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Parent Training in Nonviolent Resistance for Adult Entitled Dependence

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"Adult entitled dependence" is a condition characterized by the extreme dependence of grown children on their family and by levels of dysfunction, seemingly excessive in light of their apparent capacity to function. The family and the dependent adult become involved in an interaction in which the very attempts to alleviate the problem may aggravate it. Parent-training in nonviolent resistance (NVR) is an intervention that has been shown to be helpful to parents of behaviorally disturbed youth. Parent training in NVR offers parents means to shift away from a stance of helplessness toward realistic goals that are accomplishable without the collaboration of their offspring. We report on the parents of 27 entitled dependent grown children who participated in parent training in NVR. Additionally, we present 2 detailed case studies that exemplify the problem and the therapeutic process. Before treatment, the dependent adults were not working or studying, drew heavily on parental services (financial or otherwise), and were resistant to parental attempts to change the situation. Most parents succeeded in overcoming their helplessness and reducing the provision of parental services. In a considerable proportion of cases, the grown children started working or studying or moved to independent lodgings.

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ADULT ENTITLED DEPENDENCE

Low functioning grown children who are highly dependent on their parents are a growing phenomenon in many parts of the world. This trend is reflected in the coining of many special words to describe the situation: In Japan they are called

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"Hikikomori" (Malagon, 2010), in Italy "Bamboccioni," in Germany and France "Tanguy Syndrome" (Janne, 2007), and in England (Finlay, 2010) "NEET" (not in employment, education, or training) or "Kippers" (kids in parents pockets eroding retirement savings). In Canada, they are termed "Boomerang Children" (Ravanera, Rajulton, & Burch, 1995; Settersten, Furstenberg, & Rumbaut, 2005), in Austria "Mamma's Hotel Children," and in South Korea, they are known as "Kangurus."

In the Unites States, the phenomenon has been given various names including the "Full Nest Syndrome" (Schnaiberg & Goldenberg, 1989; White, 1994) and "ILYA" (incompletely launched young adult). The phenomenon was also brought to popular attention under the name "Failure to Launch," in a movie by the same name in which parents hired a "relationship expert" to help lure their 35-year-old son away from their all too comfortable home and toward independence.

In Greece, Italy, Portugal, and Spain, well over half of all young adults currently live with their parents (Giuliano, 2007). In the United Kingdom and North America, rates are significantly higher compared with past decades (Berrington, Stone, & Falkingham, 2009; Settersten et al., 2005), and in Japan, there are estimated to be millions of self-isolating and dependent adults who have aroused considerable social and financial concern (Teo, 2010).

Temporarily living at home and receiving help from one's parents may be a normative phase that allows the young person to find his way in life. In many cases, however, the transition to fully autonomous functioning does not occur or is reversed after an abortive attempt at independence (Goldscheider & Goldscheider, 1998, 1999) leading to chronic dependence on parental support.

Alongside individual and family characteristics, a number of sociocultural factors may contribute to the spread of overly dependent grown children: (1) Modern society's prolongation of adolescence as a period of search for personal, professional, and social identity creates a situation in which it is less and less clear when the young person should be expected to function independently (Arnett, 2007); (2) the belief that every person should find a career that perfectly suits his personality sanctifies the right for a personal search that may at times become interminable (Collin & Young, 2000; Twenge, 2006); (3) the decrease in traditional parental authority makes parents less able to set demands and limits (Omer, 2011); and (4) the spread of computer technology presents people with the temptation of a virtual life that satisfies their needs for entertainment and occupation without exposing them to the wear and tear of the "real world" (Shaw & Black, 2008).

The affluence of the western world may allow some families to sustain adults who do not work without experiencing excessive financial burden, but research has indicated that parents of higher socioeconomic status express greater levels of dissatisfaction with the situation, perhaps holding higher expectations for financial independent success (Aquilino, 1990). Although culture-specific factors presumably impact attitudes toward staying at home, it would appear from the data presented above that both collectivistic societies that emphasize strong family ties and individualistic ones that emphasize personal choice in career development may foster dependence in today's world.

The diagnostic characteristics of dependent adults are probably quite varied. They may suffer from social phobia, obsessive compulsive disorder (OCD), depression, conduct disorder, attention deficit hyperactivity disorder (ADHD), learning disabilities, or none of the above. The parental complaints, however, are often very similar,

usually including school drop-out, work avoidance, demands for money and other services, immersion in the computer, and inversion of the night–day cycle. We refer to this condition with the term *adult entitled dependence* (AED). This is a chronic condition involving a dysfunctional adult offspring and at least one parent who accommodates to the pattern of dependence by providing age-inappropriate services. AED is distinct from simply living with parents or enjoying their support as is widely accepted in many cultures, and is characterized by impaired functioning and by parental services which are beyond the norm for the given culture.

The family often seems caught in a vicious cycle in which the very attempts by the dependent adult or his parents to alleviate the condition actually aggravate it. Table 1 exemplifies these loops.

For example, he may try to alleviate his distress by pressing for more parental protection and services. However, the increased protection and accommodation can actually reduce his ability to cope independently. The parents, in turn, feel obliged to come to their child's rescue, but the more they do so, the less he is able to function. Occasionally, frustration may lead a parent to pose impulsive and rigid demands. The dependent adult responds in kind, escalating his behavior, perhaps through an exhibit of violence or suicidality, after which the temporary bout of "tough parenting" usually recedes. Escalation thus adds another turn of the screw to the family trap.

Numerous theoretical and clinical approaches have been suggested over the years to describe and treat dependence within the family. Where much of psychology and psychiatry has stressed the disordered individual and focused on nosological categories such as depression, anxiety, or dependent personality disorder, family-based approaches such as the Family Systems Theory (Kerr & Bowen, 1988) and Structural Family Therapy (S. Minuchin, 1974) have focused on the interpersonal aspects of the condition. Concepts such as flexibility and rigidity of family structure (Olson, 2011) and interpersonal boundaries and alliances (P. Minuchin, 1985) have been suggested to explain the dysfunctional behavior of individuals within the family context. Accordingly, family models have taken an interpersonal systemic approach to treating such situations, focusing on the communicative and relational rather than on the individual. In the current report, we both draw on such formulations and diverge from them. AED can only occur within the context of a family (or analogous) system, but the clinical approach detailed below attempts to promote change through work that is

TABLE 1
Examples of Mutually Reinforcing Dependent Behavior and Accommodation

Dependent Behavior	Accommodating Behavior
Explicit or implicit demands for money, goods, or services	Supply of money, goods, or services
Demand for continuous reassurance	Providing continuous reassurance
Aggression and victimization	Submitting to aggression and victimization
Blaming	Feeling and expressing guilt
Use of parent as a go-between and moderator for communicating with the external world	Providing communicative and other links to external reality
Maintaining a paradoxical, "present yet alienated" attitude toward the parents: "I am here all the time but I will reduce contact to a minimum"	Accepting dependant's presence while avoiding contact

conducted exclusively with the parents. The goal is to create change in the family system, through the actions of part of that system.

Another context in which accommodation to the demands of dysfunctional relatives has been researched extensively is that of (OCD). Accommodation in OCD (i.e., supplying reassurance, participating in rituals, etc.) has been linked to more severe symptoms (Merlo, Lehmkuhl, Geffken, & Storch, 2009) greater impairment (Storch et al., 2010), and worse treatment outcomes (Ferro et al., 2006). Although AED is not directly related to OCD specifically, family accommodation constitutes a related phenomenon of parents supplying services and resources that actually serve to reinforce the unhealthy behavioral patterns. Some families report coercive behaviors on the part of the OCD individual aimed at imposing accommodation on parents (Lebowitz, Omer, & Leckman, 2011; Lebowitz, Vitulano, & Omer, 2011; Lebowitz, Vitulano, Mataix-Cols, & Leckman, 2011). Furthermore, research has indicated the presence of significant populations of chronically dysfunctional young adults with various diagnostic labels who pose considerable burden to themselves and society (Pepper, Kirshner, & Ryglewicz, 2000). The present formulation applies the notion of accommodation to dependent adults, independent of the diagnostic criteria for OCD or other nosological categories.

NONVIOLENT RESISTANCE

Nonviolent resistance (NVR) offers a possible way out of the trap of dependence. The approach, originally developed in the sociopolitical sphere, refers to the practice of achieving goals through symbolic protests, disobedience, public opinion, and other nonviolent means (Ackerman & Kruegler, 1994). Made famous by such leaders as Mahatma Gandhi (Gandhi & Iyer, 1986) and Martin Luther King Jr. (King, 2003), the approach has been implemented in many political arenas including Iran, the Philippines, Czechoslovakia, Chile, and Georgia (Roberts & Garton Ash, 2009).

Nonviolent resistance has more recently been adapted for various other contexts including violence against women (Schmidt, 1995) and aggressive behaviors of children and adolescents (Omer, 2001, 2004). While other approaches, such as Strategic Therapy (Haley & Richeport-Haley, 2003), cognitive behavioral family therapy (Dattilio & Epstein, 2005), and other behavioral approaches (Kazdin, 1997), share with NVR a focus on practical, limited goals and directive interventions by the therapist, NVR draws on unique philosophical roots, which lead to particular steps and implementations.

Parent training in NVR has been manualized (Ollefs, Schlippe, Omer, & Kritz, 2009) and in a randomized wait-list-controlled trial involving the parents of 41 children with acute behavioral problems (Weinblatt & Omer, 2008), parents who received training in NVR showed reductions in parental helplessness and escalatory behaviors, and improvements in perceived social support. Children of parents who received the training exhibited significantly less negative behaviors compared with children of parents who did not undergo NVR training as measured by standard screening tools such as the Child Behavior Checklist (Achenbach, 1994).

These findings suggest that NVR might be relevant for families with AED. As far as we know, this is the first systematic report on the use of any parent-training method with a population of highly dependent adults. The recommended strategy for building an evidence base for a new treatment is to show preliminary effectiveness in a series of cases before undertaking controlled studies (Bruce & Sanderson, 2005;

Edwards, Dattilio, & Bromley, 2004). Accordingly, we present a series of cases in which NVR was implemented to address AED.

METHOD

Clients

The authors of this report are psychologists experienced in parent training in a variety of contexts, particularly disruptive behaviors and anxiety disorders. Our group, located in Israel, maintains a parent training clinic at Israel's leading children's hospital where parent training in NVR is offered to parents of youth with severe behavioral disturbances.

As our NVR program for the parents of aggressive and self-destructive children and adolescents became known by professionals and the wider public, we began to receive referrals of parents of adults with similar problems. We soon witnessed that the AED pattern characterized many of these families. Eventually, we established a team of five trained clinical psychologists devoted to investigating and treating this phenomenon.

There are no data on the prevalence of dependent adults in Israel, although the topic has garnered some media attention in recent years. Throughout this article, we use the masculine when referring to the dependent adults because of a preponderance of males in our sample. It is not clear to what extent this is a bias of the sample, but in Japan, the majority of Hikikomori are also reportedly males (Sakai, Ishikawa, Takizawa, Sato, & Sakano, 2004) and in other countries such as Italy, more adult men than women live with their parents (Giuliano, 2007).

Parents were offered training in NVR in cases characterized by the presence of a low functioning adult child (e.g., unemployed, sleeping for most of the day, self-isolating) and by demands for age-inappropriate parental services backed by threats in case of noncompliance.

Twenty-seven families met these criteria and are included in this report. There were eighteen heterosexual couples and nine single parents including four divorced mothers, one divorced father, and four widows. Based on parents' self report, 10 families (37%) had high income, 13 (48.1%) had medium income, and the remaining 4 (14.8%) had low income.

The dependent adults were predominantly male (23 out of 27). The age range was 18–47 (M = 26.8; SD = 7.4). Nineteen (70.3%) had completed 12 years of school, but only 14 (51.8%) had graduated. To their parents' knowledge, eight of the dependent adults (29.6%) had ever been involved in a romantic relationship and the same number had outstanding financial debt. Although they would probably meet the diagnostic criteria for a number of different conditions, we cannot provide a formal breakdown by diagnoses because we have not met the dependent adults.

Treatment

Parental training in NVR has been described elsewhere in detail (Omer, 2004) and, in brief, includes the following elements:

Focusing on resistance rather than control

Parents' role is to nonviolently resist negative behavioral patterns; however, they cannot dictate to the adult what to do with his life. Accepting the limitations on the

scope of one's own control and focusing on those things that fall within that sphere of influence is the starting point for all nonviolent struggles.

Parent training in NVR includes a broad set of resistance techniques such as:

- Delivery of a formal announcement declaring the intent to resist unacceptable behaviors.
- Performance of parental "sit-ins" through which parents can express their commitment to change and dissatisfaction with current conditions.
- Documentation of violent or aggressive episodes and publicizing them to supporters.
- Refusal of services and the systematic planning of a decided nonviolent response to threats and violence.

Anti-escalation training

Parents come to recognize their own escalatory patterns and learn ways of countering them. Anti-escalation strategies include: The principle of delayed response to negative behaviors (illustrated by the phrase "Strike while the iron is cold!"); Avoidance of a dominance-oriented stance (captured by the phrase "You don't need to win, but only to persevere!"); Avoidance of arguments and "ping-pong interactions"; Release from the compulsion to retaliate and development of self-control as a sign of strength. Parents are also encouraged to make unilateral conciliatory gestures, which serve to remind both the parents and the adult child that the steps are "for him" as much as "to him." Simple representative phrases such as the ones cited above are part of the NVR dialog and can help parents grasp an idea in a way they can retrieve and utilize even when under stress.

Creating a network of support

Rallying public support is basic to all manifestations of NVR both in the family and in the social arena. Parents are asked to create a broad list of potential supporters including family, friends, acquaintances, and any person who they feel might potentially be willing to become involved to even a minor degree. These are then contacted, the situation is explained, and an invitation is extended to meet with the therapist to learn about NVR and to voice any apprehensions.

Treatment lasted between 12 and 25 sessions. Initially, the sessions were held once a week, but as treatment progressed, they were spaced out.

Measures

A structured rating form, comprised of forced choice questions, was used to document the problems reported by the parents and to describe the treatment goals. Parental distress, social support, and relationship with the child were also assessed. Ratings were made at the beginning of treatment and when the parents felt they could continue on their own, or reduce their sessions to less than once a month. The therapists were instructed to base their ratings on the parents' explicit reports.

In an effort to minimize risk of positive bias inherent in having therapists complete the outcome measures, a number of steps were taken. Therapists were urged to complete the forms as objectively as possible, basing their report on facts the parents had explicitly reported to them. After the initial ratings had been performed, therapists were asked to review the forms looking for any possibility of having overstated

improvements. In cases of doubt, the therapists telephoned the parents and asked their opinion. A number of downward corrections were made after this process.

Data Analysis

Descriptive statistics pertinent to the dependent behavior of the adult children are presented. Wilcoxon's matched pair test was employed to test for significance of differences in the dependent behaviors, McNemar's chi-square for differences in occupational status, and Pearson's chi-square for changes in residential status.

RESULTS

Table 2 presents changes in the dependent adults' residential and occupational status before and after parent-training. McNemar's chi-square test showed a significant shift from "not working" to "working", indicating more adult children were employed after parent training (p = .22). Pearson's chi-square showed a nonsignificant trend toward more independent living accommodations ($\chi^2 = 1.5$, $df = 1$, $p = .214$). Other behaviors of the dependent adult child such as leaving the house, participating in chores, reversing the night/day cycle, or seeing friends also showed significant improvements and are summarized in Table 3.

Parents reported reduced parental accommodation in key areas such as doing the adult child's laundry, supplying a car, or cooking specifically for him. Table 4 presents these changes. Table 5 summarizes treatment goals set and achieved for the 27 participating families.

An additional finding was an almost complete absence of extreme reactions and adverse effects that parents feared. To wit: (1) there were no reports of suicidal or self-injurious behavior; (2) there was one case of involuntary hospitalization of a dependent adult who suffered from paranoid schizophrenia; (3) one dependent adult reacted with depressive symptomatology, taking to bed for 2 weeks (after this time, he went to work part-time); and (4) there were two cases in which the dependent adult temporarily stopped communicating with the parents for a few months. It should be emphasized that the parent training includes detailed instructions on how to cope with threats without giving in, minimizing them, or escalating.

TABLE 2

Occupational and Residential Status of Dependent Adults Before and After Parent Training ($N = 27$)

	Before (*n*)	**After (*n*)**
Residential status		
With parents	20	15
Separate lodgings	7	12
Occupational status		
Full time	1	4
Part time	3	8
Does not work	23	15

Note: Most of the young adults living in separate lodgings were living in quarters owned or paid for by their parents.

TABLE 3
Behaviors of Grown Dependent Child Before and After Parent Training in Nonviolent Resistance (Parent Report)

	N	Mean Before	Mean After	Wilcoxon Signed-Rank Test (*Z*)
Does the dependent adult fulfill home duties?	13	1.54	2.15	2.17*
Does he leave his room to other parts of the house?	12	3.25	3.42	1.0
Does he regularly lock the door to his room?	12	2.58	1.5	−2.39*
Does he allow others access to his room?	24	1.92	2.46	2.07*
Does he reverse his diurnal cycle (awake all night/ asleep all day)?	21	2.71	1.86	−3.44***
Does he leave the house?	24	3.08	3.75	2.54*
Does he use any means of transportation?	24	2.75	3.50	2.43*
Does he take over public space in your shared household?	13	2.38	1.69	−1.98*
Does he dictate rules to other household members?	13	3.00	1.92	−2.72**
Does he eat meals with the family?	13	2.23	2.62	1.5
Does he have outbursts of rage?	27	2.63	1.78	−3.36***
Does he use violence?	26	2.08	1.19	−3.37***
Does he threaten others?	26	2.27	1.38	−3.05**
Does he steal from you?	26	1.31	1.08	−1.27
Does he comply with your requests?	20	3.30	1.50	−3.78***
Does he use drugs?	21	1.67	1.43	2.23*
Does he have social ties?	25	1.92	1.88	−0.42
Does he meet friends?	27	2.15	2.63	2.41*

Notes: All questions are forced choice with a range of 1–4.
*$p < .05$. **$p < .01$. ***$p < .001$.

TABLE 4
Parental Accommodation Before and After Treatment ($N = 27$)

Supplied Services	Beginning (*n*)	End (*n*)
Cooking (specifically for dependant)	14	4
Laundry services (specifically for dependant)	15	5
Providing dependant with family car	12	6
Driving dependant places on demand	10	4
Giving dependant money	22	11

The following case reports illustrate the process in detail. These cases were chosen because they exemplify both the techniques used in the NVR parent training and the complexity of the process. The cases illustrate some of the challenges that therapist and family face, and the need to accept partial and often very gradual progress rather than focusing on "all or nothing" goals and outcomes.

Case 1

Eli and Myra, the parents of George (18) and Gina (13), asked for help with George's self-isolation. They described him as an intelligent and sensitive person who had been

TABLE 5
Intended and Achieved Treatment Goals for 27 Participating Parents

Treatment Goal	Intended (*n*)	Achieved (*n*)
Parent-centered goals		
Defend themselves better against verbal and physical violence	20	20
Reduce financial support	17	15
Reduce conflicts	16	16
Create a space for individual and marital activities	6	6
Develop ability to withstand demands for control and services	22	19
Re-establish communication	11	8
Dependant-centered goals		
Increase independent functioning	22	17
Move to separate home	9	5
Reduce self isolation	15	10
Return to work cycle	14	10
Return to studying	13	5
Improve social life	11	4
Increase financial independence	14	10
Reduce outbursts	12	10
Participate in household chores	9	6
Reduce depression and anxiety	12	8

Note: Describes the number of cases in which each parental goal was achieved relative to the number of families in which the parents regarded the given goal as relevant.

a good student with an active social life, and with whom, until recently, they had shared a warm and close relationship. About a year before the beginning of treatment, George developed a deep aversion to Gina. He avoided staying in one room with her or touching any object that might have been touched by her. He would curse her and complain about her presence in the home. George's aversion gradually developed into a rigid set of rules that were imposed on the whole household. His clothes had to be laundered separately, the air-conditioning had to stay off because it might contaminate the air in his room with Gina's breath and he refused to eat any food that came out of the kitchen. He demanded a private refrigerator in his room and his mother had to bring him food from outside the house. He would only go out occasionally when his mother took him in her car, but she had to guarantee that Gina would never sit on the front-seat that was reserved for him. George developed a similar aversion toward his father, blaming him for ruining his life. He called him "pedophile" but refused to say why. He would not leave his room, unless Myra guaranteed that he would not see his father. George stopped going to school, severed all social ties and inverted his diurnal cycle.

After many failed attempts to get in touch with his son, Eli became resigned. In the first session with the therapist, he burst into tears, saying: "It's been 6 months since I last saw my son. I don't remember what he looks like!"

George rejected professional help, stating that the real problems were his father and sister. The parents in turn felt that nobody could help them and kept their situation a closely guarded secret.

The therapist explained to the parents that George was probably suffering from OCD. He added that accommodation to his demands, though stemming from love and compassion, exacerbated George's condition. He suggested using NVR to resist the "tyranny" of George's OCD over the family.

The parents were informed of the importance of having a network of supporters to help them in their struggle. Despite initial unwillingness to lift the veil of secrecy, Eli talked to his brothers and to a couple of friends and was surprised by their warm reaction. In the supporter meeting that took place a few weeks later, 17 people participated. Eli and Myra felt a surge of energy at the impressive commitment displayed by the group.

Nonetheless, as the details of the upcoming struggle became clearer, their initial optimism gave way to paralyzing fears. Myra was terrified that any challenge to the status quo might cause George to suffer a psychotic break or possibly even lead to his suicide. Eli feared that renewed friction between himself and George could lead to physical violence. It soon became clear that Myra was too apprehensive to act, so the focus shifted to enabling Eli to undertake the first steps unilaterally. Eli objected: "I will do nothing without Myra's agreement!" Myra smiled ironically and said: "And I will do nothing without George's agreement!" Myra's words had a provocative edge, which gave an opening to the therapist. He said: "I think Myra is aware of the absurdity of the situation and may be asking us to challenge it. She was being ironic when she said that she would do nothing without George's agreement. She has already said that she is overburdened with George's demands and would like nothing better than getting your help in dealing with the problem. I think she is now telling us that if you take the initiative, she will be able to cope with that!" Myra nodded approvingly. The therapist then added to Eli: "I think you should act to reclaim your fatherhood!" Eli reacted warmly.

The parents came to the following session with an astounding proposal: Myra would travel abroad for 10 days, leaving the field open for Eli's initiative. She offered not to participate in the sessions in which a plan of action was being prepared, so that her emotional reactions would not hinder the process. Eli came to the meetings with a brother and two cousins, who would be his immediate supporters in the operation. The plan was: Eli would enter George's room (by force if necessary) on the very day of Myra's flight abroad and stay there until the situation calmed down. He would unilaterally break the communication taboo, abolish the sterile rules that had been imposed on the house, and declare he would resist George's abuse against him and Gina. The three supporters would be in the house and help him in case of need.

When Eli entered the room, George protested loudly and tried to push him out. The supporters drew closer to prevent the situation from deteriorating into outright violence, whereupon George started yelling: "He's a pedophile!" All the supporters took turns staying in the room with George, sometimes with Eli and sometimes without. After two hours, George was ready to talk. When he again called his father a pedophile, his uncle told him: "If you say this again, I will call the police and you will be required to make a formal statement." By the end of the day, George was talking to his father, without looking him in the face. He agreed to leave the house every day, to buy food for himself, and to allow Eli to enter the room when he knocked. Eli and the supporters were surprised to discover that George's refrigerator had been completely stocked by his mother before her trip. She had done this without telling Eli.

When Myra returned, she followed Eli's example in resisting some of George's rules. She told him she no longer forbade Gina's sitting in the front seat. George protested, but did not boycott the car. After the parents showed him written documentation of his verbal abuse of Gina and stated that they would share the documentation with the supporters if it was repeated, the abuse ceased.

In the following weeks, George started going out every day, met with friends, began taking driving lessons, and eventually passed his driving test. He still refused to look his father in the eyes or to initiate any conversation with him. However, he always answered and sometimes a short conversation developed.

Five months later, George started his military service, finished basic training successfully, and was given a responsible job in the military working with computers.

Case summary

With the help of the therapist and social support, including a supporters meeting, the parents were able to overcome their initial ambivalence and fears. Through decided action, including ending the acquiescence to obsessive compulsive rules, cessation of services that enabled isolation, breaking long standing taboos such as entering "forbidden rooms," refusal to be drawn into argument, and involvement of outside supporters, change was accomplished. Changes included reduced isolation, increased independence, less hostility, and improved well being for parents.

Myra's behavior before leaving on her trip illustrates the split loyalty in which she was caught: on the one hand, she flew abroad to allow for Eli's initiative; on the other hand, she left a well-stocked fridge increasing George's ability to resist and self isolate. In our experience with similar situations, this kind of partial and ambivalent collaboration by one parent is quite typical. The NVR principle of focusing on gradual steps and accepting multiple conflicting motivations allows for such ambivalence. By acknowledging the right to remain ambivalent, rather than demanding total commitment, initial steps can be taken, which in turn can raise confidence and strengthen motivation for further steps.

Case 2

Simon and Silvia described their son Ben (26) as delicate and conscientious. He lived at home, worked sporadically when opportunity presented itself and studied inconsistently. He went to the gym a few times a week, but mostly stayed in his room, lying in bed or at the computer. Ben felt ashamed when meeting with friends who, in his eyes, had already achieved something in their lives. His parents gave him a car, hoping that this would encourage him to go out, but he used it only to go to the gym. On rare occasions, when the parents dared to make any demands, Ben reacted aggressively, which was doubly frightening because it seemed so out of character.

Simon would invite Ben to go to a restaurant with him once a week to keep the parent–son relationship alive. Ben came willingly, but would block any attempt at personal or challenging conversation. If asked about his plans for the future, Ben would answer: "You will see, I will still surprise you all!" Or "I know that the right thing for me will come along!"

Ben's parents were terrified of doing anything that might disrupt the delicate fabric of their relationship with him. They feared that taking a firmer stance would lead to a deep rupture or further damage Ben's condition. They would have gladly sent Ben to individual therapy for as long as necessary, but he refused to even consider the option.

When the therapist broached the topic of practical steps that would need to be taken, such as delivering a written announcement, mobilizing supporters, or discontinuing internet service, Silvia was horrified. Simon was highly skeptical of Ben's

ability to function in a meaningful way: “What is waiting for him out there?” he asked, “working as a waiter won’t get him anywhere!” When asked how Ben would react to a determined course of NVR, Simon said: “He will withdraw completely for a very long time!”

Gradually, the parents became convinced that only unilateral action could trigger a process of change. A supporters’ meeting was convened with five members of the extended family. It was agreed that the parents would deliver an announcement to Ben stating that they would no longer accept his staying at home without studying or going to work. They wrote that they would be willing to help rent an apartment for the first months. The supporters were to contact Ben and offer their help in dealing with the new situation. His uncle, with whom Ben had been close in the past, would invite him to his house for a couple of weeks.

When the parents told Ben that they wanted to give him a written message, he warned them: “Don’t do that! You will cause big damage!” The parents were undaunted and delivered the announcement. Ben took the letter to his room, came down screaming, took out a bundle of banknotes from his pocket, tore them to pieces and threw the bits in his father’s face yelling: “You see! This is money that I earned, working. Now you have spoiled everything! Everything! Because of you I am not going to work again!” He then burst into tears and went back to his room.

Ben avoided all contact with his parents for days after their announcement. Simon would talk to Ben, but received no answer. He spoke quietly, but made it clear that the present situation could not continue. Ben did not repeat his tantrum, choosing instead to withdraw into himself, as his father had predicted.

It took over 2 months before the parents were prepared to take another step. They told Ben that they would disable the computer during the night and discontinue internet access. This time Ben showed more positive signs of coping. He began leaving the house early in the morning (he was working—the parents soon found a paycheck on his table) and after a few weeks, he came back with a laptop computer, which he was able to connect to the neighbors’ wireless internet network. He surprised his parents once again by leaving them a message that he was flying abroad with friends for 10 days. This was doubly surprising, because Ben had suffered from a fear of flying in the past! The parents were in high spirits. However, when Ben returned from his trip, he reverted to the old pattern. He now had his own computer and internet, with which he kept the world at bay.

It was now clear that Ben could withstand pressure without submitting to demands. The parents also understood that it was vain to hope that the problem would be solved on Ben’s own initiative. They told Ben that they would no longer allow him to use the computer or watch TV in their house. If he did so, they would remove the computer from the house. They also told him that they were renting him a small apartment. They would no longer agree to his living in their house without any occupation. Ben shut himself up in his room for a number of days, coming out only in the middle of the night to eat in the kitchen.

One morning, the parents found a note on the door of their room that read: “Conditions for capitulation: you must write a letter to all the people you have involved, apologizing for your offending my honor. Also, you have to donate 3,000 NIS (about 800 dollars) to the Israel Democracy Institute as compensation for your tyrannical acts. When I see the letter and the receipt from the Institute I will agree to leave.” At first, the bewildered parents wanted to refuse the ultimatum. However, after

discussing it with the therapist, they came to see it as Ben looking for a way of protecting his dignity and self-respect, accepting their demand without complete capitulation. They accepted the conditions and few days later brought him the letter and receipt. They rented an apartment and after he procrastinated for a few days, Ben moved there.

Apart from rent, the parents stopped giving Ben money. After a few weeks, it became clear that Ben was working. He was using the car to travel to friends far away and he paid for his own subscription to the gym. For months, he did not talk to his parents, though he kept contact with them in a peculiar way. He would come to visit the house when the parents were at work and leave telltale signs of his presence. He would eat a little (a yoghurt, an apple), but would leave the cooked food in the fridge untouched. He never took any food products from the house. Simon was in touch with two of Ben's friends, who told him that Ben went to pubs, visited them at their houses, and drove to visit other friends in other parts of the country.

Half a year after he had left the house, Ben met the parents at a family wedding. He sat at their table and conducted some small talk with them, without however telling them anything about his doings. This happened again a month later. The parents started to leave messages for Ben on the kitchen table. They wrote that they respected Ben's decision to keep his doings private. They said that they missed him a lot, but understood that things had to be done at his own pace. The parents were sad about the lack of contact, but satisfied with what they had achieved, feeling that Ben was now looking for ways to lead his life without isolation or dependence. In the first months, they thought that Ben was punishing them by distancing himself from them. Gradually, however, they came to see that Ben was protecting himself from the emotional reactions he feared would overwhelm him should he get any closer to his parents.

Case summary

With the help of supporters, parents used firm and clear demands in the form of written announcements and took active steps such as disconnecting computer access and placing conditions on the dependent adult's continued stay in their home. After an initial period of withdrawal, he gained employment and, through an agreement that maintained his dignity, left. Leaving home led to improved social life and general functioning. The relationship with the parents remained very constrained.

An element of NVR that is emphasized is the avoidance of negative attribution to the actions of others, which allows for less escalation and more flexibility on the part of the resistor. This is illustrated in the parents' response to Ben's letter to them. Although it is natural to see his statements as an attempt to assert dominance or set arbitrary and controlling demands, demonizing his behavior would only hinder the process the parents initiated. The determination to avoid such demonization, which allowed the parents to choose a course of action that would better promote their goals, is typical of nonviolent struggles.

DISCUSSION

The course of treatment across the 27 families showed many similarities. Parental steps elicited angry resistance on the part of their dependent child. However, detailed preparation to contain the attacks without giving in or lashing back bore fruit. After the initial flare-up, a period of passive noncooperation by the dependent adult

ensued. Some reacted by withdrawing into themselves and temporarily stopping communication with parents or supporters. After a period that ranged from a couple of weeks to several months, signs of coping began to appear. The dependent individuals started to work, met with friends, and improved their communication with the parents. Sometimes, the positive activities were pursued clandestinely at first. All the parents felt that their lives had changed for the better and were proud of their achievements.

The results of this report support the hypothesis that parent training in NVR is effective in reducing the most challenging aspects of AED. Parents reduced the services they supplied, a third of the dependent adults who were unemployed before treatment were, by its conclusion, engaged in at least part time work, and some had achieved independent lodgings. Parents also reported reductions in hostility and conflict leading to improved home environments and greater well being.

One important caveat emerged from the series of cases. Improvement in home atmosphere, such as reduced hostility, was temporary or unstable unless a change was also achieved in the "harder" aspects of AED. When the dependent adult continued to live in the parents' home, not go to work, and have full access to computers, the achievements proved unreliable.

An aspect of AED that requires further and more systematic investigation is its relationship to the various forms of psychopathology and their potential impact on NVR training. It is likely that better knowledge of underlying psychopathology could aid in shaping the goals most suited to a particular family and in selecting the most helpful means of intervention. Nevertheless, the existence of psychopathology probably does not contraindicate NVR training. Patients in hospital settings, even those suffering from severe psychopathology, such as paranoid schizophrenia, generally achieve higher levels of functioning when clear behavioral demands are set (American Psychiatric Association, 2006; Dean, 2007; Donat, 2002). An extension of the current research could be the implementation of NVR for family accommodation in other conditions such as OCD.

One factor that has proved invaluable in enabling the parent training in NVR is the creation of a network of clinicians who provide support and expert advice. Our group includes clinicians of different expertise, including physicians and psychologists, who serve as "think-tank," peer supervisors, and support network for addressing serious concerns. Supportive and collaborative ties between therapists also aid in overcoming another challenge inherent in parent training, namely the need to rely exclusively on parental report. George's case exemplifies this complexity, as when he accuses his father of pedophilia. We have often encountered similar accusations in situations of long standing parent–child conflict or estrangement and they have rarely had factual basis. The availability of additional therapists and psychiatrists is often key to navigating such tricky waters. The importance of collaborative team work has long been recognized by clinicians who work with families rather than individuals.

Some limitations of the present study are the sample size on which we report, as well as the case study design, which preclude certain conclusions and inferences from being drawn. Among the questions left unanswered are parent and child characteristics that predict response to treatment, comparison with other clinical approaches, and an investigation of the "active ingredient" or the components that are most important to a successful process. Nevertheless, it is our hope that the study offers enough support for the approach to justify further research with more systematic and

controlled methodology, and that it serves to delineate the problem and offers a conceptualization of the situations addressed.

CONCLUSION

Adult entitled dependence is a common problem in many modern societies and there are insufficient therapeutic approaches for addressing it. Parent training in NVR appears to represent a practical, feasible, and effective option for helping parents to deal with AED. By enabling parents to unilaterally reduce accommodation, it offers a way out of the dependence trap, removes the conditions for continued self isolation, and fosters productive behavior in the AED individual. NVR also reduces escalation and opens avenues for enhanced systems of social support. Further research is indicated into this therapeutic approach.

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