Theory and Technique in Psychodynamic Treatment of Panic Disorder

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The authors elaborate psychodynamic factors that are relevant to the treatment of panic disorder. They outline psychoanalytic concepts that were employed to develop a psychodynamic approach to panic disorder, including the idea of unconscious mental life and the existence of defense mechanisms, compromise formations, the pleasure principle, and the transference. The authors then describe a panic-focused psychodynamic treatment based on a psychodynamic formulation of panic. Clinical techniques used in this approach, such as working with transference and working through, are described. Finally, a case vignette is employed to illustrate the relevance of these factors to panic disorder and the use of this treatment.

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Psychodynamic psychotherapy has become relegated to a secondary status as a treatment for panic disorder in the general psychiatric literature, in large part because of the lack of systematic studies regarding its effectiveness. The necessity for such psychoanalytic research has recently been emphasized by Compton.[1] Nevertheless, many clinicians have observed that psychodynamic approaches can be of significant value in the treatment of panic patients.

One impediment to research in this area has been the lack of a defined treatment for panic disorder. Psychoanalytic approaches have tended to be more broadly applied to generalized diagnoses of character neuroses, without specifications or modifications of treatment techniques for particular disorders. We will outline core elements of psychoanalytic theory that have been used in developing a testable manualized psychodynamic psychotherapy for panic disorder. This therapy, panic-focused psychodynamic psychotherapy (PFPP),[2] is currently being used by our group in an open clinical trial for the treatment of patients with panic disorder. We include a case vignette that illustrates the use of the theory and techniques.

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THEORETICAL UNDERPINNINGS OF PFPP

In outlining PFPP, it is important to delineate several general psychoanalytic precepts that were central to the formulation of a manualized treatment for panic disorder.

The Unconscious

Psychoanalytic theory hypothesizes that all of mental life exists on two levels: within the realm of consciousness, and also within a less accessible realm that Freud labeled the unconscious.[3] Psychic or emotional symptoms arise from aspects of mental life that are at least in part unconscious.

From our early work with patients with panic disorder, it became evident that this group of patients has intense angry feelings of which they are often totally or partly unaware. Typically, panic patients tend to minimize these feelings during initial evaluation, but as exploration with the patient continues, unacknowledged rage is found to be an increasingly important part of mental life at the time of panic onset. We link these partially or totally unconscious feelings to panic onset.

In addition, we have found that patients' feelings that their panic symptoms "come out of the blue," an idea that is underscored in DSM-IV (p. 397),[4] are related to their lack of conscious awareness of the meaningful stressors and ensuing intrapsychic reactions that led to panic. Many studies suggest that acute stressors, described in the literature as "life events," occur just prior to panic onset.[5–7]

A related central organizer of mental life is unconscious fantasy.[8] Persistent unconscious fantasies often underlie people's psychological symptoms, dreams, personalities, and life choices. Unconscious fantasies are important underpinnings to panic symptoms, and it is valuable to help patients become aware of these fantasies with a goal of effecting symptomatic change.

Clinical Example 1. An example of this process is provided by a patient with panic disorder who lived with the persistent unconscious fantasy/wish that she would become closer to her beloved but rejecting physically impaired brother by being ill, impaired, and pathetic herself. At the time of her presentation, she was aware of having strong "irrational" feelings of loving and wanting to protect her brother, even though he routinely was mean to her. It emerged in the course of psychotherapy that she had completely "forgotten" about the existence of a chronic childhood illness he had that had greatly affected her life. She began to remember these things gradually, at a time of temporary worsening of her panic symptoms when she was accepted to a prestigious graduate program—something that she was surprised to discover made her "unaccountably miserable." The patient became aware that her success with graduate school acceptance triggered a fear of the loss of her fantasy of being ill and pathetic like her brother, and her worsening panic attacks served to reestablish her view of herself as being weak and damaged. Her panic resolved and she was able to alter some of her earlier tenaciously held feelings only after she was able to consciously recognize these issues in her therapy.

Compromise Formation

According to Freud, many aspects of mental life, including symptoms (such as anxiety), dreams, fantasies, and various aspects of character, are the result of "compromise formations."[3] In brief, a compromise formation symbolically encapsulates a compromise between a forbidden wish and the defense against the wish. Panic attacks represent such compromise formations, often an attempt to compromise between angry feelings and fantasies and fears of abandonment. The following case vignette is an example of panic representing a compromise formation: a symbolic representation of both a forbidden wish and the defense against the wish.

Clinical Example 2. Ms. W., an 18-year-old woman, was driving from one city to another in order to attend her eighteenth birthday party when she experienced her first panic attack. The attack was so severe that she had to drive off the road, call her mother in the city toward which she was driving, and ask her mother to pick her up on the highway. The process of her mother's finding another person to drive with her who could also drive the car back took several hours, and in the meantime, Ms. W.'s party had to be canceled. At the moment that she experienced the attack, Ms. W. had found herself thinking that her eighteenth birthday was very important to her: it symbolized her "total independence" from her family and a new ability "to get rid of them." In the process of unraveling the onset of her illness later in psychotherapy, it became clear that in her fantasy, turning 18 and being "independent" represented the emotional equivalent of killing off her parents and siblings, all of whom enraged her. The fantasy was so full of conflict for her that she had her first panic attack. The panic symptoms represented both the wish to be alone and independent (suddenly she found herself, in fantasy, feeling entirely alone) and the defense against this wish: a sudden-onset, severe illness that made her "independence" from her family (and the very existence of her birthday celebration) impossible and effectively immobilized her escape/fantasy murder plan. Rather than a dangerous murderer, she was now helpless and ineffectual. Additionally, the panic represented a real way in which she effectively punished herself for her homicidal (and unacceptable) thoughts: now she could never be free of her family.

The Pleasure Principle

Freud initially described another central principle in the organization of mental life, the pleasure principle:[9] that people unconsciously avoid "unpleasure." Clinically, the degree to which "unpleasure" is avoided varies from patient to patient. Despite the misery of panic attacks per se, from a psychodynamic perspective panic attacks represent the least unpleasurable solution to the intrapsychic conflictual situation at hand. In other words, the intrapsychic conflicts, including angry fantasies and fears of loss that underlie the symptoms, are more distressing to panic patients than the experience of the panic attacks.

Clinical Example 3. Mr. D., a 45-year-old man, presented with severe symptoms of panic, particularly focused on chest pain with fear of having a heart attack and arm weakness with a fear of having a stroke. In the initial evaluation, it emerged that his father had died from heart disease and his mother had suffered a debilitating stroke. Despite this immediate evidence of a psychological source of his fears, Mr. D. struggled with the notion that his panic symptoms were psychologically meaningful and were triggered by intense, overwhelmingly painful feelings. As he began to discuss some of the difficult experiences he recalled with his parents growing up, he became tearful and distraught. Particularly, Mr. D. remembered experiences of humiliation at the hands of his parents, particularly his father, who referred to him as "Dumbo," even in front of his friends. In calling him this his father was implying that the patient was stupid and was to blame for many of the family's ills. Mr. D. felt enraged at his parents, but was told that if he ever expressed his anger, he would be sent away to live with a woman named "Mrs. Cruela," where bad children went. He felt caught between humiliation, rage, and fears of abandonment.

Recollection of these painful experiences proved at least as distressing as the experience of panic itself, as he repeatedly struggled to understand why his parents treated him in this way. He became even more convinced of the relationship between these issues and his symptoms when it was found that his panic symptoms were regularly triggered by the experience of his wife being abandoning, paying attention to her many friends rather than to him. Panic attacks were less threatening to him than the experience of rage at his wife, which he was convinced would cause her to leave him.

Defense Mechanisms

Ideas and feelings that produce unpleasure are screened from consciousness by "repression,"[10] or processes that we now call defenses. We have found, both in clinical observations and in a systematic study, that the defense mechanisms of reaction formation, undoing, and denial are frequently employed by panic patients.[11] Reaction formation and undoing appear to be particularly active in panic patients, as these mechanisms involve both the denial of anger and an emphasis on affiliative feelings.

Clinical Example 4. Ms. C., a 32-year-old woman, developed panic attacks with claustrophobia shortly after her marriage. The courtship had gone fairly smoothly, apart from some tense discussions about whether Ms. C. should convert to the religion of her fiancé (she ultimately did not). Her symptoms intensified further about 3 months later when her husband decided to take a new job that would keep him much busier. Ms. C. readily agreed to the job change, even though she felt isolated in her environment and had already felt ignored because of her husband's level of involvement with his job. She initially denied any anger at him, stating that it was important to go along with his plan and help him as much as possible in his career because he supported her financially.

Ms. C. grew up in an environment in which she felt intensely pressured by her family to perform academically. She reported being berated repeatedly for not being a top performer. Ms. C.'s real focus was on painting, in which she demonstrated talent beginning at a very early age. In the face of her parents' pressure and attacks, she alternated between intense rage accompanied by stubborn refusal to compete academically, and a submissive, anxious state in which she felt guilty and agreed with what she saw as her parents' view that she was a bad or lazy person for not working harder. Ms. C. felt that it was necessary for her to be in this latter state in order to be accepted by her parents.

After discussion, it emerged that Ms. C. worried right from the start of her marriage that her husband would attempt to control her and push his agenda in preference to her wishes, just as she felt her parents had done—even though she had specifically married someone who did not take this approach with her. Ms. C. then began to be aware of intense angry feelings toward her husband for having encouraged her to change religions and subsequently for pushing his career needs ahead of their relationship, even though she had not indicated to him how much these issues bothered her. Her concerns that her anger would disrupt their relationship led to a denial of these feelings and the use of reaction formation, in which she emphasized her wishes to help him when she was actually furious with him. However, this pattern only intensified her unconscious anger, and the danger of its emergence was a trigger for her panic.

Transference

A cornerstone of psychodynamic theory and practice is the psychological phenomenon of transference.[12] Transference is a universal phenomenon in which aspects of important and formative relationships (such as with parents and siblings) are unconsciously ascribed to un-

related, current relationships. This fundamental unconscious process also importantly occurs in relationships between therapists and patients. In clinical practice, recognition of underlying fantasies that surround the therapeutic relationship can prove helpful to patients, regardless of the type of treatment or the therapeutic orientation of the therapist. From a psychodynamic perspective, the transference situation has far-reaching effects and necessarily influences therapeutic outcome regardless of the therapeutic modality employed.

Clinical Example 5. A psychopharmacologist who specializes in the treatment of patients with panic disorder reported the following case: an older woman patient with panic disorder who had been in treatment with him for years had been on very high doses of benzodiazepines. She and her physician had been engaged in a very slow and gradual taper of the drug as her panic attacks had remitted. She was in the middle of this taper, still on a substantially high dose of benzodiazepines, and had been tolerating the taper well. The pharmacologist lowered her dose again in a "microscopic decrement" prior to leaving for a vacation. The patient had "the worst panic attack in my life," for which she still has "not forgiven" him years later.

Benzodiazepine taper is well known to be difficult in this patient population because of the common experiences of withdrawal syndromes and rebound anxiety. It is for this reason that benzodiazepine tapers are best accomplished over a period of months. Nonetheless, in the Cross-National Panic discontinuation phase, most of the patients treated with alprazolam experienced their most severe withdrawal syndromes and rebound anxiety either at the very end of the drug discontinuation phase or during the first week in which they were medication-free.[13] The patient in Example 5 above was in neither situation. However, it is possible that this patient was experiencing a different but equally common panic-related phenomenon: anxiety when being separated from the important objects in her life—in this case, her psychopharmacologist. It is also possible that even in the context of a pharmacological treatment, some degree of focus on the transference situation might have prevented the panic attack.

Signal and Traumatic Anxiety

Two types of anxiety were delineated by Freud.[14] "Signal anxiety" is posited to be an intrapsychic mechanism that generates small doses of anxiety to alert the ego—which is the psychic apparatus that organizes perception, defenses, cognition, anxiety, and mood regulation as well as other mental functions—to the presence of psychologically meaningful dangers and to act as a stimulus to mobilize defenses. Signal anxiety and the attendant triggering of defenses serve to prevent traumatic anxiety. Freud hypothesized that during traumatic anxiety, the ego is overwhelmed by an "excitation, whether of external or of internal origin, which cannot be dealt with" (p. 81). Traumatic anxiety is experienced during what we now label panic episodes.

A Psychodynamic Formulation for Panic

Much has been written concerning the underlying meaning of panic symptoms.[15] Clinical observations indicate that fantasies surrounding separation and independence are common areas of conflict for panic patients. Several epidemiologic studies provide indirect support for this finding.[16–18] As noted above, clinical observation also suggests that patients with panic disorder have intense difficulty tolerating and modulating angry feelings and thoughts.[19,20] Additionally, although panic attacks often occur in the setting of conflicted hostility, for some patients the attacks take on an exciting significance of their own, beyond the common manifest panic thoughts of being ill, dying, or becoming "crazy." Some patients report a frightening or arousing inherent excitement associated with the attacks, often closely tied to sadomasochistic sexual fantasies.[21] Panic attacks can serve a self-punitive function with which patients unconsciously atone for guilty transgressions, as was illustrated by the second clinical example above.

Panic patients are overwhelmed by anxiety much of the time. Either their signal anxiety function is malfunctioning, or the signal warning does not help because their defenses are not operating effectively. From a psychodynamic perspective, panic symptoms are indicative of specific, intense unconscious conflicts that serve an important psychological purpose, the understanding of which forms the cornerstone of psychodynamically based treatments for panic.

We have found that fears of separation and anger are central to panic onset and persistence. From early life, individuals prone to panic struggle with feelings of inadequacy and a sense of being dependent on caretakers to provide safety. This fearful dependency can develop from an inborn excessive fear of the unfamiliar[17,22] or from actual traumatic developmental experiences, such

as loss or abandonment threats. In either case, the child experiences the parent as providing inadequate protection and becomes angry at the perceived rejecting or abandoning behavior. This anger triggers anxiety because of a fear that it will lead to further disruption in the relationship to caretakers, increasing fearful dependency. A repetition of this vicious cycle is triggered in adulthood when fantasies or experiences of disruption in attachments occur, frequently triggered by meaningful life events. The defenses of reaction formation and undoing represent efforts to deny anger and make attachments closer through compensatory positive feelings. However, because of angry feelings that are at least partially unconscious, these defenses ultimately fail to modulate the experienced threat to attachment—leading to the onset of panic.

AN OUTLINE OF PFPP

The following is an overview of our manualized form of psychodynamic psychotherapy for panic disorder. The number of sessions allotted to different phases of treatment varies from patient to patient. PFPP differs from more traditional, open-ended, psychodynamic psychotherapies in that the therapist focuses on panic symptoms and associated dynamics and relates new material in sessions to panic disorder.

Phase I: Treatment of Acute Panic

During phase I, the therapist focuses on elucidating the conscious and unconscious meaning of panic symptoms. The initial evaluation and early treatment include exploration of circumstances, life events, and feelings surrounding panic onset, exploration of personal meanings of panic symptoms, and exploration of feelings and content of panic episodes. We have observed that individual patients attribute unique significance to their symptoms, and that they also experience a variety of unconscious and conscious emotions in addition to anxiety during panic.

The therapist uses this information to begin to elucidate unconscious conflicts in panic disorder. These conflicts commonly revolve around separation and independence, anger recognition and management, and sexual excitement and its perceived dangers. The expected responses to phase I of treatment are panic symptom relief and a reduction in agoraphobic symptoms.

Phase II: Treatment of Panic Vulnerability

During phase II, core dynamic conflicts related to panic, often connected with unconscious aspects of fears of separation, anger, and sexual excitement noted above, must be understood and altered. Dynamisms are identified with the patient, often through their emergence in the transference. Phase II tasks include addressing the nature of the transference and working through.

The expected responses to phase II of treatment include improvement in relationships; a less conflicted and anxious experience of separation, anger, and sexual excitement; and a reduction in panic recurrence.

Phase III: Termination

During phase III, termination, the therapist can directly address panic patients' severe difficulties with separation and independence as they emerge in the treatment. The termination process permits patients to reexperience conflicts directly with their therapists in order for underlying fantasies to be articulated, understood, and rendered less magical and frightening. There is often a reexperiencing of central separation and anger themes in the transference, sometimes with a temporary recrudescence of symptoms as termination approaches.

The expected responses to phase III of treatment include a new ability to manage separations, anger, and independence.

A BRIEF OVERVIEW OF CLINICAL APPROACHES AND TECHNIQUES

Initial Evaluation and Early Sessions

The initial psychodynamic evaluation of the panic patient includes a careful and thorough psychiatric evaluation, including a history of the panic attacks, and thus must focus on details about where and when panic attacks occur, whether the patient experiences symptoms when alone or when with others, and what feelings and fantasies accompany panic attacks. As noted above, it is crucial to remember that the patient's view of symptoms as coming out of the blue represents a defense against the intense emotions that precipitating events have engendered. An important area of inquiry concerns which of

the many panic symptoms are most distressing to the patient, since these details often can point the way to underlying fantasies concerning the psychological meaning of the attacks. Small variations in thoughts often carry important psychological significance.

Early sessions are focused on panic symptoms. If the patient does not spontaneously mention panic, the therapist eventually actively inquires about these symptoms. Early in the treatment, it is important for the therapist to help the patient begin to think about the psychological underpinnings to these symptoms and become more aware of his or her own feeling states.

Indications for Psychodynamic Psychotherapy

Much has been said in the psychiatric community about patients' varying abilities to make use of psychodynamic psychotherapy, and there is a belief among some psychiatrists that patients should be considered candidates for psychodynamic psychotherapy only if they are verbal, psychologically minded, and curious about their motivations. Although all of these qualities can be helpful in facilitating the process of psychodynamic psychotherapy, panic patients often have difficulties in one or more of these areas because of the very nature of their somatic symptoms: that is, they experience intense affects and fantasies as symptoms in their bodies rather than as verbal thoughts.

In our clinical work and in the open trial of PFPP that we are conducting, we have not found that these personal qualities necessarily influence the outcome of psychodynamic psychotherapy for panic disorder. In our experience, patients without many of these abilities have derived significant symptomatic relief from psychodynamic psychotherapy for panic disorder. For instance, 6 of the 10 patients who had completed treatment at the time of this writing in the PFPP study were not judged to be psychologically minded, and 5 of these 6 responded to the treatment.

Reassuring, Engaging, and Calming the Patient

Patients with panic disorder often require a significant amount of reassurance that their problems can be treated. It is essential that therapists provide this reassurance to calm patients enough to begin to explore the underlying meaning of their symptoms. In PFPP, reassurance is employed in a manner that does not close off exploration. For example, the therapist may say: "We know that your internist has reassured you that there is nothing wrong with your heart, so we need to understand more about why you still have the fear that you're dying of a heart attack."

Patients' interest and curiosity can often be engaged by the demonstration of the ways in which panic symptoms are related to current and past modes of thinking and feeling. This process can be facilitated by connecting ongoing emotional concerns with panic symptoms per se.

In clinical practice, psychodynamic psychotherapy is often combined with antipanic medication to calm patients enough to enable them to think.[23] In the open trial of PFPP, however, medication is not being used. Several techniques are employed to calm patients, including reassurance; employing a firm, unruffled, but sympathetic attitude;[24] and making beginning inroads into the understanding of the psychological significance of symptoms, which demonstrates to patients that they can gain control through psychological understanding.

Working Through

The process of working through involves repetition of specific interpretations in different contexts as they apply to different manifestations of the same intrapsychic phenomenon. Although limited in a time-limited psychotherapy, the process of working through is particularly important for this population because of panic patients' difficulty putting their feelings into words and because many aspects of the psychological significance of conflictual material often do not emerge on first appearance.

Working With the Transference

Transference is a powerful phenomenon that permits the patient, within the setting of psychotherapy, to tangibly reexperience and begin to understand affective states and fantasies about important relationships. Our hypothesis is that interpretation of transferential phenomena can be an important agent of therapeutic change in PFPP. We avoid unnecessary external distortions of the unfolding of the transference—such as unnecessary manipulations of the patient's environment, directive behavioral guidance on the part of the therapist, or unnecessary involvement of the patient's family in treatment—because they will make the task of delineating

central transferential fantasies more obscure. Some common difficulties that arise in addressing the transference in these patients are that patients often have real reactions to therapists as real people; that therapists can miss patient cues; that an overly aggressive focus on the transference can foster feelings of being misunderstood and intruded on; and that panic patients commonly avoid all feelings about their therapists, much as they avoid other strong feelings.

Approaches to Termination

Termination can be a symptomatic period in these time-limited treatments, as patients grapple with chronic anxiety and rage about separation, independence, and abandonment. Some panic patients feel the urge to flee treatment at this time, in an effort to undo the experience of being abandoned and the emotions associated with loss. Because of this inherent situation, the final one-third of our study treatments (which are 24 sessions long) directly addresses patients' conflicted feelings about termination.

A TECHNICAL CLINICAL EXAMPLE

Mr. A., a 36-year-old married lawyer with three children, presented with panic disorder and hypochondriasis, having failed a year-long competent trial of cognitive-behavioral therapy. Early sessions in treatment focused on his terror and sadness over losing his mother to a chronic illness when he was 14 and his feeling that when she died he lost his identity and all sense of security. He was frightened about whether he could withstand examining himself in psychotherapy: "If I tear apart who I am and everything I do, what will I have left?" The therapist related this fear to the feeling that he had "lost himself" when his mother died.

After initially feeling angry with the therapist about the "rules" of the therapy (that he explore his feelings, that he bring in a panic diary as part of the protocol), he soon felt relieved by his beginning new self-understanding. Exploring his anger at his therapist led him to remember a feeling that his mother did not love him unless he was meek and compliant, and to discover a fantasy that his anger had killed her and would kill others, leaving him alone. These feelings were linked to castration fears, which undermined his ability to be competent and adult.

As he explored these areas, his panic attacks began to subside and he started to describe a feeling of "loving more" than he previously felt able to do. He experienced panic remission after the first five sessions. His enhanced sense of well-being made him feel terrified that now everything would surely fall apart, in punishment for his feeling better. He continued to experience 15 seconds per day of nonpanic high anxiety every morning, and continued to worry about his health in an exaggerated way that he found embarrassing.

The following excerpt of dialogue was taken from his sixteenth session. It provides an example of his anxious concerns, his style of not wanting to know, and his avoidance of frightening feelings—characteristic of panic patients—along with the inroads made toward understanding his defenses, and thereby his symptoms. The session begins with Mr. A. making a slip and denying first the occurrence of the slip, and then its significance. The patient seemed to have grasped the concept of unconscious meaning and its relation to panic before this session, so the therapist noted but did not immediately address the significance of his naive attitude. She gently but firmly confronted the patient about his efforts not to address the meanings and feelings behind his slip. Later, the therapist recognized that the scenario was an reenactment of the patient's relationship with his mother, in which he played the naive little boy and his mother "took charge." This aspect of his relationship with his mother also underlay one aspect of his panic, which turned him into a sick, helpless little boy whom others had to coddle. This connection was addressed productively.

PATIENT: That's how whacked-out I can get in terms of dying, thinking that you can die from the common cold. That's me—Joe the hypochondriac.

THERAPIST: You're saying that you feel weak and defenseless.

PATIENT: I do feel that, but I don't remember saying that. Ideally I would like to get through a common cold without going to a doctor. Because there's an old adage: take the medicine and you'll be better in seven days, or bed rest and it will be gone in a week. These articles I read tend to make me believe if I don't go to a doctor and get medicine, I'm not being treated and I'm not going to get better. I was taking pills while I was going with you. It was a five-day course of antibiotics.

THERAPIST: Going with me?

PATIENT: I was taking them while I was still here with you, I had been going to you. The last time I took one we had already started our sessions.

THERAPIST: When you say something like that, when you make a slip like that, it has a meaning. It's a flag pointing to some thought or idea that you are unaware of, some unconscious idea of which the only expression is a little slip. If you turn your attention to the slip, what comes to mind? What do you think about?

PATIENT: Let's start with *what* slip.

THERAPIST: I think you said, "while I was going with you."

PATIENT: I meant while I was going *to* you.

THERAPIST: Oh, I understand what you meant to say, but you meant something else from another part of your mind. We are interested in that. Anything that comes to mind about that?

PATIENT: No, not really.

THERAPIST: Let your imagination go a little.

PATIENT: You are full of yourself. The fact that I forgot you were going away had major grandiose implications. I did not think it did. The predominant thought in my mind was, she really feels so important like she has a major significance in my life. The fact I forgot gives me the same initial reaction

as now. In your world there is no such thing as just a slip.

THERAPIST: Yes, there is such a thing as just a slip, but it means something.

PATIENT: Let me reclarify: as a meaningless, pointless slip.

THERAPIST: No. If you say something our job is to not to dismiss it, but to understand what it is that was going on in your mind that gave rise to the slip.

PATIENT: To you that is a window into my subconscious.

THERAPIST: Yes. And I think the process of your dismissing it and saying it does not mean anything is a part of a process of pushing feelings away and pushing meanings away. As much as you do the opposite to explore and try to uncover here, I think you are still tempted to push things away. That's one of the processes that gives rise to your anxiety, which is so intense and which you experience as being "out of the blue," as you experience your slip.

PATIENT: I was going to ask you about that. I don't mean to digress—but I guess I do, because everything has a meaning. Am I correct in the assumption that all these different things we have explored, I guess, they are related? The various panic and anxiety attacks I experience don't have to be necessarily related to what I am thinking at the moment; they can be a by-product of what's going on in my head. All that stored up inside of me.

THERAPIST: Yes, very much so, except that what you're thinking and feeling at the moment that they occur is also important.

This interchange led to a flood of memories and associations. The relationship that was being enacted here was related to the patient's conflict about being an adult man and a father, a conflict that was discussed explicitly in the remainder of the session. Patient and therapist had already explored one of the settings in which the patient panicked regularly—when he had to pay for dinners. He had said, "I feel like one of the kids, but at those moments, I realize I'm the Daddy. I'm supposed to provide. Who's going to provide for me?" He felt fraudulent, inadequate, and abandoned.

These associations triggered thoughts about the other situation that routinely made him panic: shaving in the morning. "Each morning when I shave, it's a reminder that I'm getting dressed to go to work to perform as a grown-up man. It's the transition from my safe bed to the outside world." The therapist pointed out that shaving was also something only men did, not little boys. The patient replied, "It reminds me—when I was little, in my bathroom—ooh. That was a slip. I meant my father's bathroom. I wonder what that means . . . " This led to an exploration of his conflict about being a strong, effective man and a terror that if he were one, it would mean he would be eliminating and replacing his father, as he had in the slip. The patient associated to a number of sexual feelings and fantasies that he thought were inappropriate and were proof that he was an awful person. The therapist related the patient's anxieties over his competitive strivings with his father, his guilt over his sexual desires, and his panic symptoms, which emerged in particular when he "became the Daddy." They discussed his consequent defense against allowing himself to be a strong, successful, sexually fulfilled man by consistently playing the role of sick, weak, innocent little boy.

The patient then volunteered, "And don't worry—I haven't forgotten your question about my slip 'going with you.' It sort of sounds like dating." This session paved the way for further exploration of the patient's erotic transference, which permitted a deeper appreciation and working through of these conflicts and how they related to his panic. The patient responded to the treatment and remained in remission at 6-month follow-up.

As can be observed in this vignette of the use of PFPP, the therapist actively related issues the patient discussed to underlying conflicts that were associated with panic disorder. The vignette demonstrates one of the core conflicts that we have found in panic patients, a concern that their own aggression will cause disruptions in attachments, creating intense anxiety. Mr. A. appeared to associate success with unacceptable aggressive impulses. He feared the loss of close, intimate relationships, such as the one he had with his mother, through demonstrations of his competence.

DISCUSSION

We have outlined some relevant aspects of psychodynamic underpinnings in panic disorder and have provided a description of some of the methods for addressing these factors in the therapeutic situation. Panic-focused psychodynamic psychotherapy cannot be employed in a "cookbook" manner because even core conflicts involving aggression and fearful dependency, as described above, present in a unique manner in each patient, and other intrapsychic conflicts can also contribute to panic disorder symptomatology. A psychodynamic approach can be employed in conjunction with medication or cognitive-behavioral therapy. Clinicians who routinely treat panic patients may wish to consider incorporating some psychodynamic understanding of the panic syndrome, as described in this article, in their treatments.

Despite some anecdotal evidence of the clinical utility of psychodynamic psychotherapy for the treatment of panic disorder, more systematic studies of this approach, beyond our current open clinical trial, are essential. Given that many panic patients relapse after receiving short-term psychopharmacological and/or cognitive-behavioral interventions, it may take some time to determine what combination of treatments, over what time period and for which particular patients, are

most effective in the treatment of panic vulnerability. Until such data are available, it is important for clinicians to have a variety of tools available for the treatment of panic patients.

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