

Marriage under control: Obsessive compulsive disorder and partnership

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Abstract

BACKGROUND: People who have an obsessive-compulsive disorder (OCD) tend to manifest a need for excessive control over their partners and other relatives, which then constitutes a principal problem in their relationships. This behaviour probably relates to an unmet need for safety in their childhood. This review article aims to explore the interpersonal dimension of OCD.

METHOD: Sources used in this review were acquired via PubMed from January 1990 to January 2020. The search terms included "obsessive compulsive disorder", "OCD", "marital problems", "marital conflicts", "marital attachment", and "partnership". Primary search with keywords in various combinations yielded 242 articles. After applying inclusion and exclusion criteria, 68 articles were found eligible for further research, and a secondary search was performed by screening their reference lists for relevant articles. In total, 124 papers were included in the review.

RESULTS: OCD patients often have interpersonal problems that are related to symptomatology and the excessive need for control over the relationship. The patient is often addicted to his/her loved ones and transmits his excessive concerns to them. The studies describe increased marital distress, less satisfaction with their partner and couples experiencing less intimacy. The communication style of people suffering from OCD often shows a tendency to control others extensively, which is probably related to their exaggerated need for safety. Individuals with preoccupied or avoidant attachment styles are more likely to become jealous and to consider any rival as threatening than those people who have a safe attachment style.

CONCLUSION: Participation of the partner in the therapy can have positive effects. Furthermore, family-based exposure and response prevention programs might be useful for reducing OCD symptoms.

INTRODUCTION

Obsessive-compulsive disorder (OCD) is a persisting incapacitating disorder present in 1–3% of the general population (Ruscio *et al.* 2010). OCD is characterized by unwanted, recurrent, and stressful thoughts and/or repetitive behaviour that causes suffering and interferes with a patient's daily life, causing problems in occupational or school functioning, societal activities and also disturbs family relationships, relationships at work and marital functioning (Emmelkamp *et al.* 1990, Calvocoressi *et al.* 1996, Eisen *et al.* 2006, Huppert *et al.* 2009, Rosa *et al.* 2012, APA 2013, Wu *et al.* 2016, Burchi *et al.* 2018). Individuals with OCD tend to be less successful in interpersonal connections, including partner relationships (Stengler-Wenzke *et al.* 2006), and often lack sufficient social skills (Praško & Prašková 2007, Cullen *et al.* 2008, Belus *et al.* 2014). First-line OCD treatment includes cognitive behavioural therapy (CBT) and pharmacological treatment with serotonin reuptake inhibitors (i.e. SSRIs or clomipramine) (Koran *et al.* 2007, Abramowitz *et al.* 2013).

The results of the studies describe increased marital distress in people with OCD (Geffken *et al.* 2006). Individuals suffering from OCD show an excessive need to control relationships (Cooper 1996, Doron & Szepeswol 2015). Since such a high degree of interpersonal control is unattainable, relationships tend to become tenser. Apart from that, patients affected by OCD have difficulty identifying and handling negative emotions. They attribute the state of increased tension to external conditions and do not consider these as internal conflicts (Steketee 1997). Typical defence mechanisms of patients with OCD are suppression, transference, avoidance, and symbolization (Amir 2016, Angelakis & Austin 2018).

Furthermore, OCD can also be maintained unwittingly by people who are in close contact with the patient. If they take on specific responsibilities and help the patient to avoid confrontation of fearful situations, they reinforce the individual's belief that he or she is "incapable". This behaviour increases positive consequences of the disorder by rewarding the patient with "secondary profits" (Praško & Prašková 2007).

The purpose of this review is to explore the current state of knowledge regarding the following areas:

- Typical phenomena that appear in relationships of OCD individuals;
- The impact of the partnership on the development of OCD;
- The impact of the partnership on the maintenance and recurrence of OCD;
- The impact of OCD on the quality of the partnership.

METHOD

Sources used in this review were acquired via PubMed from January 1990 to January 2020. The search terms included "obsessive compulsive disorder", "OCD",

"marital problems", "marital conflicts", "marital satisfaction", "attachment" and "partnership". The primary database search was performed by repetitive usage of these terms in various combinations without language limits. The abstracts of the obtained articles were screened, and their relevance was evaluated. Reviews, books, and relevant book chapters were also included. Suitable articles were collected, systematized by their importance, and a secondary search was performed by reviewing their reference lists for relevant articles. The selected articles had to meet following inclusion criteria: (1) published in peer-reviewed journals; (2) studies in humans; or (3) reviews on the topic. The exclusion criteria were: (1) abstracts from conferences; (2) commentaries; (3) dissertations. Primary search with keywords in various combinations yielded 242 articles. After applying inclusion and exclusion criteria, 68 articles were found eligible for further research. The secondary search yielded 56 relevant articles. In total, 124 papers were included in the review process (Figure 1), in consistency with the PRISMA guidelines (Moher *et al.* 2009).

RESULTS

Insecure attachment

Bowlby established attachment theory in the late 1960s and built on it in later decades (Bowlby 1969, 1973, 1980). According to Bowlby, the attachment process is initiated and established in the early years through the development of emotional bonds between children and their parents (Ainsworth *et al.* 1978, Bowlby 1980, Bifulco *et al.* 2002) and it stays relatively constant throughout life (Klohnen & Bera 1998, Waters *et al.* 2000). Because there is a common characteristic shared by parent-child and adult-adult interactions, attachment theory was quickly extended to the romantic bond of adults, emphasizing that the relationship includes the integration of three behavioural systems: attachment, caregiving, and sexual relationship (Hazan & Shaver 1987). There are several differences between the prototypical romantic relationships of adults and infant bonding relationship. Children's attachments are complementary: the caregiver supplies care but do not obtain it, while partners in adult relations typically share the care. Besides, children may need physical contact to feel completely secure, whereas adults may feel comfortable because they know that the object of the attachment exists and is accessible when needed. The object of a child's attachment is generally the parent, while the object of an adult attachment is most often a peer, usually a sexual partner. Therefore, the object is usually required to remain exclusive to the partner. According to some authors, the possibility of abandonment and fear of losing a partner and their exclusiveness is the cause of jealousy (Sharpsteen & Kirkpatrick 1997).

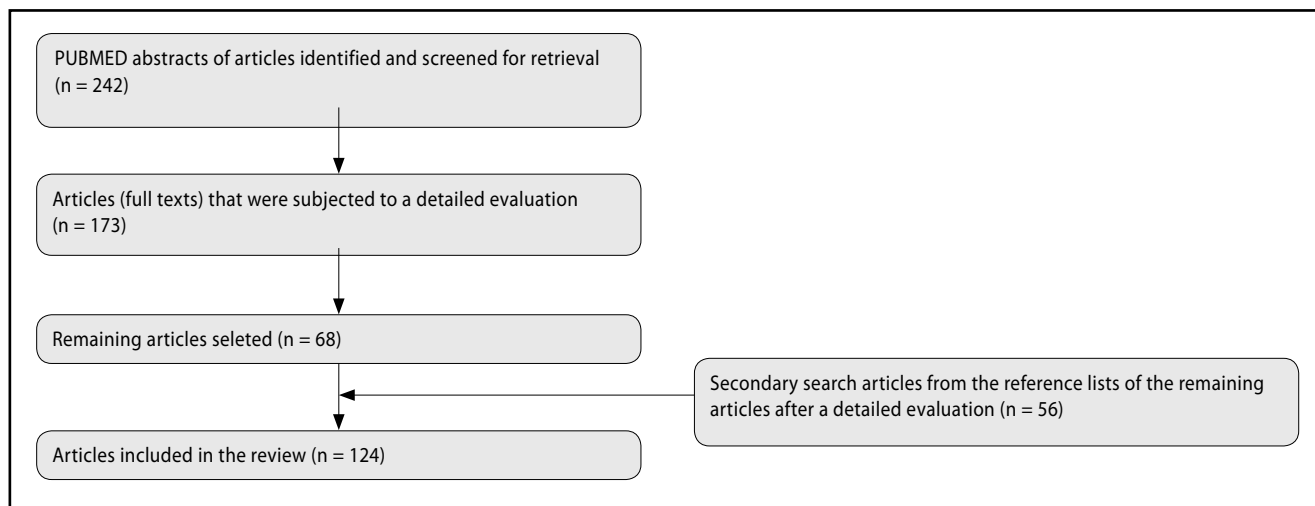


Fig. 1 . Summary of the selection process

Early maladaptive schemas in OCD

Descriptive studies found that OCD patients show elevated scores in several early maladaptive schemas (EMS) when compared to healthy controls (Atalay *et al.* 2008, Kim *et al.* 2014, Basile *et al.* 2017) and patients with other mental disorders (Kwak & Lee 2015, Lochner *et al.* 2005). Haaland *et al.* (2011) identified Abandonment/Instability as a negative predictor of treatment outcome in a combined sample of patients treated by individual or group cognitive behavioural therapy (CBT). Early maladaptive schemas are related to expectations from themselves and the partner. If an individual has a highly active Abandonment/Instability schema, they are afraid of abandonment and tend to either control their partner or maintain a certain distance from them, because abandonment would trigger severe emotional pain. A high level of pre-treatment Self-sacrifice schema, however, predict a positive outcome, according to Haaland *et al.* (2011).

In another study of the effect of EMS on OCD treatment, Thiel *et al.* (2014) reported that Failure and Emotional Inhibition schemas negatively predicted response to CBT. The Failure and Emotional Inhibition schemas can have a significant impact on the relationship - the patient tends not to reveal too much to the partner, avoiding entrustment disclosure and intimacy, because they fear that if they become too exposed, the partner will leave them. Finally, a third study involving patients with OCD, who received individual cognitive therapy without exposure and response prevention (ERP) found that EMS Dependence/Incompetence significantly mediated the reduction of OCD symptoms over time (Wilhelm *et al.* 2015).

Unfulfilled expectations and dysfunctional cognitive schemas

The primary relationship problem in individuals suffering from the obsessive-compulsive disorder is an excessive need for relationship control, which is

probably related to the unmet need for childhood safety and early maladaptive schemas (Yoosefi *et al.* 2016, Sunde *et al.* 2019). The dysfunctional cognitive patterns that are activated in OCD relate primarily to control, accountability, the need for certainty, and firm rules (Praško *et al.* 2003). These dysfunctional schemas were probably formulated long before the development of OCD, under the influence of family upbringing and they form the basis for a vulnerable personality (Praško & Prašková 2007, Sunde *et al.* 2019, Yoosefi *et al.* 2016). Most adults, however, try to escape excessive control because they do not want to be tied entirely to their partner - almost everyone needs a certain degree of freedom (Black *et al.* 1998, Ramos-Cerqueira *et al.* 2008).

Partner-focused obsessions

Relationship-related obsessive-compulsive phenomena (ROCDs) are often encountered in clinical practice and have severe implications for personal and relationship well-being (Doron *et al.* 2013). One of the common ROCD presentations is a demobilizing concentration, and doubt focused on a partner's deficiencies (partner-focused obsessions) (Doron & Szepsenwol 2015). Obsessive interest and doubts concentrated on the relationship or partner himself/herself, can harm the romantic experience of the relationship and lead to substantial stress, especially when the obsessive patient tends to discuss them frequently with his/her partner. Individuals who perceive their partner's failures or shortcomings as reflecting their own value may be more sensitive to intrusive thoughts about their partner's characteristics.

Jealousy

Jealousy is a complex emotion ranging from normality to pathology (Parker & Barrett 1997). There are several issues in distinguishing between normal and pathological jealousy. The study by Marazziti *et al.* (2003) aimed

to contribute to the delineation between obsessive and healthy jealousy using a specific questionnaire developed by the authors. The "Questionnaire on the Affective Relationships" (QAR), which consists of 30 items, was submitted to 400 university students of both sexes and 14 outpatients suffering from OCD, whose main obsession was jealousy. Two hundred and forty-five questionnaires (approximately 61%) were returned. OCD patients had a higher overall score than healthy subjects. Moreover, it was possible to identify a transient group of subjects, who were presenting concerns about jealous thoughts, but to a smaller extent than the patients. This group constituted 10% of all participants, and the authors labelled them "healthy jealous subjects" because they did not present any other psychopathological symptoms.

According to the four-group model of attachment styles created by Bartholomew & Horowitz (1991) for adult attachment, Brennan and his colleagues (Brennan *et al.* 1998) suggested that romantic attachment consists of two components: "anxiety" and "avoidance". Combinations of these two factors could create four styles of attachment: secure, anxious-preoccupied, dismissive-avoidant, and fearful-avoidant. Individuals with a secure attachment style are characterized by low anxiety and low avoidance. They feel good when looking for help, enjoy intimacy and expect support from others (Marazziti *et al.* 2010). Subjects with an anxious-preoccupied attachment style are characterized by high anxiety and fear of loss, resulting in oversensitivity and possessiveness, and they often form anxious dramatic relationships. Fearful-avoidant attachment style is characterized by high anxiety and significant avoidance: individuals with this type seek a close relationship and yet avoid intimacy. The main features of a dismissive-avoidant attachment style are low anxiety and high avoidance. These individuals show independence, avoid intimacy and distrust others. Some studies have shown that differences in attachment styles seem to affect both the frequency and the expression of jealousy: individuals with preoccupied or avoidant attachment styles are more likely to become jealous and consider a rival more threatening than those who have a secure attachment style (Radecki) - Bush *et al.* 1993, Buunk 1997, Sharpsteen & Kirkpatrick 1997, Guerrero 1998, Brumbaugh & Fraley 2006, Simpson 2007).

Furthermore, while those with avoidant attachments tend to associate relationships with fear of proximity, those with preoccupied attachments link relationships with extreme emotions, a strong desire for reciprocity, and jealousy (Hazan & Shaver 1987). Attachment style also plays an essential role in determining which kind of infidelity causes more jealousy: individuals with secure attachments are likely to experience emotional infidelity as worse than sexual infidelity. In contrast, individuals with insecure attachments are likely to consider sexual infidelity as a more significant problem (Levy & Kelly 2006). Also, people who show more jealousy, are more likely to feel uncertainty and have an

anxious or avoidant attachment style (Rydell & Bringle 2007).

Social support

Social support is a process whereby support is provided to help individuals to achieve goals (Cohen *et al.* 2000). Social support is a complex construct that can be divided into three forms. Cohen (1992) discriminates between perceived social support, received social support, and social networks. Many investigations have shown a negative link between the quality of social support and emotional distress (Cramer 1991, Panayiotou & Karekla, 2013).

A partner is commonly considered to be the primary resource of support (Boeding *et al.* 2013). Marital adjustment describes the quality of the marital relation and includes four parts (Spanier 1976): (1) difficult dyadic differences; (2) relational tensions and personal nervousness; (3) dyadic gratification and cohesion; and (4) agreement on matters of importance to marital functioning. El-Baalbaki *et al.* (2011) have written that a higher level of marital adjustment was linked to more expressions of support and validation during problem-solving communication between spouses. Hence, the marital adjustment seems to relate to the level of marital support and these two concepts likely share common aspects.

Communication problems

The communication problems of OCD patients in relationships are related both to excessive control over the relationship and avoidance of unpleasant emotional states (Boeding *et al.* 2013, Mahapatra *et al.* 2020). Empathy problems were also found in OCD patients, especially concerning negative emotional valence (Kang *et al.* 2012, Pino *et al.* 2016).

Specific controlling questions

The communication style of people suffering from OCD often shows a tendency to over-control others, which is probably related to their great need for safety (Praško *et al.* 2003, Boeding *et al.* 2013). Therefore, they often ask clarifying questions, ask for details, and circle back to the original question (Grumet 1991). This usually elicits boredom, and sometimes also annoyance in the partner (e.g. "You have already asked about it ten times today!").

Expressed emotion

This concept includes three dimensions: hostility, criticism, and emotional over-involvement. Emotional over-involvement can be described as intrusiveness, excessively self-sacrificing behaviour, or exaggerated emotional response to the patient's illness (El-Baalbaki *et al.* 2011). Criticism and hostility refer to critical comments and a negative attitude toward the patient or the disorder and are manifestations of negative social support.

Three investigations were focused on the link between expressed emotion and OCD severity. Cherian *et al.* (2014) showed that perceived criticism was linked to the severity of OCD. Van Noppen & Steketee (2003, 2009) showed no significant correlation between expressed emotions (criticism, hostility, emotional over-involvement) and the severity of OCD. After involving family accommodation in the model, criticism lost its significance.

Reassurance

Family members usually notice compulsions. Giving attention to them on its own can be an excellent reward for the patient (e.g. in a relationship that has been boring or alienated). Others often offer help, especially by reassuring that nothing terrible happens if the patient does his compulsions (Praško *et al.* 2003, Albert *et al.* 2010, Mahapatra *et al.* 2020). Reassurance compulsions often develop this way. In addition to compulsions in behaviour or thinking, another possibility of neutralizing tension arising from obsessions is reassurance from another person, most often from a partner, if the patient lives in a partnership (Gomes *et al.* 2014). The compulsive thoughts usually relate to the fear of liability for damage that might be caused by a patient's action or omission. By repeated assurance, a patient can relieve themselves by transferring responsibility to someone else, most commonly to their partner (Praško & Prašková 2007, Mahapatra *et al.* 2020). Obsessive thoughts like "Am I going crazy?", "Am I doing it right?" and "Should I recheck the taps?" can be appeased by the reassuring partner. The patient is relieved when assured, but only for a short time. This reinforcement leads to an increased demand for reassurance. This repeated assurances, however, can lead to annoyance and even make the partner feel angry. This also increases the tension of the patient, who is more likely to ask for assurance. The partner reacts either by getting angry or by trying to escape from the patient's reach. The vicious circle disrupts the closeness between the partners. Moreover, since reassurance serves to neutralize obsessions, it also leads to their consolidation (Praško & Prašková 2007).

Safety behaviour using a partner

In comparison with families of those with clinical depression, relatives of OCD patients experience a more substantial burden and have impaired functioning, partially due to more pronounced anger from the OCD patient when the relatives do not comply (Vikas *et al.* 2011, Gomes *et al.* 2014). Partners sometimes start to do activities that the patients avoid because of obsessions. They try to help them, but the opposite is happening. It provides relief in the short term, but also helps to maintain avoidant evasive behaviour, which ultimately harms them. Swearing and criticism tend to be better than indifference and disinterest. (Praško & Prašková 2007, Gomes *et al.* 2014). Relatives can get

angry and try to prevent the rituals (Chambless *et al.* 2001). This causes the patient to postpone the ritual to the time when he/she is alone. Since they have accumulated considerable tension, especially from being rejected, they usually perform rituals longer and more intensively.

A partner often strives to "save" the individual with OCD by allowing them to avoid the dreaded situations (Boeding *et al.* 2013, Mahapatra *et al.* 2020). For example, the partner takes out the garbage instead of the patient, in order to prevent him/her from getting dirty and having to wash. Sometimes the relatives even perform the patient's compulsive checks to "calm down" the patient, and very often they provide reassurance. However, this also dramatically strengthens their involvement in the vicious circle of OCD.

Family interventions aiming for accommodation and improving family functioning have been recognized to be useful for decreasing OCD symptoms (Baruah *et al.* 2018). Thus, family involvement in therapy has to be encouraged, especially in those with high family accommodation (Katzman *et al.* 2014, Abramowitz *et al.* 2018, Reddy *et al.* 2020).

The most common problems in partner relationships in obsessive-compulsive disorders

OCD patients often have interpersonal problems that are related to their symptomatology. They are often significantly dependant on their loved ones (Grumet 1991). The partner of the patient often feels confined. However, sometimes it may be convenient because it gives them a sense of domination and being needed in the relationship or a sense of value. At other times, however, it feels like a significant limitation and conflicts arise, which in turn, aggravate OCD or lead to the development of secondary depression.

Partners can overlook the symptoms of the disorder simply because their relationship began when the spouse was already suffering from the disorder. Besides, the OCD progression may be slow enough that partners simply do not notice pathological changes in the patient's behaviour. The family gradually adapts to rituals that are becoming increasingly complex. In such cases, partners may interpret rituals as tics or personality traits (Stengler-Wenzke *et al.* 2004b). Compulsions are considered as isolated incidents, and integrating insight becomes increasingly tricky as symptomatology grows. Only the open admittance of one's struggle with obsessions and compulsions, or the inability to keep them a secret, can stop the attribution of behaviour to relatively standard characteristics. The suicidal tendencies of the affected person may also be a catalyst for this transition (Stengler-Wenzke *et al.* 2004a).

Lack of intimacy

It appears that individuals with OCD describe less satisfaction with their partner and experience less

intimacy (Chambless & Steketee 1999). Because they need to have control over the relationship, they cannot experience intimacy to such an extent as other people.

Excessive control over their emotions, which hinders spontaneity in the relationship and disrupts intimacy, is also an essential problem for OCD patients. Patients with OCD sometimes also force the partner to clean excessively, and they wash themselves for a long time, especially before and after having sex. The disorder can lead to severe tension in marital relationships. The number of divorces and terminations of relationships is very high in people suffering from obsessive-compulsive disorder (Prasko *et al.* 2009, Prasko *et al.* 2016).

When obsessive concerns relate to contamination by bodily secretions, sexual difficulties routinely arise. For example, the patient may require extreme cleanliness before sexual intercourse and insists on thorough washing after it has taken place. For some people, sex can be limited to one room or a particular part of the room to prevent pollution. Some people are so afraid of "contamination" that it completely prevents them from engaging in sexual intercourse (Pozza *et al.* 2020).

It is important to evaluate sexuality in OCD patients, and the use of therapeutic approaches dedicated to sexuality in OCD patients to increase the patients' quality of life (Pozza *et al.* 2020) should also be considered. When assessing support between partners, the proper marital adjustment should be taken into account.

Family accommodation

"Family accommodation" or "partner accommodation" is a process by which the members of the OCD patient's family, such as a partner or a parent, help or participate in the patient's rituals (Strauss *et al.* 2015, Shimshoni *et al.* 2019). Accommodation of symptoms of OCD by family members is common, and it has been associated with reduced response to treatment, increased severity of symptoms, and decreased functioning (Wu *et al.* 2016). Partner accommodation has been associated with more severe symptoms of OCD, more significant functional impairment, and reduced quality of life. All in all, it predicts worse treatment outcomes (Chambless & Steketee 1999, Albert *et al.* 2010, Grover S & Dutt 2011). More than 95% of OCD families comply with the patient's rituals, provide reassurance, participate in compulsive behaviour, wait for the ritual to be completed, or help avoid obsessive triggers (Stewart *et al.* 2008, Lebowitz *et al.* 2016, Albert *et al.* 2017). Family accommodation is often a "successful" coping strategy for the patient in the short term, as it provides a sense of relief from distress and facilitates faster completion of avoidant and compulsive behaviour. However, "family accommodation" ultimately leads to a vicious cycle in which patients are more often involved in avoidant or compulsive behaviour, and it prevents them from developing more adaptive evaluations and behaviours that can cope with OCD in the long run (Wu *et al.* 2016).

Family members of OCD patients often take responsibility for the patient's duties and tasks (Steketee 1997, Laidlaw *et al.* 1999). Families of patients with OCD are subjected to considerable stress in this regard. Therefore, a growing number of research studies have recently focused on quality of life, stress management strategies, and other psychological characteristics of not only OCD patients but also their relatives (Stengler-Wenzke *et al.* 2004a, 2004b). In addition to taking on everyday duties, many relatives notice a gradual increase in their participation in the implementation of rituals. From this point of view, families of patients with OCD can be distinguished from families of patients with other mental disorders. Relatives usually help with rituals or adapt the family regimen to reduce the patient's anxiety (Marks 1995, Calvocoressi *et al.* 1995). The increasing absorption of family members in the patient's rituals and claims related to the disorder leads to increased tension and disagreement on how to proceed further. Depression, grief, blame, substance abuse, stigma and other secondary and co-morbid symptoms are also an integral part of the overall picture of family life with OCD (Tynes *et al.* 1980, Chambless & Steketee 1999, Stengler-Wenzke *et al.* 2004). All these factors affect the interaction between the patient and their family and create significant tension and stress (Stengler-Wenzke *et al.* 2004a).

Evidence shows that family adaptation is associated with poor treatment outcomes. This effect is also observed with regards to the CBT technique of exposure-response prevention (ERP), and other behavioural adaptations are known to counteract the effectiveness of treatment (Albert *et al.* 2017). Therefore, approaches aimed at reducing family adaptation by improving knowledge and improving adaptive behavioural models are essential for achieving therapeutic goals (Lebowitz *et al.* 2016). Many investigations have confirmed the significant positive correlation between accommodation and OCD severity, meaning the more accommodation the relatives provide, the more severe the OCD symptoms would be (Calvocoressi *et al.* 1999, Ramos-Cerqueira *et al.* 2008, Stewart *et al.* 2008, Ferrão & Florão 2010, Vikas *et al.* 2011, Cherian *et al.* 2013, Boeding *et al.* 2013, Cherian *et al.* 2014, Gomes *et al.* 2014, Wu *et al.* 2016).

OCD responds positively to treatment in the short term but has a high recurrence rate (Bloch *et al.* 2013, Eisen *et al.* 2013). The inclusion of a partner in learning about family adaptation and his/her capacity to function as a co-therapist with the necessary coaching skills for ERP management should, therefore, have a positive impact on the sustainability of therapeutic effects in OCD patients. Understandably, clinical practice guidelines for OCD treatment in the UK and North America recommend family involvement (Geller & March 2012).

Additional partner or family interventions in adult OCD patients may have overall better treatment outcomes. A meta-analysis of family involvement in

psychological treatment has shown that individual OCD treatment involving a partner or the whole family has had a significant impact on OCD symptoms and global functioning (Thompson-Hollands *et al.* 2014). One randomized controlled study (Thompson-Hollands *et al.* 2015) examined the effectiveness of an adjunctive, short family intervention involving two sessions to reduce family adaptation. This short addition to the common therapy led to a significant reduction in OCD symptoms.

Family pathology related to OCD is quite common. More than 40% of Japanese OCD patients reported that their families are somehow involved in helping or participating in their rituals (Yanagisawa *et al.* 2015). Such involvement in rituals is a significant predictor of poor outcomes in the treatment of OCD (Nakajima *et al.* 2018).

Partners' conflicts

In most cases, the family provides assurances despite the tediousness of recurring demands. Sometimes the client requires family members to perform the same compulsive rituals as they do. Other times, the patient demands others to adhere to specific rules of behaviour and is very angry if they do not comply (Grumet 1991). The use of the bathroom is often a source of disagreement and annoyance.

Some obsessive-compulsive patients control the family to a remarkable degree. A patient with obsessive fears of dirtiness can forbid family members from coming home without taking off their shoes, insists on them washing their hands more often, restricts them completely from accessing certain parts of the house, or impose other prohibitions. In one case, the patient allowed family members to use only a narrow pathway through the main hall where they had to pass close to the wall without touching it. They also had to have their towels wrapped in plastic to avoid contact with the patient's towel. One young mother did not allow her children and husband to use the kitchen or bathroom in the morning before thoroughly cleaning these places, which took much time. As a result, the husband was late for work, and the children arrived late to school.

Children of obsessive-compulsive clients, especially women, are often exposed to all possible restrictions. They have to perform various cleansing rituals or do everything according to a precise procedure. They, therefore, cannot bring their friends home. When they return from school or from outside, they have to take their clothes off immediately and put them in the laundry basket. One woman insisted that her children had to bathe every morning in a rigid ritualistic manner: she washed each part of their body in a particular order and then dried them with a given number of towels.

Why do partners, parents, children and other relatives tolerate such restrictions on their lives? Many initially reject the patient's requests, but eventually, they comply and begin to satisfy them. Some family

members say that they satisfy the patient's needs out of love and compassion ("The poor man cannot help himself"). However, many relatives refuse to adapt, despite disputes and rage. There can be contradictory approaches within some families, when a significant family member complies to the patient's requirements, while the others are entirely adamant about refusing. For example, one teenage girl had always been reassured by her mother that all her doubts and fears are groundless, but her father has never given her any assurance. The mother also yielded to too many of her demands, such as leaving the kitchen door, window, etc. open in a certain way. However, her father refused to concede to her fears each time. This has led to significant conflicts within the family.

Stigma and self-stigma

The general population focuses primarily on the external characteristics and manifestations of the patient - their expressions, movements, physiognomy, posture and speech - and concentrates on signs of something unusual. Many compulsive rituals may look strange to a person who has never suffered from OCD. Once the environment notices that the individual is "behaving strangely", the labelling process begins and can lead to permanent stigmatization (Stengler-Wenzke *et al.* 2004). Fear of stigmatization is the reason why individuals suffering from OCD often actively refuse to visit a psychiatrist and try to solve their mental problems by alternative means (Geffken *et al.* 2006).

In obsessive-compulsive disorder, however, external stigmatization itself is not as problematic as the patient's fear of it. This often prevents them from seeking adequate help from an expert. Typical processes associated with the maintenance of OCD include self-stigmatization, which leads to expectations of rejection from others, self-criticism, shame, demoralization and avoidance of social contacts, which are factors leading to a deepening and consolidation of the disorder (Stengler-Wenzke *et al.* 2004). A negative self-image can then become a problem on its own and becomes a major vulnerability factor (Thiel *et al.* 2014). Part of this self-image is the loss of self-confidence and hope that one's endeavours can change something.

Stengler-Wenzke *et al.* (2004a) found that the duration of OCD also increases the likelihood of social isolation of the patient and his/her close family. Uninformed witnesses to compulsions may react insensitively and stigmatize the individual with OCD as well as their family. This creates considerable tension and stress in the families of patients suffering from OCD. The presence of the disorder increases the likelihood of deficits in social roles and overall life functioning for patients and their relatives. Kalra *et al.* (2008) found that the burden that lies on the shoulders of relatives and partners with OCD is approximately as high as the one faced by caretakers of people who have schizophrenia and affective disorders. Experiencing chronic stress,

which is established as a result of the daily demands of an OCD patient, can further increase sensitivity to negative remarks and stigmatizing behaviour by others. Based on clinical experience, relatives often suffer from shame and guilt and perceive stigmatizing reactions from society. However, studies on the impact of obsessive-compulsive disorder on families and other interpersonal relationships are still in short supply (Cooper 1996, Renshaw *et al.* 2005, Ramos-Cerqueira *et al.* 2008).

The family begins to come to terms with stigma (Trosbach *et al.* 2003), but they often try to conceal the diagnosis of OCD from "outside people" (Newth & Rachman 2001). The mental disorder is a mystery, a taboo that represents an additional burden that lies on the shoulders of relatives of OCD patients (Stengler-Wenzke *et al.* 2004b). Families with obsessive-compulsive disorder may respond differently to symptoms of the disorder (Stengler-Wenzke *et al.* 2004b, Grover & Dutt 2011). OCD develops gradually, and the onset is often overlooked. This often-occurring situation cannot be explained solely by the patient's tendency to hide symptoms because of shame and fear of rejection (Wu *et al.* 2016).

When relatives find that unusual behaviour is a manifestation of a mental disorder, they can only have a vague idea of what the particular disorder, or mental illness in general, entails. They are also worried about stigmatization. Along with the tension that accompanies the urge to relieve a loved one of his/her suffering, other factors that disturb the family balance, such as insecurity, feelings of helplessness and hopelessness, often intensifies the overall level of tension. The decision to seek professional help and the onset of psychiatric treatment represents a significant burden on the family (Stengler-Wenzke *et al.* 2006). The process by which family members begin to accept and understand the symptoms of the disorder and the consequences associated with it is a significant challenge and represents a long-term task rather than a matter of rapid adaptation (Stengler-Wenzke *et al.* 2004b).

Cooper (1996) also tried to identify the symptoms that disturb relatives the most. These are particularly aggressive obsessions and obsessions with sexual content, and obsessions concerning religious blasphemy.

The patients become dependent on the care of their relatives, and their disorder becomes chronic (Stengler-Wenzke *et al.* 2006). Long-term tensions that result in interpersonal conflicts and financial difficulties are not uncommon in families of OCD patients (Tynes *et al.* 1980, Cooper 1996).

According to Chambless & Steketee (1999), a higher level of criticism and family hostility leads to lower treatment success. Another factor contributing to the lower success rate of treatment is refusal and condemnation by a parent. If a family member criticizes a patient for a long time, their self-esteem decreases, reflecting a higher degree of self-stigmatization. When

hostile emotions are present in the family, tension increases, driving the patient to increase compulsions to reduce his/her stress (Keeley *et al.* 2008). Such patterns of family behaviour create a vicious circle – the patient is criticized and perceives that hostile emotions dominate the family. The rise of compulsions follows, which again leads to remorse, criticism and tension.

IMPACT OF PARTNER RELATIONSHIP ON THERAPY

Although a significant number of individuals with obsessive-compulsive disorder have been found to have partnership problems, behavioural treatment for OCD leads to improvement in symptoms, despite the quality of the partnership or the partner's engagement in the therapy (Emmelkamp *et al.* 1990). The effects of the treatment did not lead to a deterioration in the partnership or problems with partner adaptation.

Limited investigations suggest that the participation of the partner in the therapy can have positive effects (e.g. Stern & Marks 1973, Hand *et al.* 1977, Hand & Tichatzky 1977, Hafner 1982, Emmelkamp *et al.* 1990). Emmelkamp & De Lange (1983) recognized spouse-aided therapy as being more efficacious than self-exposure, but this outcome diminished at a one-month follow-up.

Abramowitz *et al.* (2013) developed and pilot-tested a 16-session couple-based CBT program for patients with OCD and their partners. The program involved:

- (1) partner-assisted exposure with response prevention;
- (2) strategies directed to the maladaptive relationship patterns typical for OCD (e.g., symptom accommodation); and
- (3) strategies directing non-OCD-related relationship problems.

After this therapy, significant improvements in OCD, relationship functioning, communication, criticism, and depressive symptoms were recognized. Decreased OCD symptoms were maintained for up to one year, and partners showed improvements in the quality of the relationship relative to a baseline (Belus *et al.* 2014). Although family contribution in the therapy of OCD leads to a decrease of OCD symptoms and has substantial effects on global functioning, few investigations concentrating on family intervention in the therapy of OCD (Kobayashi *et al.* 2020) have been done. The efficacy of family-based exposure and response prevention program for adult patients with OCD and their family members was investigated in the study of Kobayashi *et al.* (2020). The outcomes suggest that a family-based exposure and response prevention program might be useful in reducing OCD symptoms.

CONCLUSION

OCD patients often have interpersonal problems that are related to symptomatology and the excessive need for control over the relationship. They are often dependent on their loved ones, who are being bound by their fear. The results of the studies describe increased marital distress in people with OCD. At the same time, it appears that people with OCD describe less satisfaction with their partners and experience less intimacy. Family pathology related to OCD is quite common. The communication style of people suffering from OCD often includes a tendency to over-control others, which is probably related to their enormous need for safety. Following the results of descriptive studies, OCD patients show elevated scores in some early maladaptive schemes compared to healthy controls and patients with several other mental disorders. According to the Attachment Theory, these elevated scores are the result of the type of attachment that patients experienced in their childhood, especially concerning unmet needs in childhood safety. Individuals with preoccupied or avoiding attachment styles are more likely to become jealous and consider a rival as more threatening than those who have a safe attachment style. The participation of the partner in the therapy can have positive effects. A family-based exposure and response prevention program might, therefore, be a useful program for reducing OCD symptoms.

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