

Integration of Brief Strategic Family Therapy and EMDR in Treatment of Panic Disorder

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Panic disorder patients suffer from sudden and repeated attacks of fear of disaster or of losing control at any time even though there is no real danger (American Psychiatric Association & American Psychiatric Association, 2000). They may have number of strong physical symptoms such as sweating, breathing problems, dizziness, feeling hot or a cold chill, tingly or numb hand, chest pain and feel as if they had a heart attack (Craske et al., 2010). The patients dread the possibility of having another attack. Most of them organize their life and daily routine regarding this possibility (NIH, 2013). They may avoid going to school or work; socializing; using public transportation or driving. Therefore treatment of panic disorder is essential for the patients to maintain their lives without panic attacks. An integrative approach composed of Eye Movement Desensitization and Reprocessing (EMDR) and Brief Strategic Family Therapy used in the treatment of panic disorder will be examined in this article. Both Strategic Family Therapy and EMDR will be introduced with their main ideas and the integration of these approaches will be explained. And also a case diagnosed with panic disorder will be presented.

Strategic Family Therapy

The Strategic Family Therapy was developed in 1960s and 1970s at the Mental Research Institute (MRI) in Palo Alto. Jay Haley worked at MRI and also worked with Milton Erickson, Maurizio Andolfi and Salvador Minuchin. Naturally, the concept of Strategic Family Therapy was inspired by the Structural Therapy, and the Ericksonian/MRI, also known as Palo Alto Group, of problem formation and resolution (Rambo, West, Schooley, & Bold, 2012, pp. 89-94). In our case we excluded concepts and interventions like hierarchy, boundary and subsystems which belong to Structural Therapy. In this understanding, “symptom” is defined as the repetitive actions that sustain the

process. The therapist is not interested in how the problems began or whether the patient has insight. He just focuses on the problem and works to solve it in the short-term. Haley reports that “Strategic Therapy is any type of therapy where the therapist initiates what happens during the therapy and designs a particular approach for each problem (Haley, n.d). He also states that “Strategic Therapy is not a particular approach or theory, but a name for the types of therapy where the therapist takes the responsibility for directly influencing people” (Haley, 1993, pp. 11-28).

According to MRI, the therapy should be simplified, brief, learned and thought relatively easily and also should allow working with individuals, couples, dyads, families and groups. This enables us to work with patients diagnosed with panic disorder although they attend the sessions individually.

Therapies base their formulations and interventions on their etiological position. In the Strategic Family Therapy, the emphasis is on “change” (Rambo, West, Schooley, & Bold, 2012, pp. 89-94) which technically means ‘pattern interruption’. In other words, it is known as “theory of change”. Therefore, the interventions in Strategic Family Therapy are designed to make changes and solve the problem. Interventions frequently used in Strategic Family Therapy are; go slow-don’t go fast, negative consequences of change, take a small step, reframing, paradox and U turn (Sherman & Fredman, 1986).

Eye Movement Desensitization and Reprocessing (EMDR)

In 1980s, Francine Shapiro developed EMDR Therapy. This is a psychotherapy based on Adaptive Information Processing (AIP) Model. She hypothesizes that memories are processed and stored within a memory network. The memory network consists of thoughts, images, emotions, and sensations. AIP Model posits that a traumatic memory may not be processed properly and it is recorded as it is experienced at the time of event and easily triggered. Following this idea, the model indicates that traumatic memories lie behind all psychopathology. Therefore, EMDR Therapy works with the traumatic memories in order to treat the present psychological problems. Shapiro (1995) states that EMDR Therapy helps to treat psychological problems through reprocessing the traumatic memory. When the memory is brought to an adaptive solution, present complaint is expected to disappear or decrease. Three pronged protocol is used in EMDR therapy: (1) the traumatic memories are targeted and reprocessed with the aim of building new adaptive links within memory network, (2) present stimulants that trigger the client’s symptoms are processed, (3) imaginal future scenarios are worked on to enable the client to cope better with his problems in the future. Namely, past, present and future are addressed in the treatment plan (Shapiro, Kaslow, & Maxfield, 2007, p. 3-95).

The Case: “Am I me?”

A client who suffers from panic disorder with agoraphobia for more than ten years applied to the Institute for Behavioral Studies (DBE), Istanbul in 2011. She was 28 years old and single. She was a university student from a low income family. We carried out her treatment with both EMDR and Strategic Family Therapy. She will be referred as Sheila (S.).

The psychiatrist conducted a psychiatric interview with her. He diagnosed her with panic disorder with agoraphobia. He also mentioned that she had some dissociative experiences such as depersonalization and derealization. He prescribed her medications and conducted monthly control sessions throughout the treatment.

Her present complaints include stomach aches/spasms, hot flushes, burning feelings on her body, palpitations, fear of having more panic attacks, choking, crying jag, losing control, losing her mind/memory, going crazy and harming others. As the client had fear of having a panic attack when she leaves home by herself, she stopped going out without her mother. Therefore, she had significant limitations in her daily behaviors. She resigned her job, stopped seeing her friends, broke up with her boyfriend and had difficulty to get into a bus or a mall. It seemed that she organized everything in her life around the possibility of having attacks.

The First Session

Client's history was taken as usual. While she was telling about past, she realized that her panic attacks started at the age of 17 after a worrisome argument between her father and elder sister who accused her for the family's present state of poverty. Her dad, who was a cancer patient at the time, died after a year. Sheila's attacks have continued even after her father passed away.

Therapy Goals

Goals of therapy were determined in the first session. These goals were to end the panic attacks and the fear of having a panic attack, to remove depersonalization and the question of 'is this me?', to end the fear of going crazy/losing her mind, to leave home by herself, to travel by herself and go to the mall or a movie theatre, to be able to sustain her attention, to feel that she can work again. Based on the history and goals, we made a case formulation and a treatment plan.

Case Formulation

Since the onset of panic disorder was just after a traumatic memory, and since her current life and relationships were affected by the attacks, we decided to integrate EMDR and the Brief Strategic Family Therapy for her treatment. One of our hypotheses was that her persistent avoidance of anything out of her comfort zone seems like a symptom, but this also keeps the process going on. As she wants to get rid of these symptoms, we need to talk about “change”. According to the Strategic Family Therapy, “change” could be made by targeting the problem itself (Fisch, Weakland, & Segal, 1982). Therefore, we utilized some techniques of Strategic Therapy such as go slow-don’t go fast, take a small step, reframing and paradox.

Our other hypothesis indicated that there was a traumatic memory behind her panic attacks. EMDR Therapy would be helpful in working with this memory and alleviating her panic attacks.

We assessed the client’s progress using scales and inventories throughout treatment. You can see the regarding data in Appendix.

Assessment Tools

Beck Depression Inventory (BDI)

This inventory was developed by Dr Aaron T. Beck. It has 21 items and it is used as self-report inventory. BDI basically measures the intensity of depression. The symptoms of depression such as hopelessness, irritability, feelings of guilt and punishment and physical symptoms of people aged over 13 are assessed by the inventory (Beck et. al., 1961). This is widely used by mental health professionals all around the world. There are three different versions of BDI. These are BDI, BDI-A1 and BDI-II. We used the BDI-II form to assess the depressive symptoms. The inventory’s score shows the severity of depression. Moderate depression scores are ranged between 1-17, the scores over 17 show severe depression.

Symptom Assessment-45 (SA-45)

The symptom assessment-45 (SA-45) assesses the symptomatology of patients. This is a brief version of SCL-90-RR, and it is used as a screening tool. This tool helps professionals to know about the severity of symptoms and plan psychological treatment. The inventory is made up of nine different subscales including depression, interpersonal sensitivity, hostility, obsessive-compulsive, psychoticism, paranoid ideation, somatization, phobic anxiety, general severity index and positive symptom index. It is a Likert-type 5-point scale, where each

point indicates the frequency of each symptom. 5 means “always” whereas 1 means “never” (“SA-45 - Symptom Assessment-45,” n.d.).

Application of Integrating Strategic Family Therapy and EMDR

Client history was taken in the first and second sessions as usual. We asked about her traumatic memories which were related to her panic attacks. We also asked about her panic attacks (we see them as ‘trauma’ themselves) and the other traumatic memories in her life.

After these sessions we discussed which traumatic memory should be the targeted with EMDR therapy first. Then we preferred to reprocess the big argument scene that has occurred just before the first panic attack, based on the AIP Model's hypothesis indicating a potential causality between the traumatic memories and psychological problems especially the ‘touch stone event’. Regarding the information gathered, we decided to integrate Strategic Family Therapy and EMDR at supervision.

We started to work on the traumatic memory about her dad and sister with EMDR and did Strategic Family Therapy interventions at the end of the third session. The first intervention was “go slow-don’t go fast”. S. said “I want to go out by myself but I am afraid of that! Whenever I realize that I cannot go out alone I feel so disappointed”. We said “We see that you started to take psychotherapy and you wish to go out without your mother. We hope that you will achieve your therapy goal. But for now we believe that you should not go fast. I mean we think that you should not try to go out alone yet.”

In the fourth session, we kept working on the memory with EMDR Therapy. At the end of these sessions, we used Strategic Family Therapy interventions. S. came to this session without her mother, although we had told her not to go out alone. This showed us that both EMDR Therapy and strategic intervention was working for her. She also said “I realized that I miss going out. I am so excited as I came here alone today. I want to go out and walk around our house in the evenings.” At the end of the fourth session, we said “You came here without your mother today. We see that you can go out and even get on a bus by yourself. That is very nice. But let us take small steps rather than big ones. Would you like to have a short walk in the street of your house just before the weather gets dark for five minutes only once until we meet in the next session?” She said “I wish to go to a store where I can buy clothes.” We said “Oh yes, we see that you are enthusiastic for taking new steps. But let us start with a small one.”

In the fifth session, we checked what she did. She had a short walk in the street. We again congratulated her and said “Do not go fast. You can try to go out for

ten minutes but not eleven! And do not try to go out twice a week please.” She cancelled the sixth session and came the following week. We worked on traumatic memory with EMDR Therapy and also checked the last week in the sixth session. S. stated that “I do not have any of the symptoms that I complained about when I came first. I went to Silivri (another city) by bus last week by myself. I do not have any fear or physical disturbance. I feel so good. The only problem is that I keep asking myself that “Is this me, am I me?” The psychiatrist had labeled this symptom as a dissociative experience in the beginning of treatment. In this session, she implied that she had difficulty adapting to anything or anyone due to this question. We discussed this problem using a Strategic Family Therapy reframing technique:

“While you are listening to someone, you feel that your mind goes somewhere else. When you come back, you realize that you cannot understand what the person has told you. Then you ask yourself ‘Am I me?’ Is that right?”

“Yes, definitely” she replied.

“It seems that you have difficulty focusing on the subject matter.”

“Yes”

“I just want to ask if we could call that difficulty in concentration?”

“Yes, why not? I cannot concentrate.”

Thus, we agreed upon calling this problem ‘difficulty in concentration’ with S. Then we gave a homework again based on Strategic Family Therapy intervention; paradox. We asked her to take her mind somewhere else consciously for a while listening her mother speak.”

In the seventh session, she said she did it and realized that she does not think anything else or she does not go anywhere else. She said “ No need to get anxious or worry about this question “Am I me?”.” She had done another trial by herself. She tried to focus on her own thoughts for half an hour. She kept asking questions to herself and found answers for them while she was travelling on a bus. She, for example, was asking “Who is my mother?” and answering “My mother’s name is Ayse. She is an old woman who loves me so much”. The more she concentrated on the questions and their answers, the more she became aware that “I am the one who asks and answers. This is my mind that belongs to my body travelling in this bus. I think this is me. I think I just started to feel my entire self.”

In the eight session, working on her traumatic memory process was completed. Then we checked disturbance level of her other traumatic memories. She reported that none of them were disturbing her now. We focused the occasions, people, times and places that may trigger her panic attack and worked on them

with EMDR Therapy. We worked on the most disturbing one and completed it properly. We also checked whether she achieved her therapy goals.

The outcomes of therapy according to S. were that panic attacks and fear of having a panic attack were eliminated, and depersonalization and fear of going crazy/losing her mind had ended. She was able to leave the city by bus and traveled by plane by herself and went to a mall and to a movie theatre in another city. She built healthy relationships with her mother, boyfriend and friends. She was able to sustain her attention and passed her examinations. She passed the oral, written, performance, individual and group interviews and started working in a corporate bank. She cancelled the ninth session as she was going to work. Then we did two other follow-up sessions every 6 months. It seems that the effect of therapy was constant afterwards. The psychiatrist stopped the medication at the last follow up.

Results

The results of Beck Depression Inventory indicated that the client was at the highest top limit of moderate depression. Namely, she was about to be diagnosed with severe depression by BDI. At the end of the sessions, BDI Score had decreased from 33 to 1. This shows that S. might have normal ups and downs in her life just like anyone else who is not diagnosed with depression. Symptoms which were the most frequently seen in S. are defined and presented in the SA-45 tables below. The tables indicate that her SA-45 score started to decrease after the fourth session. At the end of the treatment and in the follow up sessions, her SA-45 score was even lower. This shows that she no longer has the symptoms that she complained about at the beginning of therapy.

Discussion

BDI score of S. continued to fall down between the follow up sessions. This might be a sign of the effectiveness of the therapy. On the other hand new things she added to her life such as working and reunion with her ex-boyfriend may also be helpful for her not to feel depressed. Like the BDI scores, her SA-45 scores also fell down after therapy. On the second follow up session, she said that “Today I had a little argument with my boss. This is why I feel little bit lonely. But do not worry I am okay! If this were in the past, I would think that I was going to die. But now I feel so good and relaxed.” We were happy to see that she was able to cope with the difficulties she was faced with.

Integration of Strategic Family Therapy, EMDR and other approaches need to be examined. The result of this study depends on a single case. Effectiveness of

the integration needs to be studied with larger populations. Apart from the integration, the rapport, good conditions of the institute, recording and many other factors might be effective in the outcomes of the therapy on either a positive or negative way. Further controlled studies would be helpful for the future clinical experiences.

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Appendix







