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Apotrepic Therapy: A Follow-up Study

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Abstract

This paper gives a precise review about development and application of apotrepic therapy in cases of obsessive-compulsive neuroses.

A chronic case of obsessive-compulsive disorder treated with apotrepic therapy is presented with behavioural analysis and a follow-up of seven years.

It was found that some of the chronic obsessive-compulsive states respond favourably to a group of techniques than to an unimodal approach. Self-control for preventing relapse can be established.

Key words -

Apotrepic,
Obsessive-compulsive,
Modelling,
Implosion,
Response prevention,
Behavioural analysis

Obsessive-compulsive disorders of recent onset are instrumental avoidance responses elicited by conditioned autonomic drive (CAD), i.e., anxiety, but when it becomes chronic, such instrumental avoidance responses become 'functionally autonomous' and do not show any link with the previous 'CAD' [1]. Therapeutic programming in such conditions is often aimed at reduction of CAD through desensitization [2] or practical retraining [3]. Cognitive aspect could not be properly handled when the client remained independent of the therapeutic environment . Meyer and Chesser [4] have found that reciprocal inhibition could help phobic states, but failed to reduce compulsive phenomena because of its anxiety reducing component, existing in the intermittent recurrence of the ritualistic actions. On the other hand the patient's concern or anxiety over abstaining from the ritual further enhanced anxiety and interfered with the treatment progress.

These multifactorial issues often defeat the purpose in a therapeutic programme using unimodal procedure . Any unimodal approach has often been inadequate in providing control over the multipronged aetiological factors and helping in generalization of therapeutic effect to the natural environment. In most of the cases interventions are to be made at both cognitive and behavioural levels, which demand a more multifaceted therapeutic programme. Meyer [5] developed an approach for modification of 'expectancies' of the patients which was successfully used with obsessive-compulsive disorders. Subsequently Meyer et al [6] formulated a multimodal approach and called it 'apotrepic therapy' which means to 'turn away, deter, and disuade'. They found it to be more effective mainly because it was based on cognitive mediation of the conditioning; this had an effect not only in the therapeutic environment but also on intervals in between sessions of therapies which, according to the findings of Foa [7], usually have a negative influence in deteriorating the therapeutic gains.

Apotrepic therapy package consists of the following:

i) Therapist-patient relationship
ii) Alteration in the 'family dynamics'
iii)' Modelling' or imitation learning
iv) 'Implosion' or 'flooding' [9]
v) 'Response prevention', and
vi) 'Guidance' [6].

The rationale of the package

Precisely there cannot be a single explanation for this therapeutic package; therapeutic processes complementary to each other have been put together. In the first and second stages effect is due to 'social reinforcement' . In the third stage vicarious reinforcement is the basis. Fourth and fifth stages are effective due to 'habituation' . A 'discriminative cue controlled' response is established at the sixth stage, i.e., 'physical guidance' .

The following case-study highlights such a programming in a chronic obsessive-compulsive disorder of psychotic proportion.

Anamnesis

A 42 year-old married man without any children, working as a school teacher, presented with a twenty-two year history of obsessional thought and compulsive rituals during 1980.

Most of his thoughts pertained to a single obsession, i.e., sexual assaults on mother and sister and sexual indulgence of mother, sister and relatives with others. He used to perceive acts like spitting and aggressive gestures or actions of others as directed at his relatives. He had multiple compulsions (more than sixteen in number) which are described in the following paragraphs.

He used to walk, run, touch, and gesticulate repeatedly in a restless manner almost throughout his waking hours. He enjoyed washing for a long time in the bath room.

He often requested people to repeat gestures, actions and movements for certain number of times, so that his bad thoughts would vanish. Even in railway stations he used to request the strangers to do it, and offered them money when they refused or showed reluctance. In school he asked and forced small children to repeat words, actions and gestures in his class.

He had the habit of reading and writing sentences backwards, and words letter by letter from the reverse direction. Repeated corrections while writing, used to stop his progress in writing anything.

Often while talking he would repeatedly ask and confirm from the individuals, whether he has told something or not.

He used to touch people (strangers) repeatedly and would run from a distance and catch hold of them tightly. Often tussles used to continue till he was injured or practically thrown off by them.

All the maladaptive response patterns were of psychotic proportion, as he used to act on his thoughts. This diagnosis was arrived by the psychiatrists and psychologists in a conference unanimously.

Psychometric tests also revealed underlying psychosis.

Behavioural analysis

As it is transpired from the history and clinical interview:

1 .He was exposed to a sick model in the family during childhood, i.e., observed his uncle who suffered from obsessive-compulsive neurosis.
2. His father expired at a young age and the mother married for the second time. He was brought up with his step siblings which he did not like.
3. It was found that all these thoughts started from the age of fifteen years when he initiated the habit of masturbation; subsequently it became more due to his love affair with a woman who was of bad character. This added to his shame and guilt. Such thoughts got associated with compulsions and evidently interfered with his normal functioning, when he was 20 and he sought psychiatric help.

These events acted as the antecedent factors which caused the individual vulnerable to develop anxiety and depression (as expressed by the client). Depression was secondary to the development of the obsessive-compulsive phenomena. He had disturbed sleep and appetite.

Subsequently his dissatisfaction in the job situation (he never wanted to become a teacher), marriage against his will to a girl much taller than him, and not having any children, increased his anxiety and compulsions.

Further extreme sympathetic attitude from the family and occupational environments strengthened the maladaptive behaviour pattern in the individual. The intensity, duration, and frequency of all these were continuous, like chain of actions occurring in a feverish, restless fashion throughout his waking hours.

He had had drug treatment from psychiatrists at different places throughout the course of illness over the period of twentytwo years. During the present course of treatment he was on various antidepressant and anxiolytic drugs and there was no change in his symptoms for which he was referred for behaviour therapy.

Behavioural formulation

It is a vicariously acquired maladaptive response pattern, with a cognitive cue-control, mediated by anxiety and reinforced through drive reduction and social stimuli.

Therapeutic programme

Taking the factors delineated above into consideration the first phase of the programme consisted of:

l. Response prevention in which the client was not allowed to adopt his compulsive rituals.
2. Alternation in the 'family dynamics'. The 'significant others' in the family were explained how their sympathy and attention were reinforcing his symptoms and they were also given guidance to adopt differential reinforcement. One responsible member of the family was kept in the ward to practice

this and attend to the response prevention programme.

3. Modelling and social reinforcement: This was adopted in connection with his writing and teaching behaviour by the help of other patients and therapists.
4. Implosion or flooding: This was adopted to expose him to bigger gatherings and class room situations (simulated in a group).
5. Guidance: In this procedure the client was practically made to sit in a particular fashion, walk and write in a particular fashion by the therapists. Physical guidance with the movements, speed, accuracy, and exposure to situations were conducted.
6. Therapist-patient relationship: This procedure was used for instilling confidence, reinforcing him socially, as well as reprimanding him on his deviation from therapeutic goals.

Besides the above package in the second phase of the programme the following techniques were adopted:

1. Jacobson's progressive relaxation was adopted for reduction of anxiety.
2. Modified thought-stopping was adopted to reduce the frequency of thought process, and
3. Self-monitoring chart was added towards the latter half of the treatment for a feedback to the patient about his improvement .

Throughout the behavioural programme the patient was put on antidepressant drugs.

Assessment

Ratings were obtained using Aitken's [11] visual analogue scales for

(1) rituals,
(2) anxiety,
(3) depression,
(4) work adjustment,
(5) social adjustment,
(6) sexual adjustment, and
(7) leisure time activities.

These scales consisted of 100 mm lines, on one extreme indicating maximum degree of incapacity and on the other total normal capability. Rating was done by different observers and significant others. On the average the 100 mm lines came down to a range of 5-10 mm. To check the bias in clinical assessment of improvement, different therapists (psychiatrists and clinical psychologists of the team) were used.

Discussion

The restlessness of the patient did not allow the therapist to start relaxation procedure at the outset of the programme, which is often feasible in other cases. As such the therapeutic programme took the following shape:

1 .Response prevention and guidance - 20 sessions,

2. lmplosion, modelling, alteration in family dynamics and other social adjustment -25 sessions

3. Jacobson's progressive relaxation -30 sessions
4. Modified thought stopping procedure -20 sessions
5. Self-monitoring, modelling, and social reinforcement in group situations - 29 sessions.

The total number of sessions were 124, stretched over a period of six months. At the time of discharge the patient was fully manageable and could resume normal social and vocational habits. His hyperactivity like running, touching, holding, washing, writing and reading in a reversed fashion were completely extincted. Obsessional thought was not there. He was able to carry on conversation without asking repeatedly to confirm, whether he had told some facts or not. He could take classes on his topics taught by him in the school (which was simulated in the clinic) .

Only he was quite neat, clean, particular about his habits as seen in an obsessoid personality. At times he was anxious and doubtful about the maintenance of his improvements.

He was advised to take relaxation and maintenance dosage of anxiolytic (Hypnotex, 10 mg at bed time) prescribed by the psychiatrist at the time of his discharge from the hospital to keep his anxiety controlled in the natural environment, as he was supposed to resume his job and interact with others in the community. It is difficult to discriminate how much was the effect of drug in the improvement process. However it is obvious that Behaviour Therapy contributed significantly to the improvement, along with the drugs, when alone chemotherapy of 22 years duration could not bring any change in the patient's condition.

Training of the spouse, servant, and a responsible family member in adopting differential reinforcement and supervising response prevention in a special ward setup was quite successful.

The presence of obsessional premorbid personality and severity of the manifestation was quite challenging in this case. But the phasing of the therapeutic programme could handle the improvement in establishing extinction through habituation (response prevention), anxiety reduction (relaxation), and discrimination learning through vicarious reinforcement (modelling and guidance). Further, social environment could be shaped to socially reinforce adaptive behaviour patterns. At the cognitive level cue-control though thought stopping technique could be established. Self-monitoring reinforced the shaping of adaptive behaviour pattern.

It was found that the therapeutic effect could generalize to the natural environment because of the classroom modelling situations adopted during the therapy.

It was further observed that in the initial two phases, the treatment progress was slow, but after the client started to relax well (although it took a long time i.e., 18 sessions for him to learn because of the intrusive cognitions) there was remarkable improvement in his adjustment process. He was quite optimistic and his motivational level was boosted up for further therapeutic gains.

Intermittent follow-up of seven years have shown the maintenance of the modified behaviour pattern. He resumed his active duties in his school. Took interest in his sex life and went for medical check-ups and treatment for having a child. On the last follow-up (during April, 1987) he informed that six months back his wife, who had had no issues conceived and prematurely delivered a pair of twins (male and female). These babies expired after living for three weeks. This has proved to be a shock to him and his family. He is in a state of anxiety, but is adopting relaxation and thought stopping technique, whenever it is required, to strengthen his self-control over his psychological disturbance. However he has adopted a male child of his relation which he was not able to do earlier.

This shows that obsessive compulsives can be taught self-control procedures, which may act as

secondary prophylactic methods.

In this case study, it is further evident that incidents causing stress, always trigger a chance of relapse, even after seven years of symptom-free state.

Findings of this clinical trial of apotrepic therapy have been quite encouraging and are similar to those of Walton and Mather [1] in the behavioural treatment of acute and chronic phases of obsessive and compulsive disorders. This study supports the view of Rachman [10] that failures in the area are due to nonavailability of procedures to handle the multipronged aetiological factors. Apotrepic therapy is multimodal in nature and embraces broader aspects of pathology [6].

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