



## Let me check that for you: Symptom accommodation in romantic partners of adults with Obsessive–Compulsive Disorder



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### ABSTRACT

Obsessive Compulsive Disorder (OCD) is typically considered from the perspective of the individual, yet symptoms often occur within an interpersonal context. Family members often engage in *accommodation*, assisting patients with rituals in order to alleviate anxiety, prevent conflict, or “help out” with time-consuming compulsive behaviors. Prior research has primarily examined accommodation in parents of children with OCD or in adult caregiver relationships, where caregivers can include various family members (e.g., parents, romantic partners). The current study examined accommodation behaviors in romantic partners of adults with OCD. As part of a treatment study, 20 couples were assessed for accommodation behaviors, OCD symptoms, and relationship functioning before and after 16-sessions of cognitive-behavioral treatment. Accommodation was associated with the patient’s OCD symptoms at pre-treatment, and negatively associated with the partners’, but not the patients’, self-reported relationship satisfaction. Post-treatment partner accommodation was also associated with poorer response to treatment. The implications of these findings are discussed within an interpersonal framework, and the benefits of including partners in the treatment of OCD are described.

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Obsessive–Compulsive Disorder (OCD) is an anxiety disorder that involves *obsessions*—recurrent and unwanted thoughts, images, or impulses that provoke anxiety—and *compulsions*—behavioral or mental or rituals which are performed to reduce the anxiety arising from the obsessions (American Psychiatric Association [APA], 2000). Affecting 2.3% of the population in the United States, OCD can be a particularly disabling disorder associated with significant interference in social functioning, in the workplace, and at home (Ruscio, Stein, Chiu, & Kessler, 2010). Although OCD is typically considered an individual phenomenon, it often occurs in an interpersonal context which can both impact and be impacted by obsessional fear and compulsive rituals. For example, OCD symptom severity for adult patients is associated with greater caregiver burden and distress (Ramos-Cerqueira, Torres, Torresan, Negreiros, & Vitorino, 2008), and symptom severity and functional impairment in pediatric OCD are associated with higher levels of parental distress (e.g., Storch et al., 2009). Caregivers of OCD patients report more burden than do caregivers of depressed patients (Vikas, Avasthi, & Sharan,

2011). At the same time, family member criticism and hostility are associated with greater symptom severity and worse treatment outcome (Chambless & Steketee, 1999; Renshaw, Chambless, & Steketee, 2003; Van Noppen & Steketee, 2009). Thus, the interpersonal context is essential to consider when elucidating the course and treatment of OCD, as well as its effects on quality of life. One important but understudied interpersonal phenomenon which often arises in response to OCD, but which also negatively impacts OCD course and treatment, is family accommodation.

Accommodation refers to various behaviors that family members engage in either to prevent or alleviate the patient’s anxiety. In addition to reducing anxiety, these behaviors may also help the family or couple to get through daily routines more efficiently. For example, family members might assist with the patient’s rituals (e.g., agreeing to check locks and appliances for the patient; doing extra loads of laundry at the patient’s request), provide excessive reassurance regarding obsessional anxiety (e.g., answering frequent questions about the probability of harm), or aid the patient in avoiding obsessional stimuli (e.g., removing all “contaminated” work clothes before entering the home; keeping knives locked away; Calvocoressi et al., 1995, 1999). Research regarding accommodation is limited, however, and to date the focus has either been on parental accommodation in pediatric OCD or caregiver accommodation in adult OCD, where “caregiver” might refer

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to any family member. Such studies have found that almost 90% of caregivers of adult OCD patients report accommodating to some extent (Calvocoressi et al., 1995, 1999), although it is unclear whether this rate differs based on the type of relationship with the patient (i.e., romantic partner versus parent). Moreover, in the original validation study of the most commonly used accommodation scale, the Family Accommodation Scale (FAS), the degree of accommodation varied from none to severe, with most caregivers reporting mild to moderate levels of accommodation (Calvocoressi et al., 1995).

Although clinical observation suggests that partners often engage in accommodation in order to express care and concern for (i.e., to “help”) their loved one with OCD, accommodation is actually associated with greater OCD symptom severity (e.g., Van Noppen & Steketee, 2009). Indeed, avoidance and ritualistic behaviors (whether performed by the patient or a surrogate), often lead to a reduction in obsessional distress in the short-term; yet in the long-run, these behaviors maintain OCD symptoms because they prevent the disconfirmation of obsessional fear (e.g., Salkovskis, 1996). Accordingly, it is not surprising that accommodation is associated with greater functional impairment in OCD, above and beyond the effects of symptom severity (Storch et al., 2010). In fact, in pediatric OCD, accommodation mediates the relationship between OCD symptom severity and functional impairment such that greater symptom severity is associated with higher levels of parental accommodating behaviors, which in turn is associated with greater functional impairment for the affected child (Caporino et al., 2012; Storch et al., 2007). In addition, accommodation impacts the caregiver him or herself. For example, accommodation is positively associated with parental distress in pediatric OCD (Storch et al., 2009) and with anxiety and depression in relatives of adults with OCD (Amir, Freshman, & Foa, 2000).

Accommodation also appears to impact treatment. Higher levels of family accommodation at baseline predict poorer treatment outcome (i.e., greater symptom severity post-treatment) in pediatric OCD (Garcia et al., 2010). However, greater decreases in accommodation from pre- to post-treatment are associated with better treatment response, both in terms of OCD severity and impairment (Merlo, Lehmkuhl, Geffken, & Storch, 2009). Moreover, in a study which examined accommodation and OCD symptom severity at baseline, twice during treatment, and post-treatment, Piacentini et al. (2011) found that improvement in OCD symptoms followed decreases in accommodation behavior. Results such as these suggest that it is likely that interventions which include family members of OCD patients and target accommodation may improve treatment outcome (Abramowitz et al., in press; Steketee & Van Noppen, 2003; Van Noppen & Steketee, 2003).

Given that greater accommodation is associated with more severe symptoms and functioning for the patient, greater distress for the caregiver, and attenuated treatment outcome, it is imperative to better understand the context in which accommodation behaviors arise. Clinical observation suggests that romantic partners often engage in accommodation in order either (a) to show love, care, and concern for the patient, or (b) to avoid potential criticism and anger from the patient. Consistent with these observations, one study found that the majority of caregivers of adult OCD patients reported that the patient would become angry or distressed, or would take more time to complete rituals, if the caregiver did not accommodate (Calvocoressi et al., 1999). Additionally, empathy and consideration of future consequences interact to predict accommodation in pediatric OCD; that is, on average, parents who experience greater empathy and are lower on consideration of future consequences are more likely to engage in accommodating behaviors (Caporino et al., 2012). Given these findings, it is unsurprising that higher levels of patient OCD severity are associated with greater accommodation (e.g., Stewart et al., 2008); in particular, the

contamination symptom dimension is associated with higher levels of accommodation in both adult and pediatric samples (Albert et al., 2010; Flessner et al., 2011; Stewart et al., 2008). In addition to responding to patient anger or distress, family members might also be responding to their own distress. For example, higher levels of parental OC symptoms and general anxiety symptoms are associated with higher levels of accommodation (Peris et al., 2008).

As noted previously, research on accommodation is in its infancy, and so far has largely focused on pediatric OCD or in adult samples of mixed caregiver relationships. Thus, the nature and extent of accommodation within specific types of adult relationships is unclear. Yet, it is particularly important to attend to the effects of accommodation from a romantic partner specifically. When compared to other social relationships, romantic relationships often serve unique roles in individuals' psychological and physical well-being. For example, romantic partners tend to be the primary provider of emotional and instrumental support for most adults. Further, social support seems to be particularly important from a partner when confronting chronic stressors, and support from friends does not compensate when a partner is unsupportive (Walen & Lachman, 2000). Given accommodation is often provided as a way to support and “help” a patient suffering from OCD, it is possible that a partner's accommodation (as opposed to a parent or other family member's accommodation) when a patient is anxious plays a unique role in the patient's disorder and response to treatment. Also, treatment interventions may differ when considering only adult romantic relationships versus any type of adult caregiver relationship. For example, one component of a new intervention for OCD in adult romantic relationships (Abramowitz et al., 2013) involves decreasing the use of accommodation as a means of supporting patients and increasing alternative ways to show care and concern for patients, such as through joint activities such as date nights. Increasing joint activities for couples has been shown to strengthen romantic relationships (Epstein & Baucom, 2002) and may also decrease couples' reliance on accommodation as a means of supporting patients.

In the present study, we therefore sought to extend the existing literature by examining accommodation in the context of solely adult romantic relationships. Additionally, the degree of accommodation that occurs is likely related not only to individual factors (such as OCD severity) but relationship factors as well, such as both partners' overall relationship satisfaction and patterns of communication between partners. We therefore sought to examine associations with both individual and relationship factors. We specifically aimed to determine the extent of accommodation in adult couples with OCD and determine associations between accommodation and patient functioning (global OCD symptom severity, specific OCD symptom dimensions, and impairment), and relationship functioning (relationship adjustment and perceived criticism). We also examined accommodation as a predictor of response to cognitive-behavioral therapy (CBT) for OCD. On the basis of previous research, we hypothesized that greater symptom accommodation would be associated with more severe OCD symptoms, and particularly contamination-related symptoms. We also predicted that accommodation would be related to greater functional impairment due to OCD and greater relationship dysfunction. Finally, we hypothesized that higher levels of accommodation would be predictive of poorer response to CBT.

## Method

### Participants

We tested our hypotheses using data from our open-trial of couple-based CBT for OCD patients and their (non-OCD) partners (Abramowitz et al., in press). Both members of 20 couples

consisting of one partner with OCD completed interview and self-report measures assessing OCD symptoms, symptom accommodation, functional impairment, and relationship functioning. To be included in the study, patients had to meet diagnostic DSM-IV criteria for OCD, have a Yale-Brown Obsessive Compulsive Scale (Y-BOCS; Goodman, Price, Rasmussen, & Mazure, 1989a, 1989b) score of at least 16, and either be married or living with their partner for at least 12 months. All patients and partners were fluent in English and all attended the 16 CBT sessions as a couple. Exclusion criteria were as follows: any previous CBT for OCD, current suicidal ideation, current substance abuse, psychotic symptoms, and physical abuse within the relationship.

The OCD patients (19 female, 1 male) ranged in age from 24 to 66 ( $M = 34$ ,  $SD = 11$ ), and their partners (19 male, 1 female) ranged in age from 25 to 62 ( $M = 36$ ,  $SD = 11$ ). Patients were 90% White, 5% Hispanic, and 5% Asian; partners were 85% White, 5% Hispanic, 5% Asian and 5% other ethnicities. Education levels were similar across patients and partners: 20% had at least a college degree, with the other 80% attaining less than a 4-year college degree. Of the 20 couples (all heterosexual), 14 were married and 6 were unmarried. The OCD patients had symptoms from a variety of domains, including contamination-related concerns, concerns about unacceptable thoughts (e.g., harming children), and fears about being responsible for harm to others (e.g., fears of hitting pedestrians while driving). Although we had some patients expressing concerns about “not-just-right” feelings and a need for symmetry, this symptom dimension was less well-represented in our sample as the primary symptom of concern.

#### Procedure

Couples were recruited through newspaper ads and campus-wide mass emails. Couples responding to our recruitment efforts were screened over the telephone by the study coordinator. If the patient met initial eligibility criteria, both the patient and partner attended a baseline assessment interview. During this interview, a trained graduate student administered the Mini-International Neuropsychiatric Interview (MINI; Sheehan et al., 1998) to establish DSM-IV diagnoses and the Y-BOCS to assess the degree of OCD symptom severity. Although we did not formally assess for diagnostic reliability, if there were any questions about whether the patient met criteria for OCD, the case was discussed during supervision with two senior supervisors to confirm the diagnosis. Both the patient and partner also completed a battery of self-report measures described further below. If couples met all eligibility criteria following this baseline assessment, they were enrolled in the treatment phase of the study. The treatment program was manualized (Abramowitz et al., 2013) and consisted of 16 sessions of 90 min duration. The first eight sessions took place twice weekly and the eight remaining sessions took place weekly.

All treatment sessions were conducted by advanced clinical psychology doctoral students trained extensively by the faculty investigators who are prominent experts in CBT for OCD (JA) and couple therapy (DB). The first three sessions involved information-gathering, psychoeducation, and reviewing the rationale and procedures for exposure and response prevention techniques. This information-gathering portion of treatment also allowed the therapist to tailor subsequent sessions to address the specific OCD-related beliefs of the patient, and the accommodation-related beliefs and behaviors of the partner. During the fourth session, the therapist taught the partner how to assist with exposure therapy, and couples completed their first structured exposure under the therapist's supervision. More specifically, partners were encouraged to provide supportive but non-accommodating statements.

For example, a partner might say, “I know you're feeling really anxious right now, but you can do it,” rather than “I'm sure this isn't contaminated; you're safe.” Following this session, the couple was assigned hierarchy-driven exposure exercises to conduct between sessions with the partner assisting the patient with all assignments. The middle phase of treatment focused on reducing accommodation behaviors and assisting the couple in developing and implementing alternative support strategies that did not involve avoidance, providing reassurance, or helping with rituals. For example, rather than demonstrating care and affection via accommodation of symptoms, couples were encouraged to identify pleasant joint activities to engage in as a way of increasing non-symptom related closeness. The last phase of treatment focused on how OCD has impacted the couple's relationship, what shifts they have seen with symptom reduction, and how to handle general communication issues within the relationship. Details of the program are described in Abramowitz et al. (2013). All treatment sessions were video and audio-recorded and reviewed by the senior investigators, who also served as supervisors of graduate student therapists on the project.

Post-treatment assessment by a trained evaluator not otherwise involved in the patient's treatment followed completion of the 16 treatment sessions. This assessment was identical to the baseline assessment, except the diagnostic interview was not repeated.

#### Measures

**Yale-Brown Obsessive Compulsive Scale (Y-BOCS; Goodman et al., 1989a, 1989b).** The Y-BOCS is a widely used interview measure of global OCD symptom severity that assesses obsessions and compulsions, independent of symptom theme, on the following five parameters: (a) time spent, (b) interference, (c) distress, (d) resistance, and (e) control. The instrument also includes a symptom checklist. The Y-BOCS has good reliability, validity, and is sensitive to the effects of treatment. In our current sample, the Cronbach's alpha for the overall Y-BOCS was .77. This was our primary outcome measure of OCD, and it was administered at both the baseline and post-treatment assessments. The Y-BOCS includes an Obsessions and Compulsions subscale.

**Dyadic Adjustment Scale (DAS; Spanier, 1976).** The DAS is a 32-item scale assessing relationship satisfaction in married or cohabitating couples. It is the most widely used measure of overall relationship satisfaction, has excellent reliability ( $\alpha = .96$ ), and has been validated through its capacity to differentiate between maritally distressed and maritally satisfied couples in a wide variety of community samples. In our current sample, the Cronbach's alpha for the DAS was .89 for the patients and .91 for the partners.

**Family Accommodation Scale-Partner Report (FAS-PR; Peris et al., 2008).** The FAS-PR is a 13-item measure derived from the clinician interview Family Accommodation Scale by Calvocoressi et al. (1995). It was designed to assess the nature and frequency of a family member's accommodating behaviors toward a relative with OCD. The FAS-PR assesses: (a) participation in OCD symptom-related behavior, (b) modification of functioning of the family member, (c) distress caused by accommodating the patient, and (d) consequences of not participating in the patient's symptom-related behaviors. Items are rated on a 0–4 scale with the first 9 items corresponding to behavioral aspects of accommodation and the remaining four corresponding to distress related to accommodating behaviors. The first 9 items have good internal consistency ( $\alpha = .76$ ; internal consistency for the entire scale is  $\alpha = .82$ ), and it has demonstrated both convergent and discriminant validity. In our current sample, the Cronbach's alpha for the complete FAS scale was .93.

**Dimensional Obsessive-Compulsive Scale (DOCS; Abramowitz et al., 2010).** The DOCS is a 20-item self-report

measure that assesses the severity of the four most consistently replicated OCD symptom dimensions (which correspond to the measure's four subscales): (a) contamination, (b) responsibility for harm and mistakes, (c) symmetry/ordering, and (d) unacceptable thoughts. To accommodate the heterogeneity of OCD symptoms, and the presence of obsessions and rituals within each symptom dimension, each subscale begins with a description of the symptom dimension along with examples of representative obsessions and rituals. The examples clarify the form and function of each dimension's fundamental obsessional fears, compulsive rituals, and avoidance behaviors. Within each symptom dimension, five items (rated 0–4) assess the following parameters of severity (over the past month): (a) time occupied by obsessions and rituals, (b) avoidance behavior, (c) associated distress, (d) functional interference, and (e) difficulty disregarding the obsessions and refraining from the compulsions. Scores for each symptom dimension range from 0 (minimum) to 20 (maximum). The DOCS subscales have excellent reliability in clinical samples ( $\alpha = .94-.96$ ; in current sample  $\alpha = .93-.96$ ), and the measure converges well with other measures of OC symptoms (Abramowitz et al., 2010).

**Perceived Criticism (PC; Hooley & Teasdale, 1989).** The PC Scale used in this study consists of four items, all rated on a 10-point Likert scale (higher scores indicating greater perceived criticism), assessing perceptions of how critical one is of their partner and vice versa. The first two items have been used in previous literature and relate to general criticism (how much do you feel you criticize your partner; how much do you feel your partner criticizes you), and the second two items were added for this study specifically and relate to OCD-specific criticism. For the purposes of our analyses, we used the patient report of each item individually, as opposed to creating a summed scale. In our current sample, the Cronbach's alpha for the full PC scale was .78 for patients, and .89 for partners.

**Sheehan Disability Scale (SDS; Leon, Olfson, Portera, Farber, & Sheehan, 1997).** The SDS is a measure of role-impairment caused by a medical or psychological disorder. It consists of four questions rated on a 10-point Likert scale assessing degree of impairment in four domains: household management, work, social life, and close relationships. For the purposes of our analyses, we used each item individually, as opposed to creating a summed scale. The SDS is widely used and has established excellent internal consistency in a variety of community samples. In our current sample, the Cronbach's alpha for the SDS was .85.

## Results

### Overview

The following data analytic approach was followed: First, we computed descriptive statistics to examine levels of OCD symptom severity, the extent of symptom accommodation, functional impairment, and relationship functioning in our sample. Second, we computed Pearson correlation coefficients to examine hypothesized relationships between symptom accommodation (FAS scores) and measures of OCD symptoms, impairment, and relationship functioning. Finally, to examine the impact of accommodation on response to couple-based CBT, we computed a regression model predicting post-treatment Y-BOCS scores in which the pre-test Y-BOCS was entered as a control variable in step 1, and the pre- and post-treatment FAS was entered in step 2.

### Descriptive statistics

Table 1 provides the group means and standard deviations on all study measures at pre-treatment. The mean Y-BOCS total and DOCS subscale scores indicated clinically significant and moderate to severe

**Table 1**  
Means and standard deviations for all study measures at pre-treatment.

Measure	Patient-rated	Partner-rated
Y-BOCS total score	25.95 (5.30)	
Obsessions subscale	13.25 (2.15)	
Compulsions subscale	12.70 (3.90)	
DOCS contamination	8.95 (6.23)	
DOCS responsibility	8.90 (5.30)	
DOCS unacceptable thoughts	9.25 (6.30)	
DOCS symmetry	3.15 (4.22)	
SDS work	4.67 (3.03)	
SDS social	5.40 (2.52)	
SDS family/home	7.20 (2.57)	
FAS		35.25 (12.79)
DAS	109.10 (16.55)	108.10 (13.74)
Perceived criticism		
How much do you feel your partner criticizes you (in general)	4.20 (3.0)	
How much do you feel you criticize your partner (in general)	5.55 (2.14)	
How much do you feel your partner criticizes you (regarding handling OCD issues)	4.75 (2.95)	
How much do you feel you criticize your partner (regarding handling OCD issues)	4.10 (2.67)	

Note. Y-BOCS = Yale-Brown Obsessive Compulsive Scale; DOCS = Dimensional Obsessive-Compulsive Scale; SDS = Sheehan Disability Scale; FAS = Family Accommodation Scale; DAS = Dyadic Adjustment Scale.

levels of OCD symptoms, except for symmetry symptoms which fell in the mild range. Scores on the SDS also indicated moderate impairment in work and social functioning, with severe impairment in family/home functioning. At pre-treatment, 100% of partners reported at least some accommodation behavior toward their loved one with OCD. The mean total FAS score was indicative of significant family accommodation; when, as in Calvocoressi et al. (1995), we used only the first 9 items of the FAS to determine the severity of accommodation behavior in our sample, the group's mean score was 11.50 ( $SD = 5.95$ ; range 2–22), indicating a moderate degree of accommodation on average, but with some couples scoring in the severe range (i.e., 19–27). With respect to relationship distress, a score below 100 on the DAS is considered to be indicative of relationship distress, and a score above 110 is considered indicative of relationship satisfaction (Spanier, 1976), so our couples were not particularly distressed on average, but not highly satisfied either. Patients perceived their partners as moderately critical of them in general, as they are of their partners. Patients also perceived their partners as moderately critical of patients regarding how the patients manage OCD-related matters specifically; similarly, patients are moderately critical of how their partners handles OCD specifically.

### Correlations between partner accommodation and study measures

**OCD symptoms.** Table 2 displays the results of our correlational analyses. As can be seen, at pre-treatment, scores on the FAS (13-item total score) were moderately associated with Y-BOCS total scores, indicating that higher levels of partner accommodation were associated with more severe OCD symptoms globally. However, whereas FAS scores were significantly correlated with the severity of compulsions as assessed by the Y-BOCS, there was no significant association between partner accommodation and the Y-BOCS Obsessions subscale. Correlations with the various DOCS subscales revealed that contamination was the only OCD symptom dimension significantly related to partner accommodation, and this association was quite strong.

**Functional impairment.** As Table 2 also shows, FAS scores were not significantly related to any of the SDS subscales. A non-

**Table 2**  
Correlations between the Family Accommodation Scale (FAS) and other study measures at pre-treatment.

Measure	Correlation with FAS
Y-BOCS total score	.39*
Obsessions subscale	.39*
Compulsions subscale	.26
DOCS contamination	.65**
DOCS responsibility	.15
DOCS unacceptable thoughts	-.41
DOCS symmetry	.05
SDS work	.16
SDS social	.15
SDS family/home	.35
DAS-patient rating	-.22
DAS-partner rating	-.48*
Perceived criticism	
How much do you feel your partner criticizes you (in general)	.25
How much do you feel you criticize your partner (in general)	.33
How much do you feel your partner criticizes you (regarding handling OCD issues)	.66**
How much do you feel you criticize your partner (regarding handling OCD issues)	.65**

Note. Y-BOCS = Yale-Brown Obsessive Compulsive Scale; DOCS = Dimensional Obsessive-Compulsive Scale; SDS = Sheehan Disability Scale; FAS = Family Accommodation Scale; DAS = Dyadic Adjustment Scale.

\* $p < .05$ , \*\* $p < .01$ .

significant trend, however, did emerge for the moderate relationship with the SDS Family/Home item ( $p = .06$ ).

**Relationship functioning.** Finally, as can also be seen in Table 2, FAS scores were significantly correlated with the partner's, but not the patient's, rating of relationship functioning (i.e., DAS score). Additionally, the degree of perceived criticism that the patient gives to, and receives from, his or her partner regarding OCD (but not other) matters was significantly (and strongly) associated with accommodation.

#### Associations between partner accommodation and treatment outcome

Sixteen of the 20 couples completed the CBT program and their mean post-treatment Y-BOCS total score was 11.56 ( $SD = 5.47$ ), indicating mild post-treatment OCD symptoms and substantial and statistically significant improvement from pre-treatment (55% Y-BOCS reduction), paired  $t(15) = 6.84$ ,  $p < .001$ .

In step 1 of our regression model, the pre-treatment Y-BOCS explained only 7% of the variance in post-treatment Y-BOCS scores, and this was not significant,  $R^2 = .07$ ;  $F(1, 14) = 110.97$ ,  $p = .34$ . Addition of the pre- and post-treatment FAS in step 2, however, explained significant additional variance (68%) in post-treatment Y-BOCS scores,  $R^2$  change = .68;  $F(3, 14) = 11.08$ ,  $p < .01$ . The final model accounted for 75% of the variance and only the post-treatment FAS emerged as a significant individual predictor of Y-BOCS scores at post-treatment,  $\beta = .76$ ,  $p < .01$ . We found the same pattern of results when using the same regression equation to predict the Y-BOCS Obsessions and Compulsions subscales (entering the corresponding pre-treatment subscale in Step 1).

#### Discussion

Although OCD is typically considered an individual phenomenon, it frequently occurs in an interpersonal context, and consideration of this context is essential to fully understanding and most

effectively treating OCD. We examined one key aspect of this interpersonal context: accommodation of OCD symptoms by a romantic partner. This is the first study to examine accommodation in adults exclusively within romantic partnerships, which enabled us to elucidate how this phenomenon operates within this specific type of relationship. In the present study, we also examined how accommodation was associated not only with individual OCD functioning (including response to CBT), but also with relationship functioning, which represents an important first step in elucidating the likely bidirectional association between accommodation and relationship functioning more broadly. For example, the stress of an unhappy relationship might exacerbate OCD symptoms, causing the unaffected partner to feel a greater need to accommodate. Yet finding oneself in the frequent role of accommodating might also lead to feeling less satisfied with the relationship.

Individuals with OCD often spend considerable time and energy structuring their environment to reduce or prevent anxiety, and we have observed that romantic partners tend to respond in kind through accommodation behaviors. For most partners, accommodation is carried out with good intentions: partners do not like to see their loved ones in distress. Accordingly, they engage in activities that immediately reduce the patient's obsessional distress. However, our findings are consistent with previous research and current conceptual models of OCD which indicate that despite these good intentions, accommodation is associated with greater symptom severity and impairment, poorer relationship functioning (i.e., lower relationship satisfaction and more perceived criticism), and attenuated treatment outcome (i.e., greater severity of post-treatment OCD symptoms).

The present study advances previous work by examining symptom accommodation exclusively within adult romantic relationships. Prior to treatment, all partners in the present sample reported at least some accommodation behavior, with partners reporting accommodating to a moderate degree on average. These findings are consistent with previous research on mixed caregiver samples, and suggest that accommodation is just as common, if not slightly more, among romantic couples in which one partner has OCD.

Overall, higher levels of accommodation were associated with more severe and frequent compulsions, and as predicted, this association was strongest for contamination-related OCD symptoms. Given the correlational nature of this study, directionality cannot be determined; however there is likely a bidirectional relationship between these phenomena. On the one hand, de-contamination rituals such as washing and cleaning, and related avoidance patterns, are particularly well-suited for accommodation because they are usually overt (as opposed to covert mental rituals), often highly impairing (e.g., remaining in the shower for hours at a time), and often triggered by fears of people spreading contaminants (Tolin, Worhunsky, & Maltby, 2004). Contamination symptoms (e.g., the urge to wash or avoid certain stimuli) might also be easier than other types of OCD symptoms (e.g., the fear of hitting pedestrians by mistake with one's car) for partners to understand and relate to. Thus, it might be easier for partners to accommodate such explicit and salient symptoms.

Whereas accommodation might contribute to more severe OCD symptoms, the reverse might also be true. That is, when symptoms are less severe, the partner might be less likely to accommodate to them. However when the patient experiences high levels of OCD, they might request more assistance from the partner to lower their anxiety, or the partner might be more aware of the patient's distress and engage in higher levels of accommodation to lower the patient's distress. Given that it can be painful to observe a loved one in distress, the partner's accommodation might also be oriented to lowering their own distress, in addition to the patient's.

In our sample, almost all of the OCD patients were female (19 female patients, 1 male patient), and as all couples were heterosexual, nearly all of the partners were male. While the size of our sample does not allow us the power to test for gender effects, it is important to make note of how this gender distribution might have impacted our findings. First, it is interesting that we found it easier to recruit female OCD patients when OCD has been found to be more or less equivalent in prevalence rates across genders (Rasmussen & Eisen, 1992), or only slightly more prevalent in females (Weissman et al., 1994). Perhaps women are simply more likely than men to be interested in a couple-based treatment study. However, it could also be that for couples in which the female partner has OCD, the male partner may be more likely to become involved in the disorder through accommodation behaviors. Although this is not something we can test within the current study, we did find that accommodation was more likely to occur for contamination-related symptoms, and previous research has shown that women are more likely than men to exhibit this symptom dimension (Labad et al., 2008). Furthermore, it may be that men are more likely than women to engage in accommodation in order to inhabit a “protective” role—in a somewhat analogous area of research, protective and accommodating behaviors have been found to be more common among male partners of female cancer patients than among female partners of male cancer patients (Badr, 2004). These potential gender differences in symptom presentation and partner response deserve further empirical investigation.

We found that partner accommodation was not correlated with OCD-related work or social impairment, but there was a non-significant trend ( $p = .06$ ) with impairment in family and home responsibilities. While future research with a larger sample is necessary, one explanation for the magnitude of this correlation is that although partners might be present in patients' social and work domains, their primary interactions with patients occur within the home. Therefore, it is likely that accommodation has its greatest influence within this domain, and as with OCD symptoms, the result is poorer functioning. Indeed, as part of their accommodation, partners often assume key roles and responsibilities in the family/home domain. For example, a spouse might handle all of the cooking if working with food prompts contamination obsessions for the patient. While this arrangement serves to alleviate obsessional anxiety, it interferes with the patient's ability to fulfill responsibilities and contribute to the running of the household.

In addition to being associated with poorer individual functioning, accommodation was associated with poorer relationship functioning. Specifically, greater partner accommodation was associated with lower relationship adjustment for partners, yet not for patients. This finding supports clinical observations that partners find accommodating a loved one's OCD symptoms taxing and frustrating, and that this is linked to a broader frustration with the relationship itself. Moreover, our findings regarding perceived criticism suggest that patients are aware of their partner's frustration and dissatisfaction. Indeed, on average, patients perceived partners who accommodated more as also being more critical about the patient's OCD. Likewise, patients who report being more critical of their partners with regards to handling OCD-related matters also reported that their partners accommodated more. In concert, these findings suggest that a partner's accommodation of OCD symptoms is neither experienced by the patient nor partner as occurring in a supportive context. Although accommodation might serve to alleviate patient distress momentarily, it does not do so within the framework of a positive, satisfying relationship.

Finally, greater engagement in accommodation by the partner at post-treatment was associated with greater OCD symptom severity for the patient at post-treatment. Indeed, the degree to which

partners still engaged in accommodation following treatment explained nearly two-thirds of the variance in post-treatment Y-BOCS scores. Again, the direction of causality is unclear. Continued accommodation from a partner might interfere with treatment gains, or individuals who continue to struggle with OCD after treatment might elicit more accommodation. In either case, the findings suggest that couple-based interventions for OCD would be fruitful. Unless couples learn how to change their interaction patterns that include accommodation, the long-term effectiveness of exposure-based CBT for OCD patients is likely to be limited. This finding is encouraging, however, because it suggests that CBT for OCD, which is high effective, can be enhanced even further for patients in such relationships by involving the partner in treatment and helping him or her to understand that while their attempts to “help” are understandable, they actually do not aid the patient in the long-run. Additionally, it is important to teach partners how to be supportive in ways which do not maintain OCD symptoms. For example, partners can be taught to provide esteem support and encourage the patient to “get through” the anxiety until it habituates, rather than trying to avoid or neutralize it for the patient. The current investigators have developed just such an intervention (Abramowitz et al., 2013), and the initial findings are quite promising (Abramowitz et al., *in press*).

The present findings suggest that partner accommodation represents a significant dynamic in adult romantic relationships in which one partner has OCD. This process appears to be related to higher levels OCD symptom severity and poorer relationship functioning, as well as to poorer treatment outcome. Further understanding of this phenomenon is important for better understanding and effectively treating individuals with OCD. Nevertheless, our results should be considered with caution owing to two important limitations. First, as previously noted, this study is correlational in nature and therefore directionality cannot be determined. Second, our sample size was somewhat small, as it was based on a pilot study for a new couple-based intervention for OCD. Although larger studies with longitudinal data are warranted, even with our sample, significant findings were detected, suggesting robustness.

Additional research also should focus on understanding factors which contribute to accommodation, including factors related to the patient, the partner, and the general context in which the partners reside. For example, relationships involving strong dependency might necessarily involve the non-OCD partner taking a generally protective role toward the patient. This style might contribute to continued accommodation despite understanding the reasons that this behavior is maladaptive. There might also be factors such as a particularly strong need for taking care of others, or difficulty seeing others in pain, which predict a partner's willingness to accommodate. Finally, behavioral styles such as assertiveness among non-OCD partners (i.e., a willingness to say “no” to accommodation requests) might be investigated as protective factors against the tendency to accommodate. Whereas a greater understanding of the consequences of accommodation will help clinicians present convincing rationales to couples for the need to eliminate accommodation, better understanding the reasons that partners engage in accommodation in the first place might help in identifying methods for reducing such maladaptive behavior.

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