ORIGINAL ARTICLE

Obsessive compulsive disorder and stigmatization

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Abstract

BACKGROUND: Individuals suffering from mental disorder have to deal with both symptoms of their disorders and with stigmatizing attitudes and acts. A particular risk represents internalized stigma, which negatively influences psychological well-being of patients, as well as treatment efficiency. Patients with obsessive compulsive disorder (OCD) and their family members might be exposed to stigmatization especially when compulsive acts and rituals are performed in public.

METHOD: Studies were identified through PUBMED, Web of Science, and Scopus databases as well as existing reviews. The search terms included "obsessive compulsive disorder", "stigma", "self-stigma", psychoeducation", "psychotherapy", and "psychosocial treatment". The search was performed by repeated use of the words in different combinations with no language or time limitations. The purpose of this article is a review of recent research related to OCD and stigmatization.

RESULTS: Patients suffering from OCD and their relatives struggle with prejudices and discriminative actions based on the stigma of mental illness. In reaction, they try to keep the diagnosis secret. Family members also take over more responsibilities of patients and assist with performing rituals as the disorder gets worse. All of this creates significant stress and anxiety in families. Depression, substance abuse, criticism, hostile emotions, and perceived stigma are present in these families and lead to an escalation of the symptoms. It seems beneficial to establish support groups for partners and family members of individuals suffering from OCD.

Introduction

Individuals labeled as mentally ill struggle daily with the various forms of discriminative actions, emotions, and prejudices. These stigmatizing attitudes and behavior then create barriers to life opportunities. Stigma forms additional barriers if stigmatized persons internalize perceived prejudices and are persuaded that such beliefs are totally correct (Corrigan *et al* 2002). Symptoms of the disorders are not the only reasons for suffering of patients with mental illnesses. Stigma is sometimes called "a second illness", due to its significant impact (Finzen 1996). Experiencing stigma brings along social isolation and might lead to profound social exclusion. A stigmatized individual is devalued and comes across limited life chances (Schulze & Angermeyer 2003; Finzen 2000). Stigmatization also affects family members of patients with

mental disorders. Patients, as well as their relatives, might be disappointed and even terrified by the psychiatric diagnosis, and it subsequently reflects in their attitudes and motivation towards treatment.

Obsessive-compulsive disorder (OCD) is a mental illness associated with a significant impact on daily lives of suffering individuals and their families. Patients gradually become socially isolated as they are more and more flooded with obsessive thoughts and compulsive acts. Patients suffering from OCD maintain insight into their disorder and often perceive repetitive thoughts and actions as senseless and revolting. They become dependent on the relative´s care, and their disorder gets worse (Stengler-Wenzke *et al* 2004a).

Prevalence of OCD is approximately 2% in the pediatric population (Geller & Spencer 2003) and 1.9–3% in the adult population (American Psychiatric Association 2000). Current psychiatry and clinical psychology have developed several pharmacological and psychotherapeutical procedures to ease the burden of the disorder (Abramowitz 2006; Deacon & Abramowitz 2004; Storch *et al* 2003). The highly effective method is cognitive behavioral therapy (CBT) with exposure and response prevention and possible supplementation by reuptake inhibitors (SSRIs) (Foa *et al* 2005). Another treatment option is use of serotonin norepinephrine reuptake inhibitors, pregabalin, tricyclic antidepressants and benzodiazepines (Bandelow 2008). Exposure with response prevention affects both symptom severity, distress and impairment related to symptoms. It has also been shown that this treatment method holds its effectiveness over time (Barrett *et al* 2005; Rufer *et al* 2005). Despite the improvement provided by psychotherapeutic and pharmacological treatment, most patients remain symptomatic (Jenike 1992; Livingston-Van Noppen *et al* 1990). Only a small number of patients experience episodes of OCD with periods of being free of symptoms. Spontaneous remission is even rarer (Goodman & Murphy 1997). Symptoms of the disorder are also a difficult challenge for patients' families. Long-term tension resulting in interpersonal conflicts and financial strain are not uncommon in the families which deal with a tight OCD regime (Cooper 1996; Emmelkamp *et al* 1990; Livingston-Van Noppen *et al* 1990; Tynes *et al* 1990).

Method

Studies were identified through PUBMED, Web of Science, and Scopus databases as well as existing reviews. The search terms included "obsessive compulsive disorder", "stigma", "self-stigma", psychoeducation", "psychotherapy", and "psychosocial treatment". The search was performed by repeated use of the words in different combinations with no language or time limitations. The articles were collected, sorted by their relevance, and key articles listed in reference lists were searched. Reference lists of publications identified by these procedures were hand-searched for other relevant citations. The review also includes information from monographs referred to by other reviews. Thus, the article is a review.

Stigmatization in obsessive compulsive disorder

The fact that a disabled person is treated by a psychiatrist may lead to the labeled as "mentally ill". The label is traditionally used by the general population for severe mental disorders. Fear of stigmatization is the reason why people suffering from obsessive compulsive disorder are afraid of the psychiatric diagnosis in such extent that they might actively avoid seeking adequate help. The elemental behavior to the people labeled as mentally ill can be characterized as "keeping distance", tendency to "observe", and eventually isolate them. The lay people especially pay attention to the external manifestations of the patient – expressions, movements, physiognomy, postures, and language – and focus mainly on unusual features. Many compulsive rituals might look strange to people who have never suffered from OCD. When society notices that a certain person "behaves strangely" or "act madly", the labeling process begins and may lead to a permanent stigmatization. If the behavior is found "weird" but still tolerable, the patient is usually labeled as "nervous". In such cases, personality or a situational "breakdown" are supposed to be the underlying cause of the behavior. The causes derived from personality traits are negatively judged, seldom is the "breakdown". Laymen have created taxonomy of the mental disorders. A dichotomic approach is typical: a genuine "madness" on one side and "a nervous breakdown" on the other (Chromy 1990).

Stigmatized psychiatric patients are judged according to beliefs about underlying causes of their disorder. The intensity of rejection of labeled individuals depends on the lay interpretation of the etiology of the disorder (Prasko *et al* 2011). The lay people's attitudes to the underlying causes of mental illnesses can be divided into several groups: *the personality causes* (mental inferiority, weakness, perversity, or immorality), *the organic causes* (genetics and brain disorders), and *the situational causes* (traumatic breakdown, shock, life misfortunes, worse material condition, grief, and sorrow). According to the presumed cause, attitudes towards labeled individuals change. The more favorable is a so called peristatic interpretation which finds the cause in stress or events experienced by the individual. The other extreme is an organic interpretation that looks for the cause in the "ill brain". In the "personality" etiology, the affected one should make "some effort to get better".

Stigma and family

Limitations, which come along with the progress of OCD symptoms, increase dependence of patients on their relatives. Individuals suffering from OCD are

more and more incapable to manage their everyday tasks, due to numerous obsessive thoughts, indecisiveness, lack of self-esteem, and avoidant behavior. Thus, families often take responsibility and deal with patient's duties and activities (Steketee 1997; Laidlaw *et al* 1999). Because of the hard position of caregivers, researchers lately also started to focus on their quality of life, coping strategies, and other characteristics (Geffken *et al* 2006; Stengler-Wenzke *et al* 2006). Apart from taking over everyday responsibilities, families of individuals suffering from OCD usually take part in rituals that their relatives perform and thus present a crucial factor among maintaining factors. From this point of view, families with patients suffering from OCD can be clearly distinguished from families of patients with other disabling mental disorders. Especially family members living in the same household with the patient (such as spouses, parents, siblings, and children) are involved in daily rituals. Relatives might help with performing rituals or accommodate family schedules to reduce the patient's anxiety (Calvocoressi *et al* 1995; Livingston-Van Noppen *et al* 1990; Marks 1995; Rachman & Hodgson 1980). Increasing absorption in the relative's rituals and related behavior gradually dominates family life and leads to accumulation of tension and disagreements about how to act. Although it is not only rituals which negatively affect family cohesion. Depression, grief, blame, substance abuse, social stigma, and other secondary and comorbid symptoms are part of the picture too. All of these factors affect interactions between patients and their relatives and create a significant stress and burden (Stengler-Wenzke *et al* 2004a). Based on clinical observations, caregivers often suffer from perceived stigma and feelings of shame and guilt. However, researches that focus on the impact of OCD on families and other interpersonal relationships are scarce to this date (Cooper 1996; Emmelkamp *et al* 1990; Ramos-Cerqueira *et al* 2008).

As has been proposed, stigma affects patients with mental disorders as well as their families (Sommer 1990). Goffman (1986) named the process, in which an individual gets labeled because of his or her contact with a stigmatized person, as courtesy stigma. Psychiatric patients and their families still strive against stigma and disadvantages that come from it (Phelan 1998). Thus, the fact, that a relative has been diagnosed with a mental disorder, brings into a family much more changes than giving their relative's issues a medical name and a beginning of a treatment. The family also has to start to deal with stigma (Trosbach *et al* 2003). There is no surprise then that close relatives tend to keep the OCD diagnosis secret (Newth & Rachman 2001). Relatives might come across specific experiences and prefer to apply certain coping strategies in a hope that they could avoid stigmatization and shame, such as a tendency to isolate themselves or hide the patient's symptoms from the "outer world". The mental disorder is a secret that is not being shared. Taboo also includes unique burden related to the care of a relative with OCD (Stengler-Wenzke *et al* 2004a, 2004b).

Families of patients with OCD might react to the symptoms in different ways. Relatives can be overly helpful in performing rituals as well as refusing to take part in it (Van Noppen *et al* 1997). A particular case presents OCD connected with abnormal fear of filth or contamination. When one meets a pathogen, he or she usually starts to feel disgust which leads to avoidant behavior (Curtis *et al* 2011). Disgust serves as a form of evolutionary advantage and generally improves the adaptability. Tendencies to avoid pathogens are not uniform among the individuals. The tendencies vary depending on the extent favored type of behavior. The variance can be partly explained by obsessive compulsive disorder, pregnancy, infancy, or certain personality traits, such as so-called neurotic personality. It has been shown that part of patients with OCD are especially sensitive to disgust (Olatunji *et al* 2007) but since their symptoms are mild at the start of the disorder, disgust might be perceived as normal behavior and thus tolerated by family members. Because OCD develops gradually, its beginning is often overlooked, and only a few relatives might be able to pinpoint the moment when the disorder started. This frequently occurring situation cannot be explained as patient's tendencies to hide the symptoms because of shame and fear of rejection. Spouses might overlook symptoms simply because the relationship started when their partner had already been ill, children of patients with OCD might not be able to recognize the symptoms of mental disorder while being too young. The progress of OCD can be slow to the extent that relatives simply do not notice pathological changes in patient's behavior. Subsequently, the family adjusts to the rituals, which are more and more huge and complex. In such cases, relatives tend to interpret rituals and obsessions as personal eccentricities or tics (Stengler-Wenzke *et al* 2004a). Acts of compulsions are viewed as isolated incidents that are not connected to the patients' personality, and the integrative point of view becomes even more difficult with increasing symptomatology. On the other side, some relatives might attribute the symptoms to certain personality features of a patient. Such point of view is often rather negative and leads to a rejection of the patient. Openly admitting their struggles with obsessions and compulsions or impossibility to keep them secret can stop patients' erroneous attributions. Suicidal tendencies might be a sign of this transition as well (Stengler-Wenzke *et al* 2004a).

It is not easy to admit that relative suffers from a mental illness. When family members recognize that perceived symptoms are signs of a mental disorder, they might have only a vague image of a particular diagnosis or mental disorders generally. They can be afraid of mental illness stigma, as well. Along with a tension that brings the urge to solve the relative's mental health problems, factors such as uncertainty, powerlessness, and helplessness might come. A decision to seek

professional help and consequent start of psychiatric treatment present a significant burden on family life (Stengler-Wenzke *et al* 2004a). The symptoms of OCD, namely rituals, might look unusual or bizarre. If they are performed publicly, relatives might be embarrassed and concerned about labeling reactions. Fear from social devaluation and exclusion is further strengthened by the presence of a psychiatric diagnosis. All of this creates significant stress that families of patients with OCD need to deal with. The process of accepting and understanding the symptoms and numerous negative consequences in everyday life might be challenging and present a long-term task rather than a matter of a quick adjustment. It is not an exception when it takes entire time of treatment for relatives to cope with it (Stengler-Wenzke *et al* 2004b).

Families often hide their relative‘s mental health issues from society and attempt to appear as ordinary and normal as possible. Such behavior protects families from consequences of stigma but on the other side also increases the overall level of stress. While keeping the psychiatric diagnosis secret, a chance to confide in someone from the outside world is diminished. Concerns and coping patterns of families with OCD patients slightly resemble families with relatives suffering from schizophrenia (Schulze & Angermeyer 2003). Protective behavior of relatives might spread in repeated reassurance, taking over patient‘s household responsibilities, or personal assistance in performing rituals. According to Calvocoressi and colleagues (1995), such patterns of behavior can be found in one third of all families with individuals suffering from OCD. There was also an attempt to identify the most disturbing symptoms (Cooper 1996).

The mass media play a crucial role in building an image about psychiatry and patients with mental disorders, and thus indirectly contribute to coping reactions of families with relatives suffering from OCD (Wahl 2000; Wolff 1997). However, the image of psychiatric patients, that media bring, might be confusing (Hoffmann-Richter 2000). It is partly due to a still prevalent stereotype that people with mental disorder are dangerous, unpredictable, and aggressive (Chromy 1990; Gray 2002; Nawka *et al* 2012; Nawkova *et al* 2012).

Stengler-Wenzke and colleagues (2004b) interviewed relatives of patients with various mental disorders, including 22 family members of individuals with OCD, with a focus on burdens and stress. The performed study showed the presence of four fields of stigmatization typical for families of patients with obsessive compulsive disorder – characteristics of the onset of OCD, keeping the disorder secret, stigmatization among healthcare workers, and retrospective stigmatization. The authors conclude that stigmatization of patients with OCD and their families can be lowered by co-operation of patients, their families, and medical professionals in a way that is free from common prejudices and stereotypes.

As for the characteristics of the onset of OCD, authors of the research found that the pathway to the OCD diagnosis is often demanding and with many blind alleys. Professionals can misjudge the symptoms and misdiagnose them. Laymen might stigmatize patients as there are many prejudices about people who “act strangely“ in society. Thus, patients and their relatives become sensitive to negative judgments. When finally diagnosed with OCD, both patients and families might be so shocked and frightened of getting the label of a psychiatric patient that they profoundly deny the fact of the presence of the mental disorder. In response to possible negative judgments from others, they conceal the fact of the diagnosis and the symptoms. It creates a double edge sword – it protects families from stigma but also prevents them from obtaining so needed social support. Stigma can be present within the families itself when relatives look for a scapegoat and blame each other for the presence of OCD (Stengler-Wenzke *et al* 2004b).

According to Stengler-Wenzke and colleagues (2004b), people suffering from OCD and their close ones seldom come in public with the fact of being diagnosed and treated in psychiatry. They rather conceal it to avoid stigmatizing reactions. Relatives can feel embarrassed if compulsive rituals are done in public, especially if they violate norms of society. In reaction to such situations, they can start to avoid collective activities. The label of the mental disorder is threatening, and relatives usually prefer to see their close one‘s symptoms as “quirks” that might be laughed at. Being isolated from society and considering OCD a taboo create an area of silence where relatives and patients cannot openly talk about their worries and burdens. There are only a few who know about patient‘s condition, and it is usually the patient itself who decides who might know about his mental health problems and who might not.

Relatives can also experience stigmatizing reactions in the medical system itself. The path to the diagnosis can be long and tiresome. Patients often visit several mental health professionals who try to treat the patient in their way, which does not have to be always the right one. Professionals might be little empathetic and have a lack of knowledge about the disorder. Undergoing an individual therapy can make relatives feel rejected from the process of the treatment (Stengler-Wenzke *et al* 2004b).

The relatives from the research of Stengler-Wenzke and colleagues (2004b) admitted that they might have stigmatized their close one, especially at the start of the disorder. These family members attributed their behavior to the lack of knowledge, insecurity, and helplessness. The family members were also often taking part in performing rituals which, from a long-term point of view, led to an increased irritability, negativism, loss of interests, and deficits in other social roles. It was difficult for them to be always supportive and empathetic, when their relative was losing hope because they were struggling themselves (Stengler-Wenzke *et al* 2004b).

A specific case presents families where a parent suffering from OCD brings up healthy children. These children usually perceive the disorder in terms of normality and their insight grows slowly. It is not an exception that the children, at one point, start to worry about the possibility to develop symptoms of OCD themselves. Thus, an often used coping strategy of keeping distance from a relative with OCD might be seen as an effort to keep own mental health (Stengler-Wenzke *et al* 2004b).

Self-stigmatization in obsessive compulsive disorder

Internalized stigma (in other words self stigma or felt stigma) is a term used for a process in which an affected individual adopts negative stereotypes that society holds against him. A person, who internalized prejudices, completely agrees with their content, believes that he or she is deficient because of having the stigmatized characteristics, and anticipates being rejected by society in reaction to public disclosure of the devalued attributes (Corrigan *et al* 2005; Corrigan & Watson 2002; Corrigan *et al* 2006; Ritsher & Phelan 2004). Up to date, there exist numerous studies focusing on experiences and consequences of stigma among people suffering from various mental disorders. A review of the current state of research can be found in an article by Livingston and Boyd (2010). Authors come to a conclusion that internalized stigma strongly and negatively influences various psychosocial variables (namely hope, empowerment, and self-esteem), as well as psychiatric variables (e.g., symptom severity and treatment adherence).

Psychiatric patients have to deal with both the stigmatization from the others and the inner stigma. Patients suffering from OCD are no exception. The risk of being stigmatized discourages many individuals with OCD from seeking adequate psychiatric help. Instead of admitting that they have mental problems, they might deny or suppress psychological aspects of their issues and intensely look for somatic explanations (typically from the field of dermatology) (Prasko *et al* 2011). Patients often expect negative reactions from the others in case they would confide with contents obsessive thoughts or someone from the outer world sees repetitive compulsions. Patients and their relatives fear that they could be rejected and excluded from society, and this is why families of individuals with OCD often try to conceal the symptoms of the disorder. From what we know, such actions seem fully justifiable (Stengler-Wenzke *et al* 2004b). Patients with OCD also often try to hide behavioral symptoms of anxiety and nervousness in an attempt for others not to "recognize he, or she is mad". However, such effort cannot lead to an endless success. At some point, patients lose control, nervousness takes over them and anxiety becomes clearly noticeable. From the same reason, people suffering from OCD avoid visiting a psychiatrist who could "find out about their mental troubles" (Prasko *et al* 2011).

Society judges men and women differently at some points. There is a higher tolerance for lack of courage, shyness, and weakness in women than in men. Thus, men might be more prone to hide their mental health issues. Other potential complications hindering a successful treatment might pose attitudes from patients' surroundings; e.g. a patient can be persuaded that he cannot be helped because his mental problems are caused by his character, which is unchangeable (Prasko *et al* 2011). Such problematic belief can be fostered by reproaches from the family with appeals to "finally start to do something". Patients might attempt to hide their mental health problems. They are afraid of possible negative reactions due to presumed lack of understanding for the symptoms of OCD. All of the mentioned factors contribute to a commonly prevalent concealment of obsessions (Newth & Rachman 2001).

It is not only symptoms of mental disorders that are under the influence of stigma. Prejudices and stereotypes apply to specific methods of treatment as well. Patients and their families might have stereotypical views of psychiatric treatment and, therefore, refuse to undertake it. They can be persuaded that drugs are poisons that change personality and psychotherapy is one of brainwashing techniques (Prasko *et al* 2011).

Revealing the presence of mental issues is a gradual process which may cause additional conflicts. Patients might conceal their symptoms because they are afraid that their relatives would take the content of obsessions seriously and start to consider them being insane, dangerous, or both. Relatives, who know the "secret", often share the same belief and help to mask the symptoms. From this point of view, they become "accomplices" of OCD and fail to contribute to the seeking of psychiatric help (Steketee 1997). In addition to the stress coming from the worries that patients could be rejected by their close ones, the individuals with OCD are also often afraid of "they could go mad" or "they are already going mad". Such anxious thoughts cause another tension. This is also why patients with OCD sometimes prefer social isolation. It serves both as prevention from others to recognize their mental health problems and from harming people in reaction to aggressive obsessive thoughts. The anxiety that rises in patients is also concealed. Many patients avoid admitting being anxious and rather pretend to "actually be doing quite well". Behavior of patients with OCD towards professionals may also be affected by anxious thoughts. They might be so afraid of social rejection and labeling reactions that they do not report symptoms in their full extent while being interviewed by a professional, and rather dissimulate (Prasko 2001).

The impact of stigma on functioning

Stigmatization of people with mental disorders is nowadays a rather well-studied field. There have been published numerous studies focusing on the extent

of this phenomenon and its consequences to patients' everyday lives (Crisp *et al* 2000). According to Stengler-Wenzke and colleagues (2004b), the longer the disorder prevails the higher are tendencies of patients and their families to isolate themselves from society. Both patients and their relatives tend to keep OCD as a secret for a long time due to the anxiety deriving from the risk of stigmatization. Family members are often anxious that their relative could perform rituals in public and thus avoid such situations in prevention. If a patient performs rituals in public, family members often feel embarrassed. Uninformed bystanders might react with little empathy and stigmatize the individual suffering from OCD as well as the family members. This creates a remarkable tension and stress in families of patients with OCD. The presence of OCD heightens a chance of deficits in social roles and overall functioning not only in patients but also in relatives. Kalra and colleagues (2008) found out that burden that lies on caregivers of patients with OCD is equal to burden that caregivers of patients with schizophrenia and affective disorders struggle with. Being tense due to a significant stress, which presents the care for an individual with OCD, might further increase sensitivity towards negative evaluations and stigmatizing reactions from the others.

Impact on the treatment

The effect of stigmatization on the treatment starts early and works through several different paths (Eisenberg *et al* 2006). The risk of being stigmatized and rejected from society influences the help-seeking behavior. Patients, often by the reinforcement provided by their families, delay seeking psychiatric help in the hope that their symptoms disappear. They might try alternative routes to get better (e.g., holiday or relaxations) and continue waiting even though these attempts failed to help (Prasko *et al* 2011). Thus, patients tend to arrive late, when their mental problems are chronic, and chances for successful treatment are reduced. This seems to be the most serious consequence of stigmatization of people suffering from OCD (Stengler-Wenzke *et al* 2004b).

Family members often do not want to admit that their close one suffers from a mental disorder. As a consequence, they may impede the treatment, try to persuade their relative not to seek psychiatric help and be willing to take over some of his or her daily chores to help with handling the disorder on their own. Although relatives might realize that a mental disorder is truly present, they prefer to *reintegrate* the afflicted member back into the group by trying to make him "walk the line" (Chromy 1990). To stop the rituals, relatives may forbid them. When this approach fails to work, hostile attitudes and restrictions come on the scene – a reaction that Prasko and colleagues (2011) call an *eliminative* one. The final stimulus to seek a professional treatment may derive from both the reintegrative and eliminative reaction. If a family starts to consider visiting a psychiatrist during the eliminative phase, hospitalization might be seen as a form of punishment and the patient as a deviant. The process of reintegration might be problematic in such cases (Prasko *et al* 2011).

Expressed emotions and family attitudes to the patient

A concept of expressed emotions in families is a complex one and includes several features. It has been shown that the most salient predictor of treatment outcome in OCD is a level of criticism. According to Chambless and Steketee (1999), high levels of criticism and hostility lead to poorer treatment outcomes. Being rejected by a father, but not by a mother, presents another factor connected to fewer treatment gains (Emmelkamp *et al* 1985). Being constantly criticized by a family member leads to lower self-esteem and self-blame which reflects in higher levels of self-stigmatization. When hostility is present, it causes tension and stress which worsen symptoms of OCD by an increase of compulsions used to deal with the stress (Keeley *et al* 2008). Such family patterns of behavior lead to a vicious circle – a patient is criticized and perceives hostile emotions. The atmosphere influences the use of the patient's defense and coping mechanisms. These include an increase of compulsive rituals which leads to another increase of reproaches, tension, and criticism. The resultant exacerbation of the symptoms lowers the treatment benefits. A direct focus on negative family interactions within CBT for OCD may facilitate better outcomes for those patients who are attempting to cope with hostile and critical family members.

Those are not only conflicts with fathers that worse prognosis of patients with OCD. High maternal emotion expression negatively influences the outcome of OCD treatment in children as well. According to Peris and colleagues (2012), high maternal emotion expression did not automatically lead to an increased severity of symptoms but was connected to behavior problems in children and higher scores of depression among parents. Whereas mother's constant criticism was associated with parental blame and personal responsibility. Emotional over-involvement was influencing levels of OCD in children and both depression and anxiety in parents. If family members attribute negative events to the presence of OCD in their relative, patients had less benefit from the treatment than patients whose families do not have a scapegoat (Renshaw *et al* 2005).

Possible negative influences of families with patients with OCD might be enhanced by adding family intervention sessions to exposure relapse prevention therapy. Research from Grunes with colleagues (2001) showed that patients, whose family member attended a family intervention group, had a greater reduction of symptoms of OCD compared to patients, whose families were not involved. Patients also registered a signifi-

cantly lower level of depressive symptoms. As for whole families, participation in family intervention groups led to a bigger reduction of emotion expression when compared to families which did not take part.

Conclusion

Perceived stigma presents a fundamental issue for individuals with obsessive compulsive disorder and their families. It affects how they experience their disorder, willingness to search an adequate help, and impact of the disorder on daily functioning. Mental illness stigma, which still prevails in society, increases anxiety of patients with OCD and their family members as they anticipate rejection from other people. Specifically people suffering from OCD and their families might be terrified of reactions if someone would hear contents of obsessive thoughts or see compulsive rituals. It seems to be salutogenetic for family members and individuals suffering from OCD not to be absorbed by their relative's mental health problems and be able to keep a healthy range (Stengler-Wenzke *et al* 2004b).

The length of the presence of OCD is associated with an increased chance of social isolation of both patients and family members. The fear of stigma and its consequences presents a significant motive that drives relatives to hide the patient's symptoms or to assist with performing compulsive acts and rituals. Anxiety derived from anticipated social rejection might fuel reinforcing behavior for years. If not treated early, benefits from OCD treatment are significantly lower compared to the outcomes of early treatment. Thus, family members, their beliefs, and attributions pose the key factor in a successful treatment of OCD (Stengler-Wenzke *et al* 2004b).

It might be beneficial to establish intervention groups for partners and other caregivers of patients with OCD. The biggest profit from the support groups could have individuals with high levels of self-stigmatization and poor social networks. Such groups might be focused on destigmatization (and thus indirectly on building self-esteem), adaptive coping strategies to deal with daily hassles and interpersonal conflicts, and adopting supportive behaviors (Geffken *et al* 2006).

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