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Research report

Obsessive-compulsive symptoms and personal disposition, family coherence and school environment in Chinese adolescents: A resilience approach

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ABSTRACT

Background: Risk factors of adolescents with obsessive-compulsive symptoms (OC) have been extensively examined, but protective resilience factors have not been explored, particularly in Chinese adolescents.
Aim: This study aimed to investigate the association of resilience factors with the occurrence of OC and its symptoms in Chinese adolescents.
Method: This study consisted of two phases. The first phase used a cross-sectional design involving a stratified clustered non-clinical sample of 3185 secondary school students. A clinical interview procedure was then employed to diagnose OC in students who had a Leyton Obsessional Inventory 'yes' score of ≥ 15. The second phase used a case-control study design to analyse the relationship between resilience factors and OC in a matched sample of 288 adolescents with diagnosed OC relative to 246 healthy adolescents.
Results: Low personal disposition scores in self-fulfilment, flexibility and self-esteem, and low peer relation scores in the school environment were associated with a higher probability of having OC. Canonical correlation analysis indicated that OC symptoms were significantly associated with personal dispositions, poor peer relationships and maladaptive social life, but not to family coherence.
Limitations: The study is not prospective in nature, so the causal relationship between OC occurrence and resilience factors cannot be confirmed. Second, the use of self-report instruments in personal disposition, family coherence, and school environment may be a source of error.
Conclusions: Resilience factors at both the personal disposition and school environment levels are important predictors of OC symptoms and caseness. Future studies using prospective designs are needed to confirm these relationships.

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1. Introduction

Obsessive-compulsive (OC) symptoms are characterised by recurrent obsessional thoughts, urges or images that are experienced as unwanted and intrusive. Obsessions are typically accompanied by repetitive intentional compulsive behaviours or mental acts that are functionally linked to obsessions and serve to reduce associated distress. OC is a relatively common disorder, with a lifetime prevalence of 1–2% across both adults and youth worldwide (American Psychiatric Association, 2000; Horwath and Weissman, 2000).

Recently there has been an increased focus on paediatric OC and its causal factors, given its debilitating nature, to better inform treatment approaches. Past studies in this area have examined the impact of childhood onset OC on psychological and social functioning, including

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compulsive self-harm or suicide, anxiety, impulsiveness, feelings of depression and helplessness, poor insight, and aggressive behaviours (Adam et al., 2010; Aelterman et al., 2011; Geller, 2006; Geller et al., 1996). They have also examined functional impairment and poor quality of life due to OC (Micali et al., 2010). However, few studies have investigated the impact of resilience factors, including personal dispositions, family coherence and social support, on reducing the severity of symptoms.

Resilience is a concept that may have utility in the treatment of OC. It is broadly defined as the ability of an individual to successfully adapt to or recover from stressful or traumatic experiences (Masten and Coatsworth, 1998). Previous studies on mental disorders (e.g., severe depression) using a resilience approach have focused on protective factors to promote recovery that include positive personal dispositions (Campbell-Sills et al., 2006a), personality traits, optimism, self-confidence or self-efficacy (Sun and Stewart, 2007), and an active style of coping (Campbell-Sills et al., 2006b). They have also examined environmental protective factors such as family warmth, family members understanding within the family coherence context (Baumrind, 1991), school context such as positive peer relationships and a sense of belonging within schools (Baker et al., 2003). These factors act as assets and resources to buffer the effects of adverse experiences (Luthar, 2003, Rutter, 1985), help people to cope with adversity, make them better able to deal with stress in the future, and confer protection from the development of mental disorders (Skodol et al., 2007).

Clinical studies specifically focussed on resilience related factors have been found to be important predictors of OC symptomatology in children and adolescents. For example, De Clercq et al. (2006) found children and adolescents with OC symptoms are characterised by a spectrum of personal dispositions including negative emotional experiences (high Neuroticism), impaired engagement and enjoyment in participation in social activities (low Extraversion score). This is reflected in their high anxiety and shyness scores, and low self-confidence and optimism scores as measured by the Dimensional Personality Symptom Item Pool (De Clercq et al., 2006). Family factors including impaired family functioning, parental blame, family conflict and family cohesion have also been found to be related to OC symptoms (Peris et al., 2008; Piacentini et al., 2003b; Storch et al., 2007). Parent characteristics, such as over protectiveness are significantly related to OC symptoms, while parental care is a protective factor of OC (Wilcox et al., 2008). Although the substantial evidence indicated the correlates of family factors and OC symptoms, how these features relate to treatment outcome is unclear. Some studies found a significant link between family factors and responses to the treatment of OC symptoms, whereas others have not found this link (Peris et al., 2012). This suggests that OC symptoms attributed to family factors may need to be examined in a broad or multiple context that may impact on the family functioning (Peris et al., 2012). School contextual factors, such as social functioning and peer relationships are important predictor of OC (Sukhodolsky et al., 2005). Children with OC have been found to have difficulty to making friends, keeping friends and engaging in age appropriate peer activities (Piacentini et al., 2003b). Further, Storch et al. (2006) found that children with OC were at risk of problematic peer relations because, in part, their symptoms (washing hands, cleanliness) were not understood by peers. Cross-sectional studies have also suggested an inverse relationship between resilience and OC symptoms. For example, a study of non-clinical Norwegian adolescents found higher levels of resilience were related to lower levels of OC symptoms (Hjemdal et al., 2011).

There remains a paucity of research investigating the impact of resilience on OC caseness and OC symptoms, particularly in Chinese adolescents. Although clinical studies have identified *individual* resilience related factors, no studies have examined the interaction of *combinations* of these resilience factors in relation to the caseness and severity of OC symptoms. The aim of the present study was to examine the hypothesis that the combination of personal disposition, family coherence and school environment factors are strongly correlated with obsessive-compulsive symptoms in Chinese adolescents.

2. Methods

2.1. Participants

There were two stages in the recruitment of the study sample. In the first stage, a cross-sectional study was conducted, using a stratified clustered sample, to identify Chinese adolescents with OC among a non-clinical population using the Leyton Obsessional Inventory (LOI-CV) (Berg et al., 1988) as a screening tool. In the initial screening test, four schools that had different academic rankings, based on the quality of teaching and learning outcomes, were selected in two districts of Beijing, China. Students were then randomly selected from these four schools. Three classes per grade in each school were invited to participate in the study, resulting in 3221 potential participants across 72 classes. Of these, 3174 students ages 12 to 18 years agreed to participate in the initial OC screening test, representing a 98.5% response rate (See Table 1). Children who were not given permission by their parents and their parents did not submit consents were excluded from the study. In the initial screening process, 434 (13%) students had scores of 15 or more on the validated LOI-CV in Chinese adolescents (Sun et al., 2014), which is considered as having OC symptoms at the population level.

In the second stage of the study, students with a LOI-CV score of more than 15 were evaluated using the Structured Clinical Interview for DSM-IV Axis I Disorders-Patient Edition (SCID-I/P, Version 2.0) (American Psychiatric Association, 1994), a protocol which assesses diagnostic criteria for OC and other *Diagnostic and Statistical Manual of Mental Disorders IV* (DSM-IV) disorders. Participants were excluded if they had a documented neurological impairment or intellectual impairment, or suicidality six months prior to the start of the study. Ultimately, 288 students who met criteria on both the SCID and the Maudsley Obsessive-Compusive Inventory (MOCI) were diagnosed to have OC and were recruited to the clinical group. The control group was also recruited through the screening process and consisted of 246 adolescents who scored less than 15 on the LOI-CV and matched the students in the clinical group in terms of age and gender. These participants were also free from any psychiatric disorders.

Ethical clearance for this study was obtained through the Chinese Academy of Sciences, Beijing, China, and informed parental consent was obtained for each student after providing them with a detailed description of the study. Agreement to conduct the study was gained from school principals and teachers. All participants were Chinese, predominantly from a middle socioeconomic background, and ranged in age from 12 to 18 years ($M=16.94$, $SD=1.38$). All potential participants were screened in a psychiatric clinic and diagnosed by two doctoral level clinicians using the clinical interview procedures described above.

2.2. Measures

Those who met the above inclusion criteria for either the clinical or control groups were administered a series of measures. These measures include structure interview and self-report measures which were administrated in a psychiatric clinic located in Beijing, China. The self-report measures included the California Psychological Inventory (CPI), Maudsley Obsessive-Compusive

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