A multi-family therapy for adult obsessive-compulsive outpatients and their family members targeting family accommodation

Hannelore L.N. Tandt[1,*], Lemke Leyman[1], Chris Baeken[2,3], Christine Purdon[4], Gilbert M.D. Lemmens[1,2]

Affiliations

[1] Department of Psychiatry, Ghent University Hospital, C. Heymanslaan 10, 9000 Ghent, Belgium

[2] Department of Head and Skin – Psychiatry and Medical Psychology, Ghent University, Ghent, Belgium

[3] Department of Psychiatry, Free University of Brussels, Brussels, Belgium

[4] Department of Psychology, University of Waterloo, Waterloo, Canada

[*] Corresponding author information: Hannelore Tandt, Dept. of Psychiatry, Ghent University Hospital, C Heymanslaan 10, 9000 Ghent, Belgium (e-mail: Hannelore.tandt@uzgent.be)
ORCID : 0000-0002-7291-3162

Key words

Family accommodation, multi-family group therapy, psychoeducation, conjoint exposure and response prevention, obsessive-compulsive disorder

Acknowledgements

Role of Funding Sources. This research was not supported by any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Conflict of Interest. All authors declare that they have no conflicts of interest.

Abstract

This paper describes a multi-family therapy (MFT) group for adult obsessive-compulsive outpatients and their family members. Since family accommodation (FA) is known to maintain OCD symptoms by preventing exposure and response prevention (ERP), reduction of FA is a major focus of the treatment. Furthermore, psychoeducation, conjoint ERP as well as (re)discovering resources and strengths of families are also important therapeutic foci of the family group. The organization of the MFT is explained and involvement of family is illustrated with clinical vignettes. Finally, some reflections about the MFT are provided. Based on initial clinical impressions the MFT seems a promising approach. A clinical trial is currently underway.

Practitioner points

- Family accommodation (FA) is associated with greater familial functional impairment, burden and poorer treatment outcomes in OCD.
- Psychoeducation might help family members to increase their awareness and understanding of OCD symptoms and FA patterns.
- Conjoint ERP interventions could help family members to better tolerate their own and their relative's distress and to support their family members without accommodating to the OCD symptoms.
- Multi-family groups could make use of the resources of the different families for improving dysfunctional family patterns (e.g. FA).

Introduction

With a lifetime prevalence of 1-3%, Obsessive-Compulsive Disorder (OCD) is a chronic and disabling psychiatric disorder with considerable costs for the individual, family and society (Horwath & Weissman, 2000). In clinical settings OCD presents as heterogeneous with a mix of obsessions (‘*recurrent unwanted thoughts, images or urges that provoke anxiety or unpleasant feelings’*) and compulsions (‘*overt or covert ritualistic behavior to reduce anxiety or unpleasant feelings’*), with comorbid symptoms of mood and anxiety disorders often present (Goodwin, 2015).

A growing body of research has demonstrated that individual and group Cognitive Behavioral Therapy (CBT) are effective treatments for OCD reducing symptoms and improving the patient’s quality of life, although group compared with individual CBT is more cost effective (National Instituate for Health and Care Excellence (NICE), 2005; Olatunji et al., 2013; Rosa-Alcázar et al., 2008; Cordioli et al., 2003; Jónsson & Hougaard, 2009).

However, outcomes of (group) CBT remain unsatisfactory with approximately 40-50 percent of people not meeting recovery criteria after treatment (Fisher & Wells, 2005; Öst, et al., 2015). One important factor in treatment efficacy may be family accommodation (FA), which is associated with poor response to both psychotherapy and pharmacotherapy (Garcia et al., 2010; Storch et al., 2007; Turner et al., 2018). Family accommodation (FA) is defined as the changes that family members (i.e. parents, siblings, children and partners) make to their own behavior and interactions to support and reduce the distress of the OCD relative (See Figure 1). Nearly 90% of family members of OCD patients report some form of family accommodation (Calvocoressi et al., 1995; Merlo et al., 2009; Pinto, Van Noppen, & Calvocoressi, 2013; Renshaw, Steketee, & Chambless, 2005; Stewart et al., 2008). These range from participating in compulsions (*e.g. carefully cleaning the bathroom, checking*

doors), facilitating avoidance (*e.g. doing the shopping*), providing reassurance regarding obsessional anxiety (*e.g. reassuring that the locks are checked correctly*) to taking on patient's responsibilities (*e.g. taking out the garbage*) and modifying personal and family routines (*e.g. changing clothes when coming home, stop inviting friends over*).

Main reasons why family members accommodate to some, if not all of patients' OCD symptoms, are the reduction of the patients' and their own feelings of distress, making the family life more bearable, showing understanding and support and avoiding interpersonal conflicts with the patient (Cosentino et al., 2015; Futh, Simonds, & Micali, 2012; Halldorsson et al., 2016; Shimshoni et al., 2019). Patients with OCD often become angry when family members do not accommodate (Vikas, Avasthi, & Sharan, 2011). However, by accommodating, the family members and the OCD patients get caught in vicious circles leading to more symptom severity and functional impairment, worse treatment outcome, lower quality of life and more burden, more depression and anxiety of the family members, more family dysfunction (e.g. poor problem-solving and communication) and more interpersonal conflicts (Albert et al., 2010; Amir, Freshman, & Foa, 2000; Calvocoressi et al., 1995; Caporino et al., 2012; Cherian et al., 2014; Flessner et al., 2011; Garcia et al., 2010; Lebowitz, 2017; Ramos-Cerqueira et al., 2008; Stewart et al., 2017; Storch et al., 2007; Storch et al., 2010; Strauss, Hale, & Stobie, 2015; Tandt et al., 2021; Tandt et al., 2022; Turner et al., 2018; Vikas et al., 2011; Wu et al., 2016). It has been hypothesized that FA directly impedes mechanisms targeted by exposure and response prevention (ERP) (See Figure 1). During ERP, the OCD patient learns to tolerate distress evoked by the obsession while refraining from conducting the compulsion. This process is repeated until the obsession causes only little or no distress anymore ('habituation'). However, family accommodation prevents sufficient exposure and habituation to occur reinforcing OCD

symptoms (Albert, Baffa, & Maina, 2017; Craske et al., 2008; Foa & Kozak, 1986; Lebowitz et al., 2013; Norman, Silverman, & Lebowitz, 2015). In order for ERP to be successful family members may benefit from help with regulating their own emotions and resisting the urge to accommodate when seeing their relative in distress during ERP (Abramowitz et al., 2012). Furthermore, OCD often disrupts family relations, household functioning, leisure activities and family members' social lives (Cooper, 1996; Gururaj et al., 2008; Laidlaw et al., 1999; Steketee, 1997; Stengler-Wenzke et al., 2006). Ninety percent of family members reported that their loved one's OCD had a severe impact on their lives (Calvocoressi et al., 1995). Family members are typically at a loss as to how to cope with their loved one's symptoms and demands, and thus can feel insecure, helpless, angry and distressed (Stengler-Wenzke et al., 2004; Stengler-Wenzke et al., 2006; Tandt et al., 2021). Caregivers may also work to conceal patient's symptoms from other people which leads to further social isolation and poorer quality of life. Since high family burden has been associated with more severe OCD symptoms, FA and antagonism (e.g. opposing, criticizing or rejecting attitudes towards the OCD patient), several authors have advocated for involvement of family members in treatment (Amir, Freshman, & Foa, 2000; Cherian et al., 2014; Ramos-Cerqueira et al., 2008; Renshaw et al., 2005; Vikas et al., 2011; Waters & Barrett, 2000).

Until now, most family-based interventions have focused on children and adolescents, and have showed a reduction in OCD symptoms and FA, even when conducted in a group format (Barrett, Healy-Farrell, & March, 2004; Farrell et al., 2012; Farrell, Schlup, & Boschen, 2010; Iniesta-Sepúlveda et al., 2017; Martin & Thienemann, 2005; O'Leary, Barrett, & Fjermestad, 2009; Selles et al., 2018; Thienemann et al., 2001). However, the family-focused CBT groups vary widely in both content and degree of involvement of family members, ranging from simply providing psychoeducation to families (Bolton & Perrin, 2008), to a separate group

therapy for patients and family members (Barrett, Healy-Farrell, & March, 2004; Olino et al., 2011; Selles et al., 2018), to a group session with the parents (Fischer, Himle, & Hanne, 1998), or involvement of the parents at the end of a group session (Farrell, Schlup, & Boschen, 2010; Farrell et al., 2012; Thienemann et al., 2001) to a 4 day, intensive family group treatment (Riise et al., 2016). Recently, an MFT for adolescents with OCD and their parents combined a CBT and systemic perspective simultaneously focusing on ERP and family identities and strengths (Kindynis et al., 2023).

As in child populations, different family interventions have been applied in the treatment of adult OCD. They vary from psychoeducation to the families (Baruah et al., 2018), support groups for relatives (Grunes, Neziroglu, & McKay, 2001), the involvement of family members in some group sessions (Gomes et al., 2016; Himle et al., 2001; Thompson-Hollands et al., 2015), to individual family therapy (Kobayashi et al., 2020), couple therapy (Abramowitz et al., 2013) and multi-family behavioral therapy (MFBT) (Van Noppen et al., 1997). Although family intervention studies are scarce, preliminary results look promising: MFBT resulted in less OCD symptoms compared with group CBT (Van Noppen et al., 1997), the involvement of family members during two sessions of a 12 sessions group CBT improved OCD symptoms and FA compared with a waiting list control group (Gomes et al., 2016) and a brief family-based intervention reduced illness severity, FA and expressed emotions (EE) compared to a relaxation exercises control condition (Baruah et al., 2018). In order to target the negative spiral between FA and OCD symptoms and to improve family functioning, we've developed a multi-family therapy group intervention for OCD patients and their families. The MFT group originated from a cognitive-behavioral group treatment for OCD patients, primarily emphasizing exposure to obsessional stimuli and the prevention of compulsive rituals that neutralize obsessional anxiety (i.e., response prevention)

(Summerfeldt, Rowa, & McCabe, 2017, unpublished manual). It was further adapted for the involvement of the families to reduce FA, support the family members and improve family functioning. Unlike most of the aforementioned treatment protocols, patients and one family member participated in all group sessions. Our protocol included psychoeducation, conjoint ERP, discussion of FA, communication patterns, and family values and goals in order to improve communication, support and coping strategies and decrease FA and burden within the families. These family adaptations are a major focus of this paper and will be further discussed in more detail. Further, the therapeutic goals and the organisation of the MFT group will be explained and clinical vignettes are provided to illustrate the therapeutic process. Finally, clinical reflections are offered.

Multifamily format

Families living with OCD often react by accommodating their loved one's symptoms, such as by taking over their roles and participating in or assisting with compulsions, which often results in major changes in family life, greater costs to the family and impaired family functioning (Van Noppen et al., 2003; Vikas et al., 2011). The family becomes gradually organized around OCD-related behaviours and demands ('a problem-organized system'), resulting in a drift away from the resources and strengths that had previously been of central importance in their lives (White, 1995). MFT is an excellent therapeutic tool to disrupt the escalating cycle between OCD and FA by changing problematic family attributions and response patterns (Van Noppen et al., 1997). Furthermore, families in MFT may feel validated by hearing similar stories of other families, helping them feel less isolated, experience less stigma, and be able to externalize OCD (Asen, 2002; Asen et al., 2010; Loh et al., 2023; Van Noppen et al., 2003). At the same time, they can learn from the

successes experienced by other families in developing greater insight and new ways of coping with their loved one's behavior, which is empowering and serves as a model (Asen, 2002; Asen et al., 2010; Baumas et al., 2021; Van Noppen et al., 2003). In sum, MFT may help to reduce stigma, burden, FA and EE, and increase support, resilience and strength in families of people with OCD (Calvocoressi et al., 1995; Chambless et al., 1999; March, 1995; Hibbs et al., 1991; Van Noppen et al., 2003; Waters et al., 2000).

Therapeutic aims and organization of the MFT group

The MFT is offered to adult OCD patients and one of their family members.

The inclusion criteria for participation in the MFT group were: (a) diagnosis of OCD (b) a minimum score of 16 on the Y-BOCS, (c) having a live-in family member or a family member spending an average of 10h face-to-face contact per week with the person with OCD, for at least a year, (d) age of patients between 18 and 65 years old, (e) patient and family member must speak fluent Dutch and (f) are both willing to attend all group sessions together. Participants were recruited at the Centre for OCD at the Ghent University Hospital (UZ Gent) in Belgium. A group cycle started after four to eight patients and their family member gave written informed consent to participate. All sessions were audio-recorded for research purposes approved by the Ethical Committee of the Ghent University Hospital (UZ Gent, BC-05080). Meanwhile, 4 different MFT group cycles occurred between September 2019 and March 2023. Ongoing qualitative and quantitative research will provide more insight into the treatment experiences and effectiveness of the MFT intervention.

MFT is given as an addition to individual psychological and/or psychiatric outpatient treatment. Four major aims of the family group can be distinguished: (1) educating family members about OCD symptoms, ERP and FA (2) helping them to tolerate their own and their

OCD relative's distress and supporting their relative during conjoint ERP, (3) decreasing family accommodation by changing the reciprocal relationships between family interactions and the relative OCD symptoms and, (4) improving family functioning.

The MFT consists of 12 weekly sessions which last about ninety minutes. The content of the different sessions is determined by a treatment protocol (for a detailed overview see Table 1). All sessions (except session 1, 2 and 12) are structured in a similar way: discussion of the homework task of the previous session, psychoeducation (e.g. OCD, ERP, FA, …), conjoint exposure, group discussion, and provision homework task.

TABLE 1 Framework of the 12 sessions of MFT

Session	Goals	Components	Homework
1	- Building group cohesion and safety - Increasing understanding of OCD - Normalizing patient's difficulties	- Psychoeducation on OCD - Group discussion on OCD	- Monitoring obsessions & compulsions and triggers
2 - 3	- Increasing understanding of ERP	- Psychoeducation on ERP - Group discussion on ERP	- Reviewing/discussion on exposure hierarchy and potential exposure exercises
4 - 6	- Supporting conjoint ERP	- Psychoeducation on ERP - Conjoint ERP - Group discussion on conjoint ERP	- Daily conjoint ERP
7 - 10	- Increasing understanding of FA - Supporting conjoint ERP - Reducing FA	- Psychoeducation about FA - Conjoint ERP - Group discussion on FA	- Daily conjoint ERP - Reducing FA
11 - 12	- Increasing understanding of the burden of OCD and restoring healthy family routines - Supporting conjoint ERP - Reducing FA - Restoring healthy family routines - Thinking about relapse prevention	- Exercise on values - Conjoint ERP - Group discussion on healthy family functioning and relapse prevention	- Daily conjoint ERP - Reducing FA - Organizing healthy family activity

At the beginning of the first session, all participants (patients and family members) receive a manual containing the psychoeducation, explaining all exposure exercises and homework tasks. The group sessions are conducted by two psychotherapists (a psychologist and a psychiatrist), with experience in individual CBT for OCD and systemic MFT.

The therapeutic work with the families during the MFT

The complexity of the therapeutic work with the family members gradually increases in a structured and stepwise way during the different group sessions (see table 1). Over time, the treatment evolves from educating the families to experimenting with new behaviors and interactions (e.g., conjoint ERP) in the group and at home and from focusing on OCD symptoms and family burden to improve (non-)OCD-related family interactions. This stepwise approach takes into account that families change at a different pace. It also offers the families a clear rationale for the increasingly more challenging therapy interventions during the next step helping them to stay motivated during the group. A variety of systemic techniques are used in addition to the CBT: identifying maladaptive interactions, supporting family strengths and resources, reframing, circular questioning, changing family behaviour and interactions, externalization of the OCD, and challenging of belief systems and using metaphors.

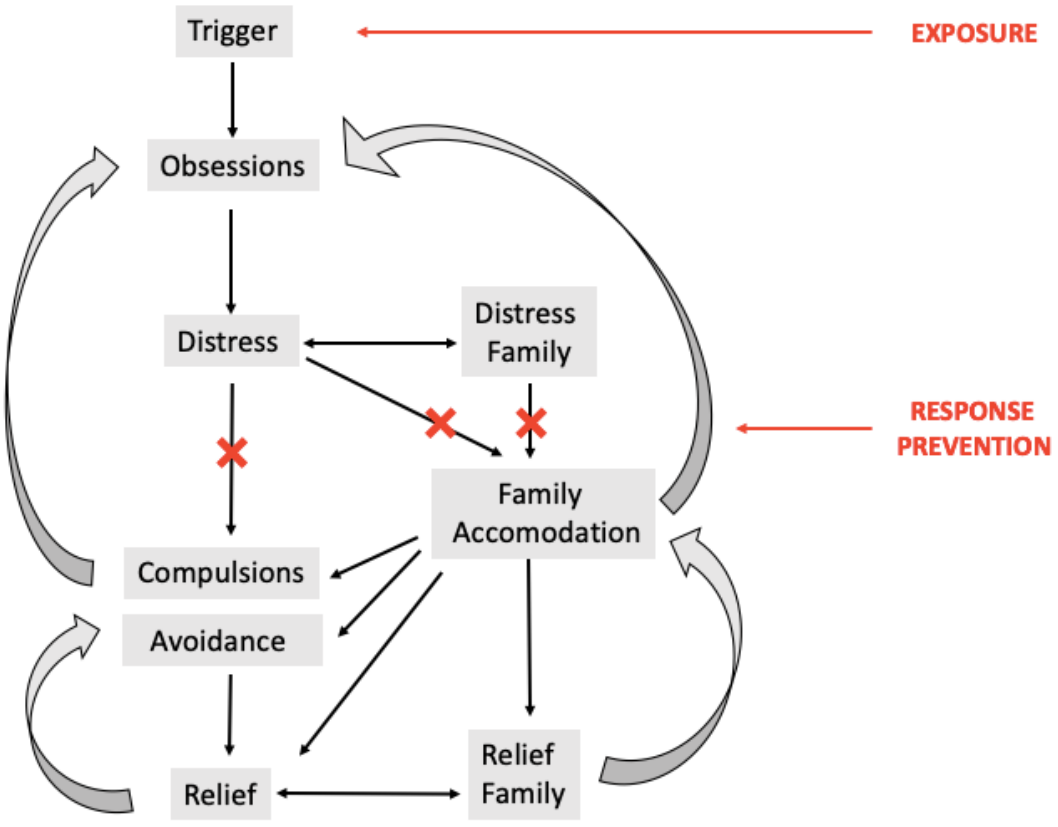
Psychoeducation

Psychoeducation, which is incorporated in all sessions, helps the families to become more aware and thus better understand OCD, its maintaining patterns, ERP and FA. Moreover, providing psychoeducation helps not only to inform and support patients and their family members to deal with the OCD, but also to feel less stigmatized (Authier, 1977; Catalan et al.,

2012; De Raedt, 2020; Rummel-Kluge & Kissling, 2008; Tynes et al., 1992). It further increases their motivation to experiment with the offered exercises (e.g. conjoint ERP and reducing FA) later on in the session and doing the homework task (Abramowitz et al., 2012; Baldisserotto et al., 2021; Grunes, Neziroglu, & McKay, 2001; Rezapour et al., 2021; Thompson-Hollands et al., 2015). Since it was offered in an interactional setting *('in exchange of the experiences of the patients and family members'*), it offered the group members the opportunity to reflect on 'their way' of living with OCD, to learn from other's experiences and to find new ways of relating to other patients and family members.

The first session focuses on the vicious obsessive and compulsive symptom cycle (obsessions – feelings of distress ('tension, anxiety, disgust, 'not just right' feelings (NJRF)') – compulsions – temporal relief – obsessions) in relation with FA and ERP.

FIGURE 1 OCD Model with FA and ERP



In the next sessions (*session 2-6*) exposure to obsessional stimuli and response prevention (‘*refraining from engaging in compulsions and learning to tolerate distress’*) are explained. Once these concepts are clearer, the psychoeducation focuses on family accommodation (*session 7-10*). Finally, as symptom reduction occurs, the importance of improving non-OCD-related family functioning (*session 11-12*) is explained. Homework tasks were always related to the psychoeducation given, were developed collaboratively by patients and family members together and included completing the OCD model discussed with patients’ own obsessions and compulsions, reviewing a list of common intrusions (this allows family members to recognize intrusions and helps patients learn to distinguish between their intrusions and obsessions, as some patients can make a distinction between their intrusions, intrusive thoughts that do not require action - similar to what people without OCD experience, and their obsessions, which cause distress and require action: compulsions, etc.), completing a self-monitoring form (patients’ triggers, obsessions, OCD behaviours), reading a text on the principles of ERP, completing an exposure hierarchy, reviewing and identifying forms of FA.

A better understanding of OCD may not only help families to blame their OCD relative less and to be more supportive but also to no longer feel responsible or guilty themselves causing the OCD (Steketee et al., 1998). Here are some illustrative vignettes from family members who say they have gained a better understanding of their relative's OCD and how it affects them:

> *It is helpful to get more insight into those obsessions and compulsions, because we had little insight into the disorder. It helps to be more understanding, because there is no one in the family with mental health problems so we are not really familiar with that.* (father)

I now realize better that she can't do much about it, so to speak, in the same way that we, as partners, can't solve this either. (partner)

During the discussion of the psychoeducation, different and similar OCD experiences of the patients and family members are shared leading to new insights and more understanding and support. By re-experiencing and re-evaluating one's own situation and relationships, families gain more understanding for "the other person's situation," which helps them to experience and experiment with new interactions. Often patients discuss some obsessions or compulsions or their struggles to cope with them for the first time, especially those who are not always visible to the family members. These disclosures are important because they help family members understand why the OCD patient is in distress or, for example, not paying attention during a conversation despite no obvious source of distraction.

I didn't realize at all that you were checking at that time, although I noticed sometimes that you were a bit absent-minded or that you asked me the same thing twice. (partner)

S*ometimes my daughter could get very angry when she was interrupted while doing a compulsion, but I didn't realize how much stress she was experiencing at that time.* (mother)

I realize now, from what is told during group discussion, that my daughter often suffers very much because of her OCD. I also perceive certain behaviour differently and notice that we didn't realize before that she was engaging in OCD. (mother)

The psychoeducation gives the families guidance how to cope with OCD, to tolerate their own and their loved one's distress during ERP and to reduce FA. At the same time, it may reveal the difficulties family members are experiencing to engage in conjoint ERP or their treatment concerns (e.g. negative impact on their relationship or patients' distress) (Merritt, Rowa, & Purdon, 2022). Such conversations are useful to create space and motivate the families to experiment with new ways of coping their loved one's OCD.

> *How can we better deal with the OCD? That's really important to me, because previously I've never been involved in my daughter's treatment*. (mother)

> *I find it very difficult to start exposure exercises because this will cause a lot of stress to my son and I know he will feel very anxious and then I feel enormously helpless.* (mother A). *I understand what you mean, I often feel helpless too when my daughter has a lot of stress, on the other hand, nothing will change if we don't try.* (mother B)

From session 7 onwards, different forms of FA (e.g. providing reassurance, waiting for the patient, participating in compulsions, facilitating compulsions or avoidance, modifying the personal or family routine) are explained to the family members. Family members are often not aware of their own FA behaviours or show FA behaviours in order to make their lives less difficult. Safety and avoidance behaviours are also addressed since they engender FA.

> *You do it so easily, without really knowing you're doing it.* (father)

> *Otherwise he will be stuck with it and then we are half an hour further and it remains the same.* (father)

Hereby, it is explained that reducing FA is a necessary but difficult process for both the patients (e.g. feeling ignored, not supported, frustrated, …) as well as for the family members (e.g. feelings of distress, feeling guilty for not helping the patient, ...).

> *When I refuse, he's very angry or he's says that I don't want to help him and then I feel very distressed.* (partner)

> *My son leaves all the doors open, because he doesn't want to touch the door handles because he believes that he will get infected. Because of the heating costs in winter, I'll close all the doors.* (mother)

> *Sometimes my son doesn't even go for a walk with his dog. Then I walk his dog, because an animal needs exercise.* (mother)

Conjoint ERP

Before the start of the conjoint ERP, patients and their family members are asked to list 10-12 specific situations that trigger different levels of distress (see homework session 2-3; exposure hierarchy): from low (e.g. touching door handle), to medium (e.g., touching elevator buttons) to high (touching toilet door handle) stress. Initially the conjoint ERP is conducted in the presence of the therapist (for example the therapist touches multiple door handles in a corridor, followed by the patients and family members doing the same as it was shown to them). It helps the family members to see how not to reassure the OCD relative but to support and encourage him/her disengaging from conducting compulsions ('response prevention'). Over time, conjoint exposure exercises become more difficult being conducted solely by the patient and family member and by choosing exercises higher on the exposure

hierarchy (e.g. being interrupted while reading an important document, without going back) or by combining different exercises at the same time (e.g. leaving notes disorderly open (*symmetry*) while touching the door handles in the hallway (*contamination*)). Conjoint ERP is a difficult process for patient and family members since they have to cope the relative's distress and to regulate their own distress at the same time. The MFT format gives families the opportunity to see other families struggling with similar difficulties and feelings, to support each other to keep going, and to give and receive advice during the conjoint ERP. In particular, the use of humor, typical of an MFT setting, often helps to create a relaxed atmosphere to overcome barriers to experimenting with new behaviors.

> *I saw you do that exercise but actually that is also something where my son suffers from and so I believe that it would also be a good exercise for him.* (mother)

> *I never expected my partner to do this, I am really impressed, at first speaking about a needle was already stressful, not to mention that now he even taps his finger with it. (partner)*
> *Wow, you did that very well indeed* (family member)
> *Practicing in group helps, because you see that everyone is experiencing stress and is searching to improve.* (partner)

Patients and family members are asked to conduct ERP exercises at home, applying what they have learned during the MFT. Family members are encouraged to adopt an autonomy-supportive style in guiding the patients.

> *I think the response prevention will be the most difficult part and for this, you have your father, who is here with you and who can support you at home, not by*

accommodating, but by reminding you what was agreed: "put your backpack aside, we're not getting anything out of it, etc.". You won't like that, but he is your coach at home. And you as a father, do not take over, just point it out to him, as it remains his responsibility. (therapist)

The discussion of the homework at the start of the next session gives the therapists insight in the progress the families are making or what difficulties they are still experiencing at home. It brings the home context to life in the group session, as in a play, but now with feedback for solutions and appreciation for achievements from multiple voices of all the participants ('polyphony').

My partner exercised with the needle container every day; we had also strategically placed it in the hallway so he could see it. He took the needles out and opened it every day as agreed. At first, I showed it again, but from the second half of the week he did it on his own. (partner)

My daughter did not do her exercises, I asked her several times when she would do them, but each time she said it was not the right time. I noticed that my husband was also losing his patience, because he did not notice any progress. (mother).

Can you tell us why it didn't work out this week? (therapists)

My mom had to visit a physician this week and it made me anxious that you might be seriously ill, as a result OCD got worse as a way of coping. (patient)

Reducing family accommodation

Once the family members have learned to regulate their own feelings of discomfort and guilt during conjoint ERP, family accommodation is tackled in a stepwise manner and consistent

with the patient's progress. It is important for family members to become more aware of FA, especially since it can be very subtle. By discussing different forms of FA in the group, a partner realized that she accommodated ('*My partner always goes to bed first, so I have to lock up and turn off the lights instead of him. By doing, I'm apparently accommodating').* It was decided that from now she would go to bed first, leave the lights on and would not lock the door. Since stopping FA may be difficult for patients and the family members, the group may act as a safeguard to support this process. Further, other more common and non-OCD related family interactions may act as an alternative for FA behavior. The group sessions provide multiple opportunities to discuss new patterns of interaction rather than ongoing dysfunctional FA interactions, and how to experiment with them. In particular, the supportive atmosphere of the MFT group, in which group members openly share their experiences, helps them better cope with failures and frustrations, pursue realistic goals and acknowledge small successes.

> *Now that we know that FA is not helpful, we pay more attention to it of course, but at the same time you sometimes fall into certain old habits (mother)*
>
> *I noticed that Cathy is still asking for reassurance, but you as a father did not do it. That was really good of you, did you find that difficult, Cathy?* (family member).
> *I still do it very automatically sometimes and do find it frustrating that my dad doesn't respond to it anymore, but I do understand why.* (patient)
>
> *I now ask my daughter what could help: giving a hug, giving space, doing something nice.* (mother)

Reducing family burden and improving family functioning

In the last two sessions special attention is paid to the impact of OCD on the family life and how family functioning can be improved. The latter is important because improving family functioning may lead to better patient recovery (Murthy et al., 2022). Hearing similar stories from other families struggling with the same difficulties reduces family members' sense of isolation, feelings of guilt, and stigmatization (Stengler-Wenzke et al., 2004).

> *You are with your friends, you cannot tell them, because they will not understand.* (mother).
>
> *My mother doesn't talk about me having OCD or maybe a little to her closest friend. I know and respect this, but understand that it must be hard for her.* (patient)

Also, by using the therapeutic technique of 'externalization' the therapists help the family to view OCD as a "dominant voice" rather than an intrinsic characteristic of the patient: *"OCD forces you, both patients and family members, to do things you don't want to do, such as certain rituals"* or *"it is important to be strict with the OCD, but gentle with the person"*. It not only reduces the patient's and family members' feelings of guilt and blame related to OCD, but it also increases insight into the impact of OCD on their lives and stimulates the patient's and family members' sense of choice (White, 1989). During the sessions, attention is paid to discussing the "dual strategy" of reducing OCD behaviour and simultaneously stimulating non-OCD-related activities and interactions. As the OCD becomes less central to family life, families are invited to explore their goals for themselves and the family independent of the OCD. To help formulate their strengths, resources, hopes and expectations, patient and family members are invited to identify 5 key values (from a list of 86 values) which are overendorsed (e.g. perfectionism, responsibility), compromised or

forgotten by the OCD. Recurrent topics that patients and family members are often mentioning, are the lack of feeling safe, the lack of intimacy, and feeling alone outside and even inside the family.

> *Feeling safe, that's something that I notice has slipped out of my hands because of the OCD. For example, in our family, the OCD just destroys everything because there are often arguments (patient*).

Since shared family activities are important during the sessions we emphasize discussion of family customs and activities and the families were asked to reorganize shared family activities such as enjoying a family meal, going to the movies or on a holiday together as homework.

> *when we were traveling together as a family in Switzerland, 10 days, it was during the summer and it was very hot, and we would often sit outside until late at night while it was still warm. That was really enjoyable (patient).*

In the last session, the families are also invited to reflect on their treatment gains ('*What gains or accomplishments have you made in the last 12 weeks?*'), to plan further conjoint ERP without FA ('*What are areas or goals that you would like to tackle next?' – 'How can you support your OCD relative without accommodating?'*) and to
plan strategies to prevent possible relapse ('*What will be the early warning signs that OCD is making its come-back?')*. A family member mentioned that asking his partner the following question: '*Is Janine* (= name the couple gave to OCD) *busy again?*', helped her to realize that she was engaging in compulsions and help her to stop them.

Discussion

We've developed a multi-family therapy group intervention for OCD patients and their families targeting family accommodation. Key therapeutic elements of this intervention include psychoeducation, conjoint ERP, reduction of FA, reducing family burden and improving family interactions and functioning. The stepwise treatment protocol starts with psychoeducation of the family members, to raise awareness and understanding of OCD and to support the change process. Subsequently, families learned how to break the vicious OCD circle and regulate their distress and how to interact with their loved one's OCD during conjoint ERP (See Figure 1). Finally, improved family functioning is supported. Although most families and the therapists are enthusiastic about the MFT groups, it is not clear how therapeutic change of the families is supported by the treatment protocol or whether some therapeutic steps should be more or less emphasized in therapy or whether the order of the different therapeutic steps is right or needs to be changed.

The conjoint ERP exercises were perceived as helpful by the therapists since they offer them the opportunity to closely observe how the patients and family members interact with each other in ERP contexts and what difficulties they encountered. It gives them the opportunities to better guide and support the families. Homework joint ERP exercises and their discussion within the group helped further to ensure that behavioral changes were incorporated within the home environment. Although the families were convinced of the necessity of the conjoint ERP exercises, they were sometimes experienced as difficult by the families and their success varied between the different families. This may be partly explained by differences in OCD symptom severity, treatment ambivalence or the family members dealing with it (e.g. treatment concerns, extent of accommodation) (Merritt, Rowa, & Purdon,2023a; Merritt, Rowa, & Purdon,2023b). Similar experiences were mentioned about FA. Some

family members felt more comfortable in not accommodating and supporting their relative without accommodation whereas for others it remained very difficult because they often felt helpless. However, most families perceived the exercising and the sharing of the experiences of the different families in the MFT group as encouraging and helpful in changing their interactions and FA at home.

Furthermore, the patients have reported that their own understanding of the underlying mechanism of OCD by hearing other stories of struggling with OCD and their willingness to challenge themselves in ERP had been improved by the group. Further, they felt that their family members were also more understanding and they now realized more how difficult their OCD symptoms were for their family members (*'It's also very confronting to see that, whether it's parents or partners, that it's really not obvious to the other person either. It is perhaps something that we do not fully realize because at that moment we are completely consumed by the OCD'*). Most family members were positive about their participation in the MFT group. The multiple opportunities for experiencing communality in the group help them to feel that they are not alone in struggling with OCD (*'we're all in the same boat, whether you have OCD or are the partner or family, it's confronting of course, but it's about the same thing'*). Furthermore, they reported to have gained new insights in how to deal with the OCD and were becoming more aware of the negative effects of family accommodation on the OCD symptoms. They also felt more comfortable to confront the patient when they were engaging in compulsions. They found the advice of the therapists and other families supportive and very 'hands on'.

However, some limitations and therapeutic dilemmas related to this MFT must be addressed. Some authors would argue that focusing on reducing EE would be equally or even more important than focusing on FA, particularly in high EE families (Chambless &

Steketee, 1999; Chambless et al., 2001; Shanmugiah, Varghese, & Khanna, 2002; Steketee et al., 1998). Although this was not specifically addressed, the MFT format itself may enhance 'intra- and cross'-family modelling of effective communication, problem solving and coping, eventually reducing EE. The involvement of only one family member in all sessions was mainly based on treatment continuity and group size. Although including a range of family members (e.g. partners, mothers, fathers, siblings) would have afforded a wider range of perspectives and voices within the group, it may also have led to less learning and change in the family interactions with the family members who did not come to the MFT. Indeed, FA may vary between the different members of one family. Thus, this may negatively impact family's boundaries and organization, because absent family members strongly depend on the information exchange of the participating family members (Briggs et al., 2017). Therefore, it might be useful to ask the family members if those absent have noticed changes in FA or family functioning or are aware of what has been discussed in the groups. Inviting some or all family members (e.g., siblings, parents) during all or some sessions would be another good alternative to consider after the current research project. At the moment, it is also unclear how and on what base (practical reasons, more understanding, more or less FA, ….) the families have decided which family member could join the MFT. The patients in the MFT group showed a wide variety of OCD symptoms (from fear of contamination, taboo thoughts, order and symmetry, …). Since families perceive the OCD symptoms, different from the one they are dealing with as much less frightening, this may have led the families to more readily encourage other families to engage in certain exposures. On the other hand, more homogeneity of OCD symptoms may increase understanding, group cohesion and modelling more quickly.

Conclusion

Multi-family therapy may help family members not only to increase their understanding about OCD, but also to better support their OCD relative with exposure and response prevention, to reduce family accommodation and to improve family functioning. Although both families and therapists experienced the MFT as helpful, the results of the ongoing clinical trial will shed more light on the effectiveness of this family intervention.

References

Abramowitz, J. S., Baucom, D. H., Boeding, S., Wheaton, M. G., Pukay-Martin, N. D., Fabricant, L. E., … Fischer, M. S. (2013). Treating Obsessive-Compulsive Disorder in Intimate Relationships: A Pilot Study of Couple-Based Cognitive-Behavior Therapy. *Behavior Therapy*. https://doi.org/10.1016/j.beth.2013.02.005

Abramowitz, J. S., Baucom, D. H., Wheaton, M. G., Boeding, S., Fabricant, L. E., Paprocki, C., & Fischer, M. S. (2012). Enhancing Exposure and Response Prevention for OCD: A Couple-Based Approach. *Behavior Modification*. https://doi.org/10.1177/0145445512444596

Albert, U., Baffa, A., & Maina, G. (2017). Family accommodation in adult obsessive-compulsive disorder: Clinical perspectives. *Psychology Research and Behavior Management*. https://doi.org/10.2147/PRBM.S124359

Albert, U., Bogetto, F., Maina, G., Saracco, P., Brunatto, C., & Mataix-Cols, D. (2010). Family accommodation in obsessive-compulsive disorder: Relation to symptom dimensions, clinical and family characteristics. *Psychiatry Research*. https://doi.org/10.1016/j.psychres.2009.06.008

Amir, N., Freshman, M., & Foa, E. B. (2000). Family distress and involvement in relatives of obsessive-compulsive disorder patients. *Journal of Anxiety Disorders*. https://doi.org/10.1016/S0887-6185(99)00032-8

Asen, E. (2002). Multiple family therapy: an overview. *Journal of Family Therapy*. 24, 3–16. doi: 10.1111/1467-6427.00197

Asen, E., and Scholz, M. (2010). Multi-Family Therapy: Concepts and Techniques. *London: Routledge.* doi: 10.4324/9780203841143

Authier, J. (1977). The Psychoeducation Model: Definition, Contemporary Roots and Content. *Canadian Journal of Counselling and Psychotherapy*, *12*(1).

Baldisserotto, G., Melo, W.V., Meyer, E. (2021). Psychoeducation on Drug (Ab)Use. In: Andrade, A.L.M., De Micheli, D., Silva, E.A.d., Lopes, F.M., Pinheiro, B.d.O., Reichert, R.A. (eds) Psychology of Substance Abuse. Springer, Cham. https://doi.org/10.1007/978-3-030-62106-3_22

Barrett, P., Healy-Farrell, L., & March, J. S. (2004). Cognitive-behavioral family treatment of childhood obsessive-compulsive disorder: A controlled trial. *Journal of the American Academy of Child and Adolescent Psychiatry*. https://doi.org/10.1097/00004583-200401000-00014

Baruah, U., Pandian, R. D., Narayanaswamy, J. C., Bada Math, S., Kandavel, T., & Reddy, Y. C. J. (2018). A randomized controlled study of brief family-based intervention in obsessive compulsive disorder. *Journal of Affective Disorders*. https://doi.org/10.1016/j.jad.2017.08.014

Baumas, V., Zebdi, R., Julien-Sweerts, S., Carrot, B., Godart, N., Minier, L. & Rigal, N. (2021). Patients and Parents' Experience of Multi-Family Therapy for Anorexia Nervosa: A Pilot Study. *Frontiers in Psychology 12:584565.* doi: 10.3389/fpsyg.2021.584565

Bolton, D., & Perrin, S. (2008). Evaluation of exposure with response- prevention for obsessive compulsive disorder in childhood and adolescence. *Journal of Behaviour Therapy and Experimental Psychiatry, 39*(1), 11-22.

Briggs, G. J., Morgan, D.M. (2017). Subsystem in Family Systems Theory. In: Lebow, J., Chambers, A., Breunlin, D. (eds) Encyclopedia of Couple and Family Therapy. Springer, Cham. https://doi.org/10.1007/978-3-319-15877-8_309-1

Calvocoressi, L., Lewis, B., Harris, M., Trufan, S. J., Goodman, W. K., McDougle, C. J., & Price,

L. H. (1995). Family accommodation in obsessive-compulsive disorder. *American Journal of Psychiatry*. https://doi.org/10.1176/ajp.152.3.441

Catalán, R., & Val, J. L. (2012). *Effectiveness of a psycho-educational group program for major depression in primary care: a randomized controlled trial*. https://doi.org/10.1186/1471-244X-12-230

Caporino, N. E., Morgan, J., Beckstead, J., Phares, V., Murphy, T. K., & Storch, E. A. (2012). A structural equation analysis of family accommodation in pediatric obsessive-compulsive disorder. *Journal of Abnormal Child Psychology*. https://doi.org/10.1007/s10802-011-9549-8

Chambless, D. L., Bryan, A. D., Aiken, L. S., Steketee, G., & Hooley, J. M. (2001). Predicting expressed emotion: A study with families of obsessive-compulsive and agoraphobic outpatients. *Journal of Family Psychology*. https://doi.org/10.1037/0893-3200.15.2.225

Chambless, D. L., & Steketee, G. (1999). Expressed emotion and behavior therapy outcome: A prospective study with obsessive-compulsive and agoraphobic outpatients. *Journal of Consulting and Clinical Psychology*. https://doi.org/10.1037/0022-006X.67.5.658

Cherian, A. V., Pandian, D., Bada Math, S., Kandavel, T., & Janardhan Reddy, Y. C. (2014). Family accommodation of obsessional symptoms and naturalistic outcome of obsessive-compulsive disorder. *Psychiatry Research*. https://doi.org/10.1016/j.psychres.2013.11.017

Cooper, M. (1996). Obsessive-compulsive disorder: effects on family members. *American Journal of Orthopsychiatry* 66, 2, 296-304.

Cordioli, A. V., Heldt, E., Bochi, D. B., Margis, R., De Sousa, M. B., Tonello, J. F., … Kapczinski, F. (2003). Cognitive-behavioral group therapy in obsessive-compulsive disorder: A randomized clinical trial. *Psychotherapy and Psychosomatics*, *72*(4), 211–216.

https://doi.org/10.1159/000070785

Cosentino, T., Faraci, P., Coda, D., D'Angelo, R., de Pari, L. A., di Crescenzo, M. R., … Scelza, A. (2015). Family accommodation in obsessive-compulsive disorder: A study on associated variables. *Clinical Neuropsychiatry*.

Craske, M. G., Kircanski, K., Zelikowsky, M., Mystkowski, J., Chowdhury, N., & Baker, A. (2008). Optimizing inhibitory learning during exposure therapy. *Behaviour Research and Therapy*. https://doi.org/10.1016/j.brat.2007.10.003

De Raedt, R. (2020). Contributions from neuroscience to the practice of Cognitive Behaviour Therapy: Translational psychological science in service of good practice. *Behaviour Research and Therapy*, 125. https://doi.org/10.1016/j.brat.2019.103545

Farrell, L. J., Schlup, B., & Boschen, M. J. (2010). Cognitive-behavioral treatment of childhood obsessive-compulsive disorder in community-based clinical practice: Clinical significance and benchmarking against efficacy. *Behaviour Research and Therapy*. https://doi.org/10.1016/j.brat.2010.01.004

Farrell, L., Waters, A., Milliner, E., & Ollendick, T. (2012). Comorbidity and treatment response in pediatric obsessive-compulsive disorder: A pilot study of group cognitive-behavioral treatment. *Psychiatry Research*. https://doi.org/10.1016/j.psychres.2012.04.035

Fischer, D. J., Himle, J. A., & Hanna, G. L. (1998). Group behavioral therapy for adolescents with obsessive–compulsive disorder: Preliminary outcomes. *Research on Social Work Practice*, 8, 629-636. http://dx.doi.org/ 10.1177/104973159800800601

Fisher, P. L., & Wells, A. (2005). How effective are cognitive and behavioral treatments for obsessive-compulsive disorder? A clinical significance analysis. *Behaviour Research and Therapy*. https://doi.org/10.1016/j.brat.2004.11.007

Flessner, C. A., Freeman, J. B., Sapyta, J., Garcia, A., Franklin, M. E., March, J. S., & Foa, E. (2011). Predictors of parental accommodation in pediatric obsessive-compulsive disorder: Findings from the pediatric obsessive-compulsive disorder treatment study (POTS) trial. *Journal of the American Academy of Child and Adolescent Psychiatry*. https://doi.org/10.1016/j.jaac.2011.03.019

Foa, E. B., & Kozak, M. J. (1986). Emotional Processing of Fear. Exposure to Corrective Information. *Psychological Bulletin*. https://doi.org/10.1037/0033-2909.99.1.20

Futh, A., Simonds, L. M., & Micali, N. (2012). Obsessive-compulsive disorder in children and adolescents: Parental understanding, accommodation, coping and distress. *Journal of Anxiety Disorders*. https://doi.org/10.1016/j.janxdis.2012.02.012

Garcia, A. M., Sapyta, J. J., Moore, P. S., Freeman, J. B., Franklin, M. E., March, J. S., & Foa, E. B. (2010). Predictors and moderators of treatment outcome in the pediatric obsessive compulsive treatment study (POTS I). *Journal of the American Academy of Child and Adolescent Psychiatry*. https://doi.org/10.1016/j.jaac.2010.06.013

Gomes, J. B., Cordioli, A. V., Bortoncello, C. F., Braga, D. T., Gonçalves, F., & Heldt, E. (2016). Impact of cognitive-behavioral group therapy for obsessive-compulsive disorder on family accommodation: A randomized clinical trial. *Psychiatry Research*. https://doi.org/10.1016/j.psychres.2016.09.019

Goodwin, G. M. (2015). The overlap between anxiety, depression, and obsessive-compulsive disorder. *Dialogues in Clinical Neuroscience*.

Grunes, M. S., Neziroglu, F., & McKay, D. (2001). Family involvement in the behavioral treatment of obsessive-compulsive disorder: A preliminary investigation. *Behavior Therapy*. https://doi.org/10.1016/S0005-7894(01)80022-8

Gururaj, G. P., Bada Math, S., Janardhan Reddy, Y.C., Chandrashekar, C.R. (2008). Family

burden, quality of life and disability in obsessive compulsive disorder: an Indian perspective. *Journal of Postgraduate Medicine* 54, 2, 91-97.

Halldorsson, B., Salkovskis, P. M., Kobori, O., & Pagdin, R. (2016). I do not know what else to do: Caregivers' perspective on reassurance seeking in OCD. *Journal of Obsessive-Compulsive and Related Disorders*. https://doi.org/10.1016/j.jocrd.2015.11.003

Hibbs E, Hamburger S, Lenane M et al. (1991), Determinants of expressed emotion in families of disturbed and normal children. *Journal of Child Psychology and Psychiatry* 32:757-770

Himle, J. A., Rassi, S., Haghighatgou, H., Krone, K. P., Nesse, R. M., & Abelson, J. (2001). Group behavioral therapy of obsessive-compulsive disorder: Seven vs. twelve-week outcomes. *Depression and Anxiety*. https://doi.org/10.1002/da.1032

Horwath, E., & Weissman, M. M. (2000). The epidemiology and cross-national presentation of obsessive-compulsive disorder. *Psychiatric Clinics of North America*. https://doi.org/10.1016/S0193-953X(05)70176-3

Iniesta-Sepúlveda, M., Rosa-Alcázar, A. I., Sánchez-Meca, J., Parada-Navas, J. L., & Rosa-Alcázar, A. (2017). Cognitive-behavioral high parental involvement treatments for pediatric obsessive-compulsive disorder: A meta-analysis. *Journal of Anxiety Disorders*. https://doi.org/10.1016/j.janxdis.2017.03.010

Jónsson, H., & Hougaard, E. (2009). Group cognitive behavioural therapy for obsessive-compulsive disorder: A systematic review and meta-analysis. *Acta Psychiatrica Scandinavica*. https://doi.org/10.1111/j.1600-0447.2008.01270.x

Kindynis, Z., Espie, J., Volz, C., Jassi, A. (2023). Multifamily therapy for young people with OCD: An acceptability and satisfaction study. *Bulletin of the Menninger Clinic*. Winter; 87(1):25-45. https://doi.org/ 10.1521/bumc.2023.87.1.25

Kobayashi, Y., Kanie, A., Nakagawa, A., Takebayashi, Y., Shinmei, I., Nakayama, N., … Horikoshi, M. (2020). An Evaluation of Family-Based Treatment for OCD in Japan: A Pilot Randomized Controlled Trial. *Frontiers in Psychiatry*. https://doi.org/10.3389/fpsyt.2019.00932

Laidlaw, T.M., Falloon, I.R.H., Barnfather, D., Coverdale, J.H. (1999). The stress of caring for people with obsessive compulsive disorders. *Community Mental Health Journal* 35, 5, 443-50.

Lebowitz, E. R. (2017). Family Impairment Associated With Childhood Obsessive-Compulsive Disorder. *Journal of the American Academy of Child and Adolescent Psychiatry*. https://doi.org/10.1016/j.jaac.2017.01.002

Lebowitz, E. R., Woolston, J., Bar-Haim, Y., Calvocoressi, L., Dauser, C., Warnick, E., … Leckman, J. F. (2013). Family accommodation in pediatric anxiety disorders. *Depression and Anxiety*. https://doi.org/10.1002/da.21998

Loh, C., Liang, W., Lee, H. & Tang, C. (2023) Development of Multi-Family Therapy for first episode psychosis in Singapore. *Journal of Family Therapy,* 45, 21-46. https://doi.org/10.1111/1467-6427.12329

March, J. (1995). Cognitive behavioral psychotherapy for children and adolescents with OCD: a review and recommendations for treatment. *Journal of the American Academy of Child & Adolescent Psychiatry* 34:7-18.

Martin, J. L., & Thienemann, M. (2005). Group cognitive-behavior therapy with family involvement for middle-school-age children with obsessive-compulsive disorder: A pilot study. *Child Psychiatry and Human Development*. https://doi.org/10.1007/s10578-005-3496-y

Merlo, L. J., Lehmkuhl, H. D., Geffken, G. R., & Storch, E. A. (2009). Decreased Family

Accommodation Associated With Improved Therapy Outcome in Pediatric Obsessive-Compulsive Disorder. *Journal of Consulting and Clinical Psychology*. https://doi.org/10.1037/a0012652

Merritt, O. A., Rowa, K., & Purdon, C. L. (2022). How do close others to those with anxiety feel about treatment ? Development and validation of the Treatment Concerns Questionnaire – Close Others. *Cognitive Therapy and Research.* https://doi.org/10.1007/s10608-022-10318-9

Merritt, O. A., Rowa, K., & Purdon, C. L. (2023a). Context Matters: Criticism and Accommodation by Close Others Associated with Treatment Attitudes in those with Anxiety. *Behavioural and Cognitive Psychotherapy.* https://doi.org/10.1017/S1352465822000455

Merritt, O. A., Rowa, K., & Purdon, C. L. (2023b) Criticism and Accommodation are Associated with Treatment Concerns in Close Others to those with Anxiety. *British Journal of Clinical Psychology.* https://doi.org/10.1111/bjc.12399

Murthy, N.S., Balachander, S., Nirmala, B.P., Pandian, R.D., Cherian, A.V., Arumugham, S.S., & Janardhan Reddy, Y.C. (2022). Determinants of family functioning in caregivers of persons with obsessive-compulsive disorder. *Journal of Affective Disorders,* 305, 179-187.

National Instituate for Health and Care Excellence (NICE). (2005). *Obsessive-compulsive disorder: Core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder. NICE clinical guideline 31*. *NICE Clinical Guidelines*.

Norman, K. R., Silverman, W. K., & Lebowitz, E. R. (2015). Family Accommodation of Child and Adolescent Anxiety: Mechanisms, Assessment, and Treatment. *Journal of Child and Adolescent Psychiatric Nursing*. https://doi.org/10.1111/jcap.12116

O'Leary, E. M. M. H., Barrett, P., & Fjermestad, K. W. (2009). Cognitive-behavioral family treatment for childhood obsessive-compulsive disorder: A 7-year follow-up study. *Journal of Anxiety Disorders*. https://doi.org/10.1016/j.janxdis.2009.06.009

Olatunji, B. O., Davis, M. L., Powers, M. B., & Smits, J. A. J. (2013). Cognitive-behavioral therapy for obsessive-compulsive disorder: A meta-analysis of treatment outcome and moderators. *Journal of Psychiatric Research*. https://doi.org/10.1016/j.jpsychires.2012.08.020

Olino T. M., Gillo, S., Rowe, D., Palermo, S., Nuhfer, E. C., Birmaher, B., & Gilbert, A. R. (2011). Evidence for successful implementation of exposure and response prevention in a naturalistic group format for pediatric OCD. *Depression and Anxiety*, 28(4), 342‑348

Öst, L. G., Havnen, A., Hansen, B., & Kvale, G. (2015). Cognitive behavioral treatments of obsessive-compulsive disorder. A systematic review and meta-analysis of studies published 1993-2014. *Clinical Psychology Review*, *40*, 156–169. https://doi.org/10.1016/j.cpr.2015.06.003

Pinto, A., Van Noppen, B., & Calvocoressi, L. (2013). Development and preliminary psychometric evaluation of a self-rated version of the Family Accommodation Scale for Obsessive-Compulsive Disorder. *Journal of Obsessive-Compulsive and Related Disorders*. https://doi.org/10.1016/j.jocrd.2012.06.001

Ramos-Cerqueira, A. T. D. A., Torres, A. R., Torresan, R. C., Negreiros, A. P. M., & Vitorino, C. N. (2008). Emotional burden in caregivers of patients with obsessive-compulsive disorder. *Depression and Anxiety*. https://doi.org/10.1002/da.20431

Renshaw, K. D., Steketee, G., & Chambless, D. L. (2005). Involving family members in the treatment of OCD. *Cognitive Behaviour Therapy*. https://doi.org/10.1080/16506070510043732

Rezapour, T., Barzegari, M., Sharifi, E., Malmir, N., Ghiasvand, H., Salehi, M., Noroozi, A., & Ekhtiari, H. (2021). Neuroscience-Informed Psychoeducation for Recovery: A Program to Promote Metacognition in People With Substance Use Disorders. *Basic and Clinical Neuroscience*, *12*(5), 597–606. https://doi.org/10.32598/bcn.2021.809.3

Riise, E. N., Kvale, G., Öst, L. G., Skjold, S. H., & Hansen, B. (2019). Does family accommodation predict outcome of concentrated exposure and response prevention for adolescents? *Child Psychiatry & Human Development*, *50*(6), 975‑986

Rosa-Alcázar, A. I., Sánchez-Meca, J., Gómez-Conesa, A., & Marín-Martínez, F. (2008). Psychological treatment of obsessive-compulsive disorder: A meta-analysis. *Clinical Psychology Review*. https://doi.org/10.1016/j.cpr.2008.07.001

Rummel-Kluge, C., Kissling, W. (2008). Psychoeducation for patients with schizophrenia and their families. *Expert Review of Neurotherapeutics.* 8(7), 1067-1077. https://doi.org/10.1586/14737175.8.7.1067

Selles, R. R., Belschner, L., Negreiros, J., Lin, S., Schuberth, D., McKenney, K., … Stewart, S. E. (2018). Group family-based cognitive behavioral therapy for pediatric obsessive compulsive disorder: Global outcomes and predictors of improvement. *Psychiatry Research*. https://doi.org/10.1016/j.psychres.2017.11.041

Shanmugiah, A., Varghese, M., & Khanna, S. (2002). Expressed emotions in obsessive compulsive disorder. *Indian Journal of Psychiatry*.

Shimshoni, Y., Shrinivasa, B., Cherian, A., & Lebowitz, E. (2019). Family accommodation in psychopathology: A synthesized review. *Indian Journal of Psychiatry*. https://doi.org/10.4103/psychiatry.indianjpsychiatry_530_18

Steketee, G. (1997). Disability and family burden in obsessive- compulsive disorder. *Canadian Journal of Psychiatry* 42, 919-28.

Steketee, G., Noppen, B. V., Lam, J., & Shapiro, L. (1998). Expressed emotion in families and the treatment of obsessive compulsive disorder. *In Session - Psychotherapy in Practice*. https://doi.org/10.1002/(SICI)1520-6572(199823)4:3<73::AID-SESS6>3.0.CO;2-9

Stengler-Wenzke, K., Trosbach, J., Dietrich, S., Angermeyer, M.C. (2004). Experience of stigmatization by relatives of patients with obsessive-compulsive disorder. *Archives of Psychiatric Nursing*, 18:88–96.

Stengler-Wenzke, K., Kroll, M., Matschinger, H., Angermeyer, M.C. (2006). Quality of life of relatives of patients with obsessive-compulsive disorder. *Comprehensive Psychiatry* 47, 6, 523-27.

Stewart, S. E., Hu, Y. P., Leung, A., Chan, E., Hezel, D. M., Lin, S. Y., … Pauls, D. L. (2017). A Multisite Study of Family Functioning Impairment in Pediatric Obsessive-Compulsive Disorder. In *Journal of the American Academy of Child and Adolescent Psychiatry*. https://doi.org/10.1016/j.jaac.2016.12.012

Stewart SE, Beresin C, Haddad S, Egan Stack D, Fama J, J. M. (2008). Predictors of family accommodation in obsessive-compulsive disorder. *Ann Clin Psychiatry*, *20*(2), 65–70.

Storch, E. A., Geffken, G. R., Merlo, L. J., Jacob, M. L., Murphy, T. K., Goodman, W. K., … Grabill, K. (2007). Family Accommodation in Pediatric Obsessive–Compulsive Disorder. *Journal of Clinical Child & Adolescent Psychology*. https://doi.org/10.1080/15374410701277929

Storch, E. A., Larson, M. J., Muroff, J., Caporino, N., Geller, D., Reid, J. M., … Murphy, T. K. (2010). Predictors of functional impairment in pediatric obsessive-compulsive disorder. *Journal of Anxiety Disorders*. https://doi.org/10.1016/j.janxdis.2009.12.004

Strauss, C., Hale, L., & Stobie, B. (2015). A meta-analytic review of the relationship between family accommodation and OCD symptom severity. *Journal of Anxiety Disorders*.

https://doi.org/10.1016/j.janxdis.2015.05.006

Summerfeldt, L., Rowa, K., & McCabe, R. (2017). Cognitive-Behavioral Treatment for Obsessive-Compulsive Disorder, Client Manuel. *Unpublished manual.*

Tandt, H., Debruyckere, I., Leyman, L., Colman, R., De Jaeghere, E., Van Parys, H., Baeken, C., Purdon, C., & Lemmens, G. (2021). How are OCD patients and family members dealing with the waxing and waning pattern of the COVID-19 pandemic? Results of a longitudinal observational study. *Psychiatric Quarterly.* https://doi.org/10.1007/s11126-021-09932-9

Tandt, H., Van Parys, H., Leyman, L., Purdon, C., & Lemmens, G. (2022). How are OCD patients and their families coping with the COVID-19 pandemic? A Qualitative Study. *Current Psychology.* https://doi.org/10.1007/s12144-021-01724-5

Thienemann, M., Martin, J., Cregger, B., Beth Thompson, H., & Dyer-Friedman, J. (2001). Manual-driven group cognitive-behavioral therapy for adolescents with obsessive-compulsive disorder: A pilot study. *Journal of the American Academy of Child and Adolescent Psychiatry*. https://doi.org/10.1097/00004583-200111000-00004

Thompson-Hollands, J., Abramovitch, A., Tompson, M. C., & Barlow, D. H. (2015). A Randomized Clinical Trial of a Brief Family Intervention to Reduce Accommodation in Obsessive-Compulsive Disorder: A Preliminary Study. *Behavior Therapy*. https://doi.org/10.1016/j.beth.2014.11.001

Turner, C., O'Gorman, B., Nair, A., & O'Kearney, R. (2018). Moderators and predictors of response to cognitive behaviour therapy for pediatric obsessive-compulsive disorder: A systematic review. *Psychiatry Research*. https://doi.org/10.1016/j.psychres.2017.12.034

Tynes, L.L., Salins, C., Skiba, W., Winstead, D.K. (1992). A psychoeducational and support group for obsessive compulsive disorder patients and their significant others.

Comprehensive Psychiatry, 33, 197-201.

Van Noppen, B., Steketee, G., McCorkle, B. H., & Pato, M. (1997). Group and multifamily behavioral treatment for obsessive compulsive disorder: A pilot study. *Journal of Anxiety Disorders*. https://doi.org/10.1016/S0887-6185(97)00021-2

Van Noppen, B., & Steketee, G. (2003). Family responses and multi-family behavioral treatment (MFBT) for obsessive compulsive disorder (OCD). *Brief Treatment and Crisis Intervention,* 3, 231-247.

Vikas, A., Avasthi, A., & Sharan, P. (2011). Psychosocial impact of obsessive-compulsive disorder on patients and their caregivers: A comparative study with depressive disorder. *International Journal of Social Psychiatry*. https://doi.org/10.1177/0020764009347333

Waters, T. L., & Barrett, P. M. (2000). The role of the family in childhood obsessive-compulsive disorder. *Clinical Child and Family Psychology Review*. https://doi.org/10.1023/A:1009551325629

White, M. (1989). The externalizing of the problem and the re-authoring of lives and relationships. Dulwich Centre Newsletter. Reprinted in M. White and D. Epstein (eds) *Narrative Means to Therapeutic Ends* (pp. 38 – 76). New York: W.W. Norton

White, M. (1995). Reflecting teamwork as definitional ceremony BT - Re-Authoring Lives: Interviews and Essays. *Re-Authoring Lives: Interviews and Essays*.

Wu, M. S., McGuire, J. F., Martino, C., Phares, V., Selles, R. R., & Storch, E. A. (2016). A meta-analysis of family accommodation and OCD symptom severity. *Clinical Psychology Review*. https://doi.org/10.1016/j.cpr.2016.03.003