Family Responses and Multifamily Behavioral Treatment for Obsessive-Compulsive Disorder

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Family responses to obsessive-compulsive disorder (OCD) that have relevance to behavioral treatments for adults with this disorder include family accommodation, family members’ expression of emotion (EE) toward patients, and the effects of including family members in treatment. Family accommodation to OCD symptoms has been linked to greater severity of symptoms and poorer family mental health. Components of EE, including hostility and perceived criticism, have proved predictive of poorer outcome following behavioral treatment, but nonhostile criticism appears to improve outcomes. A model of multifamily behavioral treatment, in which relatives and patients are trained in exposure and blocking of rituals, as well as behavioral contracting to improve communication, is presented and illustrated in case examples. [Brief Treatment and Crisis Intervention 3:231–247 (2003)]

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This paper will focus on family responses to obsessive-compulsive disorder (OCD) that have relevance to behavioral treatments for adults. Although family is particularly important for children and adolescents with this disorder, the issues are somewhat different than for adults and will not be addressed here. In this paper we will review findings from the research literature regarding family predictors of treatment outcome, especially family members’ expression of emotion (EE), and the effects of including family members in treatment. A model of multifamily behavioral treatment (MFBT) is presented.

Family responses to psychiatric symptoms can be counterproductive (Calvocoressi et al., 1995; Van Noppen, Steketee, & Pato, 1997). Family members who take over roles and participate in or assist with compulsions tend to become emotionally overinvolved, neglecting their own needs and at the same time perpetuating 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 do not 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 MFBT is to educate families about the disorder and teach them to utilize behavioral contracting to improve family responses to OCD. This can reduce family criticism responses, promote behavior consistent with the aims of behavioral treatment, and thereby help the patient to improve control over OC symptoms.

**Expressed Emotion**

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 a psychiatric patient. To date at least 14 studies have reported on the association of EE with relapse: numerous on schizophrenic patients (Brown & Birley, 1968; Brown, Birley & Wing, 1972; Karno et al., 1987; Leff & Vaughn, 1981; Moline, Singh, Morris, & Meltzer, 1985; Vaughn & Leff, 1976), 2 on depressed patients (Hooley, Orley, & Teasdale, 1986; Vaughn & Leff, 1976), 2 on bipolar manic depressives (Miklowitz et al., 1986; Miklowitz, Goldstein, Nuechterlein, Snyder, & Mintz, 1988), and one each on disturbed adolescents (Doane, West, Goldstein, Rodnick, & Jones, 1981) and weight-loss clients (Fischmann-Havstad & Marston, 1984). EE has been found to predict outcome independently of illness severity (Brown, 1972; Hooley et al., 1986; Vaughn & Leff, 1976), supporting the contention that criticism and/or emotional overinvolvement (EOI) in high EE homes is not merely a response to severe symptomatology.

The investigation of EE in OCD is quite limited. Hibbs and colleagues (1991) noted that high EE was more frequent among parents of children with OCD or conduct disorder than among controls. Leonard et al. (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 the variance) of long-term global functioning (measured by the Global Assessment Scale), superseded only by response to clomipramine at 5 weeks. Studying adults, Emmelkamp, Kloek, and Blaauw (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 three of four relapses. Although not a direct study of EE, Steketee (1993) reported similar findings, observing that negative family interactions (anger, criticism) and relatives’ beliefs that the OCD patient was malingering predicted fewer gains at average of 9-months’ follow-up.

More recently, Chambless and Steketee (1999) investigated the relationship of EE to behavior therapy outcome for OCD ($n = 60$) and panic disorder with agoraphobia ($n = 41$). The results of this study are intriguing. Controlling all other EE variables, relatives’ hostility placed a patient at six times the risk for dropout. Patients completing treatment while living with a hostile relative had less benefit from treatment and poorer functioning compared with those living with a nonhostile relative.

Contrary to expectation, nonhostile critical comments assessed via the Camberwell Family Interview predicted significantly better treatment outcome. When delivered without hostility toward the person as a whole, criticism may be a potential motivator for reducing problematic behaviors, including OCD symptoms. One explanation for this finding is that relatives who attribute the OCD to an illness rather than to the patient’s volition may be less likely to reject the person in general and be able to target critical comments toward the unwanted behav-
iors, resulting in better outcome. Thus, nonhostile criticism from relatives might push patients to face their fears. In contrast, relatives who criticize with hostility may be attributing anxiety symptoms to character flaws and manipulative efforts that are within the person’s control. Frustrating and anxiety generating for the patient, this may result in symptom persistence or even escalation. Treatment strategies directed at changing relatives’ perceptions of and responses to symptoms may improve the long-term outcome for this chronic disorder. Bressi and Guggeri (1996) suggest interventions that are aimed at improving coping strategies of families by teaching relatives how their anxiety, involvement in the symptoms, and accommodating behaviors can exacerbate the patient’s anxiety and distress.

**Family Accommodation**

In an attempt to help patients feel better, some relatives may behave in ways that inadvertently reinforce the disorder. Examples of such accommodating behaviors include participating in rituals, refraining from contact with contaminated objects, allowing living areas to become extraordinarily cluttered, providing excessive reassurance to allay unfounded fears, modifying personal and family routines because of symptoms, and facilitating avoidance of feared situations and objects (Calvocoressi et al., 1995; Van Noppen, Pato, & Rasmussen, 1997). Calvocoressi and colleagues (1999) developed the Family Accommodation Scale, a 12-item instrument administered by clinicians to OCD relatives to assess their accommodating behaviors. Family accommodation was associated with family stress and burden and poorer patient functioning. The role of family accommodation in relation to EE and to treatment gains has not been studied, although it seems likely that accommodation is most closely associated with EOI and may predict worse outcome. Research in this area is much needed to further an understanding of how behavioral and emotional family responses to symptoms of illnesses influence treatment outcome.

**A Transactional Perspective of Family Processes**

Four decades of research on the association between EE and outcome of psychiatric and medical illness have highlighted the complex interaction among genetic, biochemical, and psychosocial factors, such as family environment, and attributions regarding behavioral control. Initially, research on EE presented a one-sided focus that emphasized critical comments and EOI of the relative toward the patient. Descriptively, EE became synonymous with negative, critical interactions because these factors appeared to be related to relapse (Gottschalk & Keatinge, 1993). Unidirectional models suggest that patients’ behaviors cause relatives’ high EE or relatives’ high EE causes patients’ psychopathology.

The writings of Hooley and Richters (1995) and Rosenfarb, Goldstein, Mintz, and Nuechterlein (1995) suggest a theoretical model of EE that reflects transactional processes within families of psychiatric patients. This transactional perspective is based on reciprocal family processes in which compulsive behaviors elicit relatives’ criticism, hostility, feelings of guilt and self-sacrifice (EOI), and/or accommodation, filtered through perceptions and attributions about psychiatric illness. Patients may experience criticism as a lack of family support or understanding. Feeling rejected and stressed, patients become more symptomatic, further frustrating relatives. In addition, family overinvolvement and accommodation reinforces symptoms and poor functioning. Thus, more disturbed behavior may be generated by affective attitudes and behavioral responses of relatives. Feelings of helplessness, hopelessness, frustration, anxiety, and
depression in relatives mount as a result of coping with a potentially chronic psychiatric illness. Family dysfunction is inevitable as relatives take on extra tasks, reducing leisure and social activities to take up the slack for the patient, whose functioning and quality of life declines. This interactive cycle perpetuates the disorder unless interrupted by efforts to change family transactional patterns in relation to symptoms.

Steketee, Van Noppen, Lam, and Shapiro (1998) concluded that assessment of relatives’ emotional and behavioral responses to OCD patients is needed during treatment. Witnessing odd rituals and incessant compulsions, family members often ask in exasperation, “Why can’t you just stop!” implying an attribution of personal volition over illness-based symptoms. Other relatives call the patient crazy, a “nut-case,” and a lunatic, harsh words reflecting hostility toward the person. Hooley (1998) recommends that clinicians recognize that EE is a product of the interaction between family members and patient and, as such, is a dynamic construct. Without an appreciation for how the responses of relatives may sustain the symptoms, traditional individual therapy may have limitations. Relatives may seek advice about “how much to push” their loved one. At these times, knowledge about EE may prove invaluable.

Treatment Implications

Treatment to reduce high EE in schizophrenia and depression has centered around psychoeducational paradigms and, to a lesser extent, communication training approaches. When these treatments reduced EE levels, patients were considerably less likely to relapse than those whose families remained high on EE (Anderson, Hogarty, & Reiss, 1980, 1986; Falloon, Liberman, Lillie, & Vaughn, 1981; Hogarty et al., 1986; Leff et al., 1982; McFarlane, in press). Outcomes persisted at follow-up (Leff, Kuipers, Berkowitz, Eberlein-Vries, & Sturgeon, 1982). McFarlane (in press) explored the use of multifamily educational treatment for schizophrenia that produced lower relapse rates than single family treatment. Falloon et al. (1981) were among the few to study the effects of behaviorally oriented multifamily groups. They observed a reduction in critical comments and EOI among family members following 25 sessions of a multifamily group.

Family psychoeducational groups have been employed for OCD (e.g., Tynes, Salins, Skiba, & Winstead, 1992; Black & Blum, 1992; Cooper, 1993), but their effects have not been examined. A few studies have examined spouse and family involvement in behavioral treatment by providing assistance with exposure and response prevention (ERP). Although Emmelkamp, de Haan, and Hoogduin (1990) found no benefit from including spouses, Mehta (1990) found that assistance from family members did produce benefit. The difference in findings may be due to including spouses versus broader family members in treatment or to cultural differences between Indian and European families.

Only 2 studies have examined efforts to reduce family accommodation among relatives. Thornicroft, Colson, and Marks’ (1991) uncontrolled study of inpatients found that reducing relatives’ involvement in rituals by training them to monitor patient behavior and encourage self-exposure in a noncritical manner reduced OCD symptoms at discharge. A recent trial by Grunes, Neziroglu, and McKay (2001) examined the benefits of relatives’ participation in 8-week psychoeducational groups designed to help reduce accommodation to OCD symptoms. Patients who received individual exposure and response prevention were randomly assigned to either have their relative participate in the family group or not. Patients whose family member was involved in the group had greater reduction in OCD symptoms and in depressed mood compared with those whose relatives did not participate. Gains were maintained at a 1-month
follow-up. Family accommodation, as well as depression and anxiety, was reduced in the relatives who participated in the educational group. Which aspect of change in relatives’ behavior played a role in improved outcome in the patients is an important question for future research.

We have completed an uncontrolled study of the effects of 10 to 12 weeks of multifamily behavioral treatment (Van Noppen, Steketee, McCorkle, & Pato, 1997) for 19 OCD adults and their family members. Family members and patients together received education about OCD and exposure treatment and were taught family contracting for behavior change, along with direct exposure during family group sessions. Six monthly follow-up sessions helped families review progress and identify additional needs. Yale-Brown Obsessive Compulsive Scale (Y-BOCS) scores reduced significantly from a mean of 23 at pretest to 17 at posttreatment; gains were maintained at follow-up, with additional benefits evident in family functioning. Poorer family functioning on roles and communication predicted worse outcome on OCD symptoms. These findings argue for the need for further study of cost-effective multifamily methods that have also proved very useful for treatment of patients with chronic mental illness (McFarlane, 2002). Below we describe this treatment in detail.

**Goals**

The major goals of the MFBT program are to:

1. Establish a therapeutic alliance with the patient and family and provide a supportive therapy context in which to facilitate behavioral and cognitive change.
2. Provide education about OCD and ERP.
3. Develop and implement a behavioral treatment plan for patients to improve their level of functioning, decrease the severity of symptoms, and reduce family involvement in OCD behaviors.
4. Change the family patterns of communication to reduce hostile criticism, over-involvement, and excessive accommodation, improve family problem solving, and increase positive support.
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 ERP homework assignments.
7. Improve long-term outcome by providing behavioral strategies to manage recurrence of OCD symptoms. Group modeling offers patients a normative context to refer to when challenging irrational thoughts and unreasonable behaviors long after the formal group ends.

**MFBT for OCD**

MFBT for OCD is designed to both educate and provide direct behavioral intervention to family members in collaboration with the patient. Going beyond the mere presentation of facts about illness, MFBT provides a conduit for changing family transactional patterns that may perpetuate high EE. When combined with practice in behavioral therapy, patients and family members can interrupt the cycle of OCD via behavioral contracting, thus using ERP effectively in the home. The MFBT mimics an individual behavioral treatment program, but family members or significant support persons are trained for their role using a group format with 5–7 families present with the OCD patients.

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This treatment guide is meant to instruct clinicians on the development and implementation of MFBT for adult patients (age 18 and over) with OCD; it can be adapted for adolescents and
children (Van Noppen, 2002). MFBT differs considerably from traditional family therapy in that the clinician takes a very active role in providing information, facilitating problem solving, participating in direct and imagined exposure, making direct suggestions to families, and assigning homework exercises. For MFBT to be effective, the clinician should be clear about and comfortable with the role described. Clinicians interested in applying the methods described below are encouraged to review the list of recommended readings at the end of the article and to become familiar with cognitive-behavioral treatment (CBT) (Hyman & Pedrick, 1999; Steketee, 1999), EE in OCD (Steketee et al., 1998), multifamily intervention (Van Noppen, Steketee, & Pato, 1997), and foundations for psychoeducational groups for schizophrenia (Anderson et al., 1986; McFarlane, 1983).

Features and Procedures of MFBT

Five to 7 families (no more than 16 total participants) are recommended, including the patients and significant others identified as being in considerable daily contact with the patients. Family can include homosexual as well as heterosexual couples, stepparents, second-degree family members, etc. Co-leaders are optimal, at least one of whom should have experience with families and/or groups, proficiency in CBT, and experience with OCD. Sessions are 2 hr long and treatment should be time-limited to motivate patients. The therapist should prescreen each patient and family by phone to determine appropriateness for the group and readiness for treatment. An intake session follows, during which all family members complete assessment instruments to determine symptom severity and family response styles and to learn about goals of the group and behavior therapy principles. Therapists should address concerns about OCD and treatment. Twelve weekly group treatment sessions include the following content:

Session 1: Introductions, ground rules, education about OCD, reading of self-help material

Session 2: Definition of behavior therapy, in vivo ERP plus homework and self-monitoring

Session 3: Family responses to OCD and family guidelines, neurobiology of OCD and medications

Session 4: Behavioral contracting among family members and communication skills training, homework discussion with family group feedback and problem solving

Sessions 5 through 11: ERP and family behavioral contracting, in vivo and homework assignments

Session 12: Termination concerns and planning for monthly booster sessions

There are 6 monthly booster sessions to focus on maintaining gains and relapse prevention. Below is a manual for an 18-session MFBT and one 90-minute information-gathering session conducted with each OCD patient and family member(s).

Individual Information Gathering and Pre-group Screening (90 min)

Take a general biopsychosocial history and collect information about OC symptoms for treatment planning. Use the Y-BOCS checklist to indicate type and severity of major obsessions and compulsions (20 min).

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

Collect detailed information about symptoms and develop hierarchy of common triggers for 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 Subjec-
tive Units of Distress Scale (SUDS) and which triggers will be introduced at which treatment session. Record this information on a detailed form for use during therapy (15 min).

Describe ERP (10 min).

Describe the MFBT program and review overall goals (5 min).

Determine the degree of family accommodation and family response styles by administering the Family Accommodation Scale (Calvocoressi et al., 1999) and preferred measure of family functioning (20 min).

Assign homework including suggested readings (5 min).

Wrap up by addressing questions and concerns (5 min).

**Group Session 1**

Welcome (5 min): Group leaders introduce themselves and ask all members to introduce themselves. Outline the agenda for all 12 sessions, giving dates and times for each.

Administrative issues (15 min): Review schedule of sessions, cancellation policy, group guidelines about confidentiality, and therapist availability.

Goals (10 min): Ask each group member, “What do you hope to get out of this group?” Encourage participants to be specific about behavioral change.

Definition of OCD (1 hour): Discuss biologic and learned bases of OCD. Distribute Y-BOCS 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 ERP.

Homework (30 min): Go around and ask each patient to choose a behavioral homework task. Use feedback and support from group members to develop the optimal homework assignment. As patients select their homework, the group leader should try to translate the task into a form that can be rehearsed in the group for therapists, patients, and family members who are willing to participate in the ERP task while others observe. Examples include the following:

— For harming obsessions with reassurance seeking and checking, the group leader, patients, and relatives dampen their hands and touch light switches while no reassurance seeking or checking is...
allowed. Discuss the level of anxiety experienced and repeat this several times to model the homework assignment and 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 and touch the toilet flusher or whatever is first on the hierarchy (toilet seat, toilet paper, faucet) without washing or wiping hands. The length of contact is increased in subsequent exposures. Patients without contamination obsessions should also participate to model normal behavior. 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, the group leader and others willing to participate write checks to pay bills (checkbook and bills are brought from home to the group). Checks are put into envelopes, sealed, and placed in the mailbox without checking or reassurance seeking. After rating anxiety, repeat this sequence.

— For hoarding, patients bring a bag of items to the group (patients sometimes have excessive items in pockets, purse, or wallet) and, with the encouragement and modeling of others, discard many items. Discuss and rate level of anxiety.

— 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 or purse. All are to look at it “out of order” and resist rearranging. As anxiety decreases, rearrange again and repeat sequence.

Family role (10 min): Instruct family members to offer support and encouragement to patients who complete ERP homework. No major changes should be made without prior negotiation.

Group Session 3
Check-in (10 min) and go-round (10 min).
Psychoeducational lecture (15 min): A videotaped discussion on the neurobiology of OCD is viewed if no psychiatrist can be present to present it directly.

Exposure and response prevention (60 min): In the group, each patient selects exposure items with SUDS level of approximately 50 to 60; continue with in vivo ERP.

Family guidelines (15 min): Distribute Learning to Live with OCD (Van Noppen, Pato, et al., 1997), review family guidelines, and read as a group. Topics covered include: recognizing OCD warning signs; modifying expectations during stressful times; measuring progress according to the person’s, not others’, level of functioning; avoiding day-to-day comparisons and instead considering overall progress; recognizing small improvements; creating a supportive home environment; keeping communication clear and simple; setting limits while being sensitive to the person’s mood; sticking to negotiated agreements; keeping family routines normal; using humor when appropriate; supporting the person’s medication regime; making separate time for family members; and being flexible based on stressors and demands. Identify and label family response styles as they emerge in discussion (accommodating, antagonistic, split, oscillating) and encourage discussion within family units so patients are offering their perceptions to family members.

Homework (10 min): Patients reassess their behavioral homework task with the family guidelines in mind and add another challenge.

Group Session 4: Managing the Symptoms: “Out with Doubt!”
Check-in and go-round (20 min).
Explain family behavioral contracting (20
Leaders describe the process of behavioral contracting, which includes the following steps: Identify problems presented by OCD symptoms, select and define one problem, propose response options and select one, develop a behavioral contract between patient and family, rehearse this \textit{in vivo}, evaluate and revise as needed.

\textit{In vivo} family behavioral contracting and exposure (70 min): Each family identifies problem areas in specific behavioral terms with regard to how OCD imposes on others, family participation in rituals, criticism directed toward the patient, and family members taking over the patient’s tasks and responsibilities. Families are guided to focus on one problem and define it and then use group feedback to explore response options and their possible consequences. Family members select the best response options, and leaders facilitate the negotiation among family members. This consists of family dialogue about behavioral expectations in a specific situation, interspersed with group comments, suggestions, and feedback. Each family generates a contract establishing a behavior therapy goal for the patient and optimal behavioral responses for family members. The leaders suggest the use of ERP \textit{in vivo} whenever it is applicable. When possible, the family rehearses the behavioral contract during the treatment session, thereby beginning implementation of a new solution. The group evaluates the outcome of the contract, adding suggestions based on observations of the family’s ability to carry out the plan. If necessary, the family negotiates modifications to the contract if they find it is too stringent. All exposure homework and outcomes of contracts are recorded for homework. Leaders are advised to begin with clear, perhaps somewhat simple situations to provide a rudimentary contracting experience. The group leaders should get to each family before adjourning this session so that everyone leaves with a contract.

The following examples are illustrative of three typical family response patterns and how to utilize behavioral contracting, although not all family contracting will go this smoothly. Group leaders should be very interactive, creative, and persistent throughout this process. By session 6 or 7, group members usually become much more involved and even confrontational, indicating good group cohesion at this stage of the MFBT.

\textbf{Case 1: Behavioral Contracting with an Accommodating Family.} The group leader should state that for families who assist in carrying out rituals, withdrawal from this participation is essential. Disengagement is best done in a stepwise progression consistent with the patient’s individual ERP goals. Initially goals should be specific and achievable to build confidence. Families who, after years of participation, just stop completely find that this backfires. However, in extreme cases when the patient is not making progress and demands are excessive or the patient refuses to use his or her individual ERP treatment plan, the family may announce that they will no longer participate in specified ways and proceed to negotiate an agreement if possible. Again, the active ingredient is direct and clear communication about family responses to particular symptoms, with the goal of less family involvement. The following examples of accommodation and intervention are illustrative.

The husband of a 37-year-old nurse with severe contamination fears agreed to wash his hands excessively, follow certain rules for food preparation, use separate silverware and paper cups, avoid opening doors, and not invite guests into their home. As is typical of accommodating relatives, he removed outdoor shoes and clothing before entering the house and used only certain chairs or parts of the sofa. In some extreme cases a spouse may agree to sleep in a separate bedroom. The mother of a 20-year-old with AIDS contamination fear constantly did laundry for him and checked
his money to make sure it had no red spots on it. The mother of a 17-year-old with mental rituals stopped whatever she was doing at her daughter’s request until it was okay to proceed. The father of a 14-year-old said certain sentences in a particular tone of voice and wording so his son could continue the conversation. A 22-year-old with praying compulsions involved her mother in the praying each night for an hour so she could get to bed before midnight. Family members may avoid saying certain names or numbers, or avoid certain colors or sounds, or may take over checking rituals to help the patient leave the house or go to bed.

Families who assist in rituals often feel isolated and helpless because they have less time for themselves and their own responsibilities and interests. Careful contracting allows family members to set limits in a supportive way and regain their own activities and interests. The role of the group leader is to help the family negotiate reasonable behavioral expectations using suggestions and feedback from others in the group. Dialogue among the nurse, Susan, her husband, John, and the group leader (GL) is given below:

GL: Susan and John, it’s your turn to negotiate a behavioral contract. Have you decided where you would like to start, Susan?

Susan: Yes, I’ve been practicing limiting the frequency and length of time I wash my hands. I realize that I ask John to do this way too much and then we argue about it. He usually gives in just to stop our fighting.

GL: John, what did you hear Susan say?

John: That I end up giving in to the OCD to make her happy and that it really isn’t helping.

GL: Is that what you meant, Susan?

Susan: Pretty much. I want things to be more normal.

GL: Right! Like the guideline: Keep your family routine normal! Okay, so let’s work out a contract that is reasonable for both of you. First of all, do you both agree that John should be allowed to wash his hands less?

Susan and John: Yes!

GL: What does the rest of the group think? [Allow a few min for others to share support and encouragement, then return to the contracting task.] It sounds like you are on the right track. Now let’s get down to work. Susan, when should John be expected to wash his hands? [If the family has trouble agreeing on a target behavior, ask the group to help the family focus on and commit to a specific goal. If after 15–20 min the family still doesn’t agree on a goal, suggest a simple, nonthreatening task to start.]

Susan: He and I have talked about this, or should I say fought about this, so much. I know that most people wash their hands after they use the bathroom or before they are going to eat. So I want him to do it then.

GL: Do you think that’s reasonable, John?

John: Yes, but what should I do when Susan asks me to do it other times or questions me on how I’ve washed? She’s always on my back about it.

GL: That’s just the point here. Susan is now making a contract that she is no longer going to ask you to wash your hands, even though she will feel the urge. You now have an understanding that you will wash after using the bathroom or before eating. This implies trust that you will follow through on that expectation without a discussion about it. Now, I always like to anticipate possible slip-ups. What happens if Susan does ask John to wash? Susan, what do you think would be a good thing for John to say? Be sure to look at him when you talk.

Susan: You should tell me that’s my OCD.

GL: Good. Keep communication clear and simple. Could you do that, John?

John: Sure.

GL: Okay, but remember: It’s not going to be...
easy at first, and Susan, you will feel a strong urge to involve John. So what will happen if you feel very anxious and keep after him?

Susan: Well, I guess he should remind me of our agreement and try to be nice about it but not condescending!

GL: What do you hear Susan saying, John?

John: That I shouldn’t be nasty, critical, or patronizing.

GL: Can you ask her?

John: Is that what you’re saying, Sue?

Susan: Yes, exactly! If you could do that, I really think it would help. When you get overly fatherly with me it makes me more anxious, and the urge to ritualize gets totally unbearable.

GL: Susan just made a statement I want to highlight. What is she communicating about John’s response? Remember the ‘create a supportive environment’ guideline? [Group leaders should underscore comments that support the family guidelines. Open the discussion to the group for feedback and disclosure, then redirect the group back to the task.] So you can see others feel this way too. Other families can use this information when negotiating your contracts. Now back to Susan and John. Let’s review the whole agreement. Susan, please look at John and go over the whole contract.

Susan: John, I’m going to touch objects and resist washing. Also, I’m not going to ask you about washing your hands, but you will do so before handling food or after using the bathroom. Okay?

John: That sounds great, hon, but what about the part if you do ask me?

Susan: Well, that’s your part. If I do ask you, what will you say?

John: I will first remind you that it’s your OCD, and if that doesn’t work, I’ll remind you that we have an agreement about this. Oh, and I won’t be critical!

GL: Great job, you two! There’s only one thing left. Let’s say Susan is having a bad day and keeps pressing John. Would it be okay for John to remind you to look at one of your self-help books, call someone, or walk away? I think it’s important to go as far as you can to not get involved in the compulsion. Sometimes distancing and delaying can help a lot to overcome the urge. Susan, do you think that might help you?

Susan: I won’t like it at the time and it will probably make me angry. But it will be different because we have talked about it, which we never did before. The times he has walked away out of frustration ended up okay because it does give me a chance to think more clearly, and the urge to ritualize dies down a little. I think it would be good to remind me to look at my self-help material. I always forget about doing that.

GL: Nice job. Contracts only work if everyone involved takes them seriously. Not to contradict myself, but I also want to stress the importance of flexibility. Contracts work best if you try it out and renegotiate the parts that need refining. On some days, John, you might have to bend a little bit to get Susan through. Set limits but be sensitive to mood. How does this contract sound to the group? [Allow a few minutes for troubleshooting, feedback, and encouragement.] Okay, who wants to go next? [If no family volunteers, ask the patient from the family who just contracted to select a family to take their turn.]

Case 2: Behavioral Contracting for Reassurance Seeking. The group leader should state that reassurance seeking is a type of compulsion that goes unidentified in most families. It will receive special attention because it is so pervasive. Because most of us look to others for reassurance (“How do I look?” or “Is the meal okay?”), reassurance about obsessions can be mistaken for insecurity. Family members quickly get swept into a never-ending loop of
reassurance giving, to help patients “rationalize” obsessive fears away. Lengthy discussions on how AIDS is transmitted, the beliefs of Catholicism, how to tell if you’ve run over a pedestrian, etc., only become lengthier. Most family members feel frustrated and angry because they cannot logically talk the person out of his/her irrational fear. Reassurance seeking should be dealt with like all other rituals—the patient must learn to resist the urge through delay, self-talk, and modification, and the family members must stop offering reassurance when asked. Behavioral contracting proceeds as described above, and if family members respond in hostile, critical ways, refer to the section below on the antagonistic family.

The following contracting discussion occurred in the case of a 58-year-old father of three who worked in the shipping department of a prestigious company. He could not count the number of times he sought reassurance from his wife, but estimated 50 times a day. Conversations at work would trigger obsessive thoughts that he had said the wrong thing and he would immediately feel the urge to call his wife for reassurance. He interrupted her day at work, ignored his children, and even stopped at pay phones on the way home to resolve his uncertainty. Although his wife’s efforts to reassure him provided temporary relief, the vicious cycle remained, and frustration and arguing often resulted after hours of her trying to help.

GL: Okay, so now that you recognize that the reassurance seeking is a compulsion that Lois participates in, what do you want to do, Mike?

Mike: I want her to stop giving it to me. After talking with the group, I realize that my questions are ridiculous and that no one can really answer them.

GL: That’s right. It’s the anxiety you feel that you will have to wrestle with by using all the strategies we’ve talked about. Calling more attention to those irrational thoughts just increases your anxiety. Bringing Lois into the picture further magnifies the symptoms. So, can you look at her when you speak and describe how you would like her to stop?

Mike: Lois, I will try as hard as I can not to ask you for reassurance. If I do, I want you to tell me that it’s my OCD and change the subject.

Lois: Mike, I would love to get this out of our lives. You don’t even pay attention to our children anymore because you’re so preoccupied. I will try what you suggest.

GL: Now, what if Mike keeps hounding you?

Lois: I’ll stick to this agreement. It is important that he get some control over this.

GL: That’s right, sticking to the contract is crucial. Is there any time of day that you want to start with when this reassurance thing is at its peak?

Mike: Yeah . . . after work. That’s when it hits me the most. I’m unbearable when I come home. Lois is trying to get dinner going and all I want to do is get reassured then debate about it.

GL: Mike, what else can you do to resist the compulsion to ask your wife for reassurance?

Mike: I can use those self-help statements more, try delaying, try distraction . . . what else?

GL: Do others in the group have any suggestions? [Allow a few minutes for discussion and encourage brainstorming of useful techniques.] So how about trying what Manny suggested? When you get home and feel the need for reassurance, try engaging your wife and kids, ask them how their day went, what their plans for the evening are, etc. That will help you delay your urge, distract your mind, and improve your family relationships all in one.

Mike: I like that idea. I feel so guilty about that but haven’t known how to change.
Lois: Mike, it would be so great for all of us for you to try that suggestion. We might not recognize you.

GL: Okay, it sounds like we have a plan here. So, let’s review the contract. [Ask the family to go over the behavioral contract step by step.]

**Case 3: Behavioral Contracting with an Antagonistic Family.** The group leader should draw on previous group discussions to illustrate examples of the antagonistic type of family response. These are the family members who snap, “Just knock it off already,” “If you just tried to stop, you could,” “You’re just a loser,” “You’re mental,” “You’re a manipulator.” Comments such as these contribute to an already existing sense of failure, frustration, and helplessness within the patient. Resulting conflict adds to the patient’s anxiety, so the end result is more compulsions, which further angers the family. Feeling isolated and ashamed, patients feel more pressure to control their symptoms, which backfires due to the lack of empathetic support. Such families benefit from education and reminders that the unwanted behaviors are symptoms of OCD, which is a psychiatric disorder. Other group members can empathize with the lack of understanding and offer personal experiences that help to validate OCD as an illness. The leader may want to review guideline #1 to recognize signals of OCD symptoms.

Debbie: Well I feel that my main problem is that my parents are so critical of me. They don’t really believe I have OCD.

GL: Others here have said similar things—could you give a specific example?

Debbie: Sure. For instance, I told them I would work on my hoarding and by a certain date sort through a certain amount of stuff. Well, every day, I hear about it, especially from my mother. She’ll say “You’re just lazy, you’re a no-good, look at you wasting all your time doing nothing.” What she doesn’t realize is that I may have spent all morning fighting my OCD just to get up, shower, and dress.

GL: Hang on, Debbie. Let’s give your mom a chance to speak. Eve, we have spent a lot of time in the group defining OCD and talking about what families can do—what’s your perspective on this?

Eve: Debbie does have a point. Before I came to this group, I thought she was making excuses for her inability to hold down a job. Now, I’ve learned some things and heard from others, so I realize that she does have a problem. It’s so hard to watch someone you love suffer.

GL: Exactly, and it’s hard for the sufferer to suffer and be criticized. Remember, that actually makes the symptoms get worse, even though you are trying to get them to stop.

Eve: I guess it’s still hard for me to admit she has a disorder.

GL: Let’s look again at guideline #1: “Recognize signals.” Which of those fits for Debbie?

Eve: Gosh, a lot of them: blocks of unexplained time, repetitive behaviors, reassurance, taking a long time, always late, concern for details, extreme emotional reactions, trouble sleeping, staying up late, struggling every day with every little task. Oh . . . and avoidance. I always thought these things were just part of Debbie’s personality. My husband has been more accepting.

GL: So with this in mind, would you like to make a contract?

Debbie: I would like to keep to a more daily schedule of sorting through my belongings as my behavioral homework. I know this will help me, and my parents would be happy too.

GL: Okay. What do you want to accomplish each day and what should your parents do?

Debbie: I want to try to fill half a bag of stuff to throw out each day. We can keep the bag in
a communal place and if I don’t stick to this, either Mom or Dad can give me one reminder, but not in a put-down way. You know, just say, “Deb, you haven’t filled the bag yet.” I need to know they understand what I’m going through.

GL: Good, Debbie, that helps define reasonable expectations and keep it simple. When should your parents say something? How much time should be allowed for you to do your homework?

Debbie: By 8:00 P.M.

GL: What happens if another hour goes by and it’s still not done?

Debbie: Then I give my parents permission to fill half a bag. That will upset me but I know it’s something I need to overcome.

Eve: That should include that Debbie can’t go back and look through it all the next day.

GL: Right. Can you do that, Debbie?

Debbie: I have to challenge myself, so I’ll try. Also, when I do complete my homework, it would help if you say something positive to let me know you notice and you care.

GL: Good. Recognize “small” improvements! What do other people think of this contract?

Eve: It makes me feel so much better to be in this group. I really thought we were all alone. But there’s one other thing—my husband stays so quiet that I’m afraid he won’t follow through on our contract if I’m not home.

GL: Good point. Well, Rob, are you willing to commit yourself to this family agreement?

Rob: It will be a change for me, but if it helps Debbie and our family, I’m willing to do it. [Ask Rob to elaborate on just what he has agreed to do.]

GL: Okay, so let’s review the contract from the top.

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

**Group Sessions 5 to 11: “Practice! Practice! Practice!” and “We Can Take Charge!”**

Check-in and go-round (30 min).

Behavioral contracting (80 min): Each family practices behavioral contracting in vivo following the format described above. ERP with therapist and participant modeling should be utilized extensively. Patients are asked to be increasingly responsible for devising the in vivo ERP task challenges and family contracts. Each family is allotted 10 to 15 min.

Homework (10 min): Patients and relatives record individual ERP homework and family contracts.

**Group Session 12: “We Have Tools to Do This on Our Own!”**

Check-in (30 min).

Go-round (45 min): Each family evaluates, modifies, or adds to existing contracts. Each family presents their ERP plan for the next month.

Dealing with termination (25 min): Remind the group of the self-instructional nature of behavioral treatment. Review the steps taught: Create hierarchy, assess distress levels, select exposure situation (internal and external triggers), devise ERP challenges, record this on a form and practice it repeatedly until anxiety decreases. Remind patients and families that initial anxiety will increase while utilizing ERP, habituation takes time and practice, and long-term gains are made through perseverance and commitment to treatment. Encourage patients to refer to self-help workbooks. Leaders indicate they are available to patients and families between monthly sessions.

Discuss monthly check-in sessions (5 min): Schedule dates and describe this as a trial period to develop confidence for independent ERP and family behavioral contracting.
Monthly Group Sessions 13–18: “We Have the Tools to Beat OCD” (2 hr)

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 of progress at monthly intervals. Each session begins with the check-in and go-round, but 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 with 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 direct answers. Y-BOCS assessments are collected at each session. At the last monthly session, acknowledge issues related to treatment termination and make referrals for continued behavioral therapy or medication if necessary.

**Conclusion**

Drawing from empirical and theoretical knowledge of EE, a transactional perspective moves clinicians closer to developing family treatment interventions, like multiple family therapy, to target changeable links in cycles that may perpetuate symptoms of OCD. MFBT offers several advantages over standard individual behavioral treatment. It is cost effective by allowing for the simultaneous treatment of 5 to 7 patients and their family members with one or two therapists in 2 hrs/week, a potential savings of up to 12 hr of therapist time per week. As typically practiced, individual behavioral treatment offers little structured education, support, or guidance for family members who must cope with the demands imposed by OCD. MFBT may support relatives in dealing with frustrating patient behaviors, encourage more positive communication, and reduce anger expression. Communication training has rarely been part of family treatments, except on an informal basis, but may be especially helpful regarding managing the symptoms themselves. In particular, relatives who themselves are affected by OCD or obsessive traits may also need help to improve their own functioning. In such training, role-playing of conversations, learning to identify and stop hostile comments, correcting of faulty beliefs about the patient, finding creative solutions for problems, and engaging in behavioral contracting may prove useful. Offering education, communication and problem-solving training, and support to families coping with OCD curbs problematic family responses that may perpetuate OCD symptoms. 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 to contain symptoms. This treatment offers a marked decrease in both the cost of treatment and therapist time as well as the possibility of improving long-term outcome. MFBT may prove especially helpful for treatment-refractory patients who have not benefited readily from standard cognitive behavioral and pharmacologic methods.

**References**


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