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Family accommodation of obsessional symptoms and naturalistic outcome of obsessive–compulsive disorder

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ABSTRACT

Accommodation of symptoms by families and expressed emotion (EE) may have a negative impact on the outcome of obsessive–compulsive disorder (OCD). The study examines the effect of family accommodation (FA) and EE on the 1-year naturalistic outcome of OCD. Patients with OCD who met the criteria for the *Diagnostic and Statistical Manual of Mental Disorders-IV*, text revision (DSM-IV TR; $N=94$) were followed up for 1 year and assessed every 3 months. Assessments included measurement of symptom severity, FA, EE and family burden. By the 12th month, the cumulative probability of remission was 58%. Non-remitters compared with remitters had a significantly higher FA, EE and family burden at the baseline and did not report significant reductions on any of the family variables over the year. In a Cox proportional hazard regression analysis, a higher FA at the baseline significantly predicted time to remission. FA of symptoms has a significant negative impact on the naturalistic outcome of OCD. This emphasises the need to design specific interventions to reduce FA for a better outcome.

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1. Introduction

Various factors have been associated with the outcome of obsessive–compulsive disorder (OCD) (Miguel et al., 2005). One such factor that has been the focus of increasingly growing interest is the role of family accommodation (FA) (Lebowitz et al., 2012). FA is pervasive in families of patients with OCD and is defined as the participation of family members in patients' rituals and modification to family behaviour that are aimed at assisting the patient to avoid feeling anxious (Lebowitz et al., 2012). Most families do this with an intention to attenuate patients' distress or anger and to decrease compulsive rituals (Calvocoressi et al., 1999). These behaviours may include assisting a relative with OCD in performing or completing rituals, respecting the rigid rules that OCD imposes on the patients and family members and facilitation of avoidance of certain anxiety-provoking stimuli (Lebowitz et al., 2012). An accommodating behaviour can dominate routine family life and provoke intense disagreement among family members' concerning responses to the patient's symptoms, often leading to high expressed emotion (EE) (Maina et al., 2006). Many patients

with OCD forcefully impose accommodation on their families, often responding with aggressive and even violent reactions to refusal to accommodate (Lebowitz et al., 2011a; Lebowitz et al., 2011b).

FA is associated with greater symptom severity, increased impairment and is also linked to poorer treatment outcomes (Barrett et al., 2005; Lebowitz et al., 2012). Studies in adults, as in children (for review see (Lebowitz et al., 2012)), have shown an association between FA and the severity of illness (Calvocoressi et al., 1995; Calvocoressi et al., 1999; Ramos-Cerqueira et al., 2008; Stewart et al., 2008; Albert et al., 2010; Vikas et al., 2011), contamination and washing dimension (Stewart et al., 2008; Albert et al., 2010), current mood disorder (Albert et al., 2010) and family history of anxiety disorder (Albert et al., 2010; Amir et al., 2000). Reductions in FA (Storch et al., 2010; Waters et al., 2001) may improve outcomes (Merlo et al., 2009) and family functioning (Diefenbach et al., 2007). In the largest randomised controlled trial of treatment for paediatric OCD, elevated FA predicted poorer outcomes across treatment modalities, including behavioural, pharmacological and combined therapy (Garcia et al., 2010). In a case–control study of the adults, in which 23 patients with treatment-refractory OCD and 26 patients with treatment-responsive OCD were compared, FA was associated with treatment refractoriness along with sexual obsessions and a low socio-economic status (Ferrao et al., 2006). Accommodation of the patient's symptoms in the form of proxy compulsions, providing reassurance, aiding

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avoidance behaviour and modification of lifestyle may contribute to poor outcome by perpetuating and reinforcing OCD symptoms (Steketee et al., 1998). These behaviours help maintain obsessions by preventing habituation and disconfirmation of beliefs.

Numerous studies have examined the role of EE in the prediction of relapse in schizophrenia and depression, but the role of EE on the outcome in OCD is largely understudied (Butzlaff, 1998). The families of patients with OCD show high levels of criticism, over-involvement and hostility (Hibbs et al., 1993; Shanmugiah et al., 2002). Families can react with over-involvement (and accommodation) or hostility, criticality and antagonistic behaviour (Steketee et al., 1998). High EE, hostility in particular (Chambless and Steketee, 1999), has been associated with relapse (Emmelkamp et al., 1992) and a poorer treatment outcome (Chambless and Steketee, 1999; Leonard et al., 1993). It is quite possible that FA could be related to over-involvement in addition to other factors such as psychopathology in family members (Amir et al., 2000).

Overall, there is limited literature on the effect of FA and EE on the outcome of OCD. Furthermore, research has been largely in the context of clinical trials rather than more naturalistic settings. Effect of family variables on the long-term naturalistic outcome is needed.

1.1. Aims of the study

We hypothesised that FA and EE will have a negative impact on the naturalistic outcome of OCD. Therefore, we examined the impact of FA and EE on the naturalistic 1-year outcomes of adults with OCD. We also examined the correlation between family variables and symptom severity, global functioning, impairment and quality of life in patients with OCD. In addition, we explored the relationship between family variables and relatives' quality of life.

2. Method

2.1. Setting and participants

Of the adults who presented to the specialty OCD clinic of the National Institute of Mental Health and Neurosciences (NIMHANS), Bangalore, India between July 2008 and January 2010, 100 were recruited. Of these adults, six participants did not come for any of the follow-up assessments after baseline evaluation, thereby reducing the sample size to 94. The study was conducted with the approval of the Institutional Ethics Committee. Patients provided written informed consent before participation in the study. The inclusion criteria included the *Diagnostic and Statistical Manual of Mental Disorders-IV* (DSM-IV) diagnosis of OCD (APA, 2000), severity score of ≥ 16 on the Yale–Brown Obsessive–Compulsive Scale (Y-BOCS) (Goodman et al., 1989), illness duration of at least 1 year, age between 16 and 65 years and availability of a suitable caregiver willing to participate in the study. The principal author assessed all the patients (AVC). A senior consultant psychiatrist of the OCD clinic (YCJR or SBM) confirmed the diagnosis and associated features by reviewing all the available information.

We recruited one primary adult caregiver for each patient. The caregiver had to have been living with the patient and involved in his/her care for at least 2 years. We excluded those who were primarily involved in the care of any other family member suffering with severe physical or mental illness.

2.2. Baseline evaluation

Baseline evaluation included demographic characteristics (age, sex, years of education, marital status, domicile and referral status); clinical characteristics (onset of OCD, age at first consultation, mode of onset, duration of both OCD and untreated OCD and precipitating factors); a detailed narrative of obsessive–compulsive behaviour and other psychopathologies; mental status examination; medical, family, personal and treatment history. All patients were assessed at the baseline using the following instruments:

- (i) Mini-International Neuropsychiatry Interview (MINI). This was used for confirming the diagnosis of OCD and co-morbid axis-I disorders (Sheehan et al., 1998).
- (ii) Structured Clinical Interview. This was used for confirming DSM-IV axis-II personality disorders (First et al., 1997).
- (iii) Y-BOCS (symptom checklist, severity scale and the item 11 for insight) (Goodman et al., 1989).
- (iv) Clinical Global Impression (CGI) scale. This was used to measure global severity of OCD (Guy, 1976).
- (v) Global Assessment Functioning (GAF) (APA, 2000).
- (vi) Work and Social Adjustment Scale (WSAS) (Mundt et al., 2002). The WSAS is a five-item instrument to measure work and social impairment with acceptable psychometric properties in depression and OCD samples (Mundt et al., 2002).
- (vii) World Health Organization Quality of Life BREF (WHOQOL (BREF)) (WHO, 1996). It is a shorter version of WHOQOL-100 comprising of 26 items; it measures physical, psychological, social and environmental quality of life (WHO, 1996).
- (viii) Family Emotional Involvement and Criticism Scale (FEICS). This was used to measure EE (Shields et al., 1992). It is a 14-item scale that measures EE as perceived by the patient and generates two subscales: perceived criticism and emotional over-involvement. It has good inter-rater and test–retest reliabilities (Shields, 1992) and has been used previously in a study from this centre (Shanmugiah et al., 2002).
- (ix) Family Accommodation Scale (FAS). This scale was used for measuring accommodation of OCD symptoms by family members (Calvocoressi et al., 1995; Calvocoressi et al., 1999). The FAS is a 13-item, five-point clinician-rated Likert scale that assesses the degree to which family members accommodate the patient's rituals over the preceding month. It has two core dimensions: 'participation' in rituals (items 1–4) and 'modification' of daily routines (items 5–9). Items 10–13 measure 'distress' due to accommodation and 'consequences' of not participating in the patient's obsessive–compulsive rituals. The scale has good internal consistency, discriminate validity and inter-rater reliability (Calvocoressi et al., 1995; Calvocoressi et al., 1999).
- (x) Family Burden Schedule (FBS) (Pai and Kapur, 1981). It is a semi-structured interview to assess the dimensions of family burden in the Indian context. It has six dimensions (financial burden, disruption of family routine, disruption of family leisure, disruption of family interaction, effect on physical health of others and effect on mental health of others) and comprises of 25 items, each rated on a three-point scale with a total maximum score of 50 and minimum of 0. Psychometric properties of the scale have been established.

2.3. Follow-up assessment

Patients were assessed every 3 months over the course of 1 year. During each of the 3-month follow-up visits, patients were assessed with Y-BOCS, CGI, FEICS, FBS, GAF, WHOQOL (BREF) and WSAS scale. The caregivers were assessed with FAS, WHOQOL (BREF) and FBS. The follow-up assessments were also performed by the principal author.

2.4. Outcome measure

A patient was defined as a 'remitter' if he/she scored < 16 on the Y-BOCS (Pallanti et al., 2002) and reported minimal or no significant distress or interference in functioning in the preceding 8 weeks.

2.5. Statistical analysis

Data were analysed utilising the Statistical Package for Social Science (SPSS) version 15.0 for windows. Univariate comparisons were done using chi-square test and *t*-test. Pearson correlation test was used for correlation analysis. For univariate analysis, the significance was set at a conservative *P* value of ≤ 0.001 after Bonferroni correction. Repeated measures analyses of variance (RMANOVA) with *post hoc* comparison method of least significant difference followed by Bonferroni correction was used to examine if there were differences in the mean scores on family and illness variables between remitters and non-remitters, keeping remission status as a factor (group) and time as a within-subject measure, after adjusting for gender, age of onset and duration of illness. We employed the 'last observation carried forward' (LOCF) method for missing value imputation. Time course data were analysed using Kaplan–Meier survival analysis method. Cox proportional hazard regression (forward stepwise Wald) analysis was used to examine if FA and EE predicted time to remission after controlling for all the potential confounders. For this analysis, we entered the variables that were significant in the univariate analysis, and those clinical variables that were considered may have a potential influence on the outcome.

3. Results

Demographic and clinical characteristics are shown in Table 1. At the baseline, only 17 participants had received at least one

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