THE RELATIONSHIP BETWEEN FAMILY OF ORIGIN ENVIRONMENTAL FACTORS AND SEVERITY OF OBSESSIVE-COMPULSIVE RELATED SYMPTOMS

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The Relationship Between Family of Origin Environmental Factors and Severity of Obsessive-Compulsive Related Symptoms

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DEDICATION

This thesis is dedicated to all of those

who suffer from obsessive-compulsive disorder

or impulse-control disorders. It is also

dedicated to their families.

LIST OF ABBREVIATIONS

Achievement Orientation. . . . . AO

Active-Recreational Orientation . . . . . ARO

Adult Children of Alcoholics . . . . . ACOA

Cohesion C

Conflict . . . . . Con

Control . . . . . Ctl

Diagnostic and Statistical Manual of Mental Disorders . . . . . DSM

Expressed Emotion . . . . . EE

Expressiveness . . . . . Ex

Family Environment Scale- Form R. . . . . FES-R

Independence . . . . . Ind

Intellectual-Cultural Orientation . . . . . ICO

Moral-Religious Emphasis . . . . . MRE

National Institute of Mental Health . . . . . NIMH

Obsessive-Compulsive Disorder. . . . . OCD

Obsessive-Compulsive Personality Disorder . . . . . OCPD

Organization. . . . . Org

Positron Emission Tomography . . . . . PET

Trichotillomania . . . . . TTM

Yale-Brown Obsessive-Compulsive Scale. . . . . Y-BOCS

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Abstract

Just as Wegscheider-Cruse (1989) recognized alcoholism as a "family disease," this study was interested in the possibility that obsessive-compulsive related disorders should be viewed similarly. The term, expressed emotion (EE), refers primarily to emotions of criticism, emotional overinvolvement, and overprotectiveness (Brown et al., 1962; Hoover & Insel, 1984; Miklowitz et al., 1986a; Hibbs et al., 1993). Hoover and Insel (1984) identified higher levels of EE among families of obsessive-compulsive patients. Hibbs et al. (1993) suggested that high EE could negatively affect the course of mental illnesses. This study expanded this concept by considering impulse-control disorders as well. The two primary purposes of this research were: A) to determine if patients with obsessive-compulsive related disorders experienced different family dynamics than a comparison group, and B) to determine what, if any, family of origin environmental factors were related to severity of symptoms. Twenty-two patients completed the Yale-Brown Obsessive-Compulsive Scale to assess severity of symptoms and the Family Environment Scale-Form R (FES-R) to assess family dynamics. Fifty-seven college students served as a comparison group. Seven of the ten FES-R subscales, including Cohesion, Expressiveness, Conflict, Independence, Intellectual-Cultural Orientation, Active-Recreational Orientation, and Control, displayed significant differences between the patient and comparison groups. Perceptions of increased Control appeared to be somewhat related to greater perceived symptom severity whereas Independence and Active-Recreational Orientation were nearly associated with a

perception of decreased symptom severity. Suggestions for therapy were focused upon changing the unhealthy family behaviors identified in this study. Behavioral and drug therapies, along with family therapy, appeared to be the most appropriate treatment for patients with obsessive-compulsive related disorders.

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CHAPTER I

INTRODUCTION

In recent years, obsessive-compulsive disorder (OCD) has received an increasing amount of attention from researchers in the fields of psychiatry, psychology, and social work. Zohar, Insel, and Rasmussen (1991) claimed that monthly publications of OCD related articles in scientific journals have increased by 300% since the early 1980s. Debate concerning the cause of OCD, along with the rising number of reported cases and improved treatments, explains the growing interest from such a variety of professionals (Rapoport, 1989). The Diagnostic and Statistical Manual of Mental Disorders III-R (American Psychiatric Association, 1987) tended to attribute mental disorders to multiple factors, including genetic, chemical, and environmental influences. However, the DSM-IV (American Psychiatric Association, 1994) spoke only briefly about the causality of mental disorders. When familial pattern was discussed, it was focused more upon genetic possibilities than environmental concerns. Despite the lack of certainty surrounding the potential causes of mental illnesses, the current research intends to question the wisdom of neglecting this issue. When considering the development of OCD, Riddle et al. (1990) seemed to consider the contribution of the familial environment to be a significant factor.

Family dynamics have represented a topic of psychological interest since the days of Freud. Although Freud did not formally refer to family dynamics, he noted his observations involving relations among family members (Engler, 1985). This is particularly relevant in his discussion of the psychosexual stages of development where parents and children experience conflict over control issues. Freud claimed that any

unresolved issues would be likely to result in a poorly functioning adult who was not equipped for a productive, enjoyable life. Furthermore, Freud's theory of personality seems to consider the development of a mental illness to be a result of such family dysfunction.

More modern theorists have significantly expanded current ideology and literature surrounding family dynamics. According to prominent theorist and practitioner, Satir, the term "family dynamics" indicates the functionality of the family (Wegscheider-Cruse, 1989). Freud's view of mental disorders as stemming from family dysfunction had become fairly widely accepted. This belief is presently under attack because it implies blame. The media has dubbed this tendency to blame as the "abuse excuse." The term, "family disease," seems to be increasing in popularity as it acknowledges that all family members are somewhat accountable for their family's level of functioning.

Wegscheider-Cruse (1989) has become a popular name in the literature concerning alcoholism as a family disease. Her work has offered a description of the dysfunction which occurs among families afflicted by addiction. She explained that family members adopt various roles, including enabler, hero, scapegoat, lost child, and mascot. These roles are considered unhealthy, but adaptive. Wegscheider-Cruse's work is of great interest because it suggested that the mental illness led to the creation of the dysfunctional family dynamics. For instance, in the alcoholic family, the individual roles are considered a response which allows the person to cope with the mental illness of a

family member. Although it constitutes an adaptive coping strategy, it is considered unhealthy because the roles generally continue into relations throughout the affected person's life. Wegscheider-Cruse explained that this long-term effect is often of a negative nature. She has recommended a technique called Family Reconstruction which was pioneered by Satir.

Wegscheider-Cruse has adapted her own form of Family Reconstruction targeted at adult children of alcoholics (ACOAs). Her workshops are "designed specifically to address and intervene in the disease of co-dependency"; they involve intensive role-playing and require much preparation (Wegscheider-Cruse, 1989, p. 260). Since alcoholism is now considered a "family disease," more traditional family therapies have also been recommended for ACOAs (Brown & Lewis, 1995; Schmid, 1995). The current study argues that OCD and impulse-control disorders are also family diseases which could benefit from similar forms of family therapy.

CHAPTER II

LITERATURE REVIEW

Obsessive-Compulsive Disorders and Impulse-Control Disorders: Related Illnesses?

Before proceeding with a discussion of family dynamics, it seems necessary to describe obsessive-compulsive disorders and impulse-control disorders. Although these disorders are not identical, they possess striking similarities which have prompted a controversy concerning their proper classification (Rapoport, 1989). Research on OCD appears to be more available as impulse-control disorders had been neglected until the early and mid-1990s (Swedo & Leonard, 1992). Due to the similar characteristics of the two disorders and the long history of omitting impulse-control disorders from research, both will be included in the current study.

In 1956, Pollitt applied both cognitive and behavioral theories when he developed a definition of OCD. He described OCD as:

> "...a recurrent or persistent idea, thought, image, feeling, impulse, or movement which is accompanied by a sense of subjective compulsion and desire to resist it, the event being recognized by the individual as foreign to his personality and into the abnormality of which he has insight" (Mavissakalian, 1985, p. 50).

Although this definition is very descriptive and probably quite insightful for 1956, Foa and Tillmanns suggested some revision. Therefore, in 1980, they defined "obsessions" and "compulsions" in a manner which portrayed the functional relationship between the two. Obsessions were "thoughts, images, or actions that

generate anxiety," compulsions were "attempts to alleviate anxiety aroused by obsessions and take forms of overt actions or covert cognitive events" (Mavissakalian, 1985, p. 50-51). This definition serves as an improvement in that it enables one to recognize that compulsions are actually purposeful responses to obsessions.

The primary characteristics associated with OCD, as noted by the DSM-IV (American Psychiatric Association, 1994), are very similar to those mentioned in the stated definitions. The DSM-IV classifies OCD as an anxiety disorder where one experiences a recurrent failure to resist impulses, an increase in tension prior to acting out one's compulsions, and a sense of relief or gratification afterwards. True cases of OCD do not involve a greater psychotic episode, hallucinations, or delusions.

In her book entitled The Boy Who Couldn't Stop Washing, Rapoport (1989) of the National Institute of Mental Health in Bethesda, Maryland, spoke of the incredible normalcy of people with OCD. She commented, "I found them 'normal' and easy to deal with" (Rapoport, 1989, p. 84). The absence of a major psychosis among OCD patients appears to be part of the bizarre nature of this illness. Rapoport (1989) and Steketee (1993a) agree that the majority of those suffering with OCD have good levels of insight into the irrationality of their obsessive thoughts and compulsive rituals.

Although insight is considered helpful in treatment, it can create fears and further complications for the sufferer. He or she especially fears that others will consider him or her crazy ("Obsessive-compulsive," 1992). Thus, the OCD patient usually remains very secretive about the obsessions and compulsions. In fact, the secrecy

involved with this particular disorder is so pervasive that it accounts for the former belief that the illness was rare (Swedo, 1992). This secrecy is generally maintained by performing the rituals only at home or in a place which offers solitude (American Psychiatric Association, 1994). However, current studies and awareness have led to the discovery of numerous cases of OCD.

Current researchers suggested that the prevalence of OCD varies between two and three percent (Rapoport, 1989; Zohar, Insel, & Rasmussen, 1991; American Psychiatric Association, 1994). Zohar et al. (1991) indicated that this represents an increase of 40 to 50 times what was traditionally taught to students of psychiatry. Cooper (1993) estimated four to six million cases. According to Rapoport (1989), approximately three percent of the United States' population may suffer from OCD. This three percent is thought to include males and females equally despite the fact that each sex may be more prone to specific forms of OCD. Steketee (1993a) noted a sex difference in the age of onset for OCD. Males tended to display symptoms at a younger age than females. Whereas the average age of onset is documented as being between 19.3 to 25.6 years, males were more likely to exhibit symptoms during their adolescence. Sex differences and the specific variations of OCD will increase in relevance and will be addressed in slightly more detail during the description of impulse-control disorders.

Due to the upsurge of research on OCD, new data concerning content of obsessions and compulsions, the course of the illness, the characteristics of the sufferers,

and problems related to their illness have been recorded. An especially interesting fact regarding obsessions and compulsions is that their content appears to have changed with the times (Rapoport, 1989). Whereas obsessions involving religious themes, or scrupulosity, were once extremely popular, today's typical obsessions are more likely to focus on dirt, contamination, violence, or aggression. In a study of 200 patients, Rasmussen and Eisen (1991, p. 18) found contamination to be the most common obsession, followed by "pathologic doubt, somatic concerns, need for symmetry, aggression, sexual, and other miscellaneous, multiple obsessions." Common compulsions, which relieve one's anxieties in such areas, include checking, washing, counting, cleaning, touching, ordering and arranging, hoarding, and confessing (Rapoport, 1989). Rasmussen and Eisen (1991) also indicated washing, checking, and counting to be the most common rituals. For instance, someone who has obsessions about contamination with germs might bathe themselves or cleanse their homes excessively.

A point of interest about the illness' course involves the onset. The mean age of onset, 19.3 to 25.6 years, was previously discussed; however, it is important to realize that it can develop at any point throughout life, especially if stressors are severe (Steketee, 1993a). Current research seemed to support the idea that sufferers who develop obsessive-compulsive symptoms especially early, such as in childhood, might outgrow them. On the other hand, when symptoms develop at anticipated times and are chronic, the person will typically endure a progressive deterioration in their ability to

function ("Obsessive-compulsive," 1992).

Rasmussen and Eisen offered four terms to describe the course of OCD. They reported that the course could be "episodic, continuous, chronic with waxing and waning, and deteriorative (Rasmussen & Eisen, 1991, p. 18)." Rapoport (1989) also made frequent reference to the "waxing and waning" of OCD symptoms. These terms mean that symptoms may come and go. They may be almost nonexistent or actually disappear for an undetermined period of time, but then they may return with varying intensity. Since OCD is classified as an anxiety disorder, a correlation between a return of symptoms and onset of a stressor has been suggested. Rasmussen and Eisen (1991) offered support for this idea. Of 200 OCD patients, 72% were considered to exhibit symptoms of a chronic waxing and waning nature. Sixteen percent displayed a continuous course; 9%, deteriorative course; and 3%, episodic course. The majority of the 200 subjects agreed that stressful life events, even the menstrual cycle in women, negatively affected their obsessive-compulsive symptoms. Once again, a person with an obsessive fear of germs would likely increase their disinfecting rituals when contemplating an impending divorce or change in employment status.

Finally, OCD can result in mild to severe impairment (Rapoport, 1989; Baer, 1991; "Obsessive-compulsive," 1992). The severity of symptoms may be further complicated by comorbidity, or dual diagnoses (Steketee, 1993a). Some commonly co-occurring illnesses include depression, body dysmorphic disorder, hypochondriasis, mitral valve prolapse, panic disorder, substance abuse, social anxiety, personality

disorders, and other impulse-control disorders (Rapoport, 1989; "Obsessive-compulsive," 1992; Steketee, 1993a). The data concerning comorbidity sometimes seems conflicting. For instance, E. C. Dimitriou, Lavrentiadis, and C. E. Dimitriou (1993) indicated that comorbidity rates of OCD with alcohol abuse averaged around 26.1% which was considered high. Yet, while two prominent researchers of OCD claim that depression is the most frequently cited comorbid symptom, Black et al. (1993) claimed that 52% of their sample displayed at least one personality disorder. Regardless, one of the largest contributors to the actual impairment from OCD is the amount of time and energy that it consumes. Rapoport (1989) claimed that lengthy efforts at performing rituals may cause frequent lateness or social withdrawal. Therefore, maintaining employment or relationships might prove to be difficult. Hospitalization may even be necessary when OCD symptoms or comorbid symptoms become unmanageable.

According to Rapoport (1989) and Steketee (1993a), depression is the most commonly cited complication with OCD. Steketee (1993a) mentioned a study where 28% to 38% of subjects reported experiencing a dual diagnosis of OCD and major depression. With any case of depression, suicidal ideation is always a concern. But, Steketee (1993) claimed that it was considered unusual for OCD patients to experience suicidal thoughts, or even to attempt suicide. Most researchers also agree that personality disorders are likely to be identified in OCD patients (Rapoport, 1989; Steketee, 1993a). Of course, OCD has been associated with obsessive-compulsive personality disorder (OCPD) for a long time. Surprisingly, Steketee (1993a) reported

that less than 25% of OCD cases involve OCPD. She indicated that avoidant, dependent, and histrionic personality disorders are more frequently co-existing with OCD. Regardless of the type of personality disorder associated, Steketee suggested that these people are likely to experience more severe impairment and poorer prognosis. In acknowledgment of the entire continuum of severity, Rapoport (1989) appreciated the fact that, despite their illness, many OCD sufferers are very successful people who are greatly devoted to their occupations and professions, as well as to their relationships.

At various points throughout this discussion, reference has been made to impulse-control disorders and their similarity to OCD. They were previously mentioned as being potentially comorbid with OCD; however, they often exist without any further obsessive-compulsive symptoms. The DSM-IV (American Psychiatric Association, 1994) categorized these illnesses as impulse-control disorders not elsewhere classified. As these disorders begin to receive their fair share of research attention, it seems likely that a future revision of the DSM may classify them as anxiety disorders in a section titled, obsessive-compulsive spectrum disorders (Swedo, 1992). At this time, intermittent explosive disorder, kleptomania, pyromania, pathological gambling, trichotillomania, and impulse-control disorder not otherwise specified are listed as impulse-control disorders not elsewhere classified (American Psychiatric Association, 1994).

Of the stated impulse-control disorders, trichotillomania, or compulsive hair pulling, appears to be the first illness, other than pathological gambling, to demand

research attention. According to Swedo (1992) and Rapoport (1989), patients with trichotillomania (TTM) were the first to raise the question of the relationship between TTM and OCD. In March of 1987, ABC News aired a "20/20" television segment which highlighted OCD. The National Institute of Mental Health (NIMH) received an onslaught of phone calls from women who insisted that their symptoms of TTM fit the description and mirrored the stories told by OCD patients (Swedo, 1992). Hesitantly, NIMH agreed to include TTM in some of their OCD studies.

The results of these studies confirmed the likeness claimed by the TTM patients and even suggested similar treatments. (Rapoport, 1989; Swedo, 1992; Swedo & Leonard, 1992). Swedo and Leonard (1992, p. 788) claimed that the "comorbidity, drug response, familiality, and phenomenology of the disorder (TTM) extend the concept of OCD to a spectrum of inappropriately released, excessive grooming behaviors." TTM patients displayed levels of insight equivalent to that of OCD patients; they recognized the irrationality of hair pulling to relieve tension. TTM is usually thought to begin in early adolescence. Although this is somewhat earlier than most OCD symptoms begin, the course appears almost identical in that it is typically a chronic condition with waxing and waning of symptoms (Rapoport, 1989; Swedo & Leonard, 1992; Swedo, 1992). Like the various forms of OCD, sex differences are apparent with impulse-control disorders. TTM is most commonly seen in females; whereas, males more frequently experience pyromania (American Psychiatric Association, 1994). Although the cause of TTM is not certain, similar biological theories appear to be extremely likely as some cases

responded to clomipramine (Anafranil). For both OCD and TTM, a combination of drug therapy and behavior therapy seems to provide the greatest benefit (Rapoport, 1989; Swedo, Lenane, & Leonard, 1993).

The Role of Etiology in Determining Treatment

In the past, more credit was given to learning theories in explaining OCD. Obsessions and compulsions were believed to be reinforced (Rapoport, 1989). Reinforcement could occur purposely or by chance. If a person experienced obsessions concerning the fear of contamination, then he or she might feel compelled to wash, which is the most common of all compulsions, based upon Rapoport's studies. The person finds that compulsive washing relieves the tension that the fears had caused. Thus, this person learned through reinforcement that compulsive washing allowed him or her to temporarily overcome fears.

Although this theory may apply to some cases, recent research efforts, especially at NIMH, provided strong support for biological theories (Rapoport, 1989; Swedo & Leonard, 1992). Several case histories and studies point to brain abnormalities as the cause of OCD. Peterson (1989) spoke of a severe case of OCD which received much attention in 1988. This case involved a man who decided that he had rather die than continue to live with severe obsessive-compulsive symptoms. He responded to the pain of his illness by shooting himself in the head. Amazingly, the man survived and was no longer plagued by OCD. His mental abilities even remained intact. Whatever damage the bullet did apparently cured him. Thus, this was interpreted as evidence for biological

theories of brain abnormality or chemical imbalance.

Another recent study scanned the brains of eight patients both before and after treatment with clomipramine ("Local cerebral," 1991). When patients responded well to the drug therapy, scans displayed that the brain metabolism had returned to more normal levels in several areas. These areas included portions of the orbital frontal cortex, the caudate nucleus, and the basal ganglia. Rapoport (1989) also cited abnormalities in the frontal lobe and the basal ganglia in her sample of OCD patients.

A study employing behavior modification and the use of fluoxetine (Prozac) supported the findings of brain abnormalities in the caudate nucleus as well. After ten weeks of both Prozac and reconditioning, two-thirds of the patients improved ("Faulty circuits," 1992). Apparently, a normal caudate nucleus acts as a filter for anxious feelings from the orbital cortex and sends only the significant ones to the thalamus for appropriate response. As these patients improved, metabolic activity in the caudate nucleus declined.

These findings were paralleled by a similar study. This one even went one step further and explained that the caudate nucleus regulates impulses of aggression, sex, and objects of disgust ("Brains yield," 1992). This offered a theory of how drug treatment works for this disorder. First, the drug affects the caudate nucleus. Impulses are slowed. Then, the orbital cortex is affected. Surprisingly, this study also showed that not only drugs, but also behavior therapy could change the brain's metabolism.

These studies provided additional support for Rapoport (1989) and Swedo and Leonard's (1992) claims that drug and behavior therapy work best when combined. Any

time when two therapies are used simultaneously to treat one disorder, a debate arises. As one can see from current research, drug treatment holds the spotlight. Rapoport (1989) strongly advocated this approach for both OCD and impulse-control disorders. She is particularly fond of the use of clomipramine (Anafranil), and she claimed a 70% success rate for it. She also noted that lithium might enhance the effects of this drug. A 1991 study of the efficacy, safety, and tolerability of clomipramine claimed that the drug received superior ratings by both patients and physicians as OCD symptoms improved any where from 38 to 44%. ("Clomipramine in the," 1991).

Despite the level of success with drug therapy, behavior modification still plays an integral role in the treatment of OCD. Some, of course, believe that it should be the primary treatment. Spiegel (1992) argued that behavior therapy increases the benefits of drugs therapy and decreases relapse rates. In fact, he even suggested that drugs can only work if there is some exposure to cues that would set off one's obsessive-compulsive symptoms. Thus, he recommended that behavior therapy always be combined with drug treatment with an emphasis placed upon exposure and response prevention.

Familial Contribution to OCD and Impulse-Control Disorders

As the review of recent research indicated, biological theories have dominated the attempt to explain the cause of OCD, as well as impulse-control disorders. It seems likely that Rasmussen and Eisen (1991) would be correct in their assumption that Freud would have viewed the cause of OCD differently if today's knowledge of genetics and neurobiology had been available. Due to the strong support for biological theories, the

cause of OCD and impulse-control disorders will not be debated from a familial environment perspective. However, as previously stated, the current research does intend to describe these two illnesses as "family diseases." Spiegel (1992) made it clear that drug therapy alone may not be sufficient to prevent relapse. His view gained support from the role that anxiety and stress play in maintaining these illnesses (Rapoport, 1989; Baer, 1991; Steketee, 1993b). Oppenheim and Rosenberger (1991) exhibited the effectiveness of family therapy and an object relations approach in treating OCD. Although family dysfunction does not appear to account for the development of OCD, it seems that family dynamics could partially determine the course of the illness.

In many families where children have developed psychiatric illnesses, a history of parental psychiatric illness will often be present as well. Hibbs, Hamburger, Kruesi, and Lenane (1993) conducted a study of children with OCD and disruptive behavior disorder. It was discovered that 79% of their parents displayed some form of psychiatric difficulties whereas only 26% of the parents of the control subjects experienced psychiatric illness. Not only does this fact provide additional support for genetic theories, but it also seems to suggests a stressor which could possibly influence family dynamics.

"Expressed emotion" was a term coined by Brown, Monck, Carstairs, and Wing (1962) in their study of the effects of family stressors on schizophrenic patients. It was defined as the level of a relative's attitudes concerning overprotectiveness, emotional overinvolvement, and criticism. Hibbs et al. (1993) reported that expressed emotion is

generally high among families dealing with mental illness, including OCD. High expressed emotion among families affected by a child's OCD commonly develops as a result of parental psychiatric issues. For instance, psychiatric illness among fathers was a predictor of high expressed emotion. For mothers, several areas of psychiatric difficulty contributed to high levels of expressed emotion. Affective disorders, a child's illness, or greater hostility were cited as examples of the mothers' issues.

Expressed emotion is considered to be a major predictor of a chronic course with fewer remissions and a greater proneness to relapse of symptoms of a mental illness (Hibbs et al., 1993). According to Miklowitz et al. (1986), schizophrenic patients who left the hospital and returned to homes with high degrees of expressed emotion were three to four times as likely to relapse within a nine month period. Interestingly, with schizophrenic patients, highly critical attitudes were also predictors for the onset of the disorder.

Mathisen (1986) argued that a detailed family assessment is essential to the treatment of OCD. According to Mathisen, family dynamics might initiate, contribute to, or allow obsessive-compulsive symptoms. Just as some family members may enable an alcoholic family member to continue his or her abuse of alcohol, obsessive-compulsive patients may have one or more family members who enable them to continue their compulsive rituals (Mathisen, 1986; Wegscheider-Cruse, 1989). For instance, some may cooperate with strict and bizarre rituals or rules. One who washes compulsively might not allow others into the bathroom until he or she has completed a

lengthy, set time period of washing. If other family members go along with the behavior, then they are said to be "enabling" it (Mathisen, 1986). Calvocoressi et al. (1995) agreed that family accommodation was a common occurrence in families dealing with OCD. They argued that family stress and rejection of the identified patient negatively affected family functioning.

Much research on OCD has focused on the specific components of expressed emotion, such as overprotectiveness, emotional overinvolvement, and criticism (Miklowitz et al., 1986). Tallis (1994) described a case of a 49-year-old woman who developed compulsions in response to her obsessions of causing harm to others. In considering her family history, it seemed that her obsessive-compulsive symptoms were related to an event of extreme emotional overinvolvement of an illegal nature. The event involved sexual abuse by her father at the age of 15. In response, she had prayed that her father would be removed in some way. Her symptoms began when he was accidentally killed a week later. Logically, she knew that she had not caused his death; however, she developed difficulties in distinguishing thoughts and actions. She felt inflated responsibility and tremendous guilt. This coincidental event originated from inappropriate family dynamics and it apparently perpetuated her obsessive-compulsive symptoms.

Hoover and Insel (1984) emphasized the fact that expressed emotion, regardless of specific type, does not have to be as extreme as the case noted by Tallis (1994). They studied obsessive-compulsive patients and their families of origin and illuminated many

patterns of family dynamics which appear to have some effect (Hoover & Insel, 1984). Family constellations seemed to be important throughout several generations. Although Hoover and Insel's sample was too small to study birth order of patients, they tended to agree with Kayton and Borge's (1967) research which exhibited a prevalence of only and eldest children in their sample of OCD patients.

Familial devotion, or loyalty, was exceptionally high (Hoover & Insel, 1984). This was expected of the children. In many cases, there was a dominant grandparent who favored the child who was the OCD patient. This was especially true when the child was the firstborn grandchild. This grandparent was a very powerful member of the family. Grandparents appeared to act as substitutes for social relations which should have been the responsibility of the parents. The parents had typically isolated themselves socially ever since the beginning of the marriage.

According to Hoover and Insel (1984), many times, the parents of the OCD patient had an unsatisfactory marital relationship. Although Thomsen (1994a) found that the majority of children with OCD came from intact families, the marital relationships were generally very strained with bouts of fighting and possibly sexual problems (Hoover & Insel, 1984). This marital tension seemed to prompt one, or potentially both, of the parents to try to become overinvolved in the child's life. This intense closeness could also be sought by a parent who lost a spouse through divorce or death. The result was that the child felt overwhelmed by the intensity of the parent's desire for closeness. Thus, Hoover and Insel believed that the child developed obsessive-compulsive

symptoms as a barrier to the intense overinvolvement. Further withdrawal from this parent only served to make that parent's desires for intimacy more elevated. This phenomenon was termed "symbiotic expectations" (Hoover & Insel, 1984).

Parents of OCD patients have typically held very high expectations of their child in other areas, especially with academics and morality (Hoover & Insel, 1984). Gojer, Khanna, and Channabasavanna (1987) studied OCD, depression, and anxiety. They found that many more of the OCD subjects were students than the control subjects. However, they did acknowledge that the age of the OCD subjects could have played a role in this particular discovery. But, Gojer et al.'s implication was that the academic status appeared to be a partial result of an increased sense of ambition and perfectionism. As Tallis (1994) noted, these high expectations can lead to an increase in personal responsibility, guilt, and self-blame.

In an investigation by Frost, Steketee, Cohn, and Griess (1994), the personality traits of OCD patients and their parents were compared with those of a control group of children and parents. Some worthy differences were observed. Obsessive-compulsive patients were characterized by feelings of guilt, perfectionistic attitudes, and avoidance of risk taking. Frost et al. addressed the issue of risk-aversion among OCD patients and claimed that parental overprotectiveness seemed to be the root of this specific characteristic. According to Steketee, Quay, and White (1991), a positive correlation was discovered between guilt associated with religion and severity of obsessive-compulsive symptoms. Frost et al. also supported the claim that OCD patients expressed

higher standards of morality.

Significantly, children and adolescents with OCD possessed one particular characteristic that seemed to distinguish them from most other psychiatric patients. Based upon Riddle et al. (1990), OCD patients internalized their problems much more than most people. This was posed as a possible explanation of why kids with OCD function rather well in jobs, academics, or activities. Yet, more difficulties were suspected in the area of social functioning. In fact, Thomsen's (1994b) work affirmed that some children with OCD also suffered from a decreased capacity for social relations. He cited depression and suicidal ideation as possible extenuating circumstances. The work of Jackson, Smith, and McGorry (1990) suggested that criticism, an aspect of expressed emotion, may also contribute to decreased social skills within mentally ill populations. They found that the lack of social skills was more pronounced among schizophrenic and bipolar patients whose families experienced a high incidence of critical remarks (Jackson et al., 1990). Thus, for OCD patients, high expressed emotion and inflated personal responsibility may combine to negatively influence their level of social functioning.

It seems likely that these high expectations and underdeveloped social skills occur consequentially to the high levels of expressed emotion in dysfunctional families. Jackson et al.'s (1990) efforts seemed to support this idea, at least with respect to social functioning. Another concept, which is commonly discussed along with expressed emotion, is communication deviance. Just as high expressed emotion was cited as a

factor in the course of schizophrenia, communication deviance has also been considered in this context (Miklowitz et al., 1983). Goldstein (1984) referred to communication deviance as a distortion of role patterns among family members. He indicated that a high incidence of communication deviance among parents led to increased prospects for the development of schizophrenia. The description of his subjects with high expressed emotion was similar to that of Hibbs et al. (1993). These parents were considered to be more critical, hostile, and overinvolved (Goldstein, 1984). Miklowitz et al. (1986) also studied schizophrenics. They found that high levels of expressed emotion were most often accompanied by high levels of communication deviance as well. Emotional overinvolvement was more frequently associated with communication deviance than the other aspects of expressed emotion.

High levels of expressed emotion among families involving mental illness appears to be fairly well documented (Hoover & Insel, 1984; Hibbs et al., 1991; Frost et al., 1994). Even more significant is the suggestion that these factors could possibly affect the course of the illness in a negative fashion (Miklowitz et al., 1983; Miklowitz et al., 1986). Dozier et al. (1991) studied adults with serious mental disorders. They discovered that subjects from families with high expressed emotion identified more intense symptoms. Attachment strategies among these families were also considered to be less effective. Steketee's (1993b) work with adult OCD patients and their families supported the idea that negative interactions, such as anger and criticism, influenced relapse, or loss of treatment gains. One form of negative interaction which was

particularly detrimental was a family member's belief that the patient could control his or her symptoms. Positive interaction and empathetic responses were considered helpful in maintaining treatment progress.

Stubbe et al. (1993) discussed the differing outcomes depending upon the type of expressed emotion present in families. Of the three components of expressed emotion, it appeared that emotional overinvolvement had the greatest influence in the development of anxiety related disorders like OCD or trichotillomania. Hibbs et al. (1992) employed galvanic skin responses to demonstrate how high parental expressed emotion affects OCD patients. Subjects with higher expressed emotion parental figures revealed a slower relaxation response. Although the role of criticism in anxiety disorders was recognized, critical statements were more apt to be implicated in disruptive behavior disorders (Stubbe et al., 1993). However, Hubschmid and Zemp (1989) confirmed a correlation between criticism and emotional overinvolvement; negativity, excessive conflict, and rigidity were all cited as expressions of these components of high expressed emotion.

In her study of 13 dysfunctional families, Berkowitz (1987) reported that the families' problems were typically brought to professional attention because of a child. In other words, the child was considered the 'true' patient by the family. Wegscheider-Cruse (1989) would claim that this same pattern is frequently observed among alcoholic families. In the addicted family, the lost child, mascot, or scapegoat is often the

stated problem. Significantly, high expressed emotion was generally aimed toward these key child patients (Berkowitz, 1987). Although high expressed emotion was identified in both parents, the mothers were consider more emotionally overinvolved.

Unfortunately, this is the type of research which has spawned complaints, such as the previously mentioned "abuse excuse." Welfare (1993) conceded that early efforts in family therapy were generally considered to promote parental or spousal blaming. Breines (1985) recognized a social trend which seems to blame mothers for their children's deficits. Women were expected to focus on marital relations and childrearing responsibilities in the 1950s; whereas, current options are more open for family and career responsibilities. With interest, Breines noted that women seemed to be more scrutinized concerning their relationships with their children. Mothers of the 1950s were criticized for their dominion over their children. Today's mothers appear to be in a 'catch-22' situation where they are blamed for broadening their horizons to include careers. Breines emphasized that, in both cases, women were usually following the social norms. Yet, these mothers still received blame for their children's difficulties while the fathers' influence seemed to go unnoticed.

James and McIntyre (1983) also criticized family therapy for failing to consider the social context of family life. They advocated consideration of the women's movement in family therapy. Emotional overinvolvement by women was specifically addressed. Based upon James and McIntyre's views, social conditions should be explored in the development and maintenance of maternal overinvolvement and

paternal underinvolvement. Just as Mathisen (1986) had advocated the use of detailed family assessment in the treatment of OCD, Welfare (1993) supported the application of a family systems approach with this population. According to Welfare, modification of rigid family behavior patterns which have been linked to increased symptoms could be beneficial to both patient and their families. She also mentioned marital counseling as an alternative for couples who may be experiencing problems related to obsessive-compulsive symptoms.

It appears that Cooper (1993) would encourage family therapies of this nature, too. She strongly recommended support groups or group therapies for family members of OCD patients. These groups' goals may include educating family members about the illness, allowing expression of emotions for catharsis and support, handling emotional responses to the patient, dealing directly with obsessive-compulsive symptoms, and rebuilding their own lives outside of the patient's illness. Importantly, Cooper boasted that such group participation had actually improved the prognosis for OCD patients by decreasing the degree of expressed emotion within the family.

The current study considered several of these documented aspects of family dynamics as they exist among families affected by OCD. The concepts of "symbiotic expectations" as discussed by Hoover and Insel (1984) and "expressed emotion" as discussed by Hibbs et al. (1991) were especially important. It is necessary to recall that "symbiotic expectations" and "expressed emotion" refer primarily to issues of overinvolvement, criticism, and some times overprotectiveness.

One purpose of this study was to determine whether patients with obsessive-compulsive and impulse-control disorders perceived their family dynamics differently from a comparison group of college students. Although similar studies have previously confirmed differences, this study took the issue a step further by including patients with impulse-control disorders (Hibbs et al., 1991). Thus, obsessive-compulsive and impulse-control patients were expected to indicate different, more extreme patterns of family dynamics than the comparison group.

Another purpose concerned the relationship between family functioning and symptom severity. Calvocoressi et al. (1995) felt that higher levels of symptom severity encouraged family accommodation, or enabling. The parents of OCD patients typically have high expressed emotion; in short, there is a lot of emotional overinvolvement and criticism. (Hibbs et al., 1991). If a "symbiotic expectation" is held by a parent of an obsessive-compulsive child, then Hoover and Insel (1984) claimed that the child would withdraw from that parent and that obsessive-compulsive symptoms would act purposefully as a barrier to closeness. In this study, "cohesion" referred to the "degree of commitment, help, and support that family members provided to one another (Moos & Moos, 1994, p. 1)." In the case of "symbiotic expectation" as described by Hoover and Insel (1991), it seems that the parent's attempt at cohesion may backfire. Therefore, one might predict that a person with OCD, or an impulse-control disorder, may perceive their family of origin as having low levels of cohesion. Low cohesion was expected to be related to greater symptom severity.

CHAPTER III

METHOD

Participants

Participants for this research consisted of two separate groups, a patient group and a comparison group. The patient group included people who had been diagnosed with an obsessive-compulsive disorder or an impulse-control disorder. College students with no reported history of mental illness served as a comparison group. Each group is described in greater detail in the following paragraphs.

Twenty-two patients from various OCD related support groups, including Obsessive-Compulsive Anonymous, Hair Pullers Anonymous, and an OCD support group affiliated with a hospital, volunteered as participants for this research. Based on demographic data provided by these participants, 64% had OCD; 9% had trichotillomania; 27% had both OCD and trichotillomania. The majority of patients, 73%, indicated that they had been diagnosed by a psychiatrist. Eighteen percent reported that a psychologist had diagnosed their illness while only 4.5% had been diagnosed by a counselor and another 4.5% by a physician. The participants' ages ranged from 26 to 67 years with an average age of 38.4 years. All of the patients were white with 41% being males and 59% being females. Sixty-four percent claimed to have a dual diagnosis. Although the researcher did not request specific information concerning the dual diagnosis, many patients volunteered their other diagnoses. Some of the additional diagnoses included alcoholism, schizoaffective disorder, depression, eating disorders, bipolar disorder, kleptomania, social phobia, and sexual addictions. Some mentioned that they were adult children of alcoholics, as well.

Fifty-nine college students volunteered for participation in the comparison group. Two of the 59 participants were removed from the comparison group because they reported a diagnosis of mental illness. Eighty-one percent of the group were females and 19% were males. The comparison group was comprised of five different ethnic backgrounds. Seventy-five percent were white; 18% were African American; 3% were Asian; 2% were North American, 2% were Hispanic. Comparison group ages ranged from 18 to 50 years with an average of 23.5 years.

Materials

Two assessment instruments were employed in this research. The Family Environment Scale: Form R (FES-R), third edition, was administered to all participants. The FES-R was first developed in 1974 by Moos and was revised in both 1986 and 1994 by Moos and Moos (1994). This scale, which consists of 90 true-false statements concerning families, was used to assess the perceived family dynamics of all participants. The participants had to decide if the statements were true or false in relation to their families of origin. The FES-R provides 10 scores that include: "Cohesion, Moral-Religious Emphasis, Conflict, Achievement Orientation, Intellectual-Cultural Orientation, Control, Active-Recreational Orientation, Organization, Expressiveness, and Independence" (Moos & Moos, 1994). Table 1 displays descriptions of each subscale as provided by Moos and Moos (1994, p. 1) in the Family Environment Scale Manual.

Table 1

FES-R Subscales and Descriptions

Subscale	Description
Relationship Dimensions	
Cohesion	the degree of commitment, help, and support family members provide for one another
Expressiveness	the extent to which family members are encouraged to express their feelings directly
Conflict	the amount of openly expressed anger and conflict among family members
Personal Growth Dimensions	
Independence	the extent to which family members are assertive, are self-sufficient, and make their own decisions
Achievement Orientation	how much activities (such as school and work) are cast into an achievement oriented or competitive framework
Intellectual-Cultural Orientation	the level of interest in political, intellectual, and cultural activities
Active Recreational Orientation	the amount of participation in social and recreational activities
Moral-Religious Emphasis	the emphasis on ethical and religious issues and values

Table 1 (continued)

Subscale	Description
System Maintenance Dimensions	
Organization	the degree of importance of clear organization and structure in planning family activities and responsibilities
Control	how much set rules and procedures are used to run family life

Source: Moos, R. H., & Moos, B. (1994, p. 1). The Family Environment Scale Manual (3rd ed.). Palo Alto, CA: Consulting Psychologists Press, Inc.

The FES-R boasts good psychometric properties (Busch-Rossnagel & Lambert, 1985). According to Moos and Moos (1994), test-retest reliability for the subscales varies anywhere from .68 to .86. Busch-Rossnagel and Lambert (1985) agreed that this was true for an eight week period. Over a 12 month period, test-retest reliability remains fairly high, ranging from .52 to .89. For the Cohesion subscale specifically, test-retest reliability was .86. Face validity is also considered good in that the items appear to be related to the particular domain of family environment or dynamics. A significant difference between means of representative and distressed families provided evidence of subscale validity. Differences in family background factors were also noted (Moos & Moos, 1994).

The Yale-Brown Obsessive-Compulsive Scale (self report version), developed by Goodman and Rasmussen et al. (1989), provided a rating of the perceived severity of obsessive-compulsive related symptoms. The patient group was asked to complete this

scale based upon a typical week for them. The Y-BOCS was originally created for research purposes; however, the value of this scale has recently been expanded as a clinical tool (Steketee, 1993a). The Y-BOCS yields a score between zero and 40 as determined by a ten-item scale. A higher score indicates greater perceived severity of symptoms based upon time involved in obsessing or ritualizing, interference in daily life activities, discomfort, efforts to resist impulses, and efforts to control rituals. According to Steketee, the Y-BOCS is considered to be psychometrically sound with good reliability and validity. In fact, this scale has become the scale of choice in OCD research involving drug trials.

Procedure

First, informed consent statements were explained and signed when applicable. Since a breach of confidentiality was the greatest risk of participation for the patient group, they were not required to sign consent forms. They provided their legal consent by completing the necessary tests. Each group completed a brief demographic data sheet which was specific to their role as a participant. Then, the Y-BOCS was administered to the patients to determine their perceptions of symptom severity. The Y-BOCS took most participants about 15 to 20 minutes. To assess perceived family dynamics, participants completed the FES-R which took most about 20 to 30 minutes. However, due to the nature of obsessive-compulsive related disorders, these tests took longer for some patients who have difficulty with paperwork. Some testing was completed in groups. However, due to varying schedules, some were conducted

individually so that certain patients could be involved. The comparison group's testing followed the same procedure with the exception that they did not complete the Y-BOCS. Question and answer periods were allowed both before and after testing of all participants.

CHAPTER IV

RESULTS

Hypothesis 1

A non-directional (two-tailed) *t*-test was used to evaluate Hypothesis 1. The patient group and the student group were compared on each of the ten subscales of the Family Environment Scale-Form R. Their respective means and standard deviations on each subscale is presented in Table 2. Table 2 also reports the *t*-scores for the difference between each pair of means. As indicated by the table, significant differences between the patient group and the student group were obtained on the following subscales: Cohesion, Expressiveness, Conflict, Independence, Intellectual-Cultural Orientation, Active-Recreational Orientation, and Control.

Table 2

Results of *t*-test Comparison and Descriptive Statistics of Patients' and College Students' Perceptions of Families of Origin

Subscale	Patient Group	Student Group	*t*-score
Cohesion			
mean	28.32	49.30	-4.79**
sd	16.86	17.68	
Expressiveness			
mean	28.95	48.40	-6.83**
sd	10.92	11.51	
Conflict			
mean	63.55	50.00	3.97**
sd	12.75	13.88	
Independence			
mean	33.73	47.81	-3.81**
sd	16.13	14.14	

Table 2 (continued)

Subscale	Patient Group	Student Group	*t*-score
Achievement Orientation			
mean	57.73	53.49	1.58
sd	11.48	10.36	
Intellectual-Cultural Orientation			
mean	37.73	44.98	-2.29*
sd	13.29	12.40	
Active-Recreational Orientation			
mean	41.36	50.91	-2.91**
sd	14.22	12.59	
Moral-Religious Orientation			
mean	55.55	57.67	-0.84
sd	10.57	9.830	
Organization			
mean	55.77	50.70	1.67
sd	12.19	12.07	
Control			
mean	66.68	55.63	3.65**
sd	12.41	11.93	

Notes: *Indicates significance at $p<.05$
**Indicates significance at $p<.01$

Hypothesis 2

The examination of Hypothesis 2 was completed by employing the Pearson *r* Correlation Coefficient. The relationship between patients' perceptions of family environment and their perceptions of symptom severity was the focus. Table 3 presents the relationship between each of the FES-R subscales and the Y-BOCS scores as

correlational coefficients. Although statistical significance was not found on any subscale, the table shows that three of the subscales, Independence, Active-Recreational Orientation, and Control, were approaching the point of significance at $p < .05$.

Table 3

Correlation Coefficients Between FES-R Subscales and Y-BOCS (N=22)

Subscale	Pearson *r*
Cohesion	-.127
Expressiveness	-.076
Conflict	.207
Independence	-.306*
Achievement Orientation	.075
Intellectual-Cultural Orientation	-.275
Active-Recreational Orientation	-.421*
Moral-Religious Emphasis	.162
Organization	.083
Control	.334*

Note: *Indicates that correlations are approaching statistical significance at $p<.05$

In order to provide additional information, the relationships between each of the FES-R subscales were also considered. Pearson *r* Correlation Coefficients were computed as a means of determining these relationships, and they are presented in Table 4.

Table 4

Correlation Matrix of FES-R Subscales

Subscales	C	Ex	Con	Ind	AO	ICO	ARO	MRE	Org	Ctl
C										
Ex	0.551**									
Con	-0.652**	-0.335								
Ind	0.365	0.360	-0.269							
AO	-0.145	-0.674**	0.241	-0.326						
ICO	0.450*	0.370	-0.217	0.380	-0.123					
ARO	0.035	-0.020	0.078	0.364	-0.027	0.305				
MRE	0.260	0.206	-0.040	0.159	-0.129	0.223	0.163			
Org	0.119	-0.226	-0.042	-0.029	0.634**	0.000	-0.147	-0.102		
Ctl	-0.237	-0.450*	0.262	-0.584**	0.699**	-0.228	-0.076	0.100	0.401	

Notes: *Indicates significance at $p < .05$
**Indicates significance at $p < .01$

CHAPTER V

DISCUSSION

Concept of Family Disease

This research focused on OCD and impulse-control disorders as "family diseases." The intention of this study was to identify family issues that the patients perceived as problematic in dealing with their illness. This was expected to provide some direction for conducting family therapy with OCD and impulse-control populations.

Hypothesis 1 was partially supported in that family dynamics were perceived differently by patients than by a comparison group of college students. In particular, seven subscales, including Cohesion, Expressiveness, Conflict, Independence, Intellectual-Cultural Orientation, Active-Recreational Orientation, and Control, were observed as more extreme. Therefore, support for Hypothesis 1 seems to contribute to the concept of OCD and impulse-control disorders as "family diseases."

In this study, statistical support for Hypothesis 2 was found to be lacking. None of the ten FES-R subscales were significantly related to symptom severity. However, three of the subscales, including Independence, Active-Recreational Orientation, and Control, were found to be approaching the level of significance. These three subscales will be discussed in the following section as possibly impacting the course of illness.

Patients' Perspective and Family Therapy

Schwartz, a psychiatrist at the University of California at Los Angeles School of Medicine, is the author of a popular new book among those involved with OCD and impulse-control disorders. His book, entitled Brain Lock, devoted an entire chapter to

"OCD as a Family Disorder" (Schwartz & Beyette, 1996, p. 127). His chapter corresponds well with the main goal of this research which was to recognize OCD and impulse-control disorders as "family diseases" just as in the cases of alcoholism and addiction. The chapter addresses relevant topics such as "family accommodation, emotional burnout, OCD as a weapon for control, and disclosure of illness" (Schwartz & Beyette, 1996, p.127-136). This section describes the patients' perspective of this "family illness" and makes suggestions for improving family functioning.

This study found that patients perceived significantly less Cohesion, Expressiveness, Independence, Intellectual-Cultural Orientation, and Active-Recreational Orientation in their families of origin than students. Additionally, patients reported experiencing significantly more Control and Conflict than the student population. This data describes the unhealthy dynamics which are present among the patients' families.

The confirmation of Hypothesis 1 provides strong support for the concept of OCD and impulse-control disorders as "family diseases." The families of these patients function quite differently from healthy families. Family life seems difficult from the patients' perspective. The other family members are likely to express dissatisfaction with family functioning, too. Cooper (1993), as well as Schwartz and Beyette (1996), explained that this is largely due to the family members' efforts to accommodate the patient's illness. Wegscheider-Cruse (1989) described this type of family dysfunction as enabling or as being co-dependent. Each of these researchers have recommended that

the family members become involved in the treatment of the patient's condition.

Schwartz and Beyette strongly encourage behavior therapy which involves significant family members, especially those who live with the patient. If a therapist suggested that family members simply become more supportive, then they might respond angrily and express a sense of frustration. Family members generally believe that they are already being helpful; yet, they fail to realize that the type of help they are giving could actually be detrimental to the entire family. Educating the family about accommodation, obtaining their feedback, and assessing their needs in regards to family functioning seems like a good start. Many of the identified issues that give credence to the idea that OCD and impulse-control disorders are family diseases seem to coincide with family accommodation.

In this study, the greatest familial differences were found to be the degree of cohesion and expressiveness. A finding was that cohesion and expressiveness shared a significant, positive relation to one another. As one increased, so did the other. However, the patients experienced low levels of both in their families. One may recall that cohesion was of particular interest because of the discussion of "expressed emotion" and the implication that it may have impacted the course of a chronic mental illness, specifically schizophrenia (Miklowitz et al., 1983; Miklowitz et al., 1986). Thus, an important objective for therapists would be to assist families in increasing cohesion and expressiveness.

From our knowledge of "expressed emotion" and families affected by OCD, it

seems that these families are already expressing negative emotions, such as criticism. They appear to lack the essential skill of expressing pleasant emotions, such as love, support, and commitment to one another. A priority for therapists should be the assistance of families in learning and practicing more effective behaviors for communicating their feelings, both good and bad, and encouraging one another.

So, how should parents respond to the child who has OCD or an impulse-control disorder? Consider a situation where the child was crying. Although the initial reaction may be to yell at the child to stop crying, this would only maintain low levels of cohesion and expressiveness. Thus, parents should be encouraged to display warmth and concern for what is causing the child's pain. Then, they can offer appropriate parental guidance for the child. Regardless of any advice, the key seems to be validation of the feelings expressed. This results in a win-win situation where the parent-child bond is strengthened.

The patients' families also differed significantly from healthy families in the amount of independence which they experienced. Patients reported feeling less independence than students. Importantly, lower levels of independence were somewhat related to greater levels of symptom severity. Since accommodation frequently involves doing things for the patient, behavior therapy might focus on finding ways for the patient to become more independent while teaching the family to allow the patient's independence. Family accommodation generally serves to make the patient feel helpless and to make the family feel exhausted. Behavior therapy aimed at improving family

functioning may be stressful at first, but long term results could be liberating for all.

Healthy families also enjoyed a much greater degree of social and recreational activities than those of patients. A moderate negative correlation between Active-Recreational Orientation and symptom severity neared statistical significance. Similarly, healthy families experienced a greater interest in intellectual and cultural events. Despite a negative correlation between Intellectual-Cultural Orientation and symptom severity, this relationship was much weaker than that of Active-Recreational Orientation and symptom severity.

For behavior therapy, these results suggest that patients should become involved in 'social and recreational activities.' Active-Recreational Orientation and Intellectual-Cultural Orientation shared a positive relationship with each other. As Active-Recreational Orientation increased, so did Intellectual-Cultural Orientation; and, vice versa. One might reason that if a patient became active in political or cultural events, then they would probably have greater opportunity for socialization and recreation. According to this study, these types of activities may encourage a lessening of symptoms.

Idle time, boredom, and isolation are commonly cited as triggers for drug and alcohol consumption among addicts (Brown & Lewis, 1995). The findings of this research suggest that this might also be the case for patients with OCD or impulse-control disorders. Therapists should try to help the patients' families to increase outside social interaction while decreasing idle activities, such as watching television.

In the context of these results, the therapist would want to encourage greater activity which would promote the independence of the patient. For instance, children or teenagers may be encouraged to join clubs, athletics, or other organizations of their choice. Adults could be involved in employment, community organizations, or volunteer work. These activities may be beneficial for the entire family in that the patient and their family members may become less reliant on one another for socialization. Decreased "expressed emotion" may be evident as less overinvolvement with certain family members. As a precaution, the therapist would want to teach both patient and family to monitor stress levels and respond appropriately.

Finally, patients revealed significantly greater degrees of Control and Conflict than students from healthy families. The subscale of Control was found to be nearing a significant positive relationship with symptom severity. In other words, more rigid family rules and procedures almost appear to be related to increased symptoms. Reasonably, increased Control appeared to co-exist with increased Conflict. A strong positive relationship between these two family dimensions emerged. It seems that the family members' efforts to control the patients' obsessions and compulsive behaviors often backfire. Family accommodation creates tension and stress for everyone and, it can lead patients to use their symptoms as a form of retaliation. These findings could provide support for the claim that "expressed emotion" influences the course of obsessive-compulsive and impulse-control symptoms. It seems feasible that conflict could be expressed through criticism while control may be exhibited in the form of

emotional overinvolvement or overprotectiveness. It is important to recall that these represent the components of "expressed emotion" which were previously described.

Due to the nature of control and conflict, changes in these aspects of family life may require more work than areas previously discussed. These behaviors are usually learned and well-ingrained. Therapists would want to teach clients, and their families, to use more effective communication styles and appropriate ways to disagree, or fight, with one another. This would require practice and feedback from both family members and therapists. Therapists should be skilled in modeling the desired behavioral responses. Modeling could be accomplished through role-playing, as well as interactions with clients.

Therapists who attempt to use this data in their work with obsessive-compulsive and impulse-control populations should be aware of interactions between these subscales. Overwhelming these families with many changes at once is unnecessary. By examining the intercorrelations of the FES-R subscales, one can see that several of the family dimensions appear to play off of one another. It seems that a chain reaction of sorts can be set in motion by changing one issue at a time. The relationship between Independence and Active-Recreational Orientation provides one example of this phenomenon. Active-Recreational Orientation also represents one of the easier dynamics where families may initiate change. However, similar reactions appear to happen with other subscales, such as Conflict and Cohesion. As families are able to increase cohesion, then a decrease in conflict is anticipated. The therapist's clinical

judgment becomes invaluable in the development of a plan for family change.

The proposed changes in family dynamics are not expected to rid patients of all symptoms. After all, biological and chemical theories of cause are experiencing great acceptance thanks to PET scans. So, problems with brain chemistry and genetics are being considered causal agents. Regardless of this study's inability to determine cause of OCD and impulse-control disorders, the results seem promising as they provide support for the belief that the course of the illnesses may be affected in a manner which is beneficial to both patient and family. Therapists should anticipate that patients and their families may be resistant to change due to possible secondary gains from their illnesses and family dysfunction. Despite the pain involved in family therapy, relief seems to be a likely product. When family function improves, the need for accommodation of illness and use of illness as a weapon decreases. Since OCD and impulse-control disorders do appear to be 'family diseases', Schwartz and Beyette (1996, p. 128) recommended that families should enable behavioral therapy and change instead of the disease.

Limitations and Future Research Suggestions

Although the results of this study were largely consistent with expectations, some limitations may have contributed to the lack of significant findings that support Hypothesis 2. An obvious example is the small sample size which was utilized. If more participants had been available, then the observed relationships might have been more reliable. Another limitation was that the patients' involvement in therapies and treatments was unknown. Since the patients reported formal diagnoses by appropriate

professionals, it is quite certain that some form of treatment, either past or present, had been conducted. These treatments were likely to have some effect on the patients' perceptions of their symptom severity. Statistically, this would hinder the ability to determine accurate relationships between the FES-R subscales and symptom severity.

Other limitations include a reliance on perceptions. Data was based entirely upon patients' perceptions of their illness and of their family dynamics. Due to the focus on patient perceptions, other family members had no input. Some might be concerned about the accuracy of perceptions. Yet, the important finding was that patient perceptions differed from student perceptions, and they appeared to be somewhat related to symptom severity.

Some may view the issue of co-morbidity to be a limiting factor since the patient group did not consist purely of OCD and impulse-control disorders. It might be thought of as contaminated due to dual diagnoses. However, locating a totally pure sample would be extremely challenging. Finally, the issue of cause and effect could not be addressed due to the correlational nature of the research.

Future research should attempt to replicate this study with a few alterations. First, the interview version of the Y-BOCS should be used as opposed to the shorter self-report version. This would provide a more accurate clinical assessment of symptom severity. It would be important to question participants about the type of treatment they were receiving because this could affect the Y-BOCS score. It would also be interesting to obtain input from members of the family of origin.

Research should be conducted to test the results of this study within the family therapy arena. In conjunction to traditional behavior and drug therapies, family therapy should employ the results and suggestions from this study with a similar patient population. Several months, or even a year, of family therapy and/or marital therapy should be conducted with families who have either a young or an adult child with an obsessive-compulsive related disorder. After a sufficient length of time, perceptions of both family environment and symptom severity could be re-tested. Hopefully, family therapy would be found to promote symptom reduction, to decrease relapse potential, and to improve overall family functioning.

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APPENDIX

APPENDIX A

Informed Consent Statement (Patient)

PARTICIPANT:

You are about to participate in a study investigating the relationship between family dynamics and severity of symptoms related to obsessive-compulsive or impulse-control disorders. *Please read the following material carefully.* It describes the purpose of the study, the procedures to be used, risks and benefits of your participation, and what will happen to the information that is collected from you.

1) PURPOSE OF THE STUDY: To determine the relationship between family dynamics and severity of symptoms related to obsessive-compulsive or impulse-control disorders. The researcher wants to know if family dynamics differ among those with such illnesses (OCD/impulse-control disorders) and college students. If differences do emerge, the researcher hopes to determine which aspects of family dynamics may be related to symptom severity. The researcher hopes to identify ways that family therapy could benefit those with obsessive-compulsive or impulse-control disorders, as well as those who are close to them.

2) PROCEDURE: This research has three components. First, you will be asked to complete a brief demographic data sheet including information concerning age, race, gender, and diagnosis. Information concerning your psychiatric diagnosis must be gathered in order to ensure your appropriateness for this particular research. However, if you are uncomfortable in responding to any of the questions on the demographic data sheet, then you may choose to omit them. Second, you will complete the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS) which consists of 10 questions designed to assess severity of symptoms. These questions consider time occupied, interference, distress, resistance, and controllability. The Y-BOCS Symptom Checklist will be provided to you. It may help you to answer these 10 questions more accurately. Third, you will complete a pencil/paper test called the Family Environment Scale-Real Form, 2nd edition. It consists of 90 true/false statements which assess family dynamics. The following family characteristics are considered: Cohesion, Expressiveness, Conflict, Independence, Achievement Orientation, Intellectual-Cultural Orientation, Active-Recreational Orientation, Moral-Religious Emphasis, Organization, and Control. The entire process is expected to take about one hour. If you become too uncomfortable for any reason, a break may be requested, or you may terminate your participation without penalty or prejudice.

3) RISKS & BENEFITS OF PARTICIPATION: The largest, and most obvious, risk would be the possibility of a breach of confidentiality. For this reason, you will not be asked to sign a consent form. You should have thoroughly read this consent statement. By completing the required demographic sheet and the two tests described above, you are giving your legal consent for participation. Another potential risk would be that your level of anxiety might be temporarily raised in the act of considering your symptoms or

responding to statements regarding your family dynamics. Your participation in the support group, as well as a question and answer period with the researcher, may help alleviate this discomfort. Your participation in this research will help to make a contribution to the ever-increasing literature on obsessive-compulsive and impulse-control disorders. It is hoped that some new information will be gained to improve family therapies for this problem.

4) AFTER DATA COLLECTION: The data obtained from you will be coded by an arbitrary subject number and entered into a computer for analysis. The data is being gathered for the purpose of a psychology student's (Shannon Brock) graduate research. The research is being supervised by Dr. Charles Grah at Austin Peay State University in Clarksville, Tennessee. There is the possibility that the combined research results could be published in scientific publications or support group newsletters. In any such use of the information, all identities will be carefully protected. The identities of participants will not be revealed in any published or oral presentation of the results of the study. Information will be made public in the form of summaries which make it impossible to identify any participants. If you would like a summary of the findings, you may contact: Shannon Brock, 2205 East B Street, Belleville, IL 62221, or call Shannon at (618) 235-2589. Your confidentiality will be maintained during any contact. You should receive a copy of this statement to keep.

APPENDIX B

Informed Consent Statement (Student)

PARTICIPANT:

You are about to participate in a study investigating the relationship between family dynamics and severity of symptoms related to obsessive-compulsive or impulse-control disorders. *Please read the following material carefully.* It describes the purpose of the study, the procedures to be used, risks and benefits of participation, and what will happen to the information that is collected from you.

1) PURPOSE OF THE STUDY: To determine the relationship between family dynamics and severity of symptoms related to obsessive-compulsive or impulse-control disorders. The researcher wants to know if family dynamics differ among those with such illnesses (OCD/impulse-control disorders) and college students. If differences do emerge, the researcher hopes to determine which aspects of family dynamics may be related to symptom severity. The researcher hopes to identify ways that family therapy could benefit those with obsessive-compulsive or impulse-control disorders, as well as those who are close to them.

2) PROCEDURE: As college students, you are being asked to serve as a comparison group for those subjects who have the obsessive-compulsive or impulse-control disorders. Your participation will require the signing of this consent form, and the completion of a brief demographic data sheet and a pencil/paper test called the Family Environment Scale-Real Form (FES-R), 2nd edition. The demographic data sheet consists of questions concerning age, race, and gender. It will also asks questions about possible psychiatric diagnosis. This is necessary in order to ensure the purity of the comparison group. However, if you are uncomfortable with responding to any of the questions on the demographic data sheet, you may choose to omit them. You will then be asked to complete the FES-R which consists of 90 true/false statements designed to assess family dynamics. The following family characteristics are considered: Cohesion, Expressiveness, Conflict, Independence, Achievement Orientation, Intellectual-Cultural Orientation, Active-Recreational Orientation, Moral-Religious Emphasis, Organization, and Control. The entire process is expected to take less than one hour. Your participation is completely voluntary and may be withdrawn if you choose.

3) RISKS & BENEFITS OF PARTICIPATION: There are no known risks from participating in this study. Similarly, there are no direct benefits to you other than perhaps a sense of satisfaction from having participated and knowledge of what it is like to participate in a psychology experiment. In some cases, college professors may offer extra course credit for participating in research. If your instructor does this, then be sure to obtain proof of your participation which should be provided by the researcher. The student researcher is offering no special incentives for your participation.

4) AFTER DATA COLLECTION: The data obtained from you will be coded by an arbitrary subject number and entered into a computer for analysis. The data is being gathered for the purpose of a psychology student's (Shannon Brock) graduate research. The research is being supervised by Dr. Charles Grah at Austin Peay State University in Clarksville, Tennessee. There is the possibility that the combined research results could be published in scientific publications or OCD related support group newsletters. In any such use of the information, all identities will be carefully protected. The identities of participants will not be revealed in any published or oral presentation of the results of the study. Information will be made public in the form of summaries which make it impossible to identify any participants. If you would like a summary of the findings, you may contact: Shannon Brock, 2205 East B Street, Belleville, IL 62221. Your confidentiality will be maintained during any contact. You should receive an extra copy of this consent form to keep.

Participant's Signature _____

Date _____

APPENDIX C

Informed Consent Statement (student)

Please read the statements below. They describe your rights and responsibilities as a participant in this research project.

1) I agree to participate in the present study being conducted by a graduate student in Psy 5990, Thesis Research, under the supervision of Dr. Charles R. Grah.

2) I have been informed in writing of the procedures to be followed as well as the risks and benefits to me for participating. I have been given an opportunity to ask questions about my participation.

3) I understand that I may terminate my participation at any time without penalty or prejudice and that I may have all data obtained from me destroyed.

4) I understand that I may omit any questions from the demographic data sheet if they cause me to feel too uncomfortable.

5) I realize that by signing this form, I willingly consent to participate in this study. I also acknowledge that I have been given a copy of this consent form to keep.

Signature _____ Date _____

APPENDIX D

Demographic Data (Patient)

1) Age: _____

2) Ethnic Background:

African American _____
Caucasian (white) _____
Hispanic _____
Asian _____
Other _____

3) Gender: Male_____ Female_____

4) Have you been diagnosed with obsessive-compulsive disorder? (circle answer) Yes No

5) Have you been diagnosed with trichotillomania (compulsive hair pulling)? Yes No

6) Have you been diagnosed with any other impulse-control disorder, such as kleptomania, pyromania, pathological gambling, intermittent explosive disorder?

Circle answer: Yes No

7) Who diagnosed your illness?

Psychiatrist _____
Psychologist_____
Physician _____
Counselor _____
Social Worker _____
Other (write in)_____

8) Were you given more than one diagnosis? (For example, a diagnoses of both OCD and manic-depression)

Circle answer: Yes No

APPENDIX E
Demographic Data (Student)

1) Age: _____

2) Ethnic Background
African American _____
Caucasian (white) _____
Hispanic _____
Asian _____
Other _____

3) Gender Male_____
Female_____

4) Have you been diagnosed with obsessive-compulsive disorder?

Circle answer Yes No

5) Have you ever been diagnosed with trichotillomania (compulsive hair pulling)?

Circle answer Yes No

6) Have you ever been diagnosed with any other impulse-control disorder, such as kleptomania, pyromania, pathological gambling, intermittent explosive disorder?

Circle answer Yes No

7) Have you ever been diagnosed with any other mental disorder?

Circle answer Yes No

VITA

Shannon Kathleen-Adler Brock was born in Paducah, Kentucky, on August 16, 1971. She attended Lone Oak Elementary, Middle, and High Schools where she graduated in May, 1989. She moved to Owensboro, Kentucky, where she attended Kentucky Wesleyan College. She received a Bachelor of Arts degree with a double major of psychology and criminal justice in May of 1993. That June, she became a student in the Psychology Department at Austin Peay State University in Clarksville, Tennessee. She completed a Master of Science degree in Guidance and Counseling in December, 1997. Shannon is currently employed as an addictions counselor in East Saint Louis, Illinois.