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Do mothers enhance responsibility in children with obsessive-compulsive disorder? A preliminary study of mother-child interactions during a problem solving discussion

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ABSTRACT

Aims: Explored observed behaviours during a mother and child problem solving discussion, as well as examining the novel role of enhancement of responsibility in the context of a problem solving task.

Methods: Children aged 8 to 12 years, including an OCD sample ($n=12$) and non-clinical ($n=16$), and their mothers participated in a five-minute problem solving discussion. Discussions were coded across a range of behavioural dimensions including warmth, autonomy, and confidence and responsibility processes.

Results: The groups did not differ on mother or child behavioural dimensions; however, mothers of children with OCD were rated as enhancing their child's responsibility significantly more than their own responsibility, and more than mothers of children with no diagnosis. The solutions generated in the OCD dyads were more likely to implicate the child as being responsible for resolving the situation, compared to the non-clinical group.

Conclusions: Tentative support was found for the promotion and enhancement of child responsibility by mothers of children with OCD. Moreover, in line with past research, the overall quality of the interaction in the OCD group was rated as less positive. This paper provides preliminary, novel findings to support a developmental-familial role for the development of inflated responsibility in children with OCD.

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1. Introduction

Obsessive-compulsive disorder (OCD) during childhood has a profoundly negative impact on both the child and the entire family (Farrell & Barrett, 2006; Storch, Geffken, Merlo, Jacob, & Goodman 2007). For children, the effects of OCD can be far reaching, impacting on all aspects of a child's psychosocial development from family relationships, to school performance and social life (Piacentini, Bergman, Keller, & McCracken, 2003). Indeed adults with a history of childhood OCD are less likely to be married/living with a partner, more prone to experience social/peer difficulties, isolation, unemployment, and to endure greater difficulties sustaining a job (Stewart et al. 2004). Whilst empirically supported treatments for childhood OCD, including serotonergic medication and/or cognitive-behavioural treatment (CBT), have been found to be effective, there remains considerable room for improving current response and remission rates (Byrne, Farrell, & Rapee, 2011; Eddy, Dutra, Bradley, & Westen, 2004). Given that OCD

represents one of the most common psychiatric illnesses of youth (Stewart et al., 2004), is associated with profound impairments, and is not always responsive to our current best-treatments, there is a pressing need to further understand mechanisms that might be associated with childhood onset OCD to inform advancements in treatment approaches.

Cognitive theoretical models of OCD have been favoured in the adult literature in regards to understanding the development and maintenance of symptoms (e.g., Taylor, Abramowitz, & McKay, 2006), and moreover, based on these models, there is strong accumulating evidence for the efficacy of cognitive-behavioural treatments (CBT) in both adults (e.g., Rosa-Alcazar, Sanchez-Meca, Gomez-Conesa and Marin-Martinez, 2008) and children with OCD (e.g., Barrett, Farrell, Pina, Peris, & Piacentini, 2008). Despite the wealth of research into the cognitive underpinnings of OCD in adults (e.g., Frost & Steketee, 2002), there is comparatively limited research into cognitive processes during childhood. As such, examination of maladaptive beliefs, the development of such beliefs, and familial processes involved in childhood OCD warrants further investigation.

Adult cognitive models of OCD focus on six core domains of cognition, which have been identified by the *Obsessive Compulsive Cognitions Working Group* (1997, 2005) as centrally important to

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OCD. These cognitions include (1) inflated responsibility (Salkovskis, 1985; 1996), (2) over importance of thoughts (e.g., thought–action fusion, Rachman, 1993), (3) control of thoughts (e.g., thought suppression (Clark & de Silva, 1985), and meta-cognitive beliefs, (Wells & Papageorgiou, 1998), (4) over-estimation of threat, (5) intolerance of uncertainty and (6) perfectionism (Obsessive Compulsive Cognitions Working Group, 1997; 2005). Evidence for the importance of these belief domains in the development and maintenance of OCD is clearly demonstrated in adult studies. For example, a prospective study of new mothers and fathers found that scores on a measure of OCD related beliefs (e.g., overestimates of threat and responsibility for harm, importance of control of intrusive thoughts, perfectionism and the need for certainty) predicted the development of OCD symptoms post partum (Abramowitz, Khandker, Nelson, Deacon, & Rygwall, 2006).

Arguably one of the most widely investigated cognitive biases is inflated responsibility beliefs (Salkovskis, 1985; 1989). Salkovskis, Shafran, Rachman, and Freeston (1999) proposed multiple pathways for the development of maladaptive responsibility beliefs within a developmental familial context. For example, these dysfunctional beliefs may be purposely or implicitly promoted during childhood by significant figures; may develop due to exposure to rigid or extreme codes of conduct or duty; arise from deprivation of opportunities to cope with responsibility; or may stem from an actual incident whereby one's actions or inactions (or beliefs about such) contributed to serious traumatic events or circumstances (see Salkovskis et al., 1999). Using a questionnaire developed to measure these pathways proposed by Salkovskis et al. (1999), Lawrence and Williams (2011) assessed 16 youth with a history of OCD, compared to a sample of 16 adolescents without a history of OCD. Those with a history of OCD reported a higher sense of responsibility for significant incidents with a negative outcome prior to the onset of their OCD, relative to those without a history of OCD (Lawrence & Williams, 2011). Similarly, Coles and Schofield (2008) developed and validated the Pathways to Inflated Responsibility Beliefs Scale (PIRBS; Coles and Schofield, 2008) in a sample of undergraduate adults. This measure assesses the hypothesised developmental contexts that are proposed by Salkovskis et al. (1999) to be associated with the development of responsibility biases. Results from this initial validation study found the 23-item scale as having good internal consistency, retest reliability, as well as good convergent and divergent validity.

Research examining family environment and parent–child interactions also provides support that maladaptive beliefs may have origins within a familial-based developmental context (e.g., Rector, Cassin, Richter, & Burroughs, 2009). For example, in addition to inflated responsibility biases, specific parenting behaviours, such as criticism, control, and strict codes of conduct, have also been postulated to be associated with the development of maladaptive perfectionism (e.g., Kawamura, Frost & Harmatz, 2002). To date, there have been no studies that have systematically examined the proposed pathways of development of responsibility biases in childhood samples through observational methods. While very little observational research exists using childhood OCD samples, the few published studies have demonstrated that families are generally observed to be higher in criticism and over-involvement (e.g., Hibbs et al., 1991) and generally less positive in parent–child interactions during discussion tasks (Barrett, Shortt, & Healy, 2002). For example, Barrett et al. (2002) compared families with children with OCD, other anxiety disorders, externalising disorders and non-clinical children during family discussion of “hot topics” and found parents of children with OCD to be significantly less confident in their child's abilities, less rewarding of independence and used less positive problem-solving. Furthermore, children with OCD also showed less positive problem-solving, less confidence in their ability to

solve problems and displayed less warmth during interactions with their parents.

The present study aimed to provide a novel contribution to the literature by exploring mother and child behaviours during a problem solving family discussion and more specifically, whether parents and/or their child with OCD, display inflated responsibility for action during this discussion task, relative to a non-clinical children and their mothers. It was hypothesised that during a parent–child problem-solving discussion task, mothers of children with OCD compared to mothers of non-clinical children would display greater levels of control and intrusiveness, less confidence/certainty in their or their child's ability to cope, less warmth, and greater enhancement of their child's responsibility for action. Moreover, it was hypothesised that children with OCD compared to non-clinical children would display greater levels of control and intrusiveness, less confidence/certainty in their ability to cope, less warmth during the interaction, and might provide greater enhancement of their mother's responsibility—although this was an exploratory hypothesis. Finally, it was hypothesised that the overall quality of the interaction between children with OCD and their mothers during the discussion task would be less positive, compared to non-clinical children and their mothers.

2. Method

2.1. Participants

Two groups of children aged 8–12 years participated in this study, including 12 children with primary OCD (n females=5), and 16 children with no clinical diagnoses (n females=6). Mothers of all children participated, with both groups of parent–child dyads closely matched for age and gender. There was no statistical difference between ages of the children or mothers (see Table 1).

Based on the Children's Yale-Brown Obsessive–Compulsive Scale (CY-BOCS) the total severity for the OCD sample was in the moderate range ($M=20.50$; $SD=7.04$).

Within the clinical sample, all children had a secondary comorbid diagnosis, including generalised anxiety disorder (GAD; 4), followed by specific phobia (3), social anxiety disorder (1), separation anxiety disorder (SAD; 1), pervasive developmental disorders (PDD; 2), and attention deficit hyperactivity disorder (ADHD; 1). Furthermore, 75% of the sample ($n=9$) met criteria for a third diagnosis, including GAD (3), specific phobia (1), social anxiety disorder (1), SAD (1), dysthymia (1) and ADHD (2).

The clinical OCD sample were treatment seeking, with parents responding to advertisements in local papers for a free CBT research program at the university. Non-clinical children were recruited from two a local primary schools. The average Children's Anxiety Scale—Parent Version (SCAS-P; Spence, 1998) score for this group was in the non-clinical range ($M=12.34$, $SD=6.14$). Further, no children in the non-clinical group met criteria for any psychological disorder, based on the diagnostic interviews (using the ADIS-P, see below).

2.2. Measures

Anxiety disorders interview schedule for DSM-IV: Parent version (ADIS-P, Silverman & Albano, 1996). The ADIS-P is a semi-structured clinical interview for the diagnosis of childhood anxiety and related disorders. A clinician severity rating (CSR) is given for each diagnosis where DSM-IV criteria is met on a 9-point scale of severity (0=no interference to 8=severely disabling). The CSR rating that is the highest is deemed the primary diagnosis. In this study, the ADIS-P was completed by parents of children in both groups. Children with OCD had an overall

Table 1

Age (years) differences between parents and children in obsessive–compulsive and non-clinical groups.

Age group	Obsessive compulsive group mean age (SD)	Non-clinical group mean age (SD)	<i>df</i>	<i>t</i> (<i>p</i>)
Mothers	41.27 ($SD=5.16$)	40.63 ($SD=5.44$)	26	.35 (.73)
Children	9.75 ($SD=1.42$)	9.94 ($SD=1.39$)	25	.31 (.76)

Note: For mothers in the OCD group $n=12$, and for mothers in the non-clinical group $n=16$. For children in the OCD group $n=12$ and in the non-clinical group $n=16$.

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