

# Treating Obsessive-Compulsive Disorder in Intimate Relationships: A Pilot Study of Couple-Based Cognitive-Behavior Therapy

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Although cognitive-behavioral therapy (CBT) involving exposure and response prevention (ERP) is an established treatment for obsessive-compulsive disorder (OCD), not all patients respond optimally, and some show relapse upon discontinuation. Research suggests that for OCD patients in close relationships, targeting relationship dynamics enhances the effects of CBT. In the present study, we developed and pilot tested a 16-session couple-based CBT program for patients with OCD and their romantic partners. This program included (a) partner-assisted ERP, (b) techniques targeting maladaptive relationship patterns focal to OCD (e.g., symptom accommodation), and (c) techniques targeting non OCD-related relationship stressors. OCD, related symptoms, and relationship functioning were assessed at baseline, immediately following treatment (posttest), and at 6- and 12-month follow-up. At posttest, substantial improvements in OCD symptoms, relationship functioning, and depression were observed. Improvements in OCD symptoms were maintained up to 1 year. Results are compared to findings from studies of individual CBT for OCD and discussed in

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terms of the importance of addressing interpersonal processes that maintain OCD symptoms.

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OBSESSIVE-COMPULSIVE DISORDER (OCD) involves (a) recurrent intrusive thoughts that evoke fear and distress (i.e., obsessions) and (b) excessive avoidance and compulsive rituals (or mental acts) to reduce the obsessional fear (American Psychiatric Association, 2000). For example, someone with obsessional fears of germs and contamination might spend hours washing and cleaning and also demand that family members avoid feared contaminants. Research indicates that avoidance and rituals usually result in short-term fear reduction, which negatively reinforces these behaviors, leading to their repetition (e.g., Rachman & Hodgson, 1980). In the long run, however, avoidance and rituals prevent the extinction of obsessional fear, thus completing a vicious cycle that maintains OCD symptoms.

The most effective psychological treatment for OCD is cognitive-behavioral therapy (CBT) involving exposure and response prevention (ERP; e.g., Kozak & Foa, 1997). Exposure involves repeated and prolonged confrontation with obsessional triggers; response prevention entails resisting urges to perform

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compulsive rituals. These procedures weaken the associations between (a) obsessional triggers and fear provocation, and (b) compulsive rituals and fear reduction, thus allowing the patient to learn that obsessional fears are unrealistic and that avoidance or rituals are not necessary to reduce fear. Cognitive therapy techniques (e.g., Wilhelm & Steketee, 2006) are also employed to weaken cognitive distortions associated with OCD symptoms (e.g., an inflated sense of responsibility). Although there is considerable evidence for the effectiveness of CBT (e.g., Eddy et al., 2004; Olatunji, Davis, Powers, & Smits, 2013), not everyone with OCD responds well to this treatment, and many patients discontinue treatment prematurely or show relapse upon finishing an adequate trial (Olatunji et al., 2013; Simpson et al., 2004). Thus, improving the acceptability and the short- and long-term effectiveness of this intervention remains a priority.

Research on predictors of outcome with CBT suggests that tending to patients' interpersonal relationships is one way to improve the prognosis for OCD (e.g., Chambless & Steketee, 1999; Steketee, 1993). Indeed, OCD symptoms often negatively impact interpersonal functioning, which in turn maintains OCD symptoms. One way this occurs is when avoidance and rituals create relationship conflict, which increases stress and anxiety. Second, nonaffected partners frequently (albeit inadvertently) maintain patients' OCD symptoms by "helping" with avoidance and rituals (e.g., providing reassurance for the patient; Calvocoressi et al., 1999; Shafran, Ralph, & Tallis, 1995). Such symptom accommodation can occur in happy as well as in relationally distressed couples, and might be performed to prevent the OCD sufferer from becoming anxious and hostile or simply to express care and concern within the relationship. Regardless, symptom accommodation is predictive of greater OCD severity and poorer treatment outcome (Boeding et al., *in press*; Calvocoressi et al.). Finally, couples might struggle with chronic relationship discord unrelated to OCD (e.g., financial concerns) that elevates stress, exacerbates OCD symptoms, and can also attenuate treatment response (Steketee & Chambless, 1999).

The bidirectional association between OCD symptoms and relationship functioning suggests that for patients in close relationships, the effects of CBT might be enhanced by involving the partner in treatment and addressing the ways in which relationship factors (as described above) maintain OCD. Only a few studies, however, have systematically examined "partner assisted" CBT for OCD, and the results of these investigations are mixed. Mehta (1990), for example, found that including a partner (or other family member) as a coach during ERP

was more effective than individual ERP without such a coach. In a similarly designed study, however, Emmelkamp, de Haan, and Hoogduin (1990) found no between-group differences. Finally, Emmelkamp and de Lange (1983) reported that partner-assisted ERP was more effective at posttest, but not at 1 month follow-up. It is difficult to draw strong conclusions from these early studies as they suffered from various methodological limitations such as small sample sizes and suboptimal implementation of ERP (e.g., no therapist-supervised exposure), often resulting in substandard outcomes study-wide.

Another issue is that while partner-assisted ERP might facilitate cooperation between partners when it comes to completing specific exposure tasks, it does not directly address other couple interaction patterns (e.g., accommodation, hostile communication) that maintain OCD, attenuate treatment response, and increase the risk of relapse following treatment. For example, it might be beneficial to incorporate techniques to teach couples healthier and more adaptive ways of showing mutual care and concern that are not focused on OCD symptoms. Given the lack of interventions for OCD that target such relationship dynamics in combination with ERP, we developed a 16-session couple-based CBT program that involves (a) psychoeducation, (b) partner-assisted ERP, (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 stressful aspects of the relationship not directly related to OCD (Abramowitz et al., 2013).

In the present study, we conducted an open trial of this treatment program for 21 adult couples in which one partner had OCD. The aim of this pilot study was to examine the feasibility and the immediate and long-term effectiveness of the intervention in a treatment-naïve sample. We assessed OCD and related symptoms (patients only) as well as relationship functioning (both partners) at baseline, post-treatment, 6-month, and 12-month (1 year) follow-up. We hypothesized statistically and clinically significant improvement in OCD, related symptoms (e.g., insight, depression), and relationship functioning at post-treatment; and that improvements would be maintained through 12-month follow-up. We also predicted that the long-term effects of our couple-based ERP program would appear superior when benchmarked with long-term follow-up results from comparable previous studies of individual CBT.

## Method

### PARTICIPANTS

Participants were 21 adult couples (age  $\geq 18$ ) who had been married or living together for at least

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