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Impact of cognitive-behavioral group therapy for obsessive-compulsive disorder on family accommodation: A randomized clinical trial

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ABSTRACT

The aim of this study was to assess the impact of cognitive-behavioral group therapy (CBGT) with the brief involvement of family members on family accommodation and to identify predictors of family accommodation reduction (patient and family member characteristics). This randomized clinical trial assessed 98 pairs of patients with obsessive-compulsive disorder (OCD) and their family members: 52 (53.1%) were allocated to the intervention group (12 CBGT sessions – two with the family member), and 46 (46.9%) to a waiting list (control group). Symptom severity and family accommodation were assessed before and after CBGT. There was significant improvement of OCD symptoms and family accommodation scores after CBGT in the intervention group vs. the control group. The following variables were significant predictors of family accommodation reduction after multivariate analysis: patient characteristics – absence of comorbid unipolar disorder, lower obsession score, and higher education level; family member characteristics – higher hoarding score. The model explained 47.2% of the variance in family accommodation scores after treatment. CBGT for patients with OCD and the brief involvement of family members contributed to reduce family accommodation. Both patient and family member characteristics were predictors of family accommodation reduction. This finding can help qualify CBGT protocols.

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1. Introduction

Families of patients with obsessive-compulsive disorder (OCD) often change their daily routines in response to symptoms, in an attempt to relieve anxiety and/or reduce the time spent in rituals – a phenomenon that has been referred to as family accommodation (Calvocoressi et al., 1995; Merlo et al., 2009; Albert et al., 2010). Family involvement in OCD symptoms as evaluated by the Family Accommodation Scale for Obsessive Compulsive Disorder – Interviewer Rated (FAS-IR) has revealed high prevalence rates of family accommodation, ranging from 89% (Calvocoressi et al., 1999) to 98.2% (Gomes et al., 2014). Some of the most frequently reported family accommodation behaviors include providing reassurance and participating in the patient's compulsions (Calvocoressi et al., 1995; Stewart et al., 2008; Peris et al., 2008; Albert et al., 2010; Gomes et al., 2014).

Studies have shown a significant association between family accommodation and obsessive-compulsive symptom severity (Van Noppen and Steketee, 2009; Albert et al., 2010; Ferrão and Florão, 2010; Lebowitz et al., 2012; Gomes et al., 2014). For example, presence of contamination/cleaning symptoms (Stewart et al., 2008; Albert et al., 2010; Ferrão and Florão, 2010) and more severe obsession symptoms (Gomes et al., 2014) have been correlated with greater family accommodation levels. In another study, family accommodation was moderately correlated with the patient's anxiety and depressive symptoms (Ferrão and Florão, 2010).

In some cases, family members may have obsessive-compulsive symptoms of their own, and may therefore accommodate or even promote the patient's symptoms as an extension of their own anxiety (Calvocoressi et al., 1999). A recent study investigating specific family member symptoms found a positive correlation between family member hoarding and family accommodation (Gomes et al., 2014).

Previous studies have identified an association between higher family accommodation levels and worse treatment results in adult and pediatric patients treated with cognitive behavioral therapy (CBT) and/or pharmacotherapy (Amir et al., 2000; Ferrão et al., 2006; Garcia et al., 2010). In particular, a recent study has evaluated the effect of two sessions of psychoeducation and skills training in reducing accommodation in nine relatives of patients with OCD treated with exposure and response prevention (ERP),

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compared to a control group of family members who did not receive the two psychoeducation sessions. The preliminary results revealed a reduction in accommodation in the first month of patient treatment. At the end of the study, family accommodation scores in the control group remained at 78% of the initial levels, while in the intervention group, they decreased to 37% of baseline scores (Thompson-Hollands et al., 2015).

Several clinical trials have evidenced that CBT, applied either individually or in groups, is effective in reducing obsessive-compulsive symptoms (Cordioli et al., 2003; Jónsson and Hougaard, 2009, 2011; McKay et al., 2015). However, to our knowledge, only one study so far – namely, the pilot study conducted by Thompson-Hollands et al. (2015) – has evaluated the use of a brief family intervention (two sessions) focused on family accommodation in adult patients with OCD (that study, however, used individual ERP). Specifically, no previous study has evaluated the impact on family accommodation of cognitive-behavioral group therapy (CBGT) administered to adults with OCD with the brief involvement of family members (not in all sessions).

Therefore, the objectives of present study were 1) to assess the impact of CBGT with the brief involvement of family members on family accommodation, and 2) to identify predictors of family accommodation reduction after CBGT, with a focus on patient and family member characteristics. Our hypotheses were 1) that CBGT administered to patients with OCD and involving family members in two sessions could have a positive impact on family accommodation scores, and 2) that particular characteristics of patients and family members could have an influence on family accommodation reduction after CBGT.

2. Methods

Generally, the patient screening/selection process was the same employed in a previous cross-sectional study (Gomes et al., 2014). However, because several differences exist, the methodology will be described below in detail.

The present study was approved by the Research Ethics Committee of Hospital de Clínicas de Porto Alegre (protocol no. 08-566).

2.1. Study design

In this randomized clinical trial, participants were randomly allocated to either the intervention group, i.e., 12 CBGT sessions, of which 10 were conducted with patients only and two (first and eighth) involved both patients and family members, or to a control group where patients were assigned to a waiting list (no intervention with patients or family members). Group allocation was performed by an investigator not involved in the clinical trial, using a computer-generated list of random numbers provided by an independent statistician.

2.2. Participants

From 2009 to 2010, patients were recruited from the general population through lectures, radio and TV interviews, and newspaper advertisements, and invited to participate in the CBGT program offered to patients with OCD at the hospital. A total of 153 patients were screened; the patient selection process is shown in Fig. 1. The time interval between patient screening and randomization was 1–2 weeks for all patients. Following baseline assessment, the time elapsed until CBGT initiation in the intervention group was 2–3 weeks.

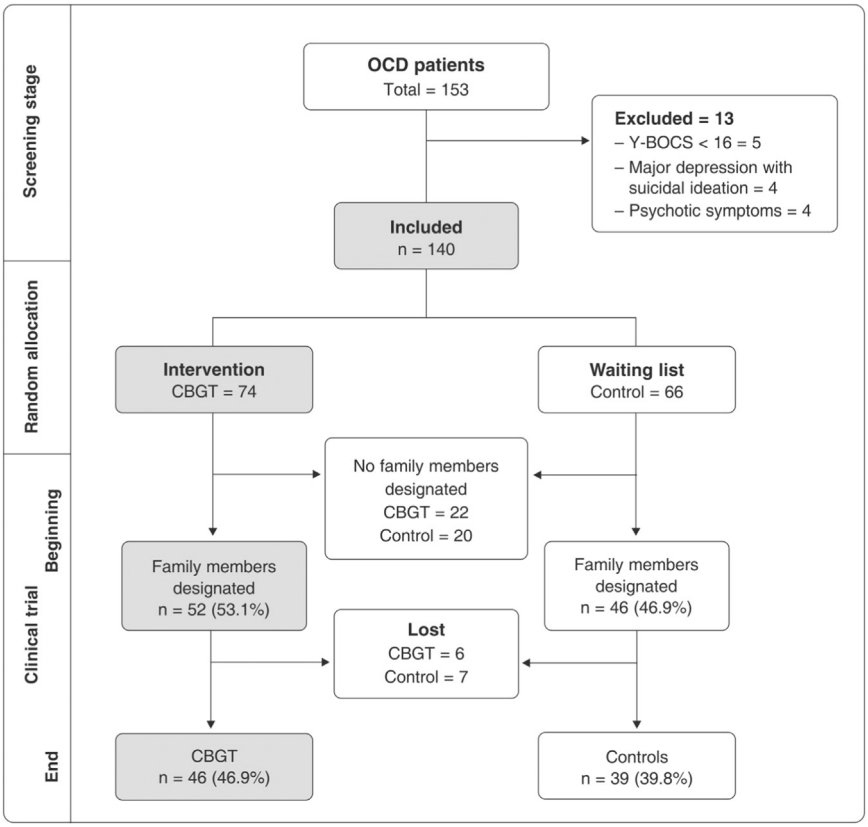

Fig. 1. Flow chart of the patient selection process. BDI=Beck Depression Inventory; CBGT=cognitive-behavioral group therapy; OCD=obsessive-compulsive disorder; Y-BOCS=Yale-Brown Obsessive Compulsive Scale.

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