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Brief humanistic counselling with an adolescent client experiencing obsessive-compulsive difficulties: A theory-building case study

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Abstract

Background: Obsessive-compulsive disorder (OCD) is a chronic, debilitating psychological condition. To date, there has been no published research exploring brief humanistic counselling as an intervention for OCD. This study presents a case study of an adolescent client with obsessive-compulsive difficulties ('Sunil') receiving school-based humanistic counselling.

Aims: (a) To test humanistic counselling for an adolescent client experiencing obsessive-compulsive difficulties; (b) to help improve brief humanistic counselling in its approach to working with adolescent clients experiencing obsessive-compulsive difficulties.

Method: This research used a mixed methods theory-building case study, based on a rich case record.

Results: The brief counselling did not reduce Sunil's obsessive-compulsive difficulties. The core conditions were delivered in sessions, and the counselling allowed for the client to share traumatic memories and build peer relationships. However, the counselling did not seem to be directive at targeting Sunil's obsessive-compulsive difficulties, and the silence in sessions was experienced by the client as awkward.

Implications: Further research should be conducted investigating the therapeutic and problematic aspects of brief humanistic counselling for OCD. These include an in-depth look at the impact of silence on the young person, integration of process-guiding tools and the counsellor not enabling compulsive in-session rituals.

KEYWORDS

adolescents, case study, humanistic counselling, obsessive-compulsive disorder, theory-building

This research took place at the University of Roehampton, UK.

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1 | INTRODUCTION

Obsessive-compulsive disorder (OCD) is widely considered a mental health disorder characterised by intrusive thoughts (obsessions), images or urges, and compulsions, which the person does to neutralise the obsessional content (Abramowitz et al., 2009). Obsessions come in many themes. Common obsessional themes focus on contamination (including emotional contamination), harming self or others, religious, health, sexual orientation and relationship fears (Taylor, 2011). Obsessions are *ego-dystonic*, which means they are in conflict with a person's wishes. They are also often recurrent and far-fetched: statistically unlikely to occur. To remove these troubling thoughts, the person may repeat compulsions (rituals) (Houghton et al., 2010). Compulsions come in many variations, including checking, washing, counting, praying, reassurance seeking and avoidance. OCD reportedly affects 1.1% of the general population in the UK (Torres et al., 2006), and an inconsistent prevalence of 0.25% to 4% in children and adolescents was found across three studies (Walitza et al., 2011). OCD can negatively affect the person's quality of life (Koran et al., 1996). Valderhaug and Ivarsson (2005) found that OCD in adolescence can negatively affect home, school and social relationships.

Cognitive-behavioural therapy (CBT), with an emphasis on exposure and response prevention therapy (ERP), is currently considered the gold standard of OCD treatment due to its research base. However, a recent meta-analysis of 36 RCTs by Reid et al. (2021) found that other active psychotherapies were as effective as ERP. In addition, Reid et al. highlighted concerns around methodological rigour in the studies: specifically that approximately three quarters of the studies (78%) had suspected researcher allegiance to ERP and that these studies showed a greater effect size than the quarter of studies (22%) that showed a low risk of researcher allegiance to ERP. In addition, only a minority of the studies with suspected researcher allegiance (28.6%) compared ERP to active controls. By contrast, the majority (87.5%) of studies that had low risk for researcher allegiance used active controls, and here, there were poorer outcomes for ERP. These findings indicate that no, one therapy has yet to be established as solely enough for treating OCD and that there is a need to continue searching for additional treatments for this difficulty.

Humanistic counselling theory assumes that experiencing is central: that the young person's subjective viewpoint and perception is their reality (Cooper et al., 2013; Rogers, 1951; Rogers, 1961). This reality can be understood by leaving diagnoses and hypotheses aside, to truly understand their world through their experiencing of it (Cain et al., 2016). The diversity of the human condition is to be treated and valued equally. Humanistic counselling holds that the individual is always striving towards actualisation and that the right environmental conditions will facilitate this process (Rogers, 1957). The six conditions outlined by Rogers that are 'necessary and sufficient' for personality change to occur are empathy, congruence and unconditional positive regard, along with psychological contact between counsellor and client, the client in a state of incongruence, and the effective communication of these conditions to the client.

Implications for Practice

The tentative implications for practice are offered as suggestions, as they are based on a single case.

1. Rogers's conditions are possibly necessary, but are not necessarily sufficient for working with clients with obsessive-compulsive disorder (OCD). These clients may need more direction; this direction could include psycho-education on the maintenance of OCD and the ego-dystonic nature of intrusive thoughts, offering suggestions for ways to reduce compulsions, and an open dialogue exploring the client's innate wisdom for how they could address their problems.
2. Silences, when working with clients with OCD, may need to be reduced or used more strategically. The space where there are silences could be used for more direction, or exploration of difficult experiences.
3. Where possible, compulsive behaviour in session should not be encouraged. Reassurance seeking will be the most common compulsion between client and counsellor. The counsellor should refrain from getting caught in an OCD cycle of reassurance seeking.
4. Where possible, OCD-specific outcome measures could be utilised to confirm that what the client says matches the reality of their symptoms.

Rogers claimed that, 'No other conditions are necessary. If these six conditions exist, and continue over a period of time, this is sufficient. The process of constructive personality change will follow' (Rogers, 1957:95–96). This is in contrast to cognitive and behavioural therapies, where more active interventionistic principles are applied (Langle & Kriz, 2014).

School based humanistic counselling (SBHC), based on person-centred principles, proposed five potential processes that may lead to psychological change (Cooper, 2016; Kirkbride, 2016). These are: (a) the client developing better relational skills through therapy leading to improved relationships, (b) the ability to express strong emotions which may reduce less subjectively unacceptable emotions, (c) the client may learn to accept the totality of their experiencing, (d) the client may develop a deeper understanding into themselves, as well as their situation, and (e) through the counsellor giving guidance, the client may develop new ways of coping with their emotions.

There have been no studies published investigating humanistic counselling as an intervention for OCD, and therefore no hypotheses have been outlined on how—if at all—it may be effective at treating OCD symptoms. A potential reason for this may be humanistic counsellors viewing the individual as the priority, and not a diagnosis, as characterised by the CBT view of OCD as a disorder (Reid et al., 2021). However, we propose two hypotheses of how humanistic counselling may work at reducing a young person's obsessive-compulsive difficulties.

Hypothesis 1: Through the 'necessary and sufficient' conditions, the counsellor may create a secure and safe space for the young person to explore what may be keeping them stuck in obsessive-compulsive patterns, such that they can re-connect with their actualising tendency. That is, through the therapeutic relationship the counsellor can 'contain' the young person while they work through previously denied traumatic experiences (Murphy, 2009), and encourage constructive choices in the direction of actualisation (Plante, 2011).

Hypothesis 2: Offering process-guiding tools for how the young person can get unstuck from OCD will support them in that process. We acknowledge that humanistic counselling is non-directive at its core; however, consistent findings in young person humanistic and person-centred studies suggest that clients value the counsellors' suggestions and advice (Griffiths, 2013).

The nature of this study is theory-building, an exploration into a single case of brief humanistic counselling for an adolescent client. The aims of this research are to (a) test humanistic counselling for an adolescent client experiencing obsessive-compulsive difficulties; (b) to help improve brief humanistic counselling in its approach to working with adolescent clients experiencing obsessive-compulsive difficulties.

2 | METHOD

This research investigated one case from the ETHOS trial (Cooper et al., 2021). The study is a randomised control trial (RCT) that investigated the effectiveness of brief humanistic counselling in a UK secondary school setting. Participants were 13–16 years of age with moderate to severe levels of emotional symptoms and received up to 10 sessions of humanistic counselling. This research will use the term 'obsessive-compulsive difficulties', instead of 'obsessive-compulsive disorder', as no clinical assessment was conducted to assess if the client's symptoms met diagnostic criteria for OCD. However, the diagnostic label of OCD will be used when referencing literature and comparing the outcomes of this study to this research base, as the wealth of existing research on this phenomenon uses this diagnostic label. As researchers, we are aware that this diagnostic label does not fit with the humanistic model, and personally feel that it may fail to acknowledge the wider context for the existence of the symptoms.

2.1 | Design

Theory-building research aims to test, explore and expand a given theory against clinical observations (Stiles, 2017). This research method is a form of quality control on any given theory (Stiles, 2007), making sure the theory is still relevant against different client issues and diagnoses. Each clinical case is informative, whether confirming the accuracy of a theory or highlighting the areas it needs to evolve. Theory-building case studies are conducted from a rich case record.

A rich case record is often comprised of case materials including audio recordings, transcripts, client demographics, outcome measures and post-treatment interviews (Elliott, 2002). The rich case record helps the researcher make more reliable inferences based on multiple sources of information (Stiles, 2007). This research draws from many data points.

2.2 | Selection procedure

The participants in the original trial were not assessed for OCD directly. For this reason, to select a case, the first author identified which items in the original trial measures included OCD-related questions. Three were identified. Therefore, to be selected for analysis, the counsellor needed to have marked 'moderate' or 'severe' on the Current View form (see Measures) for the item, 'Compelled to do or think things (OCD)' (Jones et al., 2013). Alongside this, the client needed to have indicated 'always' on all three OCD-related Revised Children's Anxiety and Depression Scale-Short Version (RCADS-SV) items (Ebesutani et al., 2012). For adequate data analysis, eight or more sessions needed to be recorded. A final criterion for inclusion was that the first author, on listening to the first two counselling sessions, found mention of OCD or obsessive-compulsive symptoms.

2.3 | Participant and counsellor

Personal details and some language in this study have been changed to protect the young person and counsellor's identities.

'Sunil' was a 15-year-old British Asian boy in Year 10 at a secondary school. The client had a younger brother and a mother and father that are married. Sunil had a history of anxiety and school refusal. Sunil had had previous experience with counselling but the specifics were unknown. His goals for counselling were: a) to be able to come into school without worrying, b) to be able to manage his anxieties so that he can have a break from worrying, and c) to develop his confidence around people and crowds to lessen panic attacks.

The counsellor assigned to work with Sunil was a white British woman, 30–39 years of age, with three years of post-qualification experience. She was trained up to bachelors' level. Her core modality was humanistic counselling.

2.4 | Intervention

The counsellor in this trial followed a humanistic clinical manual (Kirkbride, 2016). The counsellor received four days of group training in the SBHC model. Each counsellor in the trial was assessed for their adherence to the humanistic model. The mean adherence rating for all counsellors was 4.6 on the PCEPS-YP adherence measure, based on a 1–6 scale, with a cut-off for adherent practice of 3.5. The counsellor in this study was rated 4.7.

The counselling was conducted over 10 sessions. Only nine of the ten sessions were recorded. No reason was given for the missing session three recording.

2.5 | Measures

Sunil completed a battery of outcome measures at four time points: baseline, six weeks (mid-point), 12 weeks (endpoint) and 24 weeks (follow-up).

The primary outcome measure was the Young Person's Clinical Outcomes in Routine Evaluation (YP-CORE) (Twigg et al., 2009). The YP-CORE is a clinically relevant measure to assess changes in psychological distress in Sunil's age range. The measure has shown good internal reliability ($\alpha = 0.80$) and test-retest reliability across one week ($r = .76$, 95% CI 0.65–0.86) (Twigg et al., 2009). For clinical change in Sunil's gender and age range, scores must cross a cut-off point of 14.1 (male, 14–16 years) (Twigg et al., 2016).

The secondary measures included the Revised Children's Anxiety and Depression Scale-Short Version (RCADS-SV) (Ebesutani et al., 2012). The RCADS-SV is based on the original RCADS scale, which has support for its validity and reliability in clinical samples (Chorpita et al., 2005). There are no clinical cut-offs for the RCADS-SV. The shortened version has good reliability for its 15 anxiety scale questions (3 OCD questions), and its 10 depression scale questions, at $\alpha = 0.91$ and $\alpha = 0.80$, respectively, in a clinical setting (Ebesutani et al., 2012). The Strengths and Difficulties Questionnaire (SDQ) Total Difficulties score (Goodman, 2001) has satisfactory internal consistency ($\alpha = 0.73$). The Rosenberg Self-Esteem Scale (RSES) (Rosenberg, 1965) has an internal consistency 0.85 to 0.88 (Martín-Albo et al., 2007). A cut-off score of lower than 15 may indicate low self-esteem. The Warwick-Edinburgh Mental Well-being Scale (WEMWBS) (Tennant et al., 2007) was used to assess mental well-being. The scale has an internal consistency Cronbach's alpha of 0.89 (student population). A cut-off score of 40 or lower equals probable depression, 41–44 equals possible depression (Bianco, 2011), and a score of 45 and above equals average mental well-being. The Goal Based Outcome Record Sheet (GBORS) (Law & Jacob, 2015) was collected in each session. Change greater than 2.45 represents reliable change (Edbrooke-Childs et al., 2015). The Experience of Service Questionnaire (ESQ) (Attride-Stirling, 2002) was collected at the end of counselling (Week 12) to assess Sunil's experience of, and satisfaction with, the counselling.

2.6 | Ethics

The original research trial received ethical approval from the University of Roehampton. For this research project, the researcher requested additional ethical approval at the University of Roehampton. This was approved by the Department of Psychology on 15 October 2020. To protect the young person involved, their details are disguised and anonymised.

2.7 | Analysis

Stiles (2007, 2017) stated three stages of analysis for theory-building case studies. They are: (a) Gaining familiarity with the case, (b) Selecting and focusing, (c) Interpreting. In Stage 1, the first author immersed himself in the data. This included listening to the audio files, reading the transcripts and understanding the outcome measure data from different perspectives. He also took notes of themes, issues and ideas around the case. Stage 2 involved going through the data again and deciding on the specific focus of the research. At the start of the project, the researcher wanted to assess the impact of brief humanistic counselling on an adolescent client, but it was a broad exploration. Through this second stage, the issues and potential for exploration were identified. Stage 3 is a conceptual analysis phase connecting case observations to the practice of humanistic counselling. McLeod (2010) suggested that the researcher needs to identify gaps in the theory, as this allows the research to suggest ways to enhance practice.

2.8 | Reflexive statements

The first author acted as the principal researcher for this study. His training is integrative, including humanistic, psychodynamic and cognitive-behavioural therapies for children and young people. He has a personal experience of OCD and has been involved in OCD advocacy for the past six years. He had no involvement in the original research.

The second author is the principal investigator for the study in which the data were derived and a professor of counselling psychology. He is a strong advocate of person-centred, humanistic, existential and relational approaches to counselling and psychotherapy. However, he has also developed a model of integrative practices that recognises the value of multiple therapeutic theories and methods. The second author does not have a history of OCD but has attended counselling several times for anxiety-related problems.

3 | RESULTS

3.1 | Quantitative outcomes

The quantitative data indicate that the counselling was not associated with a reduction in symptom severity across most of the outcome measures collected at the 24-week follow-up point (Table 1). Sunil's RCADS total anxiety and depression score increased slightly by 3 at the end of counselling and rose after a further 12 weeks to 68 (+13). The YP-CORE score improved slightly during counselling; however, it deteriorated at 24 weeks from baseline. Sunil's YP-CORE score remained above the clinical cut-off. The SDQ Total Difficulties score deteriorated throughout counselling; however, the SDQ internalising score (emotional and peer problems) went down by 1 point at week 12. The WEMWBS improved slightly;

TABLE 1 Outcome measure data (raw scores)

	Baseline	Week 6—Midpoint	Week 12—Endpoint	Week 24—Follow-up
YP-CORE	24	21	20	28
RCADS-SV	53	56	56	68
SDQ	23	28	25	26
WEMWBS	37	40	40	47
RSES	15	17	18	14
ESQ	—	—	14	—

Abbreviations: ESQ, Experience of Service Questionnaire; RCADS-SV, Revised Children's Anxiety and Depression Scale-Short Version; RSES, Rosenberg Self-esteem Scale; SDQ, Strengths and Difficulties Questionnaire; WEMWBS, Warwick-Edinburgh Mental Well-being Scale; YP-CORE, Young Person's Clinical Outcomes in Routine Evaluation.

however, after 12 weeks, Sunil was still at the clinical cut-off for probable depression on the WEMWBS (Bianco, 2011). At 24 weeks, he was rated as having average mental well-being on the WEMWBS. Sunil's self-esteem, as measured by the RSES, got slightly better at 12 weeks; however, it decreased at 24 weeks, moving Sunil from normal levels of self-esteem to just below the cut-off for possible low self-esteem.

When asked what was good about his care (ESQ), Sunil wrote, 'That they were there to listen to me and that they also took it seriously'. This was also mentioned by Sunil in session 9: 'but it just helps talking, but even having someone there to talk, like having someone there to talk to about it and that helps out'. Sunil wrote on the ESQ form, when asked whether there is anything he did not like, 'I felt like at times they didn't ask me enough questions and that there was very little help'.

There was one change on the three RCADS-SV OCD subscale questions. Sunil's response to the 'I have to think special thoughts' item changed from 'always' to 'often'. However, responses to the other two subscale questions remained at 'always'.

Self-reported scoring (Goal based outcomes) across all three goals was a mean of 4.3 out of a possible 10 at the end of counselling.

3.2 | Qualitative outcomes: Session transcripts

Sunil talked about OCD extensively in sessions 1, 2 and 4. He mentioned it again, indirectly, in session 8. The themes of sessions 5–7 focused on the quality of a friendship, and his growing friendship group, as well as family. Session 8 was based mainly around an incident on his housing estate with a group of boys. Session 10 was a 'wrap up' session, where the counsellor introduced mindfulness.

Although Sunil's goals did not include direct reference to OCD, he explicitly expressed twice in sessions 1 and 2 that he would like help with his obsessive-compulsive difficulties, and that he wanted the OCD to stop in session 4. Throughout the sessions, Sunil referred to certain thoughts and behaviours as his 'OCDness' or 'OCD':

Sunil: Erm I don't mind, like, I have like some problems all over the place, I have problems with coming into school, and I just have worries all together and like OCDness, and socialising. (Session 1–04.33)

And,

Sunil: My family have to say, 'see you tomorrow too'. I know they don't want to because they want to try and break me out of this habit, that I've been doing with OCD, but I can't go to bed until they say, 'see you tomorrow'. Otherwise, I'm afraid I won't see them in the morning. Or they won't see me. (Session 2–13.00)

And,

Sunil: But the main thing I'd like to work on is to not worry as much, such as checking the doors let's say.

Counsellor: Yeah.

Sunil: And worried about my family and stuff, that's what I'd like to work on. (Session 2–22.24)

3.2.1 | Hypothesis 1

Through the 'necessary and sufficient' conditions, the counsellor may create a secure and safe space for the young person to explore what may be keeping them stuck in obsessive-compulsive patterns, such that they can re-connect with their actualising tendency.

Sunil and the counsellor were in psychological contact, Sunil was in a state of incongruence, and the counsellor effectively communicated these conditions to Sunil. The counsellor showed empathy throughout the sessions, was congruent and seemed to 'hold' Sunil unconditionally in high regard. This appeared to help Sunil explore difficult past memories and the processes behind his obsessive-compulsive difficulties that may have been keeping him 'stuck'. There were examples of these therapist-provided conditions throughout the transcript. Here is an example of empathy from session 4 when Sunil was talking about his OCD symptoms:

Sunil: I just want to go home.

Counsellor: You just want to go home, you want to feel ok.

Counsellor: Oh Sunil, this really upsets you doesn't it?

Counsellor: There's some tissue there. Use as much as you want. (Session 4–34.19)

In this last example, Sunil was distressed and spent most of the session stating that he wanted to go home, repeating it on seven occasions. A moment of counsellor immediate self-disclosure, an expression of congruence, happened in this session. As Sunil repeated that he wanted to go home, and was not able to engage in the conversation, the counsellor openly shared her internal experience:

Counsellor: There's nothing else, no one else can do or anyone else can do. I feel quite helpless I don't know how I can help you. I wonder if you feel helpless?

Sunil: Because I know I can't go home. (Session 4–52.52)

The counsellor showed Sunil unconditional positive regard throughout the counselling, most notably in sessions 1 and 2 when Sunil was describing his obsessions and compulsions. The counsellor listened and enquired in a way that offered acceptance and curiosity for what can be troubling behaviours in response to shameful obsessions (Weingarden & Renshaw, 2015). The counsellor, through curious exploration, seemed to help Sunil understand the function of his compulsions:

Counsellor: Before you actually go to bed. Mmm. And so, when you do those checks what did it do for you? What did you, what does it give you when you've done those checks?

Sunil: It just makes me feel, more like, that I can just relax and go to sleep now and things like that.

Counsellor: You feel relieved.

Sunil: Yeah. (Session 1–21.35)

From the transcript data and post-treatment questionnaires, it appears that the core conditions were received by Sunil and appreciated.

Early on in the relationship, Sunil was able to share some of his early memories that were concerning him, such as his mother's illness. The counsellor was attentive and actively listening (Rogers & Farson, 2015). Sunil gradually shared more around his worries about his family's safety and the theme of death, which may be linked with the harm worries he experienced as part of OCD. The counsellor, using the 'necessary and sufficient' conditions, helped Sunil to explore past experiences that seemed linked to his present obsessions:

Sunil: It's just really hard to talk about because obviously it's like a really touchy subject because your family and death, no one wants those two to actually mix.

Counsellor: Yeah.

Sunil: Because like yeah.

Counsellor: Of course, it's really scary, your family are really important to you.

Sunil: Yeah.

Counsellor: And the thought of something happening to them really frightens you.

Sunil: Yeah. Because I feel like the closest people, obviously they are the closest people, but I feel like because I feel like I'm not very social at school or anything and I feel like I don't have any friends, so they're like my only friends really as well. (Session 2–15.41)

The counsellor reflected Sunil's emotions back to him, helping him ease into his fears and worries, in a way that was non-judgemental. Sunil expressed that he did not have strong peer relationships and that

he relied heavily on his family. Later on, the counsellor reflected that, 'It sounds like they're your everything'. Sunil struggled with creating strong peer relationships, but also struggled with feeling safe in his family bonds due to worrying about their deaths. The counsellor focused on peer relationships from session 5 as a result of their discussion in session 4 of what a good friend is.

Sunil was able to share his obsessions and compulsions with the counsellor. In the first two sessions, Sunil delved deeper into the obsessive-compulsive worries, possibly due to the 'necessary and sufficient' conditions, and made connections in his understanding of his symptoms:

Counsellor: It's a thought.

Sunil: Yeah, but there's something inside my head that says this is stupid, why am I actually saying this because, like, they're all healthy there's nothing wrong with them.

Counsellor: Yeah, it's a thought. There's no...

Sunil: Yeah.

Counsellor: There's no basis behind worrying about it.

Sunil: Yeah, but I also think about my mum's really bad health condition. (Session 2–17.29)

The counsellor's reflecting of content and emotion led Sunil to reveal that there was, in fact, a possible driver to the worries of harm coming to his family, which was his mother's illness when he was younger. The safe, empathic therapeutic relationship appeared to make space for this disclosure and link between the obsession and the traumatic event in his childhood.

3.2.1.1 | Progress

Through the necessary and sufficient conditions, Sunil explored his friendships and the trouble he has with them; the counsellor's non-directivity seemed to help Sunil in this area. Towards the end of counselling, Sunil talked about worrying less due to having more friends; this moved Sunil positively in the direction of his third goal of making friends. In session 7, the counsellor enquired into what difference having friends has made to his worrying:

Counsellor: Mmm. It sounds really great. It sounds like you got less time to worry.

Sunil: Yeah.

Counsellor: How much of a difference do you think it's making?

Sunil: Like what?

Counsellor: On a scale of 1 to 10.

Sunil: Like 10 being the best and 1 being no difference?

Counsellor: Yeah.

Sunil: It might be sort of like a 7. (Session 7–21.33)

Sunil did not explicitly say it had improved his worrying in this second part. In session 7, when asked about his anxiety he rated it as 4 out of 10, whereas it was a 9 out of 10 at the start of counselling. Sunil went on to share his view of his worrying:

Counsellor: Ok, the sadness, the worrying.

Sunil: They're still there but I don't really have time for them at the moment.

Counsellor: Mmm.

Sunil: It may change in the future, let's say when it gets cold and no one really goes outside.

Counsellor: Mmm.

Sunil: So, it may be different then but I'm just going to think about now and deal with it when it comes.

Counsellor: Yeah.

Sunil: Yeah.

Counsellor: It sounds like you're thinking about what you might do to help.

Sunil: But for now, I'm just going to concentrate on this and take it one step at a time. (Session 7–23.07)

The counsellor reflected that Sunil was trying to think about what would help, but Sunil did not stay on this point. Despite Sunil saying in session that he was feeling less anxious, he stated that his obsessive-compulsive symptoms were still present, possibly suggesting that whatever was maintaining the symptoms had not shifted through counselling, or that his understanding of what was maintaining the OCD was still present. Sunil's positive reflection in session may be misleading, and when taking into account the outcome measures collected, a different picture emerges.

3.2.1.2 | Silence

Although the counselling relationship was warm and empathic, one area that may have affected the quality of the relationship was the long silences that appeared throughout the counselling, and primarily after session 2. In session 8, after 1 minute and 56 seconds of silence, the counsellor clarified with Sunil what these silences had been like for him:

Silence: (1 minute and 56 seconds)

Counsellor: Is this ok for you? Just sitting quietly like this?

Sunil: It helps sometimes just to be quiet.

Counsellor: How do you find it helpful?

Sunil: I don't know.

Silence: (2 minutes and 25 seconds). (Session 8–23.43)

Sunil suggested that he was comfortable with the periods of silence. However, in session 10, when asked about what was not helpful in counselling, Sunil clarified his feelings about the silence:

Counsellor: There wasn't anything bad did you say?

Sunil: Yeah. The only thing that I found weird was when we had that awkward stage of being silent.

Counsellor: Ok.

Sunil: I felt very awkward.

Counsellor: When?

Sunil: In the sessions where we had a period of just being silent, I didn't know what to say. (Session 10–34.07)

Sunil stated that it can be nice to sit in silence; however, as this followed his admission that it was awkward for him, he may have said the latter to not offend the counsellor. The counsellor only checked Sunil's feelings about the periods of silence in session 8, and not earlier sessions. The counsellor, we assume, based on person-centred practice, was adhering to being non-directive and letting Sunil speak when he wanted to throughout counselling.

Silence may be therapeutic for some, especially if the counsellor and client remain in psychological contact. This was hard to identify in the case of Sunil, however, without video evidence of the sessions, and Sunil indicated that he found the 'awkward' silences 'weird'. This may have made it more challenging for Sunil to stay in psychological contact. In addition, in his ESQ feedback, Sunil said that the counsellor had not asked enough questions, 'I felt like at times they didn't ask me enough questions and that there was very little help'. It is possible that these silences could have been more helpfully filled with more process-guiding questions in the area he asked for help in—his obsessive-compulsive symptoms.

3.2.1.3 | Outcome

The counselling relationship appeared strong, and the conditions were audibly present. Themes of friendship were explored, such as what makes a good friend and Sunil's lack of friends. Sunil shared two painful historic events involving friends, and his experiences of developing friendships. Sunil shared stories of his improved social functioning towards the end of counselling; however, this did not seem to impact his obsessive-compulsive difficulties in the long term, post-treatment. In the early stages of the counselling, Sunil mainly talked about these difficulties with friends. The counsellor made attempts at helping Sunil understand his emotions and thoughts, but no conclusions were made or action taken. Sunil was able to establish a possible connection between his mother's illness and his worries about his family's safety. As a result, we conclude that the counselling relationship did not have an impact on his obsessive-compulsive difficulties.

3.2.2 | Hypothesis 2

Offering process-guiding tools for how the young person can get unstuck from OCD will support them in that process.

In Sunil's ESQ feedback on the counselling, he stated that, 'I felt like at times they didn't ask me enough questions and that there was very little help'. There is no indication of which areas Sunil wanted more questions asked about; however, he explicitly expressed twice in sessions 1 and 2 that he would like help with his obsessive-compulsive difficulties, and that he wanted the OCD to stop in session 4. Here is an example:

Sunil: But the main thing I'd like to work on is to not worry as much, like checking the oven let's say.

Counsellor: Yeah.

Sunil: And worried about my family and stuff, that's what I'd like to work on. (Session 2–22.24)

The two times the counsellor was directive towards Sunil's self-described obsessive-compulsive difficulties seemed to be received well by the client. The two process-guiding suggestions aimed at soothing his anxiety received varying degrees of responsiveness. Sunil had previously mentioned how nature was soothing for his anxiety in session 2. The counsellor offered a process-guiding suggestion of spending time in nature at the end of session 6. Sunil appeared warm to the idea. However, in future sessions Sunil did not say whether he tried out this idea, and the counsellor did not ask. In session 10, the counsellor offered Sunil four mindfulness exercises as a way to soothe his anxiety. Sunil appeared enthused and took part in each exercise which took up the majority of the session. After one of the exercises, Sunil stated:

Sunil: That was really calming.

Counsellor: Yeah, so again how do you think you might use that one?

Sunil: Let's say I'm on like a train or something and I start being panicky maybe.

Counsellor: Mmm.

Sunil: I can just calm myself down. (Session 10–23.58)

When asked in session 10 what Sunil would take away from counselling, he said:

Sunil: Well, these exercises and I'll probably take away that I know that there will always be someone that I can talk to. (Session 10–36.27)

Here, Sunil stated that he would keep the mindfulness exercises in mind and continue with them, and this may be because they are fresh in his mind; however, consideration needs to be given to the idea that these practical tools were effective at calming his anxiety.

3.2.3 | Additional findings

Additionally, two other observations were noted through the analysis stage that do not fit into the two hypotheses, but are worth cautiously noting for consideration.

3.2.3.1 | Enabling compulsions

First, the counsellor offered reassurance on many occasions. From the CBT lens of OCD, compulsions such as reassurance seeking (client) and giving (counsellor) maintain the OCD cycle (Abramowitz et al., 2009; Houghton et al., 2010; Veale, 2007). Although this was a study of humanistic counselling, the literature on the maintenance of OCD symptoms is extensive. On many occasions when Sunil was expressing his worries, the counsellor sought to reassure

him, which may have given Sunil temporary relief, but is hypothesised not to break the OCD pattern in the long term, but, rather, negatively reinforces the behaviour (Law & Boisseau, 2019) in terms of operant conditioning. In session 4, when Sunil was distressed about the safety of his family, the counsellor directly asked if he knew any ways to reassure himself:

Counsellor: Do you think there are other ways you can reassure yourself that your family are ok?

Sunil: I don't know. (Session 4–10.01)

3.2.3.2 | OCD symptom-specific measures

The second observation was around the disparity between the way Sunil spoke about his obsessive-compulsive difficulties in session and the results of his outcome measures. Sunil shared in session 7 that having friends had impacted his worries positively, although they were still present, and in session 10 he rated his distress as a 4 out of 10, compared to 9 out of 10 at the start of counselling. However, in the outcome data, specifically the RCADS OCD subscale questions, there was very little movement. Using only the session data, such as the client's feedback, may result in counsellors missing the wider potency of symptoms which are still present. The potential use of an age-specific OCD-specific subscale such as the CY-BOCS (Scahill et al., 1997) or RCADS OCD subscale (Ebesutani et al., 2012) may help monitor symptoms more closely throughout the counselling.

4 | DISCUSSION

Our analysis of the case of Sunil suggests that brief humanistic counselling was not effective at reducing Sunil's obsessive-compulsive difficulties. Our findings support Elliott's (2016) argument that person-centred counselling needs to improve to better serve people with anxiety difficulties. This case study tentatively details these findings and their possible implications for practice.

Hypothesis 1: Through the 'necessary and sufficient' conditions, the counsellor may create a secure and safe space for the young person to explore what may be keeping them stuck in obsessive-compulsive patterns, such that they can re-connect with their actualising tendency.

We found in the case of Sunil that trauma was potentially present, in the form of his mother's illness when he was young, as well as Sunil sharing two distressing memories of conflicts with friends. The two main issues he presented with were OCD and friends. The hypothesis was that the necessary and sufficient conditions would help Sunil to explore anything that may be keeping him stuck. Sunil was able to share these difficult experiences; however, due to the non-directive nature of the counselling, he was not brought back to the experiences. In particular, his mother's illness was not revisited after session 2.

Additionally, we noted that the silences in the sessions were received as 'awkward' and 'weird' by Sunil (session 10) which we postulate may have negatively impacted the relationship and outcome. Regev et al. (2016) found that, in art therapy, complete silence was often negatively experienced by the client when no art material was present. Hill et al. (2003) suggested that humanistic counsellors use silence to show empathy, respect and support. We do not know if Sunil felt this, but he did express that it was awkward. Hill et al. (2003) found that humanistic counsellors were more willing to use silence across a range of conditions; they suggest this may be because the principles set out by Rogers (1957) do not focus on diagnosis. In brief counselling, the session time is precious and should be treated as such. Removal of long silences would have allowed for more questions, and a little more direct questioning towards the obsessive-compulsive difficulties, an area Sunil asked for help in. Specifically, when counselling adolescents, there is a power imbalance due to the counsellor-client relationship, but also due to age. Adolescence is an important developmental time; counselling needs to reflect this importance, and, based on this data, it is recommended that counsellors should not fill brief counselling with silence unless the client specifically asks for it. Silence, although an acceptable part of humanistic counselling, may not be effective for this clinical population, and more attempts should be made to check in on what the silences are like for the young person.

After session 4, Sunil did not bring up his obsessive-compulsive difficulties as an area of focus, although he did state in session 7 that the symptoms were still there. OCD can be episodic (Tükel et al., 2007), which appeared to be the case for Sunil. Sunil did not discuss his obsessive-compulsive difficulties in any meaningful way after session 4, where he was distressed and just wanted to go home. At the end of session 4, the counsellor reminded Sunil that he could choose what he wanted to discuss in the sessions; however, the counsellor did suggest it may be worth exploring why it is challenging for Sunil to get to school in the mornings in future sessions. This open direction may have informed Sunil about the future direction of sessions, for example, what is worth sharing, and what is not. Sunil may have felt that there was little help for his obsessive-compulsive difficulties from the counselling, so he switched to discussing friendships. This would potentially align with his ESQ feedback that, 'they didn't ask enough questions'. Instead of focusing on the obsessive-compulsive difficulties, the counsellor explored Sunil's friendships. This seemed to help Sunil as he reported having more friends towards the end of counselling, which is an important aspect for adolescent development. Session 3 was not recorded, and this preceded the distress Sunil showed in session 4 regarding his worries. Sunil may have shared more about his obsessive-compulsive difficulties in session 3, and not felt reassured about the normalities of intrusive thoughts and compulsions. This would explain the complete shift in emotional dysregulation between session 2 and 4. However, without hearing session 3, this is just a hypothesis.

Hypothesis 2: Offering process-guiding suggestions for how the young person can get unstuck from OCD will support them in that process.

Humanistic and non-directive person-centred therapies have come under question recently. This non-directivity is characterised by Rogers's popular statement, 'It is the client who knows what hurts, what directions to go' (1961, p. 11). This statement may be true for some clients; however, in the case of Sunil, it did not seem to be. Sunil wanted direction. Adolescents may require more direction as they are figuring out who they are, and the world around them. Jackson (2021) suggested that process-guiding was an important aspect in recent humanistic trials, and was appreciated by participants. Elliott (2016) found that process-guiding person-centred therapies are, on average, slightly more effective than non-directive therapies. Although it may be controversial to consider adding elements of directivity into humanistic counselling, what could be considered more controversial is not incorporating directivity in certain situations, based on the wider evidence. Process-guiding can be delivered in a person-centred way through offering suggestions and asking questions to help the client come up with their own suggestions. This may open the conversation to solutions in a non-directive way.

4.1 | Limitations

This analysis is of a single case, and, therefore, insights are to be drawn cautiously. Case studies, although rich in insight, are open to researcher biases. The biases for this study include the principal researcher having experienced OCD in adolescence and having an ongoing interest in the area, as well as humanistic counselling and CBT. However, the second author is an advocate of relational, rather than cognitive-behavioural, approaches and was motivated to find the intervention effective for Sunil's obsessive-compulsive difficulties. Overall, we believe a strength of this paper is that we came to our analysis with relative equipoise and, if anything, were emotionally invested in substantiating hypotheses that were, in fact, disconfirmed by our findings.

Additional limitations of the study include the counselling being affected by a reduction in weeks: 10 sessions occurred over 8 weeks. This resulted in sessions 2 and 3 and sessions 7 and 8 being on the same school days. The counselling did not benefit from the between session time that it would have had over 10 weeks. Session 3 was not recorded, and this left out data to be analysed. Another key limitation is that the client did not have an OCD diagnosis, and the characterisation of his difficulties is based on the researchers' experiences and available data.

4.2 | Suggestions for further research

Further brief humanistic cases should be examined using similar and different methods to test the generalisability of the findings of this study, as well as further the exploration of what aspects of humanistic counselling may be effective for adolescents with OCD, and what aspects may not be. A multiple baseline design with change interviews at the end of counselling could be used

to test brief humanistic counselling across three or more participants. This would increase the amount of young people receiving the counselling, while offering qualitative insights into what worked or did not. Longer term humanistic counselling should be researched for OCD. This may be a more accurate test of humanistic counselling's effectiveness for treating OCD, as it gives time for the therapeutic relationship to impact the young person. We propose future trials may build on the findings from this first attempt at developing a humanistic practice for young people experiencing obsessive-compulsive symptoms. These adaptations might include keeping silences to a minimum, offering process-guiding suggestions, including psycho-education on the maintenance of OCD and the ego-dystonic nature of intrusive thoughts, not enabling compulsions, and using obsessive-compulsive symptom-specific outcome measures.

4.3 | Implications for practice

The following implications for practice are offered tentatively, as they are based on a single case.

Young clients experiencing obsessive-compulsive difficulties may need more direction than is typical in non-directive person-centred therapy. Silences could be reduced, or used more strategically. Where possible, compulsive behaviour in session should not be encouraged. Reassurance seeking will likely be the most common compulsion between client and counsellor. The counsellor should refrain from getting caught in an OCD cycle of reassurance seeking. Counsellors could educate themselves on good practice with people with obsessive-compulsive symptoms to be alert to how compulsive symptoms may play out in the relationship. Where possible, OCD-specific outcome measures could be utilised to confirm that what the client says matches the reality of their symptoms.

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CONFLICT OF INTEREST

The authors have no financial interest or benefit from the direct applications of this research.

ETHICAL APPROVAL

Ethical approval for the trial has been obtained by the University of Roehampton, Department of Psychology, Ethics Committee (PSYC 16/ 227, 31 August 2016). Informed consent to participate in the study is obtained from all young people and their parents/carers before they take part in the study. The principal researcher for this case

study sought ethics approval from the Department of Psychology at the University of Roehampton, which was approved on 15 October 2020.

DATA AVAILABILITY STATEMENT

Data used in this study are from the ETHOS trial. External agencies can request data using the University of Roehampton's data sharing policy and application form available at: <https://www.roehampton.ac.uk/ethos/>.

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