

BRIEF STRATEGIC THERAPY IN PANIC DISORDER TREATMENT

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SUMMARY

Panic Disorder is often associated with low quality of life. Brief Strategic Therapy aims to reduce PD symptoms in the first sessions giving patient the ability to improve his life as soon as possible. For its brevity and cost-effectiveness, it might be suggested as a first-choice treatment for PD.

Key words: *Panic Disorder - Panic Attacks - Brief Psychotherapy - Brief Strategic Therapy*

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INTRODUCTION

Panic Disorder (PD) is a very disabling psychopathology with an estimated lifetime prevalence of 12.8% worldwide (Jonge et al 2016). Patients with PD face subjective feelings of poor physical and emotional health, alcohol and other drugs abuse, increased likelihood of suicide attempts, impaired social and marital functioning, financial dependency, an increased use of psychoactive medications, higher frequency of health care utilization and increased hospitalization for emotional problems (Markowitz et al. 1989). Brief Strategic Therapy (BST) claims high efficiency and efficacy in treating PD. This review will present BST as a treatment option in PD patients.

SUBJECTS AND METHODS

The aim is to highlight the specificities of BST that make it particularly suitable for the treatment of PD, especially in its most resistant forms. A bibliographic research and an analysis of a clinical case have been carried out.

DISCUSSION

Panic Attacks and Panic Disorder

First of all, it is important to define Panic Attacks (PA) and Panic Disorder (PD). In DSM-IV (American Psychiatric Association, 2000), criteria for PA consisted of a discrete period of intense fear or discomfort, in which four (or more) of the following symptoms develop abruptly and reach a peak within 10 min: (1) palpitations, pounding heart, or accelerated heart rate, (2) sweating, (3) trembling or shaking, (4) sensations of shortness of breath or smothering, (5) feeling of choking, (6) chest pain or discomfort, (7) nausea or abdominal distress, (8) feeling dizzy, unsteady, lightheaded, or faint, (9) derealization (feelings of unreality) or depersonalization (being detached from oneself), (10) fear of losing control or going crazy, (11) fear of dying, (12) paresthesias (numbness or tingling sensations), (13) chills or hot flushes.

In DSM-IV, diagnostic criteria for PD include recurrent, unexpected PAs, with at least one of the attacks has been followed by 1 month (or more) of one (or more) of the following: (1) persistent concern about having additional attacks, (2) worry about the implications of the attack or its consequences (e.g., losing control, having a heart attack, “going crazy”), (3) a significant change in behavior related to the attacks. Finally, it is checked that PAs are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism), and whether PAs are not better explained by another mental disorder, such as social phobia (e.g., occurring on exposure to feared social situations), specific phobia (e.g., on exposure to a specific phobic situation), obsessive-compulsive disorder (e.g., on exposure to dirt in someone with an obsession about contamination), posttraumatic stress disorder (e.g., in response to stimuli associated with a severe stressor), or separation anxiety disorder (e.g., in response to being away from home or close relatives) (Jonge et al 2016) these definitions are consistent between DSM-IV and DSM 5. So, it is possible to experience PAs without suffering from PD or to suffer from PD without so many PAs thanks to avoidance behavior (Nardone 2016).

Epidemiology

Jonge et al. in 2016 analyzed data from 27 different countries to verify the cross-national epidemiology of PAs and PD following DSM 5 criteria. Their findings were:

“Lifetime prevalence of PAs was 13.2% [...]. Among persons that ever had a PA, the majority had recurrent PAs [...], while only 12.8% fulfilled DSM-5 criteria for PD. Recurrent PAs were associated with a subsequent onset of a variety of mental disorders [...] and their course [...] whereas single PAs were not [...]. Cross-national lifetime prevalence estimates were 1.7% [...] for PD with a median age of onset of 32 [...]. Some 80.4% of persons with lifetime PD had a lifetime comorbid mental disorder.”

Moreover, PD seems to be associated to pervasive social and health consequences that are similar or even major than those associated with major depression (Markowitz et al 1989).

Therapy

Cognitive Behavioral Therapy (CBT) is one of the elective therapeutic approaches for PD. Brief Strategic Therapy (BST) has been compared in few randomized controlled trials to CBT and showed a similar outcome, with a decrease in the therapy length (Barcons et al. 2016). Shorter therapy means less cost both for the public health system and for patients in private practice. Often PD is associated with work impairment and financial dependency, thus the therapy cost is a very important factor in choosing a therapeutic approach. Research held from Centro di Terapia Strategica in Arezzo showed a success rate of 86% in treatment of PD in an average of 7 sessions (Nardone 2016).

The Brief Strategic Therapy of Panic Disorders starts from recognizing the need for patient compliance – therefore, has as its first aim the elimination or at least the reduction of the patient's resistance. This is why paradoxical injunctions, therapeutic double binds, fallacy of the false alternative and symptom prescriptions are used.

The model of Brief Strategic Therapy is based on the assumption that, in order to know a problem, you need to be able to change it, and only afterwards, through its solution, you will be able to know how it works. According to the intervention-research model of Kurt Lewin: "If you want to know how a system works, try to change its functioning" (Lewin 1972). BST is based on the theory of change (Nardone & Watzlawick 1990) in which the adjective "brief" does not refer to the fact that it is the abbreviated version of an otherwise long process, but to its intrinsic characteristic (Weakland et al. 1974). A basic principle of BST is the "Attempted Solution": if a problem persists, it is because of the failed efforts that the patient, the people around them (or both) made to solve it. Likewise, if the person (or persons) involved stop applying Attempted Solutions, the problems disappear, regardless of their nature, origin or duration (Weakland et al. 1974).

Attempted Solutions in Panic Disorder

As stated before, BST studies the Attempted Solutions (AS) given to a specific problem that, instead of solving it, make it worse.

In Panic Disorder, AS are:

Socializing the problem

Those who suffer from PD in some cases tend to talk a lot about their problem. This way of doing, from a constructivist point of view, keeps the problem alive.

Requesting help to people around them

PD patients usually, due the fear of PAs, ask for help from people close to them. This kind of help received time to time, makes the patients feel unable to complete daily tasks, making their fear of experiencing PAs even bigger.

Trying to control one's physical reactions

When a PA is rising, the patients tend to try controlling their own reactions. This usually has the paradoxical effect of making symptoms getting worse.

Avoidance behavior

Whenever it is not possible to ask for help from anybody, patients with PD usually avoid some behaviors considered 'dangerous', i.e. behaviors that could trigger a PA.

Brief Strategic Therapy techniques for Panic Disorder

BST coded different techniques to overcome PD, but greater importance is given to the process than to maneuvers themselves. This kind of therapy is, in fact, similar to a chess game: every move is followed by an answer, and the therapy goes ahead based on the answers we get, in a cybernetic process.

Each AS has its own therapeutic answer in the shape of 'homework', meant to make the AS collapse over itself.

Conspiracy of silence

Conspiracy of silence is the answer to the patients' tendency of socializing the problem. In recent years, socializing is not only made through in-person interactions, but often through forums and social networks. In any case, it is necessary to stop any communication involving the problem. The patients will be asked to talk about their problems with their therapist only.

Fear of help

Fear of help is the answer to the request for help. During the first session, the patients are persuaded that asking for help is something that will make them feel unable to perform even smaller tasks. Then it is suggested, in a therapeutic double bind, that although we cannot ask the patients to refrain from asking for help (because they might not be able to do this just yet), by doing so the problem will become bigger. In fact, the idea that is prompted is: "I will not forbid you to ask for help, but every time you do it, you will get worse."

Board Diary

Board Diary is the answer to the patients' attempts of controlling their reactions. It is required from the patients to keep note of their PAs in the exact moment they are starting, and not a second later. The board diary has 8 fields to be filled out: date, time, situation, location, present people, thoughts, symptoms, reactions. It makes it impossible to the patients to try controlling any symptom, because they are 'distracted' from all the things they have to write down.

Worst Fantasy

Worst Fantasy it is the answer to the avoidance behavior. It is a particular version of 'symptom prescription'. It is asked to the patients to spend 30 minutes every day in a room, trying to think to their worst fears, suggesting them that, in such a way, they should induce themselves, on purpose, a PA. The usual effect of this prescription is paradoxical: the patients feel relaxed, sometimes they fall asleep. In some cases, the effect is contradictory: the patients are able to evoke their fears, but just after the exercise they feel relaxed. In both cases, we can use this effect to overcome the fear when it shows up in real life. Indeed, after some weeks of daily training, the patients will be able to evoke their fears just when they feel that a PA is being triggered. Thanks to the aforementioned paradoxical effect, the PA will suddenly fade away.

Clinical case

A man in his 50s comes to my office because he is living a very unsatisfying life due to his fears. The patient talks about his long-dated PD, started when he was 20 and preventing him from keeping any job because, whenever he was feeling PAs coming, he needed to go open air - literally quitting his workplace. He is living from money from his old parents and decided to seek for help because after quitting so many jobs, now he has got the chance of his life: he has been hired from a municipal administration in a town that is one hour by train from his home. Nonetheless, he feels he cannot face his PAs if he can't get out of the train. Despite this, he is commuting for 2 hours every day with vigorous PAs. This patient in particular, uses the attempted solutions of talking about his problem and trying to keep his symptoms under control. That's why, after the first session, he was assigned the Board Diary and the Conspiracy of Silence.

All the following sessions will be held at 2-weeks interval.

During *the second session*, the patient reports that despite the fact that he has been traveling by train daily, he had some stressful moments, but as he started writing on his Board Diary his anxiety faded away. At this point, it was possible to explain the patient that this task is already a therapeutic assignment and he was invited to continue with the same maneuver. After the patient notices the first improvements, he is prescribed the Worst Fantasy technique.

During *the third session*, the patient reports that his PAs have disappeared. Even though he brought with him his Board Diary during his travelling, he didn't use it at all. The patient also reports not having followed the WF technique, fearing it could have worsened his situation. For this reason, he is re-assigned the same exercise for the next 2 weeks.

During *the fourth session*, the patient reports not having experienced any PA. During the 30 minutes of

WF, the patient reported that he got extremely relaxed and the negative fantasies faded away. He is then reassured that he experienced the paradoxical effect of the WF technique and he is prescribed to change the duration and frequency of the WF exercise: instead of 30 minutes per day, he is instructed to do the exercise 5 minutes per 5 times a day at fixed times, and without isolation. This is used to train the patient to learn how to use the WF technique whenever PAs will possibly be rising.

During the fifth session, the patient again reports no PAs and, as expected, during the 5 minutes of WF, he had not been able to recall negative thoughts. At this stage, he was asked to make a list of all the situations he avoids due to his PD, sorted from the most dangerous to the less one, and to try approaching these situations using the 5 minutes of WF before that.

During the sixth session, the patient still reports zero PAs and a feeling of well-being also during the worktime. He didn't follow the prescription to counter-avoid all the things in his list so, during the session, it is asked him to rank the avoided situations and, again, to start facing them.

During the seventh session, patient reports a satisfying event: he has been able to drive in a traffic jam and parked in an underground parking lot, there he applied the WF technique and felt no discomfort at all. He described this happening as a 'miracle'.

Since then, the sessions were aimed to counter-avoid stressful situations. On session 9, we concluded our intervention and started with follow-up sessions. Results are confirmed at 3, 6 and 12 months after the last session.

The patient completely solved his PD in 9 sessions, despite he skipped homework twice, and he was totally free from PAs after just 1 session, he could keep his job and he daily commutes for 2 hours without fearing that PAs could come back.

CONCLUSIONS

Brief Strategic Therapy starts from the need to minimize resistance to the therapy, and seems very effective in providing important improvements in the quality of life since the very first sessions in patients with Panic Disorder.

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