

***Commentary on Treating a Mother's Accommodation of Her Adult Son's OCD:
The Case of "Brienne" and "Charlie"***

Treatment Refusal and Family Accommodation

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ABSTRACT

This commentary discusses a case study by James Marinchak (2013), who treated a mother's accommodation of her adult son's obsessive-compulsive disorder (OCD). A variety of issues raised by the case are considered. These include: the relationship between dependency and OCD, the presence of rituals without apparent obsessions, the pros and cons of treating one primary relative versus the family, ways of handling treatment refusal, methodological issues, and the relationship between stress, high emotionality and severity of OCD. The main topic of helping families cope with OCD when the person manifesting it refuses treatment is an overlooked and important area of research.

Key words: obsessive-compulsive disorder (OCD); accommodation; treatment refusal; high emotionality; case study; clinical case study

James Marinchak (2013) presents a case study of therapy with "Brienne," a mother who engages in the accommodation of her 18-year-old son "Charlie's" obsessive-compulsive disorder (OCD). The case study touches on several important issues related to the nature of OCD, its treatment, its impact on the family, and the role of accommodation as it affects both the individual with OCD and the nuclear family. The study is of additional interest because it concerns a person with OCD who also suffers from a developmental disability (mild cognitive impairment) and who refuses to go for treatment himself. Given the negative impact of OCD on the rest of the family and the significant rate at which people with OCD either refuse treatment or do not comply with it, developing alternative interventions for other family members becomes an important practical goal.

Charlie, who lived at home with his mother, his father "Jack," and 21-year-old brother "Shane," developed multiple ritualistic behaviors following a traumatic injury suffered by Shane. This accident occurred three years prior to the current intervention. Although apparently well adjusted and showing no evidence of OCD before the accident, Charlie subsequently developed numerous time consuming, disruptive rituals involving symmetry, numbers, repetition, and retracing of his movements. These rituals occurred within the context of more general regressive, phobic, and dependent behavior. Charlie's withdrawal from friends, his fear of

leaving home, and his extreme dependence on his mother are significant treatment issues in their own right and are not necessarily secondary to the OCD.

Of interest here is the relationship between this general dependency and the OCD. Most likely the social withdrawal and the worsening of the OCD formed a positive feedback loop. As Charlie's life narrowed it gave him more time to ritualize and presented him with fewer diversions. Conversely, as the rituals increased it likely became harder for him to engage in normal, age appropriate behavior. Fortunately for Charlie and his family, the social withdrawal was only partial; he continued to go to school and subsequently got a job as a teacher's aid. Although I do not know of any research addressing this issue, in my clinical practice I have found that adult children with OCD living at home who are not attending school or working are extremely difficult to treat.

WHO SHOULD BE THE CLIENT IN THERAPY?

Here the focus is on helping the mother to reduce her accommodation of her son's OCD. It was hypothesized that such a reduction might improve the mother's quality of life and even increase the son's motivation to seek treatment himself. This is a pilot study. The research design specifically calls for recruiting a single adult relative of the person with OCD. Although the father was eventually brought into treatment during the ninth session, 90% of the sessions involved only the mother. It would be useful to know the study's rationale for targeting a single primary relative rather than the family unit. There are pros and cons for each approach. On a practical level, especially for research purposes, it is easier to recruit and schedule one adult than an entire family. Yet there are several advantages to seeing the family, or even just the mother and father together, early on in treatment. It can lead to a more complete assessment of the OCD, better treatment compliance by the family as a whole, an opportunity for coaching the family in lowering expressed emotion, and a clearer understanding of the family dynamics. Here the mother Brienne appears over-involved in her son's problems and the father Jack under-involved. Additionally the parents' own relationship seems to have cooled. These types of dynamics appear well suited to a family or couples approach.

In this case, Charlie refused to enter treatment. Yet he did cooperate with a pre- and post-treatment assessment. I wonder what Charlie conceived of as "treatment." In my clinical practice specializing in OCD I find that some but certainly not all people who initially refuse treatment are willing to attend one or two sessions and then stop if they so choose. These few sessions can be valuable tools for psychoeducation and limit setting. Here, though, the whole point of the study is to assess the impact of accommodation without directly treating the person with OCD. With Charlie I think it would have been helpful to frame the new limits and family rules which were instituted in terms of wanting him to act in a more adult, age-appropriate manner. Framing them in terms of respecting other's privacy, as the author did, is also helpful. The key is that you want to provide a meaningful reason for reducing the accommodation beyond just its affect on the OCD per se. Charlie after all may not want to reduce his rituals.

The fact that Charlie is 18 and therefore legally cannot be forced into treatment is less important in my judgment than his probable unwillingness to cooperate with treatment. In my experience, children and adolescents who are forced into treatment rarely do well because they do not comply with homework assignments. If children or adolescents refuse to cooperate, I find

it better to work some with their parents and then terminate treatment rather than prolong a forced and ultimately ineffective intervention. At a later date they may be more open to treatment, as appears to be the case with Charlie.

CHARLIE'S REFUSAL OF TREATMENT

Charlie's treatment refusal may be related to his particular type of OCD. In classical OCD, a thought—often of a catastrophic nature—triggers a compulsion (American Psychiatric Association, 1994). The compulsion magically prevents the feared outcome, reduces anxiety, and thereby gets reinforced.

Charlie, however, is either unable or unwilling to give any reason for his compulsions. Nor does he express any apparent discomfort or desire to eliminate them. His OCD does not appear ego-dystonic. He may not have actual obsessions or thoughts which precipitate the rituals. He may be responding to environmental cues or to vague feelings. Although he gets agitated if he cannot carry out the rituals it is not entirely clear what function they serve. On a superficial basis, they seem to function like a security blanket. And who wants to give up a security blanket?

Charlie certainly is not unique in his inability to articulate a triggering thought for his compulsions (Mansueto & Keuler, 2005; Foa & Wilson, 2001). Parents and treatment providers sometimes make the understandable error of assuming that a particular, logically related obsession drives the compulsion, e.g. that hand washers are scared of germs. Marinchak here made no such error.

THE PROCESS OF TREATING BRIANNE

In regard to the treatment itself, Marinchak provides a detailed, insightful session by session summary. He describes well the inevitable ups and downs of the change process. The treatment plan is well conceptualized, holistic, and sensitively implemented. I especially liked the focus on encouraging the mother to pay more attention to her personal needs and to her marriage. This emphasis probably helped her to be able to detach some from Charlie's problems. Her short vacation away from Charlie demonstrated and reinforced her own greater independence. Helping her to articulate that she too, not just Charlie, was anxious during their brief separations probably further assisted her in detaching.

In this regard, at several points Marinchak refers to Charlie's family as viewing Charlie as a "loved one." I have a minor quibble with this term. For me it has funereal associations and seems antithetical to developing a strong, non-accommodative attitude. I have seen too many families where the person with OCD is anything but loved.

Another strength in Marinchak's treatment is the selection and prioritization of problem behaviors. During the early sessions the therapy focused on behaviors which significantly interfered with the mother Brienne's life and which were within her power to change. Charlie's morning rituals were time consuming and prevented him from being ready to leave for work early enough for Brienne to drive him there and still get to work on time herself. She dealt with this by stopping to drive him. Thus Charlie was forced to take responsibility for his own life (he

walked to work) and Brianne was able to assume more control of her own. Similarly Brianne insisted that Charlie stop entering her bedroom and disturbing her after 10:30 PM. These two changes alone had a large impact on Brianne's life and probably strengthened her resolve to continue with therapy.

In deciding what to treat and what to ignore I find the everyday acronym "MYOB" ("mind your own business") helpful. If the OCD behavior only affects the individual himself (e.g. privately done symmetry rituals) it might best be ignored until the person himself wants to change. On the other hand, if the ritual negatively impacts others (e.g., using up all the hot water while showering), then it becomes fair game for intervention. In general, the idea is to stop participating in or facilitating compulsions (e.g., not driving Charlie back to the hospital as part of a "retracing" ritual), setting limits when the OCD affects others (e.g., no constant touching of the mother), and ignoring other behaviors.

MECHANISMS OF CHANGE

I think it would be helpful to look at the treatment here in terms of common behavioral change principles. Charlie was displaying tantrums and extreme clinginess. Brianne wanted to extinguish these behaviors. Brianne needs to know that the extinction curve does not show an immediate decline when reinforcement is withheld (Persons, 2008, p. 46). In other words, if ignored, Charlie's tantrums likely will continue for a while; they may even get worse before they get better (Chansky, 2000, p. 84). If Brianne doesn't know this she might react inconsistently and inadvertently strengthen the behavior via intermittent reinforcement. She then might balk in trying not to accommodate the rituals.

At one point in his discussion of the OCD literature Marinchak (2013) suggests the advantages of family members employing "non-hostile criticism" with the family individual member with OCD.

OCD therapists typically advocate an approach whereby family members adopt a communication style towards their loved ones of "non-hostile criticism." This style is characterized by direct, concise verbalized criticism and dissatisfaction towards the OCD-family member for their decision to ritualize (e.g. "I know it's not an easy thing to do, but I wish you would try harder to fight back against your OCD") rather than an outright rejection of the whole person (e.g. "I can't stand being around you when you're like this!"). Several authors suggest that relying on non-hostile criticism implicitly communicates the belief that their loved one has the ability to cope with and overcome their OCD (Chambless & Steketee, 1999; Steketee & Van Noppen, 2003). Such communications may increase patients' feelings of self-efficacy towards fighting their OCD and result in increased motivation to seek therapeutic help (p. 7-8).

However, any attention, even negative attention like non-hostile criticism, might function as a reinforcer. Aside from providing negative attention, it can provoke fights and shouting matches in highly emotional families. In other cases though, non-hostile feedback to "fight the OCD" can heighten awareness and help reduce rituals. The benefit of feedback in my experience depends on the tone of delivery, family relationships, and the receptivity of the person with OCD.

Differential reinforcement of other behavior (DRO)—that is, behavior that is positive and prosocial as opposed to dysfunctional—is another relevant principle (Matson et al, 2011). One goal of therapy was to increase the father Jack's involvement with Charlie. We want to ensure that Jack attends to Charlie when he is behaving appropriately. We don't want Jack to be more involved in assisting Charlie with his rituals or in showing hostile criticism. Since OCD is so frustrating and wearing for the whole family, it becomes very easy to forget about DRO and just ignore the person if they are not causing a problem.

Finally, if the treatment plan does call for Charlie to try harder to resist the OCD, then it would help to provide him with alternative, incompatible behaviors (Matson, 1982). (Here the case shifts from simply reducing accommodation to training the parent to function like a therapist.)

The case write-up does not describe much resistance or protest from Charlie when the accommodation was reduced. Sometimes it does proceed smoothly like this. I have seen several cases, though, where the person with OCD strongly objected to any changes in family routines related to the OCD. Hoarders in particular, who often refuse treatment, can be resistant and hostile towards other family members when they attempt to reclaim shared living spaces (Tompkins & Hartl, 2009). Handling such situations requires all of one's clinical skills.

From a psycho-educational standpoint, the mother found it very helpful to be told that she was not responsible for controlling Charlie's rituals. She had mistakenly assumed that if she did not stop them, they would get worse. Yet OCD often is a private affair (Rachman, 1976). Interpersonal contingencies exert only some influence on it. Much ritualizing occurs in the privacy of one's bedroom where no one else is even aware of it. Thus it is not altogether surprising if reduced accommodation fails to result in an overall reduction in OCD. That said, it is still of utmost importance to address accommodation in every treatment protocol because of its impact on the family and its ability to maintain some rituals. In this regard I recall a case in my clinical practice in which a woman in her late 40s recounted that as a child her mother once screamed at her that she would field "no more questions about dirt!" Her symptoms then went into remission for nearly 40 years until hormonal changes may have triggered their reappearance.

COMPARISON OF BRIANNE'S THERAPY WITH SELF-HELP GROUPS

It is useful to compare Marinchak's therapy approach for reducing accommodation in this case with the operation of a self-help group like Al-Anon (<http://al-anon.alateen.org/home>). Aside from differences in vocabulary ("enabling" vs. "accommodating") and the emphasis or not on spirituality, the two approaches share several commonalities. Both stress the importance of not facilitating the unwanted behaviors, of detachment via involvement in other activities, and most importantly, of one's inability to change another adult's behavior. My understanding is that their primary benefit is in assisting the family to cope more effectively with the disorder rather than changing it. Systematic research as piloted in Marinchak's case study of Brianne and Charlie is important because it will specify the components of treatment, note what if any rituals do change, and report on any changes in the well-being of other family members. It then might be

possible to develop a group treatment that provides similar benefits more economically (Kazdin & Blase, 2011).

TREATMENT OUTCOME AND DISCUSSION

As the author mentions, at the end of treatment there were two indicators that the therapy was not fully successful. Charlie did not express an immediate desire to seek treatment for himself, and Brianne did not show significant improvement in her quality of life as measured on standardized quantitative measures. However, the lack of change on these instruments seems due to the fact that Brianne initially presented herself in the normal range as having no impairment on her quality of life even though as she became involved in the therapy, she did reveal her distress and frustration.

Overall, other than the data on the standardized quality-of-life measures, Brianne did show clear benefits from therapy, as indicated by the decrease in her FAS-IR measure of family accommodation, by the therapist ratings of the decrease in Brianne's accommodation over the course of therapy, and by other qualitative data in the case. For example, Brianne set much needed limits on Charlie, she showed better self care, and she seemed relieved of false responsibility in curing him of his disorder. While Charlie did not report any improvement in his own symptoms despite experiencing a less accommodating home environment, he did not report a deterioration. While as noted above, Charlie's self reports may not be valid in themselves, his reports were consistent with other qualitative data in the case.

In future case studies like this it would be desirable to obtain before and after measures of specific behaviors (e.g., requests for reassurance, number of times he was late for work, and observed frequency of retracing his route), using a daily diary. These types of measures would more definitively highlight the impact of decreased accommodation on the OCD.

Also I would be interested in a brief global measure of family functioning and expressed emotionality before and after treatment. My guess is that both would have shown some improvement. In general I would expect the level of improvement in family relations at the end of treatment to correlate positively with a reduction in accommodation and a lessening of expressed emotionality. Initially, though, a reduction in accommodation might worsen family relations. Lastly, in terms of measuring change, it would be better to have someone other than the treatment provider perform the final assessment

Clinicians working with OCD know that it can be a severe stress for the entire family (Chansky, 2000). I would hypothesize that as the level of stress increases, families become more emotional and hostile. High emotionality in turn is counter therapeutic for the person with OCD (Przeworski et al., 2012). A vicious cycle could ensue. As such, I would like to see expressed emotionality specifically targeted in research emerging from the Brianne and Charlie pilot case study. Such research nicely complements the focus on minimizing the accommodation of individual family members with OCD who refuse treatment. Teaching family members how to stay calm as they disengage from the rituals and demands of OCD can benefit the entire family. Even if not a single individual with OCD becomes more motivated to seek individual treatment, well implemented interventions which reduce accommodation and restore family harmony can narrow the topography of the OCD and help everyone to feel better.

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