

## **Evolved Strategic Treatment for Panic Attack Disorders**

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### **Abstract**

At the Centro di Terapia Strategica -Strategic Therapy Centre- of Arezzo, various projects and research have been in progress during these last fifteen years. Starting from general models of brief therapy formulated at the Mental Research Institute of Palo Alto, these have lead to a therapy model based on specific intervening protocols constructed “ad hoc” for particular pathological problems.

Phobic disorders were in fact, the first category of disorders to which, this methodology of research that articulates in three phases was applied. This has lead to the construction of five specific protocols of therapy for the diverse phobic variants.

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The first published research dates back to 1988 (Propagations, 1995) and it showed that 19.2 % of the resolved cases took place between the first and the tenth session, 61.5 % were resolved between the tenth and the twentieth session, 3% were resolved between the twentieth and the thirtieth and 15.3% at the thirtieth and the thirty fourth session. At the moment, the efficacy of the treatment for anxiety, phobia and panic attacks is equivalent to 95% (Watzlawick-Nardone, 1997; Nardone-Watzlawick 2001) with a mean of seven sessions to be resolved, during which the majority of the cases (81%) got unblocked within the fifth session and in 50% of these cases, there were no traces of the relevant symptoms already, after the first session.

By analysing the process and the typical retroactions relative to the emerging and the constitution of the disorder, what seems to come into sight is the fact that severe phobic disorders have surfaced and have got gradually more complicated by the thoughts and the subject's doubts of feeling sick.

That which determines the construction of strong phobic symptomatology is not however the initial event, but the actions of the subject to avoid his fear, that is, the attempted solutions devised by the person in order to escape from giving rise to emotional and somatic reactions, typical reactions of fear. This will take fear to a higher level of severity.

In order to break the pathogenic perceptive-reactive system of panic, the therapist employs suggestive stratagems, devised ad hoc, that make the person undergo concrete experiences to overcome the problem without being aware of it. In fact awareness comes along once the subject cannot do anything but recognise that he has carried out exactly what he until then, considered impossible to do. The methodology used in such work reconciles with Lewin's ideas, relative to psychosocial research-action, which reads that in order to get to know how a system functions, one should only introduce change. Therefore to study a phenomenon (of any nature) we need to change it and observe its effects. In other words, we arrive to know a reality by acting on it.

Parallel to this is the fact that the new knowledge that emerges from the effects of the interventions, serve to guide in the progressive adjustment of the intervention itself, by determining a continuous self-correction, based on the interaction with the problem to be resolved.

In this case, a first real or imaginary casual experience introduces in the mind of the subject, a new perceptive-reactive possibility: that of fear. From such an experience, all that is carried out in order to defend oneself from such fearful reality, if it does not function, will do nothing but further confirms it, making the effects worse, leading it to a panic reaction, both in terms of the generalization of fear and of the psychic and behavioural responses.

In particular, three typical attempted solutions carried out by the subject, were identified: (Nardone, 1993, 2001) avoidance, request for help and control.

The effect of avoidance in fact, is that of confirming the threat of the avoided condition, thus preparing the successive evasive behaviour.

All this does not have as a unique effect that of incrementing fear by confirming it, but also that of rendering the subject always more sceptic regarding his own resources, increasing in this way even his phobic reactions, thus rendering the disorder always more invalidating and limiting.

Once the vicious circle of avoidance is activated, the person often utilises a second ‘strategy’ that reveals to be decisively counterproductive: request for help, that is, the need of being always accompanied around and comforted by someone who is willing to intervene in case of panic crises and of lose of control.

The effect of such a request is initially that of reassuring the person but gradually it will lead to increase fear and its consequential limitation.

In fact, it is therefore this possibility of having someone intervening promptly to help that ends up confirming to the subject that he/she is unable to confront the feared situation in first person and thus be able to manage the consequences. Even this process tends to generalise itself- it functions as a real and proper prophecy that fulfils itself- until it becomes some sort of necessity and brings the person to a more severe form of the phobic disorder based on the logic that reads “I depend” and not “I can control”.

On the other hand, it is in fact the control over one’s physiological and behavioural reactions, that become the redundant and unsuccessful perceptive-reactive script that the subjects puts in action so as to affront one’s fear.

What happens is that in attempt to maintain control over one’s organic and psychiatric functions, the subject experiments a paradoxical situation: by focalising attention on one’s physiological reactions (heart beat, breathing, equilibrium, etc.) lead inevitably to an alteration of at least one of the above, provoking fear that in return generates further alterations, activating in this way the typical vicious circle where “the attempt to control leads to lose of control”.

Taking into consideration the three levels of therapy, that is the strategy used, the communicative interaction and the patient-therapist relationship, with phobic patient we can regard as practically irrelevant the latter (decisively important in other types of disorders), on the contrary we have underlined the fundamental importance of the strategy used and consequently the modality of communication by which it is expressed.

One has to denote that the patients that arrive in therapy with a panic problem are first and foremost in a state of emergency.

Generally we will be dealing with subjects who would like to be collaborative (due to its urgency) but they cannot be: they are highly motivated and need to change but they cannot do so, not even minimally.

What they are in need of, is therefore of a “specialised technician” able to “ride” their fear and who with veiled indirect highly suggestive manoeuvres can lead them to change without being aware of doing so.

The first therapeutic step follows, due to this motivation, an Ancient Chinese motto that reads “*to plough the sea unknown to the skies*” (Anonymous, 1990), that is that of shifting one’s attention in a way to make the subject, unknown to him/her, to overcome obstacle regarded as insurmountable and thus consequently, to open new paths to diverse forms of representations of reality and new behavioural modalities.

Generally, the first phase of therapy coincides with the first session. In this phase takes place above all, the definition of the problem, that is, we gather the perceptive-reactive

system of the patient and are put in practice for the first time, manoeuvres that unblock the vicious circle triggered off by the attempted solutions.

However, to do so, the therapist prevails of a particular questioning process that might seem banal, which rather than being formulated in an open-ended form, they offer the patient the possibility of choosing from two or more options. In this way a sort of illusion of alternative is given, that give rise to a process in which every answer constructs the successive question, according to a sequence that gradually narrows down in a funnel-like manner. In doing so, the therapist will seem to maintain a one-down position which will permit him to guide the patient along a determined discovery process and at the same time, an operative itinerary. This modality of "investigation" is in fact already in itself capable to produce changes in the way the patient perceives his reality, just because it permits him to open new perceptive-reactive modalities regarding his disorder.

At this point, the therapist moves onto the first therapeutic prescriptions, which in this first phase are, generally: *the log, fear of help (or of avoiding) and how to worsen*.

The log is a notepad appropriately prepared to be given to the patient together with the prescription: it is made up of a scheme subdivided in various columns relative to date, time, place, situation, person, thoughts, symptoms and reactions, which the patient should always carry along with him and fill-in every time an "episode" of panic presents itself.

The aim of this manoeuvre, apparently banal, is that of shifting the attention of the subject from his state of panic, right at the very moment that the first anxiety symptom arises, thus avoiding the successive dysfunctional attempts to control the symptom and one's reactions. The effect achieved is generally that of a substantial reduction (if not of total absence) in the number of episodes of panic throughout the entire period that elapses from the first session to the second session.

The reframing of the *fear of help* and the *fear of avoidance* induce the patient to think that every time he asks for help to anyone or avoids an ansiogenic situation, this worsens one's symptoms: "*Every time you ask for help and you get it, you feel protected but at the same time you confirm to yourself that you are capable to make it on your own. Therefore in reality, every time you ask for help and you receive it, you confirm to yourself your incapability and this does not only maintain your disorder, but it makes it worse. However, we are convinced that you are not able not to ask for help so we ask you only to think about it*".

To sum up, we place the subject in a condition to substitute a fear with another bigger fear (*Ubi major minor cessat*), by using the force of the fear against itself.

With the prescription of *How to worsen* we ask the patient to ask himself the following question on a daily basis: "*What do I have to do or not do, if I voluntarily wanted to worsen my situation*", and come back with the answers given to the successive session. In asking oneself this question, the patients generally come to recognise that what they already carry out in attempt to feel better, in reality worsen the situation. In short, the dysfunctional attempted solutions are revealed without having the therapist suggesting so.

Throughout the second phase of the treatment (approximately from the second to the fifth session, depending on the case), we have the unblocking or the falling apart of the perceptive-reactive system and of the attempted solutions so far used. The first change that takes place is therefore redefined and addressed towards further progressive changes that will take place in virtue of a new perception of reality.

At this point, certain prescriptions given in the first session (for example the log) are kept and we proceed in giving the prescription of the *worst fantasy* (see session two). This

is a paradoxical prescription that functions following the logic of a Chinese stratagem “*to put out the fire by adding more wood*”. In fact we ask the subject to voluntarily prescribe to himself, every day, his most fearful symptoms, to deliberately submerge himself in his worst fantasies in a sort of precise and formal behavioural ritual.

Generally, the prescription of the worst fantasy brings about two types of effects: some people, even though they try to immerse themselves in the phobic situation, they are not able to feel nothing and might arrive to even fall asleep; others (a small percent) try to evoke their “ghosts” and manage to feel bad. In both cases, however, through out the rest of the day, the majority of the patients report that they did not have moments of crises, expect some sporadic ansiogenic episode but which was easily managed.

In the third phase (generally comprising of the fifth session on wards), once there is the unblocking of the perceptive-reactive system and consequently, the first direct triumphant experience in overcoming the problem, the patient is lead towards those changes agreed upon as being the solution to the problem. Therefore, there is a redefinition of the relationship with and the perception of oneself, others and the world.

According to the effect achieved from the prescription of the “half an hour of worst fantasies”, we will have two types of *redefinition of the situation*. In the case of the subject who did not manage to feel bad, the therapist underlines how the problem might be annulled by voluntarily provoking it; on the other hand, in the second case, he will reframe the ability of provoking the symptoms as the ability to also reduce them, underlining the fact that the more one manages to put in the half an hour, less will be present outside, through out the rest of the day.

At this point, we prescribe 5 minutes of worst fantasy every 3 hours (at the strike of the hour, at 9am, noon, 3pm, 6pm and 9pm) where the patient has to try to provoke his symptoms. The 5 minutes every three hours are successfully transformed in *5 minutes when necessary*, through which it is given to the patient the opportunity to “*touch the ghost in the moment in which it appears to make it go away instantaneously*”. Therefore it is given the possibility to exploit the paradoxical effect of the worst fantasy in the moment when anxiety arises.

Moreover, we start to work in a *solution-oriented* (De Shazer, 1988) manner by introducing two types of new prescriptions: the prescription of the *As if* (Watzlawick, 1990) and the *Scale Technique*.

The former asks the subject to ask himself a question, every day, or better “how will I behave differently from how I behave myself today, as if I had no longer my problem?” and moreover we ask him to chose from all the things that come to his mind, a small minimal thing and put it into practice, ever day something new. This does not only trigger off a series of changes and concrete experiences of triumph over the problem, but it furthermore, generates in the patient the awareness that he was the one to arrive to the solution and not the therapist.

The scale technique is introduced both when the enhancement of situation is extremely precocious that it takes place between the second and the third phase of the therapy, and also after having used the technique previously described. Through the use of this technique, we require to fragment the objectives along a scale that goes from 0 (when the problem is at its maximum) to 10 (when the problem is at its minimum). Once the patient has defined his position along the scale, we ask him to do something, ever day, that might allow him to say, “I made a step ahead”. In order to achieve this, it is necessary to carry out

small interventions, that is, even something which might seem very minimal, but which is sufficient to activate a chain reaction that will subvert the entire equilibrium of the system.

Even this technique, which might seem directive, offers a fine modality to overcome the patient's "resistance to change".

The final phase coincides with the last session (in this case the tenth) and holds as an objective, the definitive consolidation of what has been achieved, by underlining and by repeating that change has taken place thanks to the personal abilities of the patient.

In fact, it entails the affirmation of how well the patient has learned to utilise his own resources and thus has reached complete autonomy.

At this point, the therapist comes to an agreement about the modality of the follow-ups that correspond to forthcoming "check-ups" after 3 months, 6 months and then a year. This is to guarantee that the results reached are maintained over time and that the therapy can be retained as concluded and successful.

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