Dora. The distinction may be further clarified by a final quotation from Bateson (1973):

> In general in communicational systems, we deal with sequences which resemble stimulus-and-response, rather than cause-and-effect. When one billiard ball strikes another, there is an energy transfer such that the motion of the second ball is energised by the impact of the first. In communicational systems, on the other hand, the energy of the response is usually provided by the respondent. If I kick a dog, his immediate sequential behaviour is energised by his metabolism, not by my kick.

Dog and foot are likely to meet again: the patterning of behaviour is what makes psychology possible. Psychoanalysis is concerned with the 'metabolism' of foot and dog and how this leads them to seek each other out; family therapy with the consequences of their contact. At this stage in the evolution of the psychotherapies it is not clear whether family therapy is the dog and psychoanalysis the foot, or vice versa, and in what ways their relationship is likely to change.

Chapter 9

Phobia and counterphobia

Family aspects of agoraphobia

INTRODUCTION

Family therapists tend to see disturbance in children in terms of parental difficulty. The aim in treatment is to 'return the repressed' (Cooklin 1979) to the parental relationship where it belongs, and so free the symptomatic child from the role of marital 'distance regulator' (Byng-Hall 1980). Those family therapists whose work is primarily with disturbed adults find that the presenting *symptom* or illness often acts in a similar way to that of the disturbed child, being both a concentrate of and a diversion from marital and family difficulty (e.g. Haley 1977). This chapter looks at some phobic and agoraphobic patients and their families from this perspective.

Bowlby (1973) has used the phrase 'the suppression of family context' to describe the commonly unacknowledged fact that the majority of agoraphobic patients have had severely disturbed childhoods. This leads, he claims, to 'anxious attachment' between the pre-phobic patient and her mother, inhibition of exploratory behaviour and ultimately to the development of symptoms.

Others have looked at the contemporary relationships of agoraphobic patients, whose spouses are described by Fry (1962) as 'negativistic', subtly disinvolved men with a tendency to be over-compliant to their wives' demands, thus covertly encouraging dependency and thereby making themselves both indispensable and distant. Haffner's study (1977) confirmed this impression systematically, finding that 'denial of problems and disability and vulnerability was a central feature of the psychological make-up of these men'. These findings have implications for treatment. Family and marital difficulties can reduce the effectiveness of behavioural treatment in social phobias. (Falloon *et al.* 1977) and Haffner (1977) found that agoraphobic patients whose spouses could not cope with their own internal feelings of aggression improved less than those with more self-tolerant husbands.

This chapter attempts to delineate a recurring sequential family pattern seen in some phobic and agoraphobic patients. Two paradigmatic cases are first described in an attempt to establish the pattern. A family model for the

development of the agoraphobic syndrome is then put forward. Then, using the model, family methods in the treatment of phobic syndromes are discussed.

CLINICAL EXAMPLES

The steeplejack's wife

A young woman developed phobic symptoms soon after the birth of her first child. Initially her fears were of harming the baby; later she became afraid to go out alone and took to telephoning her mother frequently for reassurance. She insisted on moving house so as to be near her mother. Her mother 'helped' her by looking after the child, and would ring several times a day to see if the boy was 'all right'. When the patient told her mother of a dream in which her son had fallen under a lorry, her mother (who was not likely to have read Freud) told her that this meant she wanted to kill her son. The patient had felt neglected as a child since her mother devoted all her attention to her two younger sisters, one of whom had been chronically ill with kidney disease while the other was epileptic.

In the initial individual session she was able to link her fears of harming the baby with aggressive feelings towards her sisters, but her symptoms persisted. At a joint session she announced proudly that her husband – unlike herself – was afraid of nothing. He accepted this compliment somewhat hesitantly and confirmed that he had indeed been self-reliant since the age of ten, which was when his parents divorced and he and his younger brother had more or less been left to fend for themselves. He worked as a scaffolder on high buildings. When asked if it was true, as his wife suggested, that he was frightened of nothing, he confessed that he had slipped on a rope that morning and had been very scared. His wife seemed surprised at this revelation but visibly relaxed and perked up. He then said that he could never tell his wife about his fears or worries because of her illness. For example, the one thing of which he was petrified was confronting his mother-in-law. This emerged when he was given the task of protecting his wife by answering the telephone, so that when her mother rang to check on the baby, *he* would tell her that she was busy and could not speak. He insisted that this would be impossible: his mother-in-law would not take no for an answer.

The would-be travellers

This young couple's problems also began after the birth of a child: their second. Mrs J, a plump, chatty, attractive woman, became terrified to leave the house. Her first child had just started school and shamed his mother into seeking help when he asked her why their family never went away for weekends or holidays like the other children's. Mrs J was an only child whose mother had gone out to work when she was a baby, leaving her with her grandmother. She became very attached to her parents, had few friends and had often missed school through illness. The very first time she spent a night away from home was when she was sixteen. Her husband, also an only child, was an irritable, withdrawn-seeming man who – in striking contrast to his wife – had developed a remarkable premature independence. From the age of nine he was fascinated by railways and became a railway 'boffin'. His parents had encouraged him to travel on his own from an early age. His wife worried about everything. He had a nerveless, *laissez-faire* approach: he was sure that everything would be all right in the end. He was unmoved by her needless rehearsal of possible disasters. One of her fears of travelling was that the car would break down; he would reassure her that there was nothing to worry about and thus persuade her occasionally to come out with him: but then the car *did* break down. It was the same with money: he would suggest they go away. She – who ran the family's finances – insisted they could not possibly afford to. He would then back down and so the pattern continued: he was frightened of nothing except standing up to his wife; she was frightened of everything except her ever-so-tolerant husband.

ELEMENTS IN THE EVOLUTION OF THE PHOBIA

According to the 'family phobic syndrome' I am putting forward, these cases have a common underlying structure. The phobic patient has or has had a relationship with her mother in which there have been strong elements of dependency and often unconscious aggression. Her father is frequently conspicuous by his absence, either physically or emotionally. She is married to a 'counterphobic', apparently intrepid husband, who himself turns out to be covertly fearful and dependent on his wife and who felt neglected by his parents as a child. The illness is usually precipitated by a life event such as the arrival or departure of children. There are five main elements in this structure which I shall now consider in turn.

1 Anxious ambivalent attachment

According to Bowlby (1973) the key issue in the childhood origins of agoraphobia is 'anxious attachment' to the mother – caused by disturbed family relationships. In the present series there were certainly frequent feelings of disappointment and of having been neglected by parents. The steeplejack's wife, for example, felt that her mother had lavished all her love on her epileptic younger sister. However, such feelings of neglect are not uncommon and some degree of ambivalence is normal between children and parents. The central issue may not be the fact of disturbance in itself, nor the demandingness and resentment that feelings of neglect may evoke in the

child, but rather how such demandingness and hostility is handled. As Bowlby (1969) suggests in his discussion of the evolution of bonding, the normal biological response on the part of the primate parent to hostility or demandingness by the infant is an *increase in proximity* between parent and child. Under certain circumstances, however, there may be a paradoxical *decrease* in proximity when the child is demanding or angry – and it is this that can lead to pathology.

There are at least three situations in which this may happen. First, the parent may be physically absent as a result of illness, death or divorce at a time when ambivalent feelings are at their height. An example of this would be the *fifteen-year-old schoolgirl* who came home from school one day after quarrelling with her mother in the morning to find that her depressed mother was in a coma after taking an overdose. When the phantasy is confirmed by reality in this way, the damage may be greatest. Second, there may be emotional distancing by the parent who fails to register or 'accept' hostile responses from the child. This may follow from the mother's guilt about her own hostile impulses towards her child. These are the idealised mother-daughter relationships, so often seen in agoraphobic systems, where daughters are for ever 'good' and mothers are always 'wonderful'. Third, the physically or emotionally absent father may fail to provide an alternative parental figure who can provide compensatory proximity when the mother is withdrawn, or withdrawn from.

The result of any or all of these circumstances, especially if repeated, may be that demandingness and hostility come to be linked in the child's mind with separation and loneliness. The anxiety and pain that this arouses must be reduced. This can happen in one of two possible ways.

(a) Detachment, distancing and denial of hostility. By remaining detached and distant the threatened separation is forestalled, pre-empted, since it has already happened. Denial of hostile impulses further reduces the possibility of the feared separation.

(b) Clinging, cautiousness and compliance. In (a) the hope is that by remaining distant, hostility and demandingness may be avoided altogether. Clinging behaviour assumes that hostility is unavoidable and the defence concentrates on the feared consequence: i.e. the separation, and aims to minimise it by meeting it with an equal and opposite attachment. Defence (b) is that of the phobic patient, defence (a) that of her counterphobic spouse. They correspond roughly with the two main types of anxious attachment described by Bowlby (1973): avoidant and ambivalent attachment.

2 The 'solution': the phobic/counterphobic marriage

The pair, as yet unknown to each other, have in common a central fear of their own demandingness and hostility. They have reacted with contrary strategies to their childhood feelings of loss and disappointment (cf. Dicks 1967; Cooklin 1979). With the unerring antennae of the unconscious they seek each other out. Courtship and early marriage provide them with the ideal escape vehicle from their childhood difficulties (Freud 1916–17; Dare 1979). She has found in him the perfect partner from whom she need never be separate and with whom no feelings of hostility need ever arise. In her, he has found someone whom he can protect and from whom at the same time he can remain detached. So long as she is in need of protection he need fear no separation. Her anxiety about exploration is matched by his fear of being explored. In their 'Jack-Spratt' marriage her capacity to socialise (masking a fear of being alone) is balanced by his self-reliance and independence (masking a fear of closeness). Another common ingredient in such a marriage involves incomplete separation from the phobic partner's mother. The wife, with her inhibition of hostile drives, marries a man who is 'acceptable' to her parents. Her husband, frightened of true intimacy, is happy to settle for an interfering mother-in-law as a buffer between himself and his wife.

3 The precipitant: alone with change

Transient agoraphobic reactions are not uncommon in response to stress. Mothers frequently feel uneasy about going out after the birth of a baby; the bereaved find it difficult to be on their own in the early days after their loss; patients may be frightened to go out alone immediately after leaving hospital. For the potential agoraphobic these experiences are especially frightening since they threaten the illusion of invulnerability she has built up with her husband. The newborn child is a wedge that may split their unity; when grown-up children leave home the middle-aged mothers are reminded of their separateness. Both partners' earlier feelings of being abandoned are reactivated. *Where the spouse is not counterphobic* these anxieties may be accepted and shared and both may grow to feel that it is possible to be separate yet related. Alternatively the non-counterphobic husband may be straightforwardly intolerant of his wife's anxieties and the marriage may break up with the wife perhaps going back to her mother. In neither case is an agoraphobic syndrome a likely outcome. Where the husband is counterphobic he dare not show his weakness and so share it, nor can he be aggressive enough to precipitate a marital crisis. What he does offer his wife is the appearance of increasing invulnerability and apparent concern. The stage is now set for the development of a true phobic illness.

4 The failure of reassurance: escalation

A brief digression on the phenomenon of reassurance is necessary at this point. Reassurance occurs typically between parents and children, doctors and patients, and also from time to time between husbands and wives. The 'weaker' partner expresses an anxiety which is then 'contained' by the more powerful member of the dyad. A number of rules appear to govern the interchange. For example, the reassurer's certainty and power is often exaggerated and any anxieties that he may have are discounted, thus introducing an element of falsehood into the interchange. However, this is strictly limited in scope and there is a ban on 'false reassurance'. There is a similar constraint on the person to be reassured who must be 'genuinely' frightened and not using fear as a covert demand for something else. Repeated requests for reassurance are liable to be treated with suspicion. The normal function of reassurance is the reduction of anxiety caused by an external factor by means of an unequal relationship, but occasionally the inequality of the relationship is tested by means of an anxiety. The child who wakes his or her parents in the night for reassurance may have had a nightmare and want reassurance that the dream was not real; or the nightmare may *be* that his or her parents are not really all-powerful and reassurance is needed that they are. Reassurance involves a subtle, mutually agreed blend of the genuine and the illusional, aiming to place anxiety in its real perspective – somewhere between the foreground of boundless fear and the distance of absolute security.

In the threatened phobic-counterphobic system this comforting complementarity, which has been an integral part of the marriage so far, goes wrong. Rather than assuaging her fears, his reassurances serve only to augment them. She becomes more and more anxious, rings him continually, insisting that she cannot cope, that she needs him. No sooner has she rung off than her doubts redouble, she must contact him again. He becomes more and more of a 'superman', hiding his worries, helping his wife, protecting her from stress, distancing himself from her all the while. He rings her from work, 'just to see how she is'. The more he tries to reassure her, the more desperate she becomes. The stronger he seems, the more helpless she feels.

A good example of this process occurred with *the couple who wanted to emigrate*.

> They were a happily married couple in their early forties, with three teenage children. She was renowned in the family as a 'coper' who had looked after her two sisters as a child when her mother had suffered from 'nerves'. Her husband was a 'wonderful' man, laconic, Irish, self-sufficient, who worked every night at an adventure playground as well as his lorry-driving job so as to give his children a better childhood than he had had. Their secure complementarity – in which he coped with 'outside' worries and she looked after the 'inside' of the family – was upset when he decided they should emigrate to Canada where his sister lived. She then developed agoraphobia and he had to take over running the house and shopping, as well as his two other jobs. He accepted this role without complaint. She became more and more 'nervy'. Eventually they heard from the Canadian Embassy that their application had been rejected. The husband opened the letter but did not tell his wife for fear of 'upsetting' her. When he did tell her in a family-therapy session two days later, she was angry at first but then greatly relieved; then *she* was able to help her husband with his denied feelings of upset. Their normally complementary system of reassurance had changed catastrophically into a symmetrical escalation of anxiety and unsuccessful reassurance. The husband's secretive protectiveness acted as a positive feedback to his wife's anxiety, creating a 'runaway'.
>
> (cf. Bateson 1973; Hoffman 1971; Byng-Hall 1980)

5 The new solution: the stabilising role of the illness

Finally the runaway levels off with the emergence of the illness: the phobia. The spouse now knows that reassurance is useless and that professional help must be sought. Through the illness the anxiety is legitimised and so, partially, relieved. It is no longer the couple's relationship that is in question, their mode of communication and interaction, but the illness that is the problem. The illness becomes a 'distance-regulator' (Byng-Hall 1980) that maintains the marriage by saving the wife from her fear of separation and the husband from his fear of intimacy.

The relationship has now become a 'compulsory marriage' (Fry 1962). The wife is tied to a husband whom she needs to help her cope with a world from which she is excluded by her illness. He is tied to her by her need for him. Through the illness they are kept together – and safely apart – she in her sick role, he in his care-giving role. Thus they can, as a unit, 'avoid and control' their inner demandingness and angry feelings of deprivation that have pursued them from childhood. They have achieved – albeit at the price of sacrificing freedom and intimacy – the very relationship they felt they lacked as children: *un*anxious *un*ambivalent attachment.

TREATMENT

A number of different theories have been used in building this model of the evolution of agoraphobia. These include (a) a life-events approach, with its emphasis on the 'contextual threat' of a life-event (Brown and Harris 1978); (b) attachment theory; (c) psychoanalytic ideas, especially projective identification; and (d) systems theory, especially the symmetrical/complementary dichotomy. I would not view these models as essentially incompatible; indeed elements of each are required if the richness of the clinical phenomena

is to be encompassed. However, such an eclectic approach does pose problems when treatment is to be considered. Here there are two main questions. First, what method is most appropriate – systemic, strategic or psychoanalytic? Second, what is the best focus for intervention? The model suggests five possible levels at which treatment may be directed. In a given case it may be necessary to focus on any one or more of these levels. Each represents a different 'hypothesis' (cf. Palazzoli *et al.* 1980) which may need to be elaborated or abandoned as treatment proceeds.

Anxious attachment: the pacifists

Here the therapeutic task is to break the psychological link between demandingness and aggression on the one hand and separation on the other. This involves mobilising the counterphobic partner to respond to demandingness with firmness or even anger, to move not 'away' nor 'towards' but 'against', to use Karen Horney's (1939) clasification. Paradoxical intervention can be helpful here. Aggression is what is most feared since it leads to separation: for that reason it must be prescribed.

K was an attractive twenty-eight-year-old nanny whose phobic symptoms started while her parents were on holiday. Her parents, as we shall see, played the role of the counterphobic element in the system. Her symptoms consisted of agoraphobia and a curious fear of looking at herself in the mirror. She was the youngest of three children and the last to leave home. Her parents – who had met at school – were strong pacifists both politically and domestically and believed in the paramount importance of reason in solving problems. K's mother, a counsellor, was very anxious to help her daughter who always seemed to be in some sort of trouble: losing her job, getting robbed, being thrown out of her digs and becoming involved with 'unsuitable' boyfriends. Her father, a quiet man, sided with K when her mother tried to stand up to her, saying that she was being 'unfair' and that he, like K, had had his troubles in his twenties.

At interview the parents, after an initial period of trying to 'understand' K's exasperating behaviour, said that they were at their wits' end. They had done everything they could for her: lending her money, arranging jobs for her, allowing her to live in their house, but still she was unhappy and dissatisfied. Now she had become 'ill', which was worrying enough in itself: it meant that she exempted herself even more from being considerate and responsible. At this point K's behaviour was reframed as an attempt to 'help' her parents by remaining dependent and thus sparing them from the pain of losing their last child. The father perked up and at the following session reported that K's symptoms had improved and that they were all feeling more cheerful. Her irresponsible behaviour continued, however. By reframing her behaviour as 'helpful' the basic family ideology of avoidance of anger had not been challenged. K still evoked distant concern and understanding in response to her intolerable demandingness. The secret alliance between the daughter and father against the mother, the centrality of the mother–daughter relationship and her assault on the parental couple (her symptoms had started when the parents went away alone together on holiday) had yet to be tackled. In a subsequent session, therefore, K was told that she now had to help her parents some more: she must do something to them that was so outrageous that her father would have no option but to put his foot down, to punish her, even to involve the law. The family then laughed and revealed that K and her boyfriend had recently used her parents' house while they were away for the weekend, and that they had taken her father's car and smashed it. He had been furious and as a result K had agreed to move out and was now living in a 'squat' on her own. Her mother was very worried about this and felt it was unsuitable and unhygienic. She was encouraged by the therapist to continue to worry about K.

Although this case is atypical in that the counterphobic part of the system consisted of a parental couple it illustrates the point that we are dealing with a phobic-counterphobic *system*, rather than any specific family constellation. The father's anger and his daughter's demandingness were reframed as attempts, in their different ways, to 'care' for each other. This enabled them to stay in touch while they became more separate. The mother, to some extent, was held by the therapist until the father and daughter were able to give up their secret alliance and so make some space for her between them.

The collusive marriage: the Oxbridge graduates

In these collusive marriages each member takes over part of the other's psychological functioning. The wife holds the anxiety while the husband is apparently caring and responsible. One of the mysteries of marital pathology is to identify the difference between this and the normal division of psychological labour that occurs in healthy families. A key issue seems to be that of flexibility. In pathological families the partners seem stuck in their respective roles and much of their interpersonal work has to do with maintaining this system. Thus if one partner departs from the expected position the other may subtly manoeuvre him back so as to maintain the status quo. This means that changes achieved in individual sessions, whether behavioural or psychodynamic, may later be undermined or nullified by the family system. In marital therapy with phobics, the aim is to unlock the projected parts of the self: to uncover the counterphobic's anxieties and difficulties, to help the phobic patient to be in touch with the coping part of herself. It often takes a crisis, either naturally occurring, or therapeutically generated, to achieve this.

In the case of the Oxbridge graduates this happened spontaneously under the stress of an initial psychiatric consultation. They had two children of five and three, the younger of whom was adopted. Her agoraphobic symptoms started soon after she had an abortion. She had been agonised by the decision to have this abortion, but had finally decided on it as she felt she could not really cope with the demands of the children she already had, especially her adopted daughter towards whom she often felt frighteningly aggressive. Both of them were science PhDs and had been hardworking children of striving working-class families. She, as a child, had always felt outshone by her elder sister in attractiveness and liveliness. She had clung first to her mother and then to her books. Her father was remote and suffered from anxiety. The husband was a reliable-seeming, phlegmatic man who had patiently tolerated his wife's anxieties. After taking the history at the first interview the comment was made that it must have been a difficult year for both of them. To the interviewer and the wife's surprise, the husband suddenly started to cry and then to speak of his father's death which had happened earlier in the year. He had not been able to cry about this before, because, he said, he did not want to upset his wife who had enough troubles of her own. He went on to say how sad he felt that education had separated him from his father and that he had only realised this when it was too late. His wife – who had never seen her husband cry before – could then add that she felt alienated from *her* father and together they seemed to have discovered that men can be vulnerable and show their feelings.

In this case the technique seemed simply to involve giving the husband a chance to speak for himself and not always to be speaking for, and feeling responsible towards, his wife. It is not usually as simple as this. In the case of the *steeplejack's wife* it was only when the intrepid husband was given the task of answering the telephone to his interfering mother-in-law that he had to admit he too had fears: he would far rather he had been asked to climb the Post Office Tower than tackle her!

The precipitating change: the divorced train driver

Change implies both gain and loss, even when it involves the 'happy events' which provoked the onset of phobic symptoms in the patients in this series: marriage, having a baby, children getting into university, promotion, planned emigration. In these phobic systems the negative aspect is denied by common consent. The patient is then left feeling guilty about the anxieties and resentment that change evokes in her. Her spouse, on the other hand, his ambivalence safely located in his wife, cannot see what she is making such a fuss about.

Therapeutic work has to be directed towards achieving a shared acceptance

of the anxieties and difficulties aroused by the change. The counterphobic spouse has to be 'taught to worry' by the symptomatic patient.

A West Indian train driver in his thirties, a part-time all-in wrestler, developed hypochondriacal fears centring around his genitals for which he had been extensively investigated. His symptoms, which also included mild agoraphobia, had begun soon after he set up house with a new woman. At first he resisted the idea that he had any worries or problems other than his symptoms. Later he confessed that he had been deeply hurt when his two children who initially had come to live with him and his cohabitee had returned to their mother after a quarrel with their 'stepmother'. When the couple were seen together his cohabitee appeared to be strong and competent. She was also divorced: a nurse who had brought up her three children on her own. She said that this had not been difficult as she had learned to fend for herself after her father had died when she was ten. The therapist challenged her strong façade and directed the patient to discover what she was really feeling underneath. She began to cry and said how much she wished that her 'husband' would protect her and in particular to help her cope with her fifteen-year-old son who was out of control and in trouble with the law. The patient then decided that he would take his 'stepson' to wrestling. At the next session they spoke more openly about their difficulties in living together, their hopes and anxieties about the change. Later they decided to marry and began saving for a flat.

Escalation: the secondary school teachers

In order to de-escalate, the normal balance of symmetry and complementarity has to be re-established (cf. Bateson 1973). At some point in the evolution of the symptom, it was suggested, a shift occurs from 'normal' reassurance which, by negative feedback, has an anxiety-reducing effect, to 'runaway' whereby the more the patient asks for reassurance from her spouse, the more anxious she becomes. To reverse this 'catastrophe' (Woodcock and Davies 1980) two things must change. First, the wife must learn to trust her husband again, and, paradoxically, this can only be achieved by his showing some sign of weakness. This will reassure her that when he does offer her his strength it is real and not counterfeit. Second, her demands for reassurance must be seen by him *as* demands (or better, requests) and not as intolerable attacks, or a swamping insistence on symbiosis.

The secondary school teachers provide a good example. The wife, who was the patient, came from a difficult background in which her father, of whom she was very fond, had died when she was in her early teens, leaving her with a mother and elder sister who were in strong alliance. As she began to be interested in boys she developed fears that she might magically contract VD, but these disappeared when she met her husband at college. He was a

cool, controlled, strong-seeming man in whom she had complete confidence. He came from a Jewish background and had to wrench himself away from an overpowering mother, who appeared to despise her henpecked husband. He prided himself on his independence and scorned middle-class aspirations. After leaving college the couple went to a developing country for a year, during which time they were constantly in each other's company. When they returned to England her symptoms of hypochondriasis and agoraphobia returned. Around this time they got married. A major part of their interaction consisted of her confiding her worries to him and of his trying to reassure her that there was 'nothing' wrong. He found her infuriating but never showed it. However, he took to disappearing for a few hours which would add to her sense of panic. Direct efforts by the therapist to persuade him to reveal anxieties were met with a stonewalling intellectualising scepticism. It was suggested that it might be harder for him to let her look after him than it would be for her to relinquish her fears. At the next session they related how he had got completely drunk at a party and had started crawling round the floor. Neither she nor their friends had ever seen him like this: he had to be put to bed 'like a baby'. Further work involved rationing her to two 'symptom sessions' per day, at which she could be sure that he was genuinely sympathetic and caring. A marked improvement followed and they decided to move back out of London to their home town after she had been offered a promotion there. However, about eighteen months later she made contact again, saying that her fears had returned and asking to be referred for help locally.

The compulsory marriage: the frightened violinist

In many cases described, the symptoms have been of relatively recent onset. Here, cure may be a reasonable goal, as the marital relationship is still pliable enough for considerable change. In long-standing cases the couple's mode of relating may have set hard, with the symptom firmly embedded in the matrix of the marriage. In these cases, more modest aims and prolonged work are necessary, and the therapist must be prepared to remain – to some extent – part of the system (cf. Chapter 5). Only thus can the fire of the wife's anxiety be drawn, the therapist-husband be freed from his enmeshed detachment. The couple fear that without symptoms their marriage will fall apart, and excessive therapeutic zeal will be met with an equal-and-opposite resistance or breaking off. The aim is to make the marriage feel more voluntary by encouraging shared enjoyment and pleasure on the one hand, and the open expression of hostility and irritation on the other. The therapist must be prepared to contain the anxiety that will be aroused by this change. Another danger is that the compliant husband may start to try and please the therapist in the same way that he has acceded to his wife's demands.

The frightened violinist had been an outpatient for many years following a manic episode in her early thirties. She was always accompanied by her husband, a research chemist. Just as her two children were leaving home to go to college, she began to develop moderately severe agoraphobia symptoms. Her husband had 'rescued' her in her teens from an overbearing, ambitious father who was determined that his daughter should become a famous musician. Her husband was everything that her father was not: calm, quiet, understanding. He coped with his wife's worries by adopting a professional role, treating her like a patient, never getting angry and offering himself as a kind of resident nurse-co-therapist to her outpatient psychiatrist. On one occasion there was a long discussion about whether it was a 'good thing' for him to do all the shopping for her. With prompting from the therapist, the husband reluctantly admitted that often this was the 'last thing' he felt like doing when he got back from work. He then tried to manoeuvre the therapist into giving him a *dictat* (rather as his father-in-law would have done) either not to do the shopping because it was bad for his patient-wife, or to go on doing it because it was 'good' for her. Instead they were given the rather obvious, but to them intensely puzzling, instruction that she was to ask him to do the shopping, and he was to refuse, but *only* if he really didn't feel like doing it.

DISCUSSION

I will give two general conclusions from the cases I have described. First, in some cases of agoraphobia and other phobic syndromes the spouse – or a significant other such as parent, boyfriend or doctor – may play a key role in the maintenance of the symptoms, thus contributing to a *phobic-counter-phobic system*. Second, successful treatment can result from trying to alter this system, rather than by concentrating on the symptomatic individual alone.

This takes us into the difficult area of aetiology. Family theories of mental illness are numerous but have tended to founder on the question of specificity. If a specific family constellation is to be accepted as an aetiological agent for a particular illness – in this case phobic syndromes – then a number of negative conditions must be fulfilled. If, for example, families can be found with the illness but without the constellation, or conversely there are families with the constellation but without the illness, then the constellation can be neither a necessary nor a sufficient cause for the condition. Thus have Hirsch and Leff (1975) cast doubt on family theories of schizophrenia. Recently Minuchin has claimed that there is a specific pattern of enmeshment in families of children with psychosomatic disorders such as anorexia nervosa (Minuchin *et al.* 1978). However, this pattern can be found in many families without a psychosomatically ill member, and has been shown not to be present in about half of a group of psychosomatic families (Loader *et al.* 1980).

Perhaps, as discussed in the previous chapter, proponents of family factors in adult mental illness should settle for more of a modest role therefore, viewing families as stressors and perpetuators of pathology rather than as aetiological agents as such. Hoffman's (1971) use of the concept of deviance amplification is a good example of such an approach, and is the one followed in this account of the development of phobic symptoms. The role of the family therapist would then be one of deviance reduction, aiming to uncouple the ill member and the homeostatic system so that both can change, either spontaneously or with further outside help.

CONCLUSION

The model of agoraphobia put forward here is a developmental one, based on a series of sequential stages. At each of these there is a choice of pathways which – depending on environmental conditions – will lead the individual closer to, or further from, becoming ill. I have focused particularly on the patient-to-be's spouse who, by denial of his own anxieties, may augment his wife's fears and so push her on towards illness. The illness is not *caused* by the husband's personality, but without it the outcome might have been different – marital breakdown or a chance for the wife spontaneously to overcome her difficulties. The marriage-plus-illness becomes the compromise by which the couple manage to control fears that have dogged them since childhood. Each is trying to escape – but to do so each needs the other. Therein is the paradox of the marriage. By being together they run the risk of evoking those old feelings of anger and demandingness that were so terrifying; but only by being together can those feelings be avoided. Therein too lies the promise of change. Each sees in the other their own mirror-image, also vainly struggling to escape from its shadow. If she can accept her husband's weakness, his denied anxieties – and if he is brave enough to reveal them – she may come to realise that she too has a hidden aspect, a strong side, and with it can start to overcome her fears.

Part III

Literature and psychotherapy