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Brief report

Mental health, coping and family-functioning in parents of young people with obsessive-compulsive disorder and with anxiety disorders

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Objective. To compare mental health, coping and family-functioning in parents of young people with obsessive-compulsive disorder (OCD), anxiety disorders, and no known mental health problems.

Method. Parents of young people with OCD ($N = 28$), other anxiety disorders ($N = 28$), and no known mental health problems ($N = 62$) completed the Brief Symptom Inventory (Derogatis, 1993), the Coping Responses Inventory (Moos, 1990), and the McMaster family assessment device (Epstein, Baldwin, & Bishop, 1983).

Results. Parents of children with OCD and anxiety disorders had poorer mental health and used more avoidant coping than parents of non-clinical children. There were no group differences in family-functioning.

Conclusion. The similarities across the parents of clinically referred children suggest that there is a case for encouraging active parental involvement in the treatment of OCD in young people.

Obsessive-compulsive disorder (OCD) occurs in between 1% and 4% of children and adults (Geller *et al.* 1998). Developmental considerations, including their dependence on family members, complicate the psychological treatment of OCD in young people (Swedo, Leonard, & Rappoport, 1992). Investigators are starting to address family issues in treatment protocols for OCD that include concurrent family management sessions (Piacentini, Gitow, Jaffer, Graae, & Whitaker, 1994).

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Behavioural and cognitive theories regard OCD as a psychological disorder based on learning processes. Salkovskis, Shafran, Rachman, and Freeston (1999) proposed that parents of children with OCD are similar to parents of anxious children, in that they often hold beliefs that the world is threatening or dangerous. Parents' own psychological states may significantly impact the experiences of their children and may contribute to the emergence and maintenance of obsessive behaviours and rituals. Psychoeducation of parents, support groups, and family-assisted treatment are common in the treatment of other anxiety disorders in children and are, therefore, plausible components of a comprehensive psychological treatment for OCD. It has been hypothesized that parental mental health (March & Curry, 1998), coping (Pollock & Carter, 1999) and family-functioning (Valleni-Basile *et al.*, 1995) are important aspects of the family context of OCD that may require appropriate intervention. However, little research has investigated these constructs in families which have a young person with OCD.

This study examined whether parents of adolescents with OCD have an increased rate of psychiatric symptoms, a reliance on avoidance coping, and poorer family-functioning compared with parents of adolescents with other anxiety disorders and parents of adolescents with normal development.

Method

Participants

Three groups of parents were recruited; two based on their child's diagnosis of OCD ($N = 28$) or anxiety disorders ($N = 28$), and a non-clinical group ($N = 62$). Their children were aged between 11 and 18 years (mean 14.6 years). The clinical groups were recruited from two Child and Adolescent Mental Health Services in the east of England. The non-clinical group were recruited from a random sample of 250 families with children attending a school in the east of England. The response rate was 25.2%.

In the OCD group, all young people met diagnostic criteria for OCD and 93% had a co-morbid anxiety disorder (Libby, Reynolds, Derisley, & Clark, 2004). Parents in the anxiety disorders group had children who did not meet criteria for OCD and presented with the following primary diagnoses: separation anxiety ($N = 4$), generalized anxiety disorder ($N = 6$), panic disorder with agoraphobia ($N = 8$), and social phobia ($N = 10$).

The majority of parents were mothers (24 of the 28 in the OCD group, 22 of the 28 in the anxious group, and 60 of the 62 in the non-clinical group). Their children were recruited to a linked project investigating cognitive appraisals in young people with OCD (Libby *et al.*, 2004). There were no group differences in age for young people or their parents; children's age: $F(2, 116) = 0.05$, $p = .95$; mother's: $F(2, 116) = 0.86$, $p = .42$; or father's: $F(2, 116) = 2.06$, $p = .132$.

Measures

The Leyton Obsessional Inventory (LOI; Child Version; Berg, Whitaker, Davies, Flament, & Rapoport, 1988). The LOI has acceptable internal reliability with a Cronbach's α of .82 (Berg *et al.*, 1988). One young person in the non-clinical group scored in the range indicative of OCD (i.e. above 15 on the yes score and above 25 on the interference scale; Flament *et al.*, 1988) and their parent was not included in the study.

The Anxiety Disorders Interview Schedules for Children and for Parents (ADIS-C and ADIS-P; Silverman & Albano, 1996) was used to establish DSM-IV diagnosis (American Psychiatric Association, 1994).

The Brief Symptom Inventory (BSI; Derogatis, 1993) was completed to assess parental psychiatric symptoms and severity. This is a 53-item self-report inventory scored in terms of nine primary symptom dimensions, and three global indices of distress. The BSI has acceptable internal consistency ranging from .78 to .83 (Derogatis, 1993). Test-retest reliability is also satisfactory ranging from $r = .68$ (somatisation) to $r = .91$ (phobic anxiety); global severity index $r = .90$.

The McMaster Family Assessment Device (FAD; Epstein *et al.*, 1983) assesses general family-functioning. This 53-item self-report questionnaire has seven scales that measure problem solving, communication, roles, affective responsiveness, affective involvement, behaviour control, and general functioning. The FAD has acceptable validity and internal reliability; Cronbach's α ranges from $\alpha = .72$ to .92 (Epstein *et al.*, 1983).

The Coping Responses Inventory (CRI; Moos, 1990) assesses personal coping strategies. Participants identify a recent stressful episode and rate on a 4-point scale their reliance on each of 48 coping responses. The questionnaire identifies four types of coping processes: cognitive approach coping, behavioural approach coping, cognitive avoidance coping, and behavioural avoidance coping. The internal consistency of the subscales and test-retest reliability are satisfactory (Moos, 1990).

Procedure

Clinical group

The young person and one parent were interviewed separately using the ADIS-C and ADIS-P. While their parent was interviewed, the young person completed the child version of the Leyton Obsessional Inventory in the clinic waiting room. While the young person was being interviewed their parent completed the BSI, CRI, and the FAD in the clinic waiting room.

Non-clinical group

When consent forms were received from parents, the Leyton Obsessional Inventory (Berg *et al.*, 1988) was sent to the young person and the BSI, CRI, and the FAD were sent to a parent to complete and return.

Results

We were interested in differences between the three groups of the parent's ratings on the BSI, CRI and FAD. Mean scores for the scales and subscales are shown in Table 1. For parental mental health (BSI global severity), there was a significant effect of group, $F = 6.42$, (2, 116), $p < .01$. *Post hoc* Tukey tests showed that parents of non-clinical children scored significantly lower on the GSI than parents of both clinical groups; there were no differences between the two groups of parents with clinically referred children. Subscale scores on the BSI were then compared in a 3-group (OCD, anxious, non-clinical) MANOVA. There was a significant effect of group, $F = 2.40$, (9, 109), $p < .02$. Univariate results showed significant group differences on all subscales except for somatization and paranoid ideation. *Post hoc* Tukey tests showed that there were no significant differences between the parents of anxious children and those of children with OCD on any of the subscales. Parents of children with OCD had higher scores than

Table 1. Group means for parental mental health and coping

Measure	Subscales	OCD group		Anxiety group		Non-clinical group		Univariate <i>F</i>
		<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	
Brief Symptom Inventory	Somatization	52.10	9.16	52.00	9.64	49.76	9.43	0.88
	Obsessive compulsive	58.55	10.31	59.53 ^b	10.33	54.32 ^b	8.18	3.93*
	Interpersonal sensitivity	58.65 ^a	10.05	57.96	9.02	53.35 ^a	9.54	4.04*
	Depression	56.10 ^a	10.66	55.86 ^b	9.97	50.73 ^{ab}	8.50	4.64*
	Anxiety	56.76 ^a	10.44	54.18 ^b	8.83	47.85 ^{ab}	9.40	10.05**
	Hostility	56.55 ^a	8.12	54.32	11.06	51.53 ^a	8.65	3.15*
	Phobic anxiety	52.90 ^a	8.97	51.82	9.81	48.34 ^a	5.90	4.14*
	Paranoid ideation	57.79	9.91	56.75	9.25	53.74	8.51	2.37
	Psychoticism	58.03	10.85	56.07	10.64	52.82	7.70	3.44
	Global severity index	58.10 ^a	10.18	57.17 ^b	9.69	51.73 ^{ab}	9.41	6.42*
Coping Skills Inventory	Cognitive approach	47.34	5.81	47.36	7.63	45.45	9.51	0.77
	Behavioural approach	48.36	6.81	49.02 ^b	7.59	44.38 ^b	8.25	4.58*
	Cognitive avoidance	49.62 ^a	4.90	48.80 ^b	7.17	44.75 ^{ab}	7.75	6.06**
	Behavioural avoidance	52.76 ^a	7.80	50.21	6.43	47.89 ^a	6.68	4.99**

Note. Superscripts a and b indicate groups which are significantly different. * = $p < .05$, ** = $p < .01$

parents of non-clinically referred children on the subscales of interpersonal sensitivity, depression, hostility, phobic anxiety and psychoticism. Parents of children with anxiety reported significantly higher obsessive-compulsive symptoms, depression, and phobic anxiety than the parents of non-clinical children.

Parental coping was also compared with a 3-group MANOVA which was significant; $F = 5.54$, (4, 113), $p < .001$. Univariate results showed group differences on behavioural approach, cognitive avoidance and behavioural avoidance coping and no group differences on cognitive approach coping. *Post hoc* Tukey tests indicated that the parents of anxious children used significantly more behavioural approach coping than the parents of non-clinically referred children, that both clinical groups used more cognitive avoidance than the non-clinical parents, and that the parents of children with OCD used significantly more behavioural avoidance than the parents of non-clinical children.

Finally, we examined family-functioning, as measured by the FAD, again with a 3-group MANOVA. Although there was a significant multivariate effect, there were no univariate group differences between the subscales.

Discussion

The results of this study show clear differences between the clinical and non-clinical groups, and no differences between the two clinical groups. Consistent with the literature, the parents of young people with OCD and anxiety were significantly more likely to report mental health problems, compared with parents of normally developing adolescents. Furthermore, parents of adolescents in the clinical groups used more coping strategies overall than the non-clinical group. Parents of children with OCD used significantly more cognitive and behavioural avoidance strategies than non-clinical parents. Surprisingly, there were no group differences in family-functioning.

The design of this study called for the recruitment of three groups; parents of children with OCD, parents of children with anxiety, and parents of children with no known mental health problems. Both clinical groups were recruited from the health service and children met DSM-IV criteria for an anxiety disorder or obsessive-compulsive disorder. Therefore, they constituted a clinically representative sample. However, this was a cross-sectional study, which limits the interpretation of this data. Although the characteristics of parents who had children with anxiety and OCD are consistent with psychological models of aetiology, it cannot be assumed that parents' mental health problems and coping responses pre-dated the child's mental health problems and thus contributed to their development. However, parental mental health and coping responses may also be implicated in the maintenance of OCD and anxiety in children, and these data are consistent with that interpretation.

There is already good evidence that actively involving parents in cognitive therapy for anxiety disorders in children is effective (e.g. Cobham, Dadds, & Spence, 1998), and these data suggest that further developments in the treatment of OCD in young people may also be fruitful. Further research is needed to systematically investigate whether CBT, with the addition of a family component, improves effectiveness in the short-term and long-term for young people with OCD.

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