12. TREATMENT OF OBSESSIONS, COMPULSIONS AND PHOBIAS AS HIDDEN COUPLE-COUNSELING

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Introduction

It has now become commonplace that psychological problems - usually called 'neurotic symptoms' - occur in a social microsystem and not only in the sick individual, the patient. Yet, in many cases, individual treatment of circumscribed problems like compulsions or phobias remains the most sensible form of help. If the patient learns to give up, reduce or cope with one particular set of problems he may become able to tackle others in a similar way, including those in human relationships. Generalization may be enhanced if specific treatments include management of general anxiety/depression and training in problem solving. Nevertheless, when patients with obsessions and compulsions or phobias suffer simultaneously from marital discord, a purely "symptom" - directed approach may not be sufficient. Behaviour therapy literature usually does not mention the frequency, function or relevance for treatment-outcome of marital discord in patients who have received symptom-treatment. Some of the reports which refer to this topic give contradictory views (Emmelkamp 1977; Goldstein 1971; Hafner and Marks 1976; Hand and Lamontagne 1976; Lazarus 1971; Liotti and Guidano 1976; Schaper 1971). There is also a lack of controlled investigations about how successful symptom-treatment affects relationships. Thus, it is difficult to deduce possible interactions between a symptom and relationship problems. From a social systems approach symptoms are supposed to have an instrumental function in relationships, but the current state of research in psychotherapy does not allow reliable predictions as to what it is best to do under particular conditions, when a patient with compulsions or phobias lives in a disturbed interpersonal setting. A basic methodological problem must be solved regarding the measurement of marital discord in couples where symptoms have a protective function i.e. the couple's ratings about their marriage would always be positive. Successful symptom-treatment can have manifold, though hardly predictable effects on "good" and "bad" relationships (Hand and Lamontagne 1976). The same seems to apply to unsuccessful symptom-treatment. When marital discord is evident, with certain patients the therapists' incentive to undertake couple-counseling is much stronger than the couple's willingness to receive it. We find ourselves in such a position whenever assessment interviews give the impression that phobic or obsessional symptoms are indeed symptomatic of a disturbed relationship - whether the symptoms are caused by or are simply maintained for this reason.

We agree with Marks that, generally the label "symptom" should not be used to differentiate phobias or obsessions from relationship "problems", since this would suggest that these are always two entirely different classes of illness. The term "symptom" is used in the following because, for the particular couple involved, we had the impression that their obsessions, compulsions and phobias were symptomatic of their marital discord.

One way of predisposing such couples, for relationship-counseling is first to satisfy their wish for more symptom-treatment. If this fails, the couple may reach such a crisis that both partners come to want to improve their relationship. An example of successful contract therapy, after failure of individual behavioural treatment with an obsessive-compulsive patient, has been published by Stern and Marks (1973).

Obviously a different approach is necessary for a second type of couples when, after symptom-treatment, only one partner wants contract therapy while the other refuses it.

Further there is a third type of couples where both partners deny the existence of or refuse help for their relationship problems, in spite of long-lasting and treatment-resistent symptoms that make them suffer. For these patients the treatment approach proposed here has been disigned. Essentially it means doing couple-counseling without naming it, in the context of symptom-therapy.

The treatment hypothesis

Behaviour therapy literature about phobics and obsessive-compulsives, as well as general clinical experience, gives the impression that patients' spouses quite readily accept the role of a co-therapist in individual symptom-treatment (Marks 1975; Mathews, Teasdale, Munby, Johnston and Shaw, 1976). If patients and their spouses in type three couples are prepared to do the same then it would seem promising to try and change their symptom-centered "patient-cotherapist" interaction into exercises concerning their general interaction, both then having a "patient"-role. This would have to be done in a way that the couple does not consciously realize the shift from the symptom-level to the relationship-level, as otherwise they would probably drop out of treatment. This strategy may well be possible, because such couples complain about a lot of concrete difficulties in their daily life - and they regard these as due to the symptom, not to a disturbed relationship. If the therapist does not argue about their theory, he can still work with the basic problems on the practical level. This appears to be a legitimate way to use paradoxical communication. Such an approach is the reverse of what Stern and Marks described above with a "type one" couple.

So far we have completed one treatment of this kind, including a six months follow-up. Systematic research into this area is under way.

The couple

The couple had been married for twenty years when the 48 years old husband came for treatment of his obsessions and compulsions. One complaint was the ruminations which he had first experienced shortly after he became engaged to his wife. They consisted of aggressive thoughts against her.

Three years after their wedding, when their only son had been born, his thoughts turned against his son and remained so with varying intensities until the son died in 1972, then aged 17. Later his thoughts increased to an unbearable extent at home as well as at work. He now labelled them "bad thoughts", as he could not stop thinking "how nice that our son is dead". At the same time this caused severe feelings of guilt. His wife on the other

hand had shown a continuous grief reaction after the death of the son, and took this as a reason for not engaging in any pleasurable activity, neither alone nor with her husband. These two responses to their son's death seemed to have become quite independent from their original cause, now being used by the couple to fight each other.

A second problem of the husband was his insistance on extreme cleanness and orderliness in their home, where his wife on the other hand had always been proud of her qualities as a house wife. The couple did not fight openly about this question, but frustrated each other indirectly in many subtle ways. He would control a number of items when coming home, pretending not to do so; she would always try to do things 101% so as to give him no chance to make her feel humiliated.

A third problem of the husband was his checking ritual at work. His working ability had always been impaired by an inferiority complex and varying self-imposed checking rituals, according to the specific conditions of his work. At the time of this treatment, he was spending up to four hours checking rather than working and he was again worried that he would loose his job.

Over the years several treatment measures (hypnosis, medication) had shown little or no effect. Only a psychoanalysis over three years, some 15 years ago, had helped him to give up a specific checking ritual at work, gain more self-confidence and eventually get a better job. Ruminations and marital discord had remained unchanged. He stopped his analysis when it had led to a point where changes in his marriage seemed unavoidable. He had a first relapse when his company went bankrupt some 6 years ago and further deterioration began after his son died.

The wife had suffered from agoraphobia ever since their engagement. Several treatment attempts (including 3 years of psychoanalytic group therapy) had little or no effect. When our treatment started she was able to walk only very short distances on her own, after having taken tranquillizers.

For the 1.5 years before this treatment started the couple had not had sexual intercourse because of the husband's psychogenic impotence. This was another field of continuous mutual indirect attacks. The husband seemed convinced that he had married his wife only because he "felt sorry" for her due to her unattractiveness.

Therapists' treatment aims and treatment package

After an individual as well as a joint interview had shown that there was no way of getting the couple to accept direct marital therapy, we offered treatment for the husband's complaints with the wife as co-therapist. Additionally the wife was to get some advice how to overcome her agoraphobia.

We decided to direct the symptom-treatment at the "bad thoughts" and the controlling-behaviour at home, as both seemed directly connected with their general interaction problems. Our hypothesis was that, if this symptom-treatment could be turned into hidden marital counseling, then any success in this area should extend to the symptoms at work. To test this assumption, no direct treatment was to be given for the checking ritual.

The "treatment-package"

1. Symptom-specific techniques:
   a) "acting out" of ruminations (bad thoughts) during treatment sessions.
   b) symptom-prescription for control-behaviour in the home and for ruminations, both as part of their home work.
   c) Change of the patient's labelling of his ruminations as "bad thoughts" into "specific thoughts".

2. "Hidden" couple-counseling:
   a) Structured communication about symptom-related topics of discord like control-behaviour and standards of cleanness in the home, i.e. "symptom-centered interactional retraining" as one specific aspect of problem solving skills.
   b) Contract exercises for mutual positive reinforcements (Azrin and Naster 1973; Liberman 1975; Stuart 1975).
   c) Structured exercises in open communication of feelings, at the beginning of treatment only during the occurance of the symptoms (see "executive sessions" Liberman 1975).
   d) Assertive training, including strategies to gain independence from the husband's family.
   e) Advice in line with the early stages of the Masters and Johnson programme, consisting of prohibition of sexual intercourse, and prescription of cuddling exercises not involving the genital area.

This package of strategies was administered in five successive phases, in 7 sessions of individual symptom-treatments for the husband and 32 joint sessions with the couple. Total treatment time was 87 hours, spread over 6 months, as compared to 6.5 years of individual and group psychoanalysis which both had in the past.

Treatment process and effects

Phase one: Symptom-treatment with the obsessive-compulsive husband. He had 4 sessions during 1.5 weeks period. Three of the four sessions consisted mainly of "acting out" of the ruminations. The most remarkable event during this phase occured in the first session, when the patient while hammering at a cushion and shouting thoughts against his son, suddenly turned the aggressiveness against his wife. After a very brief break of surprise he went on in this way until he reached a state of physical and emotional exhaustion. This seemed to confirm our pre-treatment hypothesis about the function of these ruminations in the relationship. Outside these particular exercises the husband did not admit aggressive feelings against his wife although he behaved increasingly aggressively in a direct way. The therapists did nothing to confront him with the marital problem any further than this spontaneous process initiated during the first three sessions. The "bad thoughts" were labelled as "specific thoughts" to make the exercise easier to accept by the patient. In between sessions the patient was given home work mainly as symptom-prescription, i.e. he had to repeat any spontaneously occuring rumination at least five times in order to interrupt his usual response chain.

During this phase the patient recorded a decrease in ruminations and an increase in tension at home. He became worried about the marriage. The wife had stopped taking tranquilizers and had made a considerable improvement in

her agoraphobia, with very little advice on how to apply graded exposure in vivo.

Phase two: "Hidden" couple-counseling (exercises a-d). One individual and 8 joint sessions with the couple during 4 weeks period.

The co-therapist function of the wife was easily accepted by both. The joint sessions and the in between (tape-recorded) home work consisted mainly of training in structured communication (norm-finding about cleanness and orderliness) about the symptoms at home. Because of the nature of the symptom this led quickly to dealing with the real feelings towards each other and allowed us to add structured exercises in open communication. Further, we introduced the exchange of small positive reinforcements in daily life activities. Another long lasting reason for mutual indirect attacks, i.e. how to gain more independence from the husband's family, was dealt with by assertive training and problem-solving techniques. Additionally the wife was given further instructions regarding her agoraphobia. Both were cooperative in all sessions.

At the end of phase two both felt their living together was much improved. The husband continued feeling definitely improved in his ruminations and also in the symptoms at home. The couple went on a holiday after having received intensive "behaviour rehearsal" regarding rules to follow during holiday. It turned out to be a honeymoon, "our best time ever". But the husband had a relapse in his ruminations and he did not apply the symptom-prescription.

Phase three: Continuation of phase two exercises, now including sexual therapy. One individual and 12 joint sessions during 7 weeks period.

The relapse in the ruminations was quickly overcome by using again symptom-prescription. Newly introduced were an assertive training for their general social anxiety and the early exercises of a modified Masters and Johnson programme for their sexual problem. During the latter, intercourse being prohibited, the couple had one "accidental" but successful intercourse which they "could not believe" afterwards. It was followed by an immediate increase in obsessive-compulsive symptoms. This might be interpreted as a signal that the sexual improvement - like the early rapid improvement in the ruminations and home-related symptoms - was threatening as it was much faster than the improvement of the emotional side of their relationship.

The relapse did not show a continuous pattern, but rather an increase (Fig 12.2) in "relapse-spikes". These seemed to depend more on previous distress at home than on stress at work. In spite of them, the husband reported an increase in satisfaction at work and a remarkable overall decrease in symptoms. He also started reducing his psychopharmacological medication.

Phase four: Intensified attempt of the therapists to leave the symptom level and treat the relationship directly. Offer of marital therapy. Ten joint sessions during 6 weeks period.

The wife refused to continue the structured dialogue about the symptoms concerning the home. Both had had to express dissatisfaction openly whenever they felt it while the symptom occured. The husband used this "right" in a way that the wife felt attacked on a general, not just the household, level.

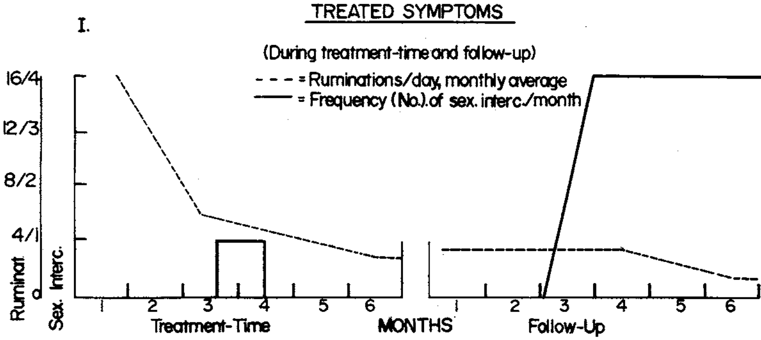

Fig. 12.1 Treated symptoms (during treatment-time and follow-up)

- - - - - =Ruminations/day, monthly average
——————=Frequency (No.) of sexual intercourses/month

She insisted that this was distrust rather than criticism, and she no longer accepted it as one of his illness-behaviours. She got scared about the future of their marriage and felt "paralyzed".

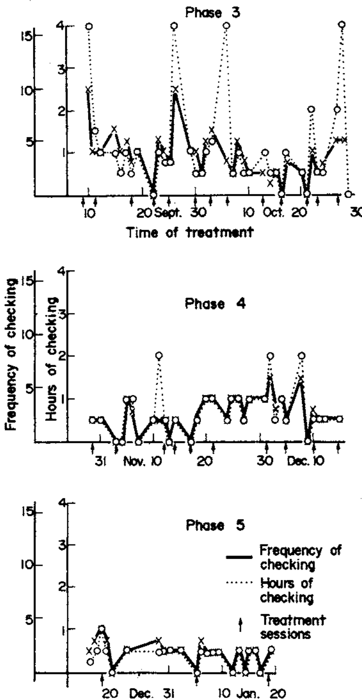

Fig. 12.2 Untreated symptom (During treatment-time)

At this point both experienced intensive separation anxiety. They could talk about it openly and made a contract without the therapists, which did not allow him any further critical or aggressive remarks during the exercises at home, but only in the meetings with the therapists.

The therapists made another attempt to motivate the couple for a frankly accepted marital counseling. This was refused mainly by the wife who insisted that the marriage was good and that they only needed some more help for his symptoms.

The checking at work was reduced by about fifty percent as compared to that in phase three. The specific thoughts and the symptoms in the home were also reduced further. The wife's agoraphobia was much improved. During phase four, the couple had had a second "accidental" sexual intercourse following one of the prescribed cuddling-exercises which at this point, still excluded the genitals. This time the couple did believe it and responded with happiness rather than symptoms.

Phase five: Separation from therapists. One individual and 2 joint sessions during 4 weeks period.

The husband had agreed with his wife in the last joint interview but tried to get a coalition with the therapists in a subsequent individual session which he had requested. The therapists adopted a "Colombo" strategy, telling the couple that they had no power to do any more for the remaining symptoms and that all ought to be happy if there were no marital problems for which they could offer some help.

For the first time the couple became aggressive with the therapists, accusing them of incompetence and inability to solve difficult problems. Both made clear they would do the remaining work on their own.

Surprisingly, in a subsequent final joint session the couple agreed with the termination of treatment, in a friendly way, expressing satisfaction with the goal achieved.

The symptoms were further reduced. Checking at work had decreased to a negligible extent. The ruminations occured even less than in phase four. The symptoms in the home had nearly disappeared. The wife's agoraphobia remained much improved. The general interaction had been constantly more rewarding. The husband felt that he had learned that his criticism was really his own problem and he had begun to open up to his wife more trustfully. The only severe disturbance left was the sexual problem. Also both wanted still more independence from his family.

Four months' follow-up

The couple appeared to be very happy at their first follow-up. The checking rituals were down nearly to zero. The ruminations still occured 2-3 times a day, briefly without really bothering the husband. The home-related symptoms had completely disappeared, which the husband felt was due to his insight and his acceptance that his wife's standards were different from those of his mother.

The psychogenic impotence had dramatically improved during the last four weeks before the follow-up, the couple now having intercourse once a week. They felt, this had been due to their continuation of the prescribed fondling exercises. Their daily life interaction was much improved. Both had developed a number of joint activities and regarded their living together as much more rewarding than at any time before this treatment.

The wife had completely lost her agoraphobia, she had never used tranquillizers since phase two. The husband had reduced his medication to fifty percent of the original dosage.

Six months' follow-up

The ruminations were further reduced and now did not bother the husband at all. The checking rituals could not be judged as the couple had just come back from another honeymoon-holiday. The wife's agoraphobia remained cured. Sex life had improved even more, as both could now openly discuss their wishes and feelings in this area and continued to enjoy intercourse once a week. Both also regarded the relationship as further improved, both being in a better mood than at the previous follow-up.

They still wanted more independence from his family, but appeared confident in this respect.

Discussion

We feel that we were able to follow the treatment design and that the effects were in the anticipated direction. Unfortunately, treatment process and outcome are documented inadequately as far as "hard" data are concerned. Except for sexual behaviour there is also no pre-treatment baseline. Work with this kind of couple now uses standardized ratings for symptoms, emotions and interaction patterns.

This research uses the whole treatment-package as we feel each of the components was important. The relative impact of the single ingredients might be investigated if future results with the whole package are as encouraging as in this pilot-treatment.

The objective evaluation has been tried from the second and third phase of therapy. It was only possible to get the husband to do "average estimates" for intervals of from one week to one month, but they seem sufficient to show changes in the treated and untreated symptoms (Figs. 12.1 and 12.2). There are no such ratings about the wife's symptom and the interactional patterns of the couple.

The narrative evaluation has been in an unusually detailed manner, not only to make up for the lack of "hard" data, but also to encourage replications.

We hesitate to discuss possible mechanisms on the background of these data. The following are tentative suggestions about what might have happened. The treatment may have confronted the couple in a sort of successive approximation, via symptom-centered exercises, with the disrupted parts of their relationship. But this the symptoms may have lost their protective function. At this point (phase four) the couple broke the contract with the therapists

and created their home-made solution which only allowed them to be nice with each other. The symptoms no longer were a safeguard against painful confrontation with each others' real feelings. If this had been the only effect, i.e. scaring them into a compromise, lasting benefits would seem most unlikely, even for the six months' follow-up. The couple may therefore additionally have become stimulated to apply at their own speed during follow-up, the techniques and skills learned during treatment. This seems to be supported by the continuing improvement during follow-up showing itself most clearly in their sexual behaviour.

The couple quit treatment when open emphasis was put on marital counseling - at the same point when the husband had quit his previous psychoanalysis. The difference of this couple-oriented behavioural approach seems to lie in the follow-up effects, the stability of which still remains to be shown.

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The treatment of phobic and obsessive compulsive disorders

Selected Papers from the Sixth Annual Meeting of the European Association of Behaviour Therapy, Spetsae, Greece, September 1976

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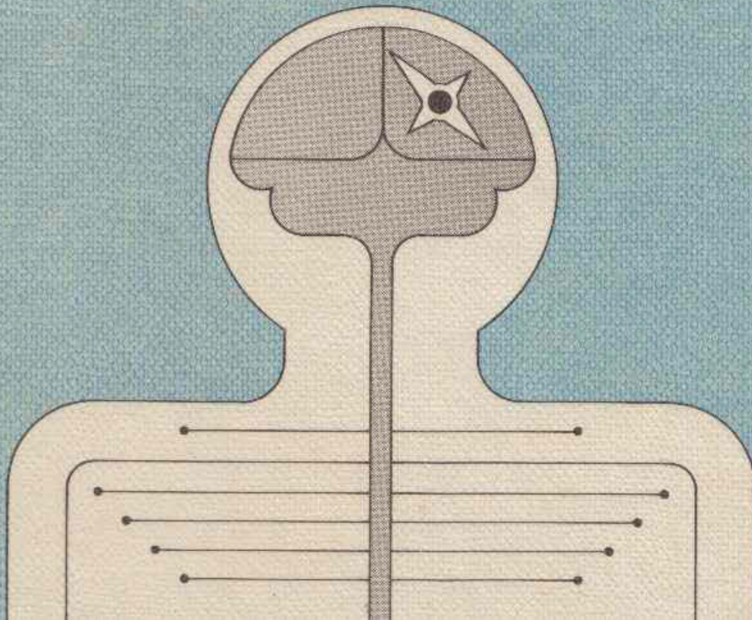

The treatment of phobic and obsessive compulsive disorders

The treatment of the two clinical syndromes with which this book is concerned have so much in common as to warrant a unified presentation. Hence, papers from some of the symposia held during the annual meeting of the European Association of Behaviour Therapy in September 1976 have been selected to provide an up-to-date account of clinical research in the treatment of phobic and compulsive obsessive disorders. These papers show the enormous recent progress in the effectiveness of behaviour therapy which has resulted in alleviating these illnesses, which have previously been largely untreatable. They also discuss many salient issues current in contemporary psychotherapy.

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