



Original Article

Perceived emotions in patients with obsessive-compulsive disorder: Qualitative study

Rezvan Saei¹; Zahra Sepehrmanesh^{2*}; Afshin Ahmadvand²

¹ BS. in psychology, Kashan University of Medical Sciences, Karegarnejad Hospital, Kashan, Iran

² Associated professor of psychiatry, Kashan University of Medical Sciences, Karegarnejad Hospital, Kashan, Iran

Abstract

Introduction: Various social factors play important role in obsessive compulsive disorder (OCD). Type of behavior and emotions of family members to patient have been identified as effective factors in onset, severity and relapse of OCD. This study has been carried out to determine of family emotions to their patients.

Materials and Methods: This is quantitative study that was performed with targeted sampling method on 10 patients with OCD. In this study, focus group method was used for gathering data. All of statements was recorded and written words by word. Data were analyzed by content analysis method.

Results: The finding of this study show that perceived emotions of patients classify in four field such as over involvement, criticism, neglect and lack of emotional support and hostility; that this emotions was causing feeling including lack of self-confidence, the feeling of being in control, lack of privacy, lack of empathy, nervousness, guilt and hopelessness, lonely, depression, worthlessness, neglect, anxiety, self-blaming.

Conclusion: Patients' perceived emotions indicates on maladaptive reactions of family in communication of patients that these threatening patients health and failure of therapeutic outcomes, severity and relapse of OCD. Also these emotions propose of lack of family education, lack of information about of nature of psychiatric disorders, family psychopathology and abnormal communications. Therefore holding family psychoeducation as base and supplement of treatment in prevention of disorder relapse should be in attention of clinicians.

Keywords: Expressed emotions, Family, Obsessive-compulsive disorder

Please cite this paper as:

Saei R, Sepehrmanesh Z, Ahmadvand A. Perceived emotions in patients with obsessive-compulsive disorder: Qualitative study. *Journal of Fundamentals of Mental Health* 2017 Mar-Apr; 19(2): 84-9.

Introduction

Emotion, in psychology, usually refers to sentimental feelings as well as reactions. Each emotion includes three basic components: cognitive, physiological and behavioral. Emotion involves patterns of physiological responses and special behaviors. Most people consider emotions as the feeling they receive; however, emotion is a behavior not a personal experiment (1). Family, as one of the major pillars of treatment, is taken for granted in psychiatry and in the treatment of patients with mental disorders. Hence, the emotional environment of the family against the disease is of great importance in a way that it can affect either onset or relapse of disease (2).

Expressed emotion (EE) is one of the most

important issues in family affecting incidence and severity of mental disorders. Representing emotional conditions of the family, EE reflects the quality of the relationship between family members and the patient. It includes critical and hostile dimensions and comment as well as intensive emotional involvement (3). Among family factors influencing the treatment, expressed emotion in most of the studies is determined as predictor of schizophrenia, dementia and anxiety disorders recurrence while very few studies have addressed the role of emotion in obsessive-compulsive disorder (4).

A study by Hibbs indicated 46% of fathers and 66% of mothers of 49 children with OCD showed high levels of expressed emotion which is higher in comparison with that in parents of normal children. Furthermore, parents with high level of EE had more psychiatric diagnosis, familial conflicts and marital dissatisfaction (5). Studies illustrate that higher EE may have worse prognosis for obsession, whereas positive feelings of families toward the patient show

*Corresponding Author: Karegarnejad Hospital, Kashan, Iran

z.sepehrmansh@gmail.com

Received: Apr. 28, 2016

Accepted: Nov. 07, 2016

more improvement in long time (6). Steketee evaluated family interactions within 9 months after treatment. Poor social and familial functions as well as negative family interactions (expressed emotion) with patient before treatment resulted in less benefits after treatment, while positive emotions led to greater improvement in treatment (7).

Various studies prove that the levels of expressed emotion are closely related with an increase in drug taking, level of performance and disease relapse rate (4). The expressed emotion is not often fixed in some families even although Scazufca, in his study during a 9-month follow up, suggested that, EE remains constant at the beginning of the disease in two thirds of families. He also stated that changes in family deterioration as well as the extent of relationship between the patient and the family can predict the changes in the level of expressed emotion (8). Barrowclough argues that expressed emotion may result in complicated interactions between patients and their family members. In fact, disease and the patient's behaviors are an important part of the process aiding the root of the expressed emotion and its changes over time in a family (9).

In his study, Shanmugiah showed a high expressed emotion in patients with obsessive compulsive disorder and noted the existence of criticism and intense emotional involvement in family, but the intensity of emotional involvement was more than criticism (10). One study on obsessed children treated by medication showed that children living with parents with high expressed emotion appeared to be weaker in compatibility after 2 to 7 years of follow-up in comparison with those having a family with low EE (11). Thus, assessment of EE level in a family may be a useful tool to indicate whether family relationships may affect the progression of the disease or not?

High prevalence of obsessive-compulsive disorder in Kashan, its frequent relapse, and inappropriate attitude of some families toward mental disorders made us do a qualitative study to attain patients' experiences regarding the behavior of their caregivers. We aimed to find useful methods by accurate understanding and actual perception of the patient to decrease relapse and intensity of the disease. In this regard, this qualitative study was carried out in Kashan to describe the perceived emotions of patients with obsessive-compulsive disorder in relation with their families.

Materials and Methods

Our study aimed to understand the perceived emotion of patients suffering from obsessive-

compulsive disorder associated with their families. This is a qualitative study using purposive sampling of 10 patients with obsessive-compulsive disorder who were hospitalized in Kargarnejad psychiatric hospital, Kashan University of Medical Sciences. Inclusion criteria include patients with obsessive-compulsive disorder according to DSM-IV-TR diagnostic criteria and a psychiatric diagnosis, having at least 20 years of age, and patients whose disorder severity is more than 25 based on Yale-Brown test. Exclusion criteria were associated with mental retardation, cerebral organic defects, seizure disorders, psychosis and bipolar disorder. Selected patients were almost homogeneous in terms of severity, duration of illness, education level and the frequency of hospitalization. Regarding ethics, prior to the start of the study, the participants were given explanations on the purpose of the study and how to do it. Informed consent was taken and they were assured about the confidentiality of personal data in all phases of study.

In this study, the focus group was the source of gathering data. Both a psychiatrist assistant and a psychologist moderated the group and the data were recorded by the psychologist. The analysis was done via content analysis method along with collecting the data. Firstly, meaningful units were specified and, then, the related codes as well as their subgroups were extracted and summarized in 4 main classes and 12 subclasses. To validate the data, data gathering, note taking, manuscript, recorded items, revise and continuously comparison of data were used. To make sure about the validity and reliability of the study, the qualitative data were submitted to the participants to be revised if necessary. And to clarify the contradictory cases in coding, all the remarks expressed by participants were separately coded by three other researchers and the contrasts were eradicated.

Results

The participants included 10 patients (6 females and 4 males, aged 22-38 years with mean age of 30 ± 4.89 years) with obsessive-compulsive disorder hospitalized in psychiatric hospital, half of which were married and all of them had high school education. Based on Bill Brown Test, all patients were severely ill with an average duration of 7 years. They all were reported to have more than 5 times hospitalization experience. Based on data analysis, perceived emotions of the patients were classified into 4 main groups, each with several subgroups. Table 1 represents perceived emotions

of the patients using their quote.

Table 1. Perceived emotions of OCD patients

Semantic unit	Main groups	Sub-groups	
Perceived emotions of OCD patients in relation with family	Excessive emotional involvement	Lack of self-Confidence	
		Feeling of being observed	
		Lack of privacy	
	Criticism	Lack of empathy	nervessness
			Guilt feeling and hopelessness
	Lack of emotional support	Violence and immorality	Loneliness
			Depression
			Sense of worthlessness
			Anxiety
			Self-blaming

Family related emotions of the patients with obsessive-compulsive disorder

1. Emotional over-involvement

Reactions of both families and caregivers against patients' behavior were interfering patient tasks, so most patients resented such reaction and their feeling reflected this emotion clearly.

A) Lack of Self-confidence

Some patients stated that their family reaction toward their illness lead to lack of self-confidence.

"While I was doing my tasks, they insist to be with me. For example, in doing the washing up, they stand beside me and order me to wash the dishes there, wash that one first, use less water, keep quick, etc." A 22-year-old female patient said.

B) Feeling of being under control

My mum always controls me; if I want to do a personal thing, even not an important one, she slinks; or whenever I want to go to WC, if I return to take a toilet napkin she asks: "What do you want it for?" They are watching me like a child.

C) Lack of privacy

Some patients were dissatisfied because their family wasn't friendly and warm and also their home wasn't a place for peace and tranquility to do the tasks easily.

A patient stated that if a friend of mine calls me, I don't dare to talk to him or her privately because my family wants to control me and know everything

about that call. They make me explain everything to them. This has made me act the same out of home. In our house talking over the phone with friends is not accepted. My parents don't behave kindly, so I don't get on well with them easily. Sometimes, I need to talk with my friends.

2. Criticism

A) Feeling of not being understood

"When I feel anxious or get severely obsess, they insult me and blame me and accuse me of being responsible for such behavior. They say we begged you lessen the washing and doing other staffs but you didn't", said a 31-year-old woman, upset and frustrated.

Another patient mentioned: "when I resent sever anxiety and as a result I start doing the household or pick on my kids, they beat me or threaten me to breaking or messing my staffs. They said that they had had enough of my behavior." They think I do it intentionally.

B) Anger

"My family doesn't want to accept that I am ill and think I am obstinate. I feel they don't like me. I'm very upset and sometimes want to shout", expressed a 38-year-old man.

Another participant said: "My relatives tell me you are responsible for your behavior and your act, you do them intentionally. This makes me angry."

C) Guilt and hopelessness

A woman of 31 said: "whenever my family ask me to act as they wish and I am unable to do so, I feel that I am torturing my family members and this is not good."

A 32 year-old-girl stated: "whenever I am having a bath and it takes longer than usual, my mum calls out loud and says the toilet well is filing up, what the hell you are doing there. And after that starts shouting, booring, and swearing me. Then I feel worse and at that time I want to kill myself to let everyone free from all worries about me especially my old mom because she cannot stand it.

3. Lack of emotional support

A) Loneliness

Participant No 7 said: "I am very lonely, there is no one to talk to or to back me. I am being treated in a way that even if I am in spirit, I feel people are tired of me.

B) Depression

A patient acclaimed that no one pays attention to us unless he or she suffers from obsess. My dad is used to telling me that I am ok and there is no problem with me and I say I wish they could have understood me.

C) Feeling of neglect and rejection

Another patient said that, instead of helping us, families say you are a stain in the society, you are fanatic. They ignore us. They believe that an obsess person is doom to die. They also say that they didn't have such a nasty thing in their family, we disrepute them.

D) Worthlessness

They don't care me at all let alone ask me to do something for them. Whenever I start talking they interrupt me and put me down before others. They even call me with a name.

4. Violence and immorality

A) Anxiety

When I am highly obsessed, my family starts violating me. They stop the tap and this makes me tenser. When they see I am tense, this makes them agitated and row. And, finally, I get anxious.

B) Self-blame

My mum doesn't stand me and gets headaches. I blame myself but I can do nothing because I can't help it. My sisters say you will finally make mum have a heart attack. She is sick because of you and they start insulting and swearing me. Blaming a lot gets us to feel worthless.

Discussion

This study aimed to understand perceived emotion in patients suffering from obsessive-compulsive disorder in relation with their families. The perceived emotions by patients were classified as excessive emotional involvement, criticism, lack of emotional support, violence and immorality which include subclasses.

Based on the findings of this study, patients received a wide range of negative emotions by family. Among the perceived emotions of patients, excessive interference and lack of emotional support were found to be more than that of two other classes. According to what patients expressed, negative emotions had led to the changes in their mental condition and consequently confusion.

Patients with excessive controller families and without enough emotional support faced much more lack of confidence, a sense of being controlled, lack of privacy, loneliness, lack of empathy, ignorance by the family, and feelings of worthlessness.

To justify this issue, it can be said that obsessive-compulsive disorder often has debilitating effects on family. The family response range from support and sympathy to excessive accompany and from affability with the patient to violence and rejection (12). High frequency of the two expressed emotions of patients' families with OCD-excessive emotional involvement and lack of emotional

support - may be explained in this way that patients' families use excessive involvement as a response to the patient's agitation at the beginning of disorder. Later, because of chronic nature of obsesdisorder, they get frustrated and leave the patient and this comes up as lack of emotional support. Since all participants suffer from chronic OCD, these two opposite excitement are justifiable.

One of the factors which play a key role in recognizing expressed emotions is the culture of the families. Attitude toward the patient and the family expectations are such examples.

Excessive emotional involvement with the patient has gone to be a norm in most families; and caregivers without severe emotional involvement are known as the one who is not qualified to care the patient (13). This may be due to lack of enough knowledge of the family members about the nature of mental disorders which result in adverse effects on treatment.

Findings from Perceived Emotion of the patients illustrate that Families try to make the situation better for the patient with interfering and over controlling.

Kendel says: "If the family presumes that the symptoms can be controlled by the patient, they will attempt to force the patient to return to normal mode by means of oppositional response such as criticism and hostility; however, these Illogical reactions aggravate the disease (14).

Kulpers, in his study, has shown that hostility, criticism and too much emotional involvement are the most common causes of relapse (15). The studies indicate that Family interactions and patients' perception of EE are so effective in treatment planning that due to excessive emotional involvement and criticism, exposure therapy in patients with OCD may have negative effects. Too much support and accompaniment of relatives have been considered as a negative effect on OCD that May decrease the sense of self-efficacy in patients. All these findings reflect the stress-vulnerability model of expressed emotion on mental health So that the patients exposed to higher expressed emotion experience higher stress in interpersonal relation (16).

Chambless evaluated the role of expressed emotion as a predictor of the results of behavior therapy, in 60 patients with OCD and 41 patients suffering from Agoraphobia. Expressed emotion including 5 variables (criticism, excessive emotional involvement, violence, warmth and positive reaction) was questioned in an interview.

The results showed that intense emotional

involvement, as a violent reaction from the patients, increased the probability of leaving further treatment and patients with violent caregivers left treatment 6 times more than others. Violence has led to poorer results after treatment (17).

According to Emmekamp, expressed emotion results in the recurrence of obsessive-compulsive disorder. Families, who are extremely involved in the patients' activities, may make them feel rage and reject the patient. Non-adaptive reactions of family cause more stress in patients and even lead to further symptoms and relapse (18).

Previous studies have also evaluated intense emotional involvement and criticism as the main components of expressed emotion. They recommended that high criticism was connected with the family perception of patient's ability of controlling himself and the disorganized behavior of the patient can be considered as a failure in his effective activities (19).

Families with high levels of excessive emotional involvement might believe that patients cannot solve their matters by themselves. Therefore, they involve themselves in patients' matters which are kind of a controlling; therefore, the patient may feel confused and frustrated. This is obtained from the results of this study (6).

Beradis study showed that patients suffering from obsess which had less insight about the disease experienced more symptoms and more expressed emotion in comparison to other patients with intermediate, good and excellent insight. Lack

of insight associated with high criticism of the family (20).

Due to the existence of expressed emotion in families of the patients and its importance in the prevention and treatment of mental disorders, it is highly recommended that clinicians pay more attention to training sessions for the families as the basic and complementary therapy. The sessions should be planned base on patients' understood emotions as well as the entity of the disease especially for the families who face such disorder for the first time. Moreover, to attain a successful treatment especially in patients with obsessive-compulsive disorder, the family should have an active and effective participation in all sessions of behavioral therapy being hold in accordance with the condition of the OCD patient.

Conclusion

Patients' perceived emotions indicates on maladaptive reactions of family in communication of patients that these threatening patients health and failure of therapeutic outcomes, severity and relapse of OCD.

Acknowledgment

The authors would like to thank all the participants. In addition, our special thanks to Mrs. Zahra Gharedaghi (nurse), the Clinical Research Unit of Kargarejad Psychiatric Hospital, Matini hospital, and Kashan University of Medical Sciences.

References

1. Cannon, Walter B. The James-Lange theory of emotion: A critical examination and an alternative theory. *Am J Psychol* 1927; 39: 106-24.
2. Butzlaff RL, Hooley JM. Expressed emotion and psychiatric relapse. A meta-analysis. *Arch Gen Psychiatry* 1998; 55: 547-52.
3. Lobban F, Barrowclough C, Jones S. Does expressed emotion need to be understood within a more systematic framework? *Soc Psychiatr Psychiatr Epidemiol* 2006; 41: 50-55.
4. Chien WT, Chan SW. Further validation of the Chinese version of the level of expressed emotion scale for research and clinical use. *Int J Nurs Stud* 2010; 47(2): 190-204.
5. Hibbs ED, Hamburger SD. Determinants of expressed emotions in families of disturbed and normal children. *Journal of perceptions of their parents and the course of their illness. Br J Psychiatry* 1999; 153: 344-53.
6. Steketee G, Vannoppen B. Family approaches to treatment for obsessive compulsive disorder. *J Psychiatry* 2003; 25(1): 43-50.
7. Steketee G. Social support and treatment outcome of obsessive compulsive disorder at 9 month followup. Behavioral perceptions of their parents and course of their illness. *Br J Psychiatry* 1993; 153: 344-53.
8. Sczufca M, Kuipers E. Coping strategies in relatives of people with schizophrenia before and after psychiatric admission. *Br J Psychiatry* 1992; 174(2): 154-8.
9. Barrowclough C, Haddock G, Lowen I, Conner A, Pidliswiy J, Tracey N. Staff expressed emotion and causal attributions for client problems on a cow security unit: an exploratory study. *Schizophr Bull* 2001; 27(3): 517-29.
10. Shanmugiah A, Varchese M, Khama S. Expressed emotions in obsessive compulsive disorder. *Indian J Psychiatry* 2002; 44(1): 14-18.
11. Leonard HL, Swedo SE, Lenane MC, Rettew DC, Hamburger SD, Bartko JJ, et al. A 2-7 year followup study of 54 obsessive compulsive children and adolescents. *Arch Gen Psychiatry* 1993; 50: 429-39.

12. Koujalgi SR, Nayak RB, Pandurangi AA, Patil NM. Family functioning in patients with obsessive compulsive disorder: A case-control study. *Medical journal of Dr. D.Y. Patil University* 2015; 8(3): 290-4.
13. Bhugra D, McKenzie K. Expressed emotion across cultures. *Adv Psychiatr Treat* 2003; 20(4): 342-8.
14. Wendel JS, Miklowiz DJ, Richards JA, George EL. Expressed emotion and attributions in the relative of bipolar patients: an analysis of problem-solving interactions. *J Abnorm Psychiatry* 2000; 109(4): 792-6.
15. Kuipers E, Onwumere J, Bebbington P. Cognitive model of care giving in psychosis. *Br J Psychiatry* 2010; 196: 259-65.
16. Tynes LL, Salins C, Skiba W, Wihstead Dk. A psycho- educational and support group for obsessive compulsive disorder patients and their significant others. *Compr Psychiatry* 1992; 33: 197-201.
17. Chambless DL, Steketee G. Expressed emotion and behavior therapy outcome: A prospective study with obsessive compulsive and agoraphobic out patients. *J Consult Clin Psychol* 1999; 67: 658-65.
18. Emmekamp PMG, Delange I. Spouse involvement in the treatment of obsessional neurosis in a family setting. *Aust NZJ Psychiatry* 1983; 21: 341-6.
19. Chien WT, Norman J. A randomised controlled trial of a mutual support group for family caregivers of patients with schizophrenia. *Int Nurs Stud* 2004; 41(6): 637-46.
20. Beradis DD, Campandla D, Serroni N, Gambi F, Carano A, Rovere RL. Insight and perceived expressed emotion among adult outpatients with obsessive compulsive disorder. *J Psychiatr Pract* 2008; 14(3): 154-59.