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## **Applying a Contextual Therapy Framework to Treat Panic Disorder: A Case Study**

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*Despite limited attention in empirical and clinical literature, we propose that contextual therapy is a useful framework for intervening at both the individual and relational level, and we provide a detailed description of the process of multidirected partiality. A case study is provided to demonstrate multidirected partiality in individual and family therapy to treat a woman in her 60s with panic disorder. The client identified relational fears triggering her panic attacks and developed her coping skillset and support system, successfully managing her symptoms of panic and anxiety. Implications for expanding research and clinical practice based in contextual therapy are offered.*

**KEYWORDS** *anxiety, contextual therapy, empathy, multidirected partiality, panic disorder, relational ethics*

As Rosenberg and Sandberg (2004) described, contextual therapy has been put “on the endangered species list of psychotherapeutic and family oriented treatment approaches” (p. 389). Although contextual therapy is often dismissed for seeming too complex (Rosenberg & Sandberg, 2004), we argue that contextual therapy remains underutilized by individual, couple, and family therapists. Contextual therapy is a foundational theory of systemic family

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therapy that provides new and seasoned therapists alike with the ability to conceptualize a wide variety of clinical cases by acknowledging that the human experience is composed of both individual and relational realities (Boszormenyi-Nagy & Krasner, 1986).

As an integrative model, one of the most useful aspects of contextual therapy is its versatility in either being used as a primary model or being integrated with other therapeutic models (e.g., Lyness, 2003). Despite some therapists' hesitation about the accessibility of contextual therapy, Goldenthal (1996) explained:

It is difficult to find an experienced therapist who would argue with the notion that knowledge of a person's past and present family relationships is crucial to understanding and helping the person, or one who would deny that the issues of loyalty and fairness are central to life and to close relationships. (p. xiii)

This demonstrates the applicability of foundational concepts in contextual therapy to a wide variety of clinical cases treated by couple and family therapists. Even when therapists do not identify as contextual therapists in training or in practice, there is a strong likelihood that a contextual therapy framework will help provide additional insight to be used in case conceptualization and enactment of therapeutic interventions to improve individual and relational functioning.

## CONTEXTUAL THERAPY

As a model of systemic family therapy, contextual therapy addresses how trust, loyalty, and love impact the functioning of individuals in their systemic interactions. Contextual therapy emphasizes the importance of fairness in relationships (Goldenthal, 1996). According to Boszormenyi-Nagy and Krasner (1986), fairness in relationships is demonstrated by the balance of giving and receiving that takes place over time. In contextual therapy, therapists seek to improve individual and relational functioning by providing clients with opportunities to engage in dialogue about experiences of trust and fairness that impact family functioning both on a day-to-day basis and in patterns re-occurring throughout generations. Contextual therapists specifically address the role of communication in relationships (Hargrave & Pfitzer, 2003). By facilitating this dialogue with clients, therapists are able to identify communication patterns that either enhance or detract from clients' experiences of fairness and trust within their family systems.

The most fundamental dimension of contextual therapy is relational ethics (Boszormenyi-Nagy & Krasner, 1986), which highlights the expectations that people hold for themselves and others in their relationships (Hargrave & Pfitzer, 2003). These expectations often concern what people

feel obligated to give in their relationships and what they feel entitled to receive in their relationships. Relational ethics addresses the balance of trust, loyalty, and entitlement (Hargrave, Jennings, & Anderson, 1991), and this balance in relationships is often conceptualized as a relational ledger. Contextual dialogue focuses on the dynamic nature of relational ethics, including individuals' need for and expectation of respect, care, and intimacy that is both earned by nature of the relationship (i.e., a parent-child relationship) or through giving that same respect, care, and love to another person (Hargrave & Pfitzer, 2003).

The clinical utility of relational ethics has been emphasized in the literature in a few research studies (Gangamma, Bartle-Haring, & Glebova, 2012). For instance, Grames, Miller, Robinson, Higgins, and Hinton (2008) found that a lower perception of relational ethics was related to an increased number of health problems and increased depressive symptoms, and these relationships were mediated by marital satisfaction. Just as the balance of giving and taking affects individual and relational functioning, relational ethics also impacts both physical and psychological health.

Multidirected partiality is the primary technique used in contextual therapy for promoting individual and interpersonal health within relational systems. Through this intervention, therapists balance tasks related to (1) helping clients to recognize and value multiple perspectives and (2) highlighting issues related to relational ethics affecting themselves and others. Not only is multidirected partiality an intervention, but it is also an attitude that contextual therapists should have (Hargrave & Pfitzer, 2003). Through multidirected partiality, clinicians actively recognize each individual's claims to both giving and receiving in the relationship. In a true systemic fashion, contextual therapists also take into consideration all of the people outside of therapy who may be affected by the intervention (Boszormenyi-Nagy & Krasner, 1986; Dankoski & Deacon, 2000). There are four main components of multidirected partiality: empathy, crediting, acknowledgement of efforts, and accountability.

Central to the concept of multidirected partiality is the importance of empathy (Hargrave & Pfitzer, 2003). In this context, empathy refers to therapists' ability to emotionally and cognitively tune into the experiences of the client (Rogers, 1980). A meta-analysis conducted by Elliott and colleagues (2011) revealed that therapist empathy is a significant factor in therapy outcomes. Of course, the effective expression of empathy is a crucial factor for the client to actually perceive empathy in the other person and "feel felt" (Barrett-Lennard, 1981). True empathy may require therapists to adjust expression of understanding based on the client's needs (Duan & Hill, 1996; Elliott et al., 2011; Martin, 2000).

As an aspect of multidirected partiality, empathy is necessary for interventions to hold the greatest therapeutic impact (Hargrave & Pfitzer, 2003). Perceiving empathy from the therapist allows the client to be more in touch

with his or her own experiences, especially relational experiences (Rogers, 1961). The intrapersonal attunement stemming from empathy from the therapist also facilitates an expanded capacity for interpersonal attunement. From the perspective of contextual therapy, experiencing empathy from others enhances one's ability to direct concern toward others (Jordan, 1997) and offer due consideration of others' needs and values. The ability to understand and consider relational experiences from the vantage point of others, as well as the self, is a major facet of genuine autonomy (Boszormenyi-Nagy & Krasner, 1986). Being grounded in empathy sets the stage for additional elements of multidirected partiality.

Contextual therapists also use the technique of crediting, which is instrumental in highlighting the relational injuries that may have occurred between family members. The technique of crediting includes two essential aspects (Hargrave & Pfitzer, 2003). First, therapists acknowledge the ways in which each individual has experienced relational injustice and violations of love, trust, and loyalty within and outside the therapy room. According to Hargrave and Pfitzer (2003), if the "patient feels that the psychotherapist has acknowledged his or her issues of relational violation, then the second aspect of crediting becomes possible" (p. 100).

The second aspect of crediting involves the acknowledgement of efforts. Acknowledgement of both hurtful and healing aspects of relationships helps set the stage for a more multidimensional view of relational interactions and emotional attachments, which opens up possibilities for exoneration, or forgiveness (Hargrave, 2001). This second aspect of crediting emphasizes the importance of contributions that the client has made within relationships (Hargrave & Pfitzer, 2003), as well as the equally important contributions of others in the relationships (Goldenthal, 1996). Various kinds of contributions—such as sharing supportive words, demonstrating affection, providing financial assistance, or offering help with physical tasks—are included. This acknowledgement of positive efforts helps to create an expanded picture of systemic functioning to all of the individuals in the relationship. Instead of only focusing on negative relational behavior, therapists are able to help clients understand what they and others have done in the relationships that may have been beneficial in building trust and relational fairness.

The final aspect of multidirected partiality is accountability. After clients' efforts are acknowledged, contextual therapists help clients identify and act upon their obligations to others within the family and broader system. Accountability holds each party in a relationship responsible for what takes place within the relationship (Hargrave & Pfitzer, 2003). There is a tendency for some people who have been exposed to difficult, painful life experiences, especially if those experiences occurred early in life, to develop a reliance on destructive entitlement (Goldenthal, 1996). Rather than accept responsibility for their own choices, individuals who rely on destructive entitlement feel

entitled to treat others unjustly because they have previously been wronged themselves (Goldenthal, 1996; Hargrave & Pfitzer, 2003). As explained by Goldenthal (1996):

Reliance on destructive entitlement may be seen in a person's lack of sensitivity, caring, or concern for others; for their needs, feelings, hopes, and misfortunes . . . Everybody occasionally does things that hurt others; this does not represent destructive entitlement, only human frailty. People who rely predominately on destructive entitlement when relating to others; however, have experienced so much pain and injustice, that they have become blind to the harm that they cause others. (p. 17)

Destructive entitlement is a response to experiencing the injustice of not receiving what one is entitled to receive, and children and spouses are especially vulnerable to the cycle of injustice perpetuated by acting upon a sense of destructive entitlement (Boszormenyi-Nagy & Krasner, 1986).

By framing all therapeutic dialogue in deep respect for clients' autonomy and empathy for all individuals, contextual therapists work with clients to balance the focus between self and others. Whether working with individuals, couples, or families, therapists work at the client's pace. It is essential to first build rapport by crediting individuals for the ways in which they have contributed positively to the relationship. As individuals acknowledge the efforts they themselves have made, therapists then guide the conversation to the ways in which others, even those perceived as persecutors or enemies, have also provided something beneficial to the relationship. Over time, this also opens space for clients to explore the consequences of actions on relational ethics within the family. When individuals are willing to accept responsibility for their own actions influencing this balance, families become empowered to create lasting change promoting trust, loyalty, and justice within the family system.

## PANIC DISORDER

Individuals with panic disorder experience unexpected and recurring panic attacks accompanied by persistent worry about or avoidance of situations that may lead to a panic attack (American Psychiatric Association, 2013). Panic disorder can be specified as with or without agoraphobia, a fear and avoidance of situations in which escape or receiving help might be difficult if a panic attack did occur. Individuals who experience panic disorder tend to report relatively high levels of interruption in both physical activities and interpersonal relationships (Marshall, Zvolensky, Sachs-Ericsson, Schmidt, & Bernstein, 2008) due to the pervasive nature of these anxiety symptoms, which interfere with emotional regulation (Tull & Roemer, 2007).

Individuals with panic disorder—especially women—typically experience significantly low rates of remission and high rates of relapse for panic attack symptoms (Sibrava et al., 2013; Yonkers, Bruce, Dyck, & Keller, 2003), calling attention to the need for improved treatment of patients facing panic disorder with agoraphobia. Evidence has suggested high rates of comorbidity of panic disorder with various medical conditions, including gastrointestinal disorders such as irritable bowel syndrome (Gros, Antony, McCabe, & Lydiard, 2011a), asthma (Lavoie et al., 2013), cardiovascular and cerebrovascular disease (Morris, Baker, Devins, & Shapiro, 1997; Smoller, et al., 2007), and migraines (Smitherman, Kolivas, & Bailey, 2013). Likewise, panic disorder can be comorbid with a variety of other mental health disorders, including bipolar disorder (Forty et al., 2009; Goes et al., 2012; Lee & Dunner, 2008), major depressive disorder (Forty et al., 2009; Goes et al., 2012; Sibrava et al., 2013), substance use disorders (Sibrava et al., 2013), and post-traumatic stress disorder (Cogle, Feldner, Keough, Hawkins, & Fitch, 2010; Gros, Frue, & Magruder, 2011b). As with many mental health issues, panic disorder often presents chronic difficulties to those diagnosed with this disorder due to recurring episodes of panic attacks.

Treatment options for panic disorder include engagement in psychotherapy, as well as pursuing pharmacological treatment. The American Psychological Association (APA, 2009) recommends the use of a selective serotonin reuptake inhibitor (e.g., Citalopram), serotonin-norepinephrine reuptake inhibitor (e.g., Effexor), tricyclic antidepressant (e.g., Imipramine), or benzodiazepine (e.g., Alprazolam) as the initial pharmacological intervention for panic disorder and asserts that there is not adequate empirical evidence to recommend any of those interventions over another. In addition, Moylan et al. (2011) reported no statistically significant differences between the use of alprazolam or other benzodiazepines in the treatment of panic disorder symptoms. A significant amount of empirical evidence has supported the use of cognitive behavioral therapy (CBT) to treat depressive and anxious symptoms associated with panic disorder (Clum, Clum, & Surls, 1993; El Alaoui et al., 2013; Gros et al., 2011a; Mitte, 2005; Schmidt & Woolway-Bickel, 2000). CBT for panic disorder includes training clients to become aware of bodily sensations associated with anxious arousal (Arch & Craske, 2011), increase self-efficacy, and reduce catastrophic thinking. Vos, Huibers, Diels, and Arntz (2012) declared CBT the current treatment of choice for reducing primary symptoms, such as panic attack frequency and idiosyncratic behaviors. There is also some evidence to suggest the cost effectiveness of CBT over the use of pharmacological treatment for individuals with panic disorder (Heuzenroeder et al., 2004).

Despite the effectiveness of CBT in treating panic disorder, authors have explored additional options to treat secondary symptoms such as panic and agoraphobia severity, panic-related cognitions, interpersonal functioning, and general psychopathology. Other approaches to treating panic



disorder include eye movement desensitization and reprocessing (EMDR; Leeds, 2012), intrapersonal psychotherapy (Vos et al., 2012), psychodynamic psychotherapy (Sandberg et al., 2012), functional analytic psychotherapy (Bermúdez, García, & Calvillo, 2010), and emotion-focused psychotherapy (Shear, Houck, Greeno, & Masters, 2001). In addition, Byrne, Carr, and Clarke (2004) concluded that couples-based interventions were at least as effective as individually focused CBT in treating panic disorder since relationally focused interventions enhance treatment gains by encouraging interactions that positively reinforce attempts of persons diagnosed with panic disorder to cope effectively with fear of anxiety-provoking situations (Byrne et al., 2004).

Relational and emotional experiences play a role in the management of anxiety symptoms for individuals with panic disorder. Levitt, Brown, Orsillo, and Barlow (2004) found that suppression of emotion was linked to an increase of subjectivity anxiety and avoidance symptoms, while acceptance of emotions promoted a decrease in anxiety. Contextual therapists address how individuals' emotional experiences are influenced by the expression of relational ethics within the family. Thus, while CBT can be helpful in reducing some of the primary symptoms of panic disorder, relationally focused therapies such as contextual therapy are useful in addressing how secondary symptoms of panic disorder may reciprocally influence and be affected by relational experiences of trust, fairness, and accountability for the consequences of one's actions on others.

### CASE STUDY<sup>1</sup>

Dolores, a 66-year-old librarian preparing for retirement, presented for therapy at a clinic

In a marriage and family therapy training program for assistance in coping with panic attacks. Within the past year, Dolores had begun experiencing intense periods of shortness-of-breath, increased heart rate, chest pain, dizziness, and nausea. At first, Dolores thought she was experiencing a heart attack. After her medical provider had ruled out any signs of a biomedical cause for these episodes, he referred her to the clinic to seek psychotherapy as well as a psychiatric evaluation for her panic attacks. The psychiatrist who performed her evaluation prescribed Dolores Alprazolam (Xanax) at .75 mg/day. Initially, she did not like the idea of being on a daily medication, but she ultimately capitulated and followed her psychiatrist's instructions exactly as they were given. She continued to seek medical attention for her high blood pressure, but she was otherwise in good health.

At the time of the intake, Dolores could not identify any specific trigger for the attacks, and she stated she could not remember exactly when they started. She constantly felt worried that she would have another panic attack,



so she avoided going to places like the grocery store unless she could have someone go with her, and she also had difficulty convincing herself to leave the house to go to work, too. It took her two tries to successfully attend her intake appointment at the university clinic because she was so concerned about leaving her home and experiencing another panic attack. Her baseline score on the Panic Disorder Severity Scale (Shear et al., 1997) was a 13 out of 28, indicating moderate distress related to the interference of panic disorder symptoms in her daily life.

During the intake session, the therapist assessed for members of Dolores' family system. Dolores reported that she and her husband, David, had been married for 34 years when he suddenly died of a heart attack 11 years earlier. She stated that she had two daughters, Olivia (age 33) and Serena (age 24). Dolores expressed feeling extremely worried about her oldest daughter, who was undergoing extensive treatment for breast cancer. Dolores reported that she and Olivia had always had a very close relationship and that they frequently shopped and went on walks together. Dolores reported that she ate dinner with Olivia's family four to five nights a week and that she sometimes felt that Olivia was the only person she could trust not to judge her for her panic attacks. If she felt she could not go to the grocery store or complete errands on her own, she would wait until Olivia was available to help her. Dolores reported feeling some frustration that it seemed like Olivia recently had less time to spend talking to her on the phone, but she was also very proud that Olivia was able to maintain a time-intensive job and complete treatment for her breast cancer. She expressed feeling lost how to help Olivia cope with breast cancer but that Olivia was being "very brave."

When questioned about her relationship with Serena, Dolores appeared uncomfortable and stated that they were estranged since Serena had a serious drug addiction. Whenever the therapist tried to ask questions about Serena, Dolores's body posture would become defensive and closed off, and she would abruptly change the subject. This alerted the therapist to a possible violation of relational ethics that Dolores perceived within the family. Since Dolores was signaling that she was not yet ready to engage in dialogue about this breakdown of trust and fairness, the therapist made note to address these issues once the therapeutic alliance had been strengthened and Dolores was more comfortable exploring these relational aspects.

Throughout therapy, the therapist was intentional about using elements of multidirected partiality to help Dolores examine the precursors and consequences of her panic attack symptoms. Empathy was an essential element of building the therapeutic alliance. The therapist reflected back to Dolores the deeper emotional meaning of her statements in a validating manner. In this way, empathizing with Dolores built trust between her and the therapist and helped her to become more engaged with and accepting of her experiences.

Empathy continued to be an essential element throughout the entire process of therapy in maintaining the therapeutic relationship and encouraging deeper processing of emotional experiences related to Dolores' experience with panic attacks and her perception that others judged her as weak.

At the beginning of treatment, the therapist spent several sessions with a specific focus on crediting Dolores for the efforts she had made to sustain her family and community relationships. Dolores had experienced many hardships in her life. Her second child, a baby boy, died when he was only a few days old. This proved to be a traumatic experience for her and her husband, and their grief was compounded by the fact that very few of the people from their small town reached out to support them during a time of great need. In Dolores' mind, this lack of support represented just one instance of the many violations of love, trust, and loyalty she had experienced in her life. Despite Dolores' sense of hurt over the abandonment from their community members, she continued to be actively involved with the women's service group at her church and a volunteer at a local food bank.

The therapist took time to process what motivated Dolores to continue giving despite feeling abandoned by her community, and Dolores cited a strong allegiance to a community in which she was raised. As the therapist questioned Dolores about how she came to have this strong sense of loyalty to her community members, Dolores softened and reported having learned the importance of giving back to others in need when her father struggled with unemployment throughout her childhood. This also opened up a therapeutic conversation about how support of one's family and one's community was a key value that had been passed down throughout generations in Dolores' family of origin.

As Dolores developed trust in the therapeutic relationship, her willingness to talk about pain she had experienced increased. In the eighth session, Dolores explained that her greatest trial occurred when she faced the untimely death of her beloved husband. With some hesitation, she stated that even though this loss was incredibly challenging for her, it seemed that her daughter Serena had the most difficulty with this loss. Sensing that Dolores had softened to the idea of talking about her estranged daughter, the therapist asked Dolores to describe more about how she was able to tell that this loss was so painful for Serena. Dolores explained that shortly after her father's death, Serena started to "hang around the wrong crowd" in high school and became "too friendly with a young man" in her school. Dolores expressed that while she knew Serena was falling into unhealthy patterns, she had a hard time seeing outside the devastating loss of her beloved husband.

Crippled by depressive symptoms, Dolores found herself relying heavily upon her other daughter Olivia to provide her with emotional support, supervise Serena, and keep the bills paid and the house clean. During treatment, Dolores repeatedly referred to this period of time as "some of the

darkest days of her life.” To Dolores’s great disappointment, her younger daughter became pregnant at the age of 16, and Dolores strongly encouraged Serena to give up the child for adoption. Serena begged her mother to raise the child as her own, but Dolores felt it was her duty to protect her young daughter from a life of teenage motherhood ripe with stigma and abandoned dreams. Dolores reported that not long after the closed adoption, Serena’s occasional use of illegal and prescription drugs escalated into a serious drug habit. Serena eventually moved out of the house at the age of 17. With a mix of sadness and harshness in her voice, Dolores said that they had not spoken in nearly a year after Dolores discovered that Serena had stolen a significant amount of money to help fund her addiction.

Even though the adoption had occurred over 10 years ago, Dolores expressed deeply mixed feelings over this decision. On the one hand, Dolores believed that it was her duty to protect her daughter from teenage motherhood and felt that the adoption helped accomplish that goal. However, she also expressed a deep sense of guilt over her concern that she had been lost in her own grief after the death of her husband and that the forced adoption had propelled Serena into a life filled with risky behaviors. For the next 10 sessions, Dolores vacillated between feelings of anger toward Serena for repeatedly failing to give up drugs and compassion for a daughter in obvious pain. During these sessions, the therapist used crediting to acknowledge the ways in which Serena had attempted to make amends over the years (i.e., by making sure to attend family holidays each year up until the last year) and the ways in which Dolores had made efforts to improve the sense of closeness within the family (i.e., by inviting her daughters on a family vacation).

During the 17th session, Dolores indicated that she believed she understood the origin of her panic attacks. She explained that when Olivia was diagnosed with breast cancer, she felt like her “whole world was going to fall apart” and the panic attacks had begun shortly thereafter. Dolores felt like if she lost Olivia, she would not have any family left since she felt like she had already lost one daughter to addiction. In this phase of therapy, the therapist explored with Dolores how her long-lasting reliance on Olivia had impacted Olivia’s well-being and that of her husband and children. Dolores expressed some guilt for knowing that Olivia and her husband frequently argued over how much assistance she required from Olivia, and she expressed some sense of embarrassment over how she felt like a burden to Olivia’s family, especially since her panic attacks had begun. The therapist processed with Dolores what it meant for her to be a “burden” and what she viewed as appropriate expectations of caregiving from her adult children at this stage of life. Dolores expressed great fear that if Olivia were not to survive her battle with cancer, she would have no one left to care for her.

The therapist helped Dolores examine the balance between giving and taking in her relationship with Olivia, and Dolores came to realize that

she expected a great deal from her oldest daughter without reciprocating. Dolores became aware that her expectations of Olivia were placing a strain on Olivia's physical health and her relationships with her husband and children, and she stated that she would like to work toward correcting this imbalance. Next, the therapist worked with Dolores to identify tangible ways for her to reach this goal (i.e., calling Olivia to check on her instead of calling to talk about her own difficulties, making dinner for Olivia's family, and having a conversation with Olivia to apologize for the ways in which she has taken without giving enough in return). To help reduce the demands placed upon Olivia, Dolores also identified other potential sources of emotional and physical support. As a result of this process, Dolores gradually found her motivation to heal her relationship with Serena. She stated that she realized whether Olivia survived cancer or not, she wanted to find peace with her other daughter.

During the next phase of therapy, the therapist worked with Dolores to prepare for several family therapy sessions with Serena and Olivia. Dolores acknowledged the ways in which she could take accountability for actions that had violated the sense of trust and fairness within the family. During these preparation sessions, the therapist also carefully interwove the perspective of Dolores' daughters, even though they were not present. In a safe therapeutic environment characterized by respect and empathy, the therapist used circular questioning (e.g., "What would you guess might be the most difficult part for Olivia in balancing her treatment for breast cancer and her loyalty to her mother who needs her support?" and "How do you think your anxiety and depressive symptoms have most impacted Serena?") to gently challenge Dolores to consider the impact of her emotional experiences and behavioral patterns on the entire family system.

After this period of preparation, Dolores decided to invite Serena to join her for several family therapy sessions. Much to her delight, Serena had recently been released from a drug treatment program and agreed to join her mother for therapy. As a result of substantial therapeutic work, Dolores was now in a position to offer due consideration to Serena, acknowledging the ways in which as a mother, she had not meet essential needs for Serena, especially during her teenage years. A genuine, two-way dialogue focusing on issues of trustworthiness and perceived fairness within the family began to emerge between Dolores and Serena over the course of several sessions. This trustworthy dialogue reflected the fact that Dolores and Serena were able to both acknowledge the ways that they had been hurt by actions of the other person and consider the ways in which each had contributed positively to the relationship, seeking a new balance of justice. Dolores and Serena were both able to view the relationship from the perspective of the other and were willing to take responsibility for their own part in the relationship.

In family therapy sessions, Dolores verbalized that she wished she had been more sensitive to Serena's needs following the death of David. She also

acknowledged that Serena's unexpected pregnancy and development of a drug addiction were, at least in part, a response to David's death, an event over which neither of them had any control. Knowing that her mother now accepted responsibility for the consequences of some of her actions upon the family, Serena also acknowledged accountability for actions that had hurt her mother and her sister. In therapy, Serena renewed her commitment to re-building their trust and re-integrating herself into the family.

In an emotion-laden final family therapy session, Serena and Dolores found deep, genuine healing as they realized the power of their ability to grieve together over the death of David and the possibility of losing Olivia to breast cancer. Serena and Dolores explored ways in which they would be willing to continue to re-build their relationship with each other and support each other as a way of relieving some of the pressure on Olivia to spend time with Dolores. Serena stated that she would soon be remodeling her apartment and that she could use some extra help; Dolores eagerly offered to assist, stating that "it would be nice to feel useful to someone else." Ultimately, by viewing the balance of give and take in the relationship more broadly and from multiple perspectives, Dolores was able to exonerate both Serena and herself, propelling her to redefine the role of trust, loyalty, and fairness in her relationships with both of her daughters.

Therapy with Dolores consisted of a total of 30 sessions. At the conclusion of therapy, Dolores' score on the Panic Disorder Severity Scale decreased from a 13 to a 3. In addition to addressing the relational stressors underlying her difficulty in regulating her emotions, Dolores stated that she found it helpful to learn how to calm herself from having panic attacks by utilizing coping skills, such as breathing exercises, derived from mindfulness techniques. At the close of therapy, Dolores expressed that she found it most helpful to process how her experiences of grieving with anticipated or experienced loss had impacted her ability to maintain fairness in her relationships with her daughters. Awareness of these relational factors helped her to feel more confident in regulating her emotions, which indirectly helped to reduce her struggles with unexpected panic attacks. During the final session, Dolores stated that she was looking forward to her retirement years and creating a "new normal" in her life now that she felt connected with both of her daughters and saw herself as being able to offer something positive to their lives.

## DISCUSSION

This case study demonstrated how contextual therapy may be used to address concerns associated with panic disorder. Early in the therapeutic process, the therapist recognized that relational concerns were maintaining and intensifying Dolores' depressive and anxious symptoms. Therapy

focused on helping Dolores to (1) process the violations of love, trust, and loyalty that she had experienced in her life, (2) identify how these violations had impacted herself and others within the family, and (3) define and act upon realistic expectations for creating a mutually supportive relationship with her daughters to restore the balance of giving and taking within the family system.

Despite not maintaining a sole focus on decreasing primary and secondary symptoms of panic attacks, Dolores was able to eliminate nearly all symptoms of panic attacks by resolving the underlying relational concerns maintaining her panic disorder. Over the course of therapeutic treatment, Dolores successfully decreased her panic attacks from occurring an average of twice per week to only occasionally experiencing minor symptoms of anxiety. As illustrated by Byrne et al. (2004), the inclusion of a relational component to therapy helped encourage Dolores to pursue activities promoting her ability to cope effectively with the fear of losing her daughter.

In working with Dolores, it was essential to highlight ways in which she had adopted an attitude of destructive entitlement. The therapist used a two-pronged approach by highlighting the ways in which Dolores had experienced injustice and encouraging Dolores to acknowledge the ways in which her actions had hurt Olivia (Ducommun-Nagy, 2002). In individual therapy, Dolores gained awareness that she felt justified in asking so much from Olivia because she felt she could not rely on others who she perceived as having abandoned her, and Olivia had proven herself to be reliable. While she was originally blind to seeing how this placed an immense amount of pressure on Olivia, she came to acknowledge the ways this injustice impacted Olivia's well-being. Initially crediting and acknowledging Dolores' positive efforts provided her with the safety and validation necessary to allow Dolores to be open to questions that hinted at her need to be accountable for the relationship. In this way, Dolores was able to begin to take responsibility for herself without feeling attacked or guilt-ridden. Taking into account the impact of aging and her struggles with panic disorder, Dolores was able to explore new relational options by balancing her requests for assistance from others and offering support to others, as well (Hargrave & Anderson, 1992).

It is also important to specifically address the role of empathy in this therapeutic process. As Dolores experienced empathy from the therapist, she was more able to empathize with her own emotional experiences. By accepting rather than trying to avoid her own emotional experiences, she experienced a decline in the frequency and severity of her panic attacks (Levitt et al., 2004). In addition, Dolores became able to take on a more empathic and accepting stance toward Serena. Thus, Dolores recognized her own perspective and merits while also acknowledging the perspective and merits of Serena, and this helped create the space for a sincere, trust-building dialogue.

With a foundation of empathy and acceptance of individual and relational perspectives, Dolores and Serena successfully used family therapy sessions to navigate the exchange of benefits and burdens in a more just manner than they had previously. The therapist helped facilitate conversations between mother and daughter in which they could each acknowledge the ways in which they had both experienced pain as a result of tragic loss and unjust interactions within the family. By making the sense of injustice in the family explicit rather than denying its existence, Dolores and Serena were able to begin the process of healing. Once they acknowledged past injustices, they discussed ways in which they could presently work to provide each other with reciprocal support, helping to restore the balance of fairness within the family. They were also able to acknowledge the ways in which the restoration of their relationship could have positive effects on other members of the family system by decreasing Dolores' overreliance on Olivia.

### Limitations

While contextual therapy was especially useful in helping Dolores decrease her symptoms of panic attacks and improve her relationship with her daughters, there are some limitations to using contextual therapy to treat panic disorder. Contextual therapy generally works best with clients who are at least somewhat inclined toward seeking insight into the nature of their individual and relational problems. In order to help clients reach a stage in which they can see the value of insight, it may be necessary to incorporate elements of CBT to first decrease symptoms of panic attacks so that clients can engage in deeper, insight-oriented work. For clients who are less inclined toward gaining insight, contextual therapy can still be useful when the therapist makes adjustments such as being more directive in turning dialogue into actions addressing the underlying issues of trust and fairness.

In addition, contextual therapy presents an optimal fit for clients who are willing to engage in working to restore trust and fairness in their relationships outside of the therapy room. Despite the misconception that contextual therapy solely emphasizes insight into the past, contextual therapy requires an active commitment to restoring relational ethics in the present tense (Ducommun-Nagy, 2002). This approach is likely to be less beneficial with clients who wish to talk about their problems but are not yet motivated to create behavioral change. In other words, insight alone is insufficient to create lasting intrapersonal and interpersonal change.

### Recommendations for Future Research

Although contextual therapy is currently underutilized as a model for individual, couple, and family therapy, an increase in clinically based literature and empirical research could help to remedy this problem. To date, there are



no publications of a manualized form of contextual therapy, which presents challenges for examining the effectiveness of using this approach with any population. Future studies could remedy this gap in the literature to examine the effectiveness of using a contextual therapy framework in relieving symptoms of anxiety and co-morbid depression. Potential outcome measures to assess progress in therapy could include the Relational Ethics Scale (Hargrave et al., 1991) and any number of validated anxiety and depression scales. Researchers could also conduct studies to determine whether there is a relationship between an improvement in perceived relational ethics and a decrease in anxiety symptoms, regardless of participation in therapy utilizing a contextual framework.

## CONCLUSION

Contextual therapy can be a successful approach to treat a wide variety of issues when working with individuals, couples, and families. As Goldenthal (1993) explained, “contextual therapy is intergenerational, integrative, multilateral, and oriented toward resources and the future” (p. 2). Contextual therapy is uniquely suited to address how fairness issues and beliefs about entitlements impact close relationships. Through this approach, therapists are able to address the perspectives of others who are not present in the therapy room but are still affected by therapeutic interventions related to the balance of fairness within the system. As a therapist empathetically acknowledges painful experiences of injustice as well the restorative contributions of all individuals within the system, clients are empowered to seek healing by resolving an imbalance of trust and fairness within the family system, extending benefits to both mental and physical health.

## NOTE

1. The case study is based on a composite of clients with whom the authors have worked. All names and identifying information have been changed to protect the clients' anonymity.

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