

FAMILY ACCOMMODATION IN OBSESSIVE-COMPULSIVE DISORDER:
A STUDY ON ASSOCIATED VARIABLES

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Abstract

The present study aimed to examine family accommodation in relatives of obsessive-compulsive disease (OCD) patients. Accommodation was assessed in a sample of 31 relatives of OCD patients by means of the Family Accommodation Scale. Other variables measured as predictors of accommodation were the tendency of a family member to feel guilty, sensitivity to guilt, anxiety sensitivity and the prevalence of a passive communication style. Accommodation was found to be rather widespread in the family members who took part in our study, and they tended to show more accommodation the greater their sensitivity to guilt and the stable tendency to experience this emotion as well as anxiety sensitivity and a passive communication style. Multiple linear regression analyses showed that, among the variables considered, the family member's sensitivity to guilt is the only factor which can predict accommodation with regard to the patient's demands for involvement. On the other hand, the small number of family members in the sample and the lack of clinical data on patients (such as the severity, typology and duration of their obsessive-compulsive disorder) pose limits to the generalizability of the results and point to the need for further research.

Key words: obsessive-compulsive disorder (OCD), family accommodation, guilt, family, relatives

Declaration of interest: the authors report no declarations of interest.

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Introduction

Obsessive-compulsive disorder (OCD) is rather frequent in the general population and has serious consequences on the quality of life of the sufferers as well as of their families and partners (Moritz and von Mühlhens 2005, Eisen et al. 2006, Stengler-Wenzke et al. 2006).

The international literature is rich in experimental studies and theoretical speculation geared to clarifying the individual factors which predispose people to developing OCD. Over the last few decades there has also been a proliferation of studies investigating the role of certain interpersonal factors in the development and maintenance of the disorder, particularly with regard to the family sphere. Compared to families of other psychiatric patients, the relatives of OCD patients are often more involved in the patients' symptoms, given that compulsions mostly take place within the home. Family accommodation is the most investigated form of family involvement today. The term accommodation means the tendency of OCD patients' relatives to provide reassurance, assist and/or actively participate in compulsions, facilitate the avoidance of anxiety-generating situations, stand in for the patient in activities which are really his or her responsibility, and modify family activities and routines (Van Noppen et al. 1991).

Some studies have revealed that a high percentage of relatives (60-88%) are actively involved in the patient's symptoms (Shafran et al. 1995, Calvocoressi et al. 1999, Renshaw et al. 2005, Albert et al. 2010).

Empirical data have shown that accommodation correlates with the severity of the obsessive-compulsive symptomatology (Storch et al. 2007, Peris et al. 2008, Stewart et al. 2008, Flessner et al. 2011, Lebowitz et al. 2012), with family distress (Amir et al. 2000), with greater attitudes of rejection towards the patient (Calvocoressi 1999), and with a worse quality of life in relatives (Steketee and Pruyn 1998; de Abreu Ramos-Cerqueira et al. 2008, Torres et al. 2012, Gururaj et al. 2008, Albert et al. 2009). For clinical purposes, it must be noted that family accommodation predicts a worse therapeutic response of the patient with regard to pharmacological treatments and to cognitive-behavioural ones such as Exposure and Response Prevention (Steketee and Van Noppen 2003, Renshaw et al. 2005, Ferrão et al. 2006, Storch et al. 2007, Garcia et al. 2010). This may be a consequence of the fact that while, on the one hand, the relative is helping the patient to avoid performing his/her rituals and checks, and is reassuring him/her on his/her fears, thereby reducing the anxiety and stress at the time, on the other, in so doing, the relative prevents the patient from acquiring knowledge useful to disconfirm his/her beliefs

(Salkovskis 1996) on the likelihood of the occurrence of the feared event, the severity of the consequences and the tolerability of anxiety and discomfort, and thus the relative contributes to maintaining those very symptoms (Saliani et al. 2011).

Most accommodating relatives realize the pointlessness of their being indulgent – something that is detrimental to their own quality of life and does not even lead to any improvement in the patient's symptoms, but they are unable to stop this behaviour.

Why do family members continue to accommodate? What prevents them from stopping? In the literature, accommodation is frequently reported as an expression of the relative's attempt to alleviate the patient's anxiety (Otero and Rivas 2007), reduce stress (Waters and Barret, 2000) or alleviate one's own anxiety (Futh et al. 2012). Various studies document the correlation between the family member's anxiety and his/her tendency to accommodate (Peris et al. 2008, Amir et al. 2000). Anxious parents may be inclined to accommodate because they share their children's fears (such as contamination), because they may also have a history of avoidance strategies towards anxiety-generating situations, or because they fear the physical sensations brought on by anxiety (Caporino et al. 2012). It may be a manifestation of anxiety sensitivity (Taylor 1999) of the family member who, by considering the consequences and effects of anxiety symptoms to be catastrophic, will tend to accommodate in order to prevent and alleviate them, in both the patient and him/herself. In other words, faced with the patient's compulsions or requests for help, the relative with a high anxiety sensitivity could imagine an escalation of the anxiety and of its related symptoms and thus decide to step in to avoid this happening and the catastrophic consequences imagined: "If I don't step in, if I don't satisfy his demands, his anxiety will go on increasing with disastrous consequences for him" (such as losing control, going crazy or having a heart attack).

As reported in the literature (Futh et al. 2012) and found in our own clinical experience, other family members say they feel responsible for the patient's disorder and also experience intense feelings of guilt when they try not to accommodate. In this case, the threatening evaluation following the patient's demands or compulsion is usually of the following type: "If I don't step in, if I don't satisfy his demands, his suffering will increase, he will get angry with me and will rebuke me for not helping him, and I shall feel terribly guilty". Hence, accommodation means avoiding the guilty feelings of not helping the patient. More than for anxiety reasons, family members who accommodate in this sense appear to be sensitive to feelings of guilt (Perdighe et al. 2015), its manifestations and consequences, and thus, as with the case of anxiety sensitivity, they are encouraged to avoid experiencing it (Shapiro and Stewart 2011).

Another dimension reported by family members in explaining their accommodation is the desire to avoid conflict and prevent the patient's anger which could arise when his/her demands are not met (Calvocoressi et al. 1999, Storch et al. 2010). In this case, accommodation could be the expression of the family member's unassertiveness in communication (Lange and Jakubowski, 1976, Anchisi and Gambotto Dessy 2009), of his/her desire to avoid conflict because s/he believes s/he would not be able to handle it, and/or his/her unwillingness to reject the patient's demands owing to the catastrophic consequences imagined.

From our analysis of the literature, no study appears to have measured anxiety sensitivity and guilt sensitivity in OCD patients' relatives, nor their

prevalent communication style. The present study springs from our desire to evaluate whether, as suggested by the data available in the literature and from our own clinical experience, the phenomenon of accommodation correlates with the family member's intrapsychic factors, and to what extent. In particular, we hypothesized that the family member is more inclined to accommodate the more s/he fears and is geared to preventing or limiting the onset of anxiety (anxiety sensitivity) and the feelings of guilt (guilt sensitivity), which are considered negatively, and the more s/he has difficulty in coping with conflict and in rejecting the patient's demands (unassertive communication style).

Method

Participants

One or more family members or cohabitants of OCD patients were selected on the basis of the following criteria: a) being over 18 years of age; b) living with the patient for at least two years; c) absence of any history of mental disorders; d) not being involved in the care of any other family member suffering from severe physical or mental illness; e) their informed consent to participate. The family members were interviewed with the Structured Clinical Interview for DSM-IV Axis I Disorders, Non-Patient version (SCID-NP; First et al. 2002) in order to exclude the presence of any current or lifetime mental disorders.

Thirty-one subjects took part in the study: 15 women (48.39%) and 16 men (51.61%), with a mean age of 50.40 ($SD = 12.16$; range = 20-77) and average schooling of 12.39 years ($SD = 3.93$; range = 5-18). The sample of family members was as follows: 13 mothers (42%), 10 fathers (31%), 4 brothers (14%), 2 husbands (7%), 1 wife (3%), 1 sister (3%).

All the subjects were relatives of 19 patients with a main diagnosis of OCD (DSM IV-TR, APA 2004), as confirmed by the Structured Clinical Interview for DSM-IV (SCID; First et al. 1997) administered by a clinical psychologist. The patients were in treatment at the following establishments: the *Villa Camaldoli* nursing home (Naples); the *Maricae* therapeutic community (Latina); the *ASL CE 2* local health service centre (Caserta); the *NA 2 Nord* local health service centre (Naples); and the *Moscato* hospital complex (Caserta). They had an average age of 27.79 years ($SD = 8.28$; range: 15-55) and a mean pathology duration of 7.24 years ($SD = 6.91$; range: 2-35).

Procedure

All procedures fully complied with the professional ethical and deontological code. After obtaining their informed written consent, the subjects were given the SCID by a clinical psychologist. The subjects then filled in a demographic questionnaire and a test battery including the scales described below. The questionnaires were administered in random sequence.

Instruments

The Family Accommodation Scale (FAS; Calvocoressi et al. 1995) was used in order to measure the degree of the relative's involvement in the patient's obsessive-compulsive symptomatology. The scale

consists of 13 items and is divided into three subscales: the FAS 1 (first 9 items), which gives an overall accommodation score (up to 9 indicates mild family accommodation, 10–18 moderate, 19–27 severe, and 28–36 very severe accommodation) and assesses the relatives' involvement in the patient's symptoms (items 1-5) along with the variations of normal family functioning (items 6-9); the FAS 2 (item 10), which measures the level of stress experienced by the relative as a consequence of accommodation; the FAS 3 (items 11-13), which evaluates the perceived severity of the consequences of not complying with the patient's demands. The FAS has shown good psychometric properties (Calvocoressi et al. 1995).

The Anxiety Sensitivity Inventory (Reiss et al. 1986), is a 16-item questionnaire devised in order to assess sensitivity to anxiety, that is, the dispositional tendency to fear the somatic and cognitive symptoms of anxiety because they are considered to be dangerous or harmful. The psychometric properties of the instrument and its predictive validity are well established (Telch et al. 1989, Mailer and Reiss 1992).

The Assertiveness Profile (Gillen 1992) allows us to evaluate the communication style most used by the subject. It consists of 36 items divided into three subscales relating to assertive, aggressive and passive communication styles. Although aware of the lack of studies documenting the statistical validity and reliability of this tool, we decided to use this scale because it enables us to distinguish the three communication styles rather than just providing an overall assertiveness/unassertiveness score. For the purposes of the present study, we shall refer only to the 12-item subscale concerning the passive communication style.

The Guilt Inventory (Kugler and Jones 1992) consists of 45 items subdivided into three subscales: state guilt, concerning the subject's regrets or guilt for current or recent transgressions; trait guilt, defined as the stable tendency to feel guilt over and beyond the immediate circumstances; moral standards, the degree of compliance with rigid moral principles without referring to specific behaviours or beliefs. The scale has shown good psychometric properties (Kugler and Jones 1992). For the purposes of the present study, we shall refer only to the 19-item trait guilt subscale.

The Guilt Sensitivity Scale (Perdighe et al. 2015) assesses personal sensitivity to guilt and consists of 9 items investigating the tendency to avoid the feeling, its influence in the subject's life and his or her capacity to tolerate it. The items include such things as "I am not worried about being guilty or deserving to be rebuked", "It hurts to deserve to be judged guilty by someone else". The scale seems to have adequate internal consistency and a good construct validity (Perdighe et al. 2015).

Statistical analyses

To assess the degree and type of accommodation, an analysis was made of the frequency response of family members to each item of the FAS questionnaire. An analysis of bivariate correlations (Bravais-Pearson's r) was performed to assess which variables among those considered (Anxiety sensitivity, Sensitivity to guilt, Trait guilt, Passive communication style) correlate with the level of accommodation.

Finally, the specific role of any significantly correlated variables was examined to predict accommodation through a series of multiple linear regressions (stepwise method, criteria: probability of F

to enter ≤ 0.05 , probability of F to remove ≥ 0.100), where the dependent variables are the FAS subscale scores. The data were analysed by means of the SPSS 17.0.

Results

Data normality was assessed by means of the Kolmogorov-Smirnov (K-S) and Shapiro-Wilk (S-W) tests. The statistical non-significance of the K-S and S-W normality tests yielded a normal distribution for most of the variables considered except for the FAS 2 "Personal Distress associated with this involvement" (K-S = 0.241, $p = 0.000$; S-W = 0.867, $p = 0.001$), FAS 3 "Perceived consequences of not participating in the patients' symptoms" (K-S = 0.174, $p = 0.018$; S-W = 0.932, $p = 0.049$), and Anxiety sensitivity (K-S = 0.160, $p = 0.041$; S-W = 0.902, $p = 0.008$). Based on these findings, we assessed multivariate normality by using Mardia's coefficient of multivariate kurtosis. Mardia's coefficient was 0.08, indicating no departure from multivariate normality for these data.

Multicollinearity was assessed by examining Tolerance and the Variance Inflation Factor (VIF). For all the independent variables, the Tolerance test was greater than 0.1 and VIF was less than 10: Anxiety sensitivity (Tolerance = 0.584 and VIF = 1.713); Trait guilt (Tolerance = 0.774 and VIF = 1.340); Passive communication style (Tolerance = 0.678 and VIF = 1.527); Sensitivity to guilt (Tolerance = 0.887 and VIF = 1.170). Multicollinearity exists when Tolerance is below .1 and VIF is greater than 10. In this case, there is no multicollinearity.

Analysis of the FAS 1 response frequency showed that most family members ($n=16$; 52% of the sample) had a moderate level of accommodation, whereas a substantial group ($n=9$; 29% of the sample) severely accommodated and a small group ($n=4$; 13% of the sample) participated quite intensely; only a small percentage ($n=1$; 3% of the sample) was not involved in the patient's symptoms or was only mildly involved.

In line with the literature, in our sample of family members, accommodation was shown to be quite a common daily practice, in the form of reassurance ($n=12$; 39% of subjects), participation in the patient's rituals ($n=8$; 26%), ease avoidance ($n=12$; 39%) and change in one's own habits ($n=10$; 32.2%). Moreover, the majority of family members ($n=25$; 80%) reported being involved in the patient's symptoms and feeling a moderate to extremely high level of stress (see **table 1**).

Correlation analysis showed several significant correlations between the variables considered and the FAS scale (FAS 1 = Participation in rituals and Modification of daily routines due to OCD; FAS 2 = Personal Distress associated with this involvement; FAS 3 = Perceived consequences of not participating in the patients' symptoms).

The FAS 1 subscale score (family participation in rituals) correlated moderately positively with Trait guilt, Sensitivity to guilt, Passive communication style and Anxiety sensitivity. The FAS 2 subscale score (levels of stress for the family member due to accommodation) correlated moderately positively with Trait guilt, Sensitivity to guilt, Passive communication style and Anxiety sensitivity. The FAS 3 subscale score (consequences of failure to participate in the patient's rituals) moderately positively correlated with Sensitivity to guilt and with a Passive communication style (see **table 2**).

In the multiple linear regression models, where

Table 1. Response frequency for each item of the Family Accommodation Scale (FAS)

FAS 1 “Participation” Items	Never n (%)	1-3 times a month n (%)	1-2 times a week n (%)	3-6 times a week n (%)	Daily n (%)
1. Frequency of patient reassurance	2 (6.9%)	4 (13.9%)	8 (24.1%)	5 (17.2%)	12 (38.7%)
2. Frequency of providing items for patient's compulsive behaviors	10 (31.0%)	5 (17.3%)	6 (20.6%)	7 (20.8%)	3 (10.3%)
3. Frequency of participating in patient's compulsive behaviors	8 (24.1%)	5 (17.3%)	6 (20.7%)	4 (13.8%)	8 (25.8%)
4. Frequency of assisting the patient in avoidance	5 (17.2%)	5 (17.3%)	7 (20.9%)	2 (6.7%)	12 (38.7%)
5. Modifying personal routine due to patient's symptoms	8 (24.1%)	8 (24.2%)	6 (20.7%)	3 (10.3%)	6 (20.7%)
FAS 1 “Modification” Items	Never, %	At times, %	Pretty much, %	Much, %	Very much, %
6. Modifying family routine due to patient's symptoms	0 (0%)	10 (31.2%)	7 (24.1%)	4 (13.7%)	10 (32.2%)
7. Taking on responsibilities that are normally the patient's responsibility	12 (37.9%)	8 (24.2%)	5 (17.3%)	3 (10.3%)	3 (10.3%)
8. Modifying work schedule due to patient's symptoms	12 (37.9%)	9 (27.6%)	6 (20.7%)	2 (6.9%)	2 (6.9%)
9. Modifying leisure activities due to patient's symptoms	4 (13.8%)	6 (20.7%)	8 (24.2%)	9 (27.5%)	4 (13.8%)
FAS 2 “Personal Distress” Item	Not at all, %	Mild, %	Moderate, %	Severe, %	Extreme, %
10. Does helping the patient lead to distress?	3 (10.3%)	3 (10.4%)	6 (20.7%)	9 (27.6%)	10 (31.0%)
FAS 3 “Perceived Consequences” Items					
11. Did the patient become distressed when you did not accommodate?	3 (10.3%)	8 (24.2%)	11 (34.5%)	6 (20.7%)	3 (10.3%)
12. Did the patient become angry/abusive when you did not accommodate?	2 (6.9%)	4 (13.8%)	15 (48.3%)	5 (17.2%)	4 (13.8%)
13. Did the ritual time increase when you did not participate?	3 (10.3%)	11 (34.5%)	8 (24.2%)	5 (17.2%)	4 (13.8%)

FAS 1= Participation in rituals and Modification of daily routines due to OCD; FAS 2= Personal Distress associated with this involvement; FAS 3= Perceived consequences of not participating in the patients’ symptoms

Table 2.. Correlation between the Family Accommodation Scale, Anxiety sensitivity, Trait guilt, Passive communication style and Sensitivity to guilt

	FAS 1	FAS 2	FAS 3
Anxiety sensitivity	0.411*	0.445*	0.125
Trait guilt	0.448*	0.479**	0.073
Passive communication style	0.494**	0.374*	0.434*
Sensitivity to guilt	0.594**	0.425*	0.434*

FAS 1= Participation in rituals and Modification of daily routines due to OCD; FAS 2= Personal Distress associated with this involvement; FAS 3= Perceived consequences of not participating in the patients’ symptoms

* $p < 0.05$
** $p < 0.01$

the dependent variables were the FAS 1, FAS 2 and FAS 3 subscales, the following independent variables were introduced: Anxiety sensitivity ($M = 22.45$; $SD = 12.17$), Trait guilt ($M = 56.58$; $SD = 11.30$),

Passive communication style ($M = 28$; $SD = 5.40$), and Sensitivity to guilt ($M = 44.52$; $SD = 8.89$).

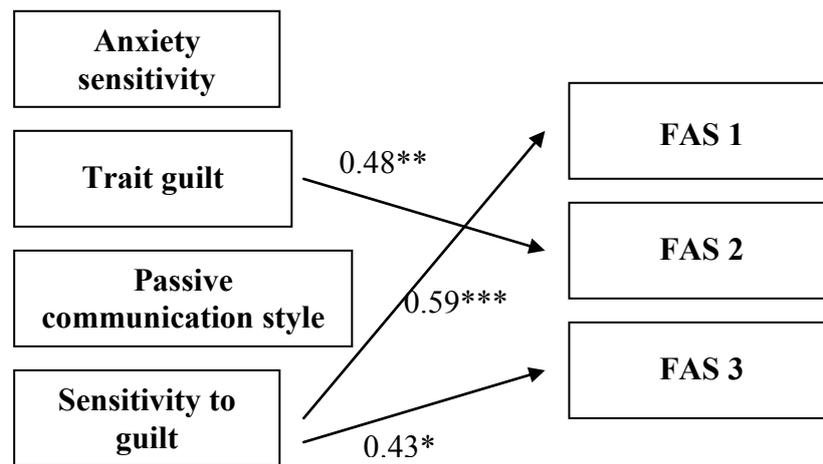
The FAS 1 subscale was significantly predicted by Sensitivity to guilt ($\beta = 0.59$, $t = 3.97$, $p = 0.000$),

but not by Anxiety sensitivity ($\beta = 0.04, t = 0.21, p = 0.837$), Trait guilt ($\beta = 0.16, t = 0.84, p = 0.408$), and Passive communication style ($\beta = 0.19, t = 0.97, p = 0.340$). Similarly, the FAS 3 subscale was significantly predicted by Sensitivity to guilt ($\beta = 0.43, t = 2.60, p = 0.015$), but not by Anxiety sensitivity ($\beta = -0.28, t = -1.26, p = 0.218$), Trait guilt ($\beta = -0.27, t = -1.34, p = 0.192$), and Passive communication style ($\beta = 0.26, t = 1.21, p = 0.236$). Conversely, the FAS 2 subscale was significantly predicted by Trait guilt ($\beta = 0.48, t = 2.94,$

accommodation with regard to the patient's demands.

The results of our study seem to indicate that a family member who is partly accommodating adopts this behavior to limit or avoid having to cope with the feeling of guilt s/he would have if s/he were to refuse to comply with the patient's demands. In this sense, then, accommodation would appear to be geared not only to alleviating the symptoms of the OCD patient, but also to avoiding feelings of guilt in the family member for not having helped the patient. By complying with

Figure 1. Beta values (standardized) of multiple regression analysis between the Family Accommodation Scale, Sensitivity to anxiety, Trait guilt, Passive communication style and Sensitivity to guilt



Note: FAS 1= Participation in rituals and Modification of daily routines due to OCD; FAS 2= Personal Distress associated with this involvement; FAS 3= perceived consequences of not participating in the patients' symptoms

* $p < 0.05$

** $p < 0.01$

*** $p < 0.001$

$p = 0.006$), but not by Sensitivity to guilt ($\beta = 0.22, t = 1.11, p = 0.278$), Anxiety sensitivity ($\beta = 0.24, t = 1.13, p = 0.269$), and Passive communication style ($\beta = 0.23, t = 1.34, p = 0.190$).

Discussion

Although the interpretation of the results is limited by some important factors, namely the small sample of family members and the lack of sufficient clinical information on patients, the present explorative study still provides some interesting indications.

In line with the data reported in the literature (Albert et al. 2009), accommodation was rather widespread among the family members of our sample who, although involved in different ways in the patient's symptoms (from providing reassurance to facilitating avoidance of anxiety-generating stimuli), reported at least a moderate level of stress caused by their involvement.

The aim of the present study was, in particular, to investigate whether and to what extent the family member's specific intrapsychic factors contribute to accommodation. On the whole, the results confirmed our starting hypotheses and showed that the family member is inclined to accommodation the more s/he feels the presence of guilt sensitivity – the sole factor, from the ones taken into consideration, that can predict

the patient's requests, the family member prevents any feelings of guilt s/he would have by not doing so, and this avoidance contributes to maintaining such behaviours, which the person also considers costly and not very useful in resolving the OCD.

In our view, the results of the present study have some important clinical implications for OCD treatment. Alongside the actual presence and extent of the accommodation phenomenon, we consider it advisable to assess the level of sensitivity to guilt in the family members most involved in the patient's symptomatology, to then take this into account when devising the specific treatment for the patient.

In cases like these, we consider it useful to provide for specific actions to help the family member grasp the role that his or her sensitivity to guilt may have in maintaining the accommodation and, consequently, the patient's actual OCD. These actions, together with general psychoeducation on OCD and on its maintenance factors, should, in particular, be geared to accepting the feeling of guilt and to restructuring the catastrophic beliefs of intolerability of this experience – also in the light of the costs deriving from behaviours enacted to prevent or limit this emotion, among which we find accommodation itself. That is to say, the family member should be helped to grasp that in trying to avoid or to limit his/her own feelings of guilt, through accommodation s/he is actually complying with the

patient's demands and, in so doing, contributing to maintaining the patient's disorder, thereby hindering the treatment process and thus becoming guilty of a greater fault.

This specific focus could improve effectiveness – something that is also amply documented by psychoeducational actions addressed to the relatives of OCD patients (Van Noppen and Steketee 2004) – and reduce the cases of lack of response, early interruption or rejection of treatment which could, in certain cases, be the manifestation of a person's refusal to exposing him/herself to situations that can trigger fears of experiencing guilt.

However, these considerations are conditioned by the important limitations characterizing the present study. Firstly, the small size of the sample (31 relatives of 19 patients) limits the power of the statistical analyses and the generalizability of the results. Secondly, the sample of family members was not balanced with respect to the type of kinship and this prevented distinguishing both the accommodation response and the subsequent investigations on the basis of this factor for exploring any possible implications. Finally, a further limitation is having privileged the family determinants of accommodation and overlooked the weight of the patients' clinical characteristics on this phenomenon, like the seriousness of the OCD and its typology, the age at onset of the disorder, and the patients' age at the time of the study.

Further studies could envisage larger samples of relatives in order to increase the significance of the results obtained in the present study and enable a greater generalizability. Future samples should also be diversified and balanced for type of kinship in order to assess whether this variable affects the degree of accommodation and, in particular, whether it alters the weight of the factors taken into consideration in the present study in predicting the phenomenon. It is also worth assessing the weight of intrapsychic factors considered here in family members with regard to accommodation in relation to the patients' clinical characteristics.

In conclusion, despite its limitations, we feel that the present study suggests future research lines with a view to understanding family accommodation with regard to relatives of OCD patients and also to grasping the factors triggering and maintaining such a dysfunctional response, with the consequent clinical implications for structuring the relative psychoeducational actions to be taken.

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