Enhancing Exposure and Response Prevention for OCD: A Couple-Based Approach

Jonathan S. Abramowitz, Donald H. Baucom, Michael G. Wheaton, Sara Boeding, Laura E. Fabricant, Christine Paprocki and Melanie S. Fischer

Behav Modif 2013 37: 189 originally published online 22 May 2012
DOI: 10.1177/0145445512444596

Behavior Modification
37(2) 189–210

DOI: 10.1177/0145445512444596
bmo.sagepub.com
SAGE

Enhancing Exposure and Response Prevention for OCD: A Couple-Based Approach

Jonathan S. Abramowitz[1], Donald H. Baucom[1], Michael G. Wheaton[1], Sara Boeding[1], Laura E. Fabricant[1], Christine Paprocki[1], and Melanie S. Fischer[1]

Abstract

The effectiveness of individual therapy by exposure and response prevention (ERP) for obsessive–compulsive disorder (OCD) is well established, yet not all patients respond well, and some show relapse on discontinuation. This article begins by providing an overview of the personal and interpersonal experiences of OCD, focusing on interpersonal processes that maintain OCD symptoms and interfere with ERP. The study then describes a couple-based treatment program that the authors have developed to enhance ERP for individuals with OCD who are in long-term relationships. This program involves psychoeducation, partner-assisted exposure therapy, couple-based interventions aimed at changing maladaptive relationship patterns regarding OCD (i.e., symptom accommodation), and general couple therapy. Three case examples are presented to illustrate the couple-based techniques used in this treatment program.

Keywords

obsessive-compulsive disorder, exposure therapy, couples therapy, response prevention

[1]University of North Carolina at Chapel Hill, USA

Corresponding Author:
Jonathan Abramowitz, Department of Psychology, CB# 3270 (Davie Hall), University of North Carolina at Chapel Hill, Chapel Hill, NC 27599, USA.
Email: jabramowitz@unc.edu

Although there is considerable evidence for the effectiveness of treatment by exposure and response prevention (ERP) for individuals with obsessive–compulsive disorder (OCD), not all patients respond well, and some show relapse on discontinuation (e.g., Foa & Franklin (2001). For a number of reasons, however, involving the patient's romantic partner or spouse might improve the short- and long-term effects of ERP. As we describe in detail later in this article, significant others often become involved in the patient's OCD symptoms (e.g., by providing reassurance, checking, or refraining from contact with contaminants), creating a relationship dynamic that is in contrast to the aims of exposure-based treatment (e.g., Calvocoressi et al., 1999). Moreover, such a dynamic is associated with OCD severity, course, and poor global functioning, further serving as a risk factor for long-term problems with OCD (Calvocoressi et al., 1999). Preliminary outcome studies also suggest that involving spouses to act as coaches for their OCD partners during exposure treatment (i.e., "spouse-assisted cognitive-behavioral therapy [CBT]") improves the efficacy of ERP (Mehta, 1990). Yet spouse-assisted ERP only partially addresses the role of the couple's relationship in the maintenance of OCD; and it does not identify and modify the stressful dynamics in couples' relationship, which likely attenuate response to treatment and increase the risk of relapse. In this article, we describe the nature and treatment of OCD focusing on these interpersonal dynamics and outline a couple-based exposure treatment program for individuals with OCD who are in long-term relationships, which we are currently evaluating at the University of North Carolina, Chapel Hill. Three case examples are also presented to illustrate the couple-based techniques used in our program.

The Nature and Treatment of OCD

OCD is an anxiety disorder characterized by two primary symptoms: *obsessions* and *compulsions* (American Psychiatric Association [APA], 2000). *Obsessions* are recurrent thoughts, ideas, images, impulses, or doubts that are experienced as senseless, unwanted, and distressing; for example, the persistent thought that one is contaminated by invisible "floor germs" and might become ill or make others ill. Although seemingly illogical or excessive, obsessions evoke anxiety, doubt, and avoidance behavior (e.g., of floors). In addition to contamination, common themes of obsessions include responsibility for causing harm (e.g., by making improbable mistakes), violent, sexual, or blasphemous thoughts, and incompleteness and imbalance (e.g., the idea that one's left shoe is tied more tightly than her right shoe).

Compulsions are urges to perform behavioral or mental rituals that serve to neutralize obsessional anxiety. Examples include washing and cleaning, checking, asking for reassurance, ordering and arranging, repeating routine activities, counting, and mentally praying or thinking a "good" thought to "balance out" a "bad thought." The rituals might be highly repetitive, such as checking doors and appliances many times before leaving the home, or less repetitious yet performed according to particular rules, such as ritualized showering or praying. Regardless, compulsive rituals are excessive in relation to the obsessional fear.

For the person with OCD, there is an internally consistent "logic" that links obsessions and compulsions. For example, someone with obsessional images of harming a loved one might repeatedly seek assurances—such as from a partner or spouse—that he is unlikely to act on such thoughts. In a similar way, someone with obsessional doubts that she will be responsible for starting a house fire might spend hours checking and rechecking that appliances are unplugged and lights turned off. Research indicates that short-term anxiety reduction usually follows the performance of rituals, which negatively reinforces these behaviors leading to their proliferation (e.g., Rachman & Hodgson, 1980). Yet compulsive rituals also prevent the natural extinction of obsessional fear, thus leading to the persistence of the obsessions. Avoidance behavior, which serves the same function as rituals, might be used when obsessional stimuli can be avoided.

Finally, there is variability in the degree of insight that patients have into the senselessness of their obsessions and rituals (APA, 2000). Whereas some individuals recognize that their fears are invalid, and rituals excessive, others believe more firmly that compulsive rituals are necessary to prevent obsessively feared outcomes. Research indicates that the less insight one has into his or her symptoms, the poorer the prognosis with exposure-based therapy (e.g., Foa, Abramowitz, Franklin, & Kozak, 1999).

Exposure Therapy for OCD

The most effective psychological treatment for OCD—CBT involving ERP—is derived from the conceptualization outlined above. Exposure involves repeated and prolonged systematic confrontation with obsessional triggers; response prevention entails resisting the subsequent compulsive urges. Exposure might be in vivo (e.g., actually touching a bathroom door or toilet) or in imagination (e.g., confronting images of killing loved ones or unwanted sexual ideas). In tandem, ERP weaken the association between obsessional triggers (external cues and intrusive thoughts) and anxiety

provocation, and between compulsive rituals and anxiety reduction (e.g., Kozak & Foa, 1997). This allows the patient to learn that obsessional fears are unrealistic and that anxiety eventually declines even in the absence of avoidance or compulsive behavior. Cognitive therapy techniques might also be used to help weaken maladaptive thought processes that underlie obsessional fear and compulsive urges (e.g., Wilhelm & Steketee, 2006).

Interpersonal Aspects of OCD

OCD frequently has a negative impact on the sufferer's interpersonal relationships, such as that with a romantic partner or spouse. In turn, dysfunctional relationship patterns can promote the maintenance of OCD symptoms so that a vicious cycle develops. We have observed several primary ways in which this process might be manifested, as we describe in the following sections. The first is when a partner or spouse inadvertently maintains symptoms by "helping" with compulsive rituals and avoidance behavior out of love for the sufferer (also known as *symptom accommodation*). The second is when anxiety problems create relationship distress and conflict, which then exacerbates the anxiety. Third, the couple might struggle with general relationship distress that does not result from the OCD; in this instance, the chronic stress of a discordant relationship can exacerbate OCD symptoms for an individual who is vulnerable to the disorder. Frequently, all of these processes occur within the same couple.

Symptom Accommodation

Accommodation occurs when the partner or spouse of someone with OCD participates in their loved one's rituals, facilitates avoidance strategies, assumes daily responsibilities for the sufferer, or helps to resolve problems that have resulted from the patient's obsessional fears and compulsive urges (e.g., Calvocoressi et al., 1999; Shafran, Ralph, & Tallis, 1995). The accommodation might occur at the request (or *demand*) of the individual with OCD, who deliberately tries to involve loved ones to help with controlling his or her anxiety. In other instances, loved ones voluntarily accommodate because they feel the need to show care and concern for their suffering partner and do not wish to see them become highly anxious. The following example illustrates this phenomenon:

Lawrence was a 65-year-old grandfather with obsessional thoughts of molesting his own grandchildren. Finding these thoughts highly repugnant, he avoided his grandchildren and other stimuli that might trigger sexual

thoughts (e.g., TV shows with children or "sexy" actors). Lawrence and his wife, Norma, also refrained from discussing their grandchildren, hanging pictures of these children on the wall, and having them visit their home. Norma agreed to watch only "wholesome" TV channels, such as the Food Network, to avoid triggering Lawrence's obsessions. Although she was upset about what had become the status quo, she was willing to go along with her husband's wishes because she knew that anything different would lead to Lawrence becoming very anxious and irritable. Norma reported that accommodating Lawrence's OCD symptoms was one way she showed him how much she loved and cared for him.

Accommodation can be subtle or overt (and extreme) and is observed in couples who are happy in their relationships as well as distressed couples. Norma, for example, boasted that she and Lawrence rarely argued about OCD-related issues. But even if there is no obvious arguing, accommodation creates a relationship "system" that fits with the OCD symptoms to perpetuate the vicious cycle that maintains obsessional fears and compulsive urges. Table 1 shows examples of accommodation behaviors we have observed in our work with couples in which one partner has OCD.

Conceptually, as avoidance and compulsive rituals prevent the natural extinction of obsessional fear and ritualistic urges, accommodation to these symptoms by a spouse or partner also perpetuates OCD symptoms. For instance, consider a woman with obsessional fears of acting on unwanted impulses to molest her newborn infant. By accommodating his wife's avoidance of changing or bathing their newborn child by doing it himself, her husband prevents his wife from learning that her intense anxiety over the senseless obsessions is temporary and will subside and that she is unlikely to act on her unwanted obsessional thoughts.

Accommodation has a number of additional negative consequences. First, it might decrease an individual's motivation to participate in ERP as he or she might not perceive good reasons to change the status quo—especially if treatment involves something as distressing as facing one's fears. For instance, a man with fears of contamination from pesticides avoided leaving his home during the spring and summer when these chemicals might be "in the air." His wife did all of the shopping and errands, and even—at her husband's request—changed her clothes and washed any items (such as groceries) before bringing them home. Although the patient regretted the impact of OCD on his life, he struggled to engage in ERP partly because he did not view exposure as worthwhile: his wife's accommodation had diminished the consequences of having OCD to the point that obsessions and compulsions

Table 1. Examples of Partner Accommodation for Different OCD Symptoms.

OCD symptoms	Partner accommodation behaviors
Contamination and washing symptoms	Washing or cleaning for the patient Doing extra laundry Avoiding contaminated stimuli
Obsessional doubting and compulsive checking	Assisting with checking rituals Providing reassurance Helping the patient avoid ambiguous situations that might trigger doubts
Violent, sexual, and religious obsessions	Providing reassurance Helping with avoidance of stimuli that trigger obsessional thoughts Helping with praying or interpreting Bible passages or religious doubts
Ordering and symmetry ("not just right") obsessions and compulsions	Checking to make sure things are "in order" or arranged properly Repeating answers until they are "just right"

Note: OCD = obsessive–compulsive disorder.

seemed tolerable relative to confronting his fears of being outside in the "pesticide-laden air."

Second, in some relationships, accommodation becomes the chief way in which the unaffected partner expresses warmth, caring, and compassion for his or her loved one. For example, one man prided himself on the fact that whenever his wife with OCD became worried about contracting a serious illness such as rabies, he would "come to the rescue" by traveling to wherever she was to calm her down, assess the situation, and reassure her that she was going to be fine. This became an important way of showing affection in their marriage. Not only does such accommodation maintain pathological fear and anxiety in the ways we have discussed previously, it also begets additional accommodation as the couple's relationship develops around this sort of "affectionate" behavior. Not surprisingly, accommodation is related to more severe OCD symptoms and poorer long-term treatment outcome (Calvocoressi et al., 1999; Merlo, Lemkuhl, Geffkin, & Storch, 2009).

Relationship Conflict

Relationship stress and conflict also play an important role in the maintenance of OCD. Couples in which one partner suffers with an anxiety disorder

such as OCD often report problems with interdependency, unassertiveness, and avoidant communication patterns that foster stress and conflict (Marcaurelle, Belanger, Marchand, Katerelos, & Mainguy, 2005; McCarthy & Shean, 1996). In all likelihood, OCD symptoms and relationship distress influence each other, rather than one exclusively leading to the other. For example, a husband's contentious relationship with his wife might contribute to overall anxiety and uncertainty that develops into his obsessional doubting. His excessive checking, reassurance seeking, and overly cautious actions could also lead to frequent disagreements and relationship conflict.

Particular aspects of a relationship that might increase distress and contribute to OCD maintenance include poor problem-solving skills, hostility, and criticism (Marcaurelle et al., 2005). Moreover, such communication problems are known to adversely affect the outcome of ERP. For instance, communication patterns characterized by criticism, hostility, and emotional overinvolvement are associated with premature treatment discontinuation and symptom relapse, whereas patterns characterized by empathy, hopefulness, and assertiveness are associated with improved outcomes with ERP (Chambless & Steketee, 1999; Craske, Burton, & Barlow, 1989; Steketee, 1993).

Involving the Partner in Treatment: A Couples-Based, ERP-Enhanced Treatment for OCD

We have developed and are currently pilot testing a couple-based, ERP-Enhanced Treatment program for couples in which one partner has OCD. The program involves 16 sessions of 90 to 120 min, the first eight of which are conducted twice weekly, and the final eight, once weekly. The couple attends all sessions together and treatment involves a significant amount of out-of-office "homework practice." Treatment involves (a) psychoeducation, (b) partner-assisted exposure therapy, (c) couple-based interventions focused on reducing OCD-specific accommodation behavior and increasing alternative strategies for couple engagement, and (d) general couple therapy focused on aspects of the relationship not necessarily related to OCD. Table 2 provides an outline of the primary topics covered in each session. In the following sections, we describe the main techniques used in this program, including illustrative case examples. The details of individual ERP for OCD are available in a number of resources (e.g., Abramowitz, 2006) and so will not be discussed here. Rather, this section focuses on techniques and intervention specific to couples-based treatment.

Table 2. Components of Couple-Based Exposure Therapy for OCD.

Sessions	Main components
1	Assessment of patient's history and OCD symptoms, psychoeducation about OCD and treatment rationale, introduce self-monitoring of rituals
2	Review of treatment rationale and self-monitoring homework, assessment of couple's history with OCD, collaborative development of exposure hierarchy
3	Finish developing the exposure hierarchy, review of treatment rationale, introduction of coping self-statements for managing with anxiety
4	EET, introduction and simulation of partner-assisted exposure, assign EET homework practice
5-7	In-session partner-assisted exposure, response prevention, assignment of daily ERP homework
8-9	Decision-making skills, partner-assisted ERP, daily ERP homework for peer review
10-11	Accommodation, making decisions about how to reduce accommodation, ERP, and decision-making homework practice
12	Focus on applying EET and decision making for areas of the relationship outside OCD, continued ERP, and decision-making homework
13-16	Continued ERP planning using decision-making and EET skills, focus on relationship within and outside the context of OCD using EET and decision-making skills, continued ERP homework

Note: OCD = obsessive–compulsive disorder; EET = emotional expressiveness training; ERP = exposure and response prevention.

Assessment of Symptom-System Fit

An important focus of assessment concerns what Rohrbaugh, Shoham, Spungen, and Steinglass (1985) call "symptom-system fit," which refers to how the couple has structured their environment so as to accommodate OCD symptoms. As we have already discussed, accommodation may occur within seemingly "happy" relationships (i.e., "good" symptom-system fit), or within conflicted relationships in which the nonaffected partner refuses to accommodate to OCD symptoms, or overtly resents the negative impact these symptoms have had (i.e., "poor" system-symptom fit). Table 3 provides a list of suggested questions for assessing symptom-system fit and identifying specific ways in which the partners might relate concerning OCD symptoms.

Although the goal of therapy is to help the healthy partner cease his or her accommodation of OCD symptoms, it is important that this is done in an

Table 3. Questions for Assessing Symptom-System Fit Within a Couple With OCD (Obtain Responses From Each Partner).

When and how did the partner become aware of the patient's problem with OCD?
What effects have OCD symptoms (obsessional fear, avoidance, rituals) had on the relationship in terms of daily life?
If there are any patterns that seem to have developed because of the patient's OCD symptoms, what are they?
How does each partner think their relationship might be different if the patient did not have difficulties with OCD?
Is there anyone else (e.g., children) who is affected in any way by the patient having problems with OCD? (If so, explore who and how.)
What types of strategies has the couple used to try to cope with the patient's OCD?
When the patient is experiencing obsessional fear or performing rituals, does it ever lead to anger or arguments? What happens in these situations? Does the unaffected partner ever have a tendency to help the patient escape from the anxiety, avoid situations that cause obsessions, or assist with compulsive rituals to lower the anxiety?
How well has this worked?
Describe how the two of you communicate about the OCD problem.

Note: OCD = obsessive–compulsive disorder.

agreeable way. A partner's negative or sarcastic reactions (which are unfortunately common) increase relationship discord and maintain the OCD symptoms. The healthy partner might initially try to resist accommodating, yet end up giving in after the patient makes repeated pleas or raises the stakes by making threats. For example, a 25-year-old woman repeatedly insisted that her husband clean all of the family's dishes in a certain ritualized way. At first, he refused to comply with the cleaning rituals, saying that he would not take part in such excessive behaviors. Yet after persistent nagging from his wife, he gave up and angrily washed the dishes in the ritualized fashion (and under his wife's careful observation).

We suggest a brief assessment of any partner who might become involved in treatment for OCD for the purpose of noting whether this individual experiences any psychopathology of his or her own, and what factors might have contributed to the development of an interpersonal system in which the patient's OCD flourishes. For instance, a woman whose first husband died of a heart attack was especially sensitive to her current husband's obsessional anxiety for fear that it would also lead to a heart attack. She therefore willingly

did everything she could to keep her husband from becoming even slightly anxious, thereby contributing to the maintenance of his OCD symptoms. This partner had to be educated about the short-term effects of anxiety, and how these are extremely unlikely to be dangerous.

Psychoeducation

Presenting the cognitive-behavioral conceptual model of OCD (e.g., Abramowitz, 2006) can help reduce a partner's expressions of resentment and criticism, normalize his or her experience, and begin to alleviate feelings of guilt and frustration. Similarly, learning about how exposure therapy works, and the evidence for its effectiveness, can increase hopefulness and reduce feelings of helplessness and of being overwhelmed. To illustrate, when a young woman began to understand that her husband's resistance to spending time at her parents' home arose from his obsessional concerns about the possibility of radon gas in their home, rather than from dislike, she was less critical of him and his behavior. Knowing that he would be participating in an effective treatment further increased her patience. In addition, without an explanation, many partners find the notion of ERP counterintuitive. Furthermore, prior to psychoeducation, they often believe that their role is to help their partner avoid or lower anxiety by staying away from anxiety-provoking situations or escaping whenever such encounters do occur. Therefore, they need to understand their role in helping the patient confront the anxiety and tolerating the anxiety rather than escaping from it. Without an understanding of ERP, many partners view the therapist's requests of the partner as confusing, unsupportive, or even sadistic toward the patient. Given the inherent difficulty of complying with ERP, it is critical that both partners understand the disorder, effective treatment, and their relative roles in making it a success.

Partner-Assisted Exposure

Once a significant other understands the principles underlying exposure therapy, he or she can be taught how to assist with exposure exercises by serving as a coach. Some treatment outcome studies have indicated that involving close relatives in this way improves treatment effectiveness for OCD, as well as the interpersonal relationship (Mehta, 1990). However, partner-assisted exposure is optimally successful when relationship conflict and partner accommodation are minimal to begin with. By learning how to play the role of "coach," the healthy partner begins to offer emotional support to the patient

as he or she completes exposure practices within and outside of the session. The coach is taught to provide gentle but firm reminders not to engage in avoidance or safety behaviors. Most importantly, the coach is trained to help the patient implement exposures correctly by making sure sufficient anxiety is provoked, that exposure continues until anxiety has decreased (habituation), and that rituals are resisted (response prevention). The couple is introduced to four phases of confronting a stressor (described in the following) and is taught how to communicate with each other at each phase. An emphasis is placed on helping the patient "get through" the obsessional anxiety as it dissipates on its own, as opposed to the partner trying to immediately alleviate this distress.

An important aspect of this stage of treatment involves teaching couples two sets of communication skills to help them complete ERP practices effectively as a team. The first skill involves "sharing thoughts and feelings," or emotional expressiveness training (EET) in which the couple is taught to discuss with one another *how they feel* (as opposed to offering solutions) during exposure, while also listening effectively to each other. The second skill involves learning how to make decisions as a couple around hierarchy building, implementing exposure tasks, and resisting rituals (Epstein & Baucom, 2002).

The actual process of confronting the obsessional stimulus is broken down into four phases as follows (see Baucom, Stanton, & Epstein, 2003 for a fuller description):

1. *Discussing the exposure task:* Initially, the therapist teaches the patient and coach to clarify the specifics of the exposure task. Both parties are encouraged to discuss how each is feeling about the upcoming practice and to identify potential obstacles. The patient is helped to specify how he or she would like the coach to help out with the exercise.
2. *Confronting the feared situation:* The second component involves actually confronting the hierarchy item. The patient is encouraged to express his or her feelings to the partner, who listens carefully. If the patient becomes anxious, the partner acknowledges this and reinforces the patient's hard work with lots of praise (e.g., "You're doing such a great job. I'm really proud of you!"). The partner continues to compliment the patient on handling the situation throughout the exercise and avoids making negative statements. The partner also resists the temptation to distract the patient or provide reassurance or any other anxiety reduction strategies.

3. *Dealing with overwhelming anxiety:* If the patient experiences extreme anxiety, he or she is taught to let his or her partner know. In turn, the partner is taught to acknowledge that the task is difficult but that eventually, the anxious feelings will lessen. If the patient absolutely cannot continue with the exposure, a brief timeout can be taken during which the partner provides support in ways the patient would like (but *not* using reassurance, rituals, or accommodation behaviors). The two parties also discuss what went wrong and how they can approach resuming the exposure. Although the partner should remind the patient of the importance of resuming, the decision whether to do so is ultimately up to the patient.
4. *Evaluation:* The fourth and final component involves the couple evaluating how the exposure went. How did the patient feel about the experience and the partner's coaching? The partner should also let the patient know how he or she felt about the exposure and, when appropriate, provide copious praise for a job well done.

Although the primary focus of partner-assisted exposure is for the partner to assist the patient in confronting the anxiety, it is important to recognize that for many partners this is a difficult process. That is, seeing one's loved one, the patient, experience significant anxiety is upsetting, and the therapist is asking the partner to tolerate this distress. In one sense, the partner is undergoing a form of ERP as well—seeing the patient in distress and allowing the distress to continue rather than reducing it by accommodating. Consequently, it is important to support the partner as well, for being an effective coach and for tolerating the patient's distress.

Reducing Accommodation

When symptom accommodation is present, the therapist works with the couple to help them change interaction patterns that maintain OCD symptoms. In such interventions, the therapist begins by describing accommodation and its deleterious effects, noting that accommodation from the partner is often well intended (as discussed earlier in this article). Then, the couple is helped to choose an activity that has become hampered by OCD symptoms, and the therapist facilitates a decision-making discussion regarding ways to handle this situation by promoting the idea of exposure, rather than relying on avoidance and compulsive rituals. In other words, without creating a specific hierarchy, the couple works on building ERP techniques into their everyday life and functioning as a couple. For example, a husband might

resume shopping at "contaminated" stores and using the various rooms in the house that had been off-limits. A wife with OCD might stop checking doors and windows before coming to bed, neither does her husband perform these acts for her. The goal of these interventions is to work toward a life in which the couple confronts the situations and stimuli that patient has been avoiding and remains in that situation (rather than using rituals) to gradually lower the anxiety.

When encouraging a partner not to accommodate to the patient's OCD symptoms, it is important to understand what function the accommodation plays in the couple's relationship and address these issues. For example, accommodation might have become a major way that a partner shows care, concern, and love for the patient. If the accommodation is removed from the couple's relationship, then the treatment inadvertently might have altered the couple's relationship such that they no longer feel as close to each other, or the patient does not feel as loved by the partner. Consequently, it is important to discuss with the couple what new ways they would want to show their love, care, and concern for each other instead of focusing their caring in terms of the OCD.

General Couple Therapy

The primary goal of the overall treatment program is to help the patient overcome OCD symptoms by employing the couple as a basis of intervention; thus, we do not consider the focal aspects of the intervention to be general couple therapy for broad relationship distress. However, some couples do have broad relationship distress that needs to be addressed within the context of treatment for two reasons. First, relationship distress can be viewed as a broad, chronic stressor on an individual. Such chronic stressors can exacerbate OCD symptoms as well as other psychiatric symptoms (see Whisman & Baucom, in press, for a discussion of the associations between relationship distress and psychopathology). Second, the couple-based interventions discussed above to address OCD are implemented most successfully when the two partners can work together as a team for this common goal. Asking a couple to conduct an ERP session together if they are angry and uncooperative with each other can result in less than optimal outcome. Some unhappy couples are more distant and disengaged, and our experience is that they often can work together on the OCD without hostility, and perhaps even use the OCD treatment as a way to have a united set of goals. Angry, hostile couples seem to struggle more working together on the OCD treatment. Although we prefer to focus the couple immediately on addressing

the OCD and then progressing to optimizing their relationship more broadly; at times, with angry couples, we begin intervention with some focus on improving their overall relationship functioning so that they can implement the OCD treatment successfully.

Following are a set of three cases that show how the general principles of this couple-based intervention can be individualized to provide assistance to a variety of couples with different OCD symptoms.

Case Examples

Anna

Anna, a 27-year-old stay-at-home mom, presented with OCD symptoms beginning in the postpartum. Immediately after bringing her newborn son home from the hospital, she began experiencing intrusive images of herself harming him, including distressing images of jabbing him with car keys, putting him in the microwave, stabbing him with a knife, and suffocating him with a rope. Anna experienced these thoughts as intrusive, unwanted, and extremely repugnant. She wondered why she was having them and feared they meant that she would actually harm her baby. Anna tried to suppress these images and use mental rituals (i.e., repeating to herself "I would never hurt him") to reduce her distress. She also avoided holding her baby in certain situations (e.g., next to the microwave) and hid any stimuli that provoked obsessions (e.g., locking all knives away). Her OCD symptoms occupied more than 8 hr per day and made it extremely stressful for her to be around her son. She also feared that if she revealed to other people the extent of her intrusive thoughts, they would take the baby away.

On intake, Anna scored in the severe range on a number of measures of OCD symptoms (e.g., her Yale-Brown Obsessive–Compulsive Scale [Y-BOCS; Goodman et al., 1989] score was 29). Her husband, Brett, however, was unaware of the extent of her symptoms. Brett reported knowing that Anna was anxious about being a mother, and he had observed her becoming agitated at things such as finding a dirty knife in the sink. Anna had told Brett that she worried about being a mother (including the fact that she had some "bad thoughts") but had never revealed the specific content of her recurring obsessional thoughts. Anna and Brett reported that they had a generally good relationship, although they had occasional disagreements about household tasks.

For this couple, psychoeducation and assessment of Anna's symptoms proved to be especially therapeutic. Over the first two sessions, the therapist assessed Anna's intrusive thoughts, inquiring about (a) their content and

triggers, (b) her interpretations of them, and (c) her responses to them. Brett was surprised to hear the content of Anna's obsessional thoughts, yet the therapist normalized these experiences by informing the couple that everyone has abhorrent thought from time to time. This made sense to Brett, who was even able to provide examples of his own unwanted thoughts. Anna was relieved to see Brett respond this way, instead of fearing that she would act on the thoughts or that he thought she was a bad person for thinking this way. Brett, in fact, said that he was confident Anna's obsessions were senseless as she was an extremely loving mother.

In the next part of treatment, the therapist introduced ERP as a way of weakening the patterns of becoming anxious when obsessional thoughts are triggered and using rituals to reduce anxiety. The therapist then trained Anna and Brett to use ERP as a team. With the therapist's help, they constructed an exposure hierarchy that included actions such as Anna tying a scarf around her son's neck while imagining choking and suffocating him and holding a kitchen knife while her son was in the room. Brett coached Anna through these exposures, offering copious emotional support without providing reassurance. Anna found that her anxiety subsided over time, and she gradually became more comfortable with having the obsessive thoughts.

Later treatment sessions focused on eliminating the couple's accommodation patterns, such as Anna's insistence that all knives be hidden away and that Brett keep his power tools where she could not see them (because they triggered obsessions). The couple used the decision-making skills they had been taught to take steps to reducing these behaviors (e.g., Brett purposefully leaving a knife in the sink for Anna to wash).

Anna and Brett worked well together planning and conducting exposures outside of the therapy office. At their 16th session, Anna reported that she could now enjoy spending time alone with her baby; and while she was still experiencing occasional unwanted intrusive thoughts, these no longer produced anxiety or the urge to perform mental rituals. Anna's Y-BOCS score was now 5—a substantial 24-point improvement from pretest.

Mark

Mark, a 30-year-old chemist, and his wife, Heather, presented for treatment of Mark's OCD symptoms because his contamination obsessions were having a negative impact on their relationship and Mark's ability to fulfill work obligations. On coming home from work, he would have the intrusive thought that he was contaminated from chemicals at the lab where he worked and that he would spread the contamination around their home. Trashcans, floors, shoes, bathrooms, and the tops of tables also provoked thoughts of contamination.

Mark stated that although he did not think that he would actually contract a disease, the state of feeling "contaminated" was in and of itself distressing. He also worried that his high levels of anxiety would cause physical harm. To control his anxiousness, Mark avoided objects (e.g., trashcans and anything that might have touched the floor), showered at least twice a day, washed his hands excessively, and scrubbed counters and other surfaces with bleach. At work he would wash and rewash lab instruments and change his gloves more than 30 times a day.

On intake, Mark reported spending more than 8 hr a day thinking about contamination and engaging in rituals, and his Y-BOCS score was 25, indicating severe symptoms. Heather, also a scientist, was accommodating Mark's OCD symptoms. For example, although she loved to go camping, she would provide an excuse for her and Mark whenever they were invited to such activities as she knew it provoked extreme anxiety for Mark. She also changed the shower curtain at least weekly as Mark was increasingly distressed by the possibility that contamination had spread from him to the shower curtain. Moreover, Heather took decontamination showers at Mark's request and cleaned a multitude of items to keep the home "safe." She reported that Mark became angry when she did not provide reassurance or participate in rituals, yet when she did engage in these behaviors, it was very time consuming and frustrating for her. Not surprisingly, OCD symptoms had become a significant source of conflict for the couple. They worried that if Mark's symptoms did not improve, their relationship would deteriorate.

During the first two sessions, the therapist conducted a thorough assessment of Mark's symptoms as well as the couple's relationship, including how they related around Mark's OCD and their relationship more broadly. The therapist also provided a cogent rationale for ERP, which both partners quickly understood. In fact, they remarked that it was helpful to understand how avoidance and rituals were maintaining Mark's OCD symptoms. Exposure involved Heather helping Mark confront "contaminated" items, such as objects that had touched the floor, trashcans, and lab instruments. Mark was helped to resist his decontamination rituals, and Heather, to motivate and support Mark during this process.

Mark found the exposures helpful, although he had difficulty generalizing what he had learned to other stimuli. For example, if he successfully completed an exposure to one lab instrument, he would continue to experience anxiety and engage in rituals after coming into contact with others. One factor which inhibited the successful generalization of learning was Heather's continued accommodation behaviors. Although she would refrain from such behaviors during exposure practices per se, outside of these exercises she was

reluctant to allow Mark to feel anxious when she believed she could easily help him immediately feel better. Indeed, the couple had developed a pattern in which Heather showed her love, care, and concern for Mark by "protecting" him and "helping" him with his anxiety. Unfortunately, these behaviors were in conflict with the goals of exposure and kept Mark from learning that he could tolerate feelings of contamination and anxiety. Therefore, accommodation was targeted next in treatment.

The therapist began by teaching the couple about accommodation and how Heather's participation in rituals and assistance with avoidance were only helpful momentarily and actually were maintaining Mark's OCD symptoms in the long term. The desire to engage in accommodation was normalized; the therapist explained that loving, caring partners often engage in these behaviors because they want to be helpful—it allows the couple to feel close and connected in the moment. Yet, as the couple had already noticed, those same behaviors can lead to conflict over time, as well as an increase in OCD symptoms.

Next, the therapist helped Mark and Heather identify their accommodation patterns and make decisions about how to shift them. For example, because Mark would not pump gas or cook meat due to his contamination fears, Heather had taken over these roles. The therapist helped the couple decide to make healthy changes so that Mark began helping with food preparation and car maintenance. As another example, when Mark was afraid that something, such as a laptop cord or coat sleeve, might have touched the floor, Heather would provide reassurance that it had not. Thus, the therapist helped Heather work on expressing empathy for Mark's anxiety and providing encouragement that he could tolerate the temporary distress, rather than giving him reassurance. The couple also used decision-making skills to end Heather's extra showers and cleaning behaviors, and instead to help guide Mark through impromptu exposures if something triggered his anxiety.

As Heather's accommodation behaviors decreased, Mark began experiencing reductions in his OCD symptoms. However, the couple stated that they felt more distant from one another as a result of Heather no longer "helping" Mark through accommodation. Mark also became angry when Heather would not provide reassurance or carry out rituals that he demanded. This was leading to conflict that the therapist helped the couple deal with using communication skills to share their thoughts and feelings. Specifically, Mark and Heather were taught how to share their thoughts and feelings (including anxiety and frustration) with each other in a constructive way. The therapist also helped the couple make decisions about activities they could engage in to feel close and connected outside of OCD. For example, before treatment,

the couple spent little time with friends because many of the places their friends would frequent (such as bars or camp sites) were "off-limits" due to Mark's OCD. The couple now made plans to spend time with friends and engaged in new activities, which helped them feel close and connected again (and helped to maintain exposure in an informal fashion). They also found that having more open and constructive conversations were helpful in building and maintaining intimacy.

Post assessment, Mark's Y-BOCS score had been reduced to 17, an 8-point reduction. Both partners remarked that they had a better understanding of OCD symptoms and how to handle them when they arose. Accommodation behaviors had significantly decreased, and the couple experienced less conflict. Overall they felt pleased with treatment, yet they acknowledged the need for continued exposure practice.

Madeleine

Madeleine, a 25-year-old mother of two young children who also worked at a day care center presented for treatment with unacceptable thoughts that she might do something sexually inappropriate with one of the children at work (e.g., fondling, molestation). She was also concerned that she might inappropriately touch one of her own children during bath time or when buckling them into their car seat. Although Madeleine said she knew she did not want to molest children, she could not dismiss the idea that she *might* lose control and do this without intending to. These doubts provoked extreme anxiety, and Madeleine repeatedly (up to 50 times per day) asked her husband Ben for reassurance that she was a "good person." When this occurred, Ben provided this assurance and told Madeleine that molesting children would be completely out of character for her. Nevertheless, the persistent nature of Madeleine's senseless reassurance seeking was irritating to Ben and caused occasional arguments. Even so, Ben felt it was important to reassure his wife to reduce her anxiety. Ben also helped Madeleine avoid obsessional triggers (e.g., news stories about child molesters) and took responsibility for tasks that provoked her obsessional thoughts (e.g., buckling the kids into the car seats). Madeleine and Ben had been married for 5 years and reported that although their relationship was strong overall, they frequently had arguments about how to handle finances. At intake, Madeleine's Y-BOCS score was 28, indicating severe OCD.

As with the other couples, treatment for Madeleine and Ben began with psychoeducation. Madeleine was relieved to learn that everyone has unacceptable thoughts from time to time, and even distasteful sexual thoughts did

not imply that she was a "bad person." Madeleine and Ben then moved on to partner-assisted exposures, which were mainly imaginal in nature. For example, working together as a team, Madeleine and Ben wrote a story about Madeleine losing control and inappropriately touching one of their children as she was buckling him into his car seat. The therapist then read this story into an audio recorder and Madeleine listened to it repeatedly, in the session and at home. For response prevention, Madeleine was instructed not to ask Ben for reassurance; Ben was coached to provide emotional support as we have described earlier.

As treatment progressed, Madeleine was able to stop asking Ben for reassurance even outside of exposures, and the number of arguments based on her seeking reassurance declined. However, the couple was still in conflict over differing points of view on issues not related to Madeline's OCD symptoms, such as finances and parenting practices. Because arguing over these topics often made it difficult for Madeleine and Ben to focus on exposure tasks, these conflicts became a focus of treatment as the couple was helped to apply the communication skills learned in the context of doing exposures (i.e., sharing thoughts/feeling and decision making) to address these other topics. Once these issues were addressed, the couple was able to work on their exposure practices more effectively and to great benefit. Post treatment, Madeleine's Y-BOCS score was 5, indicating substantial improvement. The couple also came away from treatment better equipped to handle disagreements in general and reported greater relationship satisfaction.

Conclusion

Although OCD is viewed as an individual disorder, it exists in a social and interpersonal context. As we have noted earlier, we have been quite struck by the myriad of ways that partners become a part of the OCD process—helping the patient avoid anxiety-provoking situations, actually engaging in compulsive rituals with or instead of the patient, and providing frequent reassurance (which can be viewed as interpersonal checking). Whether out of concern for the patient or resulting from an attempt to avoid arguments about the OCD, such behaviors from partners can help to maintain the OCD, although often unintended. We have also been struck by the almost universal desire of partners to be of assistance, but understandably, they do not know how prior to treatment. Thus, by educating both partners about the treatment of OCD, helping them understand the roles that each of them can take to be of assistance, and teaching them to work together as a team provides the opportunity to use the couple as an important resource in the treatment of this pernicious

disorder. The fundamental efficacious intervention of ERP remains a central focus of treatment, now enhanced by an interpersonal environment that supports the intervention and helps build a context for generalizing the exposure to everyday life on an ongoing basis. Although it is an empirical question and follow-up data are still being gathered, it is reasonable to expect that with this support in the patient's natural environment, treatment gains might well be maintained more effectively over time.

Acknowledgments

We would like to express our appreciation and acknowledgment of the contributions of Norman Epstein, Dianne Chambless, and Alan Goldstein to our thinking about couple-based interventions for OCD. They previously collaborated with Don Baucom on the development of a couple-based treatment manual for agoraphobia. Many of their ideas served as a springboard for the development of our current thoughts about treating OCD in a couple context.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

This research was supported by a grant from the International OCD Foundation.

References

Abramowitz, J. S. (2006). *Understanding and treating obsessive-compulsive disorder: A cognitive-behavioral approach*. Mahwah, NJ: Lawrence Erlbaum.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

Baucom, D. H., Stanton, S., & Epstein, N. (2003). Anxiety. In D. K. Snyder & M. A. Whisman (Eds.), *Treating difficult couples* (pp. 57-87). New York, NY: Guilford.

Calvocoressi, L., Mazure, C., Kasl, S. V., Skolnick, J., Fisk, D., Vegso, S. J., . . . Price, L. H. (1999). Family accommodation of obsessive-compulsive symptoms: Instrument development and assessment of family behavior. *Journal of Nervous and Mental Disease, 187*, 636-642.

Chambless, D. L., & Steketee, G. (1999). Expressed emotion and the prediction of outcome of behavior therapy: A prospective study with agoraphobic and obsessive-compulsive outpatients. *Journal of Consulting and Clinical Psychology, 67*, 658-665.

Craske, M. G., Burton, T., & Barlow, D. H. (1989). Relationships among measures of communication, marital satisfaction and exposure during couples treatment of agoraphobia. *Behaviour Research and Therapy, 27*, 131-140.

Epstein, N., & Baucom, D. H. (2002). *Enhanced cognitive-behavioral therapy for couples: A contextual approach*. Washington, DC: American Psychological Association.

Foa, E. B., Abramowitz, J. S., Franklin, M. E., & Kozak, M. J. (1999). Feared consequences, fixity of belief, and treatment outcome in patients with obsessive-compulsive disorder. *Behavior Therapy, 30*, 717-724.

Foa, E. B., & Franklin, M. E. (2001). Obsessive–compulsive disorder. In D. H. Barlow (Ed.), *Clinical handbook of psychological disorders* (3rd ed., pp. 209-263). New York, NY: Guilford.

Goodman, W. K., Price, L. H., Rasmussen, S. A., Mazure, C., Fleischmann, R. L., Hill, C. L., . . . Charney, D. S. (1989). The Yale-Brown Obsessive Compulsive Scale: Development, use, and reliability. *Archives of General Psychiatry, 46*, 1006-1011.

Kozak, M., & Foa, E. (1997). *Mastery of obsessive-compulsive disorder: A cognitive-behavioral approach*. San Antonio, TX: Psychological Corporation.

Marcaurelle, R., Belanger, C., Marchand, A., Katerelos, T. E., & Mainguy, N. (2005). Marital predictors of symptom severity in panic disorder with agoraphobia. *Journal of Anxiety Disorders, 19*, 211-232.

McCarthy, L., & Shean, G. (1996). Agoraphobia and interpersonal relationships. *Journal of Anxiety Disorders, 10*, 477-487.

Mehta, M. (1990). A comparative study of family-based and patient-based behavioural management in obsessive-compulsive disorder. *British Journal of Psychiatry, 157*, 133-135.

Merlo, L., Lemkuhl, H. D., Geffkin, G., & Storch, E. A. (2009). Decreased family accommodation associated with improved therapy outcome in pediatric obsessive-compulsive disorder. *Journal of Consulting and Clinical Psychology, 77*, 355-360.

Rachman, S., & Hodgson, R. (1980). *Obsessions and compulsions*. Englewood Cliffs, NJ: Prentice Hall.

Rohrbaugh, M., Shoham, V., Spungen, C., & Steinglass, P. (1985). Family systems therapy in practice: A systemic couples therapy for problem drinking. In B. Bongar & L. E. Beutler (Eds.), *Comprehensive textbook of psychotherapy: Theory and practice* (pp. 228-253). New York, NY: Oxford University Press.

Shafran, R., Ralph, J., & Tallis, F. (1995). Obsessive–compulsive symptoms and the family. *Bulletin of the Menninger Clinic, 55*, 472-479.

Steketee, G. S. (1993). *Treatment of obsessive-compulsive disorder*. New York, NY: Guilford.

Whisman, M. A., & Baucom, D. H. (in press). Intimate relationships and psychopathology. *Clinical Child and Family Psychology Review*, (2012) vol. 15, pp. 4-13.

Wilhelm, S., & Steketee, S. (2006). *Cognitive therapy for obsessive-compulsive disorder: A guide for professionals*. Oakland, CA: New Harbinger.

Author Biographies

Jonathan S. Abramowitz, Ph.D. is professor and associate chair of psychology at the University of North Carolina. He specializes in the treatment of obsessive-compulsive disorder and other anxiety disorders.

Laura E. Fabricant, M.A. is a graduate student in clinical psychology at the University of North Carolina at Chapel Hill. Her research interests include understanding the nature of anxiety disorders and enhancing treatment for these disorders.

Michael G. Wheaton, M.A. completed his graduate work at UNC chapel hill. His primary research and clinical interests focus on OCD and other anxiety-related conditions.

Christine Paprocki, M.A. is a graduate student in the clinical psychology doctoral program at the University of North Carolina. She is involved in researching the effectiveness of couple-based treatments for a variety of psychological disorders and physical health conditions.

Donald H. Baucom, Ph.D. is professor of psychology at the University of North Carolina. His research and clinical interests focus on interpersonal relationships and couple-based interventions.

Sarah Boeding, M.A. is a graduate student in the clinical psychology doctoral program at the University of North Carolina. Her research interests include interpersonal relationships and couple-based therapy.

Melanie S. Fischer is a doctoral student in Clinical Psychology at the University of North Carolina. Her research focuses on romantic relationships in the context of individual psychopathology such as anxiety and eating disorders, and couple-based interventions.