Correlates of Accommodation of Pediatric Obsessive-Compulsive Disorder: Parent, Child, and Family Characteristics

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ABSTRACT

Objective: Pediatric obsessive-compulsive disorder (OCD) is a chronic, impairing condition associated with high levels of family accommodation (i.e., participation in symptoms). Understanding of factors that may engender accommodation of pediatric OCD is limited. This study conducted exploratory analyses of parent-, child-, and family-level correlates of family accommodation, considering both behavioral and affective components of the response. **Method:** The sample included 65 youths (mean age 12.3 years, 62% male) with OCD and their parents who completed a standardized assessment battery composed of both clinical and self-report measures (e.g., Children's Yale-Brown Obsessive-Compulsive Scale, Brief Symptom Inventory). **Results:** Family accommodation was common, with the provision of reassurance and participation in rituals the most frequent practices (occurring on a daily basis among 56% and 46% of parents, respectively). Total scores on the Family Accommodation Scale were not associated with child OCD symptom severity; however, parental involvement in rituals was associated with higher levels of child OCD severity and parental psychopathology and with lower levels of family organization. Comorbid externalizing symptomatology and family conflict were associated with parent report of worse consequences when not accommodating. **Conclusions:** Although these findings must be interpreted in light of potential type I error, they suggest that accommodation is the norm in pediatric OCD. Family-focused interventions must consider the parent, child, and family-level variables associated with this familial response when teaching disengagement strategies. *J. Am. Acad. Child Adolesc. Psychiatry*, 2008;47(10):1173–1181.
Key Words: pediatric obsessive-compulsive disorder, family accommodation, criticism.

Pediatric obsessive-compulsive disorder (OCD) is among the most common psychiatric disorders of childhood, affecting between 0.5% and 2% of the youth population.[1] The disorder yields substantial impairment in psychosocial functioning[2] and carries a host of risks as youths age into adulthood.[3] Although molecular and behavior genetic work underscores the biological underpinnings of OCD, mounting evidence suggests that both shared and nonshared environmental influences are operative.[4] Indeed, a growing body of literature points to family dynamics, including distress, accommodation, and blame, that may influence the nature and course of the disorder.[5] Accommodation, the process by which family members assist or participate in patient rituals, is particularly well documented in the OCD literature[6–8] and has been linked to poorer treatment outcomes for adults with OCD.[5,9] Despite these risks, however, understanding of the factors that drive and promote accommodation remains limited.

To date, research on accommodation has provided largely descriptive accounts of the phenomenon in mixed-age, primarily adult samples.[6,10] Findings from this work suggest that distress is the norm among families of patients with OCD[11] and that accommodation is a common correlate of the family upheaval

Accepted May 8, 2008.

This article was reviewed under and accepted by Ad Hoc Editor James Leckman, M.D.

The authors are with the Division of Child and Adolescent Psychiatry, UCLA Semel Institute for Neuroscience and Human Behavior.

This research was supported by NIMH grants R01 MH58549 (J.P.) and T32 MH073517 (T.P.).

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DOI: 10.1097/CHI.0b013e3181825a91

created by obsessive-compulsive (OC) symptoms.[2,5,10] Rates of accommodation also seem to be strikingly high among families of youths affected with OCD,[12–14] with up to 75% of parents reporting actual participation in their children's OCD rituals.[12,13] Although not well studied, accommodation is likely to burden families, maintain OC symptoms, and reinforce fear and avoidance behaviors, thereby undermining progress with exposure-based treatments. Along these lines, recent research suggests that family accommodation may mediate the link between OCD symptom severity and parent-report of child functional impairment.[14]

Critically, it is unclear whether accommodation emerges in response to family distress, is a practice that precedes and fosters distress, or serves both functions. Certainly, families of individuals with OCD are faced with a troubling double bind: altering routines to make way for OC symptoms poses significant burden, but refraining from accommodation is itself a difficult and stressful task.[10] This bind is understandably frustrating and, for many families, leads to feelings of hostility and blame toward the affected child. Current conceptualizations of family responses to OCD posit that these responses fall along a continuum ranging from critical or hostile at one end to enmeshed, overinvolved, and accommodating at the other.[8] Although this framework has been investigated in the adult OCD literature,[5] it has yet to be examined empirically within the sphere of pediatric OCD. Moreover, there has been little examination of the factors underlying the range of familial responses to child OCD symptoms. Finally, the high prevalence of both accommodation and criticism suggests that children are likely to experience both reactions in the same family system and possibly from the same family member.[15] Thus, the interplay of family responses to OCD and the framework in which they are conceptualized requires further empirical examination, particularly as it relates to youths with OCD.

As a first step, it is important to examine accommodation from a perspective that considers the broad range of parent-, child-, and family-level variables with which it is associated. In particular, efforts to understand the factors that elicit and maintain maladaptive familial responses to OCD must approach these responses as complex and bidirectionally influenced. Although OC symptoms no doubt pull for parental accommodation, parental responses also play a role in either maintaining or curbing these symptoms. In addition, broader family functioning is likely to influence the strategies parents use to respond to OC symptoms as well as their degree of success.

Finally, issues remain with regard to how accommodation is conceptualized. To date, investigators have approached accommodation largely as a unitary construct measuring the involvement of others in the affected individual's OCD symptoms.[10,14] However, behavioral involvement may take many forms including modification of daily routines, verbal reassurance, and actual participation in rituals. The Family Accommodation Scale (FAS),[6] the most widely used measure of accommodation, distinguishes between these behavioral practices and their associated affective and functional sequelae (i.e., parental distress associated with accommodation, child's responses when not accommodated). Although these FAS subscales can yield potentially valuable information with regard to the phenomenology of accommodation and intervention efforts addressing this important issue, they typically are overlooked in OCD research, and most studies report only the FAS total score.

The present investigation sought to examine family involvement in child and adolescent OC symptoms and the associated sequelae of this involvement in relation to relevant parent-, child-, and family-level correlates. We were particularly interested in two aspects of accommodation that are likely to have direct treatment implications: parents' report of involvement in symptoms and their perceived consequences of not accommodating. Given the early stage of research on family accommodation in pediatric OCD, these analyses were viewed as largely exploratory. However, consistent with limited previous work, we expected higher levels of parental involvement in OC symptoms would be associated with higher levels of child symptom severity and with higher levels of parental anxiety and hostility. In addition, we expected family conflict and child comorbid externalizing symptomatology to be associated with worse consequences when not accommodating.

METHOD

Participants

Participants were 65 treatment-seeking children and adolescents (mean age 12.3 years, range 8–17 years, 62% male) and their parents who were participating in a controlled psychosocial treatment trial conducted at a university medical center OCD specialty program. To be included in the study, youths were required to have a *DSM-IV*[16] primary diagnosis of OCD and to be medication free at study entry. Participants were excluded if they met criteria for any psychiatric