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Effectiveness of Psychodrama Therapy in Patients with Panic Disorders – Final Results

Galabina Tarashoeva, Petra Marinova-Djambazova & Hristo Kojuharov

Abstract

In the last 20 years, psychodrama has become a popular method for psychological treatment in Bulgaria. However, there was no scientific evidence of its effectiveness in the Bulgarian public system for mental health care so far. Here, we present the results of an experimental interventional study of the effectiveness of Psychodrama for patients with panic disorders. Two psychodrama groups with patients (n = 20) with panic disorders were run consecutively, each in parallel with a control group with the same number of patients (n = 20) with panic disorder, receiving only pharmacotherapy.

A team of 2 certified psychodramatists, directed the psychodrama groups for one 3-hour session weekly. Each group worked for 6 months (25 group sessions). Each of the patients – in the therapy group and in the control group – continued to receive their pharmacotherapy and regular treatment from their psychiatrist. All patients were evaluated with HAM-A, SAI-R and CORE-OM three times – baseline, on the 6th month, and on the 12th month (6 months after the end of the period of the group therapy). The results show that the patients receiving parallel treatment with psychodrama and pharmacotherapy achieved significantly greater reduction in their anxiety symptoms, increase in their spontaneity, and an improvement in their quality of life and social functioning, versus the patients receiving only pharmacotherapy.

Key words: psychodrama, spontaneity, anxiety, panic disorder

Background

The questions that contemporary researchers in psychotherapy, including in psychodrama, face are undergoing development. At the beginning, researchers questioned themselves: "Is psychodrama working?"; "Is there any real change?" – looking for effectiveness and results. The next stage of research in psychodrama was the search for causality – "Is this change a result of the psychodrama, or of something else?" And now when there is evidence that there is change, and that it is due to psychodrama, we are faced with questions like: "How is psychodrama helping?", and "Which are the processes that lead to this change?" – so, the subject of research interest now is the process (Elliot, 2002).

A recent review showed that there is no evidence of a difference in the efficacy and acceptability between psychological therapies and pharmacological interventions for panic

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disorder (Imai, 2016). Although several kinds of psychotherapies are applied in the treatment of panic disorder, it is Cognitive Behavior Therapy that has been mainly studied so far. Data show significant improvement in panic disorder with different CBT techniques: graduated exposes, paradoxical intention, and progressive deep muscle relaxation. (Michelson *et al.*, 1988).

To the best of our knowledge, so far there is no published research on the effectiveness of psychodramatic psychotherapy in the treatment of panic disorder. Psychodramatists, like other existential psychotherapists, usually don't differentiate the groups on nozological criteria (Viera, 2007). The diagnosis is considered as one of the roles the patient developed in a rigid and out of context manner. The mental illness is thought to appear as an inadequate manifestation or pathology of spontaneity and creativity (Moreno *et al.*, 1975). Yet, recently psychodrama psychotherapy has been studied in different other illness like major depressive disorder (Costa, 2006).

The central theoretical and clinical concept of psychodrama is spontaneity (Moreno, 1944). Spontaneity, in a colloquial meaning, is understood as a "quick", "sudden", "impulsive" response. It is characterized as a response, free from moral inhibitions – "without restraint" or "unconstrained" emotional expression. The use of the term 'spontaneity' in this colloquial sense contains both positive (honesty and openness) and negative (uncontrolled actions without regard for personal and social norms and boundaries) connotations.

According to Moreno, spontaneity is invisible energy that propels the individual to a *"new response to an old situation or an adequate response to a new situation"* (Moreno, 1944). It is associated with good mental health and is considered a measure of therapeutic progress (Christoforou & Kipper, 2006). Moreno looked at spontaneity as a skill – *"Spontaneity can be trained and, in fact, training clients to become spontaneous has been a fundamental goal of the psychodrama treatment"* (Blatner, 2000; Kipper, 1986). Conceptualized by Prof. David Kipper, **s**pontaneity is an experiential "state of mind", rather than either energy, or a skill. His studies showed positive correlations between a measure of spontaneity and well-being, self-efficacy and self-esteem, and negative correlations between spontaneity and anxiety, stress and obsessive-compulsive tendencies (Christoforou & Kipper, 2006; Kipper *et al.*, 2008; Kipper *et al.*, 2009).

Moreno measured spontaneity with action-based methods such as the Spontaneity test (Moreno, 1944), while David Kipper created for this purpose a tool called SAI-R (Kipper *et al.*, 2008). The creation and validation of this tool allows for measurement and comparison of spontaneity among various groups in research and boosts the study of change in spontaneity during the therapeutic process.

Behavioural inhibitions is now recognized as a risk factor for development of adult anxiety disorders and studies show its roots in childhood with caution, timidity, shyness and introversion (Kagan *et al.*, 1984). A retrospective study found that panic disorder patients had a higher rate of behavioural inhibition than controls (Reznick *et al.*, 1992). These data imply blocked spontaneity in these individuals, starting in childhood and increasing during the years, reaching a maximum at the beginning of panic attacks. Psychodrama, as a method evoking the spontaneity and creativity, may be hypothesised to be very helpful and effective in these populations.

Besides, despite the growing popularity of psychodrama in Bulgaria, there is no scientific evidence of its effectiveness in our country. Therefore, we need to seek scientific evidence for the effectiveness of the psychodrama method in our settings first, and then to seek an answer to the question, *"What is the therapeutic process of psychodrama that leads to therapeutic change?"*

In this study, for the first time we study the effectiveness of psychodrama method in a Bulgarian sample and we are looking for common psychological problems in people suffering from panic disorder. In this article we present our observations and final results from our work with 2 therapeutic groups and 2 control groups.

Design of the Study

The goal of the research is to answer the research question: *"Is psychodrama an effective method in the treatment of patients with panic disorder?"* The hypothesis is that: in patients with panic disorder, a parallel treatment with psychodrama therapy and pharmacotherapy is more effective than pharmacotherapy alone.

The strategy in order to achieve this goal was to compare the reduction of symptoms, and the change in the quality of life in patients with panic disorder, before and after parallel treatment with psychodrama and pharmacotherapy versus pharmacotherapy alone, and in a parallel with this to track the change in the level of the spontaneity.

Material and Methods

We conducted an open, randomized, prospective interventional clinical research pilot with a control group. All patients were suffering from panic disorder (according the definition of DSM-IV-TR) and were receiving pharmacotherapy (standard for the disorder) under the cares of their own psychiatrist.

The patients were randomly distributed into two groups – a psychodrama group (n = 20) and a control group (n = 20), with a stratification for demographic parameters, illness characteristics, and a baseline of spontaneity and anxiety. The psychodrama treatment was conducted in two consecutive psychodrama groups, directed in the Mental Health Centre "Prof. N. Shipkovensky", Sofia, Bulgaria. In parallel with each psychodrama group, there was a control group with the same number of patients with panic disorder who were only receiving pharmacotherapy.

The first psychodrama group had nine members and took place from 17.11.2014 to 17.05.2015. The 6-month follow-up of the patients from the first psychodrama group, and from the first control group (also with 9 members), was done after 17.11.2015. The second psychodrama group had 11 members, and took place from 27.05.2015 to 09.12.2015. The 6-month follow-up of the patients from the second psychodrama group, and from the second control group (also with 11 members), was done after 09.06.2016. Both psychodrama groups were directed by team of two certified psychodrama therapists, and each of them worked for 6 months with 25 group sessions (3 hours each, weekly).

A semi-structured interview according to the diagnostic criteria of DSM-IV-TR, done by clinicians, was used for diagnostics of the patients. Afterwards, all the participants in the study were examined with 3 tools – HAM-A, SAI-R and CORE-OM, and the evaluations of the patients were performed three times: the first at the baseline; the second at the 6th month (at the end of the period of the group therapy); and the third at the 6-months follow-up, after the end of the period of the group therapy. The Hamilton test for anxiety disorders (HAM-A) (Hamilton, 1959) was used for evaluation of the severity of the disorder**;** CORE-OM (Evans *et al.*, 2000) and SAI-R (Kipper *et al.*, 2008) were used for measuring the change in symptoms, the quality of life, social functioning, and spontaneity**.** The questionnaire CORE-OM (Clinical Outcomes in Routine Evaluation) is created by Chris Evans (Evans *et al.*, 2000) and validated in Bulgarian language in 2013 (Testoni *et al.*, 2013). This is a self-reported measure with 34 items covering four dimensions: *1. subjective well being with 4*

items (W); 2. problems/symptoms with 12 items (P); 3. life/social functioning with 12 items (F); 4. Risk or harm to self and to others with 6 items (R). The measure is problem scored, i.e. the higher the score, the more problems the individual is reporting and/or the more distressed they are. CORE-OM is designed to *"help bridge the gap between research and practice"*: it is short, user friendly (client and therapist), useful and "copyright free" (Evans *et al.*, 2003). The SAI-R (Spontaneity Assessment Inventory) is a special questionnaire, created by David Kipper, to measure spontaneity (Kipper *et al.*, 2008) and validated in the Bulgarian language in 2013 (Testoni *et al.*, 2013). It is also a self-reported inventory, but with 18 items, designed to measure the intensity of feelings and thoughts that characterize the state of mind described as spontaneity. The investigated had to answer questions like, *"How strongly do you have these feelings and thoughts during a typical day?"* (Kipper *et al.*, 2008).

Sample Characteristics

All patients in the study met the diagnostic criteria of the DSM-IV-TR for panic disorder with / without agoraphobia, and were divided into 2 groups: a psychodrama group (the patients received in parallel pharmacotherapy and psychodrama) and a control group (only pharmacotherapy).

The Psychodrama group consisted of 17 females and 3 males, with an average age 43.7 years (with a range between 25 and 59 years): 11 of them had a University degree in education; 9 had graduated high school; and there is no one with just primary school education. The average duration of their illness was 7.7 years, while the average duration of the current episode was 10.7 months, with an average duration of pharmacological treatment of 8.4 months.

The Control group consists of 13 females and 7 males, with an average age 42.85 years (with a range between 22 and 60 years): 10 of them had a University degree of education; 9 had graduated high school; and 1 had a primary school level of education. The average duration of the illness was 7.58 years, while the average duration of the current episode was 11.0 months, with an average duration of pharmacological treatment of 8.7 months.

All patients in both groups were on medication prior to the study, and there was no significant difference regarding the time spent on medications. The two groups were not significantly different in any of those demographic and illness criteria (see Tables 1 & 2).

	Psychodrama	**Controls**	**Significance (Stat. test)**
Average age	43.7 years (SD 9.65) (min 25, max 59)	42.85 years (SD 11.37) (min 22, max 60)	p = 0.80 (t test)
Gender	85% females (**17** female and **3** male)	65% females (13 female and 7 male)	p = 0.273 (Fisher test)
Educational level	University: n = 11 High school: n = 9 Primary school: n = 0	University: n = 10 High school: n = 9 Primary school: n = 1	p = 0.53 (Chi square)
Partnership Status	Single: n = 6 Living with partner: n = 13 In a relationship: n = 1	Single: n = 8 Living with partner: n = 12 In a relationship: n = 0	p = 0.52 (Chi square)

Table 1. **Demographic parameters of the sample**

	Psychodrama	Controls	Significance (Stat. test)
Average Duration of illness (in years)	7.7 (SD 7.58)	7.58 (SD 6.44)	p = 0.95 (t test)
Average Duration of episode (in months)	10.7 (SD 12.95)	11.0 (SD12.43)	p = 0.94 (t test)
Average Duration of Pharmacological treatment (in months)	8.4 (SD 12.82)	8.7 (SD 12.43)	p = 0.94 (t test)

Table 2. **Illness characteristics of the sample**

There is no significant difference between the two groups in the baseline values of all the assessment tools (HAM-A, SAI-R, and CORE-OM), except for CORE-OM-F.

Results

Measure 1: *Increase in Spontaneity*

In the group that had been treated additionally with psychodrama, spontaneity was significantly increased at the 6th month evaluation (61.3 vs 49.25; t = 3.007; df = 38; p < 0.05). This increase remained significant 6 months after completion of the treatment course (60.65 vs 45.5; t = 3.824; df = 38; p < 0.05) (see Chart 1).

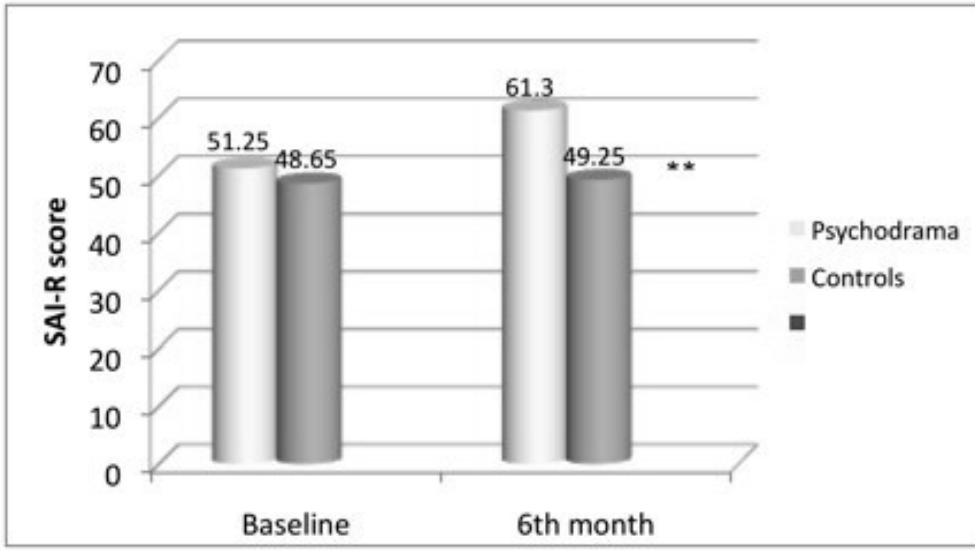

Chart 1. **Improvement in Spontaneity with Psychodrama**

Improvement of Anxiety

In the group treated additionally with psychodrama, at the 6th month evaluation, anxiety symptoms were significantly more decreased than in those treated only with standard pharmacotherapy (13.2 vs 25.75; t = -4,245; df = 38; p < 0.05). This improvement remained

significant 6 months after the completion of the psychodrama treatment course (10.9 vs 25.15; t = - 5.119; df = 31.775; p < 0.05) (see Chart 2).

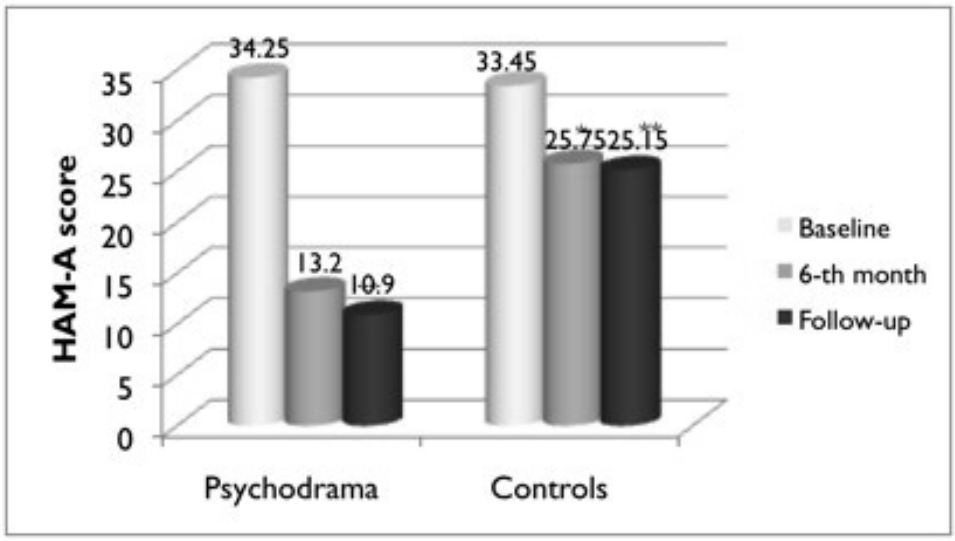

Chart 2. **Improvement in Anxiety with Psychodrama**

Measure 2: ***Improvements in the CORE - Outcome Measure***

In the group that was treated additionally with psychodrama for 6 months, the Outcome Measures were significantly improved in comparison with those treated only with standard pharmacotherapy (0.75 vs 1.35; t = -2.973; df = 38; p < 0.05). This improvement remained significant 6 months after completion of the psychodrama treatment course (0.69 vs 1.38; t = -3.694; df = 38; p < 0.05) (see Chart 3).

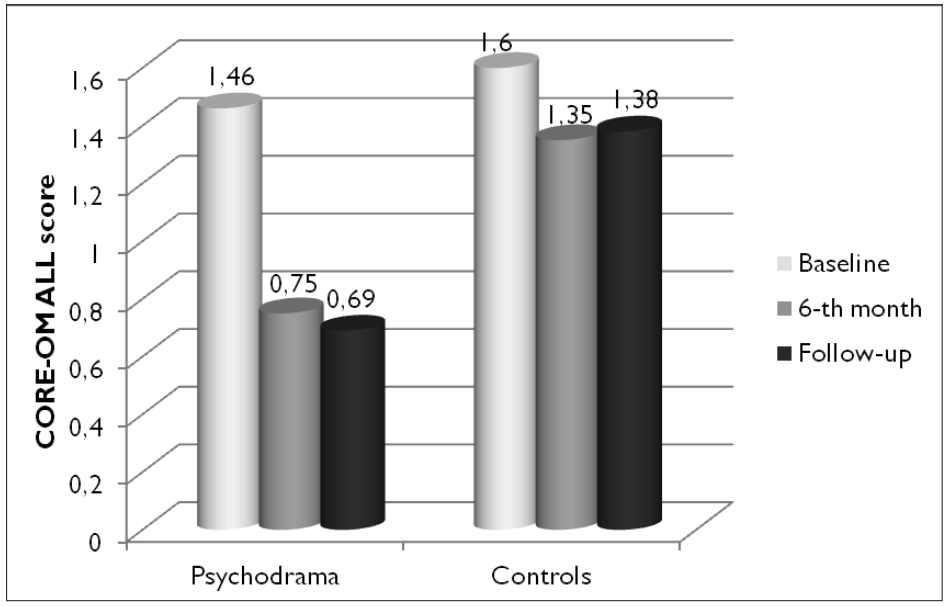

Chart 3. **Improvement in Outcome with Psychodrama**

Improvement of Well-Being

In the group, treated additionally with psychodrama for 6 months, well-being (W) was significantly improved in comparison with those treated only with standard pharmacotherapy (0.99 vs 1.69; t = -2.537; df = 38; $p < 0.05$). This improvement remained significant 6 months after completion of the psychodrama treatment course (0.94 vs 1.81; t = - 3.162; df = 38; $p < 0.05$) (see Chart 4).

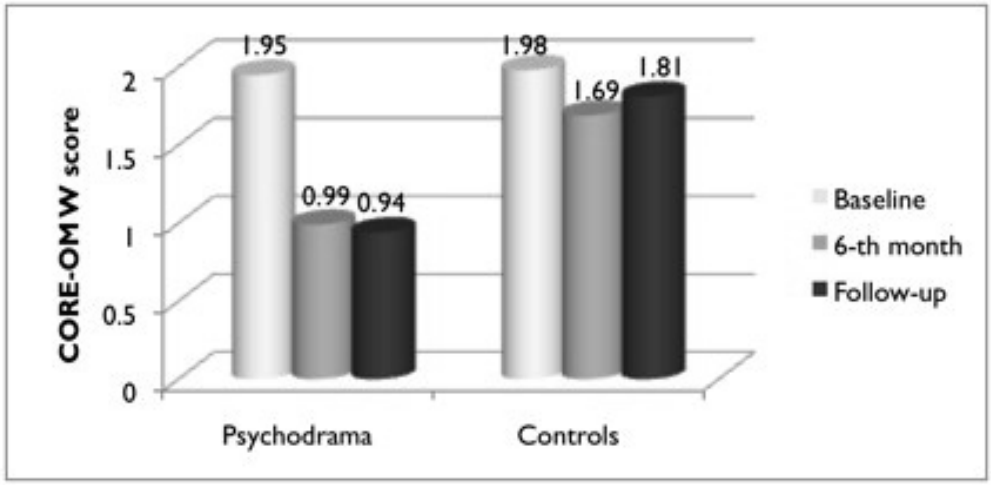

Chart 4. **Improvement in Wellbeing with Psychodrama**

Improvement of the Problems domain

In the group, treated additionally with psychodrama for 6 months, the score for problems was significantly reduced in comparison with those treated only with standard pharmacotherapy (1.08 vs 1.72; t = -2.352; df = 38; $p < 0.05$). This improvement remained significant 6 months after completion of the psychodrama treatment course (0.96 vs 1.85; t = -3.547; df = 38; $p < 0.05$)

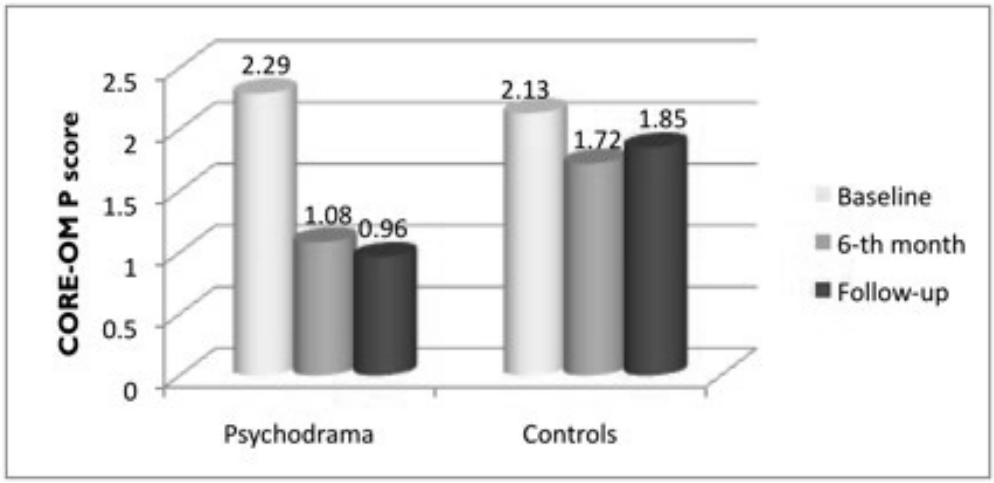

Chart 5. **Improvement in Problems/Symptoms with Psychodrama**

Functioning

Limitation: The psychodrama group and control group turned out different in their baseline score for functioning (1.15 vs 1.68; t = - 2.468; df = 30.127; p = 0.019). Although there is a tendency of improvement in functioning, no conclusions can be made. Further analyses are to be done.

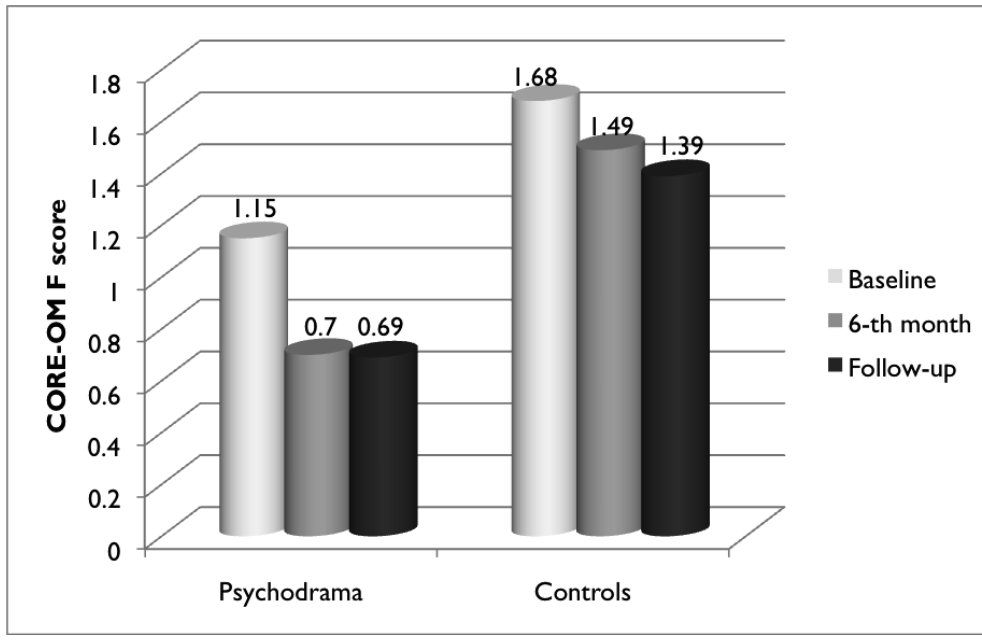

Chart 6. **Change in Functioning**

Improvement of Risks

There is a gradual tendency of improvement of the risk score in both treatment groups. There is greater, but not a significant, improvement in the group treated additionally with psychodrama (0.05 vs 0.1; t = -1.098; df = 32.345; p = 0.28). The difference in the improvement reaches statistical significance on the follow-up evaluation (0.02 vs 0.1; t = -2.231; df = 28.138; $p < 0.05$).

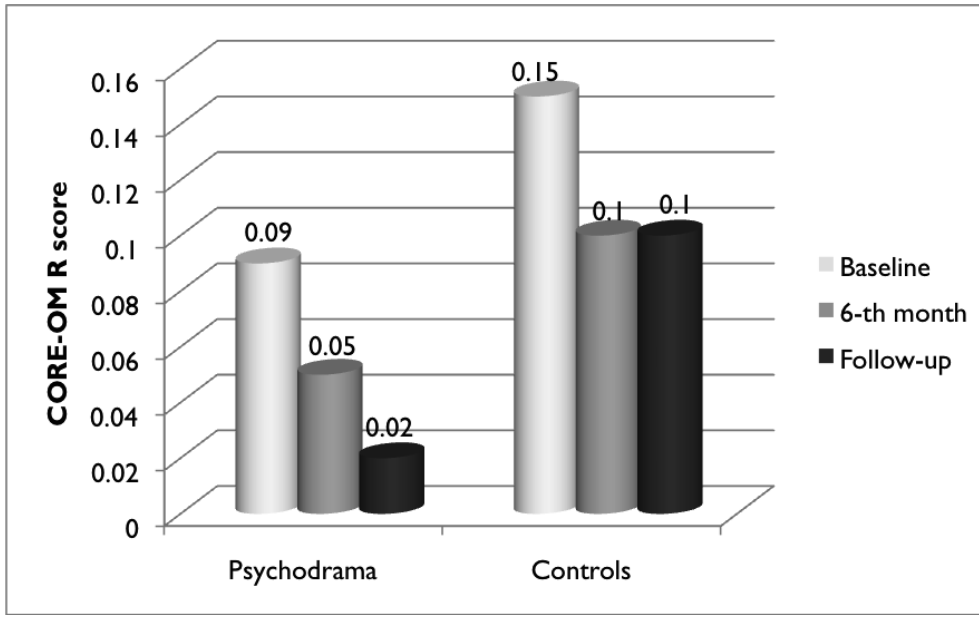

Chart 6. **Improvement in Risk with Psychodrama**

Discussion

There is more and more data on the efficacy of psychological therapies. A recent review of 16 studies with a total of 966 participants on comparative efficacy and acceptability of psychological therapies versus pharmacological interventions for panic disorder with or without agoraphobia in adults showed no evidence of a difference between psychological therapies from one side and selective serotonin reuptake inhibitors (SSRIs), or tricyclic antidepressants, or other antidepressants, or benzodiazepines, or antidepressant alone or antidepressants plus benzodiazepines from another side, in terms of short-term remission or short-term response, or in treatment acceptability as measured using dropouts for any reason (Imai, 2016).

For psychodrama in particular, a meta-analysis of psychodrama research showed that the overall treatment effect size for the 25 studies was 0.95 (Kipper & Ritchie, 2003), above the cut-off level of 0.80 that customarily indicates a large effect (Cohen, 1992). This effect size is slightly higher than the comparable results commonly reported in the group psychotherapy literature for the effectiveness of group therapy in general (0.50 – 0.70) (Fuhriman & Burlingame, 1994).

Spontaneity is a key concept in psychodrama both for understanding the pathogenesis and the therapeutic process. A healthy person is quickly able to mobilize spontaneity, necessary for him/her to respond to the pressures of life's problems. To cope with the impacts of the environment, the person must develop new roles, and update and synchronize them with the others in the role-repertoire (Tarashoeva, 2002). Passing through severe traumatic experiences in childhood without the necessary support leads to intra-role and/or inter-role conflicts and a general disintegration of the person's psychic process (Goldman, 1984). Unexpressed emotions often remain deeply repressed; emotional processes remain an "unfinished business", both of which can lead to depression or anxiety. To overcome the role

rigidity, it is necessary to 'wake up' the process of spontaneous creativity, and unblock deeply repressed and unexpressed emotions (Goldman, 1984). Activation of a person's spontaneity and creativity makes it possible for them to search for new solutions to old situations, or adequate answers to new situations. Trying out new approaches and behaviours first – in the safe space of the therapeutic group – is followed by an integration of the new experiential experience into the subjective reality of the individual, and this helps bring about the necessary therapeutic change (Goldman, 1984).

Research conducted by Kipper and Christoforou among students shows that spontaneity cannot exist alongside a state of anxiety (Christoforou & Kipper, 2006). This discovery confirms the earlier hypothesis of Moreno for competition between spontaneity and anxiety (Moreno, 1964). Spontaneity and anxiety can exist within the same person, but not at the same time, nor within the same situation (Moreno, 1964). The above-mentioned study also found that spontaneity is negatively associated with obsessive-compulsive tendencies among the surveyed (Christoforou & Kipper, 2006).

Another study conducted by an international team of institutes (including Psychodrama Center "Orpheus"), members of FEPTO (Federation of European Psychodrama Training Organizations), under the leadership of the University of Padua, explored the essence of spontaneity and its causal relationship to mental well-being (Testoni *et al.*, 2013). It found that the there was a negative correlation between SAI-R and CORE-OM. The results suggested a causal relationship between low spontaneity and mental suffering and confirmed the hypothesized model showing significant negative causation (Testoni *et al.*, 2013).

The results of our study are in line with another clinical study, performed about a decade ago in São Paulo, evaluating psychodramatic psychotherapy combined with pharmacotherapy in major depressive disorder. Patients with mild to moderate depression were divided into two groups: those in the psychotherapeutic group took part in 4 individual and 24 structured psychodramatic group sessions, whilst subjects in the control group did not participate in this psychodramatic psychotherapy. Psychotherapeutic group patients showed a significant improvement of social adjustment and depressive symptoms, compared to those of the control group (Costa, 2006). Results suggest that individual and group psychodramatic psychotherapy, associated to pharmacological treatment, provides good clinical benefits in the treatment of major depressive disorder (Costa, 2006).

The clinical study herein, built on this theoretical model tested in these non-clinical samples, now confirmed that – with an increase of the spontaneity through psychodrama – there is a significant reduction in the anxiety of the patients with clinically significant symptoms and an improvement of their sense of well-being and general outcome.

Having found evidence about the effectiveness of the psychodrama method in a Bulgarian sample, future work of the research team will be directed towards uncovering the therapeutic factors in psychodrama therapy. The field is in deep need of more research about how and with which psychodrama techniques therapists could unlock the therapeutic process in patients.

Conclusions

Patients with panic disorder treated in parallel with psychodrama and pharmacotherapy show greater improvement in their anxiety symptoms than those treated with pharmacotherapy alone. This improvement goes along with a significant increase in their spontaneity, reduction of their problems and improvement of their well-being and general clinical outcomes. The improvement in their anxiety symptoms remained significant 6 months after completion

of the psychodrama treatment course. The increase in their spontaneity, reduction of their problems, and improvement of their well-being and general clinical outcome also remained significant 6 months after completion of the course of treatment.

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