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Comparative Study of the Family Functioning of OCD Patients and Healthy Counterparts

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Abstract: The objective of the present qualitative study was to compare the perceived family functioning of the Obsessive Compulsive Disorder (OCD) patients and the normal counterparts. It was aimed to find out differences in the family functioning between clinical and non-clinical participants. It also aimed to identify dysfunctional as well as healthy patterns of family functioning. A Questionnaire was constructed based on McMaster Theory of family functioning and literature review for Interview Schedule. The Constructivist paradigm and phenomenological approach were employed to explore perceived family functioning. Sample included five OCD patients and five non-clinical participants. Purposive sampling was used for selection of the participants. Clinical sample was taken from teaching hospitals of Lahore whereas the non-clinical participants were taken from local community. The participants were screened with the help of Symptom Checklist-Revised to rule out OCD and other psychopathologies. All the participants were interviewed and their in-depth semi-structured interviews were tape-recorded, which were transcribed into Urdu language. Interpretative Phenomenological Analysis was used to analyze transcribed data. All the transcriptions were read and re-read to identify themes: exploratory, recurrent and then major themes were identified. Differences between the family functioning of both groups of participants in form of 'contrasting themes' were analyzed and interpreted further in relation to the existing evidence and literature. Interpretation of data and emergent themes would provide an insight into Pakistani socio-cultural milieu within families. Findings have been discussed in the context of family functioning theory grounded in Pakistani's culture and family therapy.

Key words: Obsessive Compulsive Disorder · McMaster Model of Family Functioning · Interpretative Phenomenological Analysis · Perceived Family Functioning · Lahore · Pakistan

INTRODUCTION

According to Walsh (1993), "Research on healthy family functioning over the past two decades has provided empirical grounding for assessment to identify key processes that can be fostered in intervention with distressed families" [1].

The aim of the present phenomenological study was to explore the comparison of family functioning of OCD patients with their healthy counterparts. A lot of research on the family functioning of OCD patients and healthy individuals has been produced in the West [2, 3, 4, 5]. In Pakistan, most of the researches have been found in the nature, demographic features of OCD, parenting styles and psychosocial characteristics of OCD patients, [6, 7, 8] but the area of family functioning in OCD has not yet been explored fully. While different familial factors like parenting styles, negative and controlling attitude of mother, expression of feelings, communication within the family, siblings' cohesiveness have been studied in the east especially in relation to anxiety, depression and schizophrenia [10, 11, 9, 12, 13, 14].

There are many factors which have been found in OCD patients such as parenting styles, [7, 15] cognitive factors, [16, 17] personality traits, [18, 19] and familial factors [2, 3, 4].

There was unavailability of any family functioning theory grounded specifically in Pakistan's socio-cultural perspective. After the review of many western models of family functioning, McMaster Model of family functioning was found to be a comprehensive model covering major dimensions of family functioning i.e.

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problem solving, communication, roles, affective responsiveness, affective involvement, behaviour control and general home atmosphere [20]. While developing an open-ended questionnaire, help was taken from this model of family functioning.

MATERIALS AND METHODS

Total sample consisted of 10 participants: 5 clinical and 5 non-clinical individuals matched on age, gender, socioeconomic status, education, marital status and family type (nuclear and joint). Age of participants ranged from 21 to 29. Six participants belonged to middle socio-economic class (i.e. income range: 10,001-30,000) and four from low socio-economic class (income range: 10,000 and less). Four participants were married (2 males and 2 females), while all others were single. Their educational level varied from Matric to Masters. The clinical participants differed on the type of obsessions and compulsions as well as in duration, severity and treatment received.

This present study was conducted on two stages: pilot study and final stage. A semi structured questionnaire was constructed keeping in view of the broader dimensions of the McMaster Model of family functioning and literature review for Interview Guide. Initially a pilot study with three volunteers from the normal population and one OCD patient was done in order to check the understand ability of the questionnaire and time for administration of interview. During final stage, total 5 OCD patients, already diagnosed by their respective Psychiatrist/ Clinical Paccordance with DSM-IV criteria were selected from teaching hospitals of Lahore. Symptom Checklist-Revised (SCL-R) was used to verify the diagnosis of OCD and absence of other psychological disorders. Reliability of the Symptom Checklist-R for different scales is: Depression, .73, Somatoform, .74, Anxiety, .47, OCD, .21, Schizophrenia, .34 and Level of Frustration Tolerance, .68. [21] Five Participants who did not meet OCD criteria, having no other psychological problems were selected from local community. Their in-depth semi-structured interviews were tape recorded. A written consent was taken from all the participants. Fake initial names of all the participants were used in analysis in order to hide the identity of the participants.

Interpretative Phenomenological Analysis was used to analyze the transcribed data through which I identified themes. [22] Interpretative Phenomenological Analysis (IPA) dwells on the insider's perspective and researcher's interpretations about the emergent themes across participants. Verification is a process that occurs throughout the data collection, analysis, report writing of a study and standards as criteria imposed by the researcher and others after a study is completed. [23] Different verification criteria were used to evaluate the credibility of the research findings which are as follow: rich thick description, participant reviewer, review of analysis by the participants and peer review or debriefing.

RESULTS AND DISCUSSIONS

Findings are discussed in the context of Pakistani socio-cultural milieu which rest in the families. While analyzing voluminous data, it was sifted out as to what types of differences exist in the families of OCD patients and healthy individuals in form of contrasting themes which includes Identification and Satisfaction with Responsibilities, Strict versus Flexible Behaviour Control, Resentment and Disengaged Communication, Mutual Sharing and Settling Disagreements, Bitterness verses Tolerance in Anger, Affective Involvement and Pleasant and Unpleasant Home Environment.

Identification and Satisfaction with Responsibilities: This first contrasting theme revealed that reported responsibilities of the clinical participants were not identified in their families, ultimately leading family members to be dissatisfied with their responsibilities and its inappropriate fulfilment. The non-clinical participants reported satisfaction of family members with their properly identified and assigned responsibilities. Non-clinical participants appropriately fulfil their assigned responsibilities. The following verbatim of clinical participants (C.P) and non-clinical participants (N.C.P) are as follows: A.B. (C.P.) reported, "No one can identify, there is only an understanding. It means that one has to realize that it is his job." S.R. (C.P.) specified, "Yes, (family members) understand (their responsibilities), but no one fulfils. All shift their work upon others. One says that other will do my work. When responsibilities are not fulfilled, then where from proposals (for marriages) would come? And would be no betterment." According to F.Z. (N.C.P.), "Yes, we mutually and appropriately fulfil responsibilities."

Some clinical participants depict the overburden situation of some family members in the household works. If all family members do not contribute to the household works mutually, then one or two family members are

burdened with responsibilities. A.N. (C.P.) stated, "Mother asked me to do every work, asked me to pick this thing. I used to be in much anger that there were five sisters, whether I am the only person to do all things……mother used to assign me all works."

Strict versus Flexible Behaviour Control: The second contrasting theme transpired from the clinical and non-clinical data indicating difference in behaviour control of both families. The nature of behaviour control differed across the clinical and non-clinical groups in form of strict ("Mother chastises the person who commits a wrong. She severely reprimands. By this way, (brothers/ sisters" reported by S.R.) refrain from doing any wrong.") versus flexible behaviour control ("Family members are more relaxed; none is strict. There are not many restrictions. Sometimes we have to get permission to go outside. Sometimes we just inform if we have to go outside, we then go at our own will." stated by F.Z.).

Resentment and Disengaged Communication: This is the third contrasting theme mentioned solely by the clinical participants ("Bitterness creeps in conversation.", "Mother becomes harsh during conversation.", "Often it happens that (family members) stop talking with each other without any reason. We stop speaking with each other in anger.").

Mutual Sharing and Empathy: Mutual Sharing and Settling Disagreements is the fourth contrasting theme emerged only from non-clinical participants who are differentiated from the clinical participants in communication of anger. F.Z. (N.C.P.) reported, "If there is any necessity, we discuss it mutually. Normally, we sit together at night. There, everyone tells, what he/she requires, like these days one is in need of cream or a suit" S.A. (N.C.P.) said, "Yes, we show our interest. We cooperate with each other and try to solve the (problem). Problem of a family member is the problem of the whole family. It is for all of us. We all get upset. I never think benefit of mine rather think about their benefit (family members' benefits). We think collectively for the benefit of the family."

Bitterness verses Tolerance in Anger: Bitterness and Tolerance in anger is the fifth contrasting theme emerged from the clinical and non-clinical data. Bitterness in anger was reported more by the clinical participants, whereas tolerance in anger more by the non-clinical participants. As reported by one participant R.S. (C.P.) explained, "It is evident that in anger one speaks in a change way. However, mother understands and keeps quite. She asks me to keep silent (when sister or brother is angry). She knows that what my condition is. But the sister can't restrain herself and then I get bitter. Brother remains in a state of anger all the time and he shouts.". A.H. (N.C.P.) stated: "We keep quiet in anger. Mostly, we keep quite in anger. We observe silence in anger and worry and keep ourselves mentally busy to find out its solution. Or, if a sister gets annoyed with another sister, she can complain to mother that I am angry with her and request (mother) for resolution of the issue."

Affective Involvement: Affective involvement has been transpired from the non-clinical data which differentiates the families of the non-clinical participants from that of clinical participants in the dimension of emotional involvement within the family. Affective involvement is manifested in the mutual empathy: taking interest into one another, doing others' works sincerely as well as the presence of healthy and necessary interference into each others' work whenever needed. S.A. (N.C.P.) said, "Yes, we show our interest. We cooperate with each other and try to solve the (problem). Problem of a family member is the problem of the whole family. It is for all of us. We all get upset. I never think benefit of mine rather think about their benefit (family members' benefits). We think collectively for the benefit of the family."

Pleasant Versus Unpleasant Home Environment: Pleasant and unpleasant home environment is the sixth contrasting theme between clinical and non-clinical data in relation to the family functioning. Pleasant home environment was reported by non-clinical participants in contrast to clinical participants who have reported unpleasant home environment.

Pleasant home environment refers to a place of family living where family members are friendly, cooperative and helpful. They counsel one another. Here, anger is expressed to a limit which does not breed bitterness or such other negative elements in the person. On the other hand, unpleasant environment can be contrary to the mentioned phenomenon of pleasant home environment. A.H. (N.C.P.) narrated, "Relationship between family members is excellent. Everyone supports one another to his/her maximum limit. I am always for the problem of other, lest I may loose something. Environment (at home) is very pleasant.".A.B. (C.P.) said,"(Home) environment is

not full of love and affection. Everyone has different temperament. Temperament of father is hot. He does not understand the pleasantries of brothers and sisters and anger takes over him. Brother, sister and bhabi, all remain busy in their works."

The perceived familial patterns of OCD participants are unclear roles and responsibilities and eventual dissatisfaction of family members and inappropriate fulfilment of responsibilities. There may be the reason that the parents are unable to communicate responsibilities clearly or these are taken for granted. This may be related with the resentment and disengaged communication, that dissatisfaction with responsibilities lead towards the resentment and disengaged talk between family members. Family members may be having annoyance with each other resulting in disengaged communication. Above all, family members are controlled strictly to correct their behaviour. This really adds fuel to the ongoing condition of the family. When such situation prevails in the family, it creates further confusion and conflicts among family members. These conflicts get more extreme when family members reflect bitterness and even anger in their communication. The entire described phenomenon develops a crumbling and deleterious picture when conflicts are growing gradually in the hearts of the family members with no sharing with each other. When there is lack of sharing between family members, then divergent views take the form of conflicts and discord. Whenever these conflicts are not resolved, relationships of family members get tense and even detachment can occur. Automatically family members leave concern and do not consider each others' feelings, interests, jobs and even their affairs. This makes the home environment unpleasant and debilitating, where no one tolerates anybody. Everybody thinks about oneself rather than for other family members or for the benefit of the whole family (Home Environment). These perceived familial patterns of OCD participants may develop apprehensions, worries, doubts, indecisiveness, low self-esteem and constant brooding over thinking in an individual.

Different researches explored the family functioning of OCD patients and normal individuals, their results are about the differences in different dimensions of family functioning in a broader way [5, 4, 7]. They did not present or might not be found specific patterns within the dimensions of family functioning. My research is different from other studies as it provides a detailed and clear picture of the family patterns within each dimension of family functioning.

It has been found that 50 percent of OCD clinical patients scored in unhealthy range of one or more aspects including affective responsiveness, roles, family problem solving or behaviour control while no significant differences found in communication between OCD and non-clinic families [24].

It has been described that different studies depicted the significant differences in family functioning between families with a patient of psychiatric illness or medical

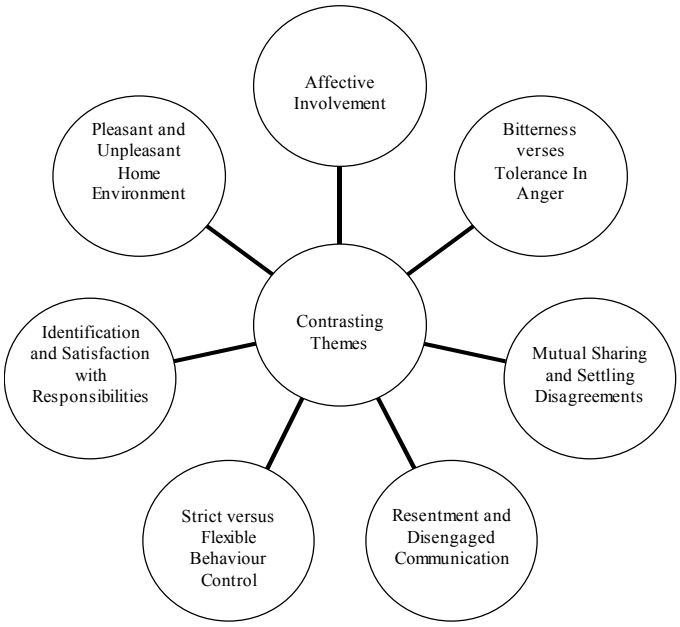

Fig. 1: Contrasting Themes between Clinical Participants of OCD and Non-Clinical Participants

pathology and families without any ill adolescent. [25] Author suggested that vice versa effect of pathology and family relationships cannot be separated.

The opposite picture is depicted in the non-clinical families which are clear roles, satisfaction with them and appropriate fulfilment of responsibilities, flexible behaviour control, mutual sharing, settling disagreements and tolerance in the communication of anger and affective involvement which results in pleasant home environment. When family members are angry, they try to control their anger and resolve the divergent views with mutual sharing. They do consider each others' interests, desires, problems and works. They think in terms of the whole family's benefit. They even interfere into each other's affairs for the betterment of the family members so that they may not be having any problem.

CONCLUSION

Findings depict the significantly emergent differences between the families of OCD participants and non-clinical participants in form of roles ambiguity, roles dissatisfaction, inappropriate fulfilment of responsibilities, strict behaviour control, poor communication, lack of mutual sharing, settling disagreements, resentment in the expression of anger, lack of affective involvement and unpleasant home environment. These dysfunctional familial factors might be the vulnerable factor for OCD symptoms: its development or maintenance. Therefore, clinicians can develop family therapeutic interventions to improve these familial patterns.

There is dire need of developing a culturally grounded theory of family functioning in Pakistan regarding healthy and unhealthy familial patterns. Both groups of the participants, clinical and non-clinical, were too small to generalize the findings from the study. Overall, significant findings would impress upon the family therapists to design interventions in specific dysfunctional familial patterns of OCD families to bring improvement in their family functioning. It may in turn inevitably have long lasting healthy impact on the OCD patients.

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