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Cognitive Behavior Marital Therapy in Distressed Couple: A Case Report

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Abstract

Quality and enriching heterosexual relationships are often associated with happiness and well-being. In reality, however, most relationships are also associated with conflicts. The quality of the relationship is also indicated by how the couples resolve their conflicts effectively and meaningfully. Cognitive behavioral intervention attempts to use behavioral and cognitive based techniques in the marital context to decrease marital distress. These techniques are individualized in the proper context to help the couples resolve their issues. The current paper presents a case of a couple wherein male was the primary patient with mixed anxiety and depression and his wife with the past history of obsessive compulsive disorder remitted during the therapy process. They also reported communication issues. Detail description of the therapy process has been described in the current paper. In all, twenty sessions were conducted on weekly basis or as per the clinical judgement and requirement of the case. Following the completion of the interventions, they reported significant improvement in their relationship and individual symptoms.

Key Words: Cognitive behaviour marital therapy, marital distress, obsessive compulsive disorder, mixed anxiety and depression.

Introduction: Cognitive-behavior marital therapy is based on the principles of social learning, social exchange and cognitive behavioral interventions. In the initial phase during the 1960s, behavioral formulation was used to reduce marital distress (Baucom, Eipstein, Rankin, & Burnett, 1996).

Social learning model posits that social behaviour is governed mostly by its consequences being learned through modelling process. There are antecedent discriminative stimuli signaling that particular reinforcement contingencies. The behavior marital therapists attempt to understand how a particular couple extinguished certain maladaptive behaviors which are causing marital distress and reinforce adaptive behaviors associated with their positive functioning. Social exchange model of interpersonal relationships assert that the quality of interpersonal functioning is a function of reward and cost the couples incur in the process of their interaction. If the amount of efforts and cost spend is less that the reward achieved in the relationship, it will strengthen the bond and if the amount of cost spend is more than the reward achieved, it will weaken the mutual bond among couples. The theory also contends that the exchange of goods between partners in a continuous relationship is reciprocal. It means that the level of reinforcement and punishment provided by one partner is influenced by the rewards and punishments of the other one. It is important to remember that nature of efforts, costs and rewards differ from person to person. Over time, this process of mutual interaction results in a relatively equitable exchange of goods between the two partners. However, reciprocity does not necessarily imply symmetry or equality. Balance in a marital partnership is when the exchange is perceived as fair by both the partners. For instance, in a particular couple the wife perhaps contribute more than the husband, but she established a sense of balance that she viewed as gratifying. The therapist working with the couples need to make sure that the couple function in a manner that both partners find gratifying and acceptable. Based on these behavioral models, marital satisfaction is defined as the prevalence of positive interactions between spouses. Initial behavioral interventions are aimed to replace negative interactions with positive ones by increasing positive behaviors through positive communication skills of partners, problem solving training to improve effective problem solving skills, and contracting to increase the positive behavioral exchange.

Cognitive behavioral model believes that behaviour, cognition, and affect are interrelated. It is, therefore, assumed that change in behaviour will automatically lead to change in cognitions and vice versa. Baucom and Eipstein (1990) formulated marital distress based on cognitive factors which cause and maintain marital dysfunction. These include *perception, attributions, expectancies, assumptions, and standards.*

Perception is the cognitive process about what events occur. In marital relationships there is a phenomenon called selective attention, in which partners selectively attend to and notice, certain aspects of an interaction or an event. This tendency of selectively attending either positive or negative aspects of the relationship while ignoring other important behaviors can lead to distorted experiences of the partner, oneself, or the relationship occur. One of the most complaints of partners is that their partner notices more negative behaviors than the positive ones.

Attribution is the process of explaining the reasons of a particular set of behaviors. It has been clinically observed that one of the most common causes of marital distress is negative attribution by them. It often leads to negative inferences. One of the examples can be when

a wife says "*my husband did this because he wants to hurt me*" when her husband makes any mistake. This often causes cycle of blame among the couples.

Expectancies are the predictions that the couple often make about the future relationship or individual behaviour related event. Expectancies often affect emotions and behaviors. For example "*I know my husband will never listen to me when I am upset, so why to talk to him about this*". Such negative expectancies often leads to relationship distress. Expectancies are integrally related to attributions because both are cognitive elements.

Assumptions that spouses hold about the characteristics of each other and intimate relationships also contribute in marital functioning. Each person usually develops an image of the partner (e.g. who he/she is, how he/she behaves, what he/she likes and dislikes). Attributions are made on the basis of assumptions. Disruption of assumptions will affect one's attention, attributions, expectancies, emotional responses, and behavior toward the partner.

Standards involve personal beliefs about the characteristics that an intimate relationship and the members "should" have. Standards are different from assumptions in that assumptions involve how things "actually" are. Standards are used to evaluate whether each person's behavior is acceptable and appropriate. Marital conflict and distress arise when spouses are aware that their marital interactions do not match the ideal characteristics of intimate relationships or their standards. Marital distress often happens when any one of the partners have extreme standards set for their partners which may not meet in their current relationship.

The current case uses various components of behavioral and cognitive interventions to work with distress couple and improve their marital and individual well-being.

Case Summary:

Husband' Name: S. K	Age: 30 years
Education: Bachelor in nursing	Place: Jaipur
Wife's Name: A.S	Age: 28 years
Education: M.A/B.Ed	Place: Jaipur

Number of sessions: 20 sessions
Therapy conducted in the months of May and July 2013

Summary and MSE: Clients were hailing from Jaipur and belonging to a middle socio economic status urban background. They were presented with the past history of OCD in wife and present history of anxiety and depression in husband, nil significant family history of any psychiatric illness. Personal history could not be elicited, however premorbidly wife was having low frustration tolerance. They were presented with the following complaints with insidious onset which started 1years ago and has increased over last 3-4 months. The presenting complaints of the husband being

a) Anger
b) Irritability

c) Lack of interest in sex
d) Threat of adequate sexual performance
e) Feeling low
f) Repeated thoughts related to get separated.
g) Anger outburst on child

MSE revealed good eye to eye contact and irritable mood of both husband and wife. The marital therapy was done in these contexts.

Having made the working alliance with the couple and their active role and the role of the therapist in bringing positive therapeutic change was discussed in detail. Other issues like confidentiality, fee structure, frequency of the session, place and duration were also discussed.

Treatment goals: After interviewing with the clients (couple), the following goals were decided. The goals were also prioritized in terms of both the clients' needs. The goals of treatment were as follows:

1. Managing Anger
2. Enhancing expressing skills
3. Decreasing general anxiety
4. Increasing communication
5. Decreasing sex anxiety

Strategies used and their rationale:

1) **Cognitive restructuring:** Cognitive restricting is the process in which cognitive distortions or dysfunctional beliefs which are leading to the problems are corrected. Through the case history it was found that they were having misbelieves about sex like *early semen release is a sign of weakness, erection should be always tight*. these dysfunctional beliefs related to sexual functioning were often the cause of fight and led blaming each other. It was thought that the client would be making cognitive errors hence subsequently it would cause his problems. Hence this treatment was utilized to help the client become more realistic and rationale in his approach and to help him correcting his cognitive errors.

2) **Deep Breathing:** It is a technique that teaches clients to breathe deeply using the diaphragm, expanding the abdomen rather than the chest. Here the client is instructed to place on abdomen while breathing slowly while having anxiety. The client is instructed to breath so that the hands on abdomen raises up, minimizing any movement in the upper chest. Deep breathing was chosen as one part of treatment modality as this technique has been shown to release stress and tension, build energy and endurance, help in pain management and also enhances mental concentration. Moreover, this technique can be easily and unobtrusively used by clients whenever other stressful situations emerge.

3) **Jacobson Progressive Muscular Relaxation (JPMR):** JPMR was planned to decrease the anger and anxious arousal of the husband and even wife.

Besides these, they were also trained in positive communication and problem solving skills.

Summary of the sessions: The total of 20 sessions was conducted. The initial two sessions focused on history taking and clarification. Actual therapy was conducted in the middle sessions (3-17) and after completion of the middle session the termination of the therapy was done in the session 17-20.

Initial sessions: The first two sessions focused on history taking and clarifications. The sessions were held with the husband and wife, they were asked to write their problem areas in which conflicts arise from most severe to least severe.

Middle Sessions: The short term and long term goals were decided. Therapeutic contract was made. It was decided that the couple will be seen twice a week as per their convenience and each session would usually be of one or one n half hour. They were told that it would take 1 to 2 months to work on their issues. They were quite motivated. As planned in the middle sessions, the therapeutic work was started. Both the clients were psychoeducated about anger, depression and anxiety as these were their major problems and it was taken first along with the approach toward the process of their marital issues. They were psychoeducated about assertiveness that anger is a natural phenomenon but it should be expressed in an assertive manner. They were also psychoeducated about how circumstances lead to decrease their interest in sex. 6-8 sessions were focused on the beliefs related to sex as they were asked to make a belief chart and were assigned to write about the beliefs. They were told to make a 4 column diary about thoughts content, feeling, activity, success and failure. And it was discussed in the sessions. In session 9-14, after exploring the problem areas and about the situations in which conflict arises the couple was taught the problem solving skills & express and share the emotions and feeling to each other in terms of writing about what they like about each other and elaborate each point. They were also told to write about what they physically like in each other and express either in session or at home to make them feel emotionally and physically connected and to increase cohesiveness towards each other. During these sessions, techniques of sensate focus was also done in terms of observing their body parts initially except sensitive ones and were told not to do intercourse initially which lead to increase the duration to hold the semen and to decrease early ejaculation. They were told to do deep breathing whenever they feel anxious during sex. They were also trained in JPMR to work on their excessive anxiety. During session 15-17, they were assigned some home works in the form of metaphors like husband wife are seen as garments for each other how? And they were told to think upon and to write about these metaphors that what they understood. These assignments were discussed in more detail in the therapy sessions.

Mutual goals and valued activities were focused till the end of the sessions to make their life more meaningful. During the last sessions the bonding was improved between both the husband and wife.

They learned problem solving skills and started using it when they face problems. They continued to practice Deep breathing and JPMR in the sessions and at home. After 17 sessions, they reported overall 70% improvement in their marital life like decrement of their anxiety, reduction in the subtle interpersonal conflicts, reduction of anger, enhancement of marital bond.

Termination: In the last session, the review of all sessions and strategies were done. And spouses were told to continue to be in touch with the therapist either through phone and mails in case if it is required.

Clinical observations and therapist's reflections:

- Initially the spouses were hesitant about their problem. Their eye to eye contact was good. But over the course of sessions, their communication significantly improved and looked less hesitant and more communicative.
- Rapport was developed easily. They were quite motivated and co-operative for the sessions.
- Working with the spouses was motivating for the therapist herself as they were very regular to the sessions.
- Their regularity in doing assignments was also highly motivating for the therapist.
- They seemed quite psychologically minded as they were able to understand the psychological models easily and implantation was easy.

Prognosis:

Good prognostic factors:

1) Spouses' high motivation to work on their problems.
2) Absence of any severe psychopathology.
3) Absence of any psychiatric illness in the family.

Bad prognosis factors: Specific bad prognostic factors could not be identified.

Conclusion: Cognitive behavioral marital interventions have been found to be efficious in the current case. The 70% reported improvement by the couple in their marital functioning and other symptoms indicate the effectiveness of cognitive behavior marital therapy in distressed couples. There is also a strong need that couples in distress be trained about recognizing the possible symptoms of their relapse and how to work on this. The current case would have been improved by using pre, middle and post assessment using statistical analysis following single case design. Statistical procedures like effect size make the results more objective. Researchers and clinicians need to use relatively larger clinical samples using various modes of psychological interventions for increasing generalization of the results.

Ethical considerations:

1. The anonymity of the case was maintained for the publication work.
2. The prior written permission was taken from the client for getting the work published with the maintaining of his anonymity.
3. It was clearly shown to the client that the therapist has been trained for doing the therapy.
4. The rationale and possible harm and limitations of the clinical work were discussed before the therapy.
5. The role of the active involvement of the client and the therapist for therapeutic success was discussed in detail before therapy work.

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