THE TREATMENT OF A WIND-PHOBIC WOMAN IN WELLINGTON

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Psychology has its fads and fashions, none of which is more pronounced than the current espousal of behaviour modification as the treatment of choice for phobic patients and others who 'emit maladaptive behaviour'. However, a single case is presented here of a severely debilitating phobia to suggest that techniques of electic psychotherapy might still be retained to advantage, with some patients.

The subject, an articulate and intelligent mother of five children, only one of whom was not yet at primary school, was referred by her general practitioner for psychiatric treatment. She had a wind-phobia of four years' standing that was a rare clinical occurrence even for the city of Wellington in which the wind rages. (For example, according to the Meterological Office, there were 324 days in the year preceding 16.11.73 on which the wind speed was at times greater than 25 knots, 188 on which it was greater than 34 knots, and 42 days on which it was greater than 52 knots.) Her symptoms began on the 10th April, 1968 during the tragic storm in which the inter-island ferry went aground and sank with the loss of 51 lives as the ship entered Wellington Harbour. At that time the wind reached 116 knots, the highest ever recorded in Wellington. She became afraid to go outdoors without her husband and she relied upon her neighbours to do her shopping. Her daily round consisted of rushing rapidly through her housework in the mornings before sitting to watch her curtains flutter for signs of impending wind. She listened attentively to the regular weather forecasts on the radio, and telephoned the weather office frequently in between forecasts for up-to-the-minute information. She cooked the evening meal for her family each night and cleared away the dishes in good time to watch the 7.15 weather programme on the television. Her family referred to the various weather forecasts as "Mummy's programmes." Her husband, a calm, long-suffering man, bore more than his share of household chores. He took over the family at 7.30 each night, when his wife retired to bed, and was the mainstay at weekends.

The woman complained of 'knots' in her stomach, heart palpitations and shortage of breath, and she was terified lest some impending disaster befall her. She realised that she was neglecting her family, was quarrelling too frequenty with her husband and was losing her self

control. Her family doctor supported her with various doses of Valium, Insidon, Surmontil, Mogadon, Serenace, and Stelazine, but finally referred her to the Public Hospital because "she has become much worse . . . is acutely tensed up all the time . . . is nauseaus, clammy, frightened . . . and depressed . . . even to hear that the wind is forecast will precipitate a panic attack."

She was seen at the hospital by a psychiatric registrar, and after three long sessions was referred to a visiting clinical psychologist for psychotherapy. Her drugs were modified to Nardil 15 mgs. t.d.s. and Valium 5 mg t.d.s., and her response to drugs was moderated at monthly appointments with the registrar.

Treatment plan

It was tempting to suggest that the patient might uproot herself and her family, and move to a less turbulent climate, but that option was impracticable because of the difficulty her husband would have had in re-establishing himself in business elsewhere. It was also conceivable that had she shifted she might simply have transferred her problems to other phobic stimuli.

Instead, the woman was to give her full case history over several sessions, omitting no details of the phobic stimuli and her responses, nor the salient features of her childhood, adolescence and adulthood.

The aim was to build her self confidence, promote her family and social activities, and minimise her phobic anxiety.

Method

The patient was encouraged to talk as much about herself and her situation as would enable her to maintain her composure. Gradually through techniques of persuasion and free association she was brought back to face topics and incidents about which she was defensive. It was emphasised that she alone had the power to solve her problems and that the therapist would do little more than guide her in such matters that she brought up as were seen by him to be of particular significance. She was invited also to write down her reflections in between sessions, and to try to recall her dreams.

The length of each session was fixed at thirty minutes, and the frequency of sessions depended upon the progress that the patient seemed to be making. She was given two sessions in the first week in order to establish rapport with the therapist and to allay her anxiety about the ambiguous treatment methods he intended to adopt. Then she was seen once a week for four weeks, and thereafter fortnightly for one month, before the gap between sessions was increased to three weeks and five weeks. Early on, the patient was told that she could ask for extra sessions were she to require them, and at the tenth session she was given complete responsibility for telephoning for the next appointment.

She did so ten weeks later, and then had a final session some seven weeks after that, making a total of twelve sessions of psychotherapy overall.

The Process

The patient was as slow to accept psychotherapy as might be expected of anyone with a chronic and intractable phobic condition. She had also to overcome the resistance that she shared with her father (and many people at large) about the value of psychotherapy in treating dysfunctional behaviour. It transpired that her father was a retired military man who paid little regard to the subjective aspects of human behaviour and was inclined to treat his family as a platoon of soldiers. Her own faith was firmly rooted in drug therapy, despite her knowledge that it had been of little help to her over the preceding four years. She was perplexed about the therapist's role, and could not conceive that she herself would do most of the work in the sessions, much less could she believe that she would assume responsibility for her own recovery.

At first she focussed exclusively upon her present symptoms and the stressful situation that precipitated her referral to hospital. She had also not recovered from an earlier period of intense community activity in which she held office simultaneously in five different organisations. She offered to arrange the traditional family feast for all the relatives at Christmas, became overwhelmed by the enormity of the task, and succumbed to bed when a gale blew on the eve of festivities.

Gradually, she unravelled her life history to give a developmental account of herself. She had always been a tense child who, as the eldest of four and the only girl, had to work hard to justify her place in her family. She was close to her father, but resented him bitterly when he came home on leave from the Army but left her to look after her brothers while he took her mother out. As a child she was afraid of the dark, and as an adult she retained a fear of lifts from having once been shut in a cupboard by her brothers. She still had vivid memories of incendiary bombs falling in her garden during an air raid.

She did well at school, and established herself afterwards as a competent secretary before coming to New Zealand with her parents. She fell in love with a fellow employee at work and changed her religion from Anglican to Catholic only to be jilted by the young man a few months later. She became acutely depressed, but recovered and decided to retain her Catholicism. Shortly afterwards she met and married her husband through their joint interest in the church choir. They had four children in quick succession, and then after a gap of four years had another. She was fond of her husband and her children, but resented a jibe from her parents about "breeding like rabbits".

She remained a dutiful daughter to her parents, attending to their needs in a way that is typical of a 'closed' family. Never did she protest

to them about the demands they were making upon her, nor did she think it unusual for her father to withdraw to bed with exhaustion every weekend.

She tried to retain her several roles intact without attempting to integrate them or to modify them. She compartmentalised her extended family, her own family, and her secretarial work and strove for perfection in each. She did not focus upon herself, and her own needs other than that of being acceptable to others. In the event she developed no independent identity, and in her insecurity she drove herself to the point of exhaustion. She was vulnerable and at a low ebb when the calamitous Wahine storm occurred. Thereafter she performed none of her roles satisfactorily, became virtually house-bound, and developed her symptoms.

The Outcome

The patient regained her self control, overcame her phobia, reappraised her situation, established herself as a person and ordered her life afresh. By the second session she had quarrelled with her parents for the first time in her life about the demands they were making on her. By the fourth she had felt well enough to receive visitors in the evening at home and she was no longer in need of Valium. By the fifth she reported having enjoyed a weekend excursion outdoors with her husband and children, and said that she looked forward to the therapy sessions. By the sixth she felt much better and more able to cope with life, and she asked for another appointment in two weeks rather than one. At the next appointment she seemed more relaxed, and said that she was able to go to bed when tired rather than when she was desperately afraid. Also she had begun to pay rather less attention to the daily weather forecasts. At the eighth session a fortnight later she reported having maintained her progress. She awoke 'chirpy' in the mornings, looked forward to her daily activities and was gaining weight. She had organised a family dinner party to celebrate her mother's birthday, and had taken herself out in the family car. She felt that she had changed completely in two months, and she no longer shook with fear and fright, nor was she so compulsive about her housework. She was slightly apprehensive about a reversal, but was developing a sense of humour about her previous condition.

At the ninth session three weeks later she was much improved again. She had survived a Force 8 gale without distress, and had responded with equanimity to the cuts, bruises and noises of her children over their school holidays, and had resumed singing lessons. She had also been much encouraged by the spontaneous comments of her neighbours about the improvement in her condition. She had three further sessions over a period of five months before she was discharged.

She agreed to be presented to a postgraduate seminar for medical practitioners, and impressed them with her insight, humour, competence

and improvement. The latter was substantiated by her general practitioner who happened to be in attendance at the seminar. His reaction was to ask about the techniques that were used so that he might try to apply them in appropriate cases in his practice. He was told that the method required two people who could arrange the time to build a relationship in which one could verbalise various conflicts under the benign guidance of the other. In the present case, the positive outcome was as much attributed to the patient's intelligence and motivation and to her supportive husband as to the effect of the therapist.

Discussion

The wind-phobic woman may well have responded to other methods of therapy, but the fact remains that after twelve sessions over a period of eight months, she was reported by independent observers to have overcome her debilitating problem. It could be argued that the therapist used a behaviourist paradigm to elicit anxiety provoking situations, and that he encouraged the systematic desensitisation of each situation in turn until finally the major phobia was confronted. However, the explanation would be stretching the events too far to fit the behaviourist theory, especially since the practice incorporated no concise juxtaposition of reward and punishment that would satisfy the tenets of learning theory. Rather, given self confidence, and an attentive ear, an intelligent highy motivated woman was able to examine her pattern of obligations before making such readjustments as were necessary for her to live in happiness instead of conflict. In the process the wind lost its emotional significance, and she her wind-phobia.