Influence of Husbands on the Outcome of their Agoraphobic Wives' Therapy

K. OATLEY and D. HODGSON

Of 30 agoraphobic married women undertaking home-based behaviour therapy, 15 each had a female friend as co-therapist and 15 had their own husband as co-therapist. At 12 months follow-up, women spent a mean of approximately 40 minutes a day more outside the home alone than at baseline. Women assisted by female friends made somewhat more behavioural gains than those assisted by husbands. Women in both groups whose husbands had been more depressed 2 months after the beginning of therapy did less well at 6 months. Husbands who become more depressed may retard their wives' progress in therapy, but the effect was small, and was outweighed by other considerations.

Patients less satisfied with their marriages did less well, and their marital satisfaction decreased. These findings suggest that families may resist therapeutic change, but the increase in husbands' psychiatric symptoms and the relapses of the patients were small and not statistically significant. Moreover, Hafner's conclusions have been questioned: Cobb et al (1984) found no decrease in marital satisfaction during agoraphobic wives' therapy, and were sceptical that spouses influence recovery from agoraphobia.

The home-based therapy of Mathews et al (1977, 1981b) for agoraphobia enabled a further test to be made of the homeostatic hypothesis of marriages in which the condition occurred. In this procedure the client undertakes outings of graded difficulty, and is in charge of her own therapy. Her husband is recruited as co-therapist, and the professional therapist acts mainly in a consultative role, making a small number of visits.

The present study was an independent trial of the treatment programme of Mathews et al, with measures taken at baseline and 2, 6 and 12 months. Either the subject's husband or a woman friend was randomly chosen to act as co-therapist. We tested Hafner's hypothesis of resistance by spouses, and included behavioural measures. We aimed to ascertain also whether the therapy of Mathews et al is effective where patients recruit friends rather than family members to assist them.

Hypothesis 1. The principal hypothesis was that there would be a difference in outcome between women with husbands as co-therapists and women with female friends as co-therapists. We could not predict which condition would do better, because Hafner’s hypothesis allows two different directions of effect.
In one direction, acting as co-therapist might provide a new role for a husband to replace the one he was losing as his wife's caretaker. This might counter depression associated with loss of his previous role, diminishing any tendency to retard his wife's progress. Hence, women whose husbands were acting as co-therapists might do better.

In the other direction a husband who wished to keep his wife at home would be more able to retard therapy in a co-therapist role. Co-therapists outside the client's marital relationship might enable the client to do better.

Hypothesis 2. In direct replication of Hafner's 1977b report, as wives become more independent, husbands might experience change in their marital equilibrium and suffer symptoms. As Hafner implied and as would be expected from a major role loss (Oatley & Bolton, 1985), these symptoms would be mainly depressive. Hence husbands' depression scores were predicted to rise at 2 months, and perhaps fall again later. Moreover, if acting as co-therapist did provide husbands with a new role, then those who were co-therapists would become less depressed than those who were not co-therapists.

Hypothesis 3. Clients whose husbands became depressed at 2 months would be expected to go out less by 6 months. There would be a negative correlation between husbands' depression scores at 2 months and their wives' behavioural improvement at 6 months.

Hypothesis 4. According to the homeostatic theory, marriages in which wives felt controlled by their husbands might be more resistant to change. Hence, there would be a larger negative correlation between husbands' early depression and wives later behavioural scores than in marriages in which wives felt less controlled.

Hypothesis 5. We derived an index of hostility to try and replicate Hafner's 1977b finding that more hostile clients made poorer progress than those who were less hostile.

Method

Subjects

Subjects were drawn from 59 women in Brighton, Eastbourne and North London who volunteered for the study: 24 were contacted via self-help organisations for phobics, 31 got in touch with us after articles in the local press, and four were referred by GPs.

Criteria for acceptance were that the subjects were aged 18–70 years; had been married or in stable heterosexual cohabitation for at least 3 years; had been agoraphobic for at least 3 years; and had both a husband (or male partner) and a woman friend prepared to help. They had to be literate (in order to fill in forms and read the therapy booklets), free of physical disability, and not be receiving treatment for agoraphobia other than tranquilisers or anti-depressants prescribed by their GP.

Agoraphobia was defined using the criteria of DSM-III (American Psychiatric Association, 1980) of (a) fear and avoidance of being alone or in public places, or of places where escape is difficult because of sudden incapacitation; (b) severely constricted daily activities because of inability to leave home alone, or to enter public places; and (c) condition not due to an obvious primary major depressive episode, obsessional–compulsive disorder, paranoid disorder or schizophrenia. In addition we administered the Leeds Self Assessment of Anxiety Specific Scale, range 0–18 (Snaith et al., 1976). This has a case threshold between 6 and 7. All but one of the 30 subjects who undertook the trial were above case threshold on this scale, with 26 of them having scores of 12 or above.

We explained the programme to the 39 women who met the criteria. We said we would decide randomly whether their husband or their woman friend would be co-therapist for them, but that to take part they had to make sure that both were willing to help. Six further women decided against going ahead after learning more about the programme or because their husbands refused to be available as co-therapists. This left 33 cases. They were assigned randomly, two to each condition in blocks of four, either to a condition in which their female friend would be their co-therapist (FF group), or to one in which their husband would be their co-therapist (HB group).

Table I

<table>
<thead>
<tr>
<th>Patient characteristics in each treatment group</th>
<th>FF group (n = 15)</th>
<th>HB group (n = 15)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age (years)</td>
<td>45</td>
<td>42</td>
</tr>
<tr>
<td>Mean duration of agoraphobia (years)</td>
<td>18</td>
<td>14</td>
</tr>
<tr>
<td>Proportion on tranquilisers (%)</td>
<td>60</td>
<td>80</td>
</tr>
<tr>
<td>Proportion on anti-depressants (%)</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Proportion on both types of drug (%)</td>
<td>20</td>
<td>7</td>
</tr>
<tr>
<td>Proportion who had previously received psychological help to overcome agoraphobia (%)</td>
<td>33</td>
<td>60</td>
</tr>
<tr>
<td>Social class (Registrar General's classification)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I &amp; II (%)</td>
<td>53</td>
<td>46</td>
</tr>
<tr>
<td>III &amp; IV (%)</td>
<td>46</td>
<td>46</td>
</tr>
<tr>
<td>V (%)</td>
<td>0</td>
<td>7</td>
</tr>
</tbody>
</table>
In the FF group, two subjects dropped out early in therapy because going out made them too anxious. Another subject was excluded from the HB group because we discovered that she had become partially blind as a result of diabetes, and had been getting her husband to fill in the assessment forms for her. This left 15 subjects in each group. We collected complete data up to 6 months. We followed up all 30 couples for 12 months, though at 12 months one FF and one HB couple would complete only the Leeds scales (see below) but no other instruments.

Table 1 shows the characteristics of the subjects. The severity and duration of symptoms were similar to those of clinical samples (cf. Buglass et al., 1977; Mathews et al., 1981a).

**Assessment methods**

Three main measures were taken at baseline, at 2 months, at 6 months (i.e. end of therapy), and at 12 months (i.e. 6-month follow-up). A Response to Treatment Questionnaire was taken at 12 months.

**Behavioural diaries**

Behavioural diaries were modified from those of Mathews et al. (1977, 1981a). After detailed discussion, a patient listed activities which for her were ‘safe’ (i.e. did not cause anxiety even on a bad day). The patient was then asked to record in the diary everything else she did. She kept the diary every day for 2 months, and then again for 2 weeks at the 6-month and 12-month assessment points.

An items score was derived from a generalised hierarchy of 15 items which provoke anxiety and avoidance by agoraphobics. At the lower end of this hierarchy, items 1 and 2 are, respectively, the patient spending up to 30 and 60 minutes outside a particular safe room in her house. These were only applicable to a few people. Items 3, 4, 5 and 6 are leaving home alone for at least 5, 15, 30 and 60 minutes, respectively. The next items, also to be accomplished alone, are (7) local shops, (8) main shops, and (9) trips on public transport. Next are items of outings up to 4 hours, which may be accompanied, and in order of increasing social constraint: (10) accompanied outings (e.g. car trips or walks with a spouse), (11) visits (e.g. to friends, or visits of others to the patient’s home), (12) visits to pubs, cafes etc., (13) attending public assemblies such as doctor’s, parents’ meetings at school, cinema etc. Finally there are two items about longer outings; (14) more than 4 hours, and (15) more than 8 hours — away from home on visits of various kinds during which the patient may be accompanied. Details of content analysis and scoring developed for these diaries are given by Oatley and Hodgson (in prep.). Item scores range from 0 to 15.

Diaries at each assessment point (baseline and 2, 6 and 12 months) were analysed to determine how many items on this hierarchy had been accomplished. To score one item the patient had to record its performance twice during a 5-day assessment period that included a weekend.

A subsidiary diary measure was the total amount of time away from home during these 5-day periods. Diary entries are made each day after performance. Hence, these scores may be more valid than retrospective questionnaire measures of phobic symptoms.

**Leeds Scales for the Self Assessment of Anxiety and Depression**

The Leeds self-report questionnaire (Snaith et al., 1976) was completed by all patients and husbands at each assessment point, with no consultation between each other. It has 15 statements, each describing a symptom of anxiety or depression to be rated on a four-point scale and scored 0–3. We used two principal measures as described by Snaith et al.; (a) for patients the Specific scale of diagnosed anxiety, which we will call Clients’ Leeds Anxiety Scores, and (b) for husbands, the General scale of non-diagnosed depression, which we will call Husbands’ Depression Scores. Each scale of six items has a range of 0–18.

**Dyad repertory grids of relationship**

To try and predict in which marriages therapy might go more or less well, we administered a dyad repertory grid (Ryle & Lunghi, 1970), to patients and husbands. Supplied constructs were ‘Feels guilty about’, ‘Looks after’, ‘Exerts control over’, ‘Gives in to’, ‘Blames’, ‘Is irritated by’, ‘Depends on’, to be rated on seven-point scales for the marital relationship and relationships with parents. Patients and husbands were asked to complete grids without consultation, though we said they could discuss them afterwards if they wished.

Two criteria derived from baseline grids were used to predict who would be most resistant to therapy. One was of patients who felt controlled by their husbands. The criterion of high control by husband was a score of 4 or more at baseline on the construct ‘Exerts control over’ as applied to the husband. Over all 30 subjects, irrespective of co-therapist, this criterion gave a split of 16 wives who felt control was high and 14 who felt control was low.

The other criterion, to parallel Hafner’s index of hostility, selected patients scoring 5 or more at baseline on either or both of the constructs ‘Blames’ and ‘Is irritated by’ applied to their husbands. This gave 14 high hostility patients and 16 low hostility patients, irrespective of co-therapist.

Principal components analysis of the whole grids will be reported elsewhere.

**Response to Treatment Questionnaires**

Response to Treatment Questionnaires were distributed at the 12-month follow-up meeting. Patients were asked to complete them not while the therapist was present but later, and return them by post. Ratings on five-point scales were made on the following questions: overall satisfaction with the programme, change in being able to go out alone, change in being able to go out accompanied, change in depression, change in anxiety, change in optimism about being able to overcome agoraphobia. The five-point scales were of the form (1) very dissatisfied, very much less able to go out, etc., (2) dissatisfied etc., (3) no change, (4) satisfied, etc., (5) very satisfied, etc. Clients were also asked for details of any other therapy or self-help they had undertaken during the 12 months.
To reduce bias we did not check any Leeds or grid measure until after the 12 month interviews.

Therapy programme

Therapy was based on the home-based treatment of Mathews et al (1977, 1981a). Instructions to client and co-therapist were provided in booklets (Mathews et al, 1981b), supplemented by our written introduction and by the relaxation audiocassette of Sharpe (1976).

The authors were the therapists. After working under supervision with four pilot cases using this therapy, one of us (KO), with 8 years' experience of conducting groups and 3 years' of giving individual interpretive and cognitive therapy, saw eight clients, and the other (DH), with 6 years' experience working behaviourally with self-help groups, saw 22.

Before the first meeting we had decided by telephone or letter if acceptance criteria were met. The random choice of husband or woman friend as co-therapist was then made. At the first visit, lasting 1.25 hours, the therapist saw the patient with her husband, irrespective of whether she had been assigned to the FF or HB group. We told the couple whether husband or woman friend would be acting as co-therapist. We described the programme and the role of the co-therapist, and explained that as well as giving the therapy we were doing research to see how husbands or friends might help in therapy and to see what feelings husbands and wives had in the course of therapy. A history and demographic information were collected.

Husband and wife were asked to complete the Leeds scales and the repertory grid forms. The patient was helped to prepare a safe list for her diary which was left so that she could make daily entries for a baseline week. We left the treatment booklets and the relaxation tape. We also left two copies of a contract recording agreement to the therapy, signed by the therapist.

We discussed the implications of therapy for the couple's relationship, and how it might mean substantial changes for both of them. We said that they should only go ahead after they had both read both booklets and discussed the programme together. If they decided to go ahead then the wife and the co-therapist should sign the contract form.

The client was asked to practice relaxation twice a day using the tape, but to make no other changes in her life until the next meeting, a week later. To acquire a baseline measure of activity, she was asked to record in her diary her performance of all activities not on her safe list.

Subsequent visits lasted an hour or less, and were at 1 week and 1, 2, 6 and 12 months, with phone calls at 2 weeks and in order to make appointments for visits.

Up to 6 months the co-therapists were asked specifically to attend meetings, which were largely concerned with describing the therapy as specified by Mathews et al, discussing progress, and advising patient and co-therapist. Some patients who had a woman friend as co-therapist had their husband also present. At 2, 6 and 12 months we also collected the measures, which were typically sent by post before visits.

At 6 months we discussed the long-term plans of the patient, and enquired about marital difficulties if this had not been raised spontaneously. We discussed further help where such difficulties had occurred.

At the 12-month follow-up visit we saw the patients and their husbands for further discussion and closure.

Two patients, one each in the FF and HB group, started further therapy near the 6-month point. At 12 months we referred two other couples, one in each of the FF and HB groups, for marital therapy.

Results

As may be seen from Figs 1 and 2, both FF and HB groups of patients improved on mean behavioural items and Leeds anxiety scores by 6 months, and the improvement was sustained at 12 months. Separate analyses of variance were performed on the scores for each measure. In the Items analysis the within-subjects improvement over time was significant ($F= 15.85; d.f. 3, 78; P<0.001$), although neither the difference between the FF and HB groups, nor the group x time interaction were significant. ($P$-values of 5% or less will be regarded as significant in this paper.) Improvement in Leeds anxiety scores over time was significant ($F= 13.75; d.f. 3, 84; P<0.01$), although again neither the between-group effect nor the group x time interaction were significant.

On both measures most of the improvement was accomplished in the first 2 months, and these gains were sustained thereafter. This was confirmed by significant a posteriori $t$-test between baseline scores and subsequent
2 months and wives' raw Item scores at 6 months were slightly lower, \( r = -0.31 \) (\( P < 0.05 \)). At baseline the association between husbands' depression and wives' Item scores was \( r = 0.09 \) over all subjects. Husbands' baseline depression correlated with wives' 6-month Items Gained at \( r = -0.14 \) (NS). These subsidiary correlations indicate that it was mainly the change in some husbands' depression in the first 2 months, rather than any association at baseline, that predicted their wives' progress.

According to Hypothesis 4, patients who saw their husbands as more controlling would be more affected by their husbands' depression. For the high perceived control set (\( n = 16 \)), correlations between husbands' depression at 2 months and wives' Items Gained at 6 months was \( r = -0.42 \) (d.f. 14, \( P \approx 0.05 \)). For the low perceived control set the correlation was \( r = -0.20 \) (d.f. 12, NS).

Hypothesis 5 predicted replication of Hafner's 1977b finding that the more hostile clients would do worse in therapy. The mean of the Items Gained by the more hostile patients (\( n = 14 \)) was 1.75 by 6 months, and by less hostile patients 2.67. Thus, there was a difference but it was not significant (\( t = 1.24, \) d.f. 28, \( P \approx 0.1 \)). The mean of the anxiety scores in the more hostile patients at 6 months was 11.36, and for the less hostile patients 11.50 (\( t = 0.9 \), d.f. 28, NS).

Patients meeting the criterion of perceiving their husbands to be more controlling, and those meeting the criterion of being more hostile were scattered evenly between FF and HB groups.

As may be seen from answers to the Response to Treatment Questionnaire, Table II, most clients were satisfied with the programme, and most rated themselves as improved on the factors asked about.

### Table II

<table>
<thead>
<tr>
<th>Positive responses to questions on the post-treatment questionnaire</th>
<th>Number of positive responses</th>
<th>Overall percentage of positive responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>FF group (( n = 14 ))</td>
<td>HB group (( n = 14 ))</td>
<td>(( n = 28 ))</td>
</tr>
<tr>
<td>Satisfied and very satisfied with programme</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>More and much more easy to go out alone</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>More and much more easy to go out accompanied</td>
<td>11</td>
<td>9</td>
</tr>
<tr>
<td>Less and much less depressed</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Less and much less anxious</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>More and much more optimistic</td>
<td>11</td>
<td>12</td>
</tr>
</tbody>
</table>

Fig. 2. Means and standard errors of Leeds anxiety scores by 15 patients with female friend (FF) co-therapists, and 15 with husband (HB) co-therapists, as baseline (0), after 2 and 6 months of therapy, and at a 12-month follow-up.
therapists. In terms of the amount of time spent out alone (1981a,b), those whose husbands acted as co-therapists did no better than those without co-therapists. In terms of the amount of time spent out alone, our results are also comparable with those of Mathews et al (1977), who state that the mean time that subjects spent out alone approached, but did not reach, an hour a day. For our subjects the mean time spent out alone rose from 13 minutes a day at baseline to 53 minutes a day at 12 months.

There was a non-significant trend towards the FF group doing better on the behavioural diary measure. The FF group was significantly better ($P<0.05$) in Items Gained at 6 months, but by 12 months the difference was no longer significant. Overall the somewhat larger behavioural gains of the FF group might imply that husbands had less interest in increasing their wives' mobility than did women friends. We had the impression that some of the women friends were better as co-therapists than most of the husbands. Certainly there was more novelty for women who had a friend helping them. They gained extra support and perhaps more understanding from another woman.

The claim of Hafner (1977b) that husbands would become symptomatic was not replicated. On average, husbands did not become significantly more depressed or anxious at any time.

We were careful to avoid provoking husbands' jealousy or feelings of exclusion. We warned each couple beforehand of possible readjustments to their marriage. We did not accept in the study couples in which the husband was not willing to act as co-therapist. Two couples were excluded because of husbands' hostility and refusal at this point. We encouraged couples to discuss changes that occurred between them. Though important therapeutically, these steps probably diminished the effect we were studying, so the study provided a severe test of Hafner's hypothesis.

In designing the study, we planned to test Hypothesis 3 only by exploring correlations between husbands' depressive symptoms at 2 months and wives' Items gained at 6 months, to avoid too many significance tests on limited data. These correlations showed that those husbands who were more depressed at 2 months had wives who had gained fewer new behavioural items by 6 months. Over all 30 couples the correlation ($r = -0.36$) accounts for only 13% of the variance of Items Gained, and even the larger correlation ($r = -0.52$) in the FF group accounts for only 27% of the variance.

Perceived control and hostility which were predicted to increase the effect (Hypotheses 4 and 5) had small influences.

There was a non-significant trend towards the FF group doing better on the anxiety measure. The FF group was significantly better ($P<0.05$) in Leeds anxiety scores at 6 months. Over all 30 couples the correlation ($r = -0.36$) accounts for only 13% of the variance of Items Gained, and even the larger correlation ($r = -0.52$) in the FF group accounts for only 27% of the variance.

Thus, we concluded that there was an effect of the kind that Hafner described, but that its size was modest. In this study, it principally took the form of husbands being slightly less effective as co-therapists than women from outside the family; and of wives whose husbands became more depressed in the first two months of therapy going out less than those whose husbands became more cheerful. No husbands became suicidal and no marital separations occurred during the year of the study.

Becoming depressed is only one possible type of influence. Several other kinds of pressure apart from onsets of symptoms did occur. For instance, one woman started a part-time job, which she liked, but her husband made her give it up. Another husband, perhaps hoping to enhance her enjoyment of being at home, had an elaborate new kitchen built for his wife early in her therapy. In another couple, the husband decided that therapy was making his wife worse despite her going out more and sent her to another clinician who gave her a course of flooding, following which she relapsed below her baseline scores. Clinical intuition about family homeostatic processes may, therefore, often be correct. The difficulty is in casting it into an empirical form. Though this trial specifically estimates the extent of resistance associated with depressive symptoms in the non-treated partner, a composite index is needed. Measures of hostility, of husbands' symptoms, or of any other single parameter may each be relevant in only a proportion of marriages.

We found nothing to negate the principle of including spouses in therapy for agoraphobia. Indirectly our results imply that including the spouse is important, as stressed by Webster (1953). For many couples change does require readjustment in the relationship. But the small negative effects for husbands are outweighed by gains in mobility for the patients.
The results also indicate something of the nature of agoraphobia as a chronic anxiety state. Most subjects went out more. Some began to use public transport. Many went on long visits, and seven (23%) started paid jobs. Most were pleased with their progress (Table II) and anxiety levels decreased. But despite this they remained anxious people (Fig. 2).

At 12 months, 27 were above the case level of Snaith et al (1976) on the Leeds anxiety scale (between 6 and 7) as compared with 29 at baseline.

The principal effect of this behavioural therapy was that more of the environment was made relatively safe. This kind of therapy leaves largely unsolved the problems of allowing comfortable levels of anxiety to be attained.

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References


OATLEY & HODGSON, D. L. Analysis and scoring of behavioural diaries kept by agoraphobics. (In prep.)


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