From
“Obsessive Compulsive Disorders A Complete Guide to Getting Well and Staying Well' By Fred Penzel Ph.D

IF THE PERSON WITH OCD REFUSES HELP

The long-term results of not getting treatment have not been studied scientifically. My experience has been that those who do not get help may end up in one of three categories, depending on the severity of their symptoms. In the first category are those with mild and unchanging symptoms. For this group, not getting help becomes a quality of life issue. These sufferers can function, but the disorder probably takes the edge of their quality of life. In the second category are those whose symptoms are more serious, but which also remain at a steady level. They can find themselves settling for a poor quality of life, in which symptoms are tolerated despite great pain and inconvenience. I call these people the "walking wounded."

In the third category are those people whose symptoms may start out mild but gradually increase and become more intense over time. For OCD and BDD sufferers in this group, life steadily deteriorates as they become caught in a vicious circle of avoidance. Such individuals often end up housebound and unable to care for themselves, living only on disability payments and the charity of friends and family members. These untreated adults who live with their parents follow an unhappy course. They hang around the house unproductively and are a burden to their families. They live in constant fear of what will happen if their parents die or become disabled. The parents, of course, worry about who will help their adult child when they are gone. These ill adults will eventually become totally dependent on the state if they are not able to recover: not a pleasant prospect.

Unfortunately, there is not much family or friends can do with an Obsessive Compulsive Spectrum Disorder (OCSD) sufferer who shows no inclination to work at recovery or even go for help at all. Individuals have many reasons for not engaging in therapy. Some of the most common reasons for not seeking help are discussed in chapter 2, Only Commitment Brings Success, and this is by no means an exhaustive list. In general, most reluctant sufferers really want to recover; however, they want it on their own terms. They would like to get well, but don't want to feel anxious or uncomfortable, or have to confront their fears while doing so. Since this is not possible, they prefer to do nothing and stay as they are with their familiar discomforts. I often receive many anguished calls from family members asking, "How can I get this person to go for treatment? Every time I bring up the subject they get angry with me and won't talk about it". Another variation on this is, "I really think he/she needs help, but when I tell them I think they have a problem they totally deny it. They say that I'm exaggerating, and that they just have a few little problem habits that really aren't anyone's business." I even hear, "Is there some story we can make up to trick them into coming to our office?" Or, "Is there any way I can force them into therapy?" Or, even worse, "Do you think there is any way we can slip medication into their food without them knowing about it?"

When someone other than the prospective patient makes the initial phone call (children included), I tend to suspect a motivation problem. I typically ask, "Why are you calling me and not the person with the disorder?" In all fairness, some sufferers actually are

motivated but are too shy, ill, or reluctant to get things started. Many times, unfortunately, the prospective patient has not been consulted, is unaware that the call has been placed at all, and would be very upset if they knew about it.

I think the biggest problem here is that family and friends find it difficult to accept that no one can *make* someone else recover. I tell patients that "We can't want you to get well more than you do." Getting well takes a lot of hard work, even when a person is motivated. When a person isn't motivated, it is obvious that little or nothing is going to happen. I have seen people dragged into therapy through the use of threats, anger, blackmail, guilt, and deception. If the person is not willing, it almost always ends badly. Therapy should be viewed as an opportunity for an individual to grow and change willingly, not some form of discipline or punishment to be forced on those with problems. If even a small spark of hope or motivation is actually there, it can sometimes be fanned into a flame with the right approach, but if it isn't, being pushed to get help only leaves the sufferer with a lasting bad feeling about therapy and therapists.

However much we wish for someone to recover, we must still respect their rights to choose as individuals, no matter how wrong we think their choices are. Significant others will say, "How can I just stand there and watch this person I care for go down the drain?" It is understandable when family and friends refuse to take "no" for an answer. It is extremely painful to watch a loved one go unaided through the agonies of a mental disorder. Friends and relatives feel a profound sense of helplessness and despair. They believe that the only reason the reluctant sufferer hasn't responded to pleas to get help is because they haven't explained things correctly or strongly enough, or that the sufferer simply didn't understand or is staying ill on purpose. They imagine that if they plead, explain, or apologize just one more time and show how much they care, the sufferer will finally hear and be moved to seek help. The odds are that this will not happen.

When this doesn't work, some people move on to the use of anger and punishment to get the person to recover. This is seen particularly in situations where it is felt that the sufferer is staying unwell on purpose, in order to get even for past wrongs and resentments. Most people react to being pushed by resisting or angrily pushing back. This approach will only lead the sufferer to back away even further from getting help. Another common outcome here is that the stress of such an approach can stimulate symptoms, and actually make them even worse.

Even where kinder and gentler approaches are tried, the result may still be the same if the sufferer is unwilling or unready. I have seen some extremely loving and caring families wait patiently for the sufferer to come round. They are afraid to confront the sufferer, and yet their lives are controlled by the sufferer's symptoms. Years go by and nothing changes, except that the family ceases to live their own lives, becomes more burned out, and parents grow older with an adult invalid on their hands in their later years.

Family and friends need to disengage from the ill person's symptoms and concentrate on living their own lives more fully. This is not a new idea and comes from the treatment of drug and alcohol addiction. Relationships where a functional person has given up important parts of their own life and assumed the running and supporting of the life of a nonfunctioning person are known as "codependent." What you end up with in such relationships are two non-functioning people.

Significant others need to stop enabling the sufferer and quit acting as if they are responsible (unless the sufferer is a child). To accomplish this they may need to get some professional advice, as this is quite difficult to do alone, especially after years of anger, guilt, and bad habits. There is no point in feeling resentful for having to get help on the sufferer's account. When others are involved in the symptoms, and in effect run a sufferer's life, then they actually have a problem themselves. Blaming the sufferer, or oneself, will not help anyone. A good counsellor can help people disengage without feeling guilty, stop participating or assisting in rituals or other compulsions, and resist answering compulsive questions. If it is clear that the sufferer cannot and will not recover while being supported at home, they may have to move out or at least set a target date for doing so. The idea here is that if you cannot save them, at least you can save yourself. These last suggestions are probably the most difficult to consider or carry out. A therapist can help explain to the sufferer what is being done, without it appearing to be punishment. Sufferers may finally be willing to negotiate about getting help when they see that their supporters are serious and won't budge, but this cannot be relied upon. Further instruction in how to handle the sufferer's anger, resentment, and attempts at manipulation will also help. Most important, allow time to make this disengagement. It doesn't happen overnight. Remember that any behavioural change is gradual change.

An important exception to disengaging is when an individual is suicidal or making suicidal threats. This must *always* be taken seriously, and help must be sought *immediately*. Temporary psychiatric hospitalization is the best answer when suicide is a possibility. If the threat was serious, a life will have been saved. If it was only a manipulation meant to control others, it probably won't be tried again. Situations of this latter type, however, are relatively uncommon in those with OCSDs. One other important exception is where the sufferer's compulsions are posing some type of serious threat to their health. I recall one patient with contamination phobias, who had developed ulcers on his legs from standing at the sink and washing for many hours. As these were in serious danger of becoming gangrenous, hospitalization was judged to be a necessity for treating them, as well as his OCD. Other situations, where sufferers are starving themselves or using dangerous chemicals on their bodies, may also have to be dealt with in this way. I sometimes encounter desperate families seeking advice about how to voluntarily hospitalize someone who is reluctant to get treatment. I tell them that these are among the only justifications for involuntarily hospitalizing someone.

I would just like to make one further point about hospitalization. You can temporarily hospitalize someone to protect their life and health, but if you are seeking real treatment for their OCSD, you may have to take them to one of the specialized inpatient programs. Your ordinary local hospital probably won't be able to offer much beyond basic treatment with medications during a stay of a few days. Owing to the current state of health insurance coverage, it is unlikely that any more than a brief stay in your local hospital will be approved, in most cases. Extremely serious cases of OCSDs that cannot be treated on an outpatient basis will sometimes be able to get approval for more intensive inpatient treatment. Obtaining this approval may involve getting letters from specialists, as well as making a formal appeal to the insurance company. All this, of course, assumes that you have the sufferer's cooperation.

Your refusal to continue supporting the sufferer in their illness is not a guarantee that they will suddenly want to work at recovering. It is more of a guarantee that the people doing the supporting will have a life. It does happen at times that the sufferer cannot continue as they have in the past because the equilibrium of their illness system has been disturbed. It might even precipitate a move toward treatment when they finally see

that there is no other acceptable option. I am always reminded in such situations of a quote from the psychologist Rollo May, who said, "People only change when it becomes too dangerous to stay the way they are."

There are many good books on co-dependency written for the friends and family of substance abusers. The disorder may be different, but the issues are the same. There is also *Obsessive-Compulsive Disorder: A Survival Guide for Family and Friends* by Roy C., a helpful book specifically written for families of those with OCD (see appendix D).

NB: OCSD refers to Obsessive Compulsive Spectrum Disorders and includes other disorders as well as OCD.

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