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THE EXACERBATION OF INTERPERSONAL PROBLEMS AFTER RAPID PHOBIA-REMOVAL

I. HAND*
M. D., Assistant Professor
University of Hamburg
Behavior Therapy Outpatient Unit

Y. LAMONTAGNE
Professor of Psychiatry
I.N.R.S.-Santé
Research Unit
St-Jean de Dieu Hospital
Montreal, Canada

INTRODUCTION

The discussion about symptom-substitution as a consequence of direct symptom removal has given rise to much argument and misunderstanding between psychodynamic and behavioristic psychotherapists.

In orthodox psychoanalysis, a symptom is regarded as a person's symbolic expression of an underlying conflict and as a defensive way of problem solving. Removing this symbolic expression would thus result in a substitute symptom or at worst lead to a breakdown of the defenseless patient (Bookbinder, 1962; Holland, 1967). In behavior therapy, little if any evidence has been reported for such complications (Birk, 1972 and 1973; Eysenck, 1964; Lanyan et al, 1968; Lazarus, 1961 and 1970; Paul, 1969; Ullmann and Krasner, 1965; Wolpe and Lazarus, 1968; Wolpe, 1969; Yates, 1958 and 1970) and where they appeared, they were often regarded as the result of "bad" applications of behavior therapy such as: neglect of the autonomic corps of neurotic reactions (Wolpe, 1969); poor appreciation of the psychodynamic, interpersonal and social context (Birk, 1972); focussing on irrelevant or misleading complaints (Lazarus, 1972); failure to give proper advice for the future (Bandura, 1969); and non-extinction of anxiety where it was a mediator for a variety of symptoms in a symptom-hierarchy (Yates, 1970).

Much of the optimism about the relative lack of complications has been derived from treatments of monosymptomatic or analogue phobias. With more complex problems like agoraphobia or obsessions, where patients usually have more personality problems, the success rate drops and complications rise, although behavior therapy is the most helpful approach for these problems.

After a period of confusion regarding the respective terminology (Montgomery and Crowder, 1972; Numberger and Hingtgen, 1973), attempts are now being made to reinterpret post-treatment complications more operationally. The major difficulty is to assess whether complications after symptom removal are: a) substitute by-products of a patient's psychopathology, b) different maladaptive responses to environmental stress, c) persistence of old maladaptive behavior, which had originally been covered by the treated symptom (Bandura, 1969) or d) reappearence of maladaptive behavior, which had preceded the development of the treated symptom (Balson, 1973). Attribution of a complication to any of these categories is obscured by the intra-individual as well as inter-individual field in which it occurs. Behavior therapists would only label a complication of the a-type as a symptom-substitution, or not even regard an entirely new symptom as a substitute (Eysenck, 1970).

* Requests for reprints should be addressed to I. Hand or Y. Lamontagne

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Clinical behavior therapists do not hold the view that symptom-removal is never followed by complications, and psychoanalysts are giving up the claim that symptom-substitution is its necessary consequence. Both now agree that brief symptom-centered therapies may well lead to long-lasting improvement (Alexander and French, 1946; Marmor, 1971; Salzman, 1972; Wolf, 1965). A symptom may interfere with productive activity, and successful treatment of a phobia, for instance, may enhance the patient's self-esteem (Marmor, 1971), encourage more social behavior and more risk-taking in difficult situations, thus initiating further constructive personality changes (Birk, 1973; Brady, 1968). In order to prevent complications after symptom removal, behavior therapists regard it as essential to treat the symptom-maintaining conditions instead of imposing a competing set of controlling variables, and to train adaptive behavior at the same time (Cahoon, 1968). However, the exaggerated claim that it is necessary to predict the fate of the treated responses in relation to their genesis and maintenance as well as to personality and social context (Yates, 1970) requires an omniscience far beyond any knowledge that could be based on experimental and pragmatic evidence.

The present authors support a multi-level approach, but the problem of how it might be handled is far from being solved. Often, when the therapist, be he behaviorally or psychoanalytically oriented, decides what is the "main" problem for a patient, it is based on belief rather than knowledge, particularly if his opinions differ from that of his patient. Most patients come with a variety of symptoms, but reliable data about their interconnection or their possible causation by an "underlying" problem are rare. "Good" therapy therefore requires a flexible approach to the needs of the patient.

CLINICAL RESULTS

The present authors found an unexpectedly high rate of acute interpersonal crises after successful treatment of agoraphobics by group exposure (flooding) in vivo (Hand et al, 1974). In this paper, we shall briefly report the main set-up and results, then elaborate on these complications and their meaning in the context of the discussion of "symptom-substitution". The data are rather anecdotal, but they seem to be suggestive for further research strategy.

Twenty-five agoraphobics (nine males) were treated in six groups of about four patients, three groups with high and three with minimal social interaction (cohesion) for a total of 12 hours spread over three days of a single week. Fifteen of these patients improved satisfactorily; statistically, the results were highly significant. The treatment was surprisingly easy for the patients to tolerate and for the therapists to conduct; it appears to be the most economical approach so far to this problem.

Twenty-one of the 25 patients (mean age: 35; mean symptom duration: 8.5 years) were married. Fourteen of the married patients were aware of chronic marital problems before the treatment began. Nevertheless, all regarded their phobia as far more crippling for the time being, and wanted phobia-therapy rather than marital-therapy which was often offered as an alternative. Immediately or soon after phobia removal, six of the 14 who had regarded their marriage as unsatisfactory and one of the seven who had not complained about their marriage before treatment, had such acute crises in their relationship that either they asked for marital treatment or it was offered by us. But, of the seven couples, only three went into joint marital therapy; two patients refused such aid, as did two spouses. During follow-up, the patients only had contact with the first author who, in most cases of complications, refered them to other therapists for further treatment when necessary.

The marital complications which are described below seem to reflect two different patterns of symptom-interaction.

The first four cases show a longitudinal pattern of interaction in that removal of the phobia was followed by an increased severity of the marital problems.

Mrs. A.: developed her agoraphobia immediately after a successful treatment of vaginism and sexual rejection of her husband. Two years of subsequent treatment for her agoraphobia, by the same therapist who had treated the vaginism, had no effect. She improved well in our trial, but at the same time, became aggressive and hateful towards her husband, rejecting his "awful and disgusting sexual attempts." She became deeply depressed, wanted an immediate divorce and, at the same time, felt guilty about her attitude towards her husband who had been understanding and

helpful about her phobia. With the help of the first therapist, she regained a generally positive attitude towards her husband, but insisted on a platonic relationship. Only at the peak of this crisis, she relapsed slightly into her phobia but was able to overcome this by herself.

Mr. B.: had a ten year history of paranoid reactions and episodes of morbid jealousy with a period of imprisonment after attempting to murder a girlfriend. He described his marriage as bad, his wife as adulterous, but saw as his main misery the fact that he had been housebound and out of work for two years because of his phobia. He felt nothing could be done about the marriage, said that he had been very jealous and paranoid until a few years ago, but that now he could even accept his wife's adultery as he had lost his sexual desire for her.

As his phobia improved, he became depressed, agitated, and paranoid not only towards his wife, but also towards policemen, the latter being possibly connected with severe feelings of guilt and a desire for punishment because of the previously attempted homicide. A few interviews sufficed to calm him down. The couple had several sessions of joint marital therapy and after some changes in their environment, they got along much better than before. At this point, he relapsed into his phobia of going out, giving as a reason his paranoid feelings about policemen. With supportive therapy, these feelings disappeared but he now felt increasingly dependent on his wife and relapsed even more into his phobia, at this stage giving his "old" reason of a fear of dying from a heart attack. When the couple wanted more flooding for his phobia, we discouraged this. A different approach was obviously necessary.

Mr. C.: developed a reaction very similar to that of Mr. B. He had had more than ten years of in-and-out-patient therapy for alcoholism, aggressive behavior and violent jealousy. He had wanted psychoanalysis for his personality problems but instead had been referred for behavior therapy of his agora - and travelling-phobia. He lost his phobic symptoms quickly but concomitantly became agitated, depressed, sleepless and jealous towards his wife. On the last treatment day, he told the group that he had thought of killing the therapist and himself, as he did not know how to cope with his admittedly irrational jealousy. The group calmed him down easily, but he remained unable to control his jealousy at home and had to be seen repeatedly with his wife in the first weeks during follow-up. He accused his wife of always having tried to destroy his personality and made some dangerous physical attacks on her, which subsequently left him feeling depressed and guilty. For a limited time, he had to be given medication, and a long-lasting marital therapy was started. As the marriage situation slowly improved, he gradually relapsed into his phobias.

Mrs. D.: was one of the few patients who, before treatment, had regarded her marriage as good. She over-responded with confusion and helplessness when a male group peer asked her for a date. Several weeks after the successful treatment, she first became frigid towards her husband, then depressed and eventually relapsed into her phobias. Not wanting more flooding, she was given an antidepressant by her previous therapist, after which she recovered quickly from her phobia and depression but remained frigid. She continued to describe the marriage as good.

With A, we find a 1-2-1 sequence in the symptoms: she had developed agoraphobia (2) after successful symptomatic treatment of vaginism and sexual rejection of her husband (1). Subsequent removal of 2, led to immediate recurrence of 1, with much more general rejection of the husband. Another treatment for 1, now dealing with the non-sexual problems of the marriage, led to an improvement on this level, but left the sexual problem unchanged; 2 remained improved. B and C show a 1-2-1-2 sequence; B and C had, over the course of years as in- and out-patients, overtly improved their marital and personality problems (1), but concomitantly had developed their phobia (2). Rapid removal of 2 led to the recurrence of paranoid ideas, jealousy, agitation and depression (1). Supportive marital therapy and time-limited medication then led to an improvement in 1, again accompanied by the recurrence of 2.

With D, the relapse might have been due to a manic-depressive episode, as antidepressants quickly improved the phobia and depression, though not the frigidity. But, judging from an interview with the husband, considerable marital problems were very likely.

The following four cases show a vertical pattern of interaction. Contrary to the previous cases, these patients suffered from both phobic and marital problems almost to the same extent

when they started treatment. The sudden change in the severity of their phobia motivated them or their spouses differently for dealing with their marital problems.

Mrs. E.: had told us about her bad marriage before treatment, but for several reasons she and her husband neither wanted a divorce nor marital therapy. Already, on the first treatment day, her phobia almost disappeared but was followed by a depression on the equally successful second day. She missed the last treatment day but soon after came back in despair to "confess" that she had had an extra-marital relationship during most of her marriage. She had not dared to get a divorce because she did not trust her lover. Shortly before treatment, she had nevertheless told her husband about this affair and that in the case of a cure she would leave him. When her husband heard about the success of the first treatment day, to her distress, he did not make any attempt to change her mind about a divorce. She then felt that she could neither face living alone, nor being married to either of the two men. She realized that she was not agoraphobic anymore but that she had no intention of going out because of this confusion about the future. The couple still did not want marital therapy, and some two months later we heard that they had made "arrangements" to stay together and that she was going out again though restricted with regards to the distance.

Mrs. F.: the joint assessment interview with her husband soon turned into a discussion of an acute marital crisis. For 18 of their 20 years of marriage, the patient had been severely agoraphobic. Originally, he had been rather dependent on her but soon after the wedding, she was severely ill for one year, repeatedly close to dying, her husband being her only visitor. Since her discharge from the hospital, she could not be separated from him without knowing that he was somewhere nearby, because she anticipated she might die and her husband might not be there to give support. With astonishing satisfaction on both sides, the husband had tolerated this complete control for about 16 years. After she had had another nearly fatal illness, he started to feel "like a prisoner", longing for freedom, mainly on a sexual level, although by no means wanting a separation. She had realized this in a sudden and painful way shortly before we saw the couple, interpreting it as a kind of mental illness on his part. Eventually, both came to the conclusion that improvement of her phobia might take some pressure from him, as well as making her feel independent enough to leave him if she wanted. Both, especially she, refused marital therapy at this stage. She improved during treatment and follow-up, but continued to refuse marital therapy, stating that her husband had overcome his problem. He, on the other hand, insisted that his situation was unchanged, but that he kept quiet so as not to hinder her progress. It was not always easy to persuade him to reinforce his wife's increasingly independent behavior with more attention. From his point of view, this meant an increased dependence on his part, whereas he wanted to use her independent behavior to demand more freedom, a punishment from her point of view. The long-term strategy, as discussed with him, was to enable her to accept joint marital therapy; only if this continued to fail, should he get help on his own.

Mr. G.: after a 26 year history of phobia, he had had to fight with his wife for "permission" to try the flooding treatment. She felt that the whole family, including two very disturbed children, had adapted to his phobia; she regarded the possibility of a treatment failure as too risky because he had repeatedly been suicidal in the past after experiences of personal defeat. He felt castrated because of her dominant role and her refusal of sexual intercourse which he interpreted as a demonstration that she did not regard him as a man at all. In spite of this, he felt obliged to her for having looked after him and the family all the time. After treatment, Mr. G. was almost symptom-free and unusually happy. Nevertheless, his wife responded with hostility, blaming him for not having improved earlier if it were so easy. She did not allow him the advised post-treatment exercises, but insisted that now he had to do all the housework she had done in the past. At three month follow-up, he reported a slight relapse and felt resentful about his wife who continued to refuse marital therapy. He had given up his previous hope of changing the family's situation. At six month follow-up, he had almost completely relapsed and his wife discouraged any more contact with the hospital.

Mrs. H.: in the assessment interview mentioned marital problems which were partly due to her husband's job as a sailor, which she hated and he felt unable to give up. She developed her phobia after his decision to remain a sailor and their subsequent moving to a city she disliked.

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She improved well during treatment and remained symptom-free afterwards. At the three month follow-up, which she thought would be the last meeting with the therapist, she asked for a discussion of her marital problems. Being an illegitimate child, her step-parents had always warned her not to become promiscuous like her mother. She therefore came to hate her real mother, but felt guilty after her death. She was pushed into marriage by her step-parents and got to like her husband because of his personality, although she could hardly ever get sexual satisfaction. In the new city, she felt easily arousable by certain men and women, which made her feel afraid of her sexuality, reminding her of her step-parents' warning about her promiscuous mother. During the interview, she was desperate about the situation and wanted either a change of the marriage or a new start on her own. Joint marital treatment was offered, but her husband refused.

E and F had wanted treatment for their phobia (2) after acute exacerbation of their marital problems (1). Both hoped that improvement of 2 would diminish their dependency on their spouses and enable them to make a "final" decision and leave the spouse if nothing else would bring about a change. After rapid phobia improvement both became frightened by the impending self-set consequences which their spouses seemed to be rather willing to accept. E coped by getting her partner to return to their previous way of frustrating but safe playing; F coped by simply denying the reality that the marriage was not improved. Nevertheless, they did not relapse into their phobia.

The reverse happened in G and H. These patients wanted to tackle the marital problems only after successful phobia treatment, in a similar straight-forward way. But, in both cases, their spouses refused to cooperate, denying the existence of a problem.

In four cases (A, E, F, H), a clear onset of the phobia could be elaborated: a classical conditioning with E, in the course of a hyperthyreosis, the anxiety attacks of which persisted after its successful treatment; with F, after a long-lasting life-threatening illness; with A, after frigidity treatment and with H, after a special decision about the marital problem. In A, B, E, H, one might say that the phobia had eventually the function of protecting the patients from running away from their spouses, which for different reasons, they wanted to but did not feel able to do. With F, it was the other way round. Nevertheless, all except B had a lasting phobia improvement, although their marital problems were not solved.

DISCUSSION

Our data are in accordance with the findings of other behavior therapists regarding complications after treatment of agoraphobia. Lazarus (1966, 1970, 1971, 1972) has repeatedly described interpersonal problems, interpreting them similarly to Haley (1963) that "many phobic cases are involved in dyadic struggles in which their phobic behaviors become aggressive weapons or manipulative devices" (Lazarus, 1972). Everaerd et al. (1972) reported that 45% of their agoraphobics spontaneously wanted a discussion of family problems during the course of an exposure in vivo treatment. Such discussion was postponed and unfortunately the study gives no further mention of the problem.

Generally, clinical behavior therapists now pay more attention to the interpersonal field in which the individual is treated and the need for dealing with a post-treatment "family disequilibrium" is frequently acknowledged (Birk, 1972). Family members of successfully treated individuals may subsequently need therapy themselves (Lazarus, 1971). Family therapists and communication analysts have sometimes overemphasized such complications saying that "most patients with symptoms tend to minimize their marital difficulties, in fact the symptom is apparently used to deny marital problems" (Haley, 1963).

Our data do not allow such a generalization. In fact, two thirds of our 21 married patients clearly stated marital problems in the assessment interview, but for different reasons they or their spouses did not want treatment for them. We cannot find, either before or after treatment, a consistent pattern of interaction between agoraphobia and interpersonal problems, especially with regard to what effect a phobia or its rapid removal has on chronic marital problems. In half of the 14 patients who were aware of their marital problems, phobia removal was not followed by an acute crisis, and sometimes, even led to an improvement.

The complications in two patients are special as regards their intra-individual reaction of a

psychotic feature (B and C). Nevertheless, this does not support the psychoanalytic claim that phobia-removal might cause such a complication; both patients had had intermittent psychotic reactions some years before becoming phobic. Yet, the final outcome of the phobia treatment was disappointing, although the complications were not too difficult to handle. It emphasizes again that experimental treatments should only be carried out in a setting that can provide a broad range of psychiatric therapy. Unfortunately, this type of patient will have difficulties in getting any psychotherapy, although they appear to need it most, since their phobias really seem to be a way of coping (by focusing) with general and inter-personal anxiety and insecurity.

Patient and therapist may disagree about what problem should be treated first. Often the therapist has to convince the patient of his point of view. However, the therapist may not be more "right" than the patient, and too often one lacks reliable data for safe prediction. We decided to follow our patients' wishes in nearly all cases. Patients always insisted on phobia treatment, even when marital therapy was offered in the first place. The overall outcome in this study of a total of six groups seems to justify this kind of approach. In fact, several patients whom we thought could not possibly benefit from a mere phobia treatment improved very well. Prospectively as well as retrospectively, we were unable to identify the underlying mechanism. In cases of multiple problems of uncertain interaction it may be useful to follow the patient's wish since his motivation to improve might be higher if he gets what he wants rather than what the therapist imposes on him. In the case where such a treatment fails, the patient might then be more willing to accept a different approach.

As we still lack reliable personality tests for psychotherapeutic purposes and as the origin and function of phobias are largely unknown (Marks, 1960 and 1969), a comparative outcome study (phobia vs marital treatment vs a combination of both) would be helpful. Such strategy would collect "hard" data about various variables, like agoraphobic and marital difficulties as such, as well as about the intra- and inter-individual field in which they both occur. In two recent psychoanalytic studies (Al Salih, 1969; Heising, 1973), a similar population to the one in this study was treated in groups with discussions centered around their marital problems, especially suppressed aggression and frustrated sexual feelings and, in both, most patients overcame their phobia, after they themselves had made home in vivo exercises a part of the group task. One study (Heising, 1973) particularly mentions that after treatment, the patients no longer discussed their marriages, whereas in the present study, dealing only with the phobia, several patients experienced their marital problems as more urgent afterwards. Of course no direct comparisons between analytic and behavior therapy studies on agoraphobia are possible. Treatments that are restricted to dealing with either the phobia or the relationship-problems can obviously be effective in their own right, but they may be more so if combined. Only a comparative study can answer that question.

A positive definition of "symptom-substitution" requires knowledge of a nearly indefinite number of variables. Thus, it would seem preferable to avoid this term and to describe, rather than label, the various complications that can arise after symptom-removal.

SUMMARY

The discussion about symptom-substitution as a consequence of direct symptom removal has given rise to arguments and misunderstandings between psychodynamic and behavioristic psychotherapists.

This paper gives a brief review of the respective literature and it is concluded that positive definitions of symptom-substitution by psychoanalysts and behavior therapists require knowledge of an indefinite number of variables. It is therefore suggested that this term should be avoided and that the various complications that can arise after symptom-centered treatment should be described rather than labelled.

An attempt in this direction is made in the discussion of the exacerbation of interpersonal problems in some of the agora- and socio-phobic patients treated in groups by flooding in vivo. It is shown that there is no consistent pattern of interaction between the symptom of referral and this specific kind of post-treatment complications and that their causal interconnections. before treatment in most cases remained obscure. With the current knowledge, treatment approaches should be flexible according to the changing needs of the patients. Suggestions for further research into the dynamics of the described kind of complications are made.

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