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Accommodation with adult obsessive compulsive disorder: patients and family perspectives

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Abstract: **Obsessive compulsive disorders experience caused distress for patients themselves and family members due to the burden of the disease which includes the feelings of frustration, anger and guilt, addition to impairment in social activities. Aim: so the aim was to determine the level of Accommodation for both patients and family with adult obsessive compulsive disorders Design: The study followed a descriptive design. Setting: this study was conducted in the psychiatric out patient's clinics of the Psychiatry, Neurology and Neurosurgery Center affiliated to Tanta University in addition to the out patient's clinic of Tanta mental health hospital, affiliated to the ministry of health at Tanta city. Subjects: a purposive sample of 50 patients with OCD and their families fulfilling the inclusion criteria of the study. Tools: Tools used were, (I) Family Accommodation Scale for Obsessive-Compulsive Disorder, Self-Rated Version (FAS-SR) and tool (II) Family Accommodation Scale for Obsessive-Compulsive Disorder Patient Version (FAS-PV). Results: The results reveled 40% of the studied subjects aged from 30-40years with Mean ± SD 32.42 ± 9.114 year, 60% of the studied patients were the majority of the patients 96% co habituated with their family. Most of the studied families (70%) had a high level of accommodation regarding their patients Obsessive-Compulsive symptoms and there was a high positive significant relationship between levels of family accommodation as reported by patients and their families. Conclusion: Based on the results it can be concluded that, regarding to the level of Family accommodation, the most of studied families had a high level of accommodation regarding their patients' Obsessive-Compulsive Symptoms as reported by the family members themselves. Recommendation: Family support may be needed to help relatives in dealing with frustrating patient's behaviors and to encourage more positive communication and reduce anger expression.**

Keywords: **Obsessive Compulsive Disorders (OCD), Family Accommodation (FA), Symptoms, Response.**

1. INTRODUCTION

Obsessive–compulsive disorder (OCD) is characterized by obsessions, defined as recurrent unwanted thoughts, images or urges that provoke anxiety, as well as by efforts to resist or neutralize the obsessional anxiety through avoidance behaviors and deliberate overt or covert actions (i.e., compulsive rituals).[1]

OCD is a common psychiatric disorder, twice as prevalent as schizophrenia or bipolar disorder, with an estimated lifetime prevalence rate of 2%–3% worldwide. It has generally an early age at onset, in childhood or early adult life, with an earlier age at onset in males. The early age at onset may greatly impact on the ability of patients with OCD to gain normal skills and abilities to function in adult life. OCD tends to have, in the majority of cases (up to 75% of patients), a chronic course; the picture is further complicated by the long duration of untreated illness, usually of 10 years or even longer. Moreover, OCD tends to run in families, because of a shared genetic predisposition combined with shared obsessive beliefs as cognitive vulnerability factors. [2,3]

There are several types of OCD; Contamination is the need to clean repeatedly with the fear that something negative will happen in case you didn't do so. Symmetry and orderliness is the need to repeatedly order items in a specific manner. Checking and repeating, Intrusive repetitive thoughts, Hoarding is the difficulty to discard useless possessions away. The feeling is coupled with anxiety when an attempt is made to get rid of the possessions. It has a great impact on the individual's quality of life. It can lead to anxiety and depression and can cause health and safety risks.(3)

OCD is sometimes coupled with other types of anxiety disorders that make it more difficult to diagnose and treat. There are several effective treatments for OCD. These treatments might be used alone or in combination to achieve the best results. Treatment differs from one individual to another; some patients are more receptive to medication while others improve with psychotherapy. Often treatment is most effective for individuals with a combination of both (4)

Family functioning in OCD is impaired in several ways. Families of individuals with OCD are, as compared to relatives of patients with other psychiatric disorders, often more involved in the illness – that is, compulsions usually involve family members and generally take place at home.[4,5]

The term accommodation has been proposed to refer to family responses specifically related to obsessive–compulsive (OC) symptoms: it encompasses behaviors such as directly participating to compulsions and/or assisting a relative with OCD when he/she is performing a ritual (e.g., controlling that the patient with OCD is "correctly" taking a shower without touching anything "dirty" or potentially "contaminating"; having to pass towels to the patient, taking particular care that they do not touch "contaminated" surfaces) or helping him/her to avoid triggers that may precipitate obsessions and compulsions (the relative has to respect rules that OCD imposes on the patient; e.g., for a patient with contamination obsessions, having to undress before entering the home and putting the "dirty" clothes in a specific place at home, avoiding to "contaminate" the house with these "dirty clothes" and having to immediately wash themselves before entering "uncontaminated" rooms). At the opposite side, not accommodating may take the forms of interfering with the rituals or actively opposing them, and this often results in distress for the patient and sometimes the occurrence of overt aggressive behaviors.[6,7]

Family accommodation has been traditionally investigated in parents of children/adolescents with OCD, and only in recent years, it has been recognized that even family members of adult patients with OCD tend to accommodate to obsessions and compulsions to a significant extent. Any significant member of the family may be involved in accommodating behaviors: parents, spouses, siblings, offspring or even non-family members or caregivers. [8,9]

It is hardly surprising that relatives find it stressful to live with a family member who has OCD. ***Cooper M*** surveyed 225 family members of adults with OCD and reported that 75% experienced disruption in their lives because of the OCD, including loss of personal relationships, loss of leisure time, and financial problems. Several researchers have commented on the often extensive family involvement in patients' OCD symptoms. Approximately 75% of OCD relatives participated at least minimally in rituals or avoidance, or modified their behavior to accommodate patients' symptoms. Accommodation includes providing reassurance, active participation in rituals and/or avoidance at patient's request, taking over patient duties, and modifying family activities and routines. These efforts were usually intended to reduce patient distress and time spent on rituals. Not surprisingly, greater family participation was significantly related to distress in family members, as well as more rejecting attitudes. Interestingly, approximately 40% of family members felt responsible for their relative's OCD. Greater accommodation was also related to more family dysfunction, family stress, and rejecting attitudes toward the patient, suggesting that family interventions may be needed to address these difficulties [10,11]

Aim of the study

The aim of this study was to investigate Accommodation in adult obsessive compulsive disorder from patients and family perspectives

Research question:

What is the level of accommodation regarding obsessive compulsive disorder from family and patients perspectives?

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2. SUBJECTS & METHOD

Subjects:

Research design:-

The design followed in this study was a descriptive design.

Research setting:

This study was conducted at the following settings

1- The out patient's clinics at The Psychiatry, Neurology and Neurosurgery Center. This center is affiliated to Tanta University Hospital. The center provides services as electroconvulsive therapy, labs, diagnostic Radiology, the intensive care department, the neurological diseases inpatient department, the Department of Neurological and Psychological diseases for Children, inpatient male and female psychiatric department, and the Addiction department. The center provides health care services to Gharbya, Menofia, and KafrElsheikh governates. It works 7 days/week, 24hrs/day.

2- The out patients department at Tanta mental health hospital;, this hospital is affiliated to the Ministry of Health and provides health care services to Gharbya, Menofia, and KafrElsheikh governates.

Subjects:

The study subjects constituted of a purposive sample of 50 patients with OCD and their families selected from the previous setting during 6 months with the following criteria

1- Free from chronic psychotic disorders

2- have insight and agree to participate in the study

3- Living with his family in the same home

4- Above 18 years old.

5- Diagnosed with OCD

Tools of the study:

Two tools were used in this study:

Tool I: Family Accommodation Scale for Obsessive-Compulsive Disorder Self-Rated Version (FAS-SR) [12]

The Family Accommodation Scale for Obsessive Compulsive Disorder - Self-Rated Version (FAS-SR) developed in 2012 by ***Anthony Pinto***. It consists of two sections; the first section requires the administration of an OCD symptom checklist to elicit current patient symptoms of which the relative is aware. The second section consists of 12 items that each assess a different type of accommodating behavior that the relative may have engaged in during the last week; e.g. providing reassurance regarding OCD symptoms, waiting for the patient to complete rituals, and modifying personal routines because of the patient's OCD symptoms. The 12 items are rated on a 0–4 scale and summed to obtain a total family accommodation score.

Scoring system :

Scores of scale range from 0-48 where lower scores indicate a higher level of accommodation:

Less than 24 = low accommodation

24- Less than 36=moderate accommodation

36+ = high accommodation

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Tool II: Family Accommodation Scale For Obsessive-Compulsive Disorder Patient Version (FAS-PV) [13]

The Family Accommodation Scale for Obsessive Compulsive Disorder - Patient Version (FAS-PV) developed in 2015 by ***Anthony Pinto et al***. The FAS-PV is a self-report measure assessing OCD symptoms and family accommodation within the last week from the patient's perspectives. The individual with OCD is the respondent, and provides information about their own OCD symptoms and the frequency of accommodating behaviors carried out by their relative. The first section consists of an OCD symptom checklist, allowing the individual to endorse the presence of certain OCD symptomology within several domains. The second section examines the frequency of accommodating behaviors carried out by their relative through 19 items. Each item in the second section assesses the frequency in a 5-point scale from 0-4; "0" means none/never, "1" means 1 day, "2" means 2-3 days, "3" means 4-6 days, and "4" means every day this past week. The total score of the FAS-PV is calculated by summing all 19 items.

Scoring system:

Scores of scale range from 0-95 where lower scores indicate a higher level of accommodation:

Less than 38 = low accommodation

38-less than 57 =moderate accommodation

57+ = high accommodation

In addition **A Socio-demographic and clinical data Questionnaire was used**. It was designed by the researchers to elicit data about socio-demographic and clinical characteristics of the studied subjects such as sex, age , residence , Physical and psychiatric diseases.

Method

1- An official permission to conduct the study was obtained from the responsible authorities.

2- Ethical Considerations:

- Consent was obtained from the clients after explanation of the aim of the study.
- Privacy and data confidentiality were assured. Clients were reassured that the obtained information is confidential and used only for the purpose of the study.
- Clients' rights to withdraw from the study at any phase were respected.

4- Tools of the study were translated into Arabic language

5-A jury composed of five experts in the psychiatric field examined the validity of the study tools.

6- All tools were tested for reliability by using Cronbach's Alpha test. Tool I (0.97) and tool II (0.98)

7-A pilot study

A pilot study was carried out before embarking in the actual of work to ascertain the clarity and applicability of the study tools and to identify obstacles that might be faced during data collection. The pilot study was conducted on 5 clients from the psychiatric medicine center. Those clients were excluded from the actual study subjects. After its implementation and according to its results, the necessary modifications were done.

6- **The actual study :**

The actual study was conducted through interviewing the studied patients and their families on individual basis .The interview time ranged from 30 to 45 minutes. The data was collected throughout five months from January 2019 to May 2019

Statistical Analysis

Using SPSS (version 20) for coding, entering and analyzing data, the range, mean, and standard deviation were calculated for quantitative data and descriptive statistics were calculated as frequencies and percentage, Spearman's correlation coefficient was used for evaluation between variables of the study. A significant was adopted at P value < 0.05 for interpretation of results of significance. High significance was adopted at P value < 0.01.

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3. RESULTS

Table 1 represents the distribution of the studied patients according to their socio-demographic and clinical characteristics. The results stated that 40% of the studied subjects aged from 30-40years with a Mean ± SD of 32.42 ± 9.114 year. Regarding marital status 60% of the studied patients were single, 68% of patients were males. Concerning the educational level, 38% the studied patients had primary education and 30%of them are illiterate. About two thirds (62%) of the studied patients were unemployed and 62 % of them residence in rural area. The majority of the patients 96% co habituated with their family. 46% of patients had an onset of disease of more than five years and 94% of them had no past history of psychiatric disease.

Table 2 represents Obsessive-Compulsive Symptoms as Reported by the Patients and their Families. The results show that regarding common type of obsession reprted by the patients, 60% of patients reported Contamination Obsessions followed by Harming Obsession (20%), Sexual Obsessions (20%), Saving Obsessions (20%) and Religious Obsessions (20%). In relation to type of compulsion, the results represent that most of the patients (70%) had Cleaning/Washing Compulsions followed by Repeating Rituals and Counting Compulsions (60%) while 50% of them reported Checking Compulsions them 40% had Ordering/Arranging Compulsions. Regarding Obsessive-Compulsive Symptoms as Reported by the Patients' Families, 60 % reported harming obsession and 80% of them reported Cleaning/Washing Compulsions which their patients are suffering

Table 3 shows Family Member's Responses to Obsessive-Compulsive Symptoms as Reported by Family Member's. The results indicated that most of studied families (70%) had high level of accommodation regarding their patients Obsessive-Compulsive Symptoms

Table 4 represents **Family Member's Responses to Obsessive-Compulsive Symptoms** as **perceived by patients**. The results stated that 60% of their families had high level of accommodation towards their Obsessive-Compulsive symptoms

Table 5 shows the relationship between family accommodation and severity of to OCD symptoms of the patients. The results showed that there is a positive significant statistical relationship between family responses and the severity of symptoms at level p= 0.000. (i.e. when patient have severe symptoms, their family members a accommodate in high level)

Table 6 illustrates the effect of Socio demographic characteristics of the patients on their Family accommodation , the results indicate that there is a significance statistic relation between parents age and residences with level of family accommodation at level p=.004 and .031 (i.e. family accommodate in high level with younger patient and patient resident in rural area)

Table 1: Distribution of studied patients according their socio demographic and clinical characteristics

Socio-demographic and work Characteristics	**Studied subject (n=50)**	
Age:	**No**	**%**
< 30	**19**	**38**
30 – 40	21	42
> 40	10	20
Mean ± SD	**32.42 ± 9.114**	
Sex:		
Males	34	68
Females	**16**	**32**
Marital status:		
Single	30	60
Married	**11**	**22**
Separated	2	4
Divorced	6	12
Widow	1	2

Residence:		
Urban	**19**	**38**
Rural	31	62
Educational level:		
Primary	19	38
Bachelor	**15**	**30**
Secondary	1	2
Illiterate	15	30
Work		
Employee	19	38
Unemployed	31	62
Income		
Enough	**25**	**50**
Not enough	25	50
Living condition		
With family	48	96
Alone	2	4
Onset of disease in years:		
< 1	12	24
1– 5	15	30
>5	23	46
Past history of disease		
Yes	3	6
No	47	94

Table 2: Obsessive-Compulsive Symptoms as Reported by the Patients and their Families

	Reported by the patients			Reported by the family	
	No	%		No	%
Obsessions					
Harming Obsessions	10	20.0		30	60.0
Contamination Obsessions	30	60.0		10	20.0
Sexual Obsessions	10	20.0		10	20.0
Saving Obsessions	10	20.0		10	20.0
Religious Obsessions	10	20.0		10	20.0
Somatic Obsessions	5	10.0		15	30.0
Compulsions					
Cleaning/Washing Compulsions	35	70.0		40	80.0
Checking Compulsions	25	50.0		30	60.0
Repeating Rituals	30	60.0		35	70.0
Counting Compulsions	30	60.0		25	50.0
Ordering/Arranging Compulsions	20	40.0		10	20.0
Saving/Collecting Compulsions	10	20.0		20	40.0

* Numbers are not mutually exclusive

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Table 3: Family Member's Responses to Obsessive-Compulsive Symptoms as Reported by Family Member's

	No	%
Low accommodation	5	10.0
Moderate	10	20.0
High accommodation	35	70.0
Total	50	100.0

Table 4: Family Member's Responses to Obsessive-Compulsive Symptoms as Reported by patients

Accommodation	Frequency	Percent
Low	9	18.0
Moderate	11	22.0
High	30	60.0
Total	50	100.0

Table 5: relationship between family accommodation and severity of OCD symptoms at the patients

Studied patient (n = 50)	**family (n = 50)**	
OCD symptoms	**Family accommodation**	
	r	**P- value**
	0.756**	0.000

Table 6: Effect of Socio demographic characteristics of patients on family accommodation

Socio-demographic Characteristics of patients	**Studied families(n=50)**		**Test of significance**
	low	**High**	
	No.	**No.**	
Age in years:			X^2 =11.164 **P= .004***
< 30	**4**	**15**	
30 – 40	3	18	
> 40	7	3	
Mean + SD			
Residence:			X^2 **=4.641** **P= .**031*
Urban	**2**	**17**	
Rural	12	19	

4. DISCUSSION

Obsessive compulsive disorders experience caused distress for patients themselves and family members due to the burden of the disease which includes negative impact in form of; feelings of frustration, anger and guilt, and impairment in social activities as; social activities are left out because of caring for the affected relative. OCD impairs functioning in several domains of life, including family and social relationships, imposes on patients a significant burden, and quality of life is greatly compromised; the impairment due to OCD is similar or even greater than by patients with major psychiatric disorders such as schizophrenia either on the patients and their family. The burden of caring for people with OCD has been extensively studied and clearly demonstrated. Family accommodation (FA) impairs relatives' quality of life, and also has an influence on the course and treatment response and it considered among key clinical factors when planning the treatment strategy

The results of the present study show that the most of studied families had a high level of accommodation regarding their patients' Obsessive-Compulsive Symptoms as reported by the patients and family members themselves and there is a high positive significant relationship between levels of family accommodation as reported by patients and their families. These

results can be explained by, the fact that responds to patients obsessive compulsive symptoms because most of the studied patients live with their families and are single. So, their families have a full responsibility toward them, and have a close contact and strong bond with the patient. This also may be due to that the most of studied patients had Cleaning and Washing Compulsions which need certain rituals that need acceptance and assistant from family members in doing this type of compulsion also most of patients in his study have OCD for more than 5 years so, the patients rituals becomes a part of daily living schedules for patient and his family and the family member share compulsive behavior to avoid the patient anxiety and aggressive feedback. Although family members tend to accommodate in hopes of attenuating the distress perceived by the affected relative, trying to mitigate the time occupied by compulsions/rituals, and sometimes because patients become angry or abusive when they do not accommodate, accommodation is thought to maintain OCD by disallowing patients to face their feared situation; in other words, accommodation is the same as performing a compulsion, that is, it prevents habituation of obsessive thoughts to occur.

These results agree with ***Calvocoressi et al. (2012)***[15]who stated that family members accommodation occur between 60% to 97% of families, and a majority of those accommodate on a daily basis in high level with their patients . also This results are consistent with ***A Lebowitz*** 2008 [16] who documented a higher family accommodation and Significant differences in family accommodation across the type of relative and gender, However, certain obsessive-compulsive symptom dimensions have been linked to higher family accommodation, especially cleaning rituals/contamination fears. In parallel with ***Caporino et al. (2012)***[17] found that most of the families accommodate in high level and mediated the relationship between obsessive-compulsive symptom severity and relative-rated functional impairment. Moreover, family accommodation conflicts with the goals of cognitive-behavioral treatment for OCD. The results are more or less similar to ***Storch, et al 2102***,[18] showed that family accommodation is related to poorer treatment outcome, and serves as an obstacle to symptom improvement). While helping facilitate compulsions or reassuring a patient will temporarily reduce their distress, it prevents the patient from habituating to the anxiety that occurs with the obsessive-compulsive symptoms

In the same stream, Umberto Albert, Alessandra Baffa, Giuseppe Maina [19]determined Specific characteristics of patients (such as contamination/washing symptoms and of relatives the presence of anxiety or depressive symptoms or a family history positive for another anxiety disorder are associated with a higher degree of family accommodation.

The result contradicted with ***Gorenstein C*** 2017 [20] who found that FA was reduced after both treatment modalities in a trial study that compared group CBT to medication SSRI for patients with OCD. On line with ***Piacentini J and Bergman R***[21] they determined that FA is reduced at the end of the treatment as a consequence of reduced OC symptom severity. Also, ***Thompson-Hollands J Iniesta-Sepúlveda M*** [22] found that low level of FA are combined with improvement of OCD symptom ,thus supporting the view that addressing FA in the treatment strategy could add to the benefits of treatment.

5. CONCLUSION

Based on the results it can be concluded that, the common types of obsession are Contamination Obsessions followed by Harming Obsession and Sexual Obsessions, while the common types of compulsion are Cleaning/Washing Compulsions followed by Repeating Rituals / Counting Compulsions and Checking Compulsions. Regarding to the level of FA, most of studied families had a high level of accommodation regarding their patients' Obsessive-Compulsive Symptoms as reported by the patients and family members themselves and there is a high positive significant relationship between levels of family accommodation as reported by patients and their families

6. RECOMMENDATION

The following recommendations are yielded from the result of this study:

1- Apply educational training program for families about responses OCD symptoms .

2- Further studies are needed for evidence-based treatment guidelines for OCD and incorporate modules targeting FA.

3- Family-based cognitive–behavioral interventions may be particularly beneficial for these families and investigate the factors that affect FA

4- Family therapy may be needed to support relatives in dealing with frustrating patient behaviors and to encourage more positive communication and reduce anger expression.

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