fascination with this cognitive phenomenon is perhaps unsurprising since UITS are present in almost every (if not all) psychological disorders. In addition, as Purdon (2005) states, the psychological disorders which are most notably characterized by the persistent repetition of such unwanted intrusions, are both the most vulnerable to relapse (depression) or the most challenging to treat (schizophrenia, obsessive-compulsive disorder, generalized anxiety disorder, paraphilias and insomnia). Counselling Psychologists (and all professionals

working within the field of mental health) will be familiar with these questions that clients will bring, repeatedly: "*How do I stop what I have not willed? What does it mean about me that my mind generates these thoughts? Why can't I control these thoughts? What can I do to stop them? Will my thoughts lead to behaviour?"* (Purdon, 2005, p.2954). Mental health professionals are then faced with the question, how can they help their clients, who are suffering with these unwanted intrusive thoughts? As Clark (2005) states, there is mounting evidence to suggest that clinicians need to target such unwanted intrusive thoughts in their clients, as well as the client's responses to these intrusions, in order to help treat numerous clinical disorders, such as OCD, depression, anxiety and many other clinical disorders.

Although there are some exceptions (which is referred to later) the main body of research in to UITs, beginning with Rachman and de Silva's (1978) seminal study (detailed below), suggests that UITs, images or impulses are experienced by all individuals, on a universal scale and that the content of which is indistinguishable from that of clinical obsessions. This finding was then supported by several other studies which followed shortly afterwards (Clark & de Silva, 1985; Edwards & Dickerson, 1987a; Parkinson & Rachman, 1981a; Purdon & Clark, 1993; Salkovskis & Harrison, 1984), demonstrating that 80-90% of non-clinical participants reported UITs, impulses or images (Clark & Purdon, 1995). As Wang (2008) states:

"Evidence of 'normal obsessions' (or intrusive unwanted thoughts) in the general population is important because it demonstrates that these thoughts can serve as an analogue to clinical obsessions and as a potential precursor to abnormal obsessions (Clark, 2004, Rachman, 1997, Salkovskis, 1985)" (p.2).

However, a number of limitations could have impacted the validity of these findings, namely the fact that the majority of the non-clinical samples in these studies were composed of university students, of which the majority were female. However, this is a limitation that can be found in most of the studies that have followed; including a far more recent study by Wahl, Van den Hout and Lieb (2019) on the effects of rumination on UITs in non-clinical participants,

which had a sample entirely comprised of students, the majority of which were female. This limitation and its potentially significant impact upon external validity will be discussed in greater depth later in this chapter, as it forms a significant gap in the current research into UITs and is present in the majority of studies examining aspects of UITs (e.g. Brewin & Smart, 2005; Byers, Purdon & Clark, 1998; Clark *et al.,* 2014; Clark, Purdon & Byers (2000); Clark & Radomsky, 2014; Corcoran & Woody, 2008; Davies & Clark, 1998; DeLapp *et al.,* 2018; Gentes & Ruscio, 2015; Groome & Pipilis, 2007; Hale & Clark, 2013; Hoping & De JongMeyer, 2003; Inozu, Karanci & Clark, 2012; Langlois, Freeston & Ladouceur, 2000; Moulding *et al.,* 2014; 1992; Muris, Merckelbach, & Horselenberg, 1996; Nota *et al.,* 2014; Reynolds & Salkovskis, Riskind, Wright & Scott, 2018; Salkovskis & Campbell, 1994; Sica *et al.,* 2006; Taylor & Bryant, 2007).

Such limitations aside, the majority of the research in to UITs does suggest that unwanted intrusive thoughts, images or impulses are experienced by all individuals, on a universal scale and that the content of which is indistinguishable from that of clinical obsessions. This then lends the question; *if such unwanted intrusions are common place amongst all individuals, why do certain individuals become so distressed by them? What causes a UIT to turn into an obsession?* In a quest to answer these questions, research has focused its attention upon four main areas in relation to UITs: their content, triggers, appraisal and response. In this introductory chapter, some of the key literature and findings in these four areas of interest will be reviewed, as well as some of the main gaps and limitations, which has helped to shape the research question and finally concluding with an explanation of the rationale for this study.

N.B. *Many of the main studies that have been chosen for discussion in this chapter, although dated, have been included and discussed in detail, as they were seminal studies within the field of research in UITs and are still regularly referenced today.*

1.3 Content

Initial research into UITs indicated that the content of UITs in clinical and non-clinical groups were indistinguishable from each other (Clark & de Silva, 1985; Edwards & Dickerson, 1987a; Parkinson & Rachman,1981a; Purdon & Clark, 1993; Rachman & de Silva, 1978; Salkovskis & Harrison, 1984). As mentioned above, the first study to find this similarity in content of UITs between clinical and non-clinical participants was the study by Rachman and de Silva in 1978. This study consisted of three related, exploratory studies with 124 non-clinical participants and 8 clinical participants, all suffering from obsessions. In the first of the three studies, the nonclinical participants were issued with a questionnaire which sought to find out if they had UITs and if so, how often they had them and if they found them easy to dismiss. They were also given another questionnaire which looked at their thoughts and impulses. Ninety-Nine out of the 124 participants stated that they did experience UITs and impulses, finding no age or sex related differences. Interestingly, most of the participants who had stated that they did not have UITs also commented that they did have many of the thoughts and sometimes impulses mentioned but that although they knew general society viewed them as being unethical, they did not consider the thoughts to be unacceptable. (This last point refers to appraisal and is discussed later on in the chapter).

In the second part of the study, an investigation using standardized interviews was conducted with a sample of 40 non-clinical participants who had responded positively to the original questionnaire and a clinical sample of 8 participants, who had sought psychiatric help for their obsessions. The aim of this study being to examine the reactions of both groups of participants when they were deliberately provoked into thinking about their UITs. Results from this part of the study showed that UITs were similar in content, form, mood and meaningfulness in both the clinical and non-clinical groups, with the main themes in both groups being aggressive/sexual themes, socially unacceptable behaviour and harm coming to either one's self or other people (Rachman, 1981). However, they differed in intensity and

frequency and were harder to dismiss amongst the clinical group when compared to the UITs in the non-clinical group. However, as sample size was so uneven and the number of clinical participants were so small, no test of statistical significance could be drawn from this data.

The final part to this study looked at repeated-practice effects where the same two groups of participants were asked to focus upon one target obsession and then to focus upon that thought for 4 minutes without carrying out any neutralizing ritual. The same practice was then repeated 2 more times. It was found that a number of participants in the non-clinical group struggled to produce an obsession on request, with the same quality it would normally have, some could not think of one at all and some required triggers (e.g., knives, newspaper reports etc.). However, all 8 clinical participants were able to produce a target obsession upon request although 3 did engage in neutralizing behaviour. Neutralisation, from a cognitive behavioural perspective, is when a person attempts to prevent the consequences of their UIT occurring, or at least engages in an action (such as checking or washing) which absolves them of the responsibility they feel they have for preventing their UIT from occurring.

In summary, findings suggested that, overall, obsessions go through a habituation process, meaning that with practise, the likelihood of developing an obsession grows, while the discomfort and duration of the UIT decreases. However, due to the short-term nature of these trials, no statistical data could be drawn from this part of the study either. The researchers were interested in why the non-clinical participants found it harder to form an obsession under instruction than the clinical participants, hypothesising that the clinical participants' experience of the intensity and frequency of past obsession made it easier for them to recall the material (Rachman & de Silva, 1978).

Numerous other studies have since examined the content of UITs in clinical and non-clinical individuals through the use of questionnaire studies, providing non-clinical participants with a prescribed list of UITs and asking them to state any that they may have ever experienced, resulting in prevalence rates of 99% (Belloch, Morillo, Lucero, Cabedo & Carrio, 2004), 74% percent (Langlois, Freeston, & Ladouceur, 2000) and 88% (Salkovskis & Harrison, 1984) (Berry & Laskey, 2012). However, as Berry and Laskey (2012) point out, this method of endorsing UITs from a prescribed list does not account for individual differences in the content of UITs. Moreover, different questionnaires differ in the different content themes which they contain. For example, the Obsessive Intrusive Thoughts (OII) questionnaire (Purdon & Clark, 1993) that was used in the study by Belloch *et al.,* (2004), assesses UITs with content themes relating to dirt and contamination and sex and aggression, whereas the Cognitive Intrusions Questionnaire (CIQ; Freeston, Laudouceur, Thibodeau & Gagnon, 1992) which were used in the study by Langlaois *et al.,* (2000), evaluates UITs that related to thoughts concerning a painful or embarrassing experience, family or friends having an accident or suffering from a fatal disease, their own personal health, verbal aggression or sexual behaviour which they find personally unacceptable (Berry & Laskey, 2012). Another limitation of these findings lies within the timeframe of these assessments. For example, England and Dickerson (1988) had their participants report any UITs which had occurred within a two-week period, whereas in Freeston *et al's,* (1991) study participants were required to report any UITs which had occurred during the last month, whilst in the studies by Purdon and Clark (1993) and Rassin *et al.* (2007) asked their participants to report any UITs which had ever occurred. Therefore, as Berry and Laskey (2012) state, these findings represent only an estimate of frequency and prevalence of UITs in the non-clinical population.

Although it is evident that non-clinical individuals experience UITs, it is also, as Clark (2005) points out, *"important not to overstate the frequency of this type of cognition in the general population",* (p.160). When studies by Clark, Purdon and Byers (2000), Purdon and Clark (2001) and Rowa and Purdon (2005) restricted the assessment of UITs to obsessional content (e.g., sex, violence, disease and contamination/dirt), non-clinical participants only reported having even their most common UIT on only a few occasions in a year (Clark, 2005). This finding of low frequency, UITs with obsessional content amongst non-clinical individuals was also found in a study with Korean students by Lee and Kwon (2003). Moreover, their findings also demonstrated that non-clinical participants rated UITs relating to harm and sex to be the most distressing to them, suggesting that UITs about contamination and disease are not the most upsetting to non-clinical individuals (Berry & Laskey, 2012). However, this last finding could be down to the young age of the participants (M = 18.5 years), as a study by Belloch et al., (2004) which utilised a community sample with a mean age of 27 years, taken from a broader age range of 19 to 62 years old, found contamination thoughts to be one of the most upsetting UITs, suggesting age may have impacted the above findings (Clark, 2005).

Furthermore, a study by Rassin and Muris (2007) set out to place the original findings by Rachman and De Silva (1978), claiming similarity in content between normal and abnormal obsessions, in context. This study was conducted in two parts. During the first part of the study, a statistical analysis of the data presented by Rachman and de Silva was conducted and this suggested that simply by examining the content of obsessions, psychologists were able to discriminate between clinical and non-clinical obsessions beyond chance level (Rassin & Muris, 2007). In the second part of the study, two sample groups of participants – the first of which consisted of 11 psychotherapists and the second was composed of 90 undergraduate psychology students, were asked to look at list of 23 clinical and 47 non-clinical obsessions that were used in the Rachman and de Silva (1978) study and to state if they believed them

to be a normal or an abnormal thought. Both groups were able to discriminate between clinical and non-clinical obsessions beyond chance level (Paired $t(89) = 5.0$, $p < .001$), with the students being statistically better at recognising the clinical obsessions from the non-clinical obsessions: (Rassin & Muris, 2007). These findings, therefore, suggest that there may - in fact - be a difference between the content of clinical and non-clinical UITs, however, as Rassin and Muris (2007) state, this finding *"has been overshadowed in the clinical literature"* (p.1067). This has significant implications for many of the cognitive theories, (many of which are discussed below in the sections on appraisals and responses to UITs) - which are all based on the premise that the content of clinical obsessions does not differ from the content of nonclinical UITs. Further research comparing the content of UITs in clinical and non-clinical participants is therefore needed and such research should look to use more representative and even samples, in order to reproduce findings that are more representative of the general population.

1.1 Triggers

"*It would appear to be assumed that most unwanted intrusive activities are entirely or largely internal in origin; that they are, in this sense, spontaneous. However, this assumption has never been supported satisfactorily" (Rachman, 1981, p.91).*

Another way that research has differentiated between UITs in clinical and non-clinical groups is through examining their triggers. In 2003, Lee and Kwon proposed that UITs could be differentiated by two different types of triggers; those which they referred to as 'autogenous intrusive thoughts' (internal thoughts which appeared suddenly, out of nowhere), with no obvious trigger or connection with stimuli, for example aggressive, sexual or immoral thoughts. Such thoughts are contrasted with 'reactive intrusive thoughts', which are thoughts that have an obvious, external, trigger - for example thoughts concerning an accident or contamination

(Lee & Kwon, 2003). Studies by Lee, Kwon, Kwon and Telch (2005) and Belloch, Morillo and Garcia-Soriano (2007), both comparing non-clinical individuals with OCD patients' responses to the OII (Purdon & Clark, 1993) found support for this distinction (Berry & Laskey, 2012). In addition, these studies also found that non-clinical individuals found autogenous UITs to be more disturbing but had them less frequently than reactive UITs, whereas OCD patients reported having autogenous UITs more often (Belloch *et al.,* 2007).

These findings are in opposition to those originally found by Rachman and De Silva (1978) which suggested that UITs were mostly spontaneous and internal in their origin, although as Rachman (1981) points out, this assumption was not satisfactorily substantiated and although Rachman (1981) had not set out to challenge this original view or indeed thought to question it, they did discover in part 2 of their investigation into the nature of UITs, that many participants reported that most of their intrusive thoughts and particularly intrusive images and impulses could be related to an external trigger. In this study, 60 non-clinical participants, drawn from a sample of friends, colleagues and acquaintances of the researchers, were all shown a list of distressing thoughts collected by Rachman and De Silva (1978) and then each participant's intrusive activities were examined in detail by the researchers, looking at content, frequency, response and triggers and as stated above, discovered the unexpected finding that most reported their intrusions to have external triggers. However, as the authors themselves note, it would be useful if the study could be extended to clinical samples.

However, since this earlier research, current studies have found that contextual factors do play an important role in the content of UITs (Clark & Inozu, 2014). In a critical review of UIT research, Julien, O'Connor and Aardema (2007) stated that a main difference between clinical and non-clinical UITs was the context (i.e. trigger) of the UIT. They claimed that clinical obsessions tended to occur in unrelated contexts as opposed to non-clinical UITs which would

occur in appropriate/related contexts. A more recent review of the determinants of UITs was conducted in 2014 by Clark and Inozu, who also support that position that the majority of UITs in non-clinical samples are provoked by an external trigger and are context-dependent as opposed to clinical obsessions which they state are more spontaneous with no obvious external trigger. However, it should be noted that many of the studies these authors cite in their reviews for example Edwards and Dickerson (1987) involved an all student, non-clinical sample, mostly female (61%) with a mean age of 23. Once again limiting the generalizability of their findings to the wider public and more specifically, to clinical populations.

Another way that research has differentiated between the triggers for UITs in clinical and nonclinical samples is by assessing if the thoughts are considered to be ego syntonic or ego dystonic. Clark (2005) in his book '*Intrusive Thoughts in Clinical Disorders: Theory, Research and Treatment',* states that there is research to support the position that obsession relevant UITs in clinical individuals are more likely to be comprised of ego-dystonic concerns *(thoughts that the person finds unacceptable and that does not match their self-concept)* than UITs in non-clinical individuals, which will relate to more ego-syntonic *(thoughts that are acceptable to the self)* worry related issues. In support of his claim Clark (2005) cites several studies, for example a study by Suedfeld, Ballard, Baker-Brown and Borrie (1985-1986) found that the thoughts reported by their non-clinical, student participants, that were kept in a room which was dark and sound- attenuated for 24 hours, were mostly focused upon current events involving their friends. Similarly, a study by Klinger (1988) found that the thoughts of his participants concerned current everyday problems for 67% of the time and that 96% of their thoughts were about everyday life (Clark, 2005). However, these studies are again only looking at non-clinical samples and do not include clinical participants as a direct comparison. Moreover, the non-clinical participants are once again comprised of students and so all findings must be treated with some caution.

1.5 Appraisal and Beliefs

"Cognitive models of obsessive-compulsive disorder (OCD) suggest that misinterpreting intrusive thoughts exacerbates obsessional thinking" (Teachman & Clerkin, 2007, p.999).

Having just explored some of the research comparing the content of UITs in the clinical and non-clinical populations, as well the potential triggers for UITs in both populations, this section will now look at the research on how both clinical and non-clinical groups appraise their UITs. This will include a discussion of the research into cognitive appraisal theories; in addition to a summary of some of the research surrounding participants beliefs and appraisals of their UITs in Schizophrenia, GAD and Depression. Finally, some of the research into how culture might impact a person's appraisal and beliefs about their UITs, is also discussed.

1.5.1 Cognitive Appraisal Theories:

Another issue which has been researched in addition to content and triggers, when comparing UITs in the clinical and non-clinical population is the way in which people appraise their UITs. This type of thinking can be classed as metacognition, which references the type of beliefs and thoughts which people hold in regard to their thoughts and also regarding the practices required to appraise, keep track of and to control their thoughts (Flavell, 1979). Several specific flawed appraisals of UITs have been identified by cognitive appraisal theories of obsessions. Rachman (1998) has proposed that 'thought action fusion' (TAF) is central to clinical individuals' biased misinterpretation of the significance of their thoughts. Rachman (1998) states that two types of beliefs describe TAF bias, these beliefs are that having a morally repugnant thought is as bad as actually carrying out the immoral thought or that any thoughts they may have about a harmful event occurring will increase the likelihood of its

occurrence. Salkovskis (1996, 1998) also proposed two processes which he felt were necessary for a normal UIT to turn into an obsession. The first involved making faulty appraisals that their UITs signify their own personal responsibility for stopping any harm occurring (either to others or to themselves) and secondly, that this inflated sense of responsibility to avoid harm is followed by neutralization strategies.

Elaborating further on these cognitive appraisal theories, Freeston, Rheaume and Ladouceur (1996), suggested five dysfunctional belief and appraisal domains, which they argue are important to the growth and continuation of OCD. These 5 domains include: 1) overestimating the significance of their UITs, 2) having an overly exaggerated sense of responsibility for events taking place that are not within their control, 3) a need to achieve absolute certainty and perfection, 4) overestimating the likelihood and seriousness of undesirable results occurring as a result of having the UIT, and 5) being unable to tolerate or accept feeling anxious (Wang, 2008).

Clark and O'Connor (2005) also suggest numerous problematic types of appraisal, which they state contributes to the perseverance of OCD. One such type of appraisal of a UIT, they argue, is that such thoughts mean that they need to be in control of their thoughts, otherwise they may lose control of themselves and their minds. Another type of faulty appraisal of their UITs, they posit, is that simply having the thought increases the chance that it will happen. A belief that having such thoughts means something about who they are as a person, e.g. bad thoughts mean that they must be a bad person, is another faulty appraisal of UITs suggested by Clark and O'Connor (2005) and finally, they also posit that in a similar vein, some people also make the faulty appraisal of their UITs that their thoughts are equal to their actions, so if they have a thought about causing someone harm that is just as bad as if they actually caused harm to that person. These faulty appraisals, they argue, cause individuals to then employ

neutralising strategies to cope with the great distress caused by them and as a way to try and avoid harm coming to themselves or others.

The significance of appraisal of UITs forms a central part of Clark's (2004) Cognitive Control Theory of Obsessions, which is outlined below in Figure 1.

Figure 1: Clark's (2004) Cognitive Control Theory of Obsessions

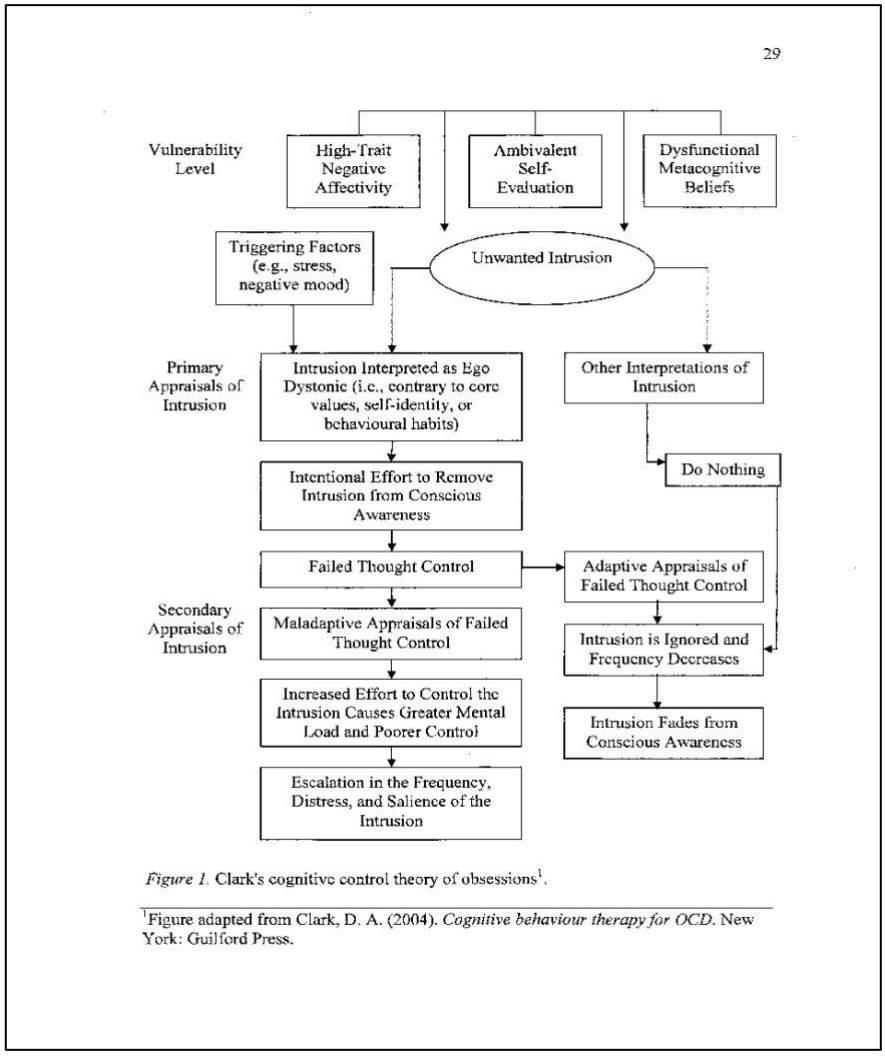


Figure 1. Clark's cognitive control theory of obsessions[1].

[1]Figure adapted from Clark, D. A. (2004). *Cognitive behaviour therapy for OCD*. New York: Guilford Press.

According to this model, people who misinterpret the content of the UITs as being a complete violation of their personal beliefs and values (ego-dystonic) will then feel a sense of responsibility for preventing any harm that may arise through continued focus on the UIT.

Clark (2004) then states that once a UIT has been categorised as a serious, personal threat, the person will then make concerted efforts to remove or dismiss the UIT completely. However, if the person then finds themselves unable to control the UIT, this then reinforces the original appraisal that the thought is, in fact, a serious threat and therefore greater effort must be invested into getting the UIT under control. According to Clark (2004), if the initial appraisal of a UIT is a dysfunctional one, which they mistakenly view as ego-dystonic and/or threatening due to the potential of serious negative consequences befalling either themselves or others, then this faulty appraisal of the UIT, along with an over estimation of responsibility, will generate the adoption of greater control strategies, such as neutralisation and compulsions.

However, what makes Clark's (2004) cognitive model of control stand out from other cognitive behavioural theories, is its inclusion of a secondary level of appraisal, which according to the model occurs after the initial appraisal and failure to suppress the UIT. At this point, further cognitive processes take place whereby the individual appraises their unsuccessful effort to control their UIT (Wang, 2008). At this secondary level of appraisal, Clark (2004) posits that the individual will then engage in either adaptive or maladaptive appraisals of their failure to control their UIT. Maladaptive appraisals can include appraisal that the UIT is a real and serious threat, unrealistic expectations of control, misinterpretation of the significance of the thought, as it's continued reoccurrence despite efforts to control it, must signify that it is important, appraisal of possibility – that is the belief that it is still possible and extremely beneficial to find a way to control the UIT. A key maladaptive appraisal is a sense of inflated responsibility, as laid out above in Salkovski's (1996, 1998) theory of OCD, as the individual's obsessional state worsens, they feel a greater need to try and control every aspect of the UIT (Wang, 2008).

However, the most widely accepted measure of dysfunctional beliefs, causing faulty appraisals of UITs, is the Obsessive Beliefs Questionnaire (OBQ), an 87-item measure which was developed by the Obsessive Compulsive Cognitions Working Group (OCCWG, 2001, 2005). This questionnaire assesses six dysfunctional beliefs that the OCCWG believe are central to the aetiology of obsessions and UITs (Clark & Inozu, 2014). These are as follows:

1) Overestimation of the significance of thoughts, so even having the thought signifies that it is of importance.
2) A need for perfectionism where they feel it necessary to have a solution for every problem and mistakes could result in disaster.
3) Having an exaggerated sense of responsibility, where the person believes that they are responsible for either preventing or causing harm to others or themselves.
4) Being unable to tolerate uncertainty, believing it to be necessary to reduce unpredictability whenever and wherever possible.
5) A belief that they must and need to be able to control their UITs.
6) Overestimating threat: “an exaggeration of the probability or severity of harm” (OCCWG, 1997, p.678) to others or themselves.

Whilst there may be some differences amongst cognitive theorists surrounding which appraisal processes they find to be the most central in the pathogenesis of obsession, the association between appraisal processes and perceived uncontrollability and frequency of UITs amongst the non-clinical population has been established by numerous research findings (Wang, 2008). For example, findings from the original study of the OBQ (OCCWG, 2003) found that the non-OCD anxious group scored significantly lower on the over importance, responsibility and control beliefs, in comparison to the OCD patients. Moreover, when these six belief domains were collapsed into just three subscales – Importance/Need for control, Perfectionism/Uncertainty and Overestimated threat/Responsibility and 87 items reduced to

44 (known as the OBQ-44, OCCWG, 2005) in their second study, the same findings were replicated (Clark & Inozu, 2014). Whilst Clark and Inozu (2014) cite the study of Tolin, Worhunsky, and Maltby (2006) in support of these findings, Fergus, Latendresse and Wu (2017) lists three more recent studies which did not replicate these findings (Moulding et al., 2011; Myers, Fisher, & Wells, 2008; Wu & Carter, 2008).

So far, the theories mentioned above have focused on the importance of appraisals of UITs and their role in the pathogenesis of OCD. However, there are numerous other studies and theories which have also explored the importance of appraisals of UITs in other clinical conditions; such as schizophrenia, GAD and depression, for example. Below is a summary of some of the research surrounding appraisals and beliefs in these conditions.

1.5.2 Schizophrenia

Recent cognitive theories of psychosis posit that psychotic experiences are the result of externally misattributing UITs and that it is the culturally unacceptable interpretation of UITs which distinguishes psychotic episodes (Morrison, 2005). An early study, in 1998, by Baker and Morrison, compared clinical and non-clinical samples (15 participants diagnosed with Schizophrenia who were experiencing auditory hallucinations against 15 non-hallucinating participants diagnosed with Schizophrenia and 15 non-psychiatric control participants). All participants were subject to a source monitoring task to assess attributional biases and all participants completed a questionnaire assessing meta-cognitive beliefs. The results indicated that patients who were experiencing hallucinations scored higher on metacognitive beliefs about danger and uncontrollability of UITs and positive beliefs concerning worry, than the other two groups. The predicted results that patients suffering from hallucinations attributed internal events to an external source was also confirmed. Moreover, a logistic

regression analysis demonstrated that beliefs about danger and uncontrollability could predict whether or not participants experienced auditory hallucinations.

Research has also pointed to the influence of societal negative stereotypes surrounding people with serious mental health problems as a threat and as out of control, which in turn influences people with mental health conditions to also view themselves in this vain (Morrison, 2005). In a study conducted by Moller and Husby (2000) with 19 first episode schizophrenic patients, almost half (8 patients) reported a fear of losing mental control as early prodromal signs. Suggesting that the maintenance of psychosis may be impacted by people's appraisals of losing control (Morrison, 2005).

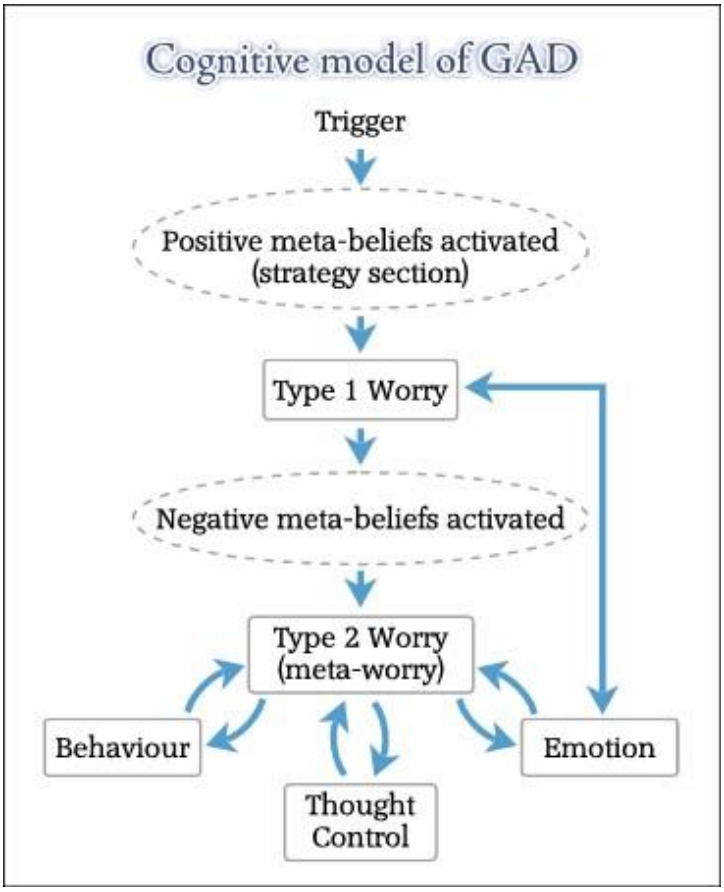
Another study which compared metacognition in clinical and non-clinical samples is that of Morrison and Wells (2003). In this study the Meta-Cognitions Questionnaire (MCQ: Cartwright Hatton & Well, 1997) was administered to 35 patients who met the DSM-IV criteria for panic disorder, 24 patients who met the DSM-IV criteria for schizophrenia spectrum delusions with persecutory delusions, 49 patients who met the DSM-IV criteria for schizophrenia spectrum with auditory hallucinations and a non-clinical control group of 50 participants recruited from health service staff and students. The MCQ (Cartwright Hatton & Well, 1997) assesses four metacognitive dimensions: 1) cognitive self-consciousness, 2) negative beliefs about thoughts related to danger and uncontrollability, 3) cognitive confidence and 4) positive beliefs about worry. Each participant was asked to complete the MCQ questionnaire and return it to the researcher. Results found that the group which demonstrated the greatest levels of dysfunctional metacognitive beliefs and scored significantly higher than the other groups on negative beliefs about uncontrollability, danger, punishment, responsibility and superstition as well as positive beliefs about worry were the psychotic patients with auditory hallucinations, supporting the hypothesis that faulty appraisals of UITs are more generally associated with

psychological disturbance. Moreover, in addition to these more general metacognitions, Clark (2005) also states that there appears to be certain beliefs that are specific to psychosis, such as positive beliefs about the utility of paranoia, for example *my paranoia keeps me safe from harm.*

1.5.3 GAD

Such beliefs, as the one mentioned above, are very similar to the positive beliefs surrounding worry that Wells (1994) discusses in his metacognitive model of GAD, for example, as given by Clark (2005) *"Worry helps me cope, if I don't worry, I'm tempting fate"* (p.2995). Below, is an illustration that summarises this model:

Figure 2:



According to Wells (1995), the initial positive beliefs about worry mentioned above, are followed by the development of negative beliefs (this occurs in type one worry sequence, as

shown in the diagram above) which he divides into two broad domains; one that worry is dangerous to their overall well-being and two that worry is uncontrollable. Wells (1994) states that once these negative beliefs have become activated, the individual now begins to worry about worry (type 2 worry, see above diagram) which he termed 'metaworry'. The rest of the model then goes on to discuss the somewhat vicious circle individuals can then find themselves in, with type 2 worry causing negative feelings of depression and anxiety, behavioural responses – such as avoidance of certain people or places which may trigger the worry, and unhelpful thought control strategies, such as thought suppression (which is a separate topic and will be discussed in the next section of this chapter). All of these responses reinforce the metaworry, whilst the negative emotions they evoke are interpreted as being unable to cope with their worry, causing the person to keep using type one worry as a coping mechanism.

Numerous studies have supported Wells (1995) cognitive model of GAD, although the majority have focused on just clinical groups (see Borkovec & Roemer, 1995; Davey, Tallis, & Capuzza, 1996; Cartwright-Hatton & Wells, 1997), confirming that people with GAD and participants classed as high worriers held positive beliefs about worry. However, a study by Wells and Carter (2001) did compare sex matched groups of patients (all groups had 10 men and 14 women) with panic disorder, patients with social phobia, patients with major depression and patients with GAD against a control group of non-anxious participants. After an initial screening and interview, all participants were required to complete a battery of questionnaires which used a number of self-report scales. These were the MCQ, as described above and the Anxious Thoughts Inventory (AnTI; Wells, 1994). This inventory measures three empirically derived subscales of worry, which are: a) health worry, b) metaworry and c) social worry. The scale contains 22 items which measure these three domains of worry. In summary, the results indicated that, consistent with hypotheses, patients with social phobia showed

greater social worry scores than the patients with panic disorder or the non-clinical group (*p*s < 0.001), patients with panic disorder obtained higher scores on health worries than the non-clinical group or the social phobia patients (*p*s < 0.001) and the patients with social phobia and panic did not differ in terms of metaworry, however they both had higher scores in metaworry than the non-clinical participants (*p*s < 0.03). In summary, these results lend support to Wells (1995) cognitive model of GAD and also to the position that beliefs and appraisals of UITs may be a significant factor in the difference between clinical and non-clinical populations.

1.5.4 Depression

A study by Starr and Moulds (2006) examined the role that negative appraisals of intrusive memories played in depression. Here 84 undergraduate students (22 male, 62 female) were interviewed in order to identify the presence of intrusive memories in the previous week and those that reported intrusive memories were administered self-report questionnaires which indexed any affective and cognitive responses to their memory. Results indicated that negative appraisals correlated positively with cognitive avoidance strategies, such as suppression, intrusion related distress and with depression symptoms. However, these findings have the familiar limitations of an absence of a clinical sample comparator and by the fact that the non-clinical sample were solely comprised of students, in addition to the fact that there were almost three times as many female participants as there were male.

In an attempt to address the limitations of the above study, Newby and Moulds (2010) set out to replicate and extend the above findings by comparing a sample of individuals who had recovered from depression with a group of clinically depressed people and also included a never depressed control group, on their appraisals of intrusive memories. The final sample

comprised of 85 participants in total (30 recovered, 25 depressed, 30 control). Results demonstrated that depressed participants did engage in greater negative appraisal of their intrusive memories than the non-clinical control group, with intermediate ratings across the majority of appraisal themes being reported by the recovered group. These results contribute to the findings of previous research, not just in depression but in most cognitive disorders, that faulty appraisals of UITs are critical to the development and maintenance of these disorders.

1.5.5 Culture, Appraisal and beliefs:

According to the research on appraisal and metacognitive beliefs, a large body of evidence now exists (as summarised above) that suggests it's centrality to the development and maintenance of OCD (Clark, 2004) and there is, as also mentioned above, research that links this to the development and maintenance of other cognitive disorders, such as GAD (Wells, 1995) and Schizophrenia (Morrison, 2005). However, as Moulding *et al.,* (2014), point out, one's construction of meaning will vary across different cultures. Moreover, they also point out that even amongst a specific culture, certain environmental and social concerns will change over the course of time, which may well be seen through an individual's primary focus. Therefore, Moulding *et al.,* (2014) point out that a person's personal and cultural background will likely influence both the content of their UITs and also impact how they appraise these thoughts. In support of this position, the authors cite the study of de Silva (2006) which found that over the past twenty to thirty years, obsessional contamination themes involving asbestos shifted to fears over contracting HIV/AIDS amongst OCD patients within the UK.

Noting a lack of studies comparing the impact of culture upon different aspects of UITs, such as content, frequency, appraisal and response, Radomsky *et al.,* (2014) developed and administered a structured intrusive thoughts interview to 777 non-clinical individuals, all drawn from 13 different countries in order to investigate the universality of unwanted intrusions. In Part 2 of this study - Moulding *et al.,* (2014) examined 516 participants responses and

appraisal of their UITs through the use of the IITIS; (RCIF, 2007) and their findings were in line with those discussed above, supporting the theory that maladaptive appraisals of the importance of UITs can increase the prominence of the intrusive thoughts. Of course, the same limitation that was discussed above with regards to Part 1 of this study in the section on contents of UITs, applies here and that is that, whilst the sample is very large and culturally broad, it has only used a non-clinical sample and all the participants were university students, therefore limiting its generalizability to both clinical and non-clinical populations.

As discussed above, due to the original support of Rachman and De Silva's (1987) findings that UITs are similar in content in both clinical and non-clinical individuals and are a universal phenomenon amongst all individuals, most of the research into UITs have focussed upon differences in how individuals appraise their UITs and how they respond to them. As quoted just above and discussed in some of the cognitive theories already mentioned, such as Clark's (2004) cognitive model of control, how a person appraises their UIT may also predict how they will then respond to it. This next section, therefore, will examine some of the research on how clinical and non-clinical populations respond to their UITs, with particular attention to the research on thought suppression. This focus on thought suppression as a response strategy for dealing with UITs, was chosen due to the very large body of research that has been conducted in this area.

1.6 Response

"The appraisal of the thought may also predict the response strategy"

(Berry & Laskey, 2012, p.129).

In their review of obsessive intrusive thoughts in the general population, Berry and Laskey (2012) found retrospective questionnaire studies which have provided further information regarding which factors may determine response strategy. It was found that where individuals appraised their UITs as reflecting reality (TAF), then this would typically illicit problem focussed strategies such as reassurance seeking and neutralisation (Freeston et al., 1991; Langlois et al., 2000). Salkovskis (1996) conceptualised neutralisation as safety seeking behaviour (Salkovskis, Wahl, Wroe and Forrester, 2003). Whereas Freeston et al., (1991) found avoidance strategies to be linked to ego-dystonic appraisals of UITs. These studies, therefore, lend support to the hypothesis that appraisals of UITs relates to response strategies (Berry & Laskey, 2012).

In terms of comparisons drawn between response strategies of clinical and non-clinical individuals, the most common strategy selected by non-clinical samples were reasoning strategies, where the individual would try to rationalise with themselves that their UIT was irrational. This finding was based upon self-report questionnaire based research (see Clark *et al.,* 2000, Ladouceur *et al.,* 2000 and Purdon & Clark, 1994).

However, these findings are limited by the unreliable recall effects involved with self-report questionnaires, in addition to the common issue of lacking a clinical sample and the nonclinical group being comprised of students (Hammersley & Atkinson, 1995).

However, Berry and Laskey (2012) do point out that some studies which have directly compared OCD patients and non-clinical groups through the same questionnaire based research and found that similar strategies were adopted between clinical and non-clinical participants, with the only differences being the higher frequency in which clinical participants engaged in these strategies, as compared to the non-clinical ones. Berry and Laskey (2012)

cite studies which demonstrate increased use of punishment and worry amongst clinical participants – as opposed to distraction, which was most commonly used by non-clinical groups (Amir, Cashman, Foa, 1997; Abramovitz, Whiteside, Kelsy & Tolin, 2003). Suggesting that there may be some differences between how clinical and non-clinical individuals respond to their UITs.

1.6.1 Thought Suppression

The control strategy which has been researched the most however, is that of thought suppression. To most of us, it would seem intuitive that if an unpleasant thought enters your mind and distracts you from what you are doing, whilst also eliciting negative emotions, a common response is to want to supress it. The use of thought suppression has been reported amongst individuals who have been diagnosed with a multitude of clinical conditions, including alcohol dependence (Marlatt & Parks, 1982) OCD (Rachman & Hodgson, 1980), PTSD (Pennebaker, 1988), GAD (Wells, 1995) and depression (Newby and Moulds (2010).

Wegner (1989) defined thought suppression as a

conscious attempt on the part of the individual to actively avoid certain thoughts, in particular, those thoughts which elicited negative emotions. Just as one cannot discuss UITs without citing Rachman and de Silva (1978), neither can the act of thought suppression be discussed without mentioning ‘White Bears’ and

Wegner, Schneider, Carter and White (1987). In the first study to look at thought suppression, Wegner, Schneider, Carter & White (1987), using 34 undergraduate students (14 men, 20 women), conducted an experimental study whereby participants were randomly allocated to one of two experimental conditions – a suppress or express condition. Participants initially assigned to the expression group were asked to monitor their thoughts by verbalising any and

all thoughts that came to mind into a tape recorder and then told to try to suppress thoughts about a ‘white bear’ for 5 minutes and any time they said or thought of a white bear during that time, they had to ring the bell on their table. Afterwards the participants were then asked for an additional 5 minutes to try and think of a white bear and to continue ringing the bell every time they thought of the white bear. Participants which were assigned to the initial expression group did the same thing but in reverse order. The results, from this now very famous study, demonstrated that attempts at thought suppression led to an increase of thoughts, in this case an increase of thoughts of a white bear and moreover they also found that attempts at thought suppression, paradoxically, led to a rebound effect, whereby the total number of thoughts about a white bear was significantly higher for the participants who were in the initial suppression group.

According to Wegner’s Ironic Processing Theory (Wegner, 1994) the act of thought suppression requires two cognitive processes – one is intentional and one which is automatic. The intentional distraction process is referred to as the ‘controlled distracter search’ which consciously diverts attention away from UITs by searching for replacement thoughts to distract them from their unwanted thought. This cognitive process requires effort and is attentionally demanding as it works to supress the UIT by consciously holding on to the distracter thought. However, the second process, Wegner (1994) argues is automatic and unconscious – this is referred to as the ‘automatic target search’. This cognitive process involves a constant monitoring system which remains alert for any signs that the target UIT has resurfaced. As this process is automatic and unconscious it does not require the same mental effort as the ‘controlled distracter search’. Any signs of the target UIT by the ‘automatic target search’ then automatically prompts the ‘controlled distracter search’ to take action and replace the target thought with a distracter thought. On one level, these two processes seemingly complement each other, as they work together to suppress the UIT. However, once the ‘automatic target

search' is activated, it remains vigilant for the very thought that the person is trying to supress, hereby creating a paradoxical rebound effect whereby the effort of trying to suppress the UIT causes an actual increase in the intrusion, as the 'automatic target search' is an unconscious process it cannot be regulated (Pisterello *et al.,* 2015).

The empirical evidence for this theory to date is mixed. Salkovskis and Campbell (1994) found support for the rebound effect of thought suppression in their study with 75 non-clinical participants (all students). Participants who had been instructed to suppress a target thought did experience an immediate rise in occurrences of the UIT, during suppression. These findings were also replicated in studies by Davies and Clark (1998) and Trinder and Salkovskis (1994), both of which also used non-clinical student samples. However, a study by Kelly and Kahn (1994) produced the interesting finding that when participants (40 male, 64 female students) tried to supress thoughts of a white bear, they too experienced the rebound effect seen in by Wegner, Schneider, Carter and White (1987) original study. However, when the participants were required to supress an obsessional thought personal to them, no rebound effect was found and participants actually found a reduction in their thoughts during attempted suppression. Suggesting that the rebound effect might not generalise to people's personal intrusive thoughts. This was supported by a study by Purdon and Clark (1998) who also found that suppression of personally significant UITs did not lead to an increase in frequency or a rebound effect.

An obvious issue with these studies is, once again, the lack of clinical participants to compare with and the non-clinical sample being comprised of students only. However, other studies have compared thought suppression effects with clinical and non-clinical groups and also did not find evidence for the rebound effect (see Janeck & Calamari, 1999), even when the thought being suppressed was a neutral one, like the 'White Bear' (see Tolin, Abramowitz, Prezeworski, & Foa, 2002).

1.7 Research Contribution and Rationale:

"Future qualitative research may provide more information on the experience of intrusive thoughts", (Berry & Laskey, 2012, p. 130).

1.7.1 Contribution to Counselling Psychology:

Studying this particular cognitive phenomenon (UITs) is of huge importance to the field of counselling psychology due to its clear presence in a number of psychological disorders (Pierce and Sarason, 1996). It's obvious role in OCD has received the most research, as discussed above but it's relevance is, arguably, just as significant in all other cognitive disorders. As Wenzelaff (2005) states, it is worth examining unwanted, depressive, intrusive thoughts in their own right as they could shed light on cognitive processes that are involved in depression and the control strategies that help to maintain the disorder. Their role in PTSD is also central, as assessing for intrusive thoughts, memories and images forms an integral part of understanding its role in the condition and also its treatment (Falsetti, Monnier & Resnick). The role of UITs in GAD is also clear, with doubting/anxious intrusions being central to the development and maintenance of the condition (Wells, 2005). Again, the role of UITs in insomnia is equally relevant, with individuals who suffer from the condition consumed with UITs that severely interrupt their sleep. With regards to psychosis, Morrison (2005) outlines how even though current definitions of UITs define them as being an internal product of one's own mind, developments in our understanding of psychosis can be made through a greater understanding of how individuals with Psychosis appraise their internal UITs as originating from an external source. In fact, it is quite a challenge, in itself, to think of a psychological condition where UITs do not have a central role to play. Moreover, not only is the cognitive phenomenon of UITs integral to our understanding of cognitive disorders, in terms of both its

development and its maintenance (Clark, 2005) but also in the multi-faceted aspects of it. This refers to the many areas of research discussed above; variations in content and frequency, examining what can trigger such disruptive thoughts and understanding what can impact differences in how individuals appraise their UITs. In addition to exploring variations in metacognitive beliefs, as well as gaining further understanding regarding why different people respond differently to UITs and what responses may be responsible for either reducing unwanted thoughts or causing them to increase, thereby causing further distress to the individual.

Although, as discussed at the start of this chapter, the researcher noted the huge body of research in relation to UITs, it can still be seen from the contradictory findings in many of the studies that, as Purdon (2005) states *"our understanding of this cognitive phenomenon is still quite rudimentary"* (p.2954). Therefore, continued research into the different mechanisms that underlie UITs is still required, in order to help anyone working in the field of counselling psychology to develop a better understanding of its role in psychological disorders. This enhanced understanding can help Counselling Psychologists (and anyone who works with mental health problems, for that matter) to develop better treatment plans. Moreover, increased research that compares clinical and non-clinical samples, can help Psychologists develop a better understanding of what can turn a passing UIT into a clinical disorder and hopefully gain a greater insight into possible ways to stop this from occurring.

1.7.2 Rationale for the study and research question

One of the possible explanations for, as Purdon (2005) described above, our 'rudimentary' understanding of UITs is likely down to the several issues relating to internal and external

validity within the research in this area, as referenced at numerous points throughout this chapter. In terms of internal validity, the heavy reliance on self-report questionnaires used in multiple studies on UITs means that participant's responses may well be prompted and it is also limited by the known issues of unreliability of retrospective recall (Bolger, Davis & Rafaeli, 2003). Laboratory studies, which have also been a primary approach used when researching UITs also has the drawback of often prompting participants' responses in different ways and does not offer a naturalistic measurement of the cognitive phenomenon. Then there is issue of the external validity of these studies relating to sample representativeness. Whilst UITs are still considered a universal phenomenon, the majority of the studies examining this topic have often failed to look at both groups together and those that have, have often used uneven samples and generally looked at specific cognitive disorders, mostly OCD. In addition to this, the non-clinical samples have predominately drawn their samples from the student population. This, therefore, greatly limits its representativeness to the general public and any comparisons drawn between clinical and non-clinical samples. Hammersley and Atkinson (1995), noted that due to the heavy reliance on student populations, the mean age of all samples was approximately 24 years old. This could have significant implications on the findings of research into UITs, as a study by Erskine, Georgio, Deans and Colegate (2017), demonstrated that age was negatively related to intrusions; with UITs decreasing as age increased. Furthermore, the majority of both clinical and non-clinical samples were often composed of an average of over 60% being female, this also could have impacted findings, as Purdon and Clark (1993) found that women experienced a greater number of obsessional themes in comparison to their male counterparts. The other issue with utilising so many student samples in the research on UITs is that as Warren *et al.,* (2002) found, obsessional symptoms are associated with stress and stress is associated with student years (Hammersley & Atkinson, 1995), with community samples measuring considerably lower on measures of general distress than student samples (OCCWG, 2003). Lastly, it is also worth considering that most

of the studies that utilised student samples, also noted that these students were often compensated, either financially or through obtaining course credits. However, Bowen and Kensinger (2017) in their study – *'Cash or Credit? Compensation in Psychology Studies: Motivation Matters'*, found that compensating psychology students through either cash or course credit can impact performance on tasks. Moreover, a quasi-experimental study by Sharp and Pelleteir (2006), recruited participants with and without the offer of course credit. In the sample that was offered credit, it was maintained in one condition and then removed from others; in the sample that was not offered credit, this was then added in one condition and not in the other. Results from both samples demonstrated that once credit was removed, participation rates plummeted.

With all this in mind, there are another two very important aspects which the researcher found lacking from this vast array of research into UITs. Firstly, there is the issue that, as the researcher began exploring the topic of UITs, they were quite surprised to see that none of it appeared to be from within the field of Counselling Psychology. They found that all the journal articles, studies, literature reviews and books were all from clinical or (mainly) cognitive psychology, in addition to some medical journals. Moreover, not only was there an apparent absence of research from the field of Counselling Psychology but there was also a seemingly complete void of qualitative research. At least to their knowledge, every study on the topic of UITs were either a purely quantitative study (using mostly self-report questionnaires and/or laboratory studies) or a mixed-methods approach. They were unable to find any studies which were purely qualitative in nature. Perhaps the absence of any research from Counselling Psychology can account somewhat for the absence of any purely qualitative research, as taking a qualitative approach to research is very common within its field. Qualitative research fits strongly with the ethos of Counselling Psychology as Hammersley and Atkinson (1995) state: *"Researchers using qualitative and naturalistic approaches to research are more concerned with the authenticity of participants' accounts. They want to use methods which show respect for participants",* (p.6).

Therefore, this research study looks to fill the gap amongst counselling psychology and the absence of qualitative research: using semi-structured, paper diaries and semi-structured interviews, along with Framework Analysis (Ritchie & Spencer, 1994), this study will aim to explore both clinical and non-clinical participants' experiences of unwanted intrusive thoughts, drawing on past research for part of the framework, whilst also allowing for any possible new emergent themes which may arise. In order to address past issues of sample representativeness, an even number of male (4) and female (4) participants have been included, as well as an even ratio of clinical and non-clinical participants, drawn from a variety of different cultures and occupations and a broad age range of 27-65 (*m*=44). To the researcher's knowledge, no previous research has ever utilised Framework analysis to explore this cognitive phenomenon, which allows the researcher to work with both inductive and deductive themes, as well as being able to compare samples which are not homogenous.

The use of the diary has also been included, in order to offer a more naturalistic measurement of unwanted, intrusive thoughts and as a real time measure, should not be as susceptible to retrospective recall issues as previous studies in this area (Berry & Laskey, 2012). This is also a method, that to the researcher's knowledge, has rarely been utilised to study UITs. Used in combination with the follow up semi-structured interviews, this should allow for a much deeper exploration of both clinical and non-clinical participants experience of unwanted intrusive thoughts, hopefully adding some meaningful findings to a cognitive phenomenon that is central to so many psychological disorders and therefore integral to the field of counselling psychology.

Below is the research question explored within this study:

Research Question: *"What are the similarities and differences in the experience of unwanted, intrusive thoughts between clinical and non-clinical participants, as explored through a Framework Analysis?"*

CHAPTER 2: RESEARCH METHODS AND PROCEDURE

2.1 Chapter Overview:

This chapter begins with this study's research question: for which the rationale and its potential contribution to Counselling Psychology has just been discussed. This is followed by a section on reflexivity, both epistemological and personal, outlining the methodological choices made by the researcher. A further section details the research process – including details of participant selection, the recruitment process, stages of data collection, analytic strategy and ethical considerations.

2.2 Research Question: *"What are the similarities and differences in the experience of unwanted, intrusive thoughts between clinical and non-clinical participants, as explored through a Framework Analysis?"*

- This question was put forward by the researcher in order to explore several facets of unwanted, intrusive thoughts. These included: comparing how clinical and non-clinical participants experienced unwanted, intrusive thoughts, drawing on past research on

unwanted, intrusive thoughts, in addition to exploring any possible themes that may emerge from within the data. The utility and effect of using diaries to record UITs was also explored.

2.3 Epistemological Reflexivity:

In this section the researcher's decisions regarding their choice for adopting a qualitative approach and choices for data collection methods, in addition to their chosen method of analysis, are discussed in light of their epistemological and ontological positioning.

2.3.1 Epistemological and ontological positioning:

> *"We can read data differently, depending on our epistemological orientation and what it is we want to understand"* (Parkinson *et al.*, 2016, p.111).

As the quote above states, the researcher's epistemological position will greatly affect both how they read their participants' data and what they are seeking to understand. In many ways the researcher viewed this as being similar to how a Counselling Psychologist's formulation of the same client may vary widely, depending upon which theoretical orientation they are formulating it in. Therefore, as Willig (2013) notes, the researcher's epistemological position should be the starting point for any researcher. In this study the researcher has taken a critical realist position (Bhaskar, 1978); believing that people can accurately detail their experiences - extracting meaning from them within an objective reality (Guba and Lincoln, 1994). The researcher views unwanted, intrusive thoughts as an objective, cognitive phenomenon which

participants can accurately describe. Ontologically speaking, the researcher found themselves in the same, critical realist position. The researcher rejected the position, outlined by Willig (2013) of extreme relativism, which argues that there is no objective reality or truth to seek out but rather 'reality' is constructed through each individual's perception, influenced by both social and cultural norms. A position which the researcher could not align themselves with. However, the researcher did question this position during the data collection process, acknowledging that societal and cultural norms could impact how a person perceived their own thoughts – meaning some people may find certain thoughts more unwanted than others. Whilst the researcher acknowledges this, it did not change their original position, as although each individual may be affected differently by different thoughts, due to a variety of factors, the researcher still believes that the experience of having UITs remains an objective cognitive phenomenon, which participants can accurately describe.

Also unsatisfying to the researcher, was the position at the other end of the spectrum: that of extreme realist, a position which views an objective reality which exists independently of people's perceptions of it. Again, the researcher takes a critical realist ontology, which views the cognitive phenomenon of unwanted, intrusive thoughts as a psychological reality, existing independently of how anyone views or understands it but also acknowledges that the only way it can be explored is through their interpretations of their research participant's interpretations (Hammersley and Atkinson, 1995). The researcher, therefore, sees their position in the research as one which uses their knowledge and expertise to uncover their findings, as opposed to being the author of their findings (Willig, 2013).

This position also directed the researcher's decision to use a qualitative approach, an approach that the researcher had never used previously, as opposed to the more familiar quantitative approach that the researcher had used in their previous Psychology studies. For

as Creswell and Clark (2007) state, a qualitative approach allows the researcher to explore the details, experience, common themes and feelings of participant's intrusive thoughts, to 'hear' their voice and understand the context in which they take place, in a way that a quantitative approach, does not. The researcher viewed this change in perspective, from past positivist positioning, utilizing quantitative methods to test specific hypotheses, with statistical 'evidence', to a genuine interest in giving voice to people's experiences and taking account of the context in which this occurs – as part of their move away from Occupational Psychology and towards Trainee Counselling Psychologist, with its humanist underpinnings.

The researcher's critical realist position also influenced their decision to explore unwanted, intrusive thoughts, through the use of a diary, which fitted with their desire to find the most ethical and practical way to access the real feelings and experience of their participants, as closely as may be realistically possible. For, as Willig (2013) states, this requires the researcher to select, design and apply a method in a way which may be able to provide as real and accurate account as is possible. The researcher was very mindful from the start of this project that unwanted, intrusive thoughts could be a very sensitive and potentially embarrassing topic for participants to share with a researcher and therefore, decided that the use of a diary may prove useful. Without having to initially face the researcher, the participants might find it easier to express themselves openly and honestly which, as also noted by Willig (2013), can often be a main obstacle for a critical researcher. Moreover, the diary could help to overcome the issue of retrospective recall issues, as the participants would be instructed to note the unwanted, intrusive thoughts as and when they occurred. (*The possible pros and cons of using diaries are discussed in much greater detail further on in this chapter during the section on procedures.)* The initial plan was to use week long diaries (formatted as a daily log book), and as this would naturally contain less data than using interviews, the researcher had planned to recruit 40 participants in total (20 non-clinical and 20 clinical participants) in order

to have enough data to explore their research question. However, after an initial pilot study, this plan was amended (see below).

Pilot study:

A pilot study was conducted in order to evaluate the suitability of the data collection method proposed and also to as assess ease of recruitment; improve the tools utilized (such as topic guides). The pilot study was conducted with a non-clinical participant, recruited through the same snowball sampling method utilised throughout the entire study. The participant was informed from the outset that this was a pilot study and their data would not be included in the final study. This was done in order to avoid contamination of the final data. As with all participants, the same procedure outlined below, regarding informed consent and debriefing etc (see sections 2.4.2 on participant selection and 2.4.3 recruitment procedure) was followed.

The main findings of the pilot study were as follows:

1.) Recruiting for this study was very challenging, as finding participants that both fitted the inclusion criteria and were also prepared to keep a week long diary, noting their most private and possibly embarrassing thoughts, proved to be very difficult. Therefore, the researcher felt that within the time frame they had to work with, the sample they would most likely be able to collect would be no more than 8 -10 participants, in total. Therefore, another mode of data collection would have to be added to the research, in order to have enough data to adequately explore the research question.

2.) Secondly, the data lacked richness in terms of both information and context, therefore it would be necessary to collect data which would not only help the researcher to gain a fuller understanding of their participants' experience of UITs but to also allow for the researcher to enquire about how the participants' experienced noting down their UITs, in their diaries. (*The potential importance of this is also addressed further on in this chapter).* After a discussion about their reflections on their pilot study with their initial research supervisor and the difficulty in recruiting participants, it was agreed that a follow up interview with participants should be conducted, for all the reasons just detailed. However, as Creswell (2003) notes, qualitative research should allow for some flexibility in its approach, to allow for further exploration of a sample or issue, in order to adequately fulfil the needs of the research being undertaken. As Janesick (2001) comments, unlike the emphasis on standardised tools and instruments found within quantitative research, it is quite common within qualitative research to be open to new methods and ideas as well as to use more than one method.

In addition to deciding how the researcher would collect their data, another important decision was to decide upon which qualitative method to use to explore and interpret their participant's data. After much deliberation, the researcher settled upon Framework Analysis (Ritchie & Spencer, 1994) which is not aligned with any particular epistemology. However, the main studies which were read by the researcher, with instructions on how to conduct Framework Analysis, all held a critical realist position (see Gale *et al,* 2013; Leal *et al,* 2014; Parkinson *et al.*, 2016 and Ward *et al*, 2013) and whilst it may have no particular epistemological leaning, its ontological position, as stated by Ward *et al*, (2013) is most closely aligned with critical realism. Below is an overview of the approach, sometimes also referred to as the Framework Method or the Framework Approach and at times shorted to (FA). This is the followed by an explanation of why this approach was selected by the researcher.

2.3.2 What is Framework Analysis?

Framework Analysis (Ritchie & Spencer, 1994) was originally developed in an independent social research institute, during the 1980s, by applied qualitative researchers, “as a pragmatic approach to real-world investigations” (Ward *et al*, 2013, p.2425). The approach has generally been used in the field of health and social sciences but has more recently been used in psychology (see Parkinson *et al.,* 2016). The methodology involves a structured approach to qualitative data analysis, providing a clear and organized process for researchers to manage and interpret large volumes of qualitative data (Parkinson et al., 2015). The Framework Method, specifically tailored to qualitative psychological researchers, offers a methodological overview and a worked example, making it a valuable resource for researchers in this field (Frazer et al., 2023). Additionally, the Framework Method has been successfully used in multidisciplinary health research, demonstrating its versatility and applicability across different domains (Gale et al., 2013).

Framework Analysis “sits within a broad family of analysis methods often termed thematic analysis or qualitative content analysis” (Gale *et al,* 2013, p.2). Here the focus is upon how varying parts of the data may relate to each other, with the aim being to draw explanatory and/or descriptive conclusions, formed around themes. Ritchie and Spencer (1994) have outlined five stages of framework analysis, these are: familiarisation, identifying a framework, indexing, charting and mapping and interpretation. These stages are detailed further below, in the analytic strategy section. These distinct but inter-related stages, offer the researcher the option to perform case-based or theme-based analysis or they can combine both, by developing charts which can be read downwards, forming themes or across, forming cases (Ward *et al*, 2013). This structured approach allows researchers to systematically manage and analyse qualitative data, ensuring rigor and reliability in the research process.

Furthermore, the Framework Method has been developed and used successfully for over 25 years, indicating its robustness and effectiveness as a research methodology (Gale et al., 2013).

Throughout the many research articles studied by the researcher that utilised FA, no specific example was given for a recommended sample size and therefore they were guided by advice given by speaking directly with Dr Nicola Gale (as referenced later on in this chapter), who assured me that my sample size of 8 participants diaries and interview transcripts would work well. However, it should also be noted that another strength of the Framework Approach is its ability to work with very large samples of qualitative data, if required (Gale et al., 2013).

2.3.3 Why the Framework Approach?

Selecting this approach took the researcher a lot of time and careful consideration and to the researcher's knowledge, although the approach is gaining popularity within the field of Psychology (Parkinson *et al.*, 2016), it has not been used within the field of Counselling Psychology, as yet. Having discounted a quantitative approach and settled upon a qualitative approach, for the reasons outlined above, the researcher found themselves in unknown territory and somewhat overwhelmed by the numerous possible options. The researcher briefly considered IPA (Smith 1996) which was initially attractive, with its idiographic focus and the comfort of the majority of the researcher's cohort using IPA. However, it was quickly discounted due to its need for a homogenous sample[1], clearly unworkable with the varied sample of this research project, with its primary aim being to compare two different participants group's experience of unwanted, intrusive thoughts.

The researcher then considered the option of using Grounded Theory (Glaser and Strauss, 1967), and found its inductive approach appealing. However, whilst wanting to remain open

[1] It is to be noted that IPA has more recently been used to compare groups (Larkin, Shaw and Flowers, 2018).

to finding new themes within the participant's diary entries and interviews, the researcher also wanted to be guided by past research. As this was not an option with the use of the Grounded Theory, this approach was also discounted.

The final approach considered and most similar to Framework Analysis, was Thematic Analysis (Braun and Clarke, 2006). Part of the same 'family' of Thematic Methodology (DixonWoods, 2011), in many ways, Thematic Analysis seemed well suited to a number of the researcher's aims, being able to not only summarise large bodies of data and/ or offer a rich description of the data, it can also highlight similarities or differences across the data. Moreover, it offered the same theoretical and epistemological flexibility as Framework Analysis (Braun and Clarke, 2006). However, whilst Thematic Analysis can be either deductive or inductive, it doesn't allow for both in the way that Framework Analysis does (Parkinson *et al.*, 2016). As Ritchie *et al* (2014) point out, no research can be solely inductive or deductive, as it would not be possible to either interpret data with a 'blank mind,' whilst those testing out a hypothesis will have developed this through a body of theory which have been born out of previous findings. Therefore, Framework Analysis's option to work both inductively and deductively fitted best with the researcher's aims and beliefs, which outweighed the researcher's fears of adopting an approach that had not been used in Counselling Psychology previously and that their research supervisor was also unfamiliar with.

However, before finally settling upon this approach, the researcher contacted Dr Nicola Gale, one of the authors of *'Using the framework method for the analysis of qualitative data in multidisciplinary health research'* (2013), as well as Dr Nick Midgley, one of the authors of *'Framework Analysis: A worked example of a study exploring young people's experiences of depression'* (2016), to discuss the suitability of Framework Analysis to the proposed research and was reassured by both parties that Framework Analysis was both a suitable and workable option.

Following this discussion of the researcher's epistemological and ontological position and how this influenced their choices regarding data collection and methods of analysis, the following section reflects on how their personal beliefs and experiences may have impacted the research process.

2.3.4 Personal Reflexivity:

"… doing research involves energy, time, effort, commitment and often-times, anxiety. It rarely goes according to plan, there will be factors outside your control, unexpected turns-ofevents, and it all takes much longer than you think (Hodgson and Rollnick, 1996)"

(Henton, 2016, p.143).

Both conducting the research itself, as well as writing the thesis, has most certainly taken a lot longer than could have been expected and there have been several factors outside of the researcher's control. For this reason, this section will be divided into two parts, the first part detailing the researcher's reflections from picking their topic, to collecting and analysing their data. The second part is written from their current perspective, as they complete the thesis write up some time later. To note this switch to the present reflections, only Part 2 of this section is written in the first person.

2.3.4.1 Reflexivity Part 1 (Then - 2018):

This first section below is presented as it was written at the time, after the data was collected and the analysis process was almost completed. Following this, the researcher had multiple breaks from study due to several health and personal issues, some of which are referred to in Part 2 of this section.

The researcher's initial interest in this topic developed through their clinical work as a trainee counselling psychologist. Having had a number of clients referred to them, with a variety of problems including Depression, Anxiety, OCD, to name a few, they noted that all shared a common theme, they all suffered from unwanted, intrusive thoughts, some which drove them to suicidal ideation - another unwanted, intrusive thought: "I don't want to be here anymore". Often and thankfully, when this latter thought was explored further, clients would state that it wasn't that they wanted to end their life but just that they didn't wish to live like this anymore. However, just having the thought seemed to cause them great distress, often expressing feeling that they should not have such dark thoughts and that if they had the thought, then it might lead to them acting upon it. The researcher then reflected on the fact that when life got them down, they sometimes shared similar thoughts to their clients and that having spoken to friends, they found that this was quite common during difficult times. Somehow, however, the researcher and the people they knew, just brushed them off as simply thoughts, without causing the same amount of distress as that which the researcher often saw in their clients. This led the researcher to want to explore this cognitive phenomenon further; questioning how do people with mental health problems really experience these unwanted, intrusive thoughts and how do people with no clinical diagnosis experience them and how may this differ? As stated in the introduction to this thesis, once the researcher begun searching the literature on this topic, they discovered that it was mostly in line with the researcher's own observations – that a main difference between clinical and non-clinical populations appeared to be in the

importance they placed upon the intrusive thoughts and the way they responded to them, rather than the actual thoughts themselves (Clarke, 2005).

In line with their critical realist position, the researcher remained cautious with regards to how their own personal experience and expectations, may have affected their interpretations of the results. For example, as seen in the study by Parkinson *et al.,* (2016), depending on the different experiences and age of the various members of the research team, these different positions were found to impact how they listened to the material differently. As Willig (2013) states, it is often not possible to know how the researcher's involvement may shape or influence the findings or, indeed, the process. Therefore, in line with the suggestions made by Clayton and Thorne (2000), in their article on diary data enhancing rigour and as recommended by Koch (1994), the researcher maintained their own field diary throughout the research process, noting all events, ideas, relationships, interactions and reactions. This provided an excellent tool for the researcher's own self-reflection both during the data collection and afterwards. This on-going diary has been extremely helpful in helping the researcher to identify the possible effects that their own feelings, thoughts and actions may have had upon the process (Clayton and Thorne, 2000).

Research diary reflection examples:

Below are a few of the main struggles and reflections that the researcher noted throughout the research process, the first one relating to conflicts when collecting their data, followed by their concerns of how the study may have impacted their participants and lastly challenges surrounding some decisions during the analysis process. These were selected as they significantly impacted the researcher and also to give an overview of the researcher's challenges throughout different stages of the research process.

Wearing the correct hat:

"Empirical studies across a number of professions have demonstrated that barriers to acting ethically commonly occur when professionals wear 'too many hats' [Seider, Davis & Gardner 2007]" (Thompson and Russo, 2012, p.34).

Looking back through their diary, the researcher noted some initial struggles during some of their interviews, particularly with their clinical participants, regarding their position as researcher, rather than therapist. The researcher noted that it was often when a participant expressed negative perceptions of themselves due to some of the UITs they were experiencing, that they experienced a strong pull to help some of their participant's reframe some of these thoughts. Aware, however, that they were there as a researcher only, they refrained from offering therapeutic input but would sometimes comment at the end of the interviews, that they had found, through their research and clinical work that having such thoughts were not unique to them and was in fact, a very common phenomenon. This way they hoped to contextualise their participants thoughts as a 'normal' phenomenon to them, without straying too far from their researcher position. Looking back at some of their reflections on this struggle between therapist and researcher, reminded them of the first time they began working therapeutically with children. Having been a teacher for most of their career previously, they recalled their initial difficulty at being told by their placement supervisor that they were never to correct any errors in their work, unless specifically asked by the child. Whilst causing some initial discomfort, the researcher soon got used to wearing their therapist 'hat', as opposed to their old teacher one, realising that correcting a child's work in that context had the potential to hurt rather than help them. This helped the researcher to be mindful of the harm that can be caused when wearing the wrong 'hat' in the wrong context. As Thompson and Russo (2012) state, when psychologists are conducting qualitative research, they need

to remember and reflect on the differences between a research encounter and a therapeutic one. Remembering that when conducting research, the purpose is to gain information, which (and this was the internal struggle) may not have the interests of the individual participant as the primary focus. Whereas the therapeutic encounter is intended to involve longer term contact with the aim to facilitate positive change. As also noted by Thompson and Russo (2012) this is a very significant distinction and one which the researcher had to actively remind themselves of.

Adding Value:

The researcher was aware throughout the research process, that all the participant's had given up a great deal of their time (keeping their diaries for a whole week and then taking part in interviews that lasted on average 1.5 hours, in addition to their travelling time). The researcher was also aware that they had not been financially rewarded for this time and as they could not provide them with any therapeutic input as the researcher, they hoped that the participant's would find some benefit in taking part in this research.

N.B. As discussed towards the end of the previous chapter, studies conducted by Bowen and Kensinger (2017) and Sharp and Pelleteir (2006) suggested that compensating participants with either course credit or cash was found to be a main incentive for participation. Therefore, the researcher chose not to offer a financial reward for participation in their study, in the hope that those who chose to partake, did so out of genuine interest in the research.

Thankfully, however, all the participants commented that they had learned a lot about themselves and their thoughts from taking part in the study and particularly from keeping the

diary for a week, with many commenting that it had been an extremely useful and even a therapeutic experience for them. *(Further details of this are discussed in much greater detail in the analysis chapter.)* The positive feedback from all the participant's helped reassure the researcher that they had not caused the participants any harm and that their participation had also proved to be of value.

Story Telling:

Fortunately, when it came time to begin the analysis, the researcher found they had an abundance of very rich data to work with, thanks to the combination of diaries and interviews from 8 very generous and open participants. However, this proved to be somewhat of both a blessing and a curse. Constant reflections and edits were made when trying to decide how much or how little to include in the write up. During these struggles, the researcher found their supervision sessions to be very useful. Their first supervisor pointed out that they had included far too much content and it was minimising the depth of analysis (the first draft of the analysis chapter was over 20,000 words long). Looking through their notes at the time, the researcher noted that this struggle appeared to be a reoccurring theme and was reminded of their own reflections at the end of their case study, that forms part of this portfolio:

taken from page 23 of the client report –

"It seems somewhat ironic, that the word count in this assignment restricts me from feeling that I can really do justice to telling my story, of working with Mark's story. Can anyone ever do justice to their story and what happens to the parts we choose to leave out?"

Still wrestling with this issue, it was a conversation with their current supervisor that helped refocus their attention. They were reminded that they were conducting Framework Analysis, not Narrative Analysis and that only the main points that illustrated each theme needed to be included. After this conversation, selecting the key parts of the participant's data became easier to do but in truth there remained some discomfort that so much rich data that was shared had to be left out. On further reflection, the researcher realised this had a lot to do with the constant weight involved in qualitative research that selecting what to include of a person's story and what to cut out was ultimately down to their own interpretation, which as Willig (2012) states *"has the power to shape what comes to be known about another person's experience"* (p.45). However, continuing to reflect on this matter ensured the researcher made every effort to take great care throughout the analysis process, always making sure to refer back to the raw data. *This is discussed in greater detail in the section on analytic strategy further on in this chapter.*

2.3.4.2 Reflexivity Part 2 (Now- 2022):

"Research is an invasive, potentially poisonous experience, an ever-present, itching, nagging, bodily experienced pain, until it can be plucked out, healed over or forgotten. Perhaps it is the central problem of the training fairy-tale, whose happy ending lies not in academia, but somewhere else – the therapy room?" (Henton, 2016, p.133).

Currently, I cannot think of a better quote than the one directly above, to sum up my experience with this entire research process, from the very start – facing obstacle after obstacle (including numerous delays that were outside of my control) – right up to this current moment, as I type these very words. I deliberately chose to write this thesis in the 3rd person, it is how I have

written all my past psychology papers and I feel it helps keep the focus on the research and on the voices of my participants, rather than on myself. However, this section is about my impact on this research, as well as the impact that this research has had upon me. First of all, if it wasn't for the numerous obstacles and struggles I've had in trying to complete this thesis, I don't think I would have ever found out that I have ADHD which, not so incidentally, makes you very prone to suffering from a lot of UITs… Going through my reflective diary, there was another common theme that came up, more than any other one and that was my continuous struggle to focus on completing this write up. It was (and is) this continuous and seemingly insurmountable struggle that led me to finally question if there was a bigger problem here that I was somehow, perhaps, missing? As it turns out there was a much bigger problem behind my struggles and last year (2021) I was diagnosed with having ADHD.

Therefore, what I thought were my reasons for wanting to explore this topic are not entirely the same reasons that I recognise them to be now. ADHD stands for Attention Deficit Hyperactivity Disorder and it is a neurological disorder and disability which I have had all my life and without the need to complete this research would most likely still be completely ignorant to. I choose to disclose this as it has undoubtedly impacted how I see the world, my struggles to complete this thesis write up, my responses to my participants' experiences, my perspective on UITs in general and perhaps my somewhat unconscious, personal, desire to explore this topic. The biggest irony to me is this last point: what I thought was my true reason for wanting to explore this topic. When I first begun thinking about what I wanted to research for my thesis, I was aware that many of my fellow students already knew what they wanted to explore and it was often a topic very personal to them. I remember thinking at the time that I didn't want to do this, that I wanted a topic that had a very broad applicability to my clinical work, as well as one that I did not feel a strong persona l attachment too, in the hope that I would have a greater chance of not letting my own feelings and thoughts towards the topic

interfere with the research process. However, with every day that goes by, I discover how much UITs disrupt my life, particularly during periods of great stress. Whilst trying to complete work such as I am now, I realised that UITs are constantly plaguing my mind, in a way not dissimilar to some of my clinical participants accounts of how their incessant and relentless presence in their life became just 'white noise' in the background and that they were left physically exhausted from it. Hearing these accounts at the time, I felt I could understand the experience they were describing. Now, as I re-read their words from the transcripts, I feel that they could just as easily be my own words. As I continue to struggle to complete this write-up with my ADHD, I note the irony every time my own UITs surrounding my fears about completing this thesis continue to interrupt my work, often leading to full 'task paralysis', a common state for those who suffer with ADHD, whereby the person becomes essentially frozen by their thoughts and emotions, unable to do or focus upon anything. This, realisation caused me to reflect on how many ways my ADHD may have impacted my position as researcher within this study. Elliot, Fischer and Rennie (1999) state that it is necessary in qualitative research to own our position within the research and is one of the reasons I felt it necessary to include this second part to my personal reflexivity section. Moreover, I agree with Woolgar (1988) who stated that reflexivity exists on a continuum which can neither remain stationary or ever be completely achieved.

Now with the new knowledge that I have ADHD, I understand some of my diary observations a little better. For example, looking at many of my notes during the data collection process and much of the analysis, I seemed to note sharing a lot of UITs with the participants from the clinical group, although I noted the most in common with the participant who was in the nonclinical group but was also a female, counselling psychology trainee at another university. This latter point seems hardly surprising, as we were both going through a very similar

experience. However, I now know why I also related so well to a lot of what the clinical participants described in their interviews and some of the thoughts they noted in their diaries. My ADHD, that I didn't know I had during that time, makes me prone to suffering from a lot of UITs and is likely what drew me towards wanting to explore this topic to begin with. However, this is not to say that my understanding of UITs through my ADHD eyes was or is any less valid, for as Willig (2013) notes, it is exactly this 'baggage' which can enable us to draw meaningful interpretations from our participants' experiences and can be exactly what allows the researcher to add vibrant colours to the participant's accounts.

I have no doubt however, that where I initially positioned myself within the research, is not where I see myself positioned now. Whilst I had never classed myself as a *"distant expert"* (Charmaz, 2000, p.513), my closeness to this topic is not just mostly professional, it is also very personal. According to Lennie and West (2010), such a discovery is not uncommon, as they state that once deeper exploration is taken, regarding why a person chose to study what they did, they will often discover that they are somehow challenged by the chosen topic and driven by a personal desire to explore and gain a better understanding of their own experiences. They also posit that the very process of taking part in this research can be personally therapeutic for the researcher and even offer opportunities for personal growth (Lennie and West, 2010). Although often painful, I certainly agree that taking part in this whole research process has led to some personal growth – particularly the struggles with the write up – leading me to understand that many of my struggles in life, that I previously classed as character flaws, are actually symptoms of my ADHD and are not my fault. This, in turn, has been very therapeutic to discover.

Having now concluded the personal and epistemological reflexivity section of this chapter, this next section will outline the methods used by the researcher in this study and the reasons behind selecting them.

2.4 Methods:

In this section an overall summary of the procedure undertaken is provided below, in addition to an explanation of how participants were selected and then recruited. Details are then provided for the two phases of data collection. Finally, a description of the analytic strategy is presented, along with all ethical considerations.

2.4.1 Summary of overall procedure

Both clinical and non-clinical participants were recruited via flyers (Appendix F) and snowball sampling. Semi-structured paper diaries (Appendix D), with instructions to carry them at all times, for a period of one week, recording any UITs that occur at the time of occurrence, not retrospectively, were specifically disseminated to participants after they had read their participant information sheet (Appendix A), consented to the study (Appendix B) and had been screened over the telephone by the researcher (Appendix C). Once participants returned their completed diaries, either by post or by email to the researcher, the researcher, upon receipt, contacted the participants in order to arrange a follow up – semi-structed interview (Appendix E), at a time and location that was convenient for both parties. On completion of participant interviews, the researcher provided all participants with debrief information sheets (Appendices G & H) and explained to them that they could contact them if they would like to request a copy of the final thesis. The researcher then proceeded to transcribe all interviews.

Framework Analysis (Ritchie & Spencer, 1994) was the qualitative method then utilised to explore participant's diary entries and their interview transcripts. All participant's data were de-identified, with the code held by only the researcher, in a secure location.

2.4.2 Participant Selection:

Before taking part in the study, all participants were screened over the telephone, to ensure they met the below criteria (Appendix C). Here the researcher deliberately sought a nonprobability, stratified sample, to address (what they viewed) as a gap within the previous research.

Inclusion criteria for non-clinical sample:

- Aged 18 or over.
- No known mental health disorder and no previous history of treatment in the past for any mental health disorder.
- Equal ratio of male and female participants.
- Participants to be selected from various cultural and occupational backgrounds.

Exclusion criteria for non-clinical sample:

- Any participants under 18 years of age.
- Anyone with a clinically diagnosed mental health problem or who have received treatment for a mental health disorder previously.

Inclusion criteria for clinical sample:

- Aged 18 or over.
- Has a current mental health diagnosis relevant to unwanted, intrusive thoughts, including: Obsessive Compulsive Disorder (OCD), Depression, Generalised Anxiety Disorder (GAD), Post-Traumatic Stress Disorder (PTSD), Eating Disorders or Insomnia and currently (or previously) to be in receipt of treatment for this diagnosis.
- Equal ratio of male and female participants.
- Participants to be selected from various cultural and occupational backgrounds.

Exclusion criteria for clinical sample:

- Any participants under 18 years of age.
- Any participants deemed to be suicidal, suffering from psychosis or are currently sectioned under the Mental Health Act (1983).

The researcher chose to exclude these participants, as they may not have been deemed to be able to give their informed consent and/or may have been too vulnerable to be exposed to the tasks involved in the study, risking too great a chance for severe emotional upset. In addition to these ethical concerns, participants suffering from psychosis were excluded from this study, due to the nature of this mental health disorder, which attributes the unwanted, intrusive thoughts to an external source, making it very different to the other mental health disorders listed above (Clark, 2005).

As will be seen from the table below:

Table 1: Participant's Demographics

Participant ID	Clinical Diagnosis	Age	Gender	Ethnicity	Occupation	Religion
Jessie	OCD	41	F	English	Support Worker	Spiritualist
Casey	Depression and Anxiety	27	F	Irish	Unemployed	Agnostic
Nathan	Depression	49	M	English	Unemployed	Atheist
Nigel	GAD and OCD	38	M	Spanish	Teacher	Greek Orthodox

Margaret	None	58	F	Welsh	Admin Officer	Christian Protestant
Sandra	None	29	F	Nigerian	Trainee Counselling Psychologist	Christian Protestant
Justin	None	44	M	Russian	University Lecturer	Atheist
David	None	65	M	English	Retired	Christian Catholic

2.4.3 Recruitment Procedure:

The researcher recruited 4 clinical (2 male, 2 female) and 4 non-clinical (2 male, 2 female) participants for the study, using snowball sampling and flyers, within their own clinical placement and through other mental health professionals and selected potential participants, using the selection criteria outlined above (stratified sampling). This simply involved the researcher posting flyers in their clinical placement, in addition to another venue that was part of the same charity. Whereas the snowball sampling involved the researcher asking both their colleagues and their personal contacts to ask any of their clients and or personal contacts, to pass their recruitment flyer onto anyone they thought might have interest in taking part in the study.

The researcher deliberately set out to recruit an even sample size for both clinical and nonclinical samples, in order to provide an even and fair comparison, unlike previous research where these two populations had been compared, the sample sizes were markedly uneven in numbers, gender (percentage of men in all samples: 38%), age and occupation (non-clinical samples nearly entirely composed of students), with average age of all samples: 24 years old, (Julien *et al,* 2007).

Recruitment procedure for non-clinical sample:

The researcher used snowball sampling and flyers again to recruit their non-clinical participants. This involved the researcher using their contacts, to recruit their contacts, to take part in the study and posting flyers in a variety of public spaces. The researcher made sure to explain the nature and aims of the study, as well as the inclusion and exclusion criteria listed above, to those recruiting participants for them and supplied them with the participant information sheet (Appendix A) and the consent form (Appendix B) to give to any participants who demonstrated an interest in the study. Once interested participants got in touch with the researcher (either via the email address provided, or over the phone - if participant had supplied the researcher's contact with their number) the researcher then screened all participants over the phone, to ensure they met the necessary inclusion criteria outlined above (Appendix C).

Recruitment procedure for clinical sample:

The researcher recruited participants from within their own clinical placement, a mental health charity (for which ethical approval was granted from the CEO, following the ethical approval being given by the City Psychology Research Ethics Committee for both stages of the research process) but excluded their own clients and some participants were recruited from clients of other mental health professionals, following written, ethical approval. Once interested participants got in touch with the researcher, the same procedure was followed, as outlined above, with the non-clinical sample. Fortunately, all the participants included had varied cultural, occupational backgrounds and therefore, no participants had to be excluded on that basis. However, 3 out of 4 of the non-clinical participants had some background in the mental health field, the possible effects of this are discussed in the section on possible limitations of this study in the discussion chapter.

2.4.4 Data Collection Part 1:

In this section an explanation is provided for both the use and design of the semi-structured diaries utilised within this first phase of the study. Discussion is given to both the benefits and drawbacks of using both paper and electronic diaries. Explanations for chosen structure; using an 'event-contingent' design strategy, along with the selection of a time-based design and a 'variable schedule' are also provided below.

Semi-Structured Diaries:

Semi-structured paper and electronic diaries were used to explore the phenomenon of UITs (Appendix D). Diaries were chosen by the researcher, due to their ability to access content where participants lead their everyday lives and capturing this content from their lived experience. Diaries can often access data which participants might otherwise conceal, which is particularly useful when looking at the sensitive topic of a person's private unwanted, intrusive thoughts, which a participant may feel reluctant to share in an interview. In addition, the use of the diary can counter the unreliability of retrospective recall (Hammersley and Atkinson, 1995), all factors in line with the researcher's critical realist position. Moreover, diary studies can also be utilised to highlight differences in experience and perspectives between participants and participant groups, which was well matched with the aims of this study.

Drawing on past research into the use of diaries, particularly the work of Bolger, Davis and Rafaeli (2003), the researcher decided to offer participants a choice of having a hard copy of the diary posted to them or to have it sent to them in an electronic format (via email). This decision was made as it allowed for greater flexibility for the participants to choose the format that was most comfortable and easiest for them to complete. By chance, half of the

participants ended up requesting hard copies and the other half asked to receive and complete their diaries via electronic mail. Both methods have their benefits and their drawbacks. Hardcopy diaries, commonly referred to as Paper and Pencil diaries were the first version of diaries to be utilised, dating back to the 1940s and are still a commonly used approach within the field of diary research (Bolger *et al.,* 2003). According to Gleaves *et al's,* (2008) study on paper versus digital diaries, some of the benefits of using paper diaries are that research participants contributed significantly more in each entry than those using digital diaries, as those using digital diaries were more concerned over who may be able to view their responses, as opposed to those who had paper diaries. Furthermore, it was also noted that participants would need to be technologically literate in order to use digital diaries. However, some drawbacks to the paper and pencil approach were also noted. These included genuine forgetfulness where participants may simply forget to carry their diaries with them, as instructed, or to complete entries in a time appropriate manner, potentially missing entries completely or filling them in, at a later time. Hereby risking the errors resulting from retrospective recall and in turn defeating one of the main benefits and reasons for using diaries in the first place Bolger *et al.,* (2003). Electronic diaries reduce the risk of forgetting to have the diary with them, as even without access to a computer, participants would usually have a smart phone with them. Thereby, reducing the chances of missed entries and/or retrospective errors compared to the hardcopy diaries (Shiffman, 2000). However, as mentioned above, drawbacks of this approach include participants having greater concerns over their privacy which, in turn, was found to lead to shorter/less entries being completed and also required both access to electronic equipment as well as the ability to use it (Shiffman, 2000).

The researcher then chose to construct a diary based on previous research themes that have been widely discussed on the topic of unwanted, intrusive thoughts. These included: content, trigger, interpretation and response, with room to note all entries for each day of the week.

Following this, a definition was provided at the front of the diary for what an unwanted, intrusive thought is, along with clear guidelines on how to complete the diary (Appendix D). Participants were instructed to note their entries as soon as the UIT/s occurred or as soon as reasonably possible. This method of recording entries in a diary is known as a 'event-contingent' design strategy (Wheeler & Reis, 1991) and was chosen in order to reduce the chances of retrospective recall. A time-based design was also utilised by the researcher, as is common with most studies that use diaries to explore 'within person processes' (Bolger *et al.,* 2003), for example Rafaeli and Ravelle's (2002) study which used diaries to examine daily levels of mood and stress. In this current study, participants were asked to complete their diaries for the time period of a single week, beginning on a Monday and ending on the following Sunday.

This time period was chosen by the researcher due to the fact that a complete week seemed long enough to gain an understanding of participants thoughts and their frequency whilst also being short enough that it would not become too taxing. The researcher was mindful that participants would also be giving up their own time to take part in follow up interviews and that they would not be being paid for their time. Finally, consideration was given to the most suitable interval of assessment, which can, as Bolger *et al.,* (2003) states, follow mixed, fixed or random intervals. This decision was also guided by the research into UITs, which are, as noted in the previous chapter frequent, 'spontaneous and involuntary' by nature. Therefore, the researcher selected to use a 'variable schedule' which allows participants to note their experiences, as and when they occur. This is different from a fixed schedule which would require participants to note down their UITs either at specific intervals, for example every morning or every couple of hours or fixed times of the day (e.g., 8am, 1pm, 5pm, 9pm). A variable schedule seemed a more suitable option to the researcher as Bolger *et al.,* (2003) states, *"Users of variable schedules are often concerned with momentary experiences, such as psychological states …"* (p.589). Moreover, using a variable schedule, also reduced the chances of unreliable retrospective recall compared to a fixed schedule (Shiffman *et al.,* 1997).

2.4.5 Data Collection Part 2:

Semi-Structured Interviews

In this section an explanation of how the researcher conducted their interviews is provided, followed by a discussion of their chosen structure, schedule, use of multiple methods and the process of transcription.

Interview Procedure:

Following the completion and successful return of participant's week-long diaries, the researcher then contacted each participant again, in turn, to thank them for completing their diary and to confirm and make arrangements to conduct a follow-up interview with them at a time and place that was convenient to both the participant and researcher. All participants who took part and completed their diaries stated that they were still happy to participate in the follow up interviews. Eight semi-structured interviews were conducted in total, with most interviews lasting somewhere between 1-2 hours (range = 1hr 27mins – 1hr 58mins).

All of the interviews were held at the researcher's main student placement, at a mental health charity, at a pre-arranged time, in one of the private therapy rooms. This was easy and convenient for most of the participants who were interviewed there, as they were generally local and familiar with the venue. The researcher made sure to inform the admin and reception staff when they would be conducting their interviews and greeted all participants in the reception waiting room upon their arrival. All participants were offered light refreshments throughout the course of the interviews as both a thank you for their time and to hopefully help put them at ease. Before the interviews began, the researcher explained again that the interviews would be discussing their diary entries and their overall experience of UITs and would last anywhere between 1-2 hours and checked if they were still happy to take part. The

researcher then reiterated that their interviews would be transcribed by only themselves, no one else would listen to their recordings or read their diaries and that all their identifying data would be anonymised. Once the participants had granted their permission to go ahead, the researcher began recording their interviews.

After each interview was completed, all participants were debriefed (Appendices G & H), full details of this are provided in the section on ethical considerations, at the end of this chapter. The researcher also made notes at the end of each interview in their field diary, regarding how they felt the interview went, any personal reactions to the participants or their content and/or of anything that stood out, in order to aid reflexivity during the analysis process (Kvale and Brinkmann, 2009).

Interview Structure:

As Patton (2002) states, the main purpose of conducting interviews is so that we can explore what cannot be directly observed. As detailed above, once the pilot study on the diary had been completed and it was decided by the researcher that follow up interviews were required for the reasons explained previously, it was then necessary to decide how these interviews should be structured. Interviews can either take a 'structured', 'unstructured' or 'semistructured' format (Green and Thorogood, 2005). A fully structured interview involves having a fixed set of questions that need to be asked in a specific order for the purpose of generating responses which are directly comparable between participants. This approach was initially considered by the researcher, as this was their first qualitative study and a fully structured interview offered the benefits of a tight focus and structure, making it reasonably easy for an inexperienced researcher to conduct (Nunkossing, 2005). However, according to Nunkossing (2005), a disadvantage of this approach is that the resulting data will be unlikely to produce results with much depth or richness. As the researcher had decided to use interviews with the diaries to gain a richer and fuller understanding of participants experience

of UITs, a fully structured interview design was discounted. However, a fully 'unstructured' approach is usually used when the research topic has very little known about it which, as mentioned in the introduction chapter, did not apply to a topic like UITs which has tens of thousands of research papers written on the topic. Therefore, the researcher decided that, as with the diaries, a semi-structured design would be the most suitable option. Semi structured interviews allow the researcher to set the direction of the interview with pre planned questions whilst also allowing participant's responses to partially guide the questioning process, as the order of questions can be varied to suit each participant (Smith *et al.,* 2009). This allows for a more fluid and flexible approach, which the researcher felt would really allow their participant's the opportunity to express their experience of both UITs and of completing their diaries. Willig (2003) notes that the semi-structured interview is the most utilised approach within qualitative research. From the lens of a critical realist, this seemed the most suitable format, allowing the participants to accurately describe their experiences as much as possible, thereby allowing the researcher the best opportunity to robustly interpret their accounts (Smith et al., 2009). Fitting with this epistemological positioning, semi-structured interviews allow for the participant to be the author and expert of their own experience.

Interview schedule

The researcher's choice of questions were guided by both previous research and the participant's diary entries. In order to help set the participants at ease, the researcher opened with questions regarding how they experienced completing their diaries, as they deemed these questions to be more emotionally neutral and of a less personal nature than the questions that addressed their actual diary entries and UITs. The final interview schedule can be found in Appendix E. The first interview was treated as the pilot interview and proved the content and structure of questions to be successful, as the interview and all the following interviews, flowed easily, lasting on average 1.5 hours each and all providing a wealth of rich

data. Of course, these interviews were semi-structured, therefore each interview varied slightly in the order of which the questions were addressed, as the participants each guided the questions in their own particular direction, reinforcing the position that the participant is the expert in their own stories (Reid, Flowers and Larkin, 2005). As a trainee counselling psychologist, the researcher was able to use their listening skills to remain sensitive to the body language and tone of their participants, in addition to their words, and made sure to allow extra time in all the interviews for anything participants might have wanted to add.

Table 2: Timeline of complete data collection:

First stage of ethical approval to conduct study with just diaries granted 4th July 2017
Initial (diary) pilot study completed 20th May 2018
5 out of 8 participants diaries collected by August 2018
Second stage of ethical approval to conduct study follow up interviews granted 16th October 2018

All data collection of all 8 participants diaries and interviews completed by 22nd February 2019.

Multiple Methods of Data Collection:

The researcher ensured that all participant's diaries were present during the interviews and the semi-structured approach allowed for the researcher to delve deeper into some responses and seek clarification where certain diary entries were unclear. This proved invaluable, as the diaries and interviews worked symbiotically – without the diaries, the interviews would lack the real time recordings of their participants UITs to explore and discuss further and without the interviews, the diary entries would lack any real depth, context or understanding. Moreover, the interviews provided invaluable information on the effects that filling in the diary had upon all the participants, which were quite significant and informative and are discussed in detail in the following two chapters of this thesis. Both instruments helped to illuminate each other and created a rich picture of the participants experiences of UITs (Nichols, 2018). As Williams (2018) notes, combining more than one qualitative method of data collection should not cause a clash between epistemology or ontology, in the way that is often a problem when quantitative and qualitative methods are combined. Instead, these different methods and findings speak *"to each other to construct an overall account where the end product becomes greater than the sum of its parts"* (Creswell, 2011, p.225).

Transcription:

Having consulted with their head of department at the time, the researcher did have the option to outsource their interview transcription. However, following guidance from Gale *et al.,*

(2013), the researcher decided to conduct all their own interview transcriptions, as this helped to begin their immersion in the data. Equally important, the researcher was able to reassure the participants that no one else would listen to their interviews or read their interview transcripts, given the delicate and very private nature of the topics being discussed. All interviews were digitally recorded and transcribed verbatim using Microsoft word. The researcher then re-listened to each recording whilst checking their transcripts to check for any errors. All pauses, laughter and any non-verbal communication were also noted down by the researcher, as they were interested in the feeling behind the of words of their participants and not just the content. Although, it should be noted that this is not necessary for FA, where the content is the primary interest (Gale *et al.,* 2013). Also, in line with guidance of Gale *et al.,* (2013), each line was numbered for easy referencing and adequate space left between the lines for any coding and notes that might be added during the analysis.

To protect participants' confidentiality and anonymity, all interview transcripts and diaries were de-coded by the researcher – names and all other possible identifying descriptions such as places of work or study etc were replaced with pseudonyms. Participants were also given additional codes of CF (Clinical Female), CM (Clinical Male), NCF (Non-Clinical Female), and NCM (Non-Clinical Male) with their pseudonyms. Further details of this process can be found at the end of this chapter.

2.5 Analytic Strategy:

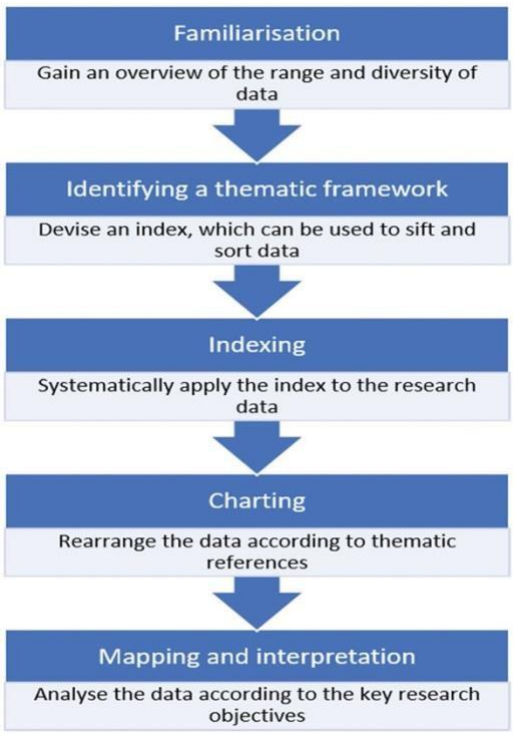
"… qualitative data analysis is essentially about detection, and the tasks of defining, categorising, theorising, explaining, exploring, and mapping are fundamental to the analyst's role" (Ritchie & Spencer, 1994, p.176).

Framework Analysis (Ritchie and Spencer, 1994) was the method utilised by the researcher to enable synthesis between the data collected from both the participant's diaries and interview transcripts (Clarissa, Quinn and Stenhouse, 2021). A combined approach of allowing themes to be developed both deductively (from the existing literature) and inductively (from the participants' experiences and views) was adopted for the analysis (Gale *et al.,* 2013).

The researcher then coded, organised and analysed the data into key themes and categories by following Ritchie and Spencer's (1994) five stages of Framework Analysis:

1. Familiarisation
2. Identifying a thematic framework
3. Indexing
4. Charting
5. Mapping and interpretation

Figure 3 from Aylott, Tiffin, Brown and Finn (2022) below provides a helpful visual of the process of Framework analysis:



Stages of Framework Analysis (adapted from Ritchie & Spencer, 1994 by Aylott, Tiffin, Brown and Finn (2022), p140.

As noted by Olsen *et al.,* (2018) the structure of FA helps to ensure a methodical and comprehensive analytic process, whilst at the same time allowing for some flexibility. Framework Analysis allows the researcher the ability to connect their data into overarching themes, highlighting intricate phenomena (Smith and Firth, 2011). Using this five-stage process, the researcher analysed all diaries and interview transcripts, multiple times, until a saturation of themes and categories were achieved (Olsen *et al.,* 2018).

Below follows a description of each of these steps taken by the researcher in this study. As there appeared to be no prior examples of any counselling psychologist's past studies or trainee's thesis to look to, the researcher drew most of their guidance from Parkinson, Eatough, Holmes, Stapely and Midgley's (2015) – *"Framework analysis: a worked example of a study exploring young people's experiences of depression"* and Gale, Heath, Cameron, Rashid and Redwood (2013) – "*Using the framework method for the analysis of qualitative data in multi-disciplinary health research".*

2.5.1 Familiarisation

> *"According to Rabiee (2004), the overall aim of this stage is to become immersed in the details of each transcript, to gain a sense of whole interviews prior to dividing them into sections and identifying recurring themes"* (Ward *et al.,* 2013, p.2426).

Although FA is grounded in participants original observations and accounts, analysis starts from the research question development and its aims and objectives (Ritchie and Spencer, 1994). Following this framework, the process of familiarisation began from the moment the

researcher developed their research question, reviewed the previous research and whilst reviewing their participant's completed diaries. This 'interim analysis' (Miles and Huberman, 1984) or 'sequential analysis' (Becker, 1971) aided the researcher in their development of their interview questions, having already examined the participant's diary entries – hereby allowing them to explore emerging themes and issues in the follow up interviews. The researcher then collated the participant's diary entries, along with their interview transcripts, immersing themselves further in the data, whilst looking for emerging themes. At this stage in the analysis the researcher is simply gathering an overview of the range and diversity of the data (Aylott, Tiffin, Brown and Finn, 2022). Using this data, the researcher began to develop preliminary codes for different types of intrusions. This was guided by past research, the initial research question, the diary headings and some of the interview questions, in addition to leaving room for any inductive themes that may arise from the data. During this stage the researcher used a pen and highlighter to go through the hard copied transcripts and diaries, *"coding anything that could be relevant from as many different perspectives as possible"* (Gale *et al.,* 2013, p.4). At this point, Framework Analysis does not require all the material to be reviewed, as this occurs later on in the data analysis (Srivastava & Thomas, 2009). However, as the sample size was not very large, the researcher chose to study all the interview transcripts and diaries, hereby ensuring that all participant's data was included and none of the data were overlooked (Ward *et al.,* 2013).

2.5.2 Identifying a Thematic Framework

Following on from this process of familiarisation, themes that were identified were then used to begin the development of a thematic framework. This involved developing framework categories, including new themes which had emerged from the data, along with a priori issues, such as the research question and previous research into UITs (Hyde, Yardley, Lefroy, Gay

and McKinley, 2020). There was also a separate part of the framework that focused entirely upon participant's responses to completing their diaries. This was deemed very important by the researcher as *"Diaries are acknowledged to be an underused method in social science research"* (Kenten, 2010, p.2), and this seemed a very important possible emergent theme to explore, with the hope of not only providing a greater understanding of participants' experience of UITs in 'real time' but also, information on the diary's future utility as a research instrument, particularly regarding research in to UITs.

Originally, the researcher had intended to use NVivo software for the analysis process, however as the data collection was delayed, the researcher no longer had easy access to this software – therefore pen and paper methods were used alongside Microsoft Word (Furber, 2010) and Excel (Swallow *et al,.* 2003). As recommended by Ritchie and Spencer (1994), during each part of the analysis process, reflective notes were made in order to stimulate reflection at every stage (Oliver, Nesbit, McCloy, Harvey & Dodd, 2022). During this stage, the researcher developed a preliminary thematic framework using both an inductive and deductive approach. The researcher was mindful to learn from the errors described by Parkinson *et al.,* (2015), where they described their false start during the development of their framework - here they had failed to simply rely on data management and had already began to try and interpret their data, which should come at a later stage. Also following their example, the researcher piloted their initial framework on 4 diaries and 4 interview transcripts to refine their a priori categories and remain open to any issues that could emerge from the data (these diaries and interviews were selected from the same 4 participants). This proved a useful step, as it identified several emergent categories for the initial framework, including 'relationship anxiety' and 'fear of death', which appeared to be separate to other a priori categories. Later these two categories were combined to form part of a new category – 'Traumatic Experience' which formed part of the final second level theme identified in the final stage of analysis –

"Triggers'. As Parkinson *et al.,* (2015), note, this process enabled the researcher to remain open to the novel and the unexpected whilst also managing their data.

N.B. *Although it is common place with FA, to work in teams and to carry out the process of analysis together, as this research method was carried out as part of the researcher's thesis and involving a much smaller data sample than FA is usually used for – the researcher carried out almost all the process alone. However, as the researcher had two, consecutive research supervisors, they were able to check some of their categories with both of them. Explaining their thought process allowed the researcher time to reflect on their coding and also feel confident in their decisions.*

During the many months of analysis that followed, all codes and categories were revisited by the researcher continually reviewing the transcripts and diaries entries. The Framework was then reviewed and adapted several times throughout these early stages of analysis, in order to reflect new and emerging themes (Clarissa, Quinn and Stenhouse, 2021). However, it was also important, as explained by Parkinson *et al.,* (2015) and Gale *et al.,* (2013) for the researcher to gain real clarity about their categories, as these categories were used in later stages to code the remaining data set. Also noting, however, that it is to be expected for *"the framework to go through several iterations"* (Parkinson *et al.,* 2015, p.118). An example of the researcher's initial working framework can be found in Appendix K.

2.5.3 Indexing

"… the development of the framework is an ongoing process that may continue to be adapted, even when you have moved on to the later stages of framework analysis. Although

there is always a risk that the indexing stage can become a somewhat mechanical process, linking it to further refinements of the framework ensures that it remains a thoughtful activity"

(Parkinson *et al.,* 2015, p.120).

Following on from the previous two stages, the researcher now felt confident to move on to the third stage of the analysis process – *Indexing* (see Appendix L). This was achieved by the researcher going through each of the participant's diary entries and interview transcripts, and as directed by Ritchie and Spencer (1994), Gale *et al.,* (2013), Ward *et al.,* (2013) and Parkinson *et al.,* (2015), applying the framework in a systematic fashion to each participant diary and transcript and assigning them to the appropriate framework categories. This was, as stated by Oliver, Nesbit, McCloy, Harvey and Dodd, (2022) an iterative process. Using Microsoft Word, the researcher then copied and pasted the highlighted texts from their typed transcripts and diaries, into the relevant framework categories that were also created in a separate word document. As stated by Ritchie and Spencer (1994), this stage in the analysis process is designed to organise all the data into the framework categories. Some parts of the data required 'cross indexing' (Oliver *et al.,* 2022) or 'double coding' (Parkinson *et al.,* 2015), as they applied to one or more codes. Themes and categories and sub-categories were combined, refined and developed (Ward *et al.,* 2013). This step in the analysis process was very helpful in making all the data begin to come together in a way that was both manageable and helpful in beginning to highlight reoccurring themes.

As also guided by Parkinson *et al.,* (2015) and Gale *et al.,* (2013), the researcher left an 'other' category for each theme in the framework, this was for any parts of the data that came up that did not seem to fit into any of the codes within their framework categories. This proved useful, as the researcher did find some parts of the data that this applied to. The 'other' category

meant the researcher was not left trying to make the data fit the framework or excluding any parts of the data. It was also useful for highlighting potential changes or additions to the framework categories.

2.5.4 Charting

"Good charting requires an ability to strike a balance between reducing the data on the one hand and retaining the original meanings and 'feel' of the interviewees' words on the other. The chart should include references to interesting or illustrative quotations"

(Gale *et al.,* 2013, p.5).

The researcher then moved on to the charting stage of the analysis (see Appendix L). Using Microsoft Word the researcher selected each category, summarised the indexed data and organised the summaries into chart form. This allowed the researcher to both compare and contrast the experiences of their clinical participants with their non-clinical counterparts, in addition to looking for patterns amongst the data (Ward *et al.,* 2013). An example of some of the early charting process can be found in Appendix K.

Participants are shown in the columns and the rows display the categories taken from the framework. To achieve this the researcher collated all the data from the diaries and transcripts that had been indexed into a particular category, then summarized this data for each participant, in each category (Parkinson *et al.,* 2015). As mentioned earlier, the researcher did not have access to NVivo software at the time they were analysing the data. Parkinson *et al.,* (2015) advised that in NVivo, there is an option in the software which allows the researcher to link the summary text to the relevant part of the transcripts. As this was not an option here,

the researcher simply chose to reference each summary to the line and page it was extracted from, as advised by Ward *et al.,* (2013) and Ritchie *et al.,* (2003). This was also done with the diary entries which, as they were so brief, did not generally require summarising. As the researcher was not dealing with the quantity of data that Parkinson *et al.,* (2015) were, this did not prove to be problematic and the references made it easy for the researcher to move back and forth between the original diaries and transcripts and their summaries. These summaries were used by the researcher to find patterns across themes and categories, which helped the researcher to begin to interpret their data. At each stage of the process, the researcher made sure to continually refer back to the original texts, thereby ensuring each stage of interpretation was extrapolated from and true to the raw data (Hyde *et al.,* 2020). The researcher then continued to revisit the data, checking their 'internal consistency' (Oliver *et al.,* 2022) by reading the content of the codes now organised in their charts and making sure that they matched the definitions they had been given. This resulted in a few parts of the data being re-coded. The researcher was now able to compare individual participant's accounts on different themes and categories (**cases**) by looking **across** the rows of the chart, in addition to comparing participant's views on each **theme** and **category** (**themes**) by looking down the rows.

Once the researcher had completed their charting stage, they were able to move on to the final phase of the analysis process – Mapping and Interpretation. The steps the researcher took to complete this final stage are outlined below.

2.5.5 Mapping and Interpretation

"This interpretive step is typically perceived as the most challenging to execute and the most difficult to elaborate in terms of what was done and how it was achieved. Ritchie and

Spencer (1994) concede this, pointing to how it requires researchers to not examine the data mechanistically but to assume an intuitive and imaginative stance – qualities that are indispensable for the production of knowledge but are not easy to articulate in a how-to sense" (Parkinson *et al.,* 2015, p.122).

In this final stage of the analysis, the researcher looked to understand the data utilising the research question as an analytic guide (Clarissa, Quinn and Stenhouse, 2021), as well as looking for any patterns within the data. As described in the quote directly above, this stage of the analysis is slightly more challenging to describe in a step-by-step process than the previous stages. Furthermore, as Bryman and Burgess (1994) state, qualitative analysis is somewhat of a 'creative process'. This part of the analysis process requires the researcher to move beyond just *managing and organising* their data and towards a place of *understanding* their data. To do this, the researcher began drawing together key themes and categories that had emerged from the data, in order to map and interpret the entire data set (Ritchie and Spencer, 1994).

Moving from data management towards a place of understanding:

At this stage, using their charted data, the researcher began reviewing all their participant transcripts and diaries, looking to understand their participants experience of UITs, looking for dominant themes and comparing how similar or different they appeared to be between the clinical and non-clinical participants. This was achieved through exploring emerging patterns in the data that had developed through the previous stages of the analysis process. Moreover, this stage of the analysis process also allows for themes and sub categories to be referenced against the audio recordings and entries from the researcher's field diary. By drawing on data from a variety of sources – triangulation can challenge the biases that can come from drawing on a single perspective (Denzin and Lincoln, 2000). Triangulation refers to the process

whereby multiple sources of data and/or methods are utilised in qualitative research to help create a coherent justification of categories and themes (Patton, 1999). The triangulation of drawing on diary entries and interview transcripts, from multiple participants, the researcher's field diary and original interview recordings, proved extremely helpful in aiding the researcher's understanding of the data (Green and Thorogood, 2005). This was, however, an extremely lengthy process, as warned by both Gale *et al.,* (2013) and Parkinson *et al.,* (2015) and the final themes, categories and sub-categories are detailed in the following chapter.

2.6 Ethical considerations:

Below is a summary of all the ethical considerations and steps taken by the researcher to meet these throughout the research process.

This study adhered to the ethical guidelines stipulated by the British Psychological Society (BPS) and those set out by City, University of London's Ethics Committee (see Appendix L). In line with this and the basic ethical considerations outlined by Willig (2013), the researcher made the following ethical considerations with regards to ensuring informed consent: that no deception was used, all participants had the right to withdraw at any point in the research, all participants were debriefed and confidentiality was ensured.

Informed consent, no deception and right to withdraw:

It was ensured by the researcher that all participants were adults, aged 18 years or over and all were provided with participant information sheets (Appendix A), explaining the nature of the research and reassuring them that they were free to withdraw from the study, at any point during the research process itself, in addition to also withdrawing their data within the threemonth period of taking part. The researcher ensured that each participant was screened

over the telephone (Appendix C) and that all participants signed consent forms (Appendix B), before they were able to participate in the study. Anyone who was deemed to be suicidal, suffering from psychosis or currently sectioned under the Mental Health Act (1983), were excluded from participating in this study, as such participants may not have been viewed as being able to give their informed consent and/or may have been too vulnerable to be exposed to the tasks involved in this study, risking too great a chance for severe emotional upset.

Prior to the follow up interviews, further precautions were added by the researcher, as they ensured that they reviewed all participant's diaries, as soon as they received them and if the researcher noted any entries, from any participants, which caused concern, the researcher could inform their research and clinical supervisor for advice and would make sure to call any such participants and check on their well-being, recommending that additional help be sought, if deemed necessary.

Debrief:

Once participants completed the research, returning their diaries by post or email to the researcher and then attending the follow-up interviews, each participant was handed a debrief form at the end of their interviews. However, due to the nature and purpose of this study, half the participants were diagnosed with a mental health disorder and therefore, the researcher did have to consider the possibility that emotional distress may be enhanced through taking part in the diary study for a week and then having to revisit their thoughts in the interview. Therefore, the researcher took extra precautions with regards to the clinical sample, creating two separate debrief forms (Appendices G & H), with the added reminder to the clinical participants to contact their counsellor that they were currently working with at the researcher's clinical placement, where a range of supportive services were available to them. Both debrief forms however, included contact details for a range of mental health services, as well as guidance to contact their GP or get in touch with the researcher or research supervisor (a

HCPC registered Counselling Psychologist) if they had any questions, which was handed to participants at their follow up interviews and that also provided the researcher with the opportunity to assess their emotional state.

Confidentiality:

Confidentiality was ensured in several ways by the researcher: all data was de-identified – a *reversible* process whereby identifiers are replaced by a code, to which the researcher retains the key, in a secure location. This had the benefit of maintaining participant's confidentiality but was also a necessary precaution, as this ensured that participants could withdraw their data within the three-month period of taking part, as promised. For added security, data and identifiers were held in separate, locked, filing cabinets and only the researcher and their supervisor had access to this data. In accordance with BPS guidelines, the researcher will ensure that all data is destroyed after 5 years of the study ending.

In addition to these essential ethical considerations, the researcher ensured distance from their participants, through the use of snowball sampling, thereby reducing the chance for participants to feel pressurized to take part in the study by the researcher and hopefully minimizing the chance of the researcher having influenced their responses. It was also hoped that this distance reduced the chance of participants feeling inhibited to note down any unwanted intrusions, which may have caused them to feel embarrassed or ashamed both during the time they kept their diaries and also throughout the interviews.

Chapter 3: Analysis

3.1 Framework Analysis – Stage 5 - Interpretation

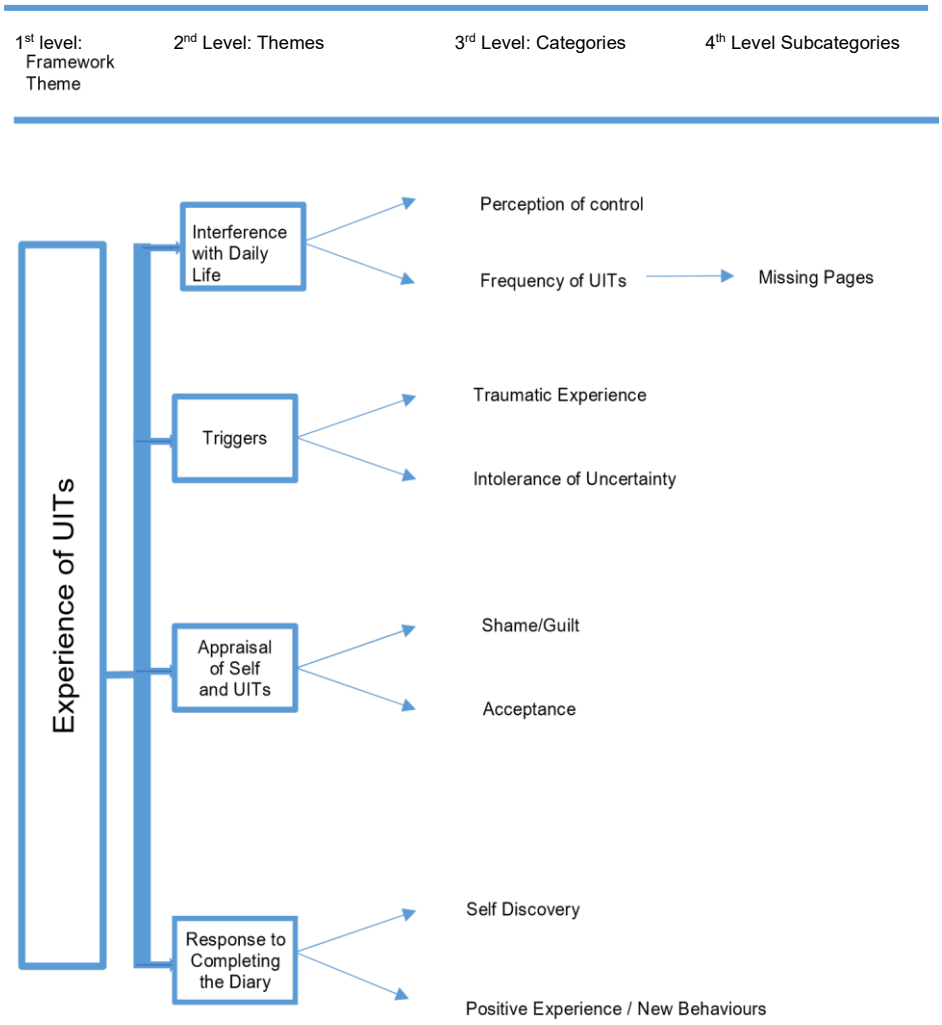
This is the final stage of analysis, as described in the previous chapter progressing from simply managing the data, as in the previous four stages (familiarisation, identifying a thematic framework, indexing, charting and mapping) and move towards a place of understanding. Ritchie and Spencer (1994) define this stage of the analysis process, as the part where the researcher begins to draw together central characteristics of the data in order to begin to map and interpret the entire set of data. At this point, they propose that the researcher can begin establishing relationships, by offering 'bottom up' explanations, as well as offering strategies for intervention and practice, if deemed appropriate. A good summary of this stage is offered by Parkinson *et al,* (2016*): "Mapping and interpretation involves finding patterns and articulating one's own sense making of the data, in the light of one's research question, this stage could take somewhat different forms, and could lead to visual and/or narrative presentation of the findings"* (p.122). The researcher chose to present their analysis in both a visual (see figure 3) and narrative form, in an attempt to offer the reader the clearest picture of the data.

3.2 Presentation of Quotations:

The findings presented here are derived from both the diaries and the interview data, with data from the diary being represented by the letter D and data from the interview by the letter I. The numbers 1-7, next to the letter D indicate the day of the week the data was extracted from, 1 being Monday – through to 7 - which is Sunday, for example **(Jessie, D,1).** For participant data extracted from the interview transcripts, a similar format has been followed, with the participants' pseudonym in brackets followed by the letter I for interview and the page of the transcript the quote was taken from, e.g. **(Nathan, I, 13).** All quotations are in italics. Three dots (…) are used to indicate either a quotation that is taken part way through a sentence or to indicate that the following quotation is from the page but does not follow on directly from its previous quotation. The dash at the end of a line (-) indicates the rest of the

quotation has continued onto the next page and ([ ]) is used occasionally, to note that a word has been replaced in the sentence. The researcher chose to present their findings from the diary and interview data together, as both are needed in order fully understand the findings. For example, the participant's interviews frequently refer to their diary entries or absence of entries, presenting a much clearer and richer picture of their true experience of UITs than either instrument could if they were to be presented separately. This is clearly illustrated throughout the rest of this chapter.

Figure 3: Conceptual Framework Experience of UITs



The tree diagram above illustrates the four second level themes that the researcher found from both the diary and interview data provided from all eight participants, within the first level Framework Theme of all participants' experience of UITs. These four second level themes were -

1: Interference with Daily Life - which comprised of two third level categories - Perception of Control and Frequency of UITs, the latter having a fourth subcategory of '*Missing Pages'*.

2: Triggers - which comprised of two third level categories - Traumatic Experience and Intolerance of Uncertainty.

3: Appraisal of Self and UITs - which comprised of two third level categories - Shame/Guilt and Acceptance.

4: Response to Completing the Diary - which comprised of two third level categories - Self Discovery and Positive Experience/New Behaviours.

Presented below are the main themes, categories and subcategories found by the researcher. Each will begin with a presentation of the clinical participant's responses first, followed by a comparison to the non-clinical participant's responses. The researcher chose to present their data in this way, as they felt it was the clearest way to compare the two groups of participants (which is the main focus of this study). The clinical participant's data are presented first, as this group is generally where the foundation of research in UITs was first formed, with the nonclinical group often forming the normative comparator.

NB: As can be seen above, none of the themes that have been included in the final framework refer to only the content of the participant's thoughts – that is to say, specific thoughts.

Although, many versions of the researcher's theoretical framework included different categories of types of UITs that have been listed in the research – such as contamination, sexual thoughts, health concerns etc., (CIQ; Freeston, Laudouceur, Thibodeau & Gagnon, 1992), throughout the analysis process, the researcher found such a wide range of thoughts covered by the various participants, most concerning health fears or social anxiety but none significant enough to form its own theme or category and more importantly, there did not appear to be a difference in content between the clinical and non-clinical groups. Possible explanations and implications of this finding and how it relates to the current research are discussed in the following chapter.

3.3 Interference with Daily Life

"I do get these thoughts and I do feel that they have a major impact on my life quality"

(Jessie, I, 3).

The extent to which participants described how much their UITs impacted upon their daily life and activities appeared to be directly related to two issues - these were, the frequency of UITs that participants' experienced and the participant's own perception of how in control they were of their own UITs. Overall, it appeared that the clinical participants expressed experiencing much greater interference from UITs in their daily lives, in terms of both frequency and effect, as well as a considerably decreased sense of being able to control and manage their UITs, as compared to the non-clinical participants.

3.3.1 Frequency of UITs:

(Clinical participants)

At first glance, Jessie's diary, appeared one of the fullest, with everyday filled in with UITs, ranging from fears about her developing cancer; *"Getting bowel cancer at a young age"* **(Jessie, D, 1)**, *"Getting cancer/brain tumour"* **(Jessie, D, 2)**, **"***fleeting thought that I may get Leukaemia"* **(Jessie, D, 3)**, "*I will get breast cancer"* **(Jessie, D, 4).** To thoughts that made her feel guilty about her mother dying and her step-children - *"I hope mum doesn't take long to pass"* **(Jessie, D, 5)**, *"I want my caring role and responsibility to end"* **(Jessie, D, 6)** and compulsions to brush her teeth to prevent harm coming to her children - *"If I don't brush my teeth for a second time 'Martin' or 'Sarah' will get a brain tumour"* **(Jessie, D, 1,7)**. From the start of the interview, Jessie confirms that she *"constantly suffer[s] from intrusive thoughts."* **(Jessie, I, 1)**. Jessie stated that her UITs were: *"…still just as intense as [they had been] 15 years ago … No matter what you do, they're always there, like the sword of Damocles over your head. Always there in the background …"* **(Jessie, I, 3,)**. Interestingly, the analogy used here by Jessie, comparing her experience of UITs, to having the 'sword of Damocles' hanging over her head appears directly comparable to Nigel's description of living with constant UITs; *"I know they're just in the background … just waiting for me to sort of not have something to concentrate on … They're waiting for me, they're definitely waiting …"* **(Nigel, I, 10)**.

The following quote from Nigel appears to capture both the frequency and interference caused by his UITs: "*…it's tiring, it's relentless and, you know, after it's all done and you go to bed and you worry…"* **(Nigel, I, 15)**. Similarly, Casey described a constant and daily struggle with her UITs that had just become an expected presence, seemingly part of her: *"…it's like the back of my hand, you know? I wake up knowing that I'm going to feel that way, I wake up probably already with anxiety because I'm going, what's going to trigger me, not trigger me? … what's going to hype it? … So, on a daily basis, so it's like a white noise, the screech on the telly …"* **(Casey, I, 6)**. With this, Casey described the same accompanying fatigue as Nigel and stated:

"*That's exhausting, like every day at 4pm I have to have a nap, just to have a break from the anxiety… so that for me is like a routine and probably another tool really, push my anxiety down because it brings me so much fatigue and stress, so yeah, I am struggling a lot at the moment …* **(Casey, I, 18)**.

Listening to the clinical participant's accounts of their UITs, the researcher noted how similar all the clinical participants described both the daily struggle and fatigue felt by having so many UITs in addition to the similar imagery they all conjured of the constant presence of these UITs were to them, just always hovering somewhere in the background. Nathan described the fatigue caused by his constant UITs: **"***… then at the end of the day, I'm always tired … it's like endless, you know? Endless misery and thoughts going round and round your head, with no actual break* **(Nathan, I, 1)** *… just endless torture* **(Nathan, I, 2)** *… Just the yap, yap, yap, yap…* **(Nathan, I, 4)** *… like anyone has any ideas where I can escape my head, let me know, yeah?" …* **(Nathan, I, 6)**. Nathan's rhetorical question here, appeared to be one that was shared by all the clinical participants; resigned to accepting their UITs as a somewhat inescapable part of their lives, causing real disruption and upset daily and all describing the fatigue that seemed to accompany their constant presence.

3.3.2 Frequency of UITs:

(Non-clinical Participants)

This daily struggle, with seemingly incessant UITs, described by all the clinical participants, as summarised above, did not appear to be the same uniform experience for the non-clinical participants. For just one, Sandra, there were many similarities to the clinical participants, in that she also detailed daily and constant UITs accompanied by the same fatigue described by all the clinical participants: *"…the intrusive thoughts just keep coming back … and it just*

becomes a big bully in your mind and it just batters you into submission … **(Sandra, I, 3)** *I feel like I've just been brow beaten into submission and I feel that in my body sometimes, I just feel this overwhelming sense of fatigue."* **(Sandra, I, 6)**. However, Justin and David described their experiences with UITs to be far less frequent and exhausting. For example, Justin stated that he found his UITs to be "*… more annoying than actually life disruptive."* **(Justin, I, 12)**, when detailing how they often interrupted him at work. Whilst David stated that whilst he had recently found himself with the repetitive UIT of his train crashing, that although a frequent thought, it did not always occur whilst travelling by train: *"I don't get it every time, I was in college last night at London, travelled by train and it didn't come into my head."* **(David, I, 3).**

3.3.3 Frequency of UITs - Missing pages:

(Clinical Participants and Non-Clinical Participants)

"I have to admit that this notebook, with its wilderness of blank pages, seems almost more threat than gift - for what can I write here that it will not hurt to remember?" (Jean Hegland, Into the Forest, p.243).

Initially, having just examined all the participant's diary entries, they seemed fairly comparable, in that a couple of the clinical participants had filled in all of the pages of their diaries, whilst a couple had many empty pages. The same issue was to be found amongst the non-clinical participants; half had full diaries and half with many missing pages. Before the interviews, the researcher viewed the empty pages as indicative of the participants not having any UITs that day. However, after completing all participant interviews, they then understood what the empty

pages actually meant for some of the participants. Here, there emerged a fourth level subcategory within the category of frequency: there appeared a marked difference between the clinical and non-clinical participant's empty diary pages. For the non-clinical participants, it appeared to be exactly as the researcher had presumed, they didn't note having any UITs on those days (both David and Justin had some empty pages in their diaries). However, during the interviews, it became apparent that the empty pages represented something very different for the clinical participants, rather than symbolising an absence of thoughts on those days, the empty pages seemed to represent the exact opposite: rather they appeared to portray a sense of being overwhelmed by too many UITs to be able to note anything down. When asked about the missing pages from Nathan's diary, he explained: *"It was really hard, yeah I have to say, I mean it's like there's just so many thoughts, that it just sort of becomes like a background noise type thing, so there is no way I could ever write that all down … and I'm so used to it that I don't always really notice what the thoughts are saying but just more of a feeling … of being miserable – … so most of the time I didn't write anything or what I did write is just one thought out of maybe hundreds/thousands, like …"* **(Nathan, I, 1)**. Similarly, Casey described the same feeling of overwhelm from too many UITs as the actual reason behind her missing diary pages: *"I get very clouded, … so I have a lot going on all the time … so then coming to go oh, I've got to write down the way I'm feeling, that would be a scatter of everything - … that's why I found it so difficult to write all of that and pinpoint exactly how I felt.* **(Casey, I, 2)** *… I'm not a full paragraph, you can't have a full paragraph with the way I feel because you need a novel of it, you know, really and it wouldn't be a cohesive novel, it would just be pages of words that might not mean nothing, to you but the whole world to me. On a page, it might just be the word 'Theo' because all day I'm worried about him and that's all it is"* **(Casey, I, 17).**

Both the struggles Nathan and Casey outline here with regards to completing their diaries match in their descriptions: both highlighted the challenge to extract and identify individual UITs from what had just become almost *"white noise"* **(Casey, I, 6)** to them. Their accounts reminded

the researcher of the mistaken assumptions one can sometimes arrive at when simply taking things at face value, an absence of diary entries did not necessarily equate to an absence of UITs; in fact, for Casey and Nathan, it meant quite the opposite. Even when one UIT had been noted, both Casey and Nathan explained that a single entry could represent maybe *"hundreds/thousands"* of thoughts **(Nathan, l, 1)**; a single entry for Casey - "Theo" (her son's 'name') actually might represent a day full of UITs about him, too difficult to extract and too many to note down in a diary.

Therefore, in summary, the way participants described their experience of UITs did appear to suggest a difference in frequency between the two groups; with the clinical group appearing to feel burdened and fatigued from seemingly constant UITs all day, everyday. Whereas, the non-clinical group (with the exception of the student, Sandra) did not appear to struggle with as many UITs. Moreover, whilst the diaries initially appeared to demonstrate an even number of UITs between the two participant groups (half the clinical group had some empty pages in their diaries, as did half the non-clinical participants), as discussed above, the following interviews informed the researcher that, for the clinical participants, these empty pages were actually a reflection of far too many thoughts on those days but for the non-clinical participants their empty pages were as they appeared, they didn't recall any UITs on those days.

However, it appeared through the analysis that it was not only the frequency of UITs that seemed to cause interference with their daily lives but also how participants viewed their ability to control their UITs, when they occurred. This is discussed below in the category 'Perception of control'.

3.3.4 Perception of control:

(Clinical Participants)

"That's the chains, that's the control it has over me" **(Jessie, I, 13).**

Another category that emerged as part of the theme on interference, was how participants appeared to perceive their ability to manage their UITs. Overall, it seemed that the non-clinical participant's felt they had much greater control over their UITs and could manage them as compared to the clinical participants, who seemed to create a picture whereby the UITs appeared to control them. All four of the clinical participants gave descriptions of feeling almost at the mercy of their UITs, rather than having any confidence that they could manage or contain them, in any way. Jessie provided a detailed account over the course of the interview, explaining how her UITs were almost like 'chains' which had control and hold over her, even though the UITs made no 'logical' sense to her.

"It's like I'm aware of how you deal with OCD with exposure therapy but exposure therapy is very difficult for someone who has OCD because you are actually asking them to, in a way, risk their life. Even though, most people would see that as complete madness, almost, of course you're not going to risk your life by not brushing your teeth so that you won't get cancer -

from that. So, to a normal person, they wouldn't see the risk. But someone with OCD lives that risk in their life and it's quite real to them" - **(Jessie, I, 8).**

During the interview, Jessie explained how even just saying the words - that she did not believe her own thoughts - filled here with fear of the potential consequences: "*… I find it difficult to vocalise and say that I don't really believe the thoughts because, that's the chains, that's the control it has over me …* **(Jessie, I, 13)** *… I feel at risk of saying I don't really believe the*

thought because then the thought could come true **(Jessie, I, 14).** In a similar sentiment, Casey discussed her UITs concerning driving on the motorway with her son and how she feared getting in an accident whereby she survived and he was killed and the lengths she went to in order to avoid this occurring, and like Jessie, fearing that if she did not listen to her UITs there would be consequences.

"Sometimes I get so stressed about that I don't drive on the motorway. So, I'll go down all the lanes because I can't, I couldn't fathom, driving, getting hit or making a mistake or my tyre popping and then him dying because of that and me surviving. Then people say you can't go your whole life avoiding things because you're scared it might happen but the thought is sometimes so overwhelming that if I don't do that then I can't, I will not be able to get on with my day, you know or I'll be punished for it and I know I will kind of thing because everything bad always happens to me…" **(Casey, I, 18)**.

Nigel however, whilst initially seeming to suggest that he had some control over how to manage his UITs, later explained that this was only through constantly checking, in order to try and reassure his doubting intrusions – leaving him tired, frustrated and depressed and finally conceding that really, the UITs had *'got control'* of him.

"I don't really, I mean I can manage my thoughts, I do manage them, it's not in a good way and I mean, I'm just trying to think, I mean, the checking, … it's not really, I'm doing the checking so therefore I've checked it. I can't manage it by making my checking less … I try and reassure myself, so that's why I say, I can manage it, but it's really got control of me… **(Nigel, I, 12)** *…The whole process, it's just tiring to have all these thoughts, to think about*

them all the time …" **(Nigel, I, 13)**.

In essence, Nigel described the similar 'chains' that Jessie and Casey discussed regarding their UITs and the consequent actions they felt compelled to do in order to 'manage' them.

Nathan also described feeling that the thoughts were almost suffocating, as he described his UITs having hold of him 'by the throat' and likened them to an endless nightmare that you never seem to 'wake up' from. *"… I wish I could say I had some idea about how to stop all these thoughts but I don't, otherwise you know, I obviously would."* **(Nathan, I, 10)**.

"… Sometimes it feels like there's a demon or something in my head and it just likes to bully me …" (Sighs, deeply) **(Nathan, I, 11)**.

Overall, it seems that all the clinical participants felt that their UITs were controlling them and their actions on a daily and continual basis, in a way that sounded both relentless and exhausting for them all.

3.3.4 Perception of control:

(Non-clinical participants)

Whilst interviewing the participants and analysing their transcripts, there appeared an obvious difference in perception regarding how the non-clinical participants described their ability to control their UITs in comparison to the clinical group. Discussing his UITs, David said: *"… I don't allow them to come into my head …* **- (David, I, 3)** *… I am very good at compartmentalising my thoughts, yeah.… I think the army has a lot to do with that …* **(David,**

I, 4) - *life experiences have … told me not to – dwell on it … because I see that as a sign of weakness"* **(David, I, 5)**. Whereas Justin explained that whilst he used to be more affected by his UITs, they no longer troubled him very much (since getting older and working with many clients as a Counselling Psychologist) and he could generally dismiss them: *"It just comes and I can easily dismiss it, yeah. You know I can even, you know, enjoy is the wrong word but I can even laugh at it"* **(Justin, I, 8)**.

Similarly, Sandra also explained that she used to find her UITs a much greater problem than she does now, having embarked on her training to be a Counselling Psychologist: *"… I think this training has been very good in the sense of teaching approaches that not only work for clients but will work for us as therapists, as well. I see how important it is because they are part of my life that I really do need to have strategies to keep them in check* **(Sandra, I, 6)** *… I think if I give myself enough distance from the situation and I allow myself time, then yes, I can cope with the intrusive thoughts and I can cope with uncertainty …"* **(Sandra, I, 9)**.

Margaret, described a similar development in finding ways to manage her UITs, since gaining a greater awareness of them through completing her diary. Now Margaret claimed that she just refused to entertain them and states that since becoming more aware of her UITs, she has also become better at dismissing them: *"… I think the thing you can do something about is when recognising when you have them, just, No! … I think you can have control of the impact they have as opposed to, because I think they're just going to keep coming. …"* **(Margaret, I, 8)**.

Overall, when comparing the clinical and non-clinical participants data, the non-clinical participants not only appeared to have far less frequent UITs than their clinical counterparts but they seemed to describe a far greater confidence in their ability to control them compared

to the clinical participants, who seem to describe the UITs having control of them. These two issues, thereby appear to offer the biggest insight into how far UITs would interfere with a participant's daily life (the first theme in this framework). The second theme within the framework of participants' experience of UITs, is 'Triggers' which explores what participants identified in both their diaries and interviews as the prompt for their UITs and is discussed in this next section, below.

3.4 Triggers

"You're altered for life because of your previous experience" **(Justin, I, 12).**

After examining all the participants' diary entries and interview transcripts, a clear theme began to emerge amongst them all which was that, most of the time, most participants (7 out of 8) could identify a trigger for their UITs. Moreover, the trigger for most of the participants UITs seemed to stem from two common areas, which were; the lingering effects of traumatic experiences and/or an intolerance of uncertainty. Therefore, any situation that either had a connection to a past trauma or created a sense of uncertainty, could be a trigger for UITs. These two triggers seemed to be shared by all participants, clinical and non-clinical, alike.

3.4.1 Traumatic Experience:

(Clinical Participants)

As mentioned above, after analysing all the data, a clear theme began to emerge around trauma and how it seemed to serve as a common trigger to both the clinical and non-clinical participants' UITs. For Nathan, the trauma of being fired from his job of ten years, still appeared to haunt him today, both during the day and at night: *"It's like, even in my dreams, it's going on … like in the day I think about it a lot, anyway, especially if I'm at the job centre, or googling jobs or whatever … yeah, like that really sets me off and I can just see and feel the humiliation of being told I had to go … then all those – thoughts of you're a loser, useless etc are happening"* – **(Nathan, I, 7)**. *"… sometimes I don't know if I'll ever be able to shake that day off and get another job …"* **(Nathan, I, 8)**.

Like Nathan, Casey explained how her past traumas, were not only the source of most of her UITs but also the cause of many nightmares: *"… it's more of my ex-partner threatening that he's going to come and take 'Theo' away from me and that triggers lots of kind of very sort of scary thoughts of that sort of stuff …"* **(Casey, I, 8)**. "*Because the suggestions been put there and I know what he's like and it's hard to drop that suggestion because sometimes it just, you know, it does happen, you know, so and it terrifies me"* **(Casey, I, 9)**. Here a threat made by her ex-partner, that he would take her son from her, was clearly central to so many of Casey's daily UITs.

For Jessie, she seemed clear that a lot of her UITs stemmed from the huge trauma of watching her mother die from cancer. During the time Jessie completed the diary, her mother was dying from a brain tumour. By the time the researcher met with Jessie for her interview, her mother had sadly passed away, leading to increased UITs and images about developing cancer. Most days in Jessie's diary were filled with at least one thought about cancer (see examples listed at beginning of this chapter). However, in the section of the diary, where participants note their interpretation of their UITs, Jessie was clear that the trigger was *"health anxiety, due primarily*

to my mother's terminal illness…" **(Jessie, D, 1).** Jessie then discussed the profound effects of her mother recently passing away had had upon her UITs and how the connection to them felt very obvious to her:

> *"With my mother it tends to be an overt link and overt trigger between the thought and perhaps the ritual as well but I do tend to react to, for example, adverts in magazines for funeral directors. That will be a trigger to a thought. A lot of my thoughts … are pretty obvious between the trigger and the thought"* - **(Jessie, I, 5)**.

3.4.1 Traumatic Experience:

(Non- Clinical Participants)

The trigger of trauma from the loss of a loved one and the trauma from an abusive ex-partner, discussed above, was also shared by some of the non-clinical participants. One of David's first diary entries noted that: *"My wife died 8 years ago. I lay in bed last night thinking that it was my fault that she had died (she had cancer), that I wanted her dead and I allowed her to suffer in the last few weeks of her life"* **(David, D, 1)**. This very first diary entry by David seemed to cut straight to the heart of the trauma behind a lot of his UITs. Discussing his recent UITs concerning travel and having fears of trains or planes etc crashing, he explained how he had previously loved travelling and felt these recent UITs had been triggered after his wife had died. "*I must label a lot back to my wife because obviously I haven't dealt with a lot of that yet, I know I haven't. But it's definitely more recently than earlier. I can remember jumping on planes and going all over the world, you know without any, any, qualm at all. Now if we get any turbulence at all I get really worried, yeah."* (David, I, 4).

Meanwhile Justin and Margaret both appeared to share Casey's trigger of (who they deemed to be) an abusive ex-partner. Margaret, described the lingering effects of her traumatic experience with her ex-husband, after 30 years of marriage and how this was very much central to all her UITs. Throughout Margaret's diary, were entries each day, related to relationships, either current or past: *"I wish my ex would just disappear, I hate him";* **(Margaret, D, 1,) "***I am not strong, my ex has made me weak (this thought went round and round in my head for hours)"* **(Margaret, D, 2)***; "I can't handle being in a relationship and want to be own my own"* **(Margaret, D, 3)***; "my partner is a pain"* **(Margaret, D, 6) "***I'd be better on my own"* **(Margaret, D, 7)**. As Margaret discussed her diary entries in the interview, the impact her exhusband had upon both her current relationship and UITs concerning her new partner, as well as fears regarding her own strength, appeared clearly linked. As Margaret stated, early on in the interview: *"When the intrusive thoughts were there and they were almost invariably connected to him or even with my new partner, there'd be some trigger but it would go back to my ex"* **(Margaret, I, 2)** *…* - *The trigger is my ex., there was always a trigger"* **(Margaret, I, 8).**

Similarly to Margaret, Justin also spoke of how the betrayal of his ex-wife cheating on him still appeared to haunt his thoughts:

"You know, so I've had some pretty nasty previous experiences around relationships … so obviously when I get into a new relationship I kind of worry, I guess, more than average about fidelity. You know, not just minor betrayal, I'm talking major betrayal, you know you're in a marriage, you've got children and you know your wife is literally having a full-blown affair, behind your back and you discover that. I think it changes who you are going forward.

… The experience shapes your intrusive thoughts" **(Justin, I, 12)** *… unfortunately you can have experiences that predisposes you to have a certain unwanted thought, er intrusive*

thought for the rest of your days …" **(Justin, I, 14)**.

Sandra, however, noted a different trigger for many of her UITs but it was also one that appeared to be born out of a traumatic event. In her diary, Sandra had noted *"This is hopeless"* and stating the trigger to be glimpsing sight of her neighbour **(Sandra, D, 2)**. When the researcher asked Sandra about this in her interview, she explained that she felt her neighbour had been making her and her mother's life extremely miserable and stressful by behaving in ways which they found threatening, for many years.

"It's been common for the past few years, my neighbour, I live in a converted Victorian house and this neighbour lives above me. … **(Sandra, I, 7)** *… She's done some horrible things, I've had her sister follow me home, right up to my front door, I've been sworn at, yelled at and the police have been called about 30 times to that property, nothing happens. So, there was a constant sense of fear with this neighbour. So that situation has brought some negative intrusive thoughts …"* **(Sandra, I, 8)**.

Here, it would seem, both groups of participants shared an awareness for a main trigger for their UITs, and that trigger was a traumatic experience. However, throughout the interviews another trigger also developed and that was participant's apparent struggle to tolerate uncertainty. This trigger also appeared to be shared by both participant groups and is discussed below, in the second category within the theme of triggers - 'Intolerance of Uncertainty'.

3.4.3 Intolerance of Uncertainty

(Clinical Participants)

"*I think it is all about gaining certainty in an uncertain world and the more you try that the more uncertain everything becomes"* **(Jessie, I, 6).**

Whilst it seems that all the participants could identify past traumas as the root for many of their UITs, another theme had also emerged from their interviews and diary entries: a seeming inability to be able to tolerate uncertainty. When the researcher discussed certain diary entries with Jessie, for example - *"If I don't brush my teeth for a second time, 'Martin' and 'Sarah' will get a brain tumour"* **(Jessie, D, 5)**, Jessie explained how she dealt with the fear and uncertainty that either herself or her children could develop cancer, through neutralisation: *"Um sometimes my rituals can be sort of overt, physical actions… if I feel anxious about my children I might brush my teeth a certain amount of times so that it will cancel out the thought that they might die of cancer"* **(Jessie, I, 2**) – … *because obviously with anxiety sufferers it's the doubt that bothers you most, it's not having control of everything in your life"* **(Jessie, I, 3**). Jessie discusses how her inability to tolerate anxiety seemingly blocks her path to recovery from OCD: *"I really do want to recover from this but it always seems to allude me. I think because the journey to recovery is so hard and in my mind there are so many risks to get there, that I'm not willing to take that step".* **(Jessie, I, 5**).

Similarly, Casey and Nathan also stated the same struggle with uncertainty: *"A change of circumstances, meeting someone new, being in a new place, I'll get anxiety, and that then will trigger all the thoughts of why am I feeling like this? and you know it's because I'm not grounded enough or this, or so, they kind of then all like tumble in if I have a change …* **(Casey, I, 3)** *… change is a big thing or just not knowing, an unanswered question".* **(Casey, I, 16)**. Whilst Nathan stated – "*One of the worst things for me can just be last minute plans being*

changed - **(Nathan, I, 4)** *or any kind of situation where I'm not sure what exactly is going to happen that day or like if I'm somewhere I haven't been before or anything where events or people are uncertain, you know? That can send my mind racing and I feel really stressed, like it's awful … that's like my worst nightmare"* **(Nathan, I, 5)**.

Although Nigel was the only participant to state that he didn't feel any of his UITs had a trigger, his interview and diary entries about his UITs and checking rituals – did appear to be rooted in a real inability to tolerate any uncertainty hence the continuous checks he felt compelled to do on a daily basis: *"… the beginning of my day is always taken up with a lot of checking … when I wake up in the morning I have this whole process of if I'm the last one in the house that I'm going to have to check everything before I go, to make sure the house is locked, things are switched off, and it's a problem I've had for a long time, but it's just grown and grown, and it probably takes me about 40 minutes or so before I can leave the house … every day, every day"* **(Nigel, I, 1)**.

3.4.4 Intolerance of Uncertainty

(Non - Clinical Participants)

The trigger of uncertainty seemed to also be shared with the non-clinical participants. For example, David's new UITs regarding travel, whilst connecting its beginnings to his wife's death, seemed to also be fuelled by some inability to tolerate uncertainty, when not in control of the situation: *"… When you are out of that position of control, I do feel a bit vulnerable, I guess. Not that I want to be a train driver, I don't want to be a train driver"* **(David, I, 6)**. Here David explained that his UITs listed in his diary relating to the train he was on crashing was because he was not in control, as he was not the one driving the train and it was these moments

where he felt he had the least control that seemed to trigger his UITs. Similarly, Justin also stated that he had more UITs when he was in a situation where he had less control:
"When there were a lot of, a lot of things going on, of which I had little control … I think, they (his UITS) intruded more" **(Justin, I, 3**). Of all the non-clinical participants, Sandra had the most to say about her struggles with uncertainty and how this related to a lot of her UITs:

"… there's a lot of thoughts about self-doubt, which I've recorded in the diary, which I think is quite representative of my general thinking process, particularly as a counselling psychologist in training, the whole journey has been like a process of sitting with uncertainty, there's just been lots of thoughts of not being good enough or not being able to do it right and just feeling like I wanting to walk away from the whole thing **(Sandra, I, 1)** – *… if I don't receive feedback on something, whether it's positive or negative, I tend to catastrophise …* **(Sandra, I, 2)** *I think the most common trigger would be not knowing where I am with something. I think uncertainty is not good for me, maybe sometimes I admit to liking certainty a bit too much"* **(Sandra, I, 9)**.

Overall, when looking at the experiences described by both the clinical and non-clinical participants, there appeared to be a shared recognition of the triggers for their UITs, with both participant groups noting traumatic life experiences and situations of uncertainty as the cause for most, if not all, their UITs. Having explored and compared participant's understanding of the triggers for many of their UITs, this next section below explores the third theme in this framework - 'Appraisal of Self and UITs' and compares how both participant groups felt about their UITs and what they thought they said about them as a person.

3.5 Appraisal of Self and UITs:

"If my thought is not morally sound to me, then I will be punished for having that thought"

(Casey, I, 13).

As described above, both participant groups seemed to acknowledge the same triggers for their UITs (trauma and uncertainty). However, having gone through 8 participant diaries and 8 interviews, a clear theme of difference did begin to emerge and that was a difference between how the clinical and non-clinical participants appraised their UITs and themselves for having the UITs to begin with. The descriptions from the non-clinical participants seemed to demonstrate a much greater comfort with their own UITs and themselves, a sense that they felt a separation between themselves and their thoughts, that their 'bad thoughts' didn't necessarily equate to 'bad actions' or to being 'a bad person'. Whereas the clinical participants, seemed to feel a considerable amount of shame and guilt surrounding their UITs and also appeared to view themselves in a negative light, as a consequence of having these UITs. Therefore, below, the researcher has chosen to present the data exactly as they found it both during and throughout their entire analysis of all the participants' combined diary and interview data - that is to say the third level category of 'Shame/Guilt' with accounts presented solely from the clinical participants and the category of 'Acceptance' comprised of only data from the non-clinical participants.

3.5.1 Shame/Guilt (Clinical Participants):

"*I don't think normal, good, people have these type of thoughts, so … yeah, so I think I'm a bad person"* **(Nathan, I, 9).**

Whilst on the topic of some of Jessie's UIT's from her diary – *"I wish 'Craig's' children would disappear"* **(Jessie, D, 7),** Jessie explained, in detail, how much she struggled having these thoughts about her step-children and what she thought these UITs said about her, as a person.

"The thoughts about my partner's children, where I wish they would disappear, make me feel very uncomfortable … These thoughts aren't necessarily a worry, they are intense guilt to feel that about other people's children … I don't really like them that much as people and that makes me feel guilty saying that" **(Jessie, I, 9)**.

Jessie then continued to explain the embarrassment she felt with her rituals, needing to salute any single magpies she would see, as this would often happen in front of her children and also the guilt she felt that she may pass this anxiety on to them: *"… I have a big problem with saluting magpies… I do find it somewhat humiliating, purely because I like to think of myself as quite a together person …* **(Jessie, I, 11)** *… I know at the time I'm doing these things that they are totally illogical. But it's like a primitive urge that forces me to do it* **(Jessie, I, 13)** *… I can't stop myself from reacting to them at the time, that's the problem. … That's where the humiliation comes in … because you can see how mad and illogical it all is"* **(Jessie, I, 14)**.

As with Jessie, Nigel explained how he felt his UITs and his checking were 'silly' and, like Jessie also stated they felt their thoughts and checking were 'not logical' and just how embarrassed that made him feel: *"I feel I have to check everything, it's not just once or twice,*

I do it three or four times. I check if the door is locked, I check if the oven is on … **(Nigel, I, 1)** *… it's not logical, but I still go down to check …* **(Nigel, I, 2)** *… I'm embarrassed about my OCD, …* **(Nigel, I, 3)** *… I feel why can't I just be like a normal person? Why am I having these thoughts? Why do I need to do these checks? I feel embarrassed for having the thoughts,* **(Nigel, I, 15)** *… that's just how I feel ..."* **(Nigel, I, 16)**.

Just as Jessie felt guilt over her UITs about her partner's children and wanting them to disappear, Nathan also spoke about some of his UITs noted down in his diary, such as – *"Sometimes I just wish I didn't have any family, then there would be no one to call me",* **(Nathan, D, 1)** or *"My brother should have been aborted"* **(Nathan, D, 4)** and *"Staring at the back of this guy's head, feel so angry, could just shove him on to the tracks"* **(Nathan, D, 7)**. Nathan described feelings of great shame, embarrassment and guilt at having, what he termed, *"nasty, evil, thoughts"* **(Nathan, I, 1, 9)**.

"… the ones about my family make me feel the worst … but the one with the bloke at the station … I just felt so angry, I thought I really wanted to push him on to the tracks … like I don't think I would have actually pushed him but how do I know? Why think it then? It just shows what kind of person I am, I think and that's probably why I live alone with no job and why everyone probably thinks I'm a loser, you know, I just have nasty, evil thoughts … **(Nathan, I, 8)**. *I don't think normal, good, people have these type of thoughts, so … yeah, so I think I'm a bad person"* **(Nathan, I, 9)**.

It seemed from this statement that Nathan felt a lot of shame and guilt at both his UITs and at himself for having these UITs in the first place, as he stated that he felt that *'normal'* people didn't have such thoughts and that as he did have these UITs, it must therefore equate to him being *'a bad person'*.

When speaking to Casey about her UITs, she shared similar sentiments to the other three clinical participants, also describing guilt and embarrassment at thoughts she felt were 'silly' and 'stupid' to have - *"… Then it will make me feel like, it will do the whole, you're being stupid, you know, all that kind of feelings,* **(Casey, I, 5)** *… I feel it's very silly to feel that way and I think that's when the self-doubt starts – you know, it's stupid to think that way"* **(Casey, I, 9)**. Describing what she thought her UITs said about her - *"… I'm crazy. You're wrong, there's something that* **(Casey, I, 12)** *– you were hard wired wrong, you're a misfit, you know, there's something that isn't right in your head and made you feel the way you do"* **(Casey, I, 13)**.

It appeared that all the clinical participants experienced real feelings of guilt and shame surrounding their UITs, expressing great discomfort at both having the thoughts in the first place and what they felt those UITs said about them as person. However, a very different account was presented by the non-clinical participants (see below).

3.5.2 Acceptance:

(Non-clinical participants)

".. *it's perfectly normal to have intrusive thoughts, they're just, they happen throughout the day"* **(Sandra, I, 9).**

During the interview, when Sandra was asked about one of her diary entries – *"This is hopeless"* **(Sandra, D, 2):** where Sandra had referenced her neighbour as the source of her woes, Sandra explained how an ongoing situation with one of her neighbours had left her feeling threatened and with violent UITs towards said neighbour. However, Sandra explains how she knew these UITs were only 'thoughts' and could understand them within their context.

"So, there was a constant sense of fear with this neighbour. So that situation has been some negative intrusive thoughts, things like wanting to kill her and stuff like that, even quite detailed ones – **(Sandra, I, 7)** *… methods of killing her, kitchen knives and stuff like that but obviously I would not do that (laughs)… I also recognise when, I've had some time to distance myself from the thought, which I'm trying to now* **(Sandra, I, 8)** – *what is the wider context? and … and also recognising that … it's perfectly normal to have intrusive thoughts, they're just, they happen throughout the day, probably hundreds or even thousands of times and it's just the way we make sense of things …* **(Sandra, I, 9)**.

In a similar vein, Justin commented that although he had some violent UITs, they did not disturb him anymore and he no longer judged himself for having them, as he could now quite easily, separate himself from his thoughts.

"I mean I can have some pretty nasty, evil thoughts but I don't find them disturbing because I think I've accepted, you know it's just, it comes from somewhere. You know, maybe you watched a horror movie, maybe later on you know, a thought pops into your head, I don't know, dismembering somebody, maybe? You just connect it, you know you just think it's not me, it's just I watched that stupid horror movie. - … Now I just think, ok, it's just a thought"

(Justin, I, 6).

Interestingly, Justin also explained that as his acceptance grew towards his UITs, the thoughts themselves appeared to decrease.

"I think they were more frequent when I didn't like them. So when I had an emotional reaction, to the thought it meant I was a bad person, I think I noticed them more, whether they were more I don't know but I get the impression they were more and I think they

bothered me more so I noticed it more **(Justin, I, 7)** *… I can even laugh at it … before, it was really, almost a moral judgement on myself whereas now, yeah there isn't really any judgement it's just, ok, bizarre thought number nine."* **(Justin, I, 8)**.

As with Justin and Sandra, David explained how he did not judge himself for having some violent thoughts. In reference to one of his diary entries - "I was watching a TV documentary about three interconnected funerals in Northern Ireland in the late 80s, … It made me want to shoot all Irish terrorists, Republican or Protestant" (David, D, 7). David went on to explain that he felt such thoughts were common amongst all people - *"… I'm sure those thoughts are always there Nadia, I'm not gonna lie, they're in everybody …"* **(David, I, 8)**.

This theme regarding how the participants appeared to appraise themselves and their UITs was the most divisive, with the clinical participants seeming to really struggle with accepting their UITs and judging the thoughts and themselves for having them. In contrast, the nonclinical participants seemed to express far greater comfort with their UITs and viewed them as a seemingly normal part of everyday life and could often contextualise them. They certainly did not seem to judge themselves negatively in the way that the clinical participants appeared to.

With this section concluded, we move to the fourth and final theme within this framework 'Response to completing the diary', where both participant group's reactions to the task of noting down their UITs for one week are explored below.

3.6 Response to completing the diary:

"I'd be lying if I said I enjoyed it but I definitely found it cathartic, this will sound so weak, a positive rather than a negative" **(Margaret, I, 1).**

How the participants' experienced completing their diaries for a whole week, logging their private UITs for a stranger to read, seemed a very important area to explore, as it could possibly offer insight into two areas of significance in the research into UITs thus far. Firstly, as diaries have been such an underutilised instrument in studies on UITs currently, information from participants on its usefulness in terms of recording UIT's in their own natural settings, unprompted and in real time could increase our knowledge of the utility of using diaries in this area of research (Kenten, 2010). Secondly, finding answers to questions surrounding how participants with UITs feel about having to note down their UITs; what it means to have to deliberately keep track of them for a whole week and what it feels like to have to physically note them down and be confronted with their UITs, in addition to how it feels to write them down with the knowledge that someone else will be reading their private thoughts, could offer a greater insight into how both clinical and non-clinical participants' experience UITs and previous research in to this topic.

When asked about their experience of completing the diary, the researcher found that all participants seemed to describe a similar experience, which had three common elements: All participants (with the exclusion of Sandra) found keeping track of their UITs in the diary for one week a challenging experience, both for practical and emotional reasons but only the clinical participants stating it was because they just had too many thoughts. This latter point has already been explored in the first theme 'frequency' subcategory of 'missing pages' and so will

not be repeated here and some of the challenges posed by completing the diary is discussed in the next chapter, when discussing the possible limitations of this study.

All participants, however, described gaining a greater awareness of their own UITs through completing their diaries (which had both positive and negative aspects to it) with many participants describing new positive behaviours that they had developed through maintaining their diaries and/or positive actions they were planning to take as a result of completing their week long diaries. Below are some of the participant's descriptions of how they experienced logging their UITs daily for one week.

3.6.1 Self-discovery:

(Clinical Participants)

All participants from the clinical group seemed to note an increased awareness of how much their UITs were affecting their life and had failed to improve as time had moved on. Jessie explained that through the action of completing her diary, she became aware that her thoughts had not really improved over the years and how depressing she found that:

> *"I think it opened up my mind to the fact that it was quite depressing to realise how many thoughts I have every day and depressing to know that I've had it for so many years and they've never actually improved, even though I've tried different therapies and I have tried self-help books. The strength of thoughts are still so hard to get over, basically it's just hard to get over the intensity of the thoughts ... and I found that quite depressing actually, to fill out the diary and to realise this is probably going to stay with me for life because the intensity has not been subdued in anyway …"* **(Jessie, I, 3)**.

Nigel explained how completing the diary had also highlighted to him that he really needed to get help, specifically with his checking: *"I am glad that I did it. Like I said, it just highlighted to me, it's been going on for a long time and it's something that I do need to address, as it's obviously not going to fix itself…"* **(Nigel, I, 8)**. A similar sentiment was echoed by Casey: "*I learnt that, I don't actually know why I feel this way, a lot of the time. I think I learnt a lot about myself in that way, that I needed more help than I thought I did"* **(Casey, I, 7)**.

Nathan also noted that completing the diary had made him to confront some negative emotions regarding his UITs, stating that prior to this he felt less aware of how much they interfered with his life: *"… I guess it was no surprise that my thoughts were a constant problem but, I don't know, somehow it was a sort of surprise, you know? Like, wow, I guess I didn't really realise they were so many, like all the time…"* **(Nathan, I, 9)**.

3.6.2 Self-discovery:

(Non- Clinical Participants)

As with the clinical participants, the non-clinical participants also seemed to have gained some insights into themselves through completing their diaries. However, they described these insights in a more positive light when compared to their clinical counterparts. Sandra, for example, explained to me that she had learnt a lot about herself and her UITs through the act of completing the diary and had found it to be a very helpful experience.

"I think what I learnt about myself is I can be quite hard on myself… **(Sandra, I, 3)** -

I think this is the first time I've written this down in any systematic way, I write them down sometimes in my personal journal, especially after personal therapy but I think writing them down systematically has helped me to, reframe them, in a way… I think it's helped me to be more aware of intrusive thoughts and when they become harmful … **(Sandra, I, 4)**.

Justin also noted, with some surprise, how much he learnt about himself and his own UITs, through completing the diary: "*I found it quite helpful for me personally, I learnt quite a lot from it, yeah, it's odd … it's made me more aware of what I was thinking … so it showed my, my brain, you just maybe how my brain works, sort of thinks, ok what's going on here? But it's interesting that you are unaware of that while it's going on … that surprised me because I thought you know, you tend to think you know your own thoughts, you know what you're doing but you don't!"* **(Justin, I, 2)**.

As Justin just explained an awareness that he discovered he had thoughts he was previously unaware of, prior to completing his diary, David also stated that he felt that the action of filling in the diary itself had maybe prompted thoughts that were possibly always there but that he had perhaps not really paid attention to, previously: *"… I think because you made me focus on that side of my mind, so to speak, of my brain a little bit, it made me think about things which maybe were always there, but hidden away, so to speak"* **(David, I, 3)**.

Whilst all participants noted gaining a greater awareness and understanding of themselves and/or their UITs, it was Margaret who spoke the most about this in her interview:

"…when I started doing it, I didn't realise that my intrusive thoughts tended to be either connected to my ex or to my new partner … the outcome has actually been quite positive because it has made me aware of thoughts and that I let him still get to me. … **(Margaret, I,**

1) - *… I didn't realise the impact that my ex could still have. … Until I filled it in. …It was really interesting. I mean maybe it sounds blindingly obvious but I didn't get it until I filled the diary in … the good thing about having done this is being aware of these intrusive thoughts, if you can stop them, to a certain extent you can get, it's enabled me to feel, actually they aren't connected to me moving forward, that is my past and I think I've got to pick myself up from that …* **(Margaret, I, 2).** *The whole thing was quite revelationary … It's just been a really interesting thing to do and actually, incredibly helpful. So, thank you!"* **(Margaret, I, 8)**

3.6.2 Positive experience**/new behaviours:**

(Clinical Participants)

With this seemingly new insight and outlet for their thoughts, many of the participants also described new positive behaviours that they were engaging in and benefiting from, since completing their diaries. Casey spoke of how since completing her diary she realised she needed to get help and had recently begun Cognitive Analytic Therapy, realising that she couldn't continue living with this amount of constant anxiety.

"So I think I have learnt a little bit; I've learnt to ask for help a little bit better. **(Casey, I, 7)**

… through doing the diary and also through understanding that I'm not going to be able to change this unless I do something about it, because it doesn't matter what I do, it doesn't matter what happens in my life, it can cause anxiety" **(Casey, I, 8)**.

Nigel and Nathan expressed very similar sentiments to Casey:

"*… I have had therapy, but not the right therapy and that's just because I wasn't honest with, you know, the situation, and that's with my checking and things like that, it's a bigger issue… I think it's doing the diary … it just feels like it's given me the push that I needed to get some help …"* **(Nigel, I, 8)**.

" … although I think most of my therapy has been a waste of time, filling in the diary and how it really made me look at my problems has made me think I probably should try it again … I don't want to stay like this, is all I know …" **(Nathan, I, 14)**.

Whilst Jessie noted some more immediate benefits from completing the diary - *"I think the positive aspect of filling out the diary, is like anything, when you give a forum to your feelings, it can lessen them somewhat, for a little while… So, in a way, filling out the diary was a form of that, like a self-therapeutic action"* (Jessie, I, 3).

3.6.2 Positive experience**/new behaviours:**

(Non- Clinical Participants)

As Jessie noted some therapeutic benefits from completing the diary, this sentiment seemed shared with both Margaret and David:

"*Because I think, it was actually, it's almost slightly therapeutic in the fact that you become aware of something and then there's a process of what do you do? I either just let it sit there or try and get something positive from it. So, it's been very good"* **(Margaret, I, 9)**.

"… one of the thoughts that came up about my wife, I've not, I've lost my wife 8 years ago and I've not dealt with it. … So that was the opportunity for me to maybe touch that part of my life, which maybe has been lacking for the last 8 years and I find that very, very soothing, actually" **(David, I, 15)**.

In addition to some of these positive emotions just described, Justin stated that since completing his diary he then felt that he needed to do something to tackle the level of anxious UITs he was experiencing in relation to his concerns over his daughter and her well-being. Realising that he had many years ahead of him to bring up his daughter still left, he stated that to be consumed by that level of constant anxiety would be unrealistic. Therefore, he explained how he took the decision to take practical steps; such as buying her a phone and going to court to gain primary custody of her.

"… since I've done it, I've kept monitoring, it's made me more aware of what I was thinking. **(Justin, I, 1)** *… from the intrusion diary I knew I couldn't really function the rest of my life with that level of worry about whether she was alright. So, I had to do something practical to ensure her living situation changed, so I could sort of rest easy … you know and now I yep, yeah, I still have worries about her but massively less."* **(Justin, I, 7)**.

Margaret also spoke of changes she had implemented since completing her diary and gaining awareness of how much UITs about her ex-husband were still haunting her and interfering with her life and her new relationship. Margaret stated that she was now able to separate her thoughts about her ex-husband from her thoughts about her new partner and how this had directly improved their relationship.

“

“… since then I think I’ve made a conscious effort to not think about him or if I’m aware of it just try and put him to the side more … **(Margaret, I, 1)** *… I have really, really tried since this to try and separate the two. … and it’s actually improved my relationship because I actually think no, you are a different person and I think maybe I am having less intrusive thoughts about my ex. … I think it’s been very helpful in letting me draw a line, especially between the two of them …”* **(Margaret, I, 4)**

Margaret also detailed that now she felt aware of her thoughts about her ex (through completing the diary) she found she was able to manage them better and how this had resulted in a direct decrease in her UITs concerning him, even describing how she felt realising that her UITs felt manipulative, Margaret felt it had taken away her ex-husband’s ability to manipulate her, noting that she was actually a lot stronger than she had thought: *“ I could see because he was terribly manipulative and almost like the intrusive thoughts were manipulative. So, by trying to understand why I was having it, it took the ability to manipulate me away”* **(Margaret, I, 6).**

When Margaret spoke, her surprise and happiness at this unexpected benefit from filling in the diary, for just one week, was clear. It seemed clear that completing the diary had had quite a profound and positive impact upon Margaret, as she also noted a realisation that she felt she had greater strength than she had previously thought.

“… And by going through the diary, the interpretation and the response … it did make me think actually, no, I am stronger than I think. It was very helpful because I could try and make

sense of possibly why I was having the intrusive thoughts. … So now if I think about him, I'm better at getting rid of it, which is a very positive thing ..." **(Margaret, I, 9)**.

Chapter 4: Discussion

4.1 Chapter Overview:

This chapter will begin with a discussion of the deductive themes found in the previous chapter and how these relate to the current research and theories into unwanted intrusive thoughts. This is then directly followed by a discussion of the inductive theme of response to completing the diary and its categories which emerged from within the data. Implications of findings for counselling psychology practice and avenues for further research are suggested. This chapter then ends with a discussion of this study's strengths and limitations and some final thoughts.

4.2 Discussion of Themes and Categories from the final Framework:

The aim of this study was to explore how clinical and non-clinical participants experienced unwanted intrusive thoughts; comparing and contrasting how this may be similar and how it may differ between these two groups. In addition, the researcher looked to explore both the effect and utility of the diary as a research instrument. The use of semi-structured diaries and follow up interviews were conducted in order to try and explore these issues. The method of Framework Analysis was then adopted in order to analyse the participant's data and a deductive and inductive approach was simultaneously adopted during analysis. Below is a discussion of how the main themes and categories found during the analysis process relate to

their deductive themes first, followed by a discussion of those that arose inductively. All themes and categories are also presented with the case comparator used throughout this study - comparing and contrasting the two participant groups.

4.3 Deductive themes:

The first 3 themes and their categories were all influenced by some of the main theories and research that exists on UITs regarding how frequently clinical and non-clinical populations experience UITs, the possible triggers for UITs in both these groups, in addition to how both participant groups appraise their UITs. These were:

1: Interference with Daily Life - which comprised of two third level categories - Perception of Control and Frequency of UITs, the latter having a fourth level subcategory of '*Missing Pages'*.

2: Triggers - which comprised of two third level categories - Traumatic Experience and Intolerance of Uncertainty.

3: Appraisal of Self and UITs - which comprised of two third level categories - Shame/Guilt and Acceptance.

Of note, is the fact that in addition to the 3rd Theme directly above, that relates to current cognitive theories of appraisal, half the categories belonging to each of the other 2 deductive themes also relate to theories and research on how a person's appraisals of their UITs may differ between participant group. These categories are Perception of Control, which forms part of the first deductive theme and Intolerance of Uncertainty, which forms part of the second

deductive theme, found within the Framework. Therefore, for the purpose of clarity, these two categories will be discussed with both the categories from the third deductive theme on Appraisals - Shame/Guilt and Acceptance. The rest of the themes and categories, however, are now presented in the same order as that found within the Analysis Chapter, with a discussion of how they may or may not relate to some of the current theories and research on UITs.

4.3.1: Second Level Theme 1 - Interference with Daily Life Third

Level Category - Frequency of UITs:

When exploring the above theme, how far UITs appeared to interfere with the participant's daily lives did seem to demonstrate some clear differences between the two participant groups. Having analysed the data, it emerged that the clinical participants appeared to describe experiencing a greater interference from their UITs, as compared to their non-clinical counterparts (with the exception of 'Sandra', the only student participant involved). A large part of this increased interference appeared to stem from the greater number of UITs that the clinical participants reported experiencing, when compared to the non-clinical group.

This apparent difference in frequency of UITs between the two participant groups was also supported by the fourth level subcategory of *'Missing Pages'*, which as discussed in the analysis chapter, demonstrated that although there was an initial, seemingly, even divide between the two participant groups (in terms of half the participants from each group completing every day in their diaries and half leaving some empty pages) this surface level difference represented a deeper meaning, that only became apparent during the interview stage of the data collection. Here the researcher discovered that the empty pages for the nonclinical participants could be taken at face value, that is to say, the non-clinical participants

– when questioned about them by the researcher – was informed that both non-clinical participants (Justin and David) did not note having any UITs on those days. However, the opposite was revealed in the interviews with Casey and Nathan, with both clinical participants explaining that their missing pages actually represented the opposite of having no UITs on those days, instead they were symbolic of having so many UITs, that they found it too overwhelming to note anything down. Moreover, Casey also explained how on the days where she may have included one or two entries – a single entry could represent *"hundreds or even thousands"* of thoughts. This seemingly substantial difference in frequency of UITs described by the clinical participants as compared to the non-clinical participants, lends support to the arguments provided by Clark (2005) who posits that whilst it seems evident that all individuals experience UITs, the frequency of this in the non-clinical population should not be overstated.

Two other points within this finding were also of interest to the researcher. Firstly, as stated above and in the analysis chapter, this apparent difference in frequency between the clinical and non-clinical participants was not found with Sandra and Sandra was the only student participant in the study. As repeatedly noted during the introduction chapter, a main criticism of the majority of the research into UITs, was that when a study did compare clinical participants UITs with non-clinical participants, the non-clinical participants were almost always comprised entirely of students. One possible problem with this, was that as previously discussed, it was found that student years are associated with stress (Warren *et al.,* 2002), supported by the finding that student samples measured much higher on measures of general distress when compared to community samples (OCCWG, 2003). Out of all the non-clinical participants, Sandra was the only one to express the same feelings of exhaustion caused by having just so many UITs that they *"just batter you into submission"* **(Sandra, I, 3)**. This lends support to the argument that relying on student samples as the non-clinical comparators in past studies, may well have impacted the results that have been found.

A second point noted by the researcher, in relation to the frequency of UITs, was that Justin remarked, as he had aged, he also noted a definite decrease in how frequently he experienced UITs. This statement lends support to the findings found in the study conducted by Erskine, Georgio, Deans and Colegate (2017) which demonstrated that age was negatively related to intrusions, that is to say, it was found that UITs appeared to decrease as age increased. As also mentioned in the introduction to this study, another possible issue with many of the these largely student samples that have been utilised in the majority of studies, examining UITs in the non-clinical population, is that it has also resulted in an overall young sample with a mean age of 24 years old. When looking at the age of the non-clinical participants within this study, only the student participant – Sandra was in her 20s, with the mean age for the group of nonclinical participants being (*M* = 49), whereas the mean age for the clinical participants was *(M* = 39). If age is really a factor which is negatively related to UITs then this may have also impacted past findings that have explored UITs, thus far.

In summary, findings from this study regarding the reported frequency of UITs experienced by the two participant groups, lends support to the large body of research that has argued that one main difference between clinical and non-clinical participants, is that clinical participants experience a higher frequency of UITs as compared with non-clinical participants. However, these findings also highlight the argument that in order to be able to extend these findings to the general population, sample selection needs careful consideration, with perhaps a move away from the current heavy reliance upon student participants.

The next deductive, second level theme to be discussed is **Triggers** - which comprised of two third level categories - Traumatic Experience and Intolerance of Uncertainty.

4.3.2: Second Level Theme 2 - Triggers

A second deductive theme to emerge from the analysis, was that almost all participants from both groups could identify a trigger for their UITs which, when examined, appeared to be broken down into two categories – either their UITs related to a past traumatic experience or to a situation which caused them uncertainty. Within the literature and as discussed in the introductory chapter, such triggers are referred to as 'reactive intrusive thoughts' as they are deemed to have an obvious, external, trigger (Lee & Kwon, 2003). However, 7 out of the 8 participants in this study did not report experiencing any of their intrusive thoughts as being 'autogenous' in nature. As also referenced in the introduction, 'autogenous' intrusive thoughts are deemed to be internal thoughts with no obvious trigger and which just occur spontaneously and seemingly out of nowhere (Lee & Kwon, 2003). This distinction between triggers argued by Lee and Kwon (2003) was supported by several studies, such as Lee *et al.,* (2005), Belloch *et al.,* (2007) and Berry and Laskey (2012), reporting that clinical participants experienced greater autogenous UITs than their non-clinical counterparts. Julien *et al.,* (2007) also argued that a main difference between the UITs experienced by clinical participants, as compared with non-clinical participants was that non-clinical participants UITs tended to be triggered by more obviously related external triggers than those of the clinical participants UITs, which they argued, tended to arise in unrelated contexts. This argument was also supported by Clark and Inozu (2014) stating that non-clinical participant's UITs were mostly triggered by external, context related events as opposed to clinical participants UITs, which generally lacked any external trigger.

However, as can be seen from the analysis chapter, the findings in this study do not support this distinction between groups; as whilst all the non-clinical participants stated that they could

identify the triggers for their UITs, the same finding was also present with 3 out of 4 of the clinical participants. Moreover, as also referenced in the analysis chapter, the researcher did note that although Nigel stated that he did not feel that his UITs had any particular triggers, this did not necessarily mean that they were 'autogenous' in nature. The researcher questions this assumption for two main reasons: firstly, the two main triggers cited by the remaining 7 participants were trauma and uncertainty and this latter trigger appeared to be present in all of Nigel's checking rituals that he describes as being 'compelled' to do before he left the house each morning, in an attempt to avoid the chance of a disaster occurring, such as a fire. As found when looking at the effect of completing the diary and as discussed further on in this chapter, participants all stated that they discovered through completing their diaries not being fully aware of all the UITs they experienced or why they had some of these thoughts. Therefore, when we assess the triggers for our thoughts, there is an assumption that we are, in fact, always able to identify them and this may not always be the case. Secondly, the researcher noted the potential significance that the rest of the participants all noted a connection to a past trauma as being a trigger for many of their UITs. This finding has many interesting layers, whilst perhaps not a surprising finding, the potential connection between trauma and UITs has been largely relegated to the specific disorder of PTSD. Clark (2005) in his book on intrusive thoughts in clinical disorders provides a lengthy discussion of the psychopathology behind trauma-related intrusions in PTSD and states that it is very evident that UITs are a common response to a traumatic occurrence. However, none of the participants in this study were diagnosed with having PTSD. This caused the researcher to consider two points: what is considered trauma and can we always identify our triggers? To elaborate, Eye Movement Desensitization Reprogramming (EMDR) is an empirically supported and internationally recognized treatment for PTSD for both children and adults (Bisson and Andrew 2007). EMDR is a form of individual therapy which was originally developed to help people who were suffering from a diagnosis of Post-Traumatic Stress Disorder (PTSD). The focus of treatment is to aid clients in first identifying and then processing past traumatic events, in

addition to any current triggers which may reactivate them, at which point the therapist introduces new behaviours with future templates (Maxfield *et al.,* 2007). EMDR was developed during the late 80s/early 90s by Psychologist Dr. Francine Shapiro and her Adaptive Information Processing (AIP) Model forms the basis of the therapy (Shapiro and Maxfield 2002). One of the main assumptions of the AIP model is that the root cause of a number of clinical disorders, including PTSD, is the upsetting and disturbing memories which have been stored by our brains in a dysfunctional way. The AIP model, therefore, suggests that if these distressing memories, which have been dysfunctionally stored, can be reprocessed and finally reintegrated in to our memory networks in an adaptive and functional way, then the corresponding psychological disturbance should be reduced (Shapiro 2001). However, when referring back to this current study and as just stated, whilst 7 participants noted trauma as a trigger for their UITs, none had a diagnosis of PTSD but this, of course, does not mean that they have not experienced trauma in their lives. In fact, whilst EMDR has been used in PTSD to target undisputed, traumatic events, such as war or a natural disaster, the AIP model also recognizes traumatic effect from events not necessary for a diagnosis of
PTSD, also referred to as 'small t' traumas which, as Taylor *et al.,* (2004) point out, often form the basis for a number of clinical disorders. Therefore, in light of the current findings of this study, EMDR may be a useful tool for other mental health conditions aside from PTSD, which all have some form of UITs at the centre of them, such as OCD, GAD and Depression, all of which may well be connected to some 'small t' traumas.

The second question put forward from the researcher, as just stated above, was: are we always able to identify our triggers? Whilst the research into triggers of UITs seems to have largely focused upon autogenous thoughts versus external triggers, the researcher was left questioning – are any thoughts truly autogenous or is it a case that those labelled as such are because we simply cannot identify the trigger? For example, research into what has been labelled as 'mind pops' or 'mind popping' *"defined as an involuntary conscious occurrence of*

brief items of ones network of semantic knowledge" (Kvavilashvili & Mandler, 2003, p.47), has been found to be a standard feature of the seemingly sudden recollection of past memories, without any obvious related cue. However, in their numerous studies on this topic, Kvavilashvili and Mandler (2003) have also suggested that whilst these memories may, at times, appear to 'pop out of nowhere', many external factors relating to all of our 5 senses may act as a 'primer' for these seemingly autogenous thoughts and that such priming can go all the way back to our childhood. The researcher therefore argues that, it is possible, that all human thought has some form of trigger but some of these triggers may be more obvious than others. Therefore, it is possible that previous focus on the differences between autogenous and external triggers for UITs may be somewhat of a 'red herring'.

Now turning to the second trigger noted by participants – situations which cause uncertainty, whilst being an issue that has been discussed in the literature relating to UITs, it is usually found under the category of cognitive appraisal theories and as mentioned above will be discussed next in this following section on appraisals and all the categories found in the analysis that also relate to this theme.

4.3.3 Cognitive Appraisal theories and how they relate to this study's current findings:

As can be seen from the introduction chapter, a large part of the research into UITs and their potential difference between clinical and non-clinical populations has stipulated that a main difference, concerns the way in which people appraise their UITs rather than their being a difference in the content of the UITs (see Rachman & de Silva, 1978; Clark & de Silva, 1985; Edwards & Dickerson, 1987a; Parkinson & Rachman,1981a; Purdon & Clark, 1993; Salkovskis & Harrison, 1984). This certainly was what the researcher found through their analysis. Many versions of the researcher's theoretical framework included different categories of types of

UITs that have been listed in the research – such as contamination, sexual thoughts, health concerns etc., (CIQ; Freeston, Laudouceur, Thibodeau & Gagnon, 1992). However, throughout the analysis process, the researcher found a wide range of thoughts covered by the various participants, most concerning health fears or social anxiety but none significant enough to form its own theme or category and more importantly, there did not appear to be a difference in content between the clinical and non-clinical groups.

However, also in support of the previous research into UITs - this study found a total of 4 third level categories, taken from 3 second level themes which all related to the theory of faulty appraisals. These were: the Category of *Perception of Control* within the second level theme titled *Interference with Daily Life*; the category of *Inability to Tolerate Uncertainty* within the theme of Triggers and the third and last theme in its entirety – Appraisal of Self and UITs with both its categories - *Shame/Guilt* and *Acceptance*. With the exception of the category *Inability to Tolerate Uncertainty*, all the other 4 categories just listed demonstrated a marked difference between the two participant groups. This is discussed in greater detail below.

4.3.3.1 Perception of Control:

When comparing the two participant groups, it appeared from examining the data, that the clinical participants viewed their thoughts as not only being beyond their control but that the UITs were controlling them. Jessie described the experience of UITs as 'chains' that controlled her, even describing feelings of fear if she stated not actually believing her thoughts, that this could *'risk'* the thought coming true. Casey also expressed similar fears of ignoring her thoughts, stating that sometimes her UITs felt *'so overwhelming'* that she needed to listen to them for fear of being *'punished'*. Likewise, Nigel stated that even though he classed his *'checking'* rituals as a tool to *'manage'* his UITs, he conceded that they had *"really got control"*

of him. Whilst Nathan stated that he had no "*idea"* of *"how to stop all these thoughts"*, describing the UITs as both a *"demon"* and a *"bully",* that lived within his head.

These descriptions of the clinical participant's perceptions of being unable to control their UITs, portrayed quite a contrast to that which was described by their non-clinical counterparts. Here, David stated that he felt he was able to 'compartmentalise' his thoughts and *"not allow them to"* enter his mind. Justin claimed that he had learnt, over the years, to be able to *"easily dismiss"* most of his UITs. Similarly, Margaret expressed that once she could recognise the thoughts, then to just say "no!" to them and that whilst she acknowledged that there may be no way to stop the UITs from occurring, she felt she was in *"control of the impact"* they had on her life. Sandra also stated that she could "cope with the intrusive thoughts" once she gave herself some time and distance away from them.

The description given by Casey that she would avoid driving on the motorway because the UITs about her son dying in a crash and then her surviving felt so overpowering and ignoring them felt too risky – seems to fit with the processes described by Salkovski (1996, 1998) that he proposed were necessary to turn a 'normal' UIT into an obsession. According to Salkovski (1996, 1998) this can occur firstly, by the person engaging in the faulty appraisal that their UIT signifies that they are now personally responsible for preventing harm coming to themselves or to others and secondly that their inflated sense of responsibility will protect themselves or others from coming to harm, will then result in them engaging in some form of neutralisation strategy. For Casey, this meant avoiding driving on the motorway, so her son would not die in a car crash. For Jessie, this meant brushing her teeth for a certain amount of times, so that she and her children would not get cancer. For Nigel, this meant checking almost every apparatus in his home before leaving for work, otherwise the house might burn down.

These descriptions, by the clinical participants, also support the cognitive appraisal theories put forward by Freeston *et al.,* (1996) that there were 5 domains of dysfunctional beliefs and appraisals necessary for the development and continuation of OCD and which were presented in the introduction. The first, second and fourth domains all appear to apply here to the clinical participants – these being overestimating the significance of their UITs, having an inflated sense of responsibility for events occurring that are out of their control (as described by Salkovski, 1996, 1998) and overestimating the likelihood and seriousness of undesirable events occurring as a consequence of having the unwanted thought – as Casey stated that if she tried to ignore her UITs and did drive on the motorway then she would *"be punished for it and I know I will kind of thing because everything bad always happens to me …"* (**Casey, I, 18)**. Whilst Jessie stated that asking a person with OCD, such as herself, to engage in exposure therapy was "*actually asking them to, in a way, risk their life … as someone with OCD lives that risk in their life and it's quite real to them"* **(Jessie, I, 8)**. Clark and O'Connor also suggest that different types of faulty appraisals are responsible for the perseverance of OCD, one of which they posit is that just by having the thought, the chances are increased that it will occur and also as seen with the clinical participants, these faulty appraisals of their UITs will lead to the engagement of neutralising behaviours – as just described above.

4.3.3.2 Inability to Tolerate Uncertainty:

The participant's struggle to tolerate uncertainty or what the British Psychoanalyst, Wilfred Bion would describe as, an absence of 'negative capability', formed the second category on Triggers (French, 2001). However, as also just mentioned, this issue has been discussed in the literature on appraisals, rather than on Triggers. Freeston *et al.,* (1996) listed *being unable to tolerate or accept feeling anxious* as one of his 5 dysfunctional belief and appraisal domains. Whilst the OBQ discussed in the introduction, arguably the most widely accepted measure for

assessing dysfunctional beliefs causing faulty appraisals, lists *"Being unable to tolerate uncertainty, believing it to be necessary to reduce unpredictability whenever and wherever possible"* as the 4th out of 6 dysfunctional beliefs that the (OBQ) measures (Clark and Inozu, 2014). Both present the case that being unable to tolerate uncertainty is a faulty appraisal that can lead to the development of a cognitive disorder. However, in this study that inability to tolerate uncertainty was shared by both participant groups and by all 7 out of 8 participants that were able to identify a trigger to begin with.

Appraisal of Self and UITs

(Shame/Guilt and Acceptance)

A very noticeable difference in the participant's appraisals of their UITs however, was found between how the two participant groups viewed both their UITs and themselves. In fact, the difference was so overt that this is the one theme where the two categories within it were each separate categories that applied solely to an individual participant group. The category of Shame/Guilt applied only to the clinical participants and referenced how they had described their feelings towards themselves and their thoughts. Several expressed thoughts that their UITs meant something about the person that they were, with bad thoughts equating to being 'a bad person'. Many described feeling embarrassed and guilty for having such thoughts to begin with. This contrasted significantly with the non-clinical groups and their category – Acceptance. All the non-clinical participants seemed to express an understanding that everyone experienced UITs, it was a normal phenomenon and did not reflect on who they were as people, even when the content of their thoughts involved methods of murder or 'dismemberment'. As Justin stated, in reference to the thought of dismemberment – "*You just connect it, you know you just think it's not me, it's just I watched that stupid horror movie"*

(Justin, p.22). Whilst Sandra stated that her 'plans' to murder her neighbour were just signs of her frustration with her situation, not signs of genuine intent.

This marked difference between how the two participant groups appraised their UITs and themselves for having the thoughts aligns well with Clark's (2004) Cognitive Control Theory of Obsessions which is discussed in detail in the introduction and states that if people make a faulty appraisal of their UIT, viewing the thought as completely violating their sense of self and values – such as thoughts of murder, then they will feel responsible for preventing the thought from coming true by continuing to focus on the UIT. This feeling of needing to control the thought will then result in strategies of neutralisation and compulsions, in a bid to control the UIT which they have now categorised as dangerous. The findings in this study also reinforce the point that how we appraise our thoughts may be far more important than the actual content. The non-clinical participants described thoughts that were as, or more, violent in nature than the clinical participants but their appraisal of those thoughts, as just discussed, were very different.

Having now explored the deductive findings in this study, below is a discussion of the inductive theme presented in the analysis –

4.4: <u>Response to Completing the Diary</u> - which comprised of two third level categories - Self Discovery and Positive Experience/New Behaviours.

This last and final theme, reported in the previous analysis chapter, is an inductive theme that arose from within the data. As detailed earlier on, in the Methodology and Procedure's chapter, when the researcher set out to collect their data, they initially planned to use diaries as their

sole research instrument, mainly as they wanted a 'real time' measure of participants UITs, that would not prompt their responses and would hopefully counter the problems involved with retrospective recall. It was also noted, at the time, that through their literature search, the researcher discovered that diaries had rarely been used to examine UITs and was overall, a seemingly underutilised research tool. For these reasons, the researcher went into the process with no real idea how useful a tool the diary may prove to be or, for that matter, what effect, if any, it might have upon the participants. However, as also discussed in the methodology chapter, after conducting their pilot diary, it became evident that the data provided was somewhat lacking in terms of richness and at times, context. Therefore, following the results of the pilot study, follow up semi-structured interviews were added to the method of data collection. As also discussed in the methodology chapter, the combination of these two methods of data collection not only worked in symbiosis, providing a wealth of rich data but they also allowed for this inductive theme to emerge from within the data. The analysis of this combined data provided 3 of the third level categories found, one of which has already been discussed – "Missing Pages". As a result of the interviews, the researcher was able to gain an understanding of the real meaning of the empty pages of different participants and this information helped inform the picture of how frequently the participants, from both groups, experienced UITs. In addition to providing this useful information on the frequency of participant's UITs, it also formed the theme of **Response to Completing the Diary** - which comprised of the two third level categories - Self Discovery and Positive Experience/New Behaviours, both of which are discussed below.

4.4.1: Self-Discovery

"But it's interesting that you are unaware of that while it's going on … that surprised me because I thought you know, you tend to think you know your own thoughts, you know what you're doing but you don't!" **(Justin, I, 2)**.

This first category, labelled ‘self-discovery’, seemed to be a theme shared by all the participants. As was stated in the previous chapter, when participants were asked in their interviews, about how they experienced filling in their diaries, it became evident that not only did they all report learning a lot from completing the diaries but that this also came as quite a surprise to them. This finding raises several issues for discussion, some of which might provide very interesting avenues for further research. Before moving on to that discussion, however, it seems important to note that this category of self-discovery, whilst interesting in and of itself and shared by all the participants - also highlights another apparent difference between both the participant groups and this difference appears to be, once again, related to the issue of appraisal. Referring back to the previous chapter, it can be seen that discoveries made by the clinical participants appeared to all be viewed through a negative lens, as compared to the non-clinical participants, who appeared to appraise their new discoveries about themselves as being very positive and useful. The non-clinical participants expressed feelings of being depressed by discovering just how badly they were being impacted by their UITs, some noting that with the passing years, there appeared to be no reduction in the frequency or intensity of their thoughts, with all of them commenting that their past therapy had not improved the issue. In contrast, however, when the non-clinical participants were describing how they felt about what they had learnt through completing their diaries, all 4 gave very positive descriptions. Many stated that whilst also learning a lot about their own UITs, they also all expressed that they were surprised at how positive the experience was for them and beneficial. As opposed to the clinical groups, the non-clinical participants stated that this new knowledge they had acquired about their UITs, through completing their diaries, had helped them reframe some of their thoughts, some felt they understood their thoughts better and that they now even understood themselves better. Moreover, they expressed that this new knowledge had led them to feel they could also gain better control over their UITs. This latter difference in appraisal between the two participant groups seems to mirror that discussed earlier on in this chapter,

when looking at the category of perception of control. Just as the clinical participants expressed feeling controlled by their UITs as opposed to the nonclinical participants, who seemed to express feeling they could control their UITs, this same difference in appraisal of control is seen again. Whilst the new knowledge of the UITs was seen by the non-clinical participants as providing them with information that helped them gain further control over their intrusive thoughts, the clinical participants viewed their new insights into their thoughts as confirmation that they had an even greater problem with their UITs than they thought, prior to completing their diaries. This apparent difference between groups regarding appraisals of feeling in or out of control of their unwanted thoughts, when reviewing their diaries, also supports the current theories on cognitive appraisal differences presented earlier on in the introduction chapter. For example, this finding can lend support to Wells (1995) cognitive model of GAD, which posits that initial positive beliefs about worry will eventually turn into negative beliefs. These negative beliefs are divided into two broad domains; one - that worry is dangerous to their overall well-being and two - that worry is uncontrollable. Individuals will now begin to worry about worry, termed 'metaworry' (Wells, 1994).

The deeper these findings are explored, the more the differences in appraisals between groups becomes highlighted, as a central issue and as a marked difference between the two participant groups. However, the researcher would argue that this also raises an important question: are these appraisals by the clinical participants all 'faulty' as the literature suggests or are they actually just expressions of a reality, whereby the clinical participants are actually not in control of their own thoughts? Perhaps the researcher asks this question because as a trainee counselling psychologist, they were always taught to accept their clients' accounts as their truth, their experience, their role was as a therapist, not a detective. Or perhaps they ask this question having recently developed a personal understanding of how their own ADHD impacts their thoughts and that this has everything to do with their neurodivergent brain,

regardless of their appraisals that their thoughts are often not based in reality. Here the researcher noted the words of Jessie, who stated that her frustration and embarrassment was that she was very aware that her thoughts and her behaviours were *"totally illogical"* and that she considered herself to be *"quite a together person"* **(Jessie, I, 11).** This did not sound to the researcher as being simply a matter of faulty appraisal but perhaps, an accurate description of her situation where, regardless of understanding the problem, something seemed to be preventing Jessie from controlling her UITs. Moreover, there remained the issue that Jessie and all of the clinical participants had already sought at least one course, if not several courses of therapy, over the years and all stating that none of their therapy had helped them to manage their UITs. Therefore, the researcher wondered, if the issue is simply a matter of appraisal, would therapy not have helped them challenge this? If we return to the earlier mention of EMDR in this chapter, the AIP model (Shapiro, 2001) is guided by the client's behaviour, emotion and beliefs - viewing these as the symptoms that have been caused by upsetting, unprocessed memories, which when processed, results in a change in symptoms (Shapiro, 2009). This is arguably a different perspective on the cause of pathology and change agents in comparison to many other therapeutic approaches where the client's behaviour, emotion and beliefs are targeted as the cause of the distress in order to reduce or remove their symptoms (Luber and Shapiro, 2009). Perhaps this could explain why none of the clinical participant's past therapy had been successful in helping them to manage their UITs.

4.4.2 Positive Experience/New Behaviours:

On a positive note, however, one apparent shared benefit expressed by both participant groups from their new knowledge gained through completing the diaries - was that all cited either already engaging in new positive behaviours or planning to make some positive adjustments, as a result. This formed the second category of the theme – response to completing the diary – titled - positive/new behaviours. This category emerged as the researcher analysed the data and saw that this was cited as being a very significant issue for all the participants. Several of

the participants, including some of the clinical participants, noted that the very action of completing the diary had let them explore and give a voice to some painful issues they had perhaps previously chosen not to focus on. They expressed this process as having a therapeutic benefit, whilst the non-clinical participants discussed feeling more aware of their UITs and therefore, more in control of their thoughts. This new awareness was the followed by several of the non-clinical participants experiencing and making significant changes in their lives. Justin made new arrangements for greater custody of his child and Margaret explained it had greatly helped to improve her relationship and reduce the hold her ex-husband had over her. Whilst all the clinical participants stated that their new realisations – whilst not as positive as perhaps the non-clinical participants, had still resulted in some positive action, as they all noted that they were planning to return to therapy, in the hope of finding some ways to gain greater control over their UITs.

4.5 Implications of findings for Counselling Psychology Practice and Avenues for further research:

> *"However, the practice of research is also conceived as a form of social action, which attempts, ultimately, not unlike therapeutic work, to alleviate human suffering through increased understanding"* (Henton, 2016, p.134).

As the quote by Henton (2016) suggests, when we embark upon research, we hope that our findings and maybe also our processes, may add to our current understanding of the topic being explored which will hopefully aid our clinical work, reducing some of the distress we often see in our clients. As discussed in the previous chapters, the researcher hoped that their study would help them gain a better understanding of the experiences of both clinical and non-clinical

participants through adopting a qualitative approach, which was seemingly lacking in the current research. The researcher wanted to give a voice to their participants' experience of UITs and to also explore the use and potential benefits of two underutilised research tools in the field of counselling psychology, which were diaries and Framework Analysis (Ritchie & Spencer, 1994).

4.5.1 Using diaries as a tool for managing UITs:

4.5.1.1 Awareness:

"…writing might be a form of thinking, or even, of coping. Pelias (2011) suggests that in research it is often a case of 'writing ourselves into position': writing is inherently therapeutic,

bringing order or recognisable shape to the sadness or chaos we may experience"

(Henton, 2016, p.143).

As discussed in this chapter and in the previous analysis chapter, this study produced the somewhat unexpected finding that all the participants claimed to have gained a greater insight into their UITs and exactly how far they were intruding upon their daily lives, after completing their intrusion diaries, for just a single week. Therefore, researching and testing out the use of keeping an intrusion diary with clients could be an important avenue to explore further. Following their interviews with all the participants, in addition to their own discovery of their ADHD *(which they were alerted to by their, repeated, entries relating to struggles with focus in*

their own research field diary) the researcher felt clear that the effects of keeping a diary could be very informative in ways that could also be quite profound. Therefore, the researcher returned to the literature and although there still appeared to be a lack of any particular research into the effects of keeping a diary on UITs, they were interested in exploring any research that discussed the effects of keeping a diary, in general. As just stated here, for both the researcher and the participants of this study, a clear benefit of keeping a diary was gaining an increased awareness of their own thoughts. Whilst not relating specifically to UITs, a study conducted by Miller (2005) did observe that when student nurses were asked to keep a diary, recording their views on older couples' romantic images, it helped to uncover some ageist beliefs that they were previously unaware of. Similarly, a study conducted by Meth (2003) in Durban, South Africa, also found diaries as a useful tool for reflection, when used by women to explore their fears of violence in violent places, providing them with a place to discuss and present their experiences (Kenton, 2010). This lends support to the findings in this study that keeping a diary, even for a short period of time, may provoke reflection and also help people to identify certain thought patterns they may otherwise remain oblivious too.

4.5.1.2 Therapeutic Benefits:

"Give sorrow words; the grief that does not speak

Whispers the o'er-fraught heart and bids it break."

(Act IV, Scene 3, Macbeth, William Shakespeare)

As just stated, when returning to the literature, the researcher still struggled to find studies that particularly used diaries to examine UITs. However, as McBain (2019) states, there does appear to be a growing body of research that is exploring how keeping a diary can improve our mental and even our physical health. For example, an experimental study by Roman, Singh

and Sharma (2018) explored the mental health benefits when teenage girls kept a diary over 3 months, to express their thoughts and feelings. One hundred girls were randomly divided into either the experimental group or to the control group, with results revealing that keeping a diary significantly improved the mental health of adolescent girls. This finding was interesting to the researcher, as a key point expressed by the participants, was that in addition to the increased awareness of their UITs, the diary also helped to give a voice to painful issues they had previously ignored, proving to be of therapeutic value. According to McBain (2019) this makes sense, as they posit that keeping a diary can not only provide structure to our many thoughts, creating order out of chaos, but this structure not only helps us to recognise and understand our thoughts - it can also provide an avenue for emotional expression, which she argues, is by its very nature, essentially therapeutic. This echoes the words of Jessie: *"I think the positive aspect of filling out the diary, is like anything, when you give a forum to your feelings, it can lessen them somewhat, for a little while… So, in a way, filling out the diary was a form of that, like a self-therapeutic action"* (Jessie, I, 3).

Of course, if discussing the therapeutic benefits of keeping a diary, then the works of James Pennebaker (1988), the founder of research into using writing for psychological treatment, must be mentioned. Several studies by Pennebaker (2010) noted emotional benefits, some long term, from engaging in expressive writing (Roman *et al.,* 2018). Moreover, Pennebaker, (1988) stated that the act of regularly keeping a diary was found to produce positive effects on the body, such as strengthening immune cells and reducing the symptoms of Rheumatoid Arthritis and Asthma (McBain, 2019).

Therefore, it would seem that keeping a diary may offer a multitude of health benefits which can be drawn on when working with clients. Findings from this study and increasing research, suggests that even asking a client to keep a diary of their thoughts for just a week, could both help shed light on issues the client may not be aware of and/or at least, offer them another avenue from which to express their emotions.

4.5.1.3 Diary Vs Record Keeping:

The act of noting thoughts and emotions in log books or thought records, as well as engaging in more expressive writing in diaries or journal keeping, have been examined for their possible therapeutic benefits. Experimental disclosure, which involves disclosing personal and meaningful information, thoughts and feelings, has been found to have various health and psychological consequences (Frattaroli, 2006). A meta-analysis by Frattaroli (2006) found that experimental disclosure is effective, with a positive and significant average effect size (Frattaroli, 2006). This suggests that expressing one's thoughts and emotions through writing can have therapeutic benefits. In addition to experimental disclosure, writing about life goals has also been studied for its health benefits. King (2001) conducted a study where participants wrote about their most traumatic life event, their best possible future self, both topics, or a non-emotional control topic. The results showed that writing about life goals was significantly less upsetting than writing about trauma and was associated with a significant increase in subjective well-being (King, 2001). Furthermore, writing about self-regulatory topics, such as life goals, can be associated with the same health benefits as writing about trauma (King,
2001). The therapeutic benefits of writing can be attributed to various factors. Ullrich & Lutgendorf (2002) found that the effects of journaling interventions were mediated by cognitive processing and emotional expression during writing (Ullrich & Lutgendorf, 2002). Writers who focused on emotions alone reported more severe illness symptoms, suggesting that cognitive processing plays a role in the therapeutic benefits of writing. Additionally, the focus on negative emotional expression during writing was associated with more severe illness symptoms (Ullrich & Lutgendorf, 2002). This highlights the importance of balancing emotional expression with cognitive processing in therapeutic writing. While both noting thoughts/emotions in log books/thought records and engaging in more expressive writing in diaries/journal keeping have therapeutic benefits, there are some distinctions between the two. Log books and thought

records are typically used in cognitive-behavioral therapy (CBT) to identify and challenge negative thoughts and beliefs (Frattaroli, 2006). This type of writing focuses on cognitive processing and is more structured and goal-oriented. On the other hand, diaries and journal keeping allow for more expressive and free-form writing, which can promote emotional expression and self-reflection (Ullrich & Lutgendorf, 2002). Therefore, it would appear, that both noting thoughts/emotions in log books/thought records and engaging in more expressive writing in diaries/journal keeping have therapeutic benefits. Experimental disclosure and writing about life goals have been found to improve subjective well-being and decrease illness symptoms. The therapeutic benefits of writing can be attributed to cognitive processing and emotional expression. While log books and thought records are more structured and goal-oriented, diaries and journal keeping allow for more expressive and freeform writing. Therefore, it appears that writing down one's thoughts can be a valuable therapeutic tool for promoting emotional well-being and self-reflection, regardless of the format in which it is done.

4.5.2 Looking beyond faulty appraisals:

The missing pages in the diaries serve as a good reminder to perhaps look beyond the surface and the somewhat obvious. As discussed in this chapter and the Analysis, the findings in this study do seem to highlight a significant difference in terms of how the two participant groups appraised their UITs and themselves, supporting much of the research and theory into cognitive appraisals and their potential role in UITs. However, as also discussed above, whilst the clinical participants seem to express a far greater negative appraisal of their UITs, of themselves for having the UITs and of their ability to deal with their UITs, compared with the non-clinical group – the researcher was left wondering if what the clinical participants were actually describing were faulty appraisals or rather just accurate descriptions of how differently the UITs affected them? As discussed above, there may be merit in taking the approach

adopted in EMDR; where practitioners view their client's behaviour, emotions and beliefs as the symptoms of rather than the cause of pathology (Luber and Shapiro, 2009).

Therefore, in summary, there are several ways that these findings can have practical applications for clinical practice. Firstly, the diary used in this study could be used with most, if not all clients, to help provide both the client and the practitioner with a deeper insight to the main thoughts that might be troubling them. Secondly, these findings highlight the importance for counselling psychologists and, indeed, all mental health practitioners, to really examine how clients appraise both themselves and their thoughts. Thirdly, as just cited above, these findings also highlight the need to explore any possible underlying issues of trauma, that may be fuelling clients UITs – and if found to be the case, considering the possible use of trauma specific treatments, such as EMDR (Luber and Shapiro, 2009).

4.6 Strengths and Limitations of this study:

4.6.1 The use of Semi Structured Diaries and Interviews:

"The diary-interview method where the diary keeping period is followed by an interview asking detailed questions about the diary entries is considered to be one of the most reliable methods of obtaining information" (Corti, 1993, p.1).

As stated during this chapter and in greater detail, during the methodology chapter, combining the two modes of data collection in this study, provided a wealth of rich data which would not have been possible to achieve if either method had been used alone. Diaries, especially when used by themselves, can come with several limitations. Firstly, asking participants to keep a diary requires trust that they will understand and follow the guidelines on their own and

secondly it requires the participants to commit their own time to complete it. There is also the issue that the validity of diary entries may be impacted by participants feeling self-conscious about the fact that someone else will be reading them (Thatcher & Day, 2016). Moreover and as seen in this study, there can be an issue with missing entries and an absence of context to help understand the entries. This latter issue, however, as stated by Kenten (2010) can (and was) overcome by a follow up diary interview.

Semi-structured interviews, however, also have their limitations. For example, if used alone, they could be subjected to both the bias of retrospective recall and prompting by the interviewer (Plummer, 2001). However, having recorded their UITs for a whole week in their diaries first, this helped to offset such potential issues and provided a helpful structure to focus the interview, allowing it to explore entries further, whilst also providing much needed context. It also allowed the participants to discuss how they experienced completing their diaries and any challenges they may have faced. This latter point also proved invaluable, as stated by Kenton (2010) "*Whilst diaries may alleviate some of the problems with recall, even over a short time span, small details may be lost or wrapped up within a larger story [Davies & Coxon 1990]*" (p.2). This latter point describes what happened when the researcher asked the participants about the pages that they had left empty and discovered very different stories from the two participant groups, explanations that would most certainly have been lost without the interviews. Moreover, the interviews allowed the participants to inform the researcher of some of the practical difficulties they incurred when completing their diaries. Overall, the feedback on this appeared to consist of the problems participants had with being able to recognise that they were having an intrusive thought and then remembering to write it down at the time of occurrence. Whilst others pointed out that it wasn't always possible to note down all thoughts as they occurred and gave the example of having UITs whilst driving. Therefore, whilst the diary should have helped prevent some of the issues with retrospective recall, it is not a realistic

expectation that all participants would note down all thoughts, exactly as and when they occurred. Moreover, as discussed in the analysis, for the clinical participants who stated they had far too many thoughts to keep track of, this would be a very unrealistic expectation. However, discovering this difference in frequency between the two groups, through the interviews provided some very meaningful data.

Another possible limitation could be found in the occupational background of the non-clinical participants. As 3 out of 4 of them had some background of working within the mental health sector, this may have impacted the findings, as such participants could arguably have a greater insight into their own thoughts. Ideally, if this study was to be repeated no more than one of the participants would have an occupational background within the field of mental health.

4.6.2 Establishing Rigour and Framework Analysis:

As Clayton and Thorne (2000) note, in order for a qualitative study to demonstrate rigour, it needs to establish trustworthiness, which means it needs to ensure that participants' experiences have been reported as accurately and clearly as possible (Holloway and Wheeler, 1996) and that the research has been carried out in a fair manner (Polit and Hungler, 1983). Arguably, one of the many strengths of Framework Analysis is the way it naturally fits with this criterion. Framework Analysis is directed by the voice of the participant's original descriptions and views, providing a comprehensive collection of their narratives with an in-depth, systematic analysis. In addition to this, the credibility of any findings in Framework Analysis and the rigour of the analytical process is further enhanced by the clear and transparent audit trail which it provides (Leal *et al*, 2015).

The method of framework analysis is a systematic approach that helps ensure rigor and quality in qualitative research . It provides a structured framework for analysing qualitative data, allowing researchers to organize and interpret their findings in a rigorous and transparent manner . One of the key ways in which framework analysis enhances rigor is through its systematic and transparent approach to data analysis . The method involves a series of distinct stages, including familiarization, identifying a thematic framework, indexing, charting, mapping, and interpretation . These stages provide a clear and structured process for analysing qualitative data, ensuring that all relevant aspects of the data are considered and that the analysis is comprehensive and rigorous. Furthermore, the use of a thematic framework in framework analysis helps to ensure that the analysis is grounded in the data and that the findings are reliable and valid . The thematic framework is developed through an iterative process of familiarization with the data, identifying key themes, and refining and revising the framework as necessary. This process allows for a deep and nuanced understanding of the data, ensuring that the analysis is based on the actual content of the data rather than preconceived notions or biases. Another strength of framework analysis is its flexibility and adaptability to different research contexts and objectives . The method can be applied to a wide range of qualitative data, including interviews, focus groups, diaries and documents. This flexibility allows researchers to use framework analysis in various research settings and to address different research questions. For example, in a study by (Braun & Clarke, 2006), framework analysis was used to evaluate regulations and survey the knowledge, attitudes, and practices of occupational health and safety professionals and logistics managers related to occupational chemical exposures in closed environments of transportation and storage. The method of framework analysis also promotes transparency and reproducibility in qualitative research. The systematic and structured nature of the analysis process allows for clear documentation of the steps taken and decisions made during the analysis. This transparency enables other researchers to understand and evaluate the analysis process, enhancing the credibility and trustworthiness of the research findings. In conclusion, the method of framework

analysis is a valuable tool for ensuring rigor and quality in qualitative research . Its systematic and transparent approach to data analysis, use of a thematic framework, flexibility, and emphasis on transparency and reproducibility contribute to the rigor and reliability of the research findings. By providing a structured framework for analysing qualitative data, framework analysis helps researchers to organize and interpret their findings in a rigorous and comprehensive manner.

4.7 Some final thoughts - Contextualising the research:

"Diaries, as well as other primary and secondary data sources, can provide decontextualised material (Meth, 2003), so it is important to situate the produced narratives within the intersecting contexts of space and time as well as the broader socio-economic and political contexts from the local to the global" (Kenten, 2010, p.3).

As the researcher was concluding their write up of this study, it occurred to them, that reading through the participants unwanted intrusive thoughts, was akin to glimpsing into the past. The data collection process ended in February 2019, a year before the world outbreak of the Covid 19 Virus and the chaos that it brought with it. How different might the participants diaries have looked if they were collected today? The intrusions presented here, aside from describing and comparing the different participants' experiences of UITs – also present a historical snap shot of concerns before masks, furlough, lockdowns and social distancing had become common vernacular. Arguably, these accounts, although full of personal distress, still represent a simpler time. With the theme of uncertainty cited as a shared trigger by all the participants and the current uncertainty of changing Prime Ministers, a new King to replace the Queen of 70

years, rising inflation, the war in the Ukraine and a cost-of-living crisis that has yet to fully unfold – it seems that finding different ways to improve people's mental health has never been more important.

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Appendices:

Appendix A

PARTICIPANT INFORMATION SHEET

Title of study: *'An exploration of the similarities and differences between clinical and non-clinical participants' experience of unwanted, intrusive thoughts: A Framework Analysis'.*

Name of principal investigator *Nadia Sampson Supervised by Dr Jessica Jones Nielsen*

We would like to invite you to take part in a research study. Before you decide whether you would like to take part it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

This research is interested in exploring and comparing how individuals experience unwanted, intrusive thoughts. Unwanted, intrusive thoughts are thoughts, impulses or images which are difficult to control, interrupt the flow of thought and generally cause negative feelings. Previous research has been conducted however, which suggests that unwanted, intrusive thoughts, impulses or images are, in fact, a universal occurrence. As these thoughts are central to numerous clinical conditions, such as depression, anxiety, insomnia, obsessive compulsive disorder and post traumatic stress disorder, for example, such findings may aid both further research into this area, as well as possibly offer further avenues for possible treatment and/or prevention. This will hopefully help us to gain further understanding into this cognitive phenomenon which can be hugely distressing to those who experience it.

This study will aim to take place from April 2018 to August 2019 and is undertaken as part of the Professional Doctorate in Counselling Psychology at City University, London.

Why have I been invited?

I am looking for 4-5 adult participants aged 18 or over, with no known diagnosed clinical disorder, as well as 4-5 adult participants aged 18 or over who have a clinical diagnosis of one or more of the following clinical disorders; depression, anxiety, insomnia, obsessive compulsive disorder, post traumatic stress disorder, any phobia or eating disorder.

Any participants, however, who are suffering from any form of psychosis, from suicidal thoughts or who are under 18 are not suitable to participate in this study, in order to protect you from any potential harm and psychological disturbance.

Do I have to take part?

You may avoid answering questions which are felt to be too personal or intrusive, and this will not affect any future treatment (if in therapy) and you will not be penalized if you choose to withdraw.

Participation in the project is voluntary, and you can choose not to participate in part or all of the project. You can withdraw at any stage of the project without being penalised or disadvantaged in any way.

It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. *If appropriate, include that once the data has been anonymised/published participants will no longer be able to withdraw their data.*

What will happen if I take part?

- You will be involved in this study for one-week, plus 1-2 hours on a separate day for a follow up interview.
- You will be given an information sheet and a consent form that you will need to sign before the study can take place.

- The researcher will email and/or call you at an agreed time to ask a few questions in order to determine your suitability to participate. These questions will be: What is your age, gender, occupation, ethnicity?

  Do you experience unwanted, intrusive thoughts?

  Have you ever been diagnosed with a mental health disorder?

  If so, are you currently in treatment for this mental health disorder?

  If receiving treatment for a mental health disorder, what is the duration of this treatment?

  Are you currently experiencing any suicidal thoughts or thoughts of harming yourself?

- You will then be provided with a paper diary; to record any unwanted, intrusive thoughts you may have for a period of one week.

- The researcher will then contact you and invite you to take part in a follow up interview. The interview will take approximately 60-120 mins and at a place and time agreed by both parties. This interview will be audio-recorded and transcribed by the researcher, ensuring that your confidentiality is maintained at all times.
- You will then be provided with a debrief form, which will have contact details should you have any further questions regarding the study as well as the option for the researcher to call you and debrief you over the phone, if you request this.

Expenses and Payments (if applicable)

- All paper diaries will be provided, as well as pre-addressed, stamped envelopes for return, if completing hard copies by post.

What do I have to do?

You will be required to complete one paper diary, noting any unwanted, intrusive thoughts you may have for the period of one week. Following the completed and returned diary, the researcher will invite you for a follow up interview at a time and place that is convenient for you both. The interview will take approximately 60-120 mins

What are the possible disadvantages and risks of taking part?

It is possible, that participation in this study may trigger different, thoughts, memories, feelings or impulses, which may be upsetting or anxiety provoking, when completing the diary, as you may pay greater attention to your thoughts.

If taking part in this research has raised any concerns for you, please consider contacting your GP or primary contact at MIND or place of treatment, in the first instance, to discuss them. Below is a list of other mental health organisations who can also provide support:

Samaritans: 116 123

SANEline: 0300 304 7000

CALM: 0800 58 58 58

Rethink Mental Illness: 0300 5000 927

Royal College of Psychiatrists: 020 7235 2351

What are the possible benefits of taking part?

By taking part in this study, you may help provide some very useful and important findings, which may aid greater understanding in to the phenomenon of unwanted, intrusive thoughts, as well as possible causes, prevention and/or treatment for a number of serious clinical disorders. Without your participation this study would not be possible, only through your help can such important information, as this, be accessed. Thanks to you, ways to help treat and prevent such thoughts, which can really disrupt people's lives, may be discovered and without your participation, I would not be able to complete my doctorate in counselling psychology. Therefore, as an added thank you, I am happy to provide all participants with the final written up findings of this study.

What will happen when the research study stops?

Once the study has been completed, all participant data will be stored confidentially, for a minimum of five years, before being destroyed, in line with the BPS code of human research ethic's guidelines.

Will my taking part in the study be kept confidential?

- Only the researcher will have access to your identifiable information.
- All documents, apart from the consent form, will be under a pseudonym, which you will provide.
- Any personal data, interview transcripts and completed diaries will be stored confidentially, for a minimum of five years before being destroyed, in line with the BPS code of human research ethic's guidelines.

- Data archiving will be done in locked cabinets and on the researcher's computer.
- However, reporting of violence, abuse, self-inflicted harm, harm to others, criminal activity cannot be kept confidential.

What should I do if I want to take part?

Having read this information sheet, if you would like to take part in the study, please sign the participant consent form.

What will happen to results of the research study?

Once the study has been completed, it can be accessed in the library of City University, London. It is also possible that, this study may be published in different journals and publications but at all times, participant anonymity will be maintained. If you wish to receive a copy of the publication or summary of the results from this study, then please email the researcher, requesting this.

What will happen if I do not want to carry on with the study?

You may choose to withdraw from this study at any point, without any explanation or penalty, at any time. If you wish to withdraw your data and/or request its complete destruction, you may do so within three months of completing your diary and interview.

Who has reviewed the study?

This study has been approved by City, University of London *[School of Arts and Social Sciences]* Research Ethics Committee

Further information and contact details

Nadia.Sampson@city.ac.uk (Researcher)

Jones.Nielsen.1@city.ac.uk (Research Supervisor)

Data Protection Privacy Notice: What are my rights under the data protection legislation?

City, University of London is the data controller for the personal data collected for this research project. Your personal data will be processed for the purposes outlined in this notice. The legal basis for processing your personal data will be that this research is a task in the public interest, that is City, University of London considers the lawful basis for processing personal data to fall under Article 6(1)(e) of GDPR (public task) as the processing of research participant data

is necessary for learning and teaching purposes and all research with human participants by staff and students has to be scrutinised and approved by one of City's Research Ethics Committees.

The rights you have under the data protection legislation are listed below, but not all of the rights will be apply to the personal data collected in each research project.

- right to be informed
- right of access
- right to rectification
- right to erasure
- right to restrict processing
- right to object to data processing
- right to data portability
- right to object
- rights in relation to automated decision making and profiling

For more information, please visit www.city.ac.uk/about/city-information/legal

What if I have concerns about how my personal data will be used after I have participated in the research?

In the first instance you should raise any concerns with the research team, but if you are dissatisfied with the response, you may contact the Information Compliance Team at dataprotection@city.ac.uk or phone 0207 040 4000, who will liaise with City's Data Protection Officer Dr William Jordan to answer your query.

If you are dissatisfied with City's response you may also complain to the Information Commissioner's Office at www.ico.org.uk

What if there is a problem?

If you have any problems, concerns or questions about this study, you should ask to speak to a member of the research team. If you remain unhappy and wish to complain formally, you can do this through City's complaints procedure. To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is:

'An exploration of the similarities and differences between clinical and non-clinical participants' experience of unwanted, intrusive thoughts: A Framework Analysis'.

You could also write to the Secretary at:
Anna Ramberg
Research Governance & Integrity Manager
Research & Enterprise
City, University of London
Northampton Square
London
EC1V 0HB
Email: Anna.Ramberg.1@city.ac.uk

City holds insurance policies which apply to this study. If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action.

Thank you for taking the time to read this information sheet.

20/07/18 Version 2

Appendix B

CONSENT FORM

Title of Study: *'An exploration of the similarities and differences between clinical and nonclinical participants' experience of unwanted, intrusive thoughts: A Framework Analysis'.*

Ethics approval code: PSYETH (P/F) 16/17 136.

Please initial box

1	I agree to take part in the above City University London research project. I have had the project explained to me, and I have read the participant information sheet, which I may keep for my records.	
	• I understand this will involve:	
	• completing a paper diary for a week, noting down any and all unwanted, intrusive thoughts I may have.	

2	This information will be held by City as data controller and processed for the following purpose(s): [*My doctoral research project and lawful basis for processing under General Data Protection Regulation (GDPR) for personal data and sensitive personal data.* Public Task: The legal basis for processing your personal data will be that this research is a task in the public interest, that is City, University of London considers the lawful basis for processing personal data to fall under Article 6(1)(e) of GDPR (public task) as the processing of research participant data is necessary for learning and teaching purposes and all research with human participants by staff and students has to be scrutinised and approved by one of City's Research Ethics Committees.	
3	I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation.	
4	I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at	
	any stage of the project without being penalised or disadvantaged in any way.	
5	I agree to City recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on City complying with its duties and obligations under the General Data Protection Regulation (GDPR).	
6.	I agree to the arrangements for data storage, archiving, sharing.	
7	I agree to the use of anonymised quotes in publication.	
8	I agree to take part in the above study.	

_____	_____	_____
Name of Participant	Signature	Date

_____	_____	_____
Name of Researcher	Signature	Date

When completed, 1 copy for participant; 1 copy for researcher file.

Appendix C

Demographic and screening questionnaire:

Age:

Gender:

Occupation:

Ethnicity:

Do you experience unwanted, intrusive thoughts?

Have you ever been diagnosed with a mental health disorder?

If so, are you currently in treatment for this mental health disorder?

If receiving treatment for a mental health disorder, what is the duration of this treatment?

Are you currently experiencing any suicidal thoughts or thoughts of harming yourself?

Appendix D

Diary cover page

Dear Participant,

Thank you for agreeing to complete this diary for one week. This diary contains a separate page for each day of the week, for you to note down any unwanted intrusive thoughts, as they may occur throughout the day. Please carry this diary with you at all times, during this week, in order to allow you to note down the thought as close to the time it occurs as possible.

Definition of an unwanted intrusive thought:

A sudden, quick, thought that sometimes occurs repeatedly, that is unacceptable and/or unwanted. Typical examples of intrusive thoughts include thoughts of contamination or of hurting someone that you would not actually wish to (Rachman, 1981).

It should also be noted that research has found such thoughts to be very common amongst the general population.

As stated in the consent and information sheet, all entries will be kept anonymous.

DIARY EXAMPLE REMOVED FOR COPYRIGHT PURPOSES

Appendix E

Interview Questions:

Questions related to completing the diary:

1) What was it like to complete this diary?
2) How representative of your thoughts would you say it was?
3) Space to ask specific questions related to each individual participant's entries – particularly the context of the trigger – i.e. related/unrelated to thought?
4) What, if anything, did you learn any about your thoughts and/or your self, completing the diary?

Questions specific to unwanted, intrusive thoughts:

5) How often would you say you experience Unwanted, Intrusive thoughts?
6) How do you deal/respond to these thoughts?
7) Could you tell me about the different types of intrusive thoughts or images that you have?
8) Could you tell me a bit about how you feel when you have these thoughts?
9) What do you think your thoughts say about you?
10) What, if any, unwanted intrusive thoughts, do you believe might be too embarrassing to share with anyone?
11) How much, if at all, would you say your unwanted Intrusive thoughts affect your day to day life?

12) Do you feel your unwanted, intrusive thoughts have a trigger and if so, what are they?
13) Do you feel able to cope with your unwanted intrusive thoughts?
14) Finally, before we conclude this interview is there anything else you would like to address that you feel has not already been discussed?

Appendix F

Department of Psychology City University London

PARTICIPANTS NEEDED FOR RESEARCH IN COUNSELLING PSYCHOLOGY

We are looking for volunteers to take part in a study on unwanted, intrusive thoughts.

You would be asked to: *note down any unwanted, intrusive thoughts you may have in a paper or electronic diary, that will be provided for you, over the course of a week. You would then be required to take part in a follow up interview with the researcher at a time and place that is convenient for you both.*

Your participation would involve *one week to complete the diary and another 60-120 minutes on a separate day for a follow up interview*.

For more information about this study, or to take part, please contact:

Nadia Sampson
Psychology Department
at
Email: Nadia.Sampson@city.ac.uk

This study is supervised by Dr Jessica Jones Nielsen Jones.Nielsen.1@city.ac.uk

This study has been reviewed by and received ethics clearance through the Psychology Department Research Ethics Committee, City University London PSYETH (P/F) 16/17 136.

Appendix G

CITY UNIVERSITY LONDON

'An exploration of the similarities and differences between clinical and non-clinical participants' experience of unwanted, intrusive thoughts: A Framework Analysis'.

DEBRIEF INFORMATION FOR NON-CLINICAL PARTICIPANTS

Thank you for taking part in this study. Now that it's finished we'd like to tell you a bit more about it.

This project is interested in exploring the experience of both clinical and non-clinical participants unwanted, intrusive thoughts. Unwanted, intrusive thoughts are thoughts, impulses or images which are difficult to control, interrupts the flow of thought and generally cause negative feelings.

As these thoughts are central to numerous clinical conditions, such as depression, anxiety, insomnia, OCD and PTSD, for example, gaining further knowledge into this experience may inform further research into this area, potentially offering further avenues for potential treatment and/or prevention.

If taking part in this research has raised any concerns for you, please consider contacting your GP to discuss them, in the first instance. You can also contact the following organisations:

MIND: 0300 123 3393

Samaritans: 116 123

SANEline: 0300 304 7000

CALM: 0800 58 58 58

We hope you found the study interesting. If you have any other questions please do not hesitate to contact us at the following:

Nadia.Sampson@city.ac.uk (Researcher)

Jones.Nielsen.1@city.ac.uk (Research Supervisor)

Ethics approval code: PSYETH (P/F) 16/17 136.

Appendix H

(Clinical participant's debrief)

-
- ***'An exploration of the similarities and differences between clinical and non-clinical participants' experience of unwanted, intrusive thoughts: A Framework Analysis'.***

DEBRIEF INFORMATION

Thank you for taking part in this study. Now that it's finished we'd like to tell you a bit more about it.

This project is interested in exploring the experience of both clinical and non-clinical participants unwanted, intrusive thoughts. Unwanted, intrusive thoughts are thoughts, impulses or images which are difficult to control, interrupts the flow of thought and generally cause negative feelings. As these thoughts are central to numerous clinical conditions, such as depression, anxiety, insomnia, OCD and PTSD, for example, gaining further knowledge into this experience may inform further research into this area, potentially offering further avenues for potential treatment and/or prevention.

If taking part in this research has raised any concerns for you, please consider contacting your counsellor at MIND or place of treatment, in the first instance, to discuss them. You may also want to contact your GP. Below is a list of other mental health organisations who can also provide support:

Samaritans: 116 123

SANEline: 0300 304 7000

CALM: 0800 58 58 58

Rethink Mental Illness: 0300 5000 927

Royal College of Psychiatrists: 020 7235 2351

We hope you found the study interesting. If you have any other questions please do not hesitate to contact us at the following:

Nadia.Sampson@city.ac.uk (Researcher)

Jones.Nielsen.1@city.ac.uk (Research Supervisor)

Ethics approval code: *[PSYETH (P/F) 16/17 136]*

Appendix I:

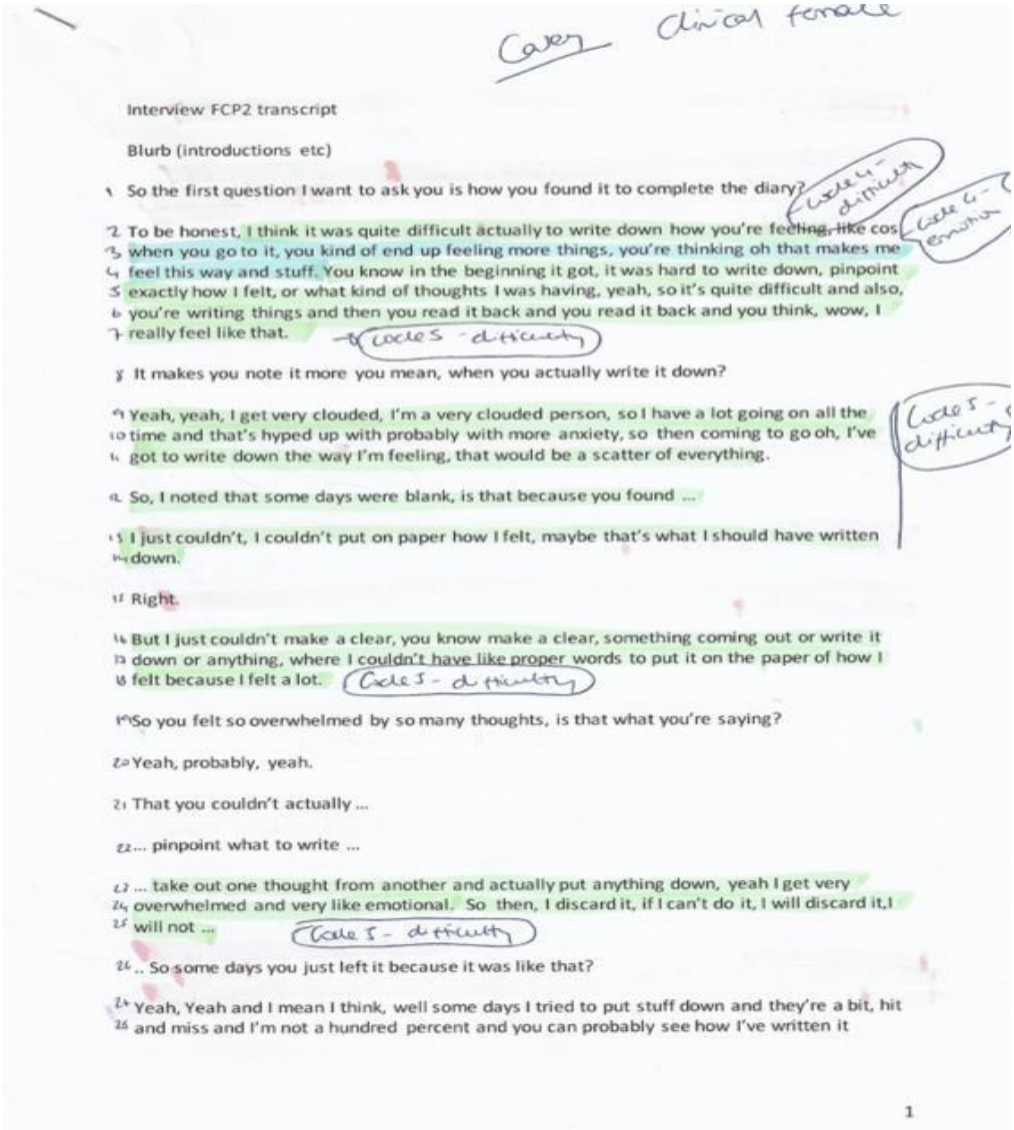
Familiarisation –

Below is an example excerpt of the first stage of analysing the data‘ Familiarisation’ – looking at one day’s diary entry from one non-clinical participant and one clinical participants one day diary entry.

The parts in black show the participant’s entries that day, to the semi-structured diary all participants were asked to complete. The parts in blue are the notes and any ideas the researcher had started to make.

Following that there is also a scanned in example of some early open coding from one page of one participants interview transcript.

DIARY EXAMPLE REMOVED FOR COPYRIGHT PURPOSES



Carer clinical female

Interview FCP2 transcript

Blurb (introductions etc)

So the first question I want to ask you is how you found it to complete the diary?

To be honest, I think it was quite difficult actually to write down how you're feeling, like cos when you go to it, you kind of end up feeling more things, you're thinking oh that makes me feel this way and stuff. You know in the beginning it got, it was hard to write down, pinpoint exactly how I felt, or what kind of thoughts I was having, yeah, so it's quite difficult and also, you're writing things and then you read it back and you read it back and you think, wow, I really feel like that.

Code 5 - difficulty

It makes you note it more you mean, when you actually write it down?

Yeah, yeah, I get very clouded, I'm a very clouded person, so I have a lot going on all the time and that's hyped up with probably with more anxiety, so then coming to go oh, I've got to write down the way I'm feeling, that would be a scatter of everything.

So, I noted that some days were blank, is that because you found ...

I just couldn't, I couldn't put on paper how I felt, maybe that's what I should have written down.

Right.

But I just couldn't make a clear, you know make a clear, something coming out or write it down or anything, where I couldn't have like proper words to put it on the paper of how I felt because I felt a lot.

Code 5 - difficulty

So you felt so overwhelmed by so many thoughts, is that what you're saying?

Yeah, probably, yeah.

That you couldn't actually ...

... pinpoint what to write ...

... take out one thought from another and actually put anything down, yeah I get very overwhelmed and very like emotional. So then, I discard it, if I can't do it, I will discard it,I will not ...

Code 5 - difficulty

.. So some days you just left it because it was like that?

Yeah, Yeah and I mean I think, well some days I tried to put stuff down and they're a bit, hit and miss and I'm not a hundred percent and you can probably see how I've written it

1

Appendix J

Example of early Working Thematic Framework:

First Level Framework Theme – Experience of UITs
Second Level Theme – Content of UITs

Categories Description

Fear of contamination and dirt	Any concerns noted related to contamination or dirt
Sexual Thoughts	Only those that are unwanted by participant, not including fantasies
Concern with cleanliness and order	Participant's need for things to be clean and order kept in an orderly fashion.
Harming others or one's self	Concerns they may harm themselves or someone else, includes all thoughts of violence.
Health Concerns	Fears about becoming ill or a loved one becoming ill
Moral shame	Thoughts which participant views as immoral and provokes feelings of guilt
Social anxiety	Includes thoughts of closely monitoring one's interactions with others, fear of interacting with others, obsessional thoughts surrounding past interactions with others, need to seclude self, feelings of not fitting in.
Relationship anxiety	Obsessional thoughts about current or past romantic relationships that are negative.
Fear of Death	Fear that they or someone they love will die.
Other	For any other thoughts which are not listed above.

Second Level Theme: Situation or trigger for UITs

Categories	Description
Related to context	UIT is trigger by the context which relates to the participants UIT, as perceived by the participant.
Unrelated to context	Trigger for UIT is unknown and seemingly just 'pops' into participant's mind, unrelated to the context, as perceived by the participant.
Other	

Second Level Theme: Reaction to UIT

Categories	Description
Interpretation	What they think their UITs say about them
Emotion	How their UITs make them feel
Response	How they react to the UITs, manage them
Other	Any other reaction not listed above

Second Level Theme: Reaction to completing the diary

Self-discovery	What participant discovered about their own thoughts and or/behaviours
Emotion	Feelings towards the act of noting down their thoughts, their thoughts being read by researcher, feelings towards 'discovering' type and or frequency of their thoughts,
Practicality	Reality of challenges to keeping diary and noting thoughts as and when they occur
Difficulty	Challenge of dealing with negative emotions evoked by and noting thoughts, also challenges of being able to
	recognize thoughts when so common and so frequent.
New Behaviours	Any new behaviour noted by participant as a result of completing the diary
Omitted thoughts	Participant admits certain thoughts too embarrassing to note down
Other	Any reaction not noted above

Categories	Description

Second Level Theme: Impact of UITs on participant's life

Categories	Description

Frequency	How often Participant has UITs
Control	Participant's perception of their ability to manage their UITs
Interference with daily life	Includes impact on relationships, romantic or otherwise, interference with work/study
Perception of self	Impact on self-esteem, sense of identity
Other	For any other thoughts which are not listed above.

Appendix K:

Example of some of the early indexing and charting process:

	Self-discovery	Emotion	Practicality	Difficulty	New Behaviours	Omitted thoughts	Other

NCF1	when I started doing it I didn't realise that my intrusive thoughts tended to be either connected to my ex or to my new partner. (p.1, 7) I found that kind of shocking in a way (p.8)	I found it very negative thing that he was there (p1,9) it annoyed me some of the things that I wrote, that he made me feel weak and that I didn't think I was that strong. (p1, 10)		It was actually far more challenging than I thought it was going to be. (p.1 13) Because it really made me think and it made me think of things I didn't particularly want to think about (p.1,14-15)	but since then I think I've made a conscious effort to not think about him or if I'm aware of it just try and put him to the side more, (p.2, 54)		
CF1		then actually then that can lead to an intrusive thought because then it can lead to thoughts, not so much obsessive thoughts but um thoughts that effect my self esteem - 'oh you can't even remember your own thoughts, you're not good enough' and 'you can never organise anything' (p.1, 5-8).	I think firstly finding the time and remembering to do the diary was a slight issue (p.1,2)	you constantly suffer from intrusive thoughts, they almost become a normal part of your day. (p.1,4)		filling it out once I was in bed, remembering what i'd done over the day, you don't always remember every single thing. (p.1, 4).	
CM1		I looked at them and I thought to myself, God these thoughts are just depressing. (p.1, 3)	I couldn't literally carry it around every where with me and you know, I'm having thoughts all the time. (p.1, 8)	I hated focusing on my nasty thoughts, it's bad enough that they are always there, let alone writing them all		There was like no chance I could write down every thought, there's so many, I wouldn't be able to get on with anything! (p.1, 27).	

				down (p.1, 4-5)			

NCM1	It was an odd thing to do really but I found it quite helpful for me personally, I learnt quite a lot from it (p,1 2) it was surprising for me to see just how many were about relationships (P1, 4)		it wasn't easy, some of it was, I tried to do it as close to the time as possible but obviously if you are driving or you're doing something, it's not easy (p.1, 8-9)		since I've done it, I've kept monitoring, it's made me more aware of what I was thinking. (p.2, 34)	You know some of it was like you had intrusive thoughts but you weren't necessarily that comfortable sharing them. (p.1, 13)	
CF2	you're writing things and then you read it back and you read it back and you think, wow, I really feel like that. (p.1,7).	To be honest, I think it was quite difficult actually to write down how you're feeling, like cos when you go to it, you kind of end up feeling more things, you're thinking oh that makes me feel this way and stuff. (p.1,46)		You know in the beginning it got, it was hard to write down, pinpoint exactly how I felt, or what kind of thoughts I was having (p.1,8)		Somedays, I just couldn't, I couldn't put on paper how I felt, maybe that's what I should have written down. (p.3, 43).	
NCF2	I think what I learnt about myself is I can be quite hard on myself (p.3, 60) but I think writing them down systematically has helped me to, reframe them in a way. It's actually really helped me to think about the sort of situations that occur and also what's helpful in trying to dissipate them, even in the short term (p.4 83-86)		It was quite straight forward to complete it, (p.1, 2)				

CM2	I never realised I had this many negative thoughts (p.1 3).	I hated it but sort of enjoyed it at the same time (p.1,2)		If it was a really busy or difficult day, it was much more difficult to fill it in (p.1 11)		If I was really down I just had to leave that day blank (p3, 53).	
NCM2	Absolutely fascinating I have to say. (p.1, 2).	I'd be lying if I say I enjoyed it but definitely found it, not even cathartic, this will sound so weak, a positive rather than a negative. (p.1, 8-9)			So, this, this, exercise or tool whatever you want to call it, this process has definitely given me a time, away from church, away from, running to actually sit back and think about me, think about my life and also think about why certain thoughts come into my head. (p.2, 61-63)		

Appendix L:

Psychology Research Ethics Committee

School of Arts and Social Sciences

City University London

London EC1R 0JD

4th July 2017

Dear Nadia Sampson and Jessica Jones Nielsen

Reference: PSYETH (P/F) 16/17 136

Project title: ‘‘An exploration of the similarities and differences between clinical and non-clinical participants’ experience of unwanted, intrusive thoughts’’: A Framework Analysis.

I am writing to confirm that the research proposal detailed above has been granted approval by the City University London Psychology Department Research Ethics Committee.

Period of approval

Approval is valid for a period of three years from the date of this letter. If data collection runs beyond this period you will need to apply for an extension using the Amendments Form.

Project amendments

You will also need to submit an Amendments Form if you want to make any of the following changes to your research:

(a) Recruit a new category of participants

(b) Change, or add to, the research method employed

(c) Collect additional types of data

(d) Change the researchers involved in the project

Adverse events

You will need to submit an Adverse Events Form, copied to the Secretary of the Senate Research Ethics Committee (anna.ramberg.1@city.ac.uk), in the event of any of the following:

(a) Adverse events

(b) Breaches of confidentiality

(c) Safeguarding issues relating to children and vulnerable adults

(d) Incidents that affect the personal safety of a participant or researcher

Issues (a) and (b) should be reported as soon as possible and no later than 5 days after the event. Issues (c) and (d) should be reported immediately. Where appropriate the researcher should also report adverse events to other relevant institutions such as the police or social services.

Should you have any further queries then please do not hesitate to get in touch.

Kind regards

Katy Tapper

Co-Chair

Email: Psychology.ethics@city.ac.uk

Richard Cook

Chair

Email: richard.cook.1@city.ac.uk