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Research Paper

Intergenerational Transmission and Family Accommodation in Paediatric OCD: A Case Report from India

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ABSTRACT

This paper demonstrates an intricate instance of adult OCD (obsessive-compulsive disorder) in a mother, and consequently, the development of paediatric OCD in a son via proxy compulsions. The adult patient has acquired contamination-based OCD that occurred five years after exposure to a family member with OCD symptoms. Her compulsions became more severe and even more intruder to force her 9-year-old son to perform rites of a comparable nature, which included phobia of contamination, avoidance, and obsessive handwashing. Both were evaluated on Yale-Brown Obsessive-Compulsive Scales with the result showing severe in the mother and moderate in the child. Cognitive-behavioral therapy (CBT) with exposure and response prevention (ERP) and pharmacological therapy of the mother as well as developmentally-specific behavioral interventions and family psychoeducation. Inhibitory factors, such as medication adherence problems, culturally based contamination beliefs, family resistance, and avoidance in school were treated with the help of motivational interviewing, culturally competent psychoeducation, active participation in school, and a gradual exposure hierarchy. significant reduction in symptoms and functional improvement underpin the importance of family dynamics, accommodation reduction, and culturally adapted psychotherapy in the management of intergenerational transmission of OCD. This case is an example of pragmatic difficulties and efficient strategies to improve engagement, overcome obstacles, and assist long-term recovery in complicated OCD manifestations.

Keywords: *Intergenerational Transmission, Family Accommodation, Paediatric OCD, Case Report*

Obsessive–Compulsive Disorder (OCD) is characterized by intrusive obsessions and repetitive compulsions causing significant distress and functional impairment. Paediatric OCD prevalence is about 2–3%, with familial risk enhanced not only by genetics but also environmental factors such as observational learning and family accommodation [1,2]. Maladaptive behaviours are maintained by modelling the influential adults, especially where rituals are involved,[11] and family members may contribute to and even generate proxy compulsions performed upon family members, especially children [4,13]. Symptom chronicity and severity are further perpetuated by proxy compulsions

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where family members, particularly parents, impose compulsive behaviours on children. The insights into these dynamics are critical to develop culturally aware interventions that include the family unit to contribute to improving the treatment adherence and the best clinical outcomes in paediatric OCD.

CASE PRESENTATION

A patient, a 35-year-old woman, reported that she had observed a gradual onset of obsessive-compulsive symptoms over the past five years, with most of them being extreme fears of contamination, persistent hand washing, obsessive checking with mental counting and frequent change of clothes. Her symptoms were first manifested by a long-term exposure to a family member with obsessive-compulsive disorder, whose cleaning and arranging actions she often witnessed and then followed. Her symptomatology was stable, and the avoidance patterns were projected into the areas of population and specific social groups of the perceived contaminants.

The patient denounced spending excessive time on the issue of hygiene, including changing clothes several times each day; cleaning home items with great care after touching potentially contaminated objects. She showed great distress when exposed to some people who were involved in jobs that were considered to be unclean, and she was afraid that things touched by these people were contaminated. Such beliefs were supported by family life because her mother encouraged her to be careful and engage herself in rituals of cleanliness. Despite pharmacological treatment attempts, her symptoms persisted and intensified, adversely impacting her occupational, social, and familial functioning. Her mood deteriorated, with concomitant fatigue, disrupted sleep patterns, and withdrawal from previously enjoyed activities.

The patient’s nine-year-old son began exhibiting ritualistic behaviours mirroring those of his mother, including prolonged bathroom use before school, avoidance of public toilets, compulsive handwashing, and repeated changing of clothes accompanied by verbalizations expressing contamination fears. These behaviours resulted in school refusal and academic decline, compounded by increased reliance on electronic devices and social withdrawal.

Family dynamics contributed to the child's symptom perpetuation, with maternal enforcement of cleanliness rituals and limited paternal emotional involvement. The child's distress was amplified by inconsistent caregiving and punitive responses, which heightened symptom severity and hampered autonomy development.

Comprehensive clinical assessment confirmed the diagnosis of obsessive-compulsive disorder in both individuals, with the child’s symptoms directly linked to modelling and proxy compulsions enacted by the mother. Both patients were engaged in a multidisciplinary treatment plan incorporating pharmacotherapy, cognitive-behavioural therapy tailored to developmental needs, parental coaching, and school-based support to facilitate symptom reduction and functional recovery.

Clinical Assessment

The Yale-Brown Obsessive-Compulsive Scale (Y-BOCS) was used to measure maternal severity at a baseline (32 - severe), and the Children Yale-Brown Obsessive-Compulsive Scale (CY-BOCS) was used to measure child severity (22 - moderate).

Structured psychiatric assessment excluded comorbidity. [1] Cognitive assessment revealed the presence of inflated responsibility and catastrophic thinking in the mother, and the child had avoidance behaviors that were caused by anxiety [9,10].

RESULTS

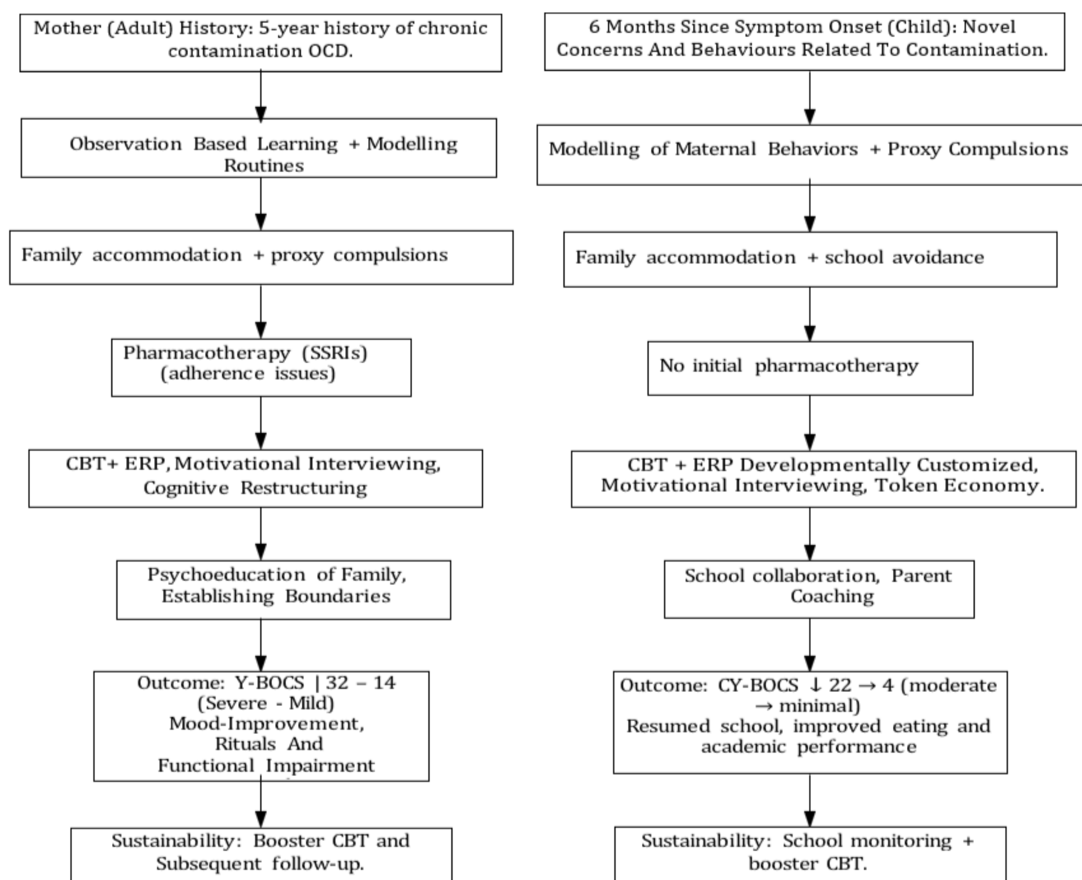

Figure 1. Summary of Clinical Course, Interventions and Outcomes of Mother-Child dyad with Contamination OCD.

Figure 1 shows the clinical process and treatment of the mother and her child and improvement of the symptoms in terms of Yale-Brown Obsessive-Compulsive Scales. (File Attached)

DISCUSSION

This case raises some vital themes in the management of obsessive-compulsive disorder (OCD), especially in issues of treatment adherence, family-related issues, cultural context, and systemic issues.

Medication Adherence

Side effects affected the initial pharmacological compliance and resulted in intermittent medication intake. The use of motivational interviewing helped shift the focus to the benefits of treatment instead of side effects to enhance compliance significantly. This highlights the relevance of patient-centred and collaborative adherence interventions in OCD care.

Family Accommodation and Proxy Compulsions

Family accommodation, particularly, proxy compulsions that the mother had to enforce on her child, became one of the central cohesive factors of symptoms. Restructuring family roles and determining boundaries were found in therapies that focused on minimising accommodations, which is consistent with evidence that accommodation correlates with the severity of symptoms and the likelihood of relapse [4,5,7,13]. Strategies that were developmentally adapted (reinforcement-based and child-centered communication methods) improved engagement and adherence to exposure and response prevention (ERP)[2,16,17].

Cultural Context

Contamination fears manifested and endured largely due to cultural beliefs. Culturally sensitive psychoeducation that respects these beliefs and balances the respect of family and social norms with empirically based treatment models was associated with therapeutic success. In hierarchical relationship patterns of most Indian families, accommodating behaviours are usually accepted as caring and, in this context, tend to mask pathological patterns and prompt intervention [13,14].

Overall Barriers and Creative Solutions.

The unavailability of mental health professionals and access to evidence-based psychotherapies, such as CBT and ERP, are significant issues in different parts of India. Possible ways to address gaps in treatment include scalable options, including those that are group-based, school-based, and tele psychiatric and lay-counsellor-guided, which have the potential to increase treatment accessibility and care reach [6,7,14]. Nevertheless, they need context-sensitive changes to overcome the challenges such as digital literacy, stigma, and resource limitations.

Clinical Implications

This instance endorses cognitive-behavioural models of the significance of reinforcement and family accommodation in the perpetuation of OCD [18,19,20]. When implemented in a manner that is family-inclusive, as seen in programmes, such as the Supportive Parenting for Anxious Childhood Emotions (SPACE), these interventions are found to be promising at reducing accommodation behaviours, and this occurs especially in low-resource environments. Permanent follow-up and booster sessions as evident in the six months remission in the current case are critical to sustain therapeutic gains and prevent relapse.

Perspective on Public Health

In addition to the personal and family treatment, the systemic public health activities such as parent support groups, community mental health education and incorporation of mental health resources in the schools are needed. These methods have the potential to minimise stigma, positively impact early diagnosis, and improve the long-term prognosis of OCD-impacted families in cultures with complicated cultural backgrounds [20].

Table 1. Mother and child showed significant improvements after individualized CBT with ERP and family-based therapies. The use of medication adherence, cultural and family relationships, and school engagement resulted in minimal symptom severity, recovered functioning, and sustained gains as outlined in the integrated clinical summary (File attached).

Domain	Mother	Child (Master)
Symptoms	Obsessions of severe contamination; washing and counting; changing of clothes; avoidance of social places.	Fear of contamination; lengthy washroom procedures; handwashing; avoidance of school, repetitive change of clothing.
Etiology	Family-member observational learning; family accommodation; cultural contamination beliefs.	Compulsions indirectly caused by the mother; imitated maternal ceremonies; family accommodation.
Duration	5 years, chronic	6 months, recent onset
Functional Impact	Low mood; sleep disturbance; impairment of household and social functioning	Academic deterioration; social isolation; excessive screen time.
Assessments Used	Y-BOCS score: 32 (severe)	CY-BOCS score: 22 (moderate)
Pharmacotherapy	SSRIs prescribed; adherence issues; supervised adjustments	No pharmacotherapy initially
Psychotherapy	CBT with Exposure & Response Prevention (ERP), mindfulness, motivational interviewing, cognitive restructuring	Developmentally tailored CBT & ERP, token economy, motivational enhancement
Family Intervention	Psychoeducation; reduce accommodation; spouse involvement; boundary-setting	Parent coaching to reduce accommodation; coordinated school interventions
Challenges	Pharmacological side effects and compliance; cultural stigma; family conflict, entrenched rituals	Child noncompliance; school avoidance; parental overinvolvement; behavioural rigidity
Solutions Applied	Motivational interviewing; culturally sensitive psychoeducation; marital therapy; hierarchical ERP.	Friendly interaction with the children; reinforcement; liaison with the schools; gradual exposure
Post Treatment Outcome	Y-BOCS decreased to 14 (mild); positive mood and household functioning; less rituals.	CY-BOCS dropped to 4 (minimal); resumed school eating; improved relating and academics
Sustainability	Periodic booster; the constant psychiatric follow-up.	Booster CBT; parental coaching follow up; school follow up.

Learning Points for Clinical Practice

- Family accommodation and proxy compulsions should be actively targeted in order to maintain the changes made in the paediatric obsessive-compulsive disorder. Symptom-sustaining and relapse-prone intervention reduces familial enabling behaviour.
- Psychoeducation that is culturally sensitive and unique interventions increase treatment acceptance and overcome resistance to exposure and response prevention (ERP), especially in sociocultural complex settings. Engaging patients and families respectfully helps to address cultural beliefs.
- Motivational interviewing and behavioural reinforcement is important to enhance cooperation and active participation in therapy, particularly in ambivalent or resistant patients to treatment. These measures help in compliance with pharmacotherapy and psychotherapeutic programs, maximizing clinical results.

Declarations

- Patient Consent: Written informed consent was obtained from the index patient and the child's legal guardian for clinical assessment and publication.
- Ethics Approval: The Institutional Ethics Committee approved the study protocol.
- Conflict of Interest: None declared.
- Funding: No external funding was received

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Conflict of Interest
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