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Obsessive-Compulsive Patients and Their Families

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This chapter mainly relies on 10 years of clinical experience and observation, on hypotheses drawn from this experience, and on guilty feelings (as a behavior therapist) resulting from the lack of hard data with which to evaluate the concepts presented.

The term "systemic–strategic behavior therapy" is introduced to include recent changes in behavior therapy, integrating concepts and techniques from systems-oriented treatment "schools" (Friesen, 1985) and elaborating the functional–behavioral analysis toward a clinical strategy that equally refers to intraindividual and interactional functions of illness behaviors—and even to "hidden intentions" (Hand, 1986a). Thus, these changes have also improved the analysis of motivation for change.

Family variables are discussed in a more general systems approach, with particular attention to dyadic communication styles of the patient in family, spouse, and therapist contacts.

From a behavior therapy point of view, this chapter is premature. From a clinician's point of view, it is hoped to stimulate development of shared concepts and of meaningful questions for joint new research in systems and cognitive aspects of obsessive-compulsive symptoms (OCSs). An extended period of doubting preceded and followed the decision to let the clinician win over the research worker when confronted with the opportunity to write this chapter. As the conflict has been noted from the beginning, writer's cramp could be avoided.

SYSTEMIC AND INDIVIDUAL FUNCTIONS OF OCS AND TREATMENT OUTCOME

"Normal" obsessive-compulsive behavior (OCB) may turn into "pathological" obsessive-compulsive symptoms (OCSs) in the context of different somatic or psychiatric disorders or within an obsessive-compulsive disorder

(OCD). For OCD, behavior therapy is currently regarded as the "treatment of choice." Yet there exists a huge body of psychoanalytic experience and publications in this field (Jenike, Baer, & Minichiello, 1986; Nagera, 1976), as well as a variety of studies from a more biological orientation (Yaryura-Tobias & Neziroglu, 1983). Among the latter, several are concerned with the effects of psychotropic medication on obsessive-compulsive behaviors and accompanying depression (Marks, 1987; Mavissakalian, Turner, & Michelson, 1985a, 1985b). Regardless of their orientations, almost all of these publications rely on an individual disease model, largely neglecting systems variables.

Generally, behavioral treatments for OCD are less successful, more time-consuming, and more interactionally demanding than behavioral treatments for phobic patients. This may be due to a variety of reasons, including the following: (1) longer delay between onset of illness and first contact with therapist when compared with phobics; (2) more severe deficits in early individual development, in particular in the development of social skills (these often appear connected with impaired communication skills, which affect private and professional contacts as well as communication with the therapist); (3)stronger adherence to symptom behaviors that in many ways resemble socially reinforced virtues (orderliness, cleanness, etc.)—even in a normal population there is a much higher prevalence of OCBs than of other neurotic symptoms (Hand & Zaworka, 1982)—unlike phobias, many OCSs are not qualitatively new behaviors; and (4) frequently, OCSs seem to bring about reduction of general anxiety (dependent on internal, cognitive triggers) rather than of phobia-like anxiety responses to external triggers.

Published treatment studies with behavior therapy vary extremely in outcome (Beech, 1974; Foa, Steketee, Grayson, & Doppelt, 1983; Marks, 1987; Mavissakalian, 1985b; Rachman, 1983; Rachman & Hodgson, 1980). To some extent, outcome may depend on the types of obsessive-compulsive subsymptoms treated: washing and cleaning rituals seem to respond positively in 75%–95% of obsessive-compulsive patients (OCPs), whereas the same only holds true for 50%–70% of compulsive checking, counting, touching, or speaking rituals. The positive results for isolated obsessions go down close to 0% (Rachman, 1983). On average, with unselected clinical OCPs, one may expect success rates of 50%–70%, depending on the distribution of the mentioned subgroups in any given sample.

Separation of these three subgroups of OCSs seems useful also with regard to intrapersonal functions. For instance, washing and cleaning much more resembles phobic (avoidance) behaviors than the other groups of OCSs. Patients with these behaviors usually have a phobia-like anticipatory anxiety, the triggers of which can either be avoided or removed by the rituals. The main intraindividual function of these symptoms appears to be a reduction of trigger-focused anxiety.

Orderliness and checking—in particular, counting, touching, and speaking—are often connected with magical thinking. These rituals seem to have the intraindividual function of reducing more generalized anxiety. They are often induced by cognitions of anticipated disasters, which are hoped to be prevented by means of their magical power. With regard to magical thinking, there are overlaps of these OCPs with a subgroup of gamblers who are hooked on magical indicators for "luck," including numbers, melodies, and a wide range of external events (Hand, 1986b). In both of these groups, there is a certain delusional quality in the magical thinking; however, unlike in schizophrenia, there is little if any generalization of this kind of thinking into everyday life. The magical belief system appears unchangeable in spite of these patients' ability to differentiate clearly between a logical stream of thought and their irrational, magical expectations. Of course, in some patients, other intraindividual functions may be more important: checking and orderliness may be connected to primary low self-esteem with the aim to assure social approval, or they may result from the attempt to reduce mistakes resulting from impaired short-term memory—which itself may be the consequence of severe depression or of organically impaired brain functions.

Ruminating appears more closely connected to depression than the other two groups of OCSs (the level of depression ratings do not allow conclusions about causal connections between depression and OCSs). The ruminator frequently has the expectancy of unavoidable disaster; in fact, sometimes he or she is even convinced that the disaster has already happened and that he or she unfortunately cannot prove this to anyone. Cognitions in this subgroup are much closer to psychotic delusions than in the other two groups; these OCPs have by far the closest links to major depression or schizophrenia.

From a cognitive point of view, these three subgroups can be divided according to their concepts (guiding cognitive principles) of mastery or helplessness when faced with subjective threats of disaster: (a) The washer is characterized by the certitude of mastery—either by avoidance of anxiety-inducing triggers or by "undoing" the triggers with the rituals; (2) the OCP with counting, touching, or speaking rituals is guided by the expectation of mastery due to belief in the magical power of rituals preventing disaster from him- or herself or significant others (checkers are somewhere between these two groups); and (3) the ruminator, in contrast, anticipates disaster out of a certitude of helplessness, with symptom behaviors frequently even increasing rather than decreasing the negative expectations (as well as anxiety, guilty feelings, or depression). This separation of cognitions in the three subtypes of OCSs may to some extent "explain" the clinical impression that depression will improve usually in successful treatment of OCSs in the first group, frequently in the second, but rarely in the third. Of course, in the individual patient with mixed OCSs, we will

find overlaps among the described cognitions and intraindividual functions. For a recent, but different cognitive-structural approach to OCBs, see Reed (1985).

With regard to differences in interpersonal functions, it appears that somewhere between the first and the third subgroups of OCPs, there is a cutoff point between "easy" and "tight" interaction styles, particularly with regard to interactional power struggles. We assume that primary impaired social skills have led to low self-esteem and high interpersonal vulnerability, for which pseudocompensation, by obsessional-dominating anancastic[1] interaction patterns, has been developed (see below).

We must strive for a combination of psychological (intraindividual as well as interactional) and biological variables in conceptionalization and treatment of OCDs. The relative importance of each of these variables in any given individual patient needs to be assessed before meaningful interventions can be derived and applied. In the context of this chapter, the family and system variables are given priority, but in the individual OCP, they are not the decisive ones *per se*! Also, it must be mentioned that for many OCPs with complex additional problems, mere exposure treatment may have better symptomatic and generalized effects than interventions in the other problem areas (Hand & Sauke, 1985). The following considerations therefore refer to those patients who are failures in traditional symptom-directed behavior therapy and for whom family and systems variables have to be considered as major sources of resistance to change.

Behavioral Treatment Strategy

Treatment of a person with OCSs requires complex pretreatment analyses, including psychopathological classification. Only with obsessions and compulsions in the context of a neurosis or psychosomatic disorder can the symptom-directed techniques of behavior therapy be applied. Even then, careful evaluation of motivation and intraindividual as well as interactional functions of the symptomatology is necessary to avoid erroneous application of exposure (Hand, 1986a).

OCS and Motivation for Change

From a combined individual and systems point of view, one can find a variety of obstacles for the development of "real" motivation for change. Neither do patients' explicit statements that they want their OCSs to be treated really indicate that this is so. Similarly, relatives' opposite statements about the patient also don't necessarily reflect the truth (Hand, 1981a). Common obstacles to motivation for change include the following.

Patients may hide symptoms. These behaviors may have been an important precondition for a professional career (meticulousness, orderliness, cleanness) or subjective well-being (magical rituals); their escalation has not been judged adequately by the OCP, and attempts from others to get him or her to reduce the behaviors are perceived as a threat to his or her personality. A feeling of shame about the subjectively meaningful but logically "silly" OCSs may additionally increase the tendency to hide the symptomatology. The experienced clinician will detect hidden OCSs in a variety of psychiatric patients as well as in normals.

Before trying to reduce a patient's OCBs, the therapist ought to keep in mind that many compulsions resemble "normal" behavior patterns that may have been severely enforced and reinforced in education, religion, and working conditions in industrial- or religion-oriented societies. These behaviors also resemble rituals in children's games and in everyday adult life, which seem to be a precondition for healthy individual development (Erikson, 1978). These behaviors seem to serve two major functions: (1) to facilitate the development of adaptive stereotypes to constant external overstimulation and (2) to reduce anxiety induced by such distinct triggers as unknown rules in spontaneous social encounters or a fear of death. Magical rituals in several aspects resemble religious rituals for reduction of generalized anxiety and feelings of guilt; these rituals also can go far beyond the desired levels, then to be called an illness.

Many patients with OCDs suffer from severe social deficits unknowingly and without displaying them immediately to the unexperienced observer. Over the years, these OCPs have developed pseudocompensation for these deficits—a latent aggressive, anancastic style of interaction (Donath, 1987; Yaryura-Tobias & Neziroglu, 1983)—that leads to a "winning the battle but losing the war" mode of social interaction. These OCPs have developed skills to dominate others in dyadic interaction, giving the immediate impression that they are socially "overskilled." Peers at work as well in private life will soon tend to avoid such people; the OCPs then receive yet more reinforcement that others don't like them and they don't like others. The resulting avoidance of dyadic closeness is motivated by the desired avoidance of any risk of being hurt when getting close. As a "coping" strategy for severe social deficits, such a pattern unfortunately appears subjectively successful; therefore, these patients are very reluctant to give up this skill and be exposed to their deficits. In treatment, it may take a long time until such patients are ready to acknowledge their deficits and to learn more adequate coping strategies. In this context, and from a systems point of view, one also has to help spouses of such patients with their own deficits, which have made them tolerate this interactional style for extended periods of time.

In the therapist–patient relationship, this interaction style is probably one of the main reasons for high dropout and failure rates. The therapist

needs specific training to detect the reasons for this communication style and to learn to cope with it in a therapeutic way, rather than responding with increasing aggression and rejection.

Initial aggressive interaction from these OCPs may not only result from their typical communication pattern, but it may also come from the above-mentioned feeling of being threatened by any attempt of the therapist to reduce the OCBs. On the basis of such experiences, therapists have developed a very specific interaction style with these patients (see below). With such patients, "successful" treatment often seems to introduce mutually acceptable compromises of the OCPs with their social environments regarding OCBs and communication styles. On rating scales (Zaworka, Hand, Jauernig, & Lünenschloss, 1983), such reductions of OCSs may look impressive and prove statistically significant, and subjective suffering of all individuals within a family system may also be considerably reduced, yet general social functioning of the OCP may remain severely impaired.

Obsessive-compulsive symptoms may become one of several weapons in interactional power struggles in couples, families, and larger systems. Sometimes the "intervention" of the OCS weapon by one family member may even be followed by the invention of "anti-OCS OCSs" in another member. To make matters even more complicated, both fighters may agree to hide the existence of these weapons in front of the therapist. Much like the previously described pseudoassertive interaction style, the use of OCSs as an interactional weapon usually results from primary interactional deficits. The following three case examples illustrate these interactional functions.

Case 1

A housewife and her husband both complained about her severe OCSs in the home. The wife expressed a strong desire to receive treatment for the OCSs and not for her considerable depression, social anxiety, and functional somatic complaints. Exposure treatment failed to help. Subsequent reanalysis of her pretreatment ratings on multisymptomatic self-rating scales (Hand & Zaworka, 1982) revealed that, in spite of the high scores in OCSs, the patient had rated highest in "behavioral resistance" (Zaworka & Hand, 1981)—the degree to which a person continues everyday activities in spite of intermittent symptomatology—against her social phobic symptomatology. According to our model of motivation, this should have indicated that motivation for change was actually highest in the area of social anxiety.

Repetition of the behavioral analysis—on the basis of a much more trustful relationship having resulted from the exposure treatment—re-

vealed that the patient lived in an increasingly unhappy marriage. She felt suppressed by her husband, a successful businessman. Because of her social deficits and dependency on her husband, she had been unable to make her point in marital power struggles. Thus, she eventually developed exaggerations of those behaviors that her husband originally had requested from her, including cleanliness and orderliness in the house (opposition by paradox). When these behaviors had reached a "pathological" level (according to the norms of her husband), they had also led to new restrictions in the family that increasingly limited the husband's freedom of behavior and power at home. The wife defended her new power by insisting that she had developed an illness for which she was not responsible. The husband finally accepted this interpretation and then concluded that there should be a cure. Thus, the wife's paradoxical communication was attacked by the husband's paradoxical communication. She had no logical reason to refuse his proposal of treatment, again finding herself in a trap. Since she had insisted on the illness quality of her hidden power strategy (i.e., OCSs), she had to pretend motivation for illness (i.e., power) reduction. She was defeated again by her husband, who was now using the paradoxical strategies that she originally had introduced into the battle. Thus, marital problems and her social deficits remained the couple's secret when they first asked for treatment. The wife had not dared to mention these problems in the early stages of treatment, and the therapists had not sufficiently used their strategy of behavior therapy and their imaginations to question her request for symptom (i.e., power) reduction.

Such a failure of exposure, here due to the hidden systems function of OCSs, can sometimes be avoided by the results of a behavioral analysis *in vivo* always preceding exposure *in vivo* interventions.

Case 2

Wife and husband together requested treatment for her extensive OCSs in and around the kitchen. No mention was made of marital or other problems. Only the *in vivo* analysis at the couple's home revealed that the living and sleeping rooms were stacked with hundreds of copies of the husband's professional journals; that is, he had been a compulsive journal collector years before the compulsions of his wife had started. Only at this point were the couple able to admit to years of arguments about the husband's compulsion, which had totally destroyed the previous *gemütlichkeit* at home. From a power point of view, when the husband had established his obsessive-compulsive empire in the sleeping and living rooms, the wife prevented his invasion into the kitchen by developing her own OCSs there ("fighting the enemy with his own weapons"). Under the heavy pressure

of her husband, she eventually came to agree that only her OCSs were an illness. As in the previous couple, she gave in to his demand to get treatment and did not dare to tell the truth even in individual interviews at the hospital office.

Assessment of motivation may also be necessary in a broader systems approach (Wynne, McDaniel, & Weber, 1986), as the following example may illustrate.

Case 3

A woman came to the intake interview because her neighbors had become intolerant of her noisy ways of checking whether or not the entrance door to her apartment was locked (referral for treatment because of interactional function of one OCS). She herself did not suffer at all from this habit, and, rather than reducing this OCS, she wanted to discuss strategies to use to calm down the neighbors. When she had developed some trust in the therapist, she started talking about her intraindividually most important OCS, which also had become her major purpose in life: compulsive bible translating. As a young woman, she had joined a monastery to withdraw from normal social contacts. At entry she had bestowed a large amount of inherited money on this institution. A year later, she left the place in disappointment but was refused refund of her money. After these experiences, she had started her private bible translations with the "hidden intention" (Hand, 1986a) of demonstrating to her (holy) father in Rome that something had to be wrong in the existing bible translations, since they were the guide for those people who had treated her so badly. Further, she indicated that monks in monasteries had not been able to deliver proper bible translations over a period of almost 2,000 years. So she had dedicated her life to bible translating.

Every year she worked as a part-time secretary for some months; for the rest of the year, she lived on this money like a nun in the solitude of her flat, devoting her time to translating. She had sent several preliminary translations to the Pope, with the hidden intention of getting father's help to educate his daughters in the monastery properly. The therapist's help was only wanted to get the Pope to respond in the desired way.

Here, in a broader systems context, social deficits—and a pseudocoping strategy for them (with latent, hidden aggressiveness or resentment)—created a vicious circle of mutual reinforcement of OCSs and of social deficits. The OCSs turned into an ultimate purpose in life.

As has been shown, OCSs can become weapons in interpersonal power struggles. Such power struggles may occur as intermittent developmental stages of a relationship, but they may also turn into a chronic exchange of hostility.

Case 4

A housebound female "washer" gained total control over her husband's behavior in the apartment. The apartment was divided into several zones of cleanness, with the husband only being allowed to move in the least clean zones, which amounted to some 20% of the total space. When entering the house, the husband had to follow the wife into the bathroom, there to undress and to get a wash from head to toe. This, among other submissions, was the result of severe power struggles earlier in the marriage; some 15 years earlier, the wife had called the husband a "dirty pig" for having an affair with another woman (which had never been confirmed then or thereafter). In this context, she had developed a brief psychotic episode with delusional jealousy. This was successfully treated by neuroleptics, but the wife had since developed her excessive "dirt-phobia," with extreme cleaning rituals of husband and apartment. (More information is given on case 4 later on in this chapter.)

Case 5

A male compulsive "speaker" developed the idea that a message is only sent properly when certain words or sentences are spoken with the "correct" sound and intonation. Only the patient could decide whether these standards for correctness were met, although he sometimes pretended to consider other persons' judgments. At home, his wife was forced to listen to him until he felt satisfied. Any attempt from her to push him to finish increased his irritation, leading to more interruptions and repetitions, and severely extended the time needed for finishing the ritual. The husband sometimes locked the wife in the bathroom, repeating his words from outside and allowing his wife out only after he decided to stop talking. If the wife then attempted to leave the house, he would lock the front door, immediately starting new words and forcing her again to listen for another extended period of time. For years this marital interaction was also characterized by the wife's constant threat to seek divorce.

Such an interaction may end in physical violence. If such a patient is then admitted to the hospital—due to pressure from his wife and a doctor—he will soon start this type of communication with the ward staff. Eventually he will provoke so much aggression on the ward that he will be discharged, against his wife's will. The best kind of help for a couple like this may be to change the wife's behavior in terms of her specific symptom-related and general interaction with the husband.

The explanation of the development of such complex OCSs on intraindividual as well as interactional levels needs to consider "pathology" in spouses who accept this kind of chronic symbiotic existence (Hafner,

1986). If, in treatment, spouses are not sufficiently involved and changed, the patient may be successfully treated, in the hospital, but the spouse will respond with deep dissatisfaction and aggression toward the patient and therapist, complaining about other deficits or problem behaviors in the patient.

If therapists do not pay attention to interpersonal functions of OCSs in couples or families, and if they neglect the impact of such functions (in particular, the expression of hostility via OCSs) on the patient–therapist relationship, they may not be able to separate real from pretended motivation for change. In such a situation, short-term symptom treatment may be wrongly applied and may result in the patient turning a treatment technique into a new OCS, as we have seen in a "licking" ritual, resulting from exposure and modeling in a dirt-phobic compulsive washer. By this, the patient constantly expressed his aggression toward the therapist, who—from the patient's point of view—caused pain to him and needed to be publicly blamed for what he did.

BEHAVIORAL TREATMENT TECHNIQUES

In behavior therapy, by far the most frequently applied treatment technique for OCSs is the combination of exposure *in vivo* and response prevention. In clinical work, there is no logic in separating these elements. Usually, exposure is only seen as a means to reduce symptomatology. But exposure can potentially serve three functions.

1. Exposure can extend the behavioral analysis in a state of higher emotional arousal. In addition to office interviews, exposure may reveal more details of symptom behavior and other problem areas. The patient may discover feelings and cognitions that he or she didn't recognize before, having avoided this state of prolonged emotional arousal. Before exposure, the patient may feel afraid of anxiety, whereas under exposure he or she may discover that the feelings provoked by confrontation with the stimulus are actually depression or anger. Tolerance of such strong feelings may then provoke "hidden cognitions" or "suppressed memory," and the patient may achieve access to highly relevant information about other problem areas, which may then become the new focus of treatment (see the continuation of case 4 below).

2. When the conduct of exposure has been done in an interactionally proper way, it can enhance the therapist–patient relationship. Trust in the therapist may increase so much that previously conscious but hidden information is now communicated to the therapist (see cases 1 and 2).

3. Effective exposure may result in response management and symptom reduction. Response management is particularly important to prevent

intermittent relapses by increasing self-help capacity. In this context, training of depression management should be applied in an identical way to anxiety management (Hand *et al.*, 1974; Hand *et al.*, 1986). In this concept, exposure to an external trigger 1 usually is much more an exposure to or confrontation with the patient's internal—cognitive–emotional–physiological—responses (i.e., trigger 2), induced by prevention of external, motor behavior responses (avoidance).

If we conceive of behavior as composed of motor, cognitive, emotional, and physiological activities constantly interacting with one another, the term "exposure response prevention" is clearly misleading, as response prevention only occurs for the motor behavior. Therefore, I have proposed (Hand, 1981c; Hand *et al.*, 1986) to rephrase the term into "exposure response management." "Response management" refers to learning coping strategies with anxiety, depression, anger, or guilty feelings, the exposure to which has become possible by prevention of the initial motor or mental avoidance response.

The latent aggressiveness of many OCPs can easily get the therapist involved in power struggles at any stage of treatment. The exposure *in vivo* sessions are the most intensive intrusions into the OCP's autonomy. They include the most threatening questioning of the obsessive-compulsive or anancastic pseudocoping strategies. Therefore, my colleagues and I have developed a very particular interaction style with these patients while conducting the exposure sessions in their homes.

We only initiate the first home visit after patients have made a clear decision that they are ready to take the risk of destroying the obsessive-compulsive concepts, thus facing any and all possible risks that might result. Once this decision has been made in the office, we tell the patients that at any point during exposure at home, they will be free to change their mind, interrupt exposure, and return to the rituals. Before doing so, however, they will be asked to reevaluate the decision, with a discussion of its consequences, before indulging in the rituals again. Having entered the first few square yards of the home, each further step will be explained to the patients and will need their approval. With this motor behavior the therapists submit themselves entirely to the control of the patients. In the first hour of exposure in the home, patients check whether the therapists know about obsessive-compulsive concepts and whether the therapists make "mistakes" in behavior in the home—due to a lack of knowledge or of caring.

The most difficult aspect of the first 4-hour contamination session at home with washers and cleaners is the mutual agreement between patients and therapists that they are to contaminate virtually every square centimeter of the flat with "dirt" or "germs." Before starting, patients and therapists have also agreed that this full contamination cannot be undone,

as it would take months of work. So the patients, when following through the whole session, are taking an extreme risk; they do not know what their responses will be, but they do know that their usual coping behaviors will no longer be available. This means that the patients have to take the risk of parting from the certitude of mastery based on the rituals. This decision to let go of a long-established cognitive concept will not be helped by pushing the patients beyond the actual state of motivation. Each interruption of the exposure by patients is therefore accepted by therapists in order to teach new coping strategies. Exposure is done in self-conduct under self-control, the therapist mainly being there to make adequate suggestions and for expert dialogue when doubt arises. With this concept, few patients drop out of the exposure treatment. Therefore, we never applied 24-hour supervision of response prevention in a hospital setting.

For the following reasons, it may become necessary to engage other family members in one or more of the exposure sessions at home: (1) successful symptom reduction in one session may be very irritating for relatives, who for years have obeyed to the OCS rules in the house; they may respond with anger or aggression, suspecting that they have been cheated if OCSs can be solved in a 1-day session; (2) the relatives may be able to profit from teaching and modeling (by observing the therapists' interaction style with the patient) of new interaction styles; training of new interaction and communication patterns regarding the symptom behavior may generalize into other relevant areas of couple and family communication (Hand, Spoehring, & Stanik, 1977); and (3) involvement of the spouse and other family members is an additional opportunity to assess family norms with regard to OCBs; sometimes other family members may show clearly pathological OCSs, even more than the designated patient.

Exposure to an external trigger is believed to work via induction of exposure to the internal cognitive–emotional–physiological responses; therefore, *there is no apparent reason to look for different treatment techniques in ruminations*! As for compulsions, one has to identify what patients try to avoid by ruminating, and then one has to expose them to these feelings and cognitions. These may be feelings of anxiety, depression, guilt, or even emotional closeness as well as confrontation with conflict situations. As in compulsions, the avoidance of insecurity with the concommittant desire for 100% predictability of future events is an additional important intraindividual function. These intraindividual functions of ruminations are often combined with the "winning the battle, losing the war" type of interactional function.

Case 6

A saleswoman from a childrens' shoe shop suffered from the rumination that, in spite of her meticulousness, she might have sold shoes that did not

fit the children. The children might then have fallen while running across roads, and they may have been killed by cars passing by. She asked, "Doctor, how can you prove to me that I am wrong?" The most frequent simplistic response to a question of this type is to try reasoning with the patient that these are clearly wrong assumptions. The outcome of such an attempt usually is an increasingly emotional and finally aggressive interaction. This "game of reasoning" is always won by the patient—and she knows it in advance (the reader is advised not to try to role-play this particular case history with friends among his colleagues or family members—afterward they may not be friends anymore). Therefore, we did not give in to that demand to supply security.

We have also never seen thought-stopping to work with this kind of ruminator. Two alternative techniques or therapist responses do appear helpful, however.

The first technique is prescribing the symptom. With this approach, the patient and the therapist get the chance to control the occurrence of the symptom (Hand, 1981b). Prescriptions seem to work particularly well when they impose frequent ruminations (e.g., every 30 minutes for 5 minutes), with constant writing of the ruminations into a little booklet in order to control mind wandering. There are several speculations as to why this works. Perhaps for the patient who follows this prescription, the rumination soon becomes a terribly boring activity. Patients learn that the more they talk about the ruminations, the more prescriptions they will get. From this, it is easy to understand that the positive effects of such prescriptions rely entirely on the therapeutic relationship. If the therapist's motivation was anger rather than benevolence, such a prescription is a dangerous weapon in the therapist–patient communication and may lead to violent counterattacks by the patient who correctly feels hurt.

When it works—and this will only happen on the basis of a trusting patient–therapist relationship—the greatest relief for the therapist is the immediate reduction in time required by the patient to discuss the rumination; this reduces the risk for the development of a power struggle, and it allows more treatment time for more important issues.

Another helpful technique is exposure to the feeling of insecurity: a request for reassurance by the patient will be answered by the therapist as follows: "I'm sorry; you may be right or you may be wrong with your worry; there is no way for me to decide." Many patients will then emphasize the therapist's responsibility to find a solution. The therapist may now argue that there is no way to find an answer that is 100% sure. The therapist can even say that it is only 100% sure that questions of this kind can never be answered for sure and, when discussed, are bound to lead to severe anger because of the lack of a possible solution.

Apart from such direct dealing with ruminations, we usually find it more important to establish alternative behaviors than to deal too directly

with the symptom behavior—which is in contrast with our and others' experiences with symptom techniques in compulsions.

FAMILY BEHAVIOR THERAPY

Behavior therapists need to integrate elements of systems-oriented treatment without leaving the paradigm or the strategy of behavior therapy. Family-oriented interventions can be derived from two basically different groups of systems-directed interventions: the psychoeducational and the systems-proper approaches.

The psychoeducational approach has been best developed in the treatment of schizophrenia (Anderson, Reiss, & Hogarty, 1986). The main emphasis is on the teaching of a certain disease model, not only to the patient but also to significant others. This approach is supposed to improve illness management by patient and family, thus reducing risks for relapse. The teaching refers to biological as well as to psychological and interactional aspects of the disease and its impact on every family member. A clear differentiation is made between the sane family member and the sick. It is still not known whether the content of the teaching material or the emotional experience of being taken care of is most helpful for the relatives. Another unresolved question is whether the teaching material is best presented in a few workshops or whether it is better to spread the information over many sessions in order to make it easier to grasp.

In a similar though much less elaborate manner, spouses and other family members have been employed in individual behavior therapy (Matthews, Teasdale, Munby, Johnston, & Shaw, 1977), including home-based exposure treatment for OCPs. In the therapist-guided approaches, the therapist remains *the* expert, comparable with the doctor in medicine. The relative is taught to become a mediator between therapist and patient. By this, the relative's understanding of the disease of the patient is hoped to improve responses to disease behaviors of the patient. This ideally might lead to reinforcement of "healthy" behaviors rather than opposition to "illness" behaviors of the patient.

Apart from the potential benefits, the therapist-assisted attribution of "sick" and "sane" roles to different family members may also be harmful in the long run—especially when interactional functions of illness behaviors are more important than intraindividual ones. Often, it seems more desirable to see the spouse as a copatient rather than a cotherapist, for instance, as with parents who bring their child with OCSs for treatment. Once a primary organic or psychotic disorder is excluded in the child, the parents are included in the patient role (see case 7, below).

Relatives who are initially reluctant to accept the patient role may enter treatment as the "helper" of the therapist in order to develop trust before daring to attempt the next step. This can be achieved in a systematic

way, in a behavioral group therapy model for obsessive-compulsives (Hand & Tichatzki, 1978) or in individual therapy. If, initially, spouse and patient refuse a joint patient role but accept the spouse as cotherapist in treatment of the patient's OCSs, and if there is a severe but denied communication problem in the everyday interaction of the couple, "hidden couple counseling" is used (Hand *et al.*, 1977). Communication training becomes part of the symptom treatment, but it is designed to affect the more general communication problems—without the couple being told so.

A family setting is regarded healthy when it is organized according to a generation hierarchy with level-specific roles, responsibilities, and power distribution (Haley, 1971). The occurrence of symptoms in a child is expected when at least one parent has settled on the child level, and at least one child has done the reverse in order to stabilize the family unit. The first aim of treatment, then, is to relocate each family member back to the appropriate hierarchical level. Parents are taught to act as a unit with the child to reestablish role-specific rules, rights, and duties. The experience of newly established joint parental power is assumed to reassure the child that both parents don't need his or her help anymore to keep the family going. Means to achieve such changes may be derived from family therapy, as well as from behavioral interventions for deficits in the parents that may have led to this mix-up of role behaviors.

We also teach parents to separate their parental from their marital problems and role expectations. If the marital relationship is impaired, but each individual parent's contact with the children is good, we frequently encounter the following problem: both spouses had successfully acted as parents, leading one spouse subsequently to demand "rights" (e.g., sexual) on the marital level; in a vicious circle, the one spouse who didn't want to intensify marital interaction therefore did not dare to show joint parental behaviors in fear of subsequent new marital demands. Provided there is good will on both sides, teaching of separation of parental and marital role expectations, rights, and duties can have immediate beneficial effects. Treatment thereafter consists of separate training in parental behavior and couple counseling. The decreases in the child's symptom behavior are indicators of treatment progress with the parents (see 7, below).

In systems theories, symptoms are believed to serve primarily interpersonal functions in social micro- and macrosystems. Whenever behavior is changing in one person, this affects the behavior of others close to him or her. Essentially, such an interactional feedback loop model appears to be similar to the operant learning theory paradigm, although in the latter, such a feedback loop was never explicitly formulated in family or systems terms. The smallest interpersonal unit is dyadic and the smallest family unit triadic. Such couple or family units may be treated as *one* systems unit with regard to bonds to a variety of other systems units.

The therapist must to some extent join this complex combination of interacting micro- and macrosystems. He or she has to reflect the role as a participant in the systems. Like a judo master, the therapist will not oppose the powers of the family but will use them to induce change. Especially in families with more than one highly vulnerable member, we have learned that direct attempts to induce major changes in the "pathological" bonds are perceived with a shared panic that these attempts might constitute a threat to the existence of the family. This panic may then mobilize resistance and even increase suffering (see case 4). Therefore, the therapist must first reassure the system that he or she, like all the family members, will help insure the family's survival. This is a strategy of "join the system where it is," in extension of Kanfer's "join the patient where he is" (see case 8, below).

The next technique is the opposite of the judo approach. It is an important element in the work of the Milano group (Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1977), derived from treatment of families with a "symptomatic" child. The main emphasis is on the detection of unhealthy family communication stereotypes, which supposedly serve the family to keep a balance in spite of internal disruptions. Although the theoretical concept is similar to the above-mentioned ones, therapists draw different consequences. In this dynamite approach, the family appears to be interpreted as an unhealthy communication castle, surrounded by strong defensive walls and almost inaccessible to therapeutic attacks from outside. The intervention is then to smuggle communication dynamite into this system, using a Trojan horse–like strategy called "prescription." Destruction of the pathological communication structure is the aim, with the very optimistic assumption that thereafter the family members will return to healthy communication patterns.

For the experienced behavior therapist, this may be a helpful technique with some families. Before using it, however, the therapist must always assess each family member's potential to return to healthy communication patterns. In adults with OCSs, who frequently suffer from long-lasting primary deficits along with impaired communication skills, such interventions without behavioral treatment for the deficits appear extremely risky. Just cutting the "pathological" bonds will leave the family without any bonds at all, and the family's individuals will be without the capacity to form new bonds in alternative social settings.

Application of the Trojan horse approach should therefore only be considered by very experienced therapists with constant peer supervision. Note that home-based exposure may unintentionally turn into such a "dynamite" approach (see case 4).

Family-directed individual behavior therapy can be tried whenever analysis reveals spouse or family problems as a major contributing factor

to an individual's pathology, and other relevant family members refuse to participate in treatment. The patient will then be taught to become the mediator for family therapy—that is, how to induce desired changes in other family members by changing his or her own behavior.

SUMMARY

Behavioral family therapy with OCPs and their relatives must be tailored to the specific needs of a given family unit. Based on the individual, familial, and systemic functional hypotheses regarding OCSs, and with the basic available family interventions in mind, three final case examples are provided to demonstrate systematic application of the various possible combinations of these elements in clinical practice. In contrast to the usual procedure, this summary will therefore not be based on an abstract comprehension of detailed clinical or research material. Rather, it provides a practice-oriented comprehension of the application of multiple, complex concepts by detailed case descriptions.

Treatment of a family with a child as the identified OCP is fairly easy as long as there are no major primary deficits in the parents and both mainly suffer from a breakdown in marital communication (see case 7 below). If there are additional individual deficits in one or both parents, treatment may become more complicated and less successful (case 8 below). The most difficult family unit to treat is one in which both family problems and severe OCSs have coexisted for a very long period of time (case 4 continued.)

Case 7

The identified patient was the 7-year-old son. He displayed OCSs ("magical" checking, touching, counting, and covert speaking of magical words) at age 3 for about 1 year; OCSs reappeared 6 months before the family sought help. The son lived with both parents at home.

The following hypotheses were developed from family and individual interviews. The main family problem was a severe marital tension with a hidden contract between parents to avoid open communication about the wife's desire to leave marriage. Symptoms in parents included the following: the wife showed severe depression and sexual withdrawal; the husband showed regular, though moderate, long-term use of alcohol in the evenings; both spouses showed signs of severe but still "normal" OCBs or obsessionality. Acting as a parent, the son tried to relieve mother's depression by sticking close to her and keeping her busy with his symptomatology. Additionally, OCSs for the son had the intraindividual function of a coping response (by magical rituals), with his own increasing anxiety and insecurity

resulting from confrontation with mother's depression and from the lack of affection between his parents, which severely threatened the existence of the family. Son responded similarly to his father, who, under professional and interactional stress, showed increased OCBs (collecting and ruminating).

The treatment plan included treatment interventions with the parents only. There was separation of two treatment areas: parental role behavior and the marital relationship. Both parents showed clear motivation to improve parental behavior and, at the beginning, marital interaction. They accepted the interpretation that their son had acted as a parent, managing to bring both child-parents into the badly needed treatment.

The treatment goals were as follows: On the parental level, both were jointly to replace the child on the child level and to resist his initial protest behaviors against such a move. They were to accept that successful joint parental efforts gave no "rights" on the marital level.

On the marital level, the couple was trained in risk-taking communication regarding the marital problems. They were to accept the risk that marital counseling might lead to improvement of marriage (not the initial aim of the wife) or to its termination (not the initial aim of the husband). Motivation to accept these opposite risks resulting from opposite marital goals was due to joint willingness to reduce the son's suffering from their marital indecisiveness.

In this context, the parents were also to accept their own symptom behaviors as indicators of mistakes in daily conduct; the sexual withdrawal of the wife and the regular use of alcohol by the husband in the evening were directly linked. The couple were to follow a new therapist-induced communication style that was designed with the intention of using their obsessionality to induce change. Every day, one is to tell the other for 1 hour how he or she experiences reality in the marriage. The listener was to learn not to feel hurt but to stay curious and to respond only on the following day when given his or her opportunity to express personal reality.

The treatment effects over five sessions were as follows: The wife experienced immediate relief and decrease of her depression since her fantasies of leaving her husband were out in the open. She felt she had gotten back choices for future conduct of her life. The husband concommittantly developed increasing depression after his initial "shock" about the extent of his wife's inner withdrawal. In spite of this shift of depression from wife to husband, a variety of important changes occurred. The couple jointly reported a substantial increase in mutual understanding resulting from the communication exercises in the evenings. The husband stopped drinking completely a couple of days after abstinence had been suggested as an experiment to find out how it might affect family life. Between sessions 4 and 5 (at 3-week intervals) the couple had taken up sexual intercourse again for the first time in years (without any direct interventions

in this area in treatment) and had repeated this interaction with mutual satisfaction. The wife felt generally much freer to respond positively to the husband, which was clearly appreciated by him. In spite of all these improvements, which were also described by the husband, the husband's depression and anxiety with regard to the potential breakdown of the marriage seemed to remain. Yet he fully agreed with treatment aims and the family development since its start.

The son showed a severe reduction in OCSs after the second treatment session and greatly increased his peer contacts outside home without any pushing from his parents. This was interpreted to the parents as a consequence of him having realized that responsibility for the parents was taken over by the therapists and that since the beginning of treatment mother's depression had lifted almost completely. The parents were no longer worried about the son's health, and they gradually forgot the threat of a child psychoanalyst that the son would need daily analysis for a couple of years.

About 90% of treatment time was devoted to marital problems, training of open communication, and mutual listening rather than defending. Parental training needed little attention after both had accepted the family model of the son's OCSs. Separation of marital and parental problems enabled the parents to use their originally existing parental skills quickly.

Case 8

The identified patient was the 15-year-old son. His multiple, somewhat bizarre OCSs had started around age 13. He developed a complex system of "good" and "bad" motor and cognitive-verbal behaviors, believed to indicate or prevent disasters. He largely restricted his food intake to a rare, difficult to buy fish and insisted on being fed by mother in a highly ritualized manner. Parents were allowed to talk to each other only in his presence, using a very restricted vocabulary regarding restricted topics, controlled by him. Mother and father were separately to conduct specific cleaning and checking rituals under his supervision (usually from his preferred recliner), he claiming to be too sick to do his rituals himself. In other areas he "regressed" to the behavioral level of a 2-year-old boy: He stopped washing and dressing himself and frequently urinated and defecated into his bed at night, forcing mother to get up to clean him. He explained these behaviors as due to certain obsessions that would not allow him to behave differently. Within half a year, he was unable to go to school. Since then, he had been housebound and alone while his parents were at work and extremely close to his mother when parents were at home. The symptoms started when his father had had an intimate relationship with a female neighbor and threatened to leave the family. When the son got "very sick," the father separated from his girlfriend.

The following hypotheses were developed after family and individual interviews: The function of the OCSs for the son was to cope with a threat of a breakdown of the family. This threat arose when the patient had entered puberty and realized that, since his very few friends had started dating girls and not seeing him anymore, he had to face growing isolation. His social deficits—resulting from a single-child role and a family atmosphere characterized by the obsessional–depressive interaction styles of his unhappily married parents—severely impaired his capacity to relate to the opposite sex. The initial "coping" response—in a vicious circle feedback loop—resulted in more pathology; the total loss of peer contacts and the now exclusive relationship with his unhappy parents increased his social deficits and reinforced his strong OCSs.

For the mother, the son's illness brought her husband back into the home, though not into the family or marriage. The mother's emotional needs then became entirely served by devoted care to her increasingly sick child; she "had to" cook strange meals of only very rare fish and vegetables; she "had to" provide sexual education, for instance, by reading to the son from pornographic journals; she "had to" get up at night from her connubial bed (with open doors to son's sleeping room), where no sex had happened for years, to follow the son's demands to be cleaned when he had urinated or defecated in his bed. The mother complained about these demanding tasks, but she had never seriously tried not to do them, even when husband or relatives had tried to stop her. She also refused discussion of her primary deficits or problems.

The father felt lost in a "responsibility trap." He failed to respond to his son's challenges (who finally even tried to provoke him by sexual closeness to the mother) to be a "strong," responsible husband and father. Yet he kept feeling responsible for his son and was trapped by the belief that he could only help the son by staying with his wife. Thus, with sad resignation, he stayed in the family, waiting for the day when the son would be sane again and he could run away.

The son's falling ill saved family from being left by the father. The son's staying ill prevented possible repetitions of the father's escape attempt. The chronically unhappy marriage deteriorated constantly, and the son's illness got increasingly worse. For the initial function of saving the family, the son had to pay an increasing price when his behavior turned against him by severely increasing his social deficits—making him even more dependent on the further existence of the family. This dependence increased his irritation and anxiety, and he totally dominated his parents with his symptoms. He forced them to talk and to move according to the laws of his OCSs—he even forced them to carry out his rituals, while he gave instructions from a wheelchair. Through this behavior, he did not leave his parents any time to talk or act out or improve their marital or individual problems.

Finally, the family was characterized by deep distrust among its three members, hidden aggression between the parents, and a total lack of open communication. The illness in each of the family members had developed self-reinforcing properties and kept all three together and possibly even alive.

A long-term multimodal treatment plan appeared necessary. When the parents had first contacted us, they had already tried various individual treatments for the son elsewhere. We insisted on initial family therapy, thereafter splitting the family for marital treatment of the parents and peer group treatment for the son. The son immediately was excited about the idea of family therapy, whereas it took the parents 1 year to accept this. During this year, they made several attempts to force us and other therapists to try yet another individual treatment of the son. Eventually, they accepted our offer and the son supported us by self-induced, far-reaching changes in his OCBs in order to enable outpatient family treatment. He stopped urinating and defecating in his bed at night, and for the first time in a year he agreed to have his long hair washed and cut and to leave home with his parents in order to come to the outpatient sessions. The parents felt very insecure about these unexpected changes.

Since the OCSs, almost like a spiritual power, had controlled the otherwise chaotic family interactions, we wanted to replace them initially with therapist control over family interaction. We had gained trust of the son during the 1-year waiting period, and we eventually won the power struggle with the parents regarding family treatment. We had gained some trust from the parents when, to their great surprise, the son reduced his OCSs dramatically at the beginning of treatment. This seemed a sufficient precondition to get each family member to accept our claim for control over family communication for a limited period of time.

Training of new communication rules was started with the exchange of "behavioral presents" among the individual family members. We purposely avoided "reciprocity counseling" (Stuart, 1980), as this is poison to obsessive-compulsive families; reciprocity counseling would result in endless debates among family members as well as between family and therapists with regard to the "fairness" of the exchange of behavioral presents (see similar criticism of reciprocity counseling by Jacobson, 1984). We demanded the right to decide whether each individual's behavioral presents to the others were acceptable or not. Previously, family communication had been governed by the rule "demand a lot to get a little." Each member was to learn that "one gets by giving and not by demanding." When this communication "game" was accepted and started to work, we additionally introduced couple sessions for the parents. Through these, we also tested our hypothesis that the son wanted to get rid of his responsibility for the parents' marriage; if we were right, the son would respond to the additional marital therapy by another clear reduction of his OCSs, which did occur.

Only thereafter did we apply a few individual and family sessions of exposure *in vivo* for the OCSs. However, the major amount of symptom reduction had already occurred during the previous treatment sessions, which did not deal with this symptomatology!

The multimodal approach, though including few and simple interventions in an apparent chaos of multiple problems, led to the establishment of new marital behaviors of the parents (except for sexual contact). The son's symptomatology was lowered to such an extent that after 3 years of a housebound life he went back to school, got his driving license, and started dating girls his age. All this took 1 year; treatment started with sessions once a week, decreasing in frequency to monthly and bimonthly intervals.

Unfortunately, the son always refused to participate in the final intervention that we had planned for him—peer group therapy for his primary social deficits and their symptomatic pseudocompensation by anancastic interaction. Without such treatment, we had predicted gradual relapse because of his primary social deficits and their increase resulting from peer isolation during the years of puberty. He would almost have to get into trouble when peer contacts at school or contacts with girls became closer.

The son managed to go to school for about a year after termination of treatment. Then gradual relapse started, first with OCSs in the son, which were soon accompanied by the mother's escape from her reestablished marital behaviors to help the son again. Another year later, the old interaction scheme was reestablished in the family. Had the son joined the peer communication training group and eventually become independent of his parents, they would probably have had to work out a mode of separation, with subsequent individual help for each of them and their deficits.

Case 4 Continued

In case 4, it was already demonstrated how OCSs can serve to express chronic anger and hate in a relationship that both spouses are unable to break up. Exposure and family therapy of this patient are particularly suited to demonstrate how powerful and dangerous intervention techniques can be if change is not really wanted by the treatment-complaint patient.

This patient, with excessive dirt-phobic cleaning rituals in her apartment, had stopped using her phone—her last communication link to the outer world (apart from her husband and one daughter who lived with her). This was to avoid contamination with the dirt that she thought would be there after her daughter had used the phone.

In exposure, when asked to touch the phone, she hesitated more than with other objects in the flat, asking the therapist, "Are you aware that I had a psychotic breakdown 15 years ago?" Only when the therapist had

asked back, "Do you really want me to get as scared as you seem to be?" did she reluctantly start this particular exposure exercise. While touching her ear and her hair with the phone, she initially reported fearfulness, then anger, and finally hate. Accompanying cognitions at this point were thoughts about her youngest daughter. First, the patient didn't know how to link the feelings of hate with the thoughts about her daughter; this particular daughter was the only person in her entire life that she had felt close to over the past 15 years. In extended exposure, the patient then recalled her most traumatic family event 15 years ago, when she had developed psychotic jealousy. For the first time in many years, she now remembered that almost worse than the assumed infidelity of her husband had been the experience that her then 6-year-old daughter, her favorite child, had not taken her part in the marital war but had continued to express her love for her father. In later years, she had suppressed her deep disappointment about this daughter to save the illusion that there was one stable, trusting relationship in her life. Only in exposure to the phone did she realize this illusion. She immediately felt sad, at the same time losing her problems with the phone completely. She apparently accepted subsequent exposure to the reality of the mother–daughter relationship in an intense prolonged treatment session with mother and daughter. Proposition of such intense family intervention in the very situation in which the family conflict had been uncovered proved a therapeutic mistake, resulting from insufficient exploration of the patient's "real" motivation for such a painful step.

Real-life exposure to the hidden mother–daughter conflict induced a highly emotional interaction between mother and daughter—including tears and exchange of resentment, aggression, disillusionment. After two sessions, the mother–daughter confrontation had to be stopped, when the patient developed clinical signs of rheumatoid arthritis in her knees. She went to the hospital, but even with the most sophisticated laboratory investigations, the clinical diagnosis could not be confirmed. It was nevertheless decided to try antibiotic treatment. The patient responded with an immediate allergy to the medication. Eventually, she was discharged with the clinical symptoms unchanged. She was then offered long-term interruption of the behavior therapy—which she gladly accepted.

Some 8 months later, we learned that the patient had made great improvement; she had stopped most of the excessive cleaning rituals in the flat—not because of behavior therapy but because of the involuntary "response prevention" of her arthritis, which hindered her from moving around in her home (this being her personal explanation). Then the arthritis miraculously improved, without the OCSs increasing. The patient then persuaded her husband to join a dancing class with her (after 15 years of OCS-induced confinement to the flat). Her expressed reason for this was not an attempt to improve marriage; instead, she wanted to exercise her knees so that they would regain full functioning.

With this development, from the therapist's point of view, the patient, who had always been treatment-compliant, proved that the aims of therapy had been correct. However, the speed of confrontation with the family conflict—accidentally uncovered by exposure for rituals—had been too fast. When left alone, the patient continued her treatment at her own speed.

This extremely vulnerable patient, with her totally dependent husband, had responded over 15 years to interactional traumata with acute psychosis, followed by chronic, severe neurotic symptomatology. Later the patient evidenced painful psychosomatic complaints when the OCSs were reduced and a traumatic past experience was uncovered. Nevertheless, short-term behavior therapy seemed to have induced changes on relevant levels, and the patient continued treatment at her own speed with limited goals to make life a little more enjoyable.

Had the accidental Trojan horse intervention not happened, a much slower paced treatment would have included interventions to improve the severe individual deficits in both spouses.

CONCLUSION

We are only in the beginning of a systematic integration of family- and systems-oriented interventions into a general strategy of behavior therapy. Among the neurotic disorders, application of such strategic–systemic interventions appears very difficult and at the same time very needed in the area of OCSs—especially with regard to the as yet unsatisfactory global outcomes of more individually centered interventions like exposure *in vivo*.

On the other hand, we have to be careful not to throw out the baby with the bathwater. As our own data show (Hand and Sauke, 1985), for the majority of the OCPs in a clinical outpatient setting, exposure-based treatment still remains the "treatment of choice." Exposure *in vivo* also remains an essential element in a variety of family-centered behavioral treatments, mainly in patients who fail to respond to exposure alone or who show a clear indication that family or couple intervention is essential and sufficient.

We hope soon to be able to delineate predictors for treatment outcome with the application of symptom- and/or family-directed modes of treatment. We feel currently that, in families where (nonpsychotic and nonorganic) OCSs occur in a child, only the parents need individual or couple treatment.

We conceive exposure *in vivo* (to trigger 1) as a technique to induce internal cognitive–emotional–physiological response sets, which are the essential trigger (trigger 2) for motor, cognitive, or emotional avoidance or undoing. Thus, exposure *in vivo* is assumed to work by exposure to and

tolerance of trigger 2, for which coping (management) srategies then need to be taught. In such a concept, one can apply identical exposure principles to compulsions and obsessions. Such an integrative concept also avoids the academic dispute on the nature of behavioral versus cognitive-behavioral treatments.

The various possible intraindividual and interactional functions of OCSs need to be analyzed for any individual patient and to be integrated into all treatment steps, including the application of exposure. The frequent interactional vulnerability of OCPs—with the difficult pseudocompensation by an anancastic interaction style—is a decisive variable in most individual as well as in systems-oriented interventions.

NOTE

1. The term *anancastic* is used in European psychopathology for OC *trait* variables, being separated from OC *state* variables.

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HANDBOOK OF BEHAVIORAL FAMILY THERAPY

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THE GUILFORD PRESS
New York *London*