Partners' Responses to Obsessive-Compulsive Disorder

McKenzie Roddy

University of North Carolina at Chapel Hill

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Departmental Advisor: _____

Reader: _____

Reader: _____

Abstract

Obsessive-Compulsive Disorder (OCD) is an anxiety disorder characterized by (a) unpleasant, intrusive thoughts or images, referred to as obsessions, and (b) ritualized actions or compulsions, which seek to decrease the anxiety caused by the obsessions. Although OCD is an individual disorder, it affects the lives of romantic partners. This study examined partners' behaviors in response to patients' OCD prior to and after a couple-based treatment intervention for OCD. The extent to which partner behaviors in response to OCD are related to treatment outcome is of particular interest. High levels of Accommodation at pretest were hypothesized to predict less improvement over the course of treatment. Sixteen couples with one partner meeting diagnostic criteria for OCD enrolled in the study and were assessed at baseline. An observational coding system was adapted to measure partner behaviors during a videotaped conversation, including Change Promotion, Acceptance/ Validation, and Accommodation. Higher levels of partner Accommodation at pretest were indicative of worse treatment outcomes, and an interaction effect between high levels of Change Promotion and high levels of Acceptance/ Validation were associated with better treatment outcome. Together, the main and interaction effects of partner behaviors explained up to 49% of the variance in OCD treatment outcome and suggest that continued accommodation across treatment resulted in worse outcomes for the patients. Findings also suggest that the optimal amount of empathy shown by partners may vary as a function of patient motivation to change. Limitations are discussed. These results emphasize the importance of the interpersonal context of OCD and possible directions for future clinical work.

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Partners' Responses to Obsessive-Compulsive Disorder

Obsessive-compulsive disorder (OCD) is defined by the American Psychiatric Association by the presence of (a) obsessions or unwanted or intrusive thoughts, urges, or images that are recurrent and persistent, and (b) compulsions, mental acts or repetitive behaviors that individuals perform according to rigid rules or in response to obsessions (American Psychiatric Association [APA], 2013). OCD is slightly more common in males than females and presents similarly around the world (APA, 2013). In the United States, it is estimated that OCD affects 2.3% of the population (Ruscio, Stein, Chiu, & Kessler, 2010). Obsessions can range from forbidden sexual or religious thoughts to worries about contamination or harm. Compulsions, likewise, vary from ordering, counting, and cleaning to ritualized thoughts or prayers.

Obsessions cause high levels of anxiety, and individuals attempt to relieve this stress with some other thought, action, or compulsion (APA, 2013). However, compulsions are not associated with obsessions in a realistic manner. For example, an individual may compulsively order his or her belongings in the closet to prevent his or her child from being in a car wreck. The order of the clothes has no real world connection to the feared event; however, for the individual, this helps to lower anxiety. Patients have differing levels of awareness into the logical fallacies relating their obsessions and compulsions, and poorer insight is associated with worse long-term outcome (Abramowitz et al., 2013b; APA, 2013). These obsessions and compulsions do not bring pleasure to individuals with OCD; to the contrary, obsessions induce high levels of anxiety, and compulsions at best serve to reduce the anxiety short term, leading to impairment of functioning. Triggers can be people, places, or objects that evoke anxiety or obsessions, and individuals with OCD often go to great lengths to avoid such triggers (APA, 2013). The

cognitive-behavioral model of OCD is the most widely used model to conceptualize and treat this disorder.

A cognitive-behavioral model of obsessive-compulsive disorder proposes that while many people have intrusive thoughts, only some people label these thoughts as significant or threatening, which can create an obsession (Abramowitz, Taylor, & McKay, 2009). As a way to combat these disturbing thoughts, individuals create routines, repetitive or ordered behaviors, or rituals as a means of lowering their anxiety. These compulsions may temporarily decrease distress but are unlikely to prevent distress from occurring (Abramowitz et al., 2009). Because compulsions are negatively reinforced by momentarily removing the obsessive thought and lowering anxiety, they can become habitual and time consuming. Furthermore, this negative reinforcement cycle prevents patients from learning that their concerns are unrealistic because they avoid instead of facing the consequences of their concerns. Each individual develops his or her own world of rules and limitations around their triggers that generate distress. By avoiding triggers that bring about anxiety, the worlds of individuals with OCD begin to contract. Avoidance can cause problems at work, in the home, socially, and can result in a loss of autonomy. Individuals with OCD report impairment in both social and occupational functioning due to their disorder (Abramowitz et al., 2009). Although OCD is an individual disorder, its consequences are not isolated to that individual.

Family Member Responses to OCD

The interpersonal context of obsessive-compulsive disorder has been studied to some extent within the context of family relationships. Accommodation is a set of behaviors that friends, family members, and partners engage in that involves changing their own behavior or altering the environment in a manner that allows the OCD to be maintained. These behaviors can

include assisting the patient in avoiding triggering stimuli, participating in rituals that decrease anxiety, assuming additional responsibilities related to the OCD, and reassuring the patient. For example, partners may do all the grocery shopping for the family if the patient is fearful of coming into contact with strangers. Typically such behaviors from family members result from good intentions, such as being motivated by an attempt to decrease the anxiety of an individual with OCD. However, their actions inadvertently maintain obsessions and compulsions (Mehta, 1990). By allowing or helping the patient to avoid anxiety-provoking triggers, family members are preventing the patient from interacting with the anxiety-provoking stimuli and experiencing his or her fears, reinforce the avoidance and compulsive behaviors, and thus the pattern is never extinguished (Peris et al., 2008).

In addition, accommodation also burdens family members. Through different behaviors such as reassurance, checking for the person with OCD, and helping the person avoid distressing situations, significant others often become heavily involved in a patient's OCD (Abramowitz et al., 2013b). Family members who modify their routine to aid the patient in avoiding triggers report increased levels of depression; furthermore, depression and anxiety of family members is even higher if they do not assist the patient and the patient becomes distressed (Amir, Freshman, & Foa, 2000). Additionally, increased levels of familial accommodation have been linked to worse treatment outcome for patients (Albert et al., 2009; Amir et al., 2000; Merlo, Lehmkuhl, Geffken, & Storch, 2009; Boeding, et al., 2013).

Within intimate relationships, it is possible that there is a bidirectional relationship between OCD symptoms and relationship distress: increased relationship distress could lead to worsening OCD symptoms, or increased OCD symptoms could exacerbate relationship distress (Abramowitz et al., 2013b). For example, in couples who fight often, patients with OCD may

then turn to their rituals to calm themselves. Alternately, patients with time-consuming rituals may fight more with their partners about being late due to their OCD. Partners may also become involved in patients' OCD through accommodation. In the context of living with an individual with OCD, partners have a limited number of options for reacting to the demands of the disorder. Ultimately, most partners want the best outcome possible for the patient, but the means through which they try to achieve this common goal are varied and often ineffective or even counterproductive.

Accommodation is one way in which intimate partners could react to OCD. Most research until this point has focused almost exclusively on the effects of familial accommodation on OCD; however, there are likely more behaviors relevant to how families interact with OCD than accommodating. In addition to or instead of accommodating individuals with OCD, partners can encourage or push the patient to make concrete behavioral change relating to the OCD or try to use logic to reason the patient out of his or her unrealistic thinking. Alternately, some partners may attempt to make the patient feel accepted and validated in their experience with OCD. In an investigation similar to the current study, Fischer and colleagues explored the communication of partners among couples in which the female had anorexia nervosa (AN). They found that women with AN showed greater improvement in a couple-based treatment for AN when their male partners promoted a high level of Change Promotion relative to AN while demonstrating lower levels of Acceptance and Validation (Fischer, Baucom, Bulik, & Kirby, 2013). Similarly, the ways in which partners react to a patients' OCD might have an impact on long-term outcome for patients; thus, it is critical that these partner behaviors are understood when designing treatments for OCD.

Treating Obsessive-Compulsive Disorder

Currently, treatment for OCD typically occurs in an individual context using cognitive-behavioral therapy (CBT) with exposure and response prevention (ERP) (Abramowitz et al., 2013b). This approach is predicated on the cognitive-behavioral model of OCD which states that obsessions arise when common intrusive thoughts are labeled as important or threatening, which evokes obsessional anxiety. Compulsions, in turn, arise as a means to reduce or prevent obsessive thoughts and anxiety (Abramowitz et al., 2009). ERP involves repeated and prolonged exposure to obsessional triggers while not allowing the patient to perform his or her compulsions (Abramowitz et al., 2009). The goal of ERP is two-fold: first, the patient learns that the anxiety will subside with time, and second, the patient realizes that his or her obsessional fears are unfounded in most instances. While a well-proven approach to treating OCD, CBT with ERP is not effective for everyone, and some individuals relapse after treatment is completed (Abramowitz et al., 2013b). Due to the interpersonal context of OCD, it is possible that treatments involving family members, especially significant others, could improve the efficacy of OCD treatment.

As mentioned previously, accommodation is one of several interpersonal dimensions related to OCD that could have an impact on treatment outcome for patients. By incorporating partners into the treatment of OCD, general relationship distress as well as accommodation and other partner behaviors can be addressed. First, by improving how couples communicate and make decisions, a reduction in general relationship distress could allow couples to focus their energy on the treatment for OCD. Additionally, poor communication skills such as hostility and criticism have been shown to adversely affect ERP (Abramowitz et al., 2013b), so directing attention to those interpersonal difficulties could show many beneficial effects. Importantly,

investigation into how partner behaviors specific to OCD relate to treatment outcome must be understood to create a more comprehensive treatment. Dimensions including partner accommodation, the promotion of behavioral change related to OCD, and acceptance or validation of OCD by the partner are of particular interest.

Early attempts to incorporate partners into the treatment of OCD did not show improved results over individual treatment (Emmelkamp, De Haan, & Hoogduin, 1990). However, Emmelkamp and colleagues solely sought to treat the OCD and did not intervene to change how partners interacted (1990). Participants were placed into two groups: maritally distressed and not distressed, and then compared with their treatment condition of individual or partner-assisted exposures (Emmelkamp et al., 1990). Although a pilot study showed promising result, no difference was found between the partner-assisted and individual exposure groups (Emmelkamp, 1990). In a more comprehensive couple-based approach to treating OCD that focused on both ERP and addressing the couple's relationship, Abramowitz and colleagues found improvement in both OCD symptoms and relationship distress following treatment, and these effects were maintained at one-year follow-up (Abramowitz et al., 2013a). In fact, improvement in OCD functioning was notably greater than is typically seen in individual ERP. Furthermore, partner accommodation of patient OCD symptoms was decreased at the time of the posttest, likely resulting from teaching couples how to function within the framework of ERP (Abramowitz et al., 2013a).

Additional analysis from the same investigation by Abramowitz and colleagues showed that pretreatment levels of partner accommodation were significantly related to the severity of patient pretreatment compulsions but not obsessions (Boeding et al., 2013). Higher levels of accommodation were also associated with poorer relationship functioning for partners at pretest,

(Boeding et al., 2013). At post-test, higher levels of partner accommodation were significantly correlated with greater OCD severity for the patient (Boeding et al., 2013). Thus, it appears that partner accommodation has an impact on treatment outcome for patients in a couple-based approach to treating OCD; however, how accommodation interacts with other partner behaviors is yet to be determined. Behaviors including promotion of change and acceptance by the partners, could affect treatment outcome by interacting with, masking the effects of, or changing how accommodation influences the patient.

It is also important to note that from a methodological perspective, investigations of partner/family accommodation in OCD have relied upon self-report measures of accommodation. However the couple literature demonstrates that partners' self-reports of their communication and behavior often are notably different from their behaviors that are assessed during couples' interaction (Epstein & Baucom, 2002). Thus it also is important to investigate the role of accommodation as observed behaviorally during couples' interactions to clarify whether results from self-reports of accommodation are replicated when actual behaviors are assessed.

Current Study

The current study seeks to better understand how partner behaviors including (a) accommodation, (b) change promotion, and (c) acceptance or validation, affect treatment outcome for individuals with obsessive-compulsive disorder participating in a couple-based intervention for OCD. An observational coding system was developed for the current investigation in order to assess partner Accommodation during conversations about OCD; in addition, refinements were made to an existing coding system to assess (a) partners' Change Promotion and (b) Acceptance/ Validation (Fischer, 2012). These partner behaviors were

measured during a videotaped conversation at pretreatment and post-treatment during a social support conversation in which the couple discussed one person's OCD.

Based upon previous findings regarding the detrimental effects of accommodation in OCD and the interactive role of Change Promotion and Acceptance/ Validation from partners in AN, several hypotheses were derived.

Hypothesis 1: *Controlling for pretreatment levels of OCD, higher levels of partner accommodation at pretest were predicted to result in worse treatment outcome at posttest in terms of OCD symptoms.* By consistently receiving accommodation from their partners, patients are able to continue avoiding anxiety-provoking stimuli and thus will likely improve less.

Hypothesis 2: *After controlling for pretreatment levels of OCD, high levels of change promotion at pretest were predicted to result in better treatment outcome at posttest in terms of OCD symptoms.* Partners who are pushing patients for change according to the treatment plan should help produce greater change in OCD symptoms.

Hypothesis 3: *While controlling for pretreatment levels of OCD, high levels of change promotion and low levels of acceptance/ validation at pretest are predicted to interact and produce better treatment outcome at posttest than either behavior on its own*. Consistent with Fischer et al.'s (2013) findings regarding AN, this combination of partner behaviors is likely to be experienced as a form of "tough love" in which the partner is focusing on what is needed for the patient to improve.

Hypothesis 4: *While controlling for pretreatment levels of OCD and pretreatment levels of Accommodation, high levels of Accommodation at posttest will be related to worse treatment outcome in terms of OCD symptoms.* Partners who continue to accommodate patients at the end

of treatment are still reinforcing patient avoidance which should lead to worse treatment outcomes.

Method

This study was approved by the Institutional Review Board (IRB) at the University of North Carolina at Chapel Hill (UNC-Chapel Hill).

Participants

Twenty-one couples were recruited for an open-trial pilot treatment intervention study employing a couple-based, cognitive-behavioral therapy for obsessive-compulsive disorder (OCD). Inclusion criteria were: (a) 18 years of age, (b) at least one year married or living together, (c) one person with a primary diagnosis of OCD as defined by a score of greater than or equal to 16 on the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS; Goodman et al., 1989a, 1989b), (d) both persons fluent in English, and (e) both persons agreeing to participate in all treatment sessions. Criteria for exclusion were prior CBT for OCD, (a) present suicidal ideation, (b) present substance abuse, (c) psychotic symptoms, or (d) physical abuse within the relationship," (Abramowitz et al., 2013a).

Of the 16 couples who completed treatment, all were heterosexual and the female partner had OCD in 15 of the 16 couples. The mean age of OCD patients was 33.13 (*SD* = 10.39) years, and the mean age of partners was 34.69 (*SD* = 10.04) years. Eleven of the 16 couples were married (69%), and the remaining couples had been living together for at least one year (31%).

Procedure

Couples completed twelve weeks of treatment according to the manual described in Abramowitz et al. (2013a). The first 8 weeks consisted of biweekly sessions for 90-120 minutes. Topics included an assessment of the patient's OCD symptoms, building of an exposure

hierarchy, education on CBT for OCD, and learning to carry out partner-assisted exposures as a part of ERP. The second 8 weeks consisted of weekly sessions for 90-120 minutes and along with continuing partner-assisted exposures, couples were taught decision making skills, ways to reduce partner accommodation, communication skills, and ways to manage relationship stress outside of OCD. Couples were also assigned homework during treatment focusing on reducing partner accommodation and conducting partner assisted exposures.

Measures

Y-BOCS (Goodman, Price, Rasmussen, Mazure, 1989a, 1989b). The Yale-Brown Obsessive-Compulsive Scale was given to patients and is a semi-structured interview designed to capture severity of the disorder in patients diagnosed with OCD. It consists of 10 items that measure the interference of, how distressing, and amount of time spent on, resistance to, and control of both obsessions and compulsions. Each item is scored on a scale of 0 (none) to 4 (extreme) and summed to provide a total measure of global OCD severity between 0 and 40. Subscores of both obsessions (0-20) and compulsions (0-20) were available for analysis, but were not used here. The Y-BOCS has been shown to have good reliability and validity for OCD severity (Goodman et al., 1989a, 1989b).

FAS (Calvocoressi et al., 1999). The Family Accommodation Scale was completed by partners and is a 13 item self-report measure addressing the amount of time and degree to which family members spend reassuring patients, assisting in rituals, modifying family routines, and avoiding anxiety provoking stimuli in the last week. For this study, the wording was changed from “the patient with OCD” to “your spouse or partner with OCD” (Abramowitz et al., 2013a). The FAS provides a score of partner accommodation and was used to validate the Accommodation observational coding score.

Partner Behaviors in the Context of Obsessive-Compulsive Disorder Coding System Manual (See Appendix 1). An observational coding system was developed for this investigation to assess partner and patient behaviors during a videotaped conversation in which patients were asked to share their thoughts and feelings on a topic related to their OCD. Patients were prompted, "Please choose an individual issue related to OCD that is important or of concern to you. During this conversation, it is your turn to share your thoughts and feelings about an issue that concerns you. So, this should not be a topic that you want to ask your partner a lot of questions about; it should be something that you personally want to talk about.". These conversations occurred at both pretest and posttest. Employing a macro-analytic system, scores were assigned on a five-point scale from 1 (very little) to 5 (a great deal) on the following dimensions based on overall behaviors during the seven-minute conversations. Coding began when the therapist left the room and continued for seven minutes.

Quality of Communication. This dimension was rated for both the patient and the partner. Conveying both positive and negative feelings in a constructive manner, being engaged in the conversation, actively listening, and trying to understand what the other person said were key components of good communication.

Change Promotion. This dimension was rated for the partner only. Making suggestions, actively trying to change or decrease the patient's OCD-related behavior, or trying to reason with the patient regarding OCD were markers of a high score on this dimension.

A*cceptance/ Validation.* This dimension also was rated for the partner only. Being emotionally supportive of the patient, showing care and concern, and trying to validate the patient's experience with OCD were signs of a high score on Acceptance/Validation.

Accommodation. Participating in rituals, assisting in avoidance, reassuring the patient, and assuming excess responsibilities were indicative of high levels of Accommodation.

As noted above, patients were scored on Quality of Communication only. Partners were assigned scores for Quality of Communication, Change Promotion, Acceptance/Validation, and Accommodation. The latter three codes were assigned regardless of how constructively partners communicated or how successful their attempts were to elicit a favorable response from the patient. Codes could be based on observable behavior within the interaction, or references to outside behavior that were made during the conversation.

The first three dimensions, Quality of Communication, Change Promotion, and Acceptance/ Validation, were adapted from a coding system developed for the observational coding of couples conversations for individuals with AN and their partners (Fischer & Baucom, 2013). The complete coding manual can be found in Appendix I.

Results

Coding was completed by four female undergraduate and post-baccalaureate research assistants who underwent six months of training led by the authors of the coding manual. Coders watched, discussed, and scored interactions from the same dataset where partners shared their thoughts and feelings. These videos were chosen for training because they were most similar to the dataset to demonstrate the behaviors of interest. Coders had no contact with the participants, and thus assigned scores based solely on the behaviors observed during the videotaped conversations. Coders were provided with a list of the most distressing/impairing obsessions and compulsions for each patient to aide interpretation of the interactions. Reliability between coders was established before starting on coding couples' conversations in the current investigation. All behaviors described in the coding system were seen in a range across videos. Inter-rater

reliability was good to very good (.70 to .94) for all codes reflected by inter-class correlation coefficients (ICC) with the exception of pretest Global Quality of Communication– patient, pretest Promotion of Change, and posttest Accommodation (.47, .50, and .00, respectively). Average ICC was .66 (Table 1). Further inspection of the posttest Accommodation code revealed coders' scores were considered a match, within one point difference, 83% of the time. For the two misses, in one instance Coder 1 was higher and in the other instance Coder 2 was higher, resulting in an inter-class correlation coefficient of 0. The high rate of agreement between coders was viewed as sufficient to use the codes in the following analyses.

Validity of the Accommodation Code

In addition to demonstrating the reliability of the new Accommodation code, it was important to demonstrate the convergent and discriminate validity of the measure. In order to demonstrate the convergent validity of the Accommodation code, scores were compared with the Family Accommodation Scale (FAS), a well-established self-report measure of accommodation that was completed by partners at both pretest and posttest. All pretest statistics were calculated with the 16 couples who completed treatment. All posttest statistics were calculated with the 12 couples who completed treatment and posttest treatment interactions. Of the four couples excluded from the posttest, two were excluded due to poor sound quality of videos; one was excluded due to technical issues with the video, and one couple failed to complete the conversations. Pretest coded Accommodation was positively correlated with posttest FAS ($r = 0.54$, $p < 0.05$), and posttest coded Accommodation was highly correlated with posttest FAS ($r = 0.88$, $p < 0.01$) (Table 2).

The discriminant validity of the Accommodation code was equally important. More specifically, we wanted to demonstrate that the degree to which a partner engages in

Accommodation was not merely the opposite of Change Promotion; that is, if a partner promotes behavior change are they not accommodating to the OCD? There were no significant correlations found between Change Promotion and the FAS at either the pretest or the posttest, demonstrating that these are separate dimensions of behavior (Table 3). Additionally, there were no significant correlations between coded Change Promotion and coded Accommodation at either the pretest or the posttest (Table 4). Likewise, it was important to demonstrate that accommodating was not the same as being supportive and empathic for the difficulty of having OCD. Hence, correlations between Accommodation and Acceptance/ Validation were calculated. Findings demonstrated that pretest Acceptance/ Validation was not significantly correlated with pretest Accommodation; however, posttest Acceptance/ Validation and posttest Accommodation were significantly correlated, ($r = -0.60$, $p < 0.05$) (Table 4). Thus, partners who demonstrated high levels of Acceptance/ Validation at the posttest were demonstrating low levels of Accommodation. Overall, the findings demonstrate the reliability and initial validity of the newly developed Accommodation code, justifying a further assessment of this variable and the study hypotheses.

In addition to the relationships between coded Accommodation and other measures, relationships between other coded variables were assessed. Global Quality of Communication for both the patient and the partner at pretest was correlated with pretest Acceptance/ Validation ($r = 0.56$, $p < 0.05$; $r = 0.86$, $p < 0.01$, respectively) (Table 4). There is some conceptual overlap between showing Acceptance/ Validation and having good communication skills, thus the high correlation between partner Global Quality of Communication and Acceptance/ Validation at pretest was expected. Posttest Global Quality of Communication for the partner was highly

correlated with posttest Acceptance/ Validation, following the same pattern of pretest behaviors ($r = 0.78$, $p < 0.05$).

Descriptive Statistics and Correlations Among Central Variables

For study related variables, means and standard deviations for the Family Accommodation Scale (FAS) and the Yale-Brown Obsessive-Compulsive Scale (YBOCS) were calculated. The means demonstrate that the patients had a Y-BOCS score of 25.75 at the beginning of therapy, and that partners had a FAS score of 34.63 when treatment began. After treatment, the mean YBOCS score was 11.56 and partners reported a mean FAS score of 25.13. Elsewhere Abramowitz and colleagues demonstrated that, as expected, there was a significant decrease in both constructs from pretest to posttest after treatment with this same sample (Abramowitz et al., 2013a).

Hypothesis testing

To test hypotheses one through three, a multiple linear regression analysis was performed. A stepwise approach was used where symptom severity at pretest (YBOCS) was entered first, followed by the observational codes of the three partner behaviors at pretest, and, if applicable, followed by interaction effects of the partner behaviors. All predictors were centered around their means for ease of interpretation.

Although the sample size was small, a complete model of all partner behaviors was created in order to understand how pretest partner behavior impacted treatment outcome. The first model was used to test the first, second, and third hypotheses. Hypothesis 1 predicted that high levels of coded Accommodation would predict a worse treatment outcome in terms of OCD symptom severity. Hypothesis 2 predicted that high levels of coded Change Promotion would predict a better treatment outcome in terms of OCD symptom severity. Hypothesis 3 predicted

that high levels of coded Change Promotion and low levels of coded Acceptance/ Validation would interact and predict better treatment outcome. Therefore, a multiple linear regression model was conducted with pretest YBOCS score in the first step as a control; all three pretest coded partner behaviors (Change Promotion, Acceptance/ Validation, and Accommodation) in the second step, and the interaction between pretest Change Promotion and Acceptance/ Validation in the third step. Posttest YBOCS served as the dependent measure.

No significant main effects were found, yet the three coded partner behaviors explained an additional 30% of the variance in posttest YBOCS scores, above and beyond what was accounted for by the pretest YBOCS scores alone (Table 5). The interaction effect of Change Promotion and Acceptance/ Validation was not significant, but it uniquely explained about 14% of the variance, above and beyond the effect of pretest YBOCS scores and the main effects of the three partner behaviors (Table 5). In order to understand whether the direction of interaction between Change Promotion and Acceptance/ Validation was similar to that seen with couples and anorexia in an earlier investigation, this interaction was explored further. Probing of this interaction by hand by computing simple slopes at high and low levels of Acceptance/ Validation revealed that a combination of high Acceptance/ Validation and high Change Promotion was associated with the best results for patients as measured by the YBOCS (Figure 1).

In order to test Hypothesis 4, which predicted that posttest Accommodation would be associated with poorer patient outcome on the YBOCS, a separate regression model including pretest and posttest Accommodation was evaluated. In the first step, pretest YBOCS score was entered followed by pretest Accommodation in the second step. In the third step, posttest Accommodation was entered (Table 6). Posttest YBOCS scores were the dependent variable. An

additional 22% of the variance in posttest YBOCS scores was explained by the third step and results neared significance (R^2 = .22, F(8,12) = 3.90, p = 0.055; Table 6).

Discussion

Although accommodation has been extensively studied in the family context with a focus on parents, very little research has been conducted examining accommodation within intimate adult relationships. This study sought to better understand accommodation as well as other partner behaviors to an intimate partner's OCD, and the impact these behaviors may have on treatment outcome. Due to the small sample size, low power, and lack of significance in the results, all outcomes should be interpreted with caution. Yet the pattern and direction of findings is worth noting and provides direction for future research. Repeating what has been found in previous literature, this study found that increased levels of partner accommodation at pretest and posttest might be associated with poorer treatment outcome for individuals with OCD (Albert et al., 2009; Amir et al., 2000; Merlo et al., 2009; Boeding, et al., 2013). Additionally, an interaction between pretest Change Promotion and pretest Acceptance/ Validation revealed a pattern that suggests that patients might experience better treatment outcome when partners overall demonstrated both high levels of Change Promotion along with high levels of Acceptance/ Validation.

The interaction effect between partners' pretest Change Promotion and pretest Acceptance/ Validation in predicting patient outcome also was important in a previous investigation of couples with anorexia nervosa (Fischer, 2013). As in the couples with anorexia sample, promotion of change seems to be a critical component of partner behavior that predicts positive patient outcome. However, the effect appears to be contingent upon the level of acceptance/validation partners engage in along with change promotion. Among OCD couples,

when partners demonstrated a *high* Change Promotion, in combination with *high* Acceptance/ Validation, patient outcome was optimized; however, among couples with anorexia, *low* levels of Acceptance/ Validation in combination with *high* change promotion was related to the best patient outcome. That is, the role of Acceptance/ Validation seemed to work in opposite directions across the two disorders. One possible explanation for this potential difference between the two patient populations is that often, patients with anorexia are so fearful of weight gain that they do not want to change (Vitousek, Watson, & Wilson, 1998). Individuals with OCD, on the other hand, are more distressed by their symptoms and want to improve. Thus, if a partner of a patient with AN shows empathy and acceptance, the patient may interpret this as agreement with the patient or permission not to change, and, therefore, the patient does not work as hard during treatment. Because most individuals with OCD have an internal motivation to change (Pinto, Pinto, Neziroglu, & Yaryura-Tobias, 2007), they might be more receptive to the full message coming from their partners: that although treatment is difficult, they should confront their difficulties and attempt to change their behavior. Individuals with AN might only listen to the first half of the message regarding acceptance and ignore the change promotion portion of the message. Phrased differently, when an adult patient engages in a high level of avoidance behavior (as seen in both OCD and AN), it might be helpful for a partner to emphasize the importance of behavior change for the patient. Whether it is helpful for the partner to demonstrate a great deal of acceptance/ validation varies. With patients who themselves have a high level of motivation to change (e.g., OCD), acceptance/ validation from a partner might be helpful. However if the patient has low motivation or is ambivalent about change (e.g., AN), acceptance/ validation from the partner might be less helpful because it could be interpreted to mean that it is too difficult to make changes.

Elsewhere in the literature, a similar pattern of varying levels of support and structure benefiting different populations exists. For most children, an authoritative parenting style, both high in support and structure, results in the best behavioral child outcomes (Baumrind, 1968). However, for African American children, authoritarian parenting, low in support but high in structure, seems to promote positive child outcomes (Chavis, 2012). This difference is likely not caused by race but by the situations in which these families find themselves. Because African American families are more likely to have lower income and live in unsafe neighborhoods, it is critical that their children listen to their parents and adopt appropriate safe behaviors. Patients with AN, likewise, are making poor judgments about their health that could put them in a dangerous situation due to low body weight. Therefore, partners of patients with AN may be in a role similar to that of many African American parents who need to be authoritative in promoting safety for their loved one. On the other hand, the partners of individuals with OCD seemed to be effective with a combination of high Change Promotion and high Acceptance/ Validation analogous to an authoritative parenting style. Of course, we are not proposing that romantic partners are in a parental role, but rather that a pattern of central family member response might be parallel across these family domains.

In addition to the interaction effect discussed above, the findings that high levels of Accommodation at both the pretest and posttest indicated a worse treatment outcome for the patient could be the result of two different phenomena. First, if partners continue to accommodate the patient's OCD throughout treatment, then patients are not confronting their fears and, thus, are not making therapeutic progress. Second, if patients improve over the course of treatment, then there are fewer opportunities for partners to accommodate, thus lowering

levels of Accommodation. Due to the correlational nature of this study, no causal inferences can be drawn.

In addition to evaluating several substantive hypotheses, this study involved the development and adaptation of a new observational coding system, with a major emphasis on assessing accommodation. Prior to this study, accommodation has been measured via a self-report measure completed by friends or family of the patient. Therefore, initial evaluation of this new coding system is appropriate since it might be useful in future investigations of accommodation. One notable concern was the poor inter-reliability of the accommodation at posttest. However a closer investigation of the coders' scores indicates less concern. For the 12 videos coded for Accommodation, the pairs of coders had a perfect match in their codes for eight of the videos. In addition, two of the remaining videos were within one point of each other on a five-point scale, which we do not consider to be a miss. There were only two videos where the coders differed by more than one point in their codes. Of these two misses, for one video, coder 1 gave a higher score, and for the other video, coder 2 gave a higher code. Although we are interested primarily in the absolute difference in scores between the coders, having the coders differ in which one rates higher significantly lowers inter-class correlations as a reliability estimate.

Initial indications of validity were also present. The patterns of correlations between pretest and posttest coded Accommodation and FAS demonstrate interesting findings. Pretest FAS and pretest coded Accommodation did not correlate with each other, but posttest FAS and posttest coded Accommodation were highly correlated. Additionally, pretest coded Accommodation was correlated with posttest FAS. This pattern of correlations could lead to different interpretations. First, prior to treatment, partners may not know exactly what

accommodation entails, thus their self-report of accommodation might not match their accommodation behavior. Over the course of treatment, partners are educated about the nature of accommodation. Therefore, they might have been better able to report accommodation at posttest, explaining the high correlation between coded and self-reported accommodation. An alternative explanation also is possible. Prior to treatment, accommodation is high. It is possible that the Accommodation code is not sensitive to capturing high levels of accommodation such as seen at pretest; if so, then pretest coded Accommodation behavior would not be highly correlated with self-reports of accommodation. However, if the Accommodation code is sensitive to lower levels of accommodation, it would be more accurate at posttest when accommodation is lower. Further investigation will be needed to clarify which of these two, or other interpretations, are more accurate. If the first interpretation is accurate, then the findings suggest that without education about accommodation, family members might not be able to self-report accurately on their level of accommodation. However if the second interpretation is correct, then refinement of the coding of Accommodation will be important to sensitively assess higher levels of accommodation.

Although the results were non-significant with this small sample size, with caution, possible clinical implications could be considered if these results are replicated in the future with a larger sample. First, this study demonstrated that for couples with OCD, a different pattern of Change Promotion and Acceptance/ Validation produced the best treatment outcome compared to couples with AN. If this study were to be replicated in a larger sample, helping the partner to learn to push for change is critical, but the appropriate amount of empathy supplied by the partner seems to vary as a function of the degree of motivation to change demonstrated by the patient. In both samples, Change Promotion is key, which is consistent with the message

therapists give in individual therapy for these populations. By teaching the partner to mirror the change promotion message the therapist is providing, the amount of empathy offered can be adjusted according to the patient's level of avoidance. If patients are resistant to change, then less empathy might be offered, whereas if patients are motivated to change, partners can provide more assurance without compromising the message of change promotion.

There were several limitations to this study. First, the sample size included only 16 couples who completed treatment for the pretest data, and due to technical difficulties reduced to only 12 couples for posttest data. This left the sample with very little power due to its small size. Second, coders were trained using videotapes of the same couples who were in the dataset. Even though these were not the same conversations and the couples talked about a different OCD-related topic, coders were familiar with the couples' general interaction patterns. Although different couples ideally would have been used for training, these videos were most representative of the behaviors expected in the dataset, and thus it was important for coders to have practice and training differentiating among behaviors of interest, such as Accommodation and Change Promotion. Third, coders were not always blind to the pretest, posttest status of the videos due to content of the couples' conversations. In several of the posttest videos, the topic of conversation was how well the patient had progressed during treatment, or where the couple hoped to continue improving after treatment was over. Fourth, the patients' main obsessions and compulsions were known for most but not all couples. Being aware of the obsessions and compulsions is helpful in understanding what couples were discussing during the coded conversations and without this information, coders had to make educated guesses for some videos about how the couple interacted around the obsessions and compulsions. In the future, this information would be valuable to assist in accurate coding.

Despite the limitations of this study, it is part of a growing body of research on the intervention strategies that consider the interpersonal aspects of psychopathology. By going beyond an assessment of general relationship functioning and instead focusing on aspects of the couples' relationships that are central to particular disorders, a more complete understanding of patient/ partner interaction within the context of psychopathology is attained. For this sample of couples with OCD, the behavioral aspect of Accommodation was added to Change Promotion and Acceptance/ Validation which had previously found to be of importance in a sample of couples with AN. It is essential to understand how both general interpersonal factors such as relationship functioning and communication quality, as well as disorder specific variables such as Change Promotion, Acceptance/ Validation, and Accommodation relate to future interventions and treatment outcome.

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Table 1

Descriptive Statistics of Observational Variables (Consensus Codes) and Inter-Rater Reliability

Code	Mean (SD)	Range	ICC
Pretest Global Quality of Communication – partner	3.78 (1.00)	2.00-5.00	.87
Pretest Global Quality of Communication – patient	3.69 (.75)	2.00-5.00	.47
Pretest Change Promotion	2.03 (1.06)	1.00-4.00	.50
Pretest Acceptance/ Validation	3.00 (1.39)	1.00-5.00	.78
Pretest Accommodation	2.66 (1.35)	1.00-5.00	.70
Posttest Global Quality of Communication – partner	4.46 (.75)	3.00-5.00	.91
Posttest Global Quality of Communication – patient	4.54 (.58)	3.00-5.00	.80
Posttest Change Promotion	3.21(1.70)	1.00-5.00	.81
Posttest Acceptance/ Validation	3.25 (1.14)	1.00-5.00	.76
Posttest Accommodation	1.21 (.45)	1.00-2.50	.00

Note: Possible range of scores was 1-5 for all codes. At Pretest N=16; at Posttest N=12. ICC = Average Measures Intraclass Correlation, Zero variance for all coders.

Table 2

Bivariate Correlations of Observational Accommodation Code and Family Accommodation Scale (FAS) self-report measure

	2	3	4
1 Pretest FAS	.04	.57*	.46
2 Pretest Coded Accommodation	1	.54*	.56
3 Posttest FAS		1	.88**
4 Posttest Coded Accommodation			1

*Note: *p < .05, **p < .01.*

Table 3

Bivariate Correlations of Observational Promotion of Change Code and Family Accommodation Scale (FAS) self-report measure

	2	3	4
1 Pretest FAS	.13	.57*	.46
2 Pretest Coded Change Promotion	1	.20	.34
3 Posttest FAS		1	-.04
4 Posttest Coded Change Promotion			1

*Note: *p < .05, **p < .01.*

Table 4

Bivariate Correlations of Observational Codes and OCD severity.

	2	3	4	5	6	7	8	9	10
1 Pretest Global Quality of Communication – partner	.37	.40	.86**	-.28	.27	-.06	-.06	.40	-.34
2 Pretest Global Quality of Communication – patient	1	.50	.56*	-.23	.05	.58*	-.09	.09	.23
3 Pretest Change Promotion		1	.32	-.07	-.27	.50	.34	-.19	.26
4 Pretest Acceptance/ Validation			1	-.36	.40	.04	.08	.50	-.34
5 Pretest Accommodation				1	.19	-.24	.01	-.19	.56
6 Posttest Global Quality of Communication – partner					1	.06	-.15	.78**	-.51
7 Posttest Global Quality of Communication – patient						1	-.12	.02	-.04
8 Posttest Change Promotion							1	-.46	.18
9 Posttest Acceptance/ Validation								1	-.60*
10 Posttest Accommodation									1

Note: *$p < .05$, **$p < .01$.

Table 5

Hypotheses One, Two, and Three: Regression Analyses Predicting Patient Outcomes from Observational Coding and Pretest OCD symptom severity.

Variable	F	R^2	$R^2\Delta$	B	SE B	β	t
a) First step	.77	.05	.05				
Pretest YBOCS Score				-.25	.278	-.23	-.87
b) Second step	1.48	.35	.30				
Pretest Change Promotion				.83	1.38	.16	.60
Pretest Acceptance/ Validation				-.20	1.08	-.05	-.19
Pretest Accommodation				2.24	1.11	.55	2.03^{+}
c) Third Step	1.92	.49	.14				
Interaction of Pretest Change Promotion and Pretest Acceptance/ Validation				1.12	1.30	.22	.86

Note: $^{+}p = .068$.

Table 6

Hypotheses Four: Regression Analyses Predicting Patient Outcomes from Pretest and Posttest Observational Accommodation.

Variable	F	R^2	$R^2\Delta$	B	SE B	β	t
a) First step	.54	.05	.05				
Pretest YBOCS Score				-.26	.25	-.24	-1.02
b) Second step	2.67	.37	.32				
Pretest Accommodation				1.02	1.18	.24	.86
c) Third step	3.90	.59	.22				
Posttest Accommodation				7.17	3.44	.58	2.09^{+}

Note: $^{+}p = .071$.

Figure 1:

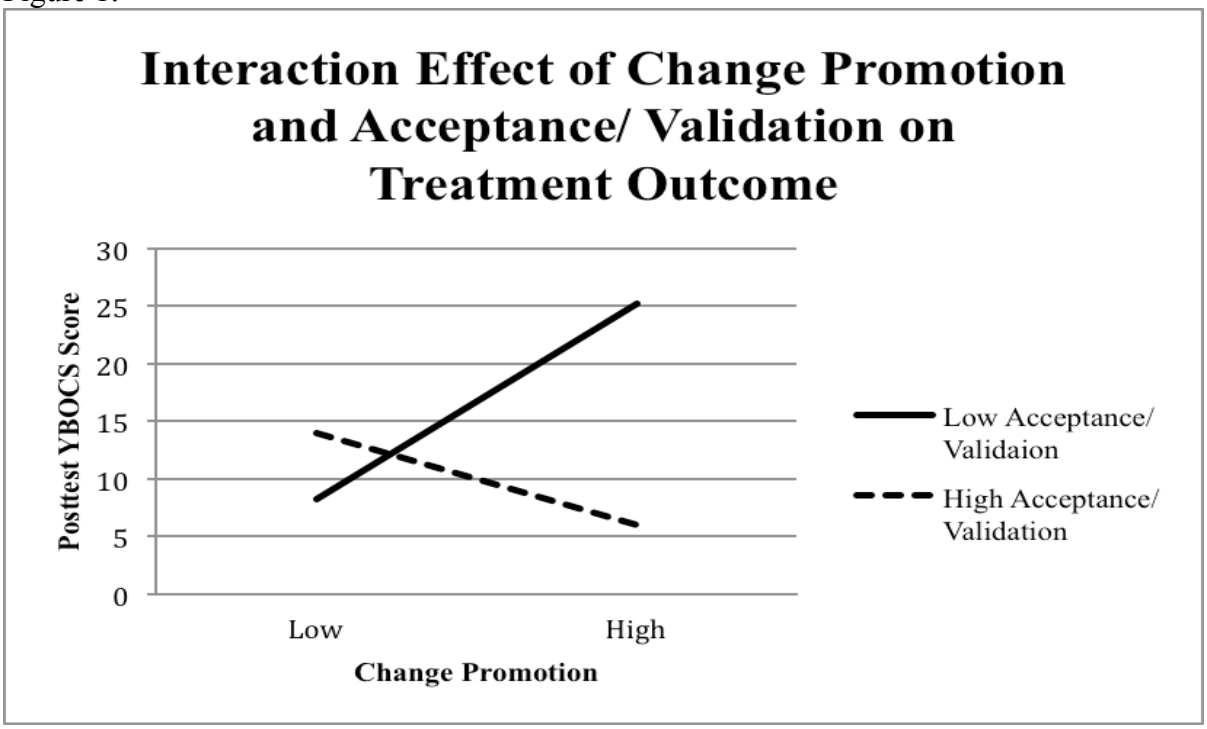

Figure 1: Probing of interaction between Pretest Change Promotion and Pretest Acceptance/ Validation. Simple slopes calculated at low and high Acceptance/ Validation and plotted with Change Promotion.

Appendix I

PARTNER BEHAVIORS IN THE CONTEXT OF OBSESSIVE-COMPULSIVE DISORDER CODING SYSTEM MANUAL

McKenzie Roddy, Melanie S. Fischer, & Donald H. Baucom

September 2013

Overview

This observational coding system is designed to assess the behaviors of a partner in the context of a patient's obsessive-compulsive disorder (OCD). These partners find themselves in a difficult situation, where the patient suffers from a mental disorder with serious psychological consequences and impairment in daily life, and the same behaviors that bring brief anxiety relief to the patient also help to maintain the disorder and define the disorder. An anxiety disorder, OCD is defined by (a) obsessions-- unwanted, reoccurring thoughts, images, or impulses that create anxiety, and (b) compulsions-- mental or behavioral rituals that help to reduce the anxiety due to the obsessions. Obsessions that create anxiety can vary from concerns about causing accidental harm, sexual actions, religion, symmetry, and contamination. Compulsions that alleviate anxiety short term include washing, checking, ordering, repeating, and mental rituals. Patients find obsessions disruptive and anxiety provoking, and compulsions can become very rigid and time consuming in an attempt to lower the anxiety. As a result, OCD can be an inhibiting disorder at work, interpersonally, and in the home.

Patients with OCD often ask for reassurance regarding their obsessions or seek help with their rituals from their partners, drawing them into the disorder. Some partners are willing to become involved to prevent further upsetting the patient. Thus the disorder can affect the life of

the partner as well as the patient in drastic ways. The goal of this coding system is to assess how the partners respond to OCD on different behavioral dimensions in the context of the patient's illness, and the quality of communication while doing so. Behaviors occurring during the conversation as well as references to outside behaviors are considered in this coding system.

This is a "macro-analytic" coding system, in which five global codes are assigned based on the entire conversation. Four codes are used to assess the partner's behavior only. One code is assigned to the patient. The context used for this system is a conversation in which the couple is asked to talk about an issue of concern in their relationship that is related to obsessive-compulsive disorder. They are asked to share their thoughts and feelings about the issue, but not to problem solve or reach a solution.

Coding Guidelines and Summary of Dimensions

Below is a summary of the coding dimensions along with guidelines about the coding process. You will find detailed descriptions of the coding dimensions and scores further below.

You will watch the entire conversations several times, each time paying attention to a subset of behaviors. A minimum of watching the conversation two times is required, but you may watch it again or go back to certain portions of the conversation if this will help you make a decision about a code. The coding process begins with several general codes, and you will subsequently make ratings of more specific behaviors.

(A) In the first step, you will assign separate global codes based on the entire conversation. Both the partner and the patient will each receive one code for the quality of communication. This is the only time you will assign a code to the patient's behavior. Watch the entire conversation once and pay attention to these concepts. Jot down notes throughout the conversation as needed. Assign the following codes:

1. Global quality of communication – partner

Regardless of the topic discussed, assign one global code for the quality of communication of the partner across the whole conversation.

Very poor		Fair		Very good
1	2	3	4	5

2. Global quality of communication – patient

This is the only code for the patient's behavior. Regardless of the topic discussed, rate the patient's quality of communication across the whole conversation.

Very poor		Fair		Very good
1	2	3	4	5

(B) In the second step, you will watch the conversation again and pay attention to more specific behaviors of the partner. Again, take notes as needed to make your rating.

The first behavioral dimension to focus on is *Change Promotion.* The second behavioral dimension is *Acceptance/Validation.* The final behavioral dimension is *Accommodation.* Assign the following codes:

3. Change Promotion

Assign one global code based on the whole conversation, rating how much the partner engaged in this behavior with a focus on the patient's OCD:

Very little		Some		A great deal
1	2	3	4	5

4. Acceptance/Validation

Assign one global code based on the whole conversation, rating how much the partner engaged in this behavior with a focus on the patient's OCD:

Very little		Some		A great deal
1	2	3	4	5

5. Accommodation

Assign one global code based on the whole conversation, rating how much the partner engaged in this behavior.

Very little		Some		A great deal
1	2	3	4	5

Coding Details and Examples

1./2. Global Quality of Communication

The partner's and the patient's quality of communication will be assessed using the same guidelines.

How well someone is able to communicate is determined by many different skills and behaviors. Capturing this in only one code necessarily omits detailed information about specific behaviors. Therefore, while you should have a good understanding of what kind of behaviors are involved in good or poor quality of communication, your rating should be based on the overall impression of the person's communication. That is, how well was the person able to convey his/her thoughts and feelings in a clear and constructive fashion? Did he/she listen actively and showed that they understood what the other person said?

The patient is asked to choose an issue related to OCD to share his/her thoughts and feelings, while the partner is asked to respond as he/she normally would Thus, it is possible that both partners and patients have negative thoughts and feelings to express. It is important to note that this code is not to be confused with how "pleasant" the conversation was or how much positive affect the person displayed. On the contrary, appropriate expression of negative thoughts or feelings would indicate good communication.

The key to effective communication of negative thoughts or feelings is being able to express them in a way that the listener is likely able to hear. That means statements should be phrased in a way that lowers the likelihood of the listener feeling attacked, blamed, or criticized, and subsequently likely to respond in a destructive manner. More specifically, good communication of the speaker would be characterized by presenting their subjective experience with clear, specific statements; if appropriate, the inclusion of positives, adequate self-disclosure,

and presenting one's ideas and feelings in a way that is respectful to the listener. For example, if the partner says "We never get to go out on nice dates because you won't eat off the cutlery at the restaurant. When is this going to stop!" this would be fairly poor communication. It is a generalized, critical statement, and depending on the tone of voice, this might come across as hostile and attacking, and the patient is likely to feel the need to defend herself. On the contrary, a constructive expression of the same idea could be, "I think you are a wonderful person, and I know you don't like eating out, but I would really love to show you how special you are to me and treat you to a nice date." In this case, the statement is much more specific, the partner shows respect and understanding for the patient, but is able to express his own concerns at the same time. In another example, the patient might express her frustration with the partner frequently asking her about her compulsions in different ways. "Stop nagging me every day about my rituals! This is none of your business!" would be poorer communication than "I know you're worried about what I do. But if you ask me several times a day how much I've been counting, I feel like you don't trust me and treat me like a little child. That is very frustrating for me".

In addition to the ability to convey thoughts and feelings constructively, active listening is also an important part of communication quality. This includes not interrupting the speaker, being attentive (includes nonverbals), asking open-ended questions to clarify, etc. Nonverbal communication should also be taken into account. The tone of voice, how loudly someone speaks, etc., will have an effect on how a statement comes across. In addition, good eye contact and a body posture that is oriented towards the other person are also part of good communication. Eye rolling, aggressive gesticulation, or withdrawn body posture are some examples of nonverbal indicators of poorer communication.

There are a number of key behaviors that lower the communication score for a person. Destructive criticism, hostility, accusations, cynicism are some examples. In addition, withdrawal (disengaging from the conversation), stonewalling (rejecting all suggestions, giving only short or evasive answers, etc.), and defensiveness (denying a problem or one's own role in it, countering blaming directed at oneself by blaming one's partner, unwillingness to reconsider own position) are also signs of poor communication.

The ratings for Quality of Communication are made on a five-point scale from "Very Poor" to "Very Good." Take the information above into account when you observe the partner or patient, and come to a global rating of their communication skills throughout the conversation. Consider the following guidelines for the different scores:

5 – Very Good

This score should be assigned to a person who consistently shows good or very good communication throughout the conversations. The person should be able to convey both positive and negative thoughts and feelings in a constructive, skillful manner, be engaged in the conversation, listen actively, and try to understand the other person's position.

3 – Fair

This score can be assigned in different scenarios. First, this might be a person who is fairly engaged in the conversation, and shows few behaviors that would be considered negative in terms of the communication quality, but also no remarkably skillful communication. Second, this might be a person who shows inconsistent communication in the conversation, who might communicate very constructively at some times but becomes critical or withdraws at other times.

1 – Very Poor

This is the lowest score that can be assigned for communication quality. To receive this score, the person might either be almost completely disengaged from the conversation, or show a high number of negative communication behaviors (or several extremely destructive behaviors).

Use scores of (2) and (4) to rate communication skills that fall in between the scores described above. For example, a rating of (4) could be assigned to a person who shows very good communication for most of the conversation, but deteriorates during a certain part of the conversation. Or, this might be a person who shows communication skills that would fall in the mid-range, but handles a difficult part of the conversations especially skillfully. Use a rating of (2) in a similar way for a quality of communication that lies between a (1) and a (3).

If one person says very little, especially if there would have been opportunities to speak, or dominates the entire conversation and rarely gives the other partner a chance to speak, the rating should be reduced. That is, a rating based on the content and manner of the person's communication should be assigned first, and then be reduced by one point if the person "hijacked" the conversation or barely said anything.

There may be conversations where the partner or the patient shows good communication skills during part of the conversation, but becomes critical, defensive, or cynical, for example, in another part of the conversation. In this case, you may decide to choose a score that would represent the "average" for the different parts of the conversation. However, there may be cases where the person's negative behavior could "trump" the rest of the conversation. This would be the case if the person becomes extremely hostile, attacking, withdraws completely, or the like, in a way that overshadows more skillful parts of the conversation. In such a case, you may decide

to assign a lower score than just the "average" across the whole conversation. However, if a person is able to break the cycle of a negative escalation in the conversation and lead it back into a more constructive interaction, this would be a sign of good communication.

3. Change Promotion:

This is a measure of the degree to which a partner tries to promote changes in the patient's behavior or cognitions related to OCD.

Attempting to promote behavior change does not imply that the partners are successful in doing so, suggest helpful changes, or that they communicate these attempts in constructive ways. For example, they may ask the patient how they can assist him/her in sticking to a treatment plan, give advice, **try to reason** with him or her about the disorder to "talk him/her out" of it, try to convince him or her that s/he is not a violent or disturbed person, become critical about his or her OCD behaviors, or threaten him or her with consequences (e.g., leaving him/her) if s/he does not get better, etc.

For this code, *only* the degree to which they show behaviors of this dimensions is rated, disregarding the quality of these efforts. Partners may try to promote behavioral change during the conversation or make references to outside Change Promotion. Partner behavior that is reported by the patient can be considered when scoring the conversation. However, if a partner and patient disagree on what happened (Partner: "I told you not to do that," Patient "No you didn't"), base your coding on what the partner says. The same principle of using the partner's report applies in situations in which a patient is describing an event and the partner corrects or disagrees with the patient about what happened.

Use the examples below to get a good understanding of this concept, but remember that partners may show behaviors that are not listed here but that are still considered Change Promotion. Make your best judgment of what the goal of the partner's communication is. Regardless of what they say exactly, if the target seems to be to get the patient to change, take it into account for your rating. As a general rule, take the whole conversation into account and make a judgment based on your overall impression of this partner, rather than focusing on single statements.

For example, partners may recommend that patients take their own cutlery allowing them to eat out at restaurants. Or, partners may offer to confront anxiety-provoking stimuli together such as going to the park where small children are present or going to the mall where many people with possible sickness are. **When partners "reason" with patients, it is crucial to distinguish Change Promotion from reassurance (i.e., accommodation, see below).** For example, if a patient is concerned about catching germs, the partner saying, "The chance of you getting sick is very low; it is very rare to get diseases from being in your own home," would be coded as Change Promotion, if it appears that the partner is trying to fundamentally change the patient's thinking about contamination. This is to be distinguished from an attempt to reassure and calm the patient *in the moment* without an attempt to promote ongoing cognitive change (e.g., Patient: "Do you think I will get sick from touching the door knob?" Partner: No, you'll be just fine.") The key for coding Change Promotion is the partner trying to use logic to <u>fundamentally change</u> the way the patient perceives or thinks about something. In this way, Change Promotion can be an attempt to change cognitions (thoughts, beliefs) in a lasting way ("We've been married 10 years; you're not gay – you have to start believing that!"), in addition to more obvious attempts to change his/her behavior ("Try playing with our niece, I know you

won't hurt her"). Reassurance may look similar at first glance, but reassurance will be directed at calming the patient in the moment without bringing about lasting change in beliefs (e.g., momentarily lowering emotional distress rather than attempting to promote ongoing cognitive change).

For Change Promotion, "complaining" is only rated as Change Promotion if the partner evolves it into more explicit Change Promotion statements. That is, sharing dissatisfaction about an issue alone is not rated as Change Promotion, but if the partner then requests changes, this could actually be a stronger Change Promotion interaction compared to a change request alone. For example, a partner complaining about the high water bill due to the lengthy showers taken by the patient would not be coded as Change Promotion; however, suggesting that the patient turn off the water while using soap and then back on again to rinse would qualify.

Guidelines for the code:

The scores for this code range from 1-5. In making the ratings, take both the frequency/duration and the intensity of the statements the partner made throughout the conversation into account.

5 – "A great deal"

For a partner who receives the highest rating, a strong message should come across that getting the patient to change her behaviors is a very important goal for the partner. The partner might persistently make statements indicating Change Promotion throughout the conversation, i.e., it will come up repeatedly. Or, a partner could also make fewer statements, but ones that come across with great strength and intensity. This might be due to the content, e.g., because a threat is included, or because the partner speaks with high affect and expresses strong emotions verbally

or nonverbally. Thus, a high rating does not mean that the partner makes statements of this category during the entire conversation, but that the importance of this goal or intention comes across strongly.

3 – "Some"

For a rating of (3), the message that the partner wants the patient to change her behaviors should be clearly present, but it is not overwhelming. The frequency or intensity of the statements will be lower. Overall, the partner's engagement in Change Promotion is clearly observable, but not on the forefront of the conversation.

1 – "Very little"

A rating of (1) indicates that the partner made no or only very few statements that would be considered Change Promotion. If the partner made a few statements, they should be of low intensity, or the partner "spoiled" them by taking them back or indicating that it is okay for the partner if the patient doesn't actually make the change (e.g. "I really wish I didn't have to put the DVDs back in a certain order. But I know this is so hard for you, so it's okay").

Ratings of (2) and (4) are used to rate conversations that fall in between the descriptions above. That is, a rating of (4) should be assigned to a partner who engaged in Change Promotion of a considerable amount and intensity, i.e., more than what would be rated a (3). The message that he wants the patient to change her behaviors should come across fairly strong, but not quite as intensely that it would warrant a rating of (5).

Use a rating of (2) for a partner who made some statements of this category, but the message is not as clearly present as would be necessary for a rating of (3). There might also be conversations in which the partner's comments that would be considered Change Promotion are very inconsistent, or occur only in a very limited part of the conversation and are not of high intensity.

4. Acceptance/Validation:

This is a measure of the partner's attempts to communicate their acceptance of the patient or his or her experiences with OCD, and validation of his/her struggles and efforts. This includes trying to show love, care, and concern for the patient as he or she is dealing with OCD-related issues or other challenges in an accepting, emotionally supportive way. Similar to Change Promotion, this code does not imply that they do so successfully or communicate effectively; therefore, quality is not a part of this rating.

Acceptance/Validation statements that are not well communicated might be more difficult to identify than Change Promotion statements with poor communication. Still, consider poorly executed Acceptance/Validation behaviors for your rating. Keep in mind that you are on the lookout for what the partner is trying to do. The following example might be a common scenario. For many partners, it might be hard to understand that their partner is concerned about committing an act of pedophilia because it is so outside their character. Thus, they might try to make him or her feel better by saying things like "You are a good person and love your nieces and nephews. You would never do something like that!" To which the patient is not reassured and shrugs off the partner's attempts to console them. The partner might then exclaim, "That is such a dumb thing to worry about!" Despite deteriorating communication quality, this would be

still considered Acceptance/Validation. (Note: The same statement could be communicated in a more skillful way, e.g. by saying "I know this is difficult for you to hear, and I know you don't feel this way, but I still want you to know that in my eyes you are a good and decent person." This takes the patient's perspective into account and emphasizes the subjectivity of this statement, and would therefore be considered good communication. See details for Communication Quality above). Asking questions in a manner that suggests the partner is trying to develop a better understanding of the patient's experience would also be considered an Acceptance/Validation behavior.

It is important to note that the expression of negative thoughts and feelings around the patient's OCD does not stand in opposition to a partner's high level of engagement in acceptance behaviors. That means, a partner could genuinely express his own struggles and worries around the patient's OCD, but still communicate that he understands and accepts him or her anyway. That is, acceptance does not always mean agreeing with the status quo or the patient's perspective. An example for this notion would be a statement such as: "You've had this for so many years now, and sometimes I feel like our whole life revolves around OCD. This is really hard for me, and I wish things were different. But I know how hard this if for you, and you didn't choose this either. I still think you are a wonderful partner, and I hope you can get past this."

For example, the couple might talk about the toll OCD has had on their relationship, e.g., because they have gotten into frequent arguments about it, or the patient could not fulfill certain roles. The partner might acknowledge these difficulties, but then offer an Acceptance/Validation statement. For example, the partner could say "Yes, this has been difficult for us, and sometimes I don't know what to say to you because we always seem to fight about the OCD. Nevertheless, I think you are a wonderful person, and I love you very much". Very likely, the goal of the partner

was to let the patient know about his love and support despite the hardships that result from the OCD. Another example would be a statement like "You are such a great mom to our kids".

Note that the concept of Acceptance/Validation is different in important ways from expressions of the partners that indicate he/she has resigned, i.e., "given up" and accepted that nothing will change. If there is a sense of "giving up" in the statements a partner makes, this would not be coded as Acceptance/Validation. For example, the following statement would fall under Acceptance/Validation: "Living with OCD has been really hard on us, and I know how difficult this is for you. We've had so many setbacks and things are moving so slowly, but I can see how hard you work on it. We'll just have to keep trying." Here, the partner acknowledges the difficulties, but is clearly validating the patient's experience and shows acceptance of the patient. Also, there is a clear indication that the partner is still hopeful and includes him or herself in the efforts. However, if the partner would phrase a similar statement in the following way, it would reflect resignation and not be taken into account for Acceptance/Validation: "Living with OCD has been really hard on us, and I know how difficult this is for you. We've had so many setbacks and things are moving so slowly, I just don't feel like there's anything I can do, and I know you can't." In this example, the partner may still appear accepting or validating, but there is also a clear sense of hopelessness and helplessness.

Additionally, acceptance should be differentiated from reassurance. Statements that are classified as reassurance seek to decrease the anxiety of the patient and are a type of accommodation. For example a partner may say to the patient, "I know that you don't like doing the homework that the therapist assigned because it makes you anxious. But I'm right here with you and I won't let anything happen to you. Everything is going to be okay. Nothing bad will happen." The partner's aim is to calm and soothe the patient. Acceptance/Validation, on the

other hand, shows love, care, concern, and/or emotional support for the patient, but does not attempt to decrease anxiety. An Acceptance/Validation statement could sound like, "I know that you don't like the homework that the therapist assigned because it makes you anxious. But I love you and believe in you. We can keep trying until we get it right." Here, the partner's focus is to make the patient feel validated in their experience and show his or her understanding of the situation. Reassurance is not coded under Acceptance/Validation, but rather under Accommodation.

Guidelines for coding Acceptance/Validation

As you watch the conversation, you will decide on an ongoing basis if the statements that a partner makes should be considered Acceptance/Validation. In making the ratings, take both the frequency/duration and the intensity of the statements the partner made throughout the conversation into account. Both acceptance during the conversation and references to outside acceptance are considered when scoring the conversation.

While it is important to pay attention to very specific behaviors and statements, we also want to accurately capture an overall sense of the partner trying to be accepting of the patient and to validate her experience. Failure to do so could result in underrating the degree of engagement in acceptance behaviors in a partner who uses more subtle yet clearly present strategies.

In general, partners can show their acceptance, understanding, and validation of the patient's experience related to OCD, or of the patient as a person in general in numerous ways. This may include explicit statements about the patient, as well as more subtle strategies expressed in the way a partner makes the statements, the use of nonverbal cues, tone of voice, emotional undertones, and the overall demeanor and approach to the conversation. For example,

a partner who is trying to validate the patient's experience and to show that he is accepting of him or her despite his or her disorder would likely make eye contact, have a body posture turned towards him or her, and display efforts to listen and understand her experience, as opposed to turning away, rolling eyes, and interrupting the patient. Asking open questions about the patient's experience or opinion, or expressions of love and affection could also be used in the service of communicating acceptance.

You will recognize that these behaviors are not specific to the construct of acceptance, but could also be interpreted as signs of good communication skills, the expression of tender feelings independent from the intent to communicate acceptance, or be characteristics of a partner who is generally an upbeat, friendly person. The fact that there is an overlap between behaviors that could be considered acceptance or belonging to a different construct means that it will be extremely important to consider the context in which the behavior occurred and interpret it accordingly.

Again, you will be looking at behaviors that could be considered acceptance in a certain context, but not in another. In order to discern if a behavior is considered acceptance, look at the context and sequence of behaviors/statements. For example, saying "I love you" could be the culmination of a series of acceptance statements and would be factored in for the rating. However, a partner might also say this just as an expression of affection in the context of a pleasant exchange of the partners. As another example, consider a partner who says "I love you and it really hurts me to see you struggle, I know this is really hard," versus "Honey, you know I love you, but I'm really tired of hearing this; this doesn't make any sense!" Although both statements include an expression of love, the first partner appears to be using it as a way to

convey acceptance, while the main message of the last statement is dismissing the patient's experience.

In making these decisions, be somewhat conservative; i.e., it should be fairly clear that the partner is using general statements such as "I love you" or good communication quality features in the service of conveying acceptance. Statements should carry an emotional component and seek to make the patient feel "unjudged" regarding their disorder rather than general statements of support, which can become habitual in conversation. To receive a rating higher than 1 for acceptance, there needs to be content in the statements of the partners that is considered acceptance. Nonspecific, more subtle behaviors that appear to be part of the broader message of acceptance will then be taken into account and likely increase the rating. That means that nonspecific behaviors that stand by themselves are not sufficient for a rating higher than 1 for acceptance; the partner needs to express identifiable content to substantiate a higher rating.

Ratings for the codes are made on a five-point scale.

5 – "A great deal"

For this highest score, a strong message of acceptance should come across from the partner. Regardless of other behaviors during the conversation, the partner should consistently try to be emotionally supportive, accepting, and show care and concern for the person. This will be your overall impression of the partner, supported by either persistent Acceptance statements, or fewer statements that come across with great strength and intensity.

3 – "Some"

For a rating of (3), Acceptance messages should clearly come across, but not as strong as described for a rating of (5). Partners who receive a (3) might make statements with lower frequency or intensity. Or, the partner might be less consistent throughout the conversation than would be required for higher ratings. That is, the partner might come across as very accepting and supportive at times, but critical and rejecting at others.

1 – "Very little"

The lowest score should be assigned if the partner shows no or only very few attempts without great intensity that would be considered Acceptance.

Ratings of 2 and 4 should be used to rate partners in conversations that would fall between the codes described above.

5. Accommodation

Accommodation is a set of behaviors that partners engage in to decrease or prevent the patient's anxiety. These behaviors, all focal to the patient's distress, can include participating in rituals, providing reassurance to the patient, assuming excess responsibilities for the patient, or assisting the patient in the avoidance of stress-inducing stimuli. The current code serves as a measure of the degree (i.e., frequency and extent) to which partners (a) actively accommodate patients during the conversation or (b) **either person** making explicit references to the partner's accommodating behaviors that occur outside of the current conversation during the couple's daily lives. Similar to the guidelines for Change Promotion, base your coding on the partner's report if s/he disagrees with the patient about an event surrounding accommodation.

Accommodation can be behavioral such as actually participating in rituals or providing reassurance.

Accommodation could occur **during** the conversation as providing reassurance following an obsessional thought the patient has (e.g., reassuring that they turned off the stove before leaving their home), participating in a ritual such as sitting in the chairs a certain way during the conversation, or actively helping the patient avoid anxiety producing stimuli such as germs in the room where the conversation currently is taking place. Reassurance is an attempt, whether successful or not, by the partner to decrease the patient's anxiety or emotional distress. Partners are not trying to reason with the patient or change his/her thoughts or beliefs about the world in a lasting fashion; rather, they are trying to calm them in the moment. For example, partners may say, "you are fine," "don't worry," or "nothing will harm you." References to accommodation **outside** of the conversation must be definitive to be considered accommodation; otherwise, such actions are viewed as support. Examples of outside accommodation include avoiding eating out so the patient does not have to use public restrooms; engaging in the patient's compulsions such as repetitive movements in certain numbers such as turning on and off the lights eight times or opening and closing the bedroom door twelve times; ordering or aligning household books or items such as picture frames in a specific way, or the partner preparing or touching raw meat to allow the patient to avoid this anxiety-provoking task. Whereas the partner and patient are not likely to use the term "accommodation" in describing what occurs outside of the session, the coder must be confident that the behavior meets the definition of accommodating behavior. For example, the partner might describe how he or she checks the doors in a ritualistic manner to make certain they are locked each night in order to appease the patient; this action would be coded as accommodation.

The degree to which coders consider the compulsions or accommodations described as absurd or inconvenient, as well as the partner's attitude or motivation toward the accommodation (e.g., the accommodation is upsetting to the partner, the accommodation is performed willingly by the partner with little distress, or the partner actively resents engaging in the accommodation behavior) should NOT be not be considered when assigning a code. The code is based only on the frequency and extent of accommodation. Partners should also be aware that they are accommodating the patient for it to be coded as Accommodation. If a patient admits that they lie to or manipulate their partners to avoid anxiety-provoking stimuli this may not be accommodation. For example, if a patient does not want go out to eat because the patient claims s/he does not like Mexican food and the partner concedes to eat at home, this is not Accommodation because the partner is unaware that the real reason they are not eating out is the patient's fear of large busy restaurants.

Ratings for the codes are made on a five-point scale:

5 – "A great deal"

For this highest score, the partner should accommodate for the patient at a high level; this would take into account frequently accommodating (many times per day), or for long periods of time during a single accommodation, either during the conversation or in references to daily activities. Regardless of other behaviors during the conversation, the partner could consistently reassure the patient, or actively help the patient avoid certain triggering stimuli. Or, if specific references are made to accommodating behaviors outside the conversation, such as participating in rituals, assuming excess responsibilities, or facilitating avoidance of triggering stimuli, they should meet

the same frequency and duration criteria as noted above. Even if the patient is not frequently asking for help, but the partner supplies a high level of accommodating behaviors when such situations do arise, a score of (5) should be awarded. Of interest is the total amount of accommodation, not proportion of compliance from the partner. This will be your overall impression of the partner's behavior, supported by either persistent accommodation statements or references, or a frequent willingness to accommodate the patient.

3 – "Some"

This rating globally should reflect a "moderate" level of accommodation to the patient's distress. For a rating of (3), accommodation messages should clearly be present, but not as strongly as described for a rating of (5). Partners who receive a (3) might make statements or perform actions with lower frequency. If references are made to accommodation outside the conversation, they may take less time than a rating of (5) would receive. For a score of (3), partners are accommodating without being asked do so less frequently than partners who score a (5); moreover, the focus is on total amount of accommodation, not percent compliance to the patient's requests. Again, this is your overall impression of the partner's behavior, and a rating of (3) should be given when partners are accommodating less frequently or for shorter durations.

1 – "Very little"

The lowest score should be assigned if the partner shows no or only very few attempts to accommodate the patient, either in the current interaction or in reference to everyday life.

Ratings of 2 and 4 should be used to rate partners in conversations that would fall between the codes described above.

Using these criteria, coders should assign a number according to the system described above; however, certain behaviors can change this anchor score up or down by one point. These special circumstances include:

- At a baseline or everyday level, the partner may not seem to accommodate much, but during a time of stress such as the holidays, a large project at work, or family stress, the partner does more for the patient. Increase the accommodation score by one point.
- The partner is accommodating more than the patient wants or asks for, such that the patient may feel their partner is taking away some of his or her autonomy, the partner is overprotective when the patient shows OCD symptoms, or the partner habitually accommodates without the patient asking. Increase the accommodation score by one point.
- The patient makes specific references to asking for accommodating behavior from their partner, and the partner refuses or offers resistance. Decrease the accommodation score by one point.

Additional Guidelines for all Codes

- Sometimes you might be unsure which one of two ratings you should assign for a code. However, if you really think that a partner's behavior places him between two scores, choose the more extreme one, away from a middle score. That is, if you cannot decide between a 1 and a 2, assign a 1. If you cannot decide between 2 and 3, assign a 2. For a

partner that falls between a 3 and a 4, assign a 4, etc. Do your best to determine which rating you think would be most appropriate, and make sure you do not fall back on this rule too quickly. Otherwise, one result would be that a rating of (3) becomes very unlikely, although this score should be taken into consideration just as the other ones as well. The bottom line is, make sure you use the full range of scores as appropriate, without a bias towards mid-range or towards extreme scores.

- At times, the same statements or set of statements of a partner may include behaviors that fall under different codes. In some cases, it may well be that "counting" a single statement for two different codes would be appropriate. For example, a partner might show acceptance for the difficulties a patient has had with OCD, but at the same time try to get her to change her behavior. If a given statement is relevant to more than one code, include it in rating all appropriate codes to which it applies.