Multifamily Behavioral Treatment (MFBT) for Obsessive Compulsive Disorder (OCD): A Step-by-Step Model

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Obsessive compulsive disorder (OCD) can be a severe, chronic anxiety disorder for which pharmacotherapy and behavioral therapy have both proven effective for approximately 75% of such patients. However, the majority of patients experience a recurrence of symptoms when medications are stopped and 25% to 35% of those treated with behavior therapy fail to benefit or relapse during follow-up. OCD rarely leaves the family system unaffected. Family research indicates that close to 90% of family members accommodate to rituals by participating directly in compulsions, facilitating avoidance, and modifying personal and family routines. These fall-out effects of OCD can inhibit behavioral treatment if not addressed in a family context. Multifamily groups have been useful in treating both medical and psychiatric patients. In particular, long-term outcome in preventing relapse for schizophrenic patients has proven to improve after a multifamily approach. Pilot data of multifamily treatment for OCD demonstrates that this modality is as effective as group behavioral therapy for patients alone, and comparable to individual behavioral therapy. This article describes in detail an 18-session multifamily behavioral family treatment program for OCD that holds promise for improving symptoms while activating family members to participate in behavioral treatment to improve outcome by understanding the disorder, managing OC symptoms more effectively, and improving the quality of life for all family members. [Brief Treatment and Crisis Intervention 2:107–122 (2002)]

KEY WORDS: obsessive compulsive disorder, anxiety disorder, multifamily groups, behavior therapy, group therapy, family treatment.

Along with pharmacologic treatment, behavior therapy has been recognized as an effective means of reducing obsessions and compulsions (van Balkom, van Oppen, Vermeulen, van Dyck, Nautas, & Vorst, 1994). But, symptom remission is quickly lost when medications are discontinued (Pato et al., 1991). Clinical trials using exposure and response prevention, however, have produced improvement in OCD symptoms that have lasted up to 6 years (O’Sullivan, Noshirvani, Marks, Monteiro, & Lelliot, 1991).

Yet, the use of behavioral treatment has been limited because of the lack of trained therapists and the cost of repeated and frequent sessions.

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Group behavioral treatment provides a method for addressing both of these problems, allowing for efficient use of therapist time and cost containment.

There is also literature on the use of behavioral family therapy (BFT) for the treatment of anxiety disorders including OCD (see Van Noppen, Steketee, McCorkle, & Pato, 1997, for review). Tynes, Salins, Skiba, and Winstead (1992), Black and Blum (1992), and Cooper (1993) have used family psychoeducational groups in the treatment of OCD. Additionally, some studies have examined spouse and family involvement in behavioral treatment, with the former making no difference (Emmelkamp, Kloek, & Blaauw, 1990) and the latter associated with more benefit (Mehta, 1990). None of these reports, however, used standardized measures of improvement, nor was family functioning or other possible variables assessed directly.

Family responses to psychiatric symptoms can be counterproductive (Calvocoressi et al., 1993; Steketee & Van Noppen, 1998). OCD family members who take over roles and participate in or assist with compulsions tend to be emotionally overinvolved. They neglect their own needs and at the same time perpetuate the cycle of obsessions and compulsions. On the other hand family members who express criticism by voicing expectations that the patient “just snap out of it” perpetuate the symptoms as well. When symptoms don’t improve, family members’ tendency to do more of the same does not work. As the patient feels isolated and ashamed, conflict ensues and symptoms escalate. One of the main goals of multifamily behavioral treatment (MFBT) is to educate families about the disorder and teach families to utilize behavioral contracting to improve family responses to OCD. This can reduce family critical responses, promote behavior in concert with the philosophy of behavioral treatment, and therefore help the patient to improve control over OC symptoms.

Given the possible relationship of high expressed emotion (EE) to increased relapse in OCD and the efficacy of behavioral treatment in OCD, MFBT is a treatment strategy that combines the benefits of behavioral therapy and a multifamily format in treating patients with OCD. Preliminary work in this area has shown that MFBT can change patterns of interaction and lead to OCD symptom improvement (Van Noppen, Steketee, & Pato, 1997).

Numerous studies consistently report that high EE is significantly correlated with high rates of relapse. EE is defined as the degree to which relatives express critical, hostile, or emotionally overinvolved attitudes toward the patient. To date 14 studies have reported on the association of EE with relapse, seven on schizophrenic patients (Brown & Birley, 1968; Brown, Birley, & Wing, 1972; Karno et al., 1987; Leff & Vaughn, 1981; Moline, Singh, Morris, & Meltzer, 1985; Vaughn & Leff, 1976a, 1976b, 1984); two on depressed patients (Hooley, Orley, & Teasdale, 1986; Vaughn & Leff, 1976), two on bipolar manic depressives (Miklowitz et al., 1986; Miklowitz, Goldstein, Neuchterlein, Snider, & Mitz, 1988), one each on disturbed adolescents (Doane, West, Goldstein, Rodnick, & Jones, 1981) and weight loss clients (Fishman-Havstad & Marston, 1984). EE has been found to predict outcome independent of illness severity (Brown et al., 1972; Hooley et al., 1986; Vaughn & Leff, 1976, 1984), supporting the contention that criticism and/or emotional overinvolvement in high EE homes is not merely a response to severe symptomatology.

EE has been less well studied in OCD. Hibbs et al. (1991) noted that high EE was more frequent among parents of children with OCD or conduct disorder than among controls. Leonard, Swedo, Leanne, Rettew, and Rappoport (1993) reported a 2- to 7-year follow-up study of 54 children and adolescents with OCD. High parental EE was the second strongest predictor (13% of variance)
of long-term global functioning (measured by Global Assessment Scale [GAS]), superceded only by response to clomipramine at 5 weeks. Studying adults, Emmelkamp and colleagues (1992) observed that a self-report measure of EE combined with patient’s coping style and life events accounted for a significant portion of relapse ($r = .44$). High EE ratings were evident in 3 of 4 relapses. Although not a direct study of EE, similar findings were reported by Steketee (1993), who observed that negative family interactions (anger, criticism) and relatives’ beliefs that the OCD patient was malingering predicted fewer gains at 9 months follow-up.

More recently, a study conducted by Chambless and Steketee (1999) investigated the relationship of EE to behavior therapy outcome for OCD ($n = 60$) and panic disorder with agoraphobia (PDA; $n = 41$). Controlling all other EE variables, relatives’ hostility placed a patient at six times the risk for premature drop out from therapy. Contrary to expectation, nonhostile critical comments were predictive of significantly better behavior therapy outcome (Chambless & Steketee, 1999). When delivered without hostility toward the person as a whole, criticism may be a potential motivator for OCD patients who use avoidance to neutralize anxiety. Exposure-based therapies instruct the patient to confront anxiety-provoking stimuli while resisting rituals and avoidance. Nonhostile criticism from relatives might push patients to face their fears, an important ingredient in exposure-based behavior therapy.

Treatment to reduce high EE in the schizophrenia and depression literature has centered around psychoeducational paradigms. Family psychoeducation and communication training approaches have demonstrated that patients from families whose EE levels were reduced from high to low following treatment were considerably less likely to relapse than those from families who remained high on EE (e.g., Anderson, Hogarty, & Reiss, 1980; Anderson, Reiss, & Hogarty, 1986; McFarlane, 1983, 2002; Falloon, Liberman, Lilli, & Vaughn, 1981; Leff, Kuipers, Berkowitz, Eberlein-Vries, & Sturgeon, 1982; Hogarty et al., 1986). Leff et al. (1982) compared subjects who received standard outpatient treatment to those who received a psychoeducational package in lieu of standard outpatient treatment. He found that the latter had a significantly better outcome that persisted at the 9-month follow-up. Also, McFarlane (in press) found that schizophrenic patients who received multifamily treatment had lower rates of relapse than those in single family treatment. Most of this literature however, has not used specific outcome measures or research paradigms and therefore comparability between existing studies and new work is difficult. There has been little data on behaviorally oriented multifamily groups. However, Falloon et al. (1981) was one of the few to make such a report and he noted a reduction in critical comments and overinvolvement among family members following 25 sessions of a multifamily group.

This MFBT for OCD is specifically designed to both educate and provide direct behavioral intervention to family members in collaboration with the patient. It mimics an individual behavioral treatment program; however, the role the family members (significant support persons) can play in therapy is examined using a group format that includes five to seven families with the OCD patient.

The major goals of the MFBT program are to:

1. Establish a therapeutic alliance with the patient and family, provide a supportive therapy context to facilitate behavioral and cognitive change.
2. Provide psychoeducation on OCD and on exposure and response prevention.
3. Develop and implement a behavioral treatment plan for the patient to improve his
or her level of functioning, decrease the severity of OCD symptoms, and reduce family involvement in OCD behaviors.

4. Change the family patterns of communication to reduce hostile criticism, overinvolvement attitudes and excessive accommodation, improve family problem solving and increase positive support. Families learn how to devise and implement family behavioral contracting independent of a therapist.

5. Promote feelings of empowerment, altruism, and empathy while decreasing feelings of isolation, stigma, shame, confusion, and impotence through the group process.

6. Teach OCD patients to utilize self-instruction through exposure and response prevention homework assignments.

7. Improve long-term outcome by providing OCD patients and their relatives with education to enhance insight into OCD and with behavioral strategies to manage recurrence of obsessive compulsive symptoms. In addition, group modeling offers patients a normative context to refer to when challenging irrational thoughts and unreasonable behaviors long after the formal group ends.

Clinicians who use this article as a guide are presumed to have experience in behavior therapy for OCD as well as a basic knowledge of and some experience in group and family treatment. For clinicians not familiar with behavior treatment for OCD, recommended reading includes Steketee (1999), and Hyman and Pedrick (1999). For a review of EE implications for OCD family treatment, see Steketee, Van Noppen, Lam, and Shapiro (1998). For a full description of the clinical application of MFBT see Van Noppen (1999). It is recommended to be familiar with the other books listed in the self-help reference list (see Appendix). Also, since this treatment guide is based on theoretical foundations used to develop psychoeducational groups for schizophrenia, it is recommended that the clinician be familiar with Anderson et al. (1986) and McFarlane (1983).

This article is meant to instruct clinicians on the development and implementation of MFBT for OCD; it is not a substitute for clinical training and ongoing supervision. The MFBT differs considerably from traditional family therapy in that the clinician takes a very active role providing information, facilitating problem solving, participating in direct and imaginal exposure, making suggestions directly to families, and assigning homework exercises. This may not be customary for dynamically trained clinicians. For MFBT to be effective, the clinician should be clear about and comfortable with the role described. This MFBT is written for adult patients (18 years of age and over); it can be adapted to be suitable for adolescents and children.

Outline of Features and Procedures of MFBT

Features

1. Five to seven families (no more than 16 total participants is recommended), including patient and identified significant others who are in considerable daily contact with the patient; “family” can include homosexual as well as heterosexual couples, step-parents, second degree family members, etc.

2. Co-leaders are optimal; at least one of the leaders should have an advanced degree in social work, psychology, or certified counseling and experience in clinical work with individuals, families, and groups. Proficiency in cognitive-behavioral therapy is expected with experience in OCD populations.
3. The sessions are 2 hours long and typically meet in the late afternoon or early evening; the time-limited nature of this treatment program is used to motivate patients.

**Procedure**

1. Each patient and family has a pretreatment screening by phone with the therapist(s) to determine appropriateness for the group and readiness for treatment, following this an intake session is scheduled.

2. At the intake session, pretreatment forms are completed, symptom severity and family response styles determined, goals of the group and behavioral therapy principles are discussed, and pretreatment concerns and questions are addressed.

3. There are 12 weekly treatment sessions. The first covers introductions, ground rules, education about OCD, and reading of self-help material. The second gives a definition of behavior therapy (exposure and response prevention), *in vivo* exposure and response prevention plus homework and self-monitoring. The third session is about family responses to OCD and family guidelines, as well as the neurobiology of OCD and medications. In the fourth session, behavioral contracting among family members and communication skills training is discussed, along with homework discussion with family group feedback and problem solving. The fifth through eleventh sessions cover continued ERP and family behavioral contracting *in vivo* and homework assignments. Finally, the twelfth session is the final weekly treatment session, covering termination issues and planning for monthly booster sessions.


Below is a manual for an 18-session MFBT and one 90-minute intake gathering session conducted with each OCD patient and family members.

**Information Gathering and Pregroup Screening (90 Minutes)**

1. Take a general biopsychosocial history and collect information about OC symptoms for treatment planning (20 minutes). Use the Yale-Brown Obsessive-Compulsive Checklist and YBOCS to indicate primary obsessions and major compulsions and symptom severity. Scales can be found in most professional books on OCD diagnosis and treatment (see References).

2. Discuss onset of OCD and efforts to cope (10 minutes).

3. Collect detailed information about OC symptoms: Develop hierarchy (15 minutes). Begin exposure hierarchy as in individual behavior therapy by collecting information about triggers of obsession and compulsions, situations and objects avoided, intrusive thoughts, and ritualistic patterns of behavior. Teach the patient and family how to rate anxiety according to the Subjective Units of Distress Scale (SUDS) and estimate at which number treatment session the trigger will be introduced. Record all information on an Exposure Hierarchy Form. The more detailed, the better. See Tables 1 and 2 and use the References for more examples. Tables 1 and 2 are two sample hierarchies for a patient who has fears of contracting cancer from items associated with a sibling, contact with cigarettes, “chemicals,” and certain foods.

4. Describe exposure and response prevention (ERP) (10 minutes). Give a treatment rationale including the following points: Treatment is called exposure and response...
Exposure refers to gradual and direct confrontation of situations that provoke obsessive fears. It is designed to break the association between the sensations of anxiety and the objects, situations or thoughts that produce it through the gradual reduction or habituation of fear. Use patient’s own experiences as examples (e.g., “every time you touch anything associated with body fluids you feel anxious, distressed or contaminated”). Response prevention is designed to break the association between ritualistic behavior and the reduction of anxiety or distress. Since compulsions (specify them) lead to less distress temporarily, they are reinforced. Treatment breaks the automatic bond between the feelings of discomfort/anxiety (specify the obsession) and rituals.

5. Description of the MFBT program and review of overall goals (5 minutes).

6. Determine degree of Family Accommodation (FA) and response styles (20 minutes). Administer the Family Accommodation Scale (FAS; Calvocoressi et al., 1999).

7. Homework assignment (5 minutes). Discuss the first homework assignment to read Steketee and White (1990), Chapters 1 through 4. Give suggested reading list.

8. Wrap-up (5 minutes). Address concerns and questions.

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**TABLE 1.** Hierarchy 1—Fears of Contamination-Cancer From Brother and Cigarettes

<table>
<thead>
<tr>
<th>Situation</th>
<th>Discomfort (1–100)</th>
<th>Treatment session</th>
</tr>
</thead>
<tbody>
<tr>
<td>Holding unopened cigarette pack</td>
<td>45</td>
<td>1</td>
</tr>
<tr>
<td>Touching mug brother used</td>
<td>50</td>
<td>1</td>
</tr>
<tr>
<td>Touching door knobs at home</td>
<td>55</td>
<td>2</td>
</tr>
<tr>
<td>Holding opened cigarette pack</td>
<td>55</td>
<td>2</td>
</tr>
<tr>
<td>Holding “clean” ashtray</td>
<td>60</td>
<td>3</td>
</tr>
<tr>
<td>Holding clothes worn by brother</td>
<td>70</td>
<td>4</td>
</tr>
<tr>
<td>Touching “dirty” clothes (basement)</td>
<td>85</td>
<td>5</td>
</tr>
<tr>
<td>Touching cigarette filter</td>
<td>90</td>
<td>6</td>
</tr>
<tr>
<td>Stepping bare foot on a cigarette</td>
<td>95</td>
<td>7</td>
</tr>
</tbody>
</table>

**TABLE 2.** Hierarchy 2—Fear of Contamination-Cancer From “Chemical” Contact

<table>
<thead>
<tr>
<th>Situation</th>
<th>Discomfort (0–100)</th>
<th>Treatment session</th>
</tr>
</thead>
<tbody>
<tr>
<td>Touching microwaved food</td>
<td>30</td>
<td>1</td>
</tr>
<tr>
<td>Pumping gasoline</td>
<td>35</td>
<td>1</td>
</tr>
<tr>
<td>Touching sand in sandbox</td>
<td>35</td>
<td>1</td>
</tr>
<tr>
<td>Touching “Sweet &amp; Low”</td>
<td>40</td>
<td>2</td>
</tr>
<tr>
<td>Holding batteries</td>
<td>40</td>
<td>2</td>
</tr>
<tr>
<td>Touching sand at beach</td>
<td>65</td>
<td>5</td>
</tr>
<tr>
<td>Eating food items “scanned” at check-out</td>
<td>75</td>
<td>6</td>
</tr>
<tr>
<td>Drinking diet soda</td>
<td>85</td>
<td>7</td>
</tr>
<tr>
<td>Eating chicken</td>
<td>100</td>
<td>8</td>
</tr>
</tbody>
</table>
**Session 1**

**Building Cohesion and Trust: “We’re Not Alone!” Psychoeducational Phase: “What Is OCD?” (2 Hours)**

*Welcome (5 Minutes).* The group leaders introduce themselves and ask each member to introduce him/herself. Then the group leaders outline the agenda for all 12 sessions, giving dates and times for each.

*Administrative Issues (15 Minutes).* Review scheduling of sessions, cancellation policy, group guidelines about confidentiality, and therapist availability.

*Goals (10 Minutes).* Each group member is asked to respond to the question: “What do you hope to get out of this group?” Encourage participants to be specific about behavioral change.

*Definition of OCD (1 Hour).* Review Chapters 1–4 in *When Once is Not Enough*, biological and learned bases of OCD. Distribute YBOCS Symptom Checklist (self-rated version). Go over each example provided with group members volunteering to read. Encourage disclosure by asking for examples from patients’ and/or family members’ experiences. Introduce concepts of exposure and response prevention.

*Homework (30 Minutes).* Go round: each patient chooses a behavioral task challenge to practice daily for homework. Distribute self-rating exposure homework form and explain how to use. If there is time in the session, ask for a patient to volunteer to demonstrate ERP and rate SUD as a group. The homework for every patient for the first week is to practice his or her chosen ERP task and complete homework form. Read *When Once Is Not Enough*, Chapters 5–10.

**Session 2**

**Psychoeducational Phase: “How Do You Treat OCD?”**

*Check-In (10 Minutes).* Review the previous group session. The check-in should begin each group.

*Go-Round (10 Minutes).* Each patient reports on homework completed during the week, including SUDS. If the homework is inadequately completed or reported, discuss problems identified by the patient and family. Encourage group feedback and trouble-shoot to define obstacles.

*Overview of Behavior Therapy (30 Minutes).* Define in vivo and imaginal exposure and give examples. A brief description of exposure in vivo may be: “This entails actual direct contact with an object or situation that evokes obsessions. For example, a person afraid of stabbing loved ones might stand in the kitchen before meal times holding knives or scissors near others.” A brief description of imaginal exposure may be: “Sometimes people cannot actually put themselves into their feared situation, such as stabbing one’s child. A mental visualization of this situation in detail will evoke fears of harming one’s child that will offer exposure practice.” Writing a scripted imagery to be read daily, or put onto a tape and listened to is a way of going about this. Provide a brief description of imaginal exposure for those patients for whom it is relevant (patients whose anxiety focuses on feared consequences that are not fully triggered by in vivo exposure or for whom in vivo exposure is difficult to execute. One possibility is a mental visualization of forgetting to check the stove and coming home to fire engines and a burning house. Another possibility is making a loop tape of a brief description or phrase (i.e., “I will kill my child”) or a few words (“kill,”
“child-killer”) that are avoided, dreaded, or evoke aggressive obsessions.

Include a few statements about tolerating initial high anxiety that will decrease over time with repeated, systematic use of exposure and response prevention (habituation). Stress that response prevention must accompany exposure, whether imagined or in vivo.

Below are instructions and examples of the sequences of in vivo and imaginal exposure for a patient with contamination fears, and response prevention.

**In Vivo Exposure**

The patient, Steve, felt contaminated by feces, urine, sweat, and contact with others. He feared contracting a debilitating disease. Each treatment session included exposure to “contaminants.”

The following hierarchy was constructed for Steve: feces, 100 SUDs; urine, 90 SUDs; toilet seats in public bathrooms, 80 SUDs; sweat, 75 SUDs; newspapers, 60 SUDs; doorknobs, 50 SUDs. During in vivo exposure treatment, the following sequence was pursued:

**Session 1**—Steve walked with the therapist through the building touching doorknobs, especially those of the public restrooms, holding each for several minutes.

**Session 2**—Steve held newspapers left behind by people in the waiting room.

**Session 3**—Steve held newspapers and doorknobs. Contact with sweat was introduced by having him place one hand under his arm and the other in his shoe.

**Session 4**—Exposure began with newspapers and sweat. Toilet seats were added by having the patient sit next to the toilet and place his hands on the seat.

**Session 5**—Exposure began with contact with sweat and toilet seats. Urine was then introduced by having Steve hold a paper towel dampened in his own urine specimen collected that morning.

Session 6—Exposure included urine, toilet seats, and sweat with the addition of fecal material (a piece of toilet paper lightly soiled with his own fecal material). Homework focused on feces, urine, and toilet seats.

**Session 7–12**—Daily exposure to the three items that provoked the greatest discomfort was continued. Homework focused on the objects used during that day’s treatment session. Weekend homework mirrored Friday’s exposure. Periodic contact with lesser contaminants was continued throughout.

**Imaginal Exposure**

First conduct in the present tense with the therapist describing images in second person (“you see” or “you are going”). When asked what he or she feels or sees or thinks in the image, the patient should respond in the first person (“I’m sitting on . . .”). The therapist will describe the image with frequent questions to the patient regarding his or her experiences in the scene. Modifications are made to the image as needed to maximize felt exposure to the item(s) selected for that session. Following therapist description, the patient imaginal scenes should be followed by in vivo exposure to objects or situations related to that scene and provoke similar levels of discomfort. For example: “I want you to imagine the following scene as vividly as you can, as if it is actually happening, and to let yourself experience the feelings as you imagine. Imagine the door opens and your mother who has just made a chicken dinner comes in. She enters the room, she sees you and says, ‘I’m glad to see you. It’s been a long time.’ She comes to you and she touches you. She wants to hug you. Your mother is astonished that you let her hug you, and she says, ‘I can’t believe that I am allowed to hug my daughter again.’ Now you feel the contamination spreading all over you. You feel her chicken-hands on your back. And you begin to feel that it will never go away. It can
never be washed off. You want your mother to leave so you can take a shower or a bath to feel clean again. You can’t say anything. You can’t move; you are overwhelmed by the feeling of being contaminated by salmonella. Your mother is standing beside you, and she is holding your hand; and you can feel how she becomes even more contaminating. You would like her to take her hand off. You can feel the chicken contamination all over your body. You wish you could run out and scream but you stay here, you stay beside her as she contaminates you more and more. You feel the burning spots on your back and hands. It is the feeling of chicken contamination, creeping up your arms, creeping up your face; it’s all over your body. You try to keep your hand close to your body to make sure that the parts that are not contaminated now will remain clean. But it is spreading over your whole body. You are so upset, your heart is beating, your heart is beating really fast. You feel as though you are going to faint. You feel trapped. You have the urge to leave the room and to forget everything about the raw chicken your mother handled but her touch is everywhere on your body.” The patient rates distress levels. Then, the patient creates a script of a similar scene and tape-records it to listen to for imaginal exposure homework.

**Response Prevention**

Remind participants of the specific instructions for response prevention on the first day of treatment as well as periodically during treatment. Give a copy of the rules to each patient and their family, modeling the instructions after these examples.

For **washers**, during the response prevention period, patients are not permitted to use water on their body, i.e., no hand washing, no rinsing, no wet towels, wash cloths, wet wipes, or antibacterial gels except as allowed by the therapist. The use of creams and other toiletry articles (bath powder, deodorant, etc.) is permitted except where use of these items reduces contamination. Water can be drunk or used to brush teeth, with care not to get it on “contaminated” body part. Supervised showers are permitted every day for target time, including hair washing. Ritualistic washing of specific areas of the body (e.g., genitals, hair) is prohibited. Exceptions may be made for unusual circumstances—e.g., medical conditions necessitating cleansing, food preparation after bathroom use. In these cases, patients may wash briefly (20–30 seconds) and then recontaminate as soon as possible. If prevention of washing forces contamination to items very high on the hierarchy, patients may wash briefly and immediately recontaminate with the items currently being exposed in treatment.

At home, relatives are instructed to be available to the patient should she or he have difficulty controlling a strong urge to wash. If the patient reports such concerns, family members are asked to remain with the patient until the urge decreases to a manageable level. Family members may attempt to stop such violations through firm verbal insistence, but no physical force should be used and arguments should be avoided. Faucets can be turned off by relatives if the patient gives prior consent to such a plan. Showers can be timed by family, with no direct observation of showering behavior.

For **checkers**, beginning with the first session of exposure and response prevention, the patient is not permitted to engage in any ritualistic behavior except as allowed by the therapist. Only normal checking is permitted (e.g., one check of door locks). Checking (through physical contact and looking) is prohibited for items ordinarily not checked.

At home, response prevention is conducted under the supervision of relatives, available at the patient’s request whenever an urge to check is difficult to resist. They are to stay with the patient until the urge decreases to a manageable level. Force is not used, but any violations are reported to the therapist.
Patients and relatives review hierarchy form and add any additional triggers for exposure. Arrange all designated items hierarchically according to anxiety evoked. The most disturbing item should be presented by session 9 or 3/4 of the way through treatment. Final sessions should include repetitions of earlier ones with minor variations, focusing on those situations that provoke the most discomfort.

Homework Go-Round: Exposure and Response Prevention (60 Minutes). Each patient chooses behavioral homework task. Use feedback and support from group members to develop the optimal homework assignment. As each patient selects their homework, the group leader should try to translate the task into a form that can be rehearsed in the group. The therapists, patients and family members who are willing participate in the ERP, in vivo while others observe.

For example, for harming obsessions with reassurance seeking and checking, the group leader and patients dampen their hands and touch light switches. Other group members follow by touching the same switch. No reassurance seeking or checking is allowed. Level of anxiety is discussed and rated. This is repeated several times to model the homework assignment and to begin the process of habituation. Another exposure challenge is to pass a pair of scissors around the group point first.

For contamination obsessions with washing and/or passive avoidance, the group leader and the patients go into a bathroom, touch the toilet plunger or whatever is first on the hierarchy (toilet seat, toilet paper, faucet). Level of anxiety is discussed and rated. Patients are not allowed to wash or wipe-off hands. Exposure is repeated and the length of contact is increased. Patients who don’t have contamination obsessions should be included to offer participant modeling. After group members return to their seats, a bag of crackers is passed in the group for everyone to eat.

For fear of being responsible for something “bad” happening and checking, modeled by the group leader and others willing to participate, checks are written to pay for bills (checkbook and bills are brought from home to the group). The check is put into the envelope, sealed, and placed in the mailbox without checking or reassurance seeking. Level of anxiety is assessed and rated. This sequence is repeated.

For hoarding, a bag of items is brought into the group (sometimes a patient has excessive items in pockets, purse, or wallet). With the encouragement and modeling of others in the group, items are discarded. Level of anxiety is discussed and rated.

For ordering and arranging, the patient, other group members and the group leader mix up the order of money, credit cards, etc. in their wallet. All are to look at it “out of order” and resist rearranging. (This can be done with items in purse as well.) Level of anxiety is discussed and rated. Repeatedly look at the items in wallet. As anxiety decreases, rearrange again and repeat sequence.

Family Role (10 Minutes). Instruct family members to offer support and encouragement for patient’s completion of ERP homework. No major changes are to be made without prior negotiation.

Session 3

Psychoeducation: Family Responses to OCD and Family Guidelines: “What Should We Do?”

Check-In (10 Minutes)

Go-Round (10 Minutes)

Psychoeducational Lecture on Neurobiology of OCD (15 Minutes). A videotaped discussion on the neurobiological underpinnings of OCD is
viewed in the group if no psychiatrist is able to be present.

**Exposure and Response Prevention (60 Minutes).** In the group, each patient selects exposure items with SUDS level of approximately 50 to 60; continue with *in vivo* ERP.

**Family Guidelines (15 Minutes).** Distribute *Learning to Live With OCD* (Van Noppen, Pato, & Rasmussen, 1997) and read as a group. Identify and label family response styles as they emerge in discussion (accommodating, antagonistic, split, oscillating). Encourage discussion within family units so patients are offering their perceptions to family members.

**Homework (10 Minutes).** Each patient reassesses behavioral homework task with Family Guidelines in mind, and adds another challenge.

**Session 4**

**Intensive Treatment Phase:**

**Managing The Symptoms:**

**“Out With Doubt!”**

**Check-in and Go-Round (20 Minutes).** Proceed as described above.

**Explain Family Behavioral Contracting (20 Minutes)**

1. One at a time, each family identifies problem areas: How does OCD impose on others? Do family members participate in rituals? Is there a lot of hostile criticism directed toward the patient by family? Do family members take over the patient’s tasks and responsibilities? The problems need to be defined in clear, specific behavioral terms.
2. Guide the family to focus on one problem area at a time and define it.
3. Utilizing feedback from the group, family members explore behavioral response options and the possible consequences of each.
4. With ERP in mind, family members select the best response options.
5. The leaders facilitate a negotiation process between family members. This consists of direct dialogue among patient and family members with regard to behavioral expectations in a specific situation. Group comments, suggestions, and feedback are interspersed. Each family creates a contract establishing a behavior therapy goal for the patient and optimal behavioral responses for family members.
6. When possible, the family rehearses the behavioral contract, during the treatment session *in vivo*, thereby beginning to implement a new solution.
7. As a group the outcome of the contract is evaluated, adding suggestions based on observations of the family’s ability to carry out the plan.
8. If necessary, the family negotiates modifications to the contract. All exposure homework and outcomes of contracts are recorded for homework.

Not all family contracting will go smoothly. The group leaders need to be extremely active, creative, and persistent when guiding each family in the MFBT through this process. By session 6 or 7, group members usually become much more involved, even confrontative during family contracting. Group cohesion should be apparent.

In *Vivo Family Behavioral Contracting and Exposure (70 Minutes).* As described above, the group leaders guide one family at a time through the process of negotiating a behavioral contract. The leaders suggest the use of ERP *in vivo* whenever it is applicable. Begin family behavioral
contracting with a clear, somewhat simple situation to provide a rudimentary experience. Get to each family before adjourning and remind families to renegotiate if they find that the contract is too stringent.

**Homework (10 Minutes).** Each patient selects individual exposure homework and each family commits to behavioral contact homework, tracked on appropriate self-monitoring forms.

**Session 5**

**Behavioral Family Treatment Phase:**
**“We Can Make A Difference!”**

**Check-In and Go-Round (30 Minutes)**

**Behavioral Contracting (80 Minutes).** Each family practices behavioral contracting in vivo. ERP with therapist and participant modeling should be utilized extensively. Each family is allotted 10–15 minutes.

**Homework (10 Minutes).** Patients and relatives record individual ERP homework and family contracts.

**Sessions 6–11**

**“Practice! Practice! Practice!” and**
**“We Can Take Charge!”**

The group leaders follow the same format as described above for the remaining weekly sessions. Progressively, patients are increasingly responsible for devising the in vivo ERP task challenges and family contracts, an expectation cultivated by the leaders.

**Session 12**

**Exposure, Contracting, and Termination: “We Have Tools To Do This On Our Own!” (Last Weekly Multifamily Session)**

**Check-In (30 Minutes)**

**Go-Round (45 Minutes).** Each family evaluates, modifies, or adds to existing contracts. Group members devise in vivo ERP tasks. Each family presents their ERP plan for the next month.

**Dealing with Termination (25 Minutes).** Remind the group of the self-instructional nature of behavioral treatment. Review the steps that were taught: create hierarchy, assess distress levels, select exposure situation (either internal or external trigger), devise ERP challenge. Record this on a form and practice it repeatedly for long periods of time until anxiety decreases.

- Initial anxiety will increase while utilizing ERP.
- Habituation takes time and practice.
- Long-term gains are made through perseverance and commitment to treatment.
- Encourage patients to refer to self-help workbooks.
- Leaders are available to patients between monthly sessions.

**Complete Clinician-Rated Y-BOCS in the Group (15 Minutes)**

**Discuss Monthly Check-In Sessions (5 Minutes).** Schedule dates and describe this as a trial period to develop confidence for independent individual ERP and family behavioral contracting.
Sessions 13–18

Monthly Check-in Sessions: “We Have the Tools to Beat OCD” (2 Hours)

The main purpose of these six sessions is to assist patients and their families in the transition from the leader-directed behavioral treatment to the self-instruction form of therapy. Check-in sessions serve to ensure maintenance of treatment gains in the vulnerable time period directly following the 12-session weekly treatment. They also provide motivation due to the requirement for accountability for progress at monthly intervals.

Each session begins in typical fashion with the check-in and go-round, the only difference being that no in vivo exposure takes place. Patients and family members report on homework tasks, contracts, successes, pitfalls, and general life events that may be influencing the OCD or interfering behavioral therapy. Group leaders take a more passive role, facilitating the group process and answering questions that require clarification. With regard to questions, the leaders should first try to cull responses from the group before offering any direct answers, just as would be done during the 12-session treatment period. Clinician-rated Y-BOCS are collected at each session.

At the last monthly session, acknowledge issues related to treatment termination and make referrals for continued behavior therapy or medication if necessary. Complete the FAS for each family in the group.

Conclusion

To conclude, MFBT offers several advantages over standard individual behavioral treatment. It is cost effective by allowing for the simultaneous treatment of five to seven patients and their family members with one or two therapists in 2 hours/week compared to the same six/seven families treated individually requiring 10–14 hours of therapist time per week. This is a savings of up to 12 hours of therapist time per week. As typically practiced, individual behavioral treatment offers little structured psychoeducation, support, or guidance for the family who have to cope with the symptoms and demands imposed by OCD. In this age of managed care and short-term treatments, it makes sense to mobilize natural supports like family systems. Once families understand OCD symptoms and are taught behavioral strategies they can participate effectively in ERP with the OCD patient. This treatment offers a marked decrease in both cost for treatment and therapist time as well as the possibility of improving long-term outcome.

Appendix

Self-Help Books

Professional Organizations

Anxiety Disorders Association of America (ADAA). (301) 231-9350; AnxDis@aol.com; www.Adaa.org.

Obsessive Compulsive Foundation (OCF). (203) 878-5669; info@ocfoundation.org; www.ocfoundation.org.

Note


References


Leff, J. P., & Vaughn, C. (1981). The role of mainte-


