

Managing Family Accommodation of OCD in the Context of Adolescent Treatment Refusal: A Case Example

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Family accommodation is a common and widely studied phenomenon in families of youth with obsessive-compulsive disorder (OCD). Family accommodation has been associated with increased symptom severity, poorer functional outcomes, and reduced treatment response. While family accommodation is increasingly targeted in family-based treatment of OCD, there are cases where youth refuse treatment. In these circumstances, parent-focused treatments that target reduction of family accommodation can be used to improve outcomes for youth with OCD. This case study illustrates the conceptualization and treatment of family accommodation in childhood OCD in the context of treatment refusal. Treatment was implemented without explicit involvement of the child. Parents reported moderate improvement in OCD symptoms at the end of treatment and a decrease in overall parent-child conflict. The findings illustrate how exposure and response principles can be implemented without direct involvement of the child in cases where youth show low motivation or refusal of treatment. © 2016 The Author. Journal of Clinical Psychology Published by Wiley Periodicals, Inc. J. Clin. Psychol.: In Session 72:1129–1138, 2016.

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In addition to having a considerable impact on the individual, pediatric obsessive-compulsive disorder (OCD) can also have a significant negative effect on the young person's parents, siblings, and broader family. The way in which these family members respond to the child's OCD symptoms can have important implications for how symptoms are maintained. Family accommodation refers to the participation of family members (e.g., parents, siblings) in the rituals of an individual with OCD and the modification of family functioning because of the individual's OCD symptoms (Calvocoressi et al., 1995, 1999; Lebowitz, Panza, Su, & Bloch, 2012). Common forms of accommodation in families of children and adolescents with OCD include enabling avoidance of certain situations or objects (e.g., opening doors for a child with contamination concerns, removal of knives from the environment for youth with harm obsessions, avoidance of certain places/people) and assisting in the completion of rituals or compulsions (e.g., increased frequency of cleaning surfaces/objects, repetition of certain phrases or routines at the child's request, or delaying/cancelling family commitments to create time for the child to complete their compulsions).

There are many reasons that family members may choose to accommodate a young person's OCD symptoms. Both high levels of parental empathy and low consideration about the future consequences of accommodation have been associated with an increase in family accommodation behaviors (Caporino et al., 2012). Similarly, high levels of parental guilt and guilt sensitivity and passive communication styles are traits that have been associated with family accommodation (Cosentino et al., 2015). The motivation behind accommodation is usually precipitated by some desire to reduce (or avoid triggering) distress in the child. However, these behaviors tend to have a paradoxical effect that ultimately maintains or exacerbates OCD, increasing longer term distress levels.

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Family accommodation has been the subject of considerable focus in the pediatric OCD literature and is having an increasing influence on family-based treatment models. Studies have shown that almost all parents of youth with OCD report some level of family accommodation, with almost half of parents participating in their child's compulsive behaviors on a daily basis and slightly more than half providing daily reassurance (Albert et al., 2010; Peris et al., 2008). One study that focused specifically on siblings also found generally high rates of accommodation from siblings (Barrett, Healy-Farrell, & March, 2004). Family accommodation has shown a robust association with increased OCD symptom severity across 41 studies (Wu et al., 2016), although this relationship is likely to be bidirectional.

Families may be more likely to accommodate symptoms when the child's symptoms are particularly severe and distressing. However, accommodation also serves to maintain and potentially exacerbate the child's symptom severity by preventing opportunities for disconfirmatory experiences, promoting use of ritualized and compulsive behaviors to neutralize distress. These behaviors also increase the likelihood of future accommodation demands. Although family accommodation is common across different OCD symptom dimensions, it appears to be particularly common in contamination/cleaning presentations (Stewart et al., 2008). Family accommodation has been associated with higher levels of functional impairment in youth (Bipeta, Yerramilli, Pingali, Karredla, & Ali, 2013; Storch et al., 2007) and subsequently greater levels of effect on family functioning (Peris et al., 2008).

Externalizing and coercive behaviors contribute to the parent-child dynamic that drives accommodation. Families of youth who experience high levels of externalizing pathology, and especially rage episodes, are at an increased likelihood of accommodating their child's OCD symptoms (Caporino et al., 2012; Lebowitz, Omer, & Leckman, 2011; Storch et al., 2012; Storch, Lewin, Geffken, Morgan, & Murphy, 2010). Even in the absence of independent externalizing psychopathology, youth with OCD often come to display certain coercive behaviors as a means of imposing and demanding accommodation behaviors from those around them. For example, children with OCD frequently demand that parents participate in (or facilitate) ritual completion, that they engage in (or refrain from) certain behaviors based on OCD-related fears, or that they complete a task in place of the child to facilitate avoidance.

The manner in which the child insists and demands these accommodation behaviors can often become highly distressed, aggressive, or manipulative to compel engagement from parents. These coercive and disruptive behaviors are most commonly directed at mothers, although fathers and siblings are also common targets (Lebowitz et al., 2011). When parents acquiesce, these negative behaviors are reinforced, increasing the likelihood of subsequent behavioral outbursts in response to parental limit setting.

Practice parameters for treatment of youth with OCD recommends cognitive behavioral therapy (CBT) involving exposure and response prevention (ERP) as a first-line treatment for pediatric OCD treatment (Geller & March, 2012). Given that children are heavily influenced by the contingencies of parents, it is critical that treatment of younger children involve parents; however, the level of parental involvement may vary in treatment of older children. Both family-focused and child-focused CBT/ERP treatments have shown good outcomes. However, higher levels of family accommodation have been shown to reduce the efficacy of CBT, pharmacotherapy (sertraline), and combination treatment (CBT + sertraline) for pediatric OCD (Garcia et al., 2010). In fact, results from the Pediatric Obsessive Compulsive Treatment Study (Garcia et al., 2010) showed that family accommodation was one of only five characteristics that was found to lead to poorer outcomes and the only family-based characteristic to have a significant effect.

Several studies have shown that family accommodation can be reduced during treatment for OCD by specifically targeting parental and family reactions, and that these reductions in family accommodation are associated with better treatment outcomes for OCD (Merlo, Lehmkuhl, Geffken, & Storch, 2009; Storch, Lehmkuhl, et al., 2010). Overall, it is clear that family accommodation is an important clinical and prognostic variable to assess in pediatric OCD to facilitate treatment planning.

With the awareness that family accommodation is commonplace in families of youth with OCD, that family accommodation is associated with negative outcomes and poorer treatment response, it logically follows that directly targeting these behaviors during treatment would be

beneficial. However, working with families to change accommodation behaviors is a challenge in itself. It can be very distressing for parents to hold firm boundaries with a child when the child's OCD is clearly causing so much distress. Furthermore, when parents (caregivers, siblings, etc.) initially change their response, it is common to see a strong reaction from the child. This escalated reaction is sometimes described as an extinction burst, but it also often involves heightened verbal and even physical aggression aimed at eliciting the desired accommodation (Lebowitz et al., 2011). This initial escalation of the child's reaction (especially when the strategy used by youth triggers specific parental vulnerabilities such as guilt and empathy) is often sufficient to weaken parents' limit setting, reinforcing these coercive behaviors.

Treatment of youth with OCD can be complicated when they have limited insight or poor motivation to engage with treatment. In contrast to adults who usually self-initiate treatment, parents often initiate treatment for their child. This can create some complexity to distinguishing who the presenting "client" is. In ideal circumstances, a collaborative relationship can be formed between the child and therapist, with parents working alongside children in a support role to facilitate ERP tasks out of session. However, in some cases, youth can show resistance to engaging with treatment and even outright treatment refusal. Particularly in cases where family accommodation appears to be an important maintaining factor for the child's symptoms, it is still possible to work with the family and create changes for the child.

Regardless of child participation in treatment, parents can learn to understand the role that family accommodation plays in maintaining and exacerbating OCD symptoms over time. Therapists can work with parents to (often gradually) reduce accommodation behaviors, necessitating exposure to anxiety-provoking stimuli for the child. At the same time parents begin to set limits on accommodation, it is important to teach parents skills to support their child's difficult emotional reactions. For example, emotion coaching strategies allow parents to verbally or nonverbally communicate that they understand and accept their child's struggle, that they are confident that their child can overcome this feeling/challenge, and that they are willing to help and support their child during this experience.

It is also important for parents to learn how to tolerate their child's experience of negative emotions, without conceding to accommodation demands to alleviate the child's distress (i.e., being able to see the bigger picture to support limit setting around accommodation). Therapists often work with parents to decrease their level of emotionality. Parents often attempt to explain the rationale for placing boundaries and can end up in an escalating argument with children about the validity of this reasoning. Rather, parents are encouraged to calmly validate the child's feelings, inform children of the limit, and resist engaging in further conflict about this.

During treatment, parents identify all accommodation behaviors and then choose a target behavior that will be gradually (or immediately) reduced. Before starting to reduce accommodation, it is important for parents to consider potential reactions from their child and plan how they will respond to these. Children can be informed of the treatment plan by the parent or in collaboration with the therapist if the child is attending the therapy sessions. If children attend sessions, then they are invited to participate in treatment planning discussions as long as their participation can be negotiated to be in line with the general goals of treatment. Empowering parents to support their child through helping them become less impaired is important in this method of treatment.

Case Illustration

Presenting Problem and Client Description

The complexities of working with family accommodation in the context of treatment refusal are illustrated in the case of Gemma, a 13-year-old Caucasian female. Gemma was the middle of three children, with an older brother (Sid, 15 years) and younger brother (Andrew, 10 years). Her parents, Joan and Garry, both worked full-time and scheduled an assessment because of their concerns about Gemma's escalating preoccupation with contamination and her compulsive washing.

During the assessment, Joan reported that Gemma had always preferred to be clean. As a toddler, she would cry when she got mud on her dress and would ask to change outfits; however, this had not concerned Joan at the time. At age 9, Gemma had a single incident of food poisoning after eating food from a gas station. After that, Gemma became increasingly fussy with the preparation and types of foods she would eat. She initially refused to eat foods served from buffet or communal serving arrangements and would no longer eat unsealed foods from cafes or gas stations (e.g., cakes, cookies). This had progressed over the next year to her refusing to eat particular foods, including eggs, meat, and dairy. When Joan would try to serve Gemma one of these foods, she would insist that it was “off” or “smelled/tasted funny” and would demand another food option (which Joan would provide).

At the time of assessment, Gemma was showering 2 to 3 times per day, using a fresh towel each time because reusing the same towel was “disgusting.” As a result, she insisted that Joan washed the used towels daily to ensure clean ones were available. Gemma was also concerned about being unclean and washed her hands excessively (totalling approximately 2.5 hours per day). Gemma would sit at the counter in the kitchen while her mother prepared meals and would comment on perceived hygiene breaches. She insisted on observing that fruits and vegetables were washed twice, and repetitively demanded that her mother wash her hands in between handling different foods during meal preparations.

As Gemma’s contamination concerns had escalated, her parents had begun to get frustrated with her increasing demands. She refused to take her plate to the kitchen after dinner or wash the dishes. She often bribed her younger brother to do these jobs for her by giving him small chocolate bars that she had bought with her pocket money. Gemma’s demands about washing surfaces and foods were becoming increasingly unreasonable at home. When Joan would refuse to comply, Gemma would raise her voice, yell, and cry and insist that Joan “did not love” her and/or threaten not to eat the food Joan was preparing. Fearing that Gemma would not eat a sufficient amount, Joan usually prepared meals in accordance with Gemma’s requests, or she prepared a second meal. Garry often reprimanded Gemma for speaking rudely to her mother, to which Gemma would argue that her requesting for her mother stop being so “disgusting” and “unhygienic” were not unreasonable.

Despite being frustrated by Gemma’s behaviors, both Garry and Joan described feeling guilty about the hours that they worked and wanted their time with the children to be calm. They recognized that they were “giving in” to her OCD demands and were rewarding her negative behaviors; however, they often complied with Gemma’s unreasonable requests because it was easier to “keep the peace.” Her brothers often complained that Gemma always “gets her way.” Joan and Garry were becoming increasingly frustrated as Gemma’s accommodation demands were becoming more time consuming for them. They acknowledged that Gemma’s OCD was worsening and increasingly encroaching on the family; however, they reported that Gemma was resistant to their suggestions that she had OCD or that she needed help. They had asked her to attend the session with them, but she refused to get in the car, insisting that they were “the ones with the problem.”

Case Formulation

A clinical interview with Joan and Garry confirmed that Gemma met criteria for a diagnosis of OCD. There was some evidence of generalized anxiety symptoms, although these were less impairing in nature relative to OCD. In addition, they completed a parent-report version (see Peris et al., 2008) of the Family Accommodation Scale (Calvocoressi et al., 1995), which identified the degree of family accommodation and involvement in the child’s OCD over the previous month, and endorsed a significant amount of accommodation.

Gemma’s OCD appears to have been precipitated by the incident of food poisoning. Her escalating avoidance of surfaces, items, and foods combined with a reinforcing cycle of washing served to reinforce and perpetuate her contamination concerns. In addition to the vicious cycle of avoidance and compulsive behaviors, there were also family factors that escalated and maintained her OCD symptomatology. As the severity of Gemma’s contamination fears increased, her avoidance began to affect her family. Her initial requests to allow avoidance, for supporting

her compulsions (e.g., washing used towels), and for participating in washing rituals themselves were minor, but then were reinforced and intensified by their repeated accommodation. Joan and Garry's reactions were largely motivated by empathy (and parental guilt), but this ultimately increased the likelihood that she would continue to involve them in her OCD behaviors. This also served to maintain and exacerbate the cycle of avoidance and compulsive behaviors.

With the increasing demands that accommodating Gemma's OCD was placing on the family, Joan and Garry began to get frustrated at Gemma's increasingly unreasonable requests. This frustration prompted their refusal to comply with her OCD requests, which precipitated an escalation in her level of distress at their sudden refusal to accommodate her demands. During this state of high distress, she alternated between extreme tearfulness and verbal aggression, which led to her parents acquiescing to her original request. This pattern unintentionally reinforced her use of coercive and disruptive behaviors, increasing the frequency with which Gemma employed these behaviors in response to subsequent refusals.

Given Gemma's low levels of insight about her symptoms and an increasing level of family accommodation to facilitate her avoidance and washing, it is unsurprising that she had limited motivation to engage in treatment. The clear pattern of family accommodation maintaining and escalating Gemma's OCD symptoms highlighted the importance of parental involvement in treatment. This was especially important given Gemma's low level of insight and motivation to change her OCD. While Gemma had started to display some externalizing and coercive behaviors, these appeared to be secondary to her OCD symptoms and served to elicit accommodation behaviors from her parents. While it was ideal to try and engage Gemma in treatment, her resistance and insight necessitated a parent-focused intervention that had the goals of reducing family accommodation behaviors, improving Gemma's OCD symptoms, and increasing Gemma's motivation to engage with treatment as appropriate.

Course of Treatment

The first two treatment sessions focused on familiarizing Garry and Joan with the vicious cycle of OCD and the role of family accommodation in maintaining Gemma's symptoms. The therapist also validated the compassionate motives driving their accommodation to minimize parental blame while highlighting the importance of changing these patterns. The therapist explained the rationale and process involved with ERP treatment, but because Gemma refused to attend sessions, the potential to create ERP tasks at home by reducing parental accommodation behaviors was discussed. Joan and Garry were encouraged to voice their concerns with treatment as well as their fears about Gemma's reactions as they changed the way they responded to her OCD. Joan and Garry noted their fears that Gemma would hate them or that she "couldn't cope" with the distress. The therapist reinforced the pattern of accommodation in increasing her longer term distress and discussed the importance of changing their reactions to help her recover.

During this early phase of treatment, Joan and Garry monitored their accommodation, including what precipitated their engagement in the accommodation (e.g., Gemma saying "you don't love me" and their feeling of guilt) and what the consequence of the accommodation was (e.g., Gemma stopped yelling but did not eat the prepared meal). Once accommodation triggers and problematic patterns of parent-child interactions were identified, Joan and Garry discussed particular target behaviors that they wanted to change. They were informed that the changes they made to accommodation would be made systematically, and that ideally they would identify a behavior that *they* were highly motivated to stop performing (to maximize their motivation to implement the change). They nominated reducing the frequency of Gemma's showers as the top priority because of the excessive amount of laundry that this was creating.

Before beginning to change accommodation behaviors, Garry and Joan prepared to inform Gemma about their plan and once again invited her to engage with the treatment. The therapist worked with them to prepare a script that included the following points:

- Validate Gemma's contamination concerns and her desire for them to accommodate these.
- Describe that they had been accommodating because they love her very much and don't like to see her suffer.

- Identify their new awareness about how their reactions had actually made her symptoms worse.
- Express confidence in her ability to tolerate discomfort/anxiety and overcome her OCD.
- Define their new role in how they respond to the OCD (i.e., that they are no longer going to give in to what the OCD was making her do or let the OCD take over her life).
- Inform her that they are going to make some changes in their responses, which change was going to be implemented first, and when this would begin. They planned to validate that they understood that the changes would be hard for her initially but were confident that she would be able to cope.
- No matter how hard the OCD made her try to get them to change their mind, they were going to stick to these changes because they care for her.

Joan and Garry spent some time role-playing this discussion with the therapist, including planning nonemotional (but validating) responses to Gemma's attempts to argue about the fairness of these changes. Joan and Garry were encouraged to discuss the option for Gemma to attend sessions so she could help to negotiate changes that they would make at home but they were to reiterate that the changes would be implemented regardless of her participation. They also planned a token reward system in which Gemma could accumulate points toward desired toys, treats, or activities. If she was able to complete the task without arguing with her parents, then she would accumulate one point.

When Joan and Garry introduced this idea, Gemma initially attempted to argue with them. However, Joan's calm matter-of-fact demeanor stopped the escalation and Gemma eventually walked out, seeming dismissive of the pending changes.

With target behaviors in mind, the therapist and parents planned how to implement changes to accommodation, with explicit planning around how to manage Gemma's escalating reactions to maximize the probability of them sticking to the treatment goal. To begin, Joan committed to washing towels every second day. She anticipated that Gemma would be outraged and would likely retrieve new towels daily from the linen cupboard. As such, Joan and Garry devised a plan to store the spare towels in a locked car to limit access.

The first day that Joan implemented the change, Gemma attempted to get a new towel from the cupboard and became very aggressive upon finding the clean towels missing. Garry was not home on this day due to a work meeting, so Joan was tasked with managing this reaction on her own. Gemma raised her voice at Joan, insisting that she get a clean towel, and stormed around the house searching for the towels until she found the spare towels in the locked car. At this point Gemma started hitting the car window with her fists. At this time, Joan became concerned that Gemma would smash the window (and injure herself) and eventually unlocked the car to retrieve a clean towel.

Garry was disheartened when he found out that Joan had "given in" to Gemma. The following week they asked the therapist for guidance on how to get back on track with their plan and discussed their concerns about Gemma injuring herself. The therapist reinforced the experience children's behavior initially becoming worse when parents changed the way they responded. The therapist described how confusing it is for a child when behaviors that previously elicited a certain reaction (e.g., yelling/aggression) were no longer effective and that there was often a temporary increase or escalation in that behavior. The therapist also reinforced the importance of Joan and Garry supporting each other to get back on track with their treatment goals, for Gemma's sake. Joan expressed her fears that Gemma would harm herself, to which Garry expressed doubt that she would actually destroy property because she was a "good girl, underneath it all." They decided to handle the situation together the following day; they accepted that if the window was smashed, then they would attend to an injury as necessary and set a logical consequence that any destruction would be repaid by deducting money from her allowance.

The next time Gemma was required to reuse a towel, Garry and Joan calmly responded to Gemma's escalation by reminding her that they were going to stick to their plan of washing towels every 2 days, that they would not unlock the car, and that destruction would be paid for. As Garry saw Joan becoming unsettled, he stepped in to respond to Gemma's reactions.

Although she attempted to yell, plead, cry, and beg her parents, they did not change their response, and Gemma eventually stormed off to her room and slammed the door. She emerged about 20 minutes, sullen, but calmer. She eventually showered and reused her towel, quipping that her parents were “unfair and disgusting” for the remainder of the night.

On subsequent days when Gemma was required to reuse her towel, there was less conflict, although it still elicited a variety of coercive behaviors initially. Garry noted that Gemma gradually stopped asking for a spare towel from the car. Two weeks later Joan moved the towels back into the house but she continued to wash them only every second day.

Over the following weeks, Joan extended the required amount of days Gemma had to reuse her towel. Although Gemma would initially argue, it was not to the same extent as initially and dissipated faster. Over several weeks, Gemma reached the goal of reusing her towel for weekly periods and accumulated enough reward points to earn a trip to the movie theatre for her and two friends to celebrate her achievement.

The next phase of treatment involved identifying a new target. The target became limiting Gemma’s frequency of showering to once daily. Gemma was given a choice about when she wanted to shower (morning or night) and elected that to shower at night. On the first day Gemma showered in the morning and attempted to shower again in the afternoon. Failing to respond to Joan’s reminders, Joan turned off the water main to the house. Gemma initially began crying and yelling. However, Joan had a new confidence in managing Gemma’s emotions and calmly validated her distress at this new change and her confidence that she could overcome this new step. Gemma’s outburst eventually subsided. Over the subsequent days, Gemma showered only once.

Once showering was addressed, Joan and Garry implemented similar strategies of reducing accommodation around Joan washing foods twice during cooking (at Gemma’s insistence). Joan washed appropriate fruits and vegetables only once and did not engage with Gemma’s requests of rewashing or her threats of refusing to eat. The therapist and parents reviewed the realistic likelihood of Gemma “starving” if she refused to eat a meal and reinforced the importance of offering only one meal option. To reduce the likelihood of Gemma eating other packaged foods as a substitute, Joan stopped purchasing these types of foods where possible so that Gemma’s food options were more limited to those prepared for her. While Gemma refused to eat dinner the first night, and objected to the limited selection of foods available in the pantry, she was hungry the following day and begrudgingly ate a small portion of her dinner. Joan also began washing her hands less frequently while cooking.

After Gemma was regularly eating meals with vegetables having been washed only a single time, Joan began adding new foods into Gemma’s meal (e.g., eggs or cream) and refusing to cook a second meal. Over the weeks, Gemma became less resistant to new foods (albeit with some ongoing complaints that the food tasted “off” and that it was her parents’ fault if she “got sick/died”).

As Gemma made more progress, Joan and Garry would invite her to participate in making decisions about new targets, providing two viable options from which she could choose. If she refused to select one, then they would choose the new target behavior for her.

Outcome and Prognosis

After 19 treatment sessions, Gemma had shown a significant reduction in compulsive washing behaviors and restrictive eating. She was showering once daily, reusing her towel for one week at a time, and was eating a greater variety of foods that Joan prepared. In addition, Gemma’s coercive externalizing behaviors had subsided significantly. Joan and Garry described an increased confidence in their ability to set limits around her OCD and reported they do not become overwhelmed by her reactions. They also noted that her extreme reactions were far less frequent, so their interactions overall had become more pleasant. They reported having more fun experiences with Gemma and feeling less resentful toward her.

Gemma still showed increased frequency (and daily duration) of hand washing, although this had limited interference on her daily functioning and her skin did not appear to show any obvious signs of dryness or irritation. Although Gemma had become less resistant to

the idea of treatment, she was unmotivated to reduce her hand washing at this time. With less obvious scope for Joan and Garry to reduce this behavior via parental accommodation, they decided to monitor the behavior and re-present to treatment should symptoms worsen.

Joan and Garry reported being pleased with Gemma's progress but that they also reported needed a break from treatment. The therapist validated their effort and the effect that their hard work had on improving Gemma's outcomes. The therapist also highlighted the importance of both closely monitoring Gemma's residual symptoms and maintaining (or possibly extending) the current areas that had already been achieved to reduce the risk of relapse. Although Gemma had shown significant improvements, her insight remained somewhat limited, and therefore any slow creep in their accommodation behaviors was likely to result in some symptom exacerbation.

Clinical Practices and Summary

Gemma's case illustrates four relevant points about treatment for pediatric OCD in the context of family accommodation and treatment refusal.

Consider Parent-Only Treatment in the Case of Treatment Resistance

First, it is possible to implement a treatment for pediatric OCD even if the child refuses to engage. Parent-focused treatments can target the child's OCD via changing parental reactions and accommodation behaviors. Parents are able to limit their own involvement in OCD compulsions, as well as setting limits around the modifications that they make to enable their child's OCD behaviors. When presenting the treatment rationale to parents, it is important to minimize any sense of blame, validating that family accommodation reactions are usually underpinned by empathic motives but that they do ultimately perpetuate symptoms. It is important to reinforce the important role that parents can play in helping their child overcome OCD by building parental motivation and engagement in treatment.

Plan for Things to get Harder Initially

It is extremely common for a young person's reactions to become more extreme in the early phases of change. In the context of families who accommodate in response to coercive or externalizing behaviors, it is especially important to prepare parents for how to respond to this escalation. Parents, as in the case of Joan and Garry, can become disillusioned at failed attempts to implement limits and hopeless about the potential for success with treatment. Role-plays in the session can help identify a range of possible scenarios to prepare for. At the same time, it is important to help parents to take a compassionate (not punitive) stance toward their child's escalated responses, highlighting that these responses come from a place of extreme distress caused by OCD. It is important to differentiate between limit setting and punishment, encouraging parents to set limits on behavior but not inflict punishment.

Consider Use of Rewards and Logical Consequences

While there is some variability between clinicians in their use of rewards as part of ERP, it can be a relevant clinical decision to make in the context of treatment refusal. Rewards are usually used as an incentive (and reinforcer) for youth to engage in ERP tasks. In the context of treatment refusal, parents initiate the limits around accommodation of OCD symptoms. With these ERP tasks being somewhat "inflicted" on children, it can be relevant to consider whether reinforcing their participation in the ERP task may help to increase their engagement (or at least decrease their resistance). In this context, parameters for appropriate behavioral reactions can be specified, and parents can offer (but not force) a reinforcer to the child. For example, parents may elect to withhold purchasing a nonessential (but highly desired) item in place of the child "earning" points toward purchasing the item.

This strategy of reinforcing ERP participation usually works best when coupled with logical consequences for inappropriate behavior in the context of coercive or externalizing behaviors. Logical consequences (as opposed to natural consequences or punishments) refer to limits that are created by parents to show youth the consequence that arises from their behavior. For example, in the case of Gemma, her failure to limit shower frequency independently resulted in the water being turned off for periods of time. Unfortunately, this also restricted the capacity for, for example, flushing the toilet and watering the garden for these periods (which was an inconvenience to others in the house). However, it was necessary to enforce engagement with the ERP task. Over time, youth are continually required to experience the distress that comes with not satisfying their OCD urges and thus their symptoms decrease. When used in combination with reinforcement, there is also the potential for youth to feel that they can “benefit” in some way from managing their reactions (or actively engaging with the task) during these non-negotiable situations.

Assess Risk of Harm to Self or Others

Externalizing behaviors, rage episodes, and/or coercive behaviors are all common phenomena in youth with OCD. As discussed already, these behaviors often escalate in the early phases of changing family accommodation. It is important to discuss and assess whether the child poses a risk of harm to herself (as in the case of Gemma) or others. If so, then it is critical the therapist and parents carefully plan responses to minimize escalation. It is also important to engage in safety planning regarding how to address potential injury (e.g., calling an ambulance); discuss whether other factors may de-escalate the child or minimize the occurrence of violent behaviors (e.g., the presence of a second parent or a sibling); and decide how parents themselves can best maintain their own safety (e.g., withdrawing from the situation or calling police if necessary). In many cases, careful planning can help prepare parents to respond in ways that maximize the chance of safe outcomes for all and minimize the likelihood of aggressive or coercive behaviors being used to elicit accommodation.

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