Present in Daily Life: Obsessive Compulsive Disorder and its Impact on Family Life from the Partner's Perspective. A focus group study.

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Abstract

This focus group study explores the experiences of five partners of patients suffering from obsessive-compulsive disorder concerning how this disorder might influence couples' relationships in the long-term. We find that the disorder might give rise to power struggles concerning "normality", deprive couples of opportunities for rewarding fellowship during household chores and leisure time, and persistent analytic processes concerning predicaments of what to do. They also express a need for more help from the health services. The results might be of value to therapists in their daily work, and might have implications for future research on couple's therapy involving this group.

Key Words: obsessive-compulsive disorder, partner, relationships, couple treatment, power imbalance, focus groups, Norwegian

Obsessive-compulsive disorder (OCD) is characterised by obsessive thoughts, often concerning contamination or security, and compulsive actions, such as excessive cleanliness or exaggerated safety precautions (Clark, 2004). The lifetime prevalence of OCD is 2-3% (Ruscio, Stein, Chiu, & Kessler, 2010), and the symptom severity and functional impairment can reach considerable dimensions (Markarian et al., 2010). It is reasonable to assume that OCD affects a couple's relationship in many ways. If, for example, the dishes must be cleaned in a special way or the door must be checked multiple times before leaving the house, this can represent challenges for a partner.

Partner relationships are in general under pressure. The divorce rate in Norway in the last five years was on average 10.3. The highest risk for divorce was after five to nine years of marriage, where on average 27.3% of all couples divorced (Norway Statistics, 2019). Partners of patients with OCD often experience their life situation as burdensome (Grover & Dutt, 2011), and divorce is more common in relationships where one partner has a mental disorder (Mojtabai et al., 2017). Hence, we know that long-term marriages are at risk of divorce and that mental disorders increase this risk. This indicates that couples where one of them has OCD struggle in their partnership in the long-term as well, and that there are good reasons to take a closer look into what their specific troubles are.

There is little research on how these relationships are actually experienced by the partners. In the present study, we explore the experiences of long-term spouses of OCD sufferers, and aim to increase the understanding of the impact of OCD on intimate relationships and family life. Long-term marriages are here defined as being married ten years or more, i.e. longer than the period of a marriage that most often ends with divorce. This applies to all participants in the present study. Hence, their marriages have "survived" the most vulnerable period.

We already know that OCD often has a broad impact on family life and relationships, affecting several domains of life. Patients with mental disorders and their families tend to be stigmatised in society (Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000), and family members of OCD patients can feel socially embarrassed because of the patient's excessive obsessive and compulsive behaviours (Torres, Hoff, Padovani, & Ramos-Cerqueira, 2012). Likely due to stigma and embarrassment, OCD is often kept a secret (Newth & Rachman, 2001). The family can try to hold onto facades of normality and rationalize the symptoms (Stengler-Wenzke, Trosbach, Dietrich, & Angermeyer, 2004). It is reasonable to believe that both stigmatisation and concealment can lead to social isolation. The resulting social disturbance puts the family at risk for decreased psychological well-being (Baumeister & Leary, 2000). Hence, partners of OCD patients who stay in their marriage are at risk of experiencing these social challenges in their everyday life, and it is likely that this will have an impact on their relationship.

Not only has OCD been found to have a negative impact on the patient's and family's interaction with the outside world, it has also been shown to have a negative impact within families as well. In one study, up to 82% of partners and parents of OCD patients report that OCD disturbed the social interaction between family members (Cooper, 1996). Partners can become annoyed and intolerant towards the OCD patient (Torres et al., 2012), even to the point of being hostile and critical (Chambless & Steketee, 1999). Over 80% of family members have trouble with interpersonal boundaries when relating to the OCD patient (Cooper, 1996). This often concerns a tendency to be over-involved with the patient's life, where family members devote a considerable amount of time in an attempt to help their loved one deal with their symptoms (Chambless & Steketee, 1999). The result can be that the patient feels that their family members are overstepping their boundaries (Torres et al., 2012). The patient might also feel a power-imbalance where they have a sense of being monitored

and pathologized in everyday life (Walseth, Haaland, Launes, Himle, & Håland, 2017). At the same time, the partners of OCD patients may feel that *their* personal space is being invaded, as the patient's symptoms are often also affecting them personally (Torres et al., 2012). This combination of trying to help yet feeling pushed can eventually make the partners act out antagonistically (Renshaw, Steketee, & Chambless, 2005). Hence, partners living with a person with OCD can be said to be at risk of experiencing a range of negative emotions and negative behaviours because of a challenging life situation. This can lead to unfortunate dynamics between them and their partner.

Furthermore, it has been found that nearly all family members of people with OCD “accommodate” to the OCD (Lebowitz, Panza, Su, & Bloch, 2012; Peris et al., 2012; Stewart et al., 2008). In these studies, accommodation is defined as either “helping” the patient by engaging in ritualistic behaviour themselves or “helping” the patient to avoid situations that trigger obsessions and associated compulsions. Such accommodation tends to increase as the OCD worsens, and can increase when the family members have their own psychological problems (Lebowitz et al., 2012; Peris et al., 2012; Stewart et al., 2008). Accommodation often provides some initial symptom relief, but as the disorder progresses it contributes to the maintenance of OCD and is a substantial obstacle to effective therapy (Garcia et al., 2010). Family members of OCD patients have increased risk of depression and anxiety both when they make such accommodations and when they choose not to accommodate and instead passively watch their loved ones suffer (Amir, Freshman, & Foa, 2000). Hence, the partners experience dilemmas throughout their everyday life that are difficult to handle, and that might represent challenges to their relationship.

Recently, the challenges that these couples are facing have been included in treatment of OCD (Abramowitz, Baucom, Boeding, et al., 2013; Abramowitz, Baucom, Wheaton, et al., 2013). The following elements were included: exposure and response prevention therapy for

the OCD patient, training of the partner to be a coach for the homework, assessment of the couple's history concerning the OCD symptoms, addressing specific challenges concerning accommodation and expressed emotions, in addition to more general communication skills. Initial results indicate that this treatment leads to greater improvement of OCD symptoms and significant improvement of short-term couple satisfaction. However, the programme did not increase relationship satisfaction after one year, it did not generate specific knowledge about which elements of the intervention were responsible for the observed improvement, and it did not provide suggestions for how the treatment may be modified to increase relationship satisfaction in the long-term. Hence, more knowledge is needed to help these couples.

In sum, partners of OCD patients are at risk of experiencing both social and emotional challenges, displaying a range of negative behaviours towards the patient, and even developing mental disorders like anxiety and depression. However, despite this broad body of knowledge, there is still a need to learn more about their relational experiences in order to help these couples through therapy. The documentation in this field is mostly derived from quantitative studies, where the questions are predefined. Qualitative research holds promise as a method to acquire more basic, specific and detailed knowledge by asking open-ended questions. It is highly interesting and relevant to ask partners of OCD patients about their experiences concerning how OCD might influence on their couple relationships. Performing such qualitative inquiries of individuals who have maintained their relationship over the long-term, over ten years, will provide knowledge specifically concerning those who have not given up. This will supply the basic research on the relational consequences of OCD, constitute important knowledge for OCD therapists, and might serve as a foundation for future quantitative research. On this background, we have performed such qualitative inquiry, which to our knowledge has not been done before.

Methods

To explore partner experiences concerning how OCD could influence a couple's relationship we chose a qualitative method with a hermeneutic phenomenological approach (Denzin & Lincoln, 1994; Kvale, 1996; Malterud, 2011). Hermeneutics is based on the notion that reality is interpreted on the basis of past experiences, and that this interpretation is obtained from a first-person perspective. Hence, two different partners of OCD patients can perceive the same situation differently. Their personal experience is, however, according to phenomenology, still something that indisputable exists (Zahavi, 2003). This experience can be revealed using qualitative methods (Denzin & Lincoln, 1994; Kvale, 1996; Malterud, 2011).

To gather the data we chose to use focus group interview, to take advantage of focus groups' ability to stimulate associations and the fruitful exchange of experiences, opinions and ideas among peers (Malterud, 2012a). To analyse the transcribed material from the interviews we used systematic text condensation, which is based on Giorgi's phenomenological method (Malterud, 2011, 2012b). The steps in this method consist of thorough reading of the material, identifying and coding of meaningful units, create various categories, condense and summarise each category, and abstract and further describe each condensate. In this way, the experiences that the participants have shared are maintained and reflected in the results.

Informants

The study is part of "The Norwegian long-term OCD project". The project started with an effectiveness study in which 65 patients diagnosed with OCD received group cognitive behavioural therapy (CBT) at an outpatient clinic from 2003 to 2009 (Haaland et al., 2010). Forty of the 65 patients participated in a study on the long-term effect of the therapy, from

2013 to 2014 (Sunde et al., 2017). With the aim of recruiting 10-15 partners into two or three focus groups, all 40 patients received a letter during the winter of 2015/2016 in which we requested contact with their partner, if they had one. Each patient was informed that we wanted to interview their partners concerning what impact OCD had had on their relationships and family life. Only two responded, both positively. We then made phone calls to all patients who had revealed that they had a partner last time we spoke to them. Often, the patients did not want to involve their partners in the study, or simply did not answer the phone. Three agreed to invite their partner, all of whom consented to participate. Despite the small sample, we decided to complete the study because the unique specificity of the sample made promise of valid valuable knowledge, in accordance with the aim of the study. On this background, we gathered the total of five informants into one focus group.

The five informants completed written informed consent to participate in the study. The sample consisted of three men and two women aged between 50 and 63 years, with a mean age of 57 years. The duration of their marriages was from 10 to 38 years, with a mean of 25 years. Four of them had participated in a family meeting during the partner's initial treatment six to 11 years before.

Before participating in group CBT (between 2003 and 2009) the informants' partners all had moderate to severe OCD symptoms measured by the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS) (Goodman et al., 1989), with Y-BOCS scores ranging from 20 to 29 (Haland et al., 2010). At present, the informants' OCD partners had symptom levels ranging from sub-clinical to moderate OCD, with Y-BOCS scores ranging from 3 to 22. Four had received additional treatments for OCD or other problems since receiving group CBT. Four of the couples had joint children, one of the informants lived with his partner's child.

To obtain a broader description of the informants we wanted to know how much the

informants accommodated to OCD in daily life. The Family Accommodation Scale for Obsessive Compulsive Disorder – Self Rated Version (FAS-SR) (Pinto, Van Noppen, & Calvocoressi, 2013) was translated into Norwegian following standard procedures by Gunvor Launes (GL) and Ingrid Klovning (IK) in cooperation with the scale developers. The FAS-SR has been shown to have excellent internal consistency (Cronbach's $\alpha=.90$) and is considered a valid measure of family accommodation within the OCD field. The rating scale consists of 19 items scored from zero to four with a maximum score of 76, where the degree of accommodation increases with higher scores. FAS-SR was completed by each informant as a supplement to the focus group interview. The informants' scores ranged from three to 17, which is in the lower range of the FAS-SR and far from the maximum score (76), indicating a limited amount of family accommodation. Concerning four of the informants we observed that the higher their respective partners with OCD had scored on the Y-BOCS, the higher they scored on the FAS-SR, while for the fifth it was the other way around.

Procedures

We gathered the five informants at an outpatient clinic for a focus-group interview in the spring of 2016. The interviews were led by Liv Tveit Walseth (LTW) (M.D., PhD, female), with Gunvor Launes (GL) (specialist in psychiatry, OCD therapist, female) and Tor Sunde (TS) (specialist in psychology, PhD-candidate, OCD therapist, male) as co-interviewers. LTW had met one of the informants while gathering data in the quantitative part of the study (Sunde et al., 2017). GL had met all informants except one during therapy of their partners. TS had not met any of the informants. The interviewers sought to reduce their influence on the answers by taking a diminished role in the interview, asking open questions and stimulating the group dynamic by soliciting members to reflect together (Kvale, 1996; Malterud, 2012a). The informants were asked to elaborate and offer practical examples when their statements were vague. The overarching question and focus was how, in their

experience, the OCD influenced their relationship with their husband or wife. In order to access these experiences questions were posed concerning concrete situations that worsened or improved the OCD during their everyday lives, how they handled these situations, and how their daily life was influenced by OCD in general. They were also asked what they as partners and families felt that they needed from the health care system.

The interview lasted for 90 minutes and was audiotaped. IK transcribed the audio-taped material. To achieve higher validity all verbal and non-verbal (sighs, laughter, etc.) information on the tape were transcribed (Mishler, 1984).

The analysis was performed by LTW and GL in collaboration, according to systematic text condensation (Malterud, 2011, 2012b), and was discussed with the other co-authors until agreement. The material was thoroughly read. Meaningful units were identified and coded into categories. It was early revealed that the themes ‘what is normal?’, ‘OCD intrudes on all parts of everyday life’, ‘OCD takes time’, ‘it is necessary to pay constant attention to OCD’ and ‘need for more help’ were necessary to include. Later on, the theme “there is a dynamic between OCD and personality” also became obvious. All these were included in the final results. The computer programme NVivo 10 (QSR, 2015) was used as a practical help in the coding process. The units belonging to each category were condensed and summarised. The summaries were abstracted and further described. This represents the results. To protect the anonymity of the informants, the descriptions were not underpinned by direct quotations. Nevertheless, the informant’s words, expressions and examples were used as far as possible. Finally, the transcribed material was reread to ensure that the results were consistent with the material. All steps of the analysis were repeated and discussed by LTW and GL in several rounds, and then by the other authors, until agreement. The Regional Committee for Medical and Health Research Ethics in Norway approved the study ¹.

¹ REC number: 2013/1210 sør/øst

Results

The dialogue was characterised by openness. The communication was largely complementary where the informants supported each other and filled in nuances, but they also pointed out contradictory experiences.

The results are described in five main themes: 1) Power struggles concerning normality – Is this OCD?, 2) Depriving opportunities to fellowship – even creating jealousy, 3) Ongoing predicaments and analytic processes of what to do, 4) Unfortunate and fortunate dynamics between OCD symptoms and partner's personality, and 5) Missing understanding of the seriousness of OCD – Need for more help. These themes are further described below.

Power struggles concerning normality – Is this OCD?

The informants found it hard when the OCD patient argued that he or she indeed behaved in a normal standard way and now had control over his or hers OCD, when the behaviour in question was obviously pathological. One of the informants actually found this type of dispute the most frustrating aspect of the disorder. In such situations, some of them had a feeling of observing something foreign, and one of them expressed that he saw this as something dangerous and that he could be outright scared. At times, during their everyday lives, they found themselves in power struggles where they had to define and defend normality.

Sometimes they were not able to interpret what took place right in front of them, and they could lose their perspective about what was and was not “normal”. One informant shared that her husband destroyed two water faucets because of OCD rituals before either of them understood that the broken faucets were a consequence of a mental disorder. Another informant thought that he and his wife shared ordinary perfectionism as a common trait, but later on he understood that her “perfectionism” had a pathological dimension. There was in

general an agreement that the *time* spent on the behaviour was the crucial eye opener, and the factor that eventually made them realise that their partner's behaviour was pathological.

Depriving opportunities to fellowship – even creating jealousy

In the informants' experience, OCD had the capacity to occupy a huge amount of time, with ripple effects on the relationship and overall family life. Typically, practical tasks such as household chores, security checks, carpentry or gardening, took substantially more time than normal. A typical consequence of prolonged time spent on checking was that they often were late for appointments. One informant expressed the opposite concern; that her husband felt compelled to arrive one, two or even three hours too early to appointments. The informants seemed to have in common an intention to show patience or use humour on these occasions. One said that he, to be witty, had asked their friends to invite them 15 minutes before the other guests, to be sure that they came on time. However, it was obvious that most of them felt that their patience was stretched, and thus these everyday situations were a strain on their experience of fellowship with their partner.

However, the informants seemed to emphasize even more that OCD could dominate time meant for joy and recreation, resulting in additional tension in the relationship. They used strong words about how they characterized such situations, like “ruined” or “exhausting”. For example, one informant stated that evenings at the cinema with their children could be ruined if one child's jacket touched the floor, because his partner became distressed about the obsession that the jacket was now contaminated. Another informant told of a ruined evening at a restaurant when a part of the waiter's shirt accidentally touched a tray that held their dinner plates, which led his partner to have obsessions about contamination. Others described exhausting days during vacations, with hours spent looking for a restaurant that met the OCD patient's strict standards of cleanliness. The leisure time that could have

brought enjoyment and strength to the relationship became exhausting because of the intrusion of OCD instead.

OCD's capacity to reduce the experience of fellowship was further underlined by an informant who said that he actually felt jealous of OCD, as it took so much of the time they could have used together on other more valuable and rewarding activities, and where they could have experienced a sense of community. He found himself put aside in favour of the OCD, time after time. This left the informant envious of the OCD and the place it took in his relationship with his partner.

Ongoing predicaments and analytic processes of what to do

It was clear that OCD was present in the informants' mind during much of the time they spent with their partner. They all described various predicaments where they on the one hand had their own spontaneous reactions, and on the other hand needed to evaluate what was wise to say or do in the light of OCD and their partner's needs. They tried to take a step back and process the alternatives, in order to make wise decisions. One of the informants thought of it as a "filter" consisting of what he knew about OCD and about his wife. He let his own utterances and behaviour be "filtered" through this. In this way he adapted to his wife's disorder and her personal needs at that moment. Another informant saw this analytic process with considerations of his own needs, his wife's needs, and the intrusive nature of OCD, as a safeguard to their marriage.

The informants included two main themes in their analytic processes. Firstly, the informants all saw it as crucial to avoid pointing out pathological behaviour during an ongoing ritual, in order to avoid quarrels and to prevent extending the ritual even further. One of the informants had explicitly been instructed by his wife to not interfere during a ritual, because everything got worse if he was angry or patronised her. She needed him to be patient

and calm. He tried to comply with this need, despite feeling upset, and saw this as a help to preserve their marriage. One of the other informants said it was a waste of time and effort to protest in the face of a compulsive behaviour, even though he often felt very frustrated inside. He actually used war metaphors to describe the situation, and thought of it as choosing between “peace” or “war.” He mostly chose peace, and only fought the battles that truly mattered to him.

Secondly, all informants aimed at maintaining an analytic stance in situations where the OCD patient did *not* perform rituals. They tried to recognize and give praise in situations where the OCD patient was exposed to obsession triggers and still managed to withstand the urge to engage in compulsive actions. They all agreed that such praise seemed helpful to their partner. It was, however, not their natural reaction. Several of the informants found it hard to remember, hard to do, and hard to accept that ordinary behaviour should be praised. For example, one informant found it hard to remember to give praise when his wife managed to go down the stairs without doing rituals, since going down the stairs in an uncomplicated way was a natural thing for him to do. He felt guilty when forgetting it, but at the same time it frustrated him that he was expected to remember it. Other informants told stories of similar situations and experiences where they struggled with frustration and guilt because they had explicitly been asked by their partners to give praise in these situations. Some informants had been encouraged to do this when attending family sessions during OCD treatment as well.

To handle these analytical processes, they used their patience and their wish to be kind, as well as humour. However, it was made obvious that it demanded strong self-discipline to hold back spontaneous reactions and not least to also pay attention to their partner’s *normal* behaviour. They sometimes lost their temper and could act in a patronising way. One described that he “allowed” his wife to do the checking on some occasions but not others. Another informant said that she sometimes made decisions for her husband, although

she knew it was a stupid thing to do and saw that such behaviour was tearing down the relationship rather than building it up. Yet another informant mostly chose not to interfere, but intervened by saying “enough is enough” or “now you have to do this only one time” when they were under time pressure.

The interview also revealed stress and fear. For example, one informant told that he was distressed, and that his impetus for holding on to an analytic process was fear; he was constantly afraid of saying something that would upset his wife, and he stated that he never felt free when they were together.

Despite these examples, all the informants showed remarkably good intentions, willingness and capability to work through the difficulties to overcome the burdens of OCD in order to have a good relationship.

Unfortunate and fortunate dynamics between OCD symptoms and partner’s personality

All the informants obviously truly cared about the well-being of their partner and possessed a strong underlying wish to help, understand, and handle the situation in the best possible way. The strategy of holding back and making considerations concerning OCD before they reacted indicated that the informants possessed certain personality traits. They had an ability to be patient, adaptable and put aside their own needs. However, their ability to hold on to this strategy seemed to vary depending on the informants’ other personality traits and the specific OCD ritual that was unfolding. One informant found it especially difficult to be late for appointments because, as he said, being late was at odds with his own personality and values. Another informant, who described himself as a perfectionist, for a long time rather appreciated his wife’s OCD rituals of accuracy, before he understood that it was a disorder. In contrast, one of the others got truly angry and frustrated and had a feeling of nearly exploding when her partner had to be so precise in nearly everything he did.

There were some examples of unfortunate dynamics between the partners' OCD and the informants' vulnerability. One female informant said that she always found it hard to feel that she had to be the strongest partner in the marriage, the one who continuously encouraged the other. She sometimes wished that she could be the weaker part in some situations, handing over the position of strength to her husband. She stated that she felt that she had to be the "man" in the relationship. One of the other informants felt humiliated, like a "school boy being spanked by his teacher", when his wife criticised his way of doing the household chores, and he longed for appreciation. In this way, OCD contributed to a power imbalance in their relationship.

The informants also expressed that their ability to manage being a good and supportive partner to a person with OCD varied with their own general stress level in life as a whole.

Missing understanding of the seriousness of OCD – Need for more help

The informants expressed that they were satisfied with, and grateful for, the treatment program their wives or husbands had attended. They did however not see this as enough, and wanted their loved one to keep in touch with his or her therapist after the standard treatment program. Also, out of concern for the challenges relapses of OCD gave the OCD patient and the family, they needed their partner to seek and receive help quickly during relapses, instead of being put on a waiting list. Some of them said this with a strong emotional undertone, underscoring how important this was for them, and they stated that OCD could quickly overshadow the whole relationship and family life and cause considerable suffering. Some of them clearly expressed that they saw the situation as more serious than therapists and the health care system did. They missed an understanding of how debilitating the disorder can be, how easily it relapses, and how fast additional worsening becomes during exacerbations with huge influence on the families.

For themselves, informants expressed the need to meet together with others in the same situation in order to comfort each other and, as one of them put it, talk about their “common fate”. In line with this, they even found the sense of community achieved during the brief focus group interview as rewarding and meaningful. There was a general agreement among informants that it was good to meet others in the same situation, implying a certain degree of loneliness in living with a partner suffering from OCD. Some informants reported that they benefited from being together with their partner during treatment sessions years ago and one had benefited from attending at OCD conferences. However, they called for more help for their children, who they thought would have benefited from groups sessions without the presence of their parents. They had a sense that their children protected their parents and needed a place to talk freely.

Discussion

The five informants’ have unique experiences from long-lasting relationships with an OCD sufferer. The study is not claiming to be exhaustive on the topic, both due to the methodology and the very small number of participants. However, the study still provides valuable knowledge, specifically on how OCD might influence a couple’s relationship in the long-term. The results show that informants even after many years perceived it as an everyday challenge to distinguish between normality and OCD symptoms, which could lead to power struggles between them and their partner. OCD could deprive opportunities to fellowship by dominating household chores and leisure time, and even create jealousy. The informants experienced an ongoing dilemma between what they felt and what was wise to do. When together with their partner, they had an ongoing analytic process trying to understand their partner’s behaviour, to evaluate what to say and how to react to avoid conflict, as well as protect their partner and the relationship. Strikingly, the analytic process went on regardless of whether the symptoms were present or not; when present, informants aimed to be tolerant,

and when symptoms were not present, they aimed to give praise. They showed a remarkable ability to put their own needs aside, but were inclined to lose their temper when distressed, when they were exposed to their own vulnerabilities, and when their own personality traits were challenged. Although thankful for the help their loved ones had received in the treatment programs, they missed a more comprehensive understanding from the treatment system, and expressed a desire for groups for partners, groups for children, and most importantly quick help with relapses.

The informants' urge to identify whether they were facing symptoms or normal behaviour reflects that they found OCD difficult, but yet important, to grasp. This finding is supported by research showing that family members of OCD patients emphasise the importance of seeking out information about the disease (Cooper, 1996). Such deeper understanding can function as a coping strategy (Wilbram, Kellett, & Beail, 2008). Research suggests that both partners and OCD patients can find it difficult, but important, to understand and grasp the difference between the disorder and the OCD patient as a person (Walseth et al., 2017; Wilbram et al., 2008). When partners mistake behaviour for OCD when it actually reflects personality this can be hurtful for the patient and destructive for the relationship (Walseth et al., 2017). Hence, research indicates that clarification of what is normal and what is symptoms, especially distinguishing OCD rituals from personality traits, can be of importance.

The informants' ability to have a positive, cooperative approach with elements of altruism seems to correspond with the personality trait agreeableness, which is significantly correlated with lower relational stress (Gattis, Berns, Simpson, & Christensen, 2004). Hence, it is probable that this has contributed to their endurance in the long-standing relationships these informants have showed that they are capable of. We do not know whether they

developed such an approach over the years as an adaptation to the situation or whether they initially had those qualities.

Their capability of performing a nearly constant analytic process in their everyday life shows an ability to take a metacognitive perspective and observe their own thoughts, similar to therapeutic tools from metacognitive therapy (Wells, 2009). They also show an ability to direct their attention and take a positive emotional tone, both of which are elements of mindfulness (Van Dam et al., 2018). The informants in the present study found this useful, and necessary to protect their relationship. It would have been interesting to investigate whether it is possible to teach partners of OCD patients the skills of taking a metacognitive perspective, mindfulness and taking a positive emotional approach, and to investigate the consequences for the couple relationship. However, in that case the researchers should also be investigating whether such an approach would represent an overload and too much pressure on the partners.

The informants indicate various sources of asymmetry in their relationships. They put themselves in a helper position during their daily lives, which can be challenging. Their constant attention to OCD might be helpful, but might damage the relationship as well because the attention in itself can give the OCD patient a feeling of being monitored and patronised (Walseth et al., 2017). This further underlines an asymmetric relationship, which can actually remain even after successful therapy (Walseth et al., 2017). The informants in the present study also described a reverse asymmetry where the domination and pressure from the OCD symptoms could make the partner come in contact with his or her own vulnerabilities, and by this push partners of OCD patients into states of humiliation. This finding is supported by quantitative research showing that partners of OCD patients experience compromised boundaries (Torres et al., 2012). The informants of the present study expressed that the constant vigilance could be exhausting, and that they could be irritated or act patronising

towards their partner. This is in line with research showing that OCD patients have a tendency towards antagonistic behaviour (Renshaw et al., 2005). These perspectives support that asymmetry and power imbalance seems to be relevant themes in these relationships. (Walseth et al., 2017). Power imbalance is suggested to be included in all kinds of couple therapy (Knudson-Martin et al., 2015) and the significance of these aspects seem interesting to investigate with respect to OCD therapy as well.

The informants point to issues that might be in mismatch with current OCD therapy. Therapists encourage partners to give praise when the OCD patient succeeds with not doing OCD rituals. However, the partner is perhaps already overloaded because of the consequences OCD might have for the family life. Perhaps the advice of giving such praise constitutes too much additional burden for the partner. Such advice will perhaps also underscore the partner's helper-role, and hence possibly increase the asymmetry in the relationship. For some couples advice of giving praise when the OCD patient succeed in not doing a ritual might be helpful, and this is used in well-known treatment programmes, but the programmes do not touch upon the consequences for the partner and for the couple relationship (Clark, 2004; Foa, Yadin, & Lichner, 2012).

Interestingly, the informants scored low on FAS-SR, despite reporting remarkable attention on what to say and do in the face of their partner's OCD, which indeed can be seen as an accommodation. However, this is not an accommodation according to the definition in the OCD field, where it is defined as either "helping" the patient by engaging in ritualistic behavior themselves or "helping" the patient to avoid situations that trigger obsessions and associated compulsions. This suggests that there might exist an important aspect of accommodation that is not fully captured in the definition of accommodation and by FAS-SR, which both are directed to more concrete actions. It would have been interesting to investigate the scope and clinical usefulness of using a more extended definition of accommodation.

Furthermore, it could be worth investigating whether those who score high on FAS-SR have less ability to have an ongoing attention on what is wise to do, and whether this aspect is specific for partners who have lived with an OCD patient over many years. Perhaps such “accommodation” has a tendency to emerge over time, as a coping strategy based on experience.

There seems to be a gap between the health care system’s and the informants’ view on the nature of the course of OCD. The informants pointed to the need for more follow-up consultations even after successful treatment, in line with research suggesting that OCD is a chronic fluctuating disease despite initially successful treatment (Catapano et al., 2006; Skoog & Skoog, 1999). Some of the informants perceived relapses as nearly an emergency because they had experienced how debilitating relapses could be for the patients and for the families. In contrast, OCD patients in Norway who relapse are being put on a waiting list partly because they are supposed to have learned tools to handle the symptoms. Further exploration should be given to the need for and usefulness of systems that quickly take care of patients with relapses.

In line with earlier research (Cooper, 1996; Wilbram et al., 2008) the informants missed having groups for spouses and for children, beyond the short educational programmes included in treatment programs. Neither of these are offered in the Norwegian health care system. The encompassing presence of OCD in daily life and the secrecy of the disorder have much in common with the field of substance use disorders in which the Norwegian health care system systematically offers children care and support in groups. It is likely that children in families with OCD can benefit from this resource as well.

Clinical implications

Qualitative research has the ability to reveal how reality *can* be, and lay the ground for further quantitative research. The present study does not have the ability to yield knowledge which have great impact on the OCD field and OCD therapy in and of itself. However, it still points to aspects which can be useful for OCD therapists to be aware of in their daily work. For example, it might be useful for therapists to know that the partner of their OCD patient might have a nearly constant analytic process over the predicament between his or her own needs, what the OCD patient needs, and what they as a couple needs. Moreover, therapists should be aware that asking the partner to help and give praise has the potential to overload some partners, and for some couples this might also undermine the relationship by amplifying power imbalance in the relationship. It can also be useful for therapists to know that partners can see relapses as more disastrous than the therapists do.

Limitations and strengths of the study

The recruitment procedure was challenging. One of the challenges was that the study required two consents; the OCD patient's and the partner's. During the data collection to the quantitative part of "The Norwegian long-term OCD project" several OCD patients did not want to include their partners because the partner was not supportive, or they had a new partner who they did not want to involve in their OCD. The individuals that eventually agreed to participate in the present qualitative study might have had less trouble in their relationships than did those who refused, and was maybe a highly selected group. They were all over 45 years old and had stayed in their marriages more than ten years, and their partners had been diagnosed with OCD for several years. This might give certain characteristics to the results, as they have had many years to be conscious about the role of OCD in their relationships. Younger participants in shorter relationships might have provided other results, as would participants where the OCD patients to a higher degree conceal the OCD from their partner. One can only speculate, but perhaps these participants could have provided experiences where

they felt more helpless due to not being allowed to attempt helping their partners. Also, it would have provided other result if we had asked partners who had divorced from OCD patients.

A sample of 15 informants distributed in three focus groups would have been more ideal and would probably have revealed more themes and nuances. However, the study is strengthened by the purposive sampling of specific informants holding experiences of living with a partner with OCD over several years, in line with the research questions.

Living with a partner with OCD in daily life might give rise to habits and behaviours that one is not aware of during daily life. The use of focus groups might have made up for this, where the informants were helped in describing their experiences by reflecting with each other.

The dialogue was characterised by openness, and negative emotions were to some degree put into words. However, there were no directly hostile statements about their partners who had OCD, although such statements are widespread in families with OCD patients (Chambless & Steketee, 1999). Perhaps these informants did not have hostile emotions, or perhaps individual interviews would have been able to reveal this more extensively. Individual interviews would also be more suitable to reveal problems with intimacy, which can be challenging for many OCD patients. Another thing that could potentially obscure openness in the group was that one of the interviewers, GL, was the therapists for their spouses.

Despite these limitations, the information power of the study is still considered high, with a narrow aim, specific sampling of informants, and a high quality of dialogue (Malterud, Siersma, & Guassora, 2015). Additionally, the interview procedure followed recommended

guidelines for focus groups interviews (Malterud, 2012a), and the analysis was performed according to a well-established qualitative method (Malterud, 2011, 2012b). Hence, the study is considered to contribute valid knowledge regarding how OCD can influence family life over the long-term.

Suggestions for future research

The scope of these results should be investigated in a quantitative study to reveal what weight the findings might have beyond the clinically advantage of knowing what partner's experiences *can* be. How frequent are these phenomena among OCD patients and their partners, and does the frequency depend on the duration of the relationship? Furthermore, it would have been interesting to investigate whether extensive education of the partners about OCD, as well as focusing on delimitation between symptoms and the OCD patient's personality, could increase couple functioning and couple satisfaction. It would also be interesting to investigate how individually tailored treatment programmes, including tailored manageable advice to partners, could support better health within these couples. Taking seriously the manifold possibilities for asymmetry of power in these relationships, OCD couples' treatment would probably benefit from including the power aspect as well. The effect of increased follow-up therapies for these families, including the children, and quicker help, should also be investigated.

The recruitment challenges in the present study might indicate similar problems in future research. Perhaps more education of OCD patients concerning what we already know about the consequences of OCD on relationship, as well as the negative consequences of accommodation and hostile environments on the OCD, could motivate OCD patients to include their partners in future research.

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