DYNAMIC THERAPIES FOR PSYCHIATRIC DISORDERS

Emotion-Focused *Treatment* for Panic *Disorder*:

A Brief, Dynamically Informed Therapy

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Table of Contents

Emotion-Focused Treatment for Panic Disorder: A Brief, Dynamically Informed Therapy

HISTORY AND DEVELOPMENT

DYNAMIC ISSUES IN PANIC DISORDER

TREATMENT GOALS

THEORY OF CHANGE

TECHNIQUES

TRAINING

EMPIRICAL EVIDENCE FOR THE APPROACH

REFERENCES

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Patients who meet diagnostic criteria for panic disorder experience recurrent panic episodes, anticipatory anxiety, and phobic avoidance. Panic attacks are characterized by the abrupt onset and rapid, crescendo escalation of intense apprehension, associated with physical symptoms such as heart palpitations, chest pain, shortness of breath, hot or cold feelings, trembling or shaking, dizziness or lightheadedness, feelings of unreality, and fears of such events as going crazy, having a heart attack or stroke, or losing control. Full panic episodes include at least four of these symptoms, while limited-symptom episodes are marked by three or fewer. Anticipatory anxiety is focused on fear of panic and/or panic-related physical sensations. Such fearfulness is the focus of a successful panic-targeted, cognitive-behavioral treatment approach. Fear of bodily sensations is a consequence of, and perhaps a risk factor for, the onset of panic episodes. Cognitive theorists see these fears as a manifestation of a learned false belief system.

Agoraphobia is a common complication of panic disorder and contributes substantially to morbidity. Agoraphobic individuals report fear and avoidance of situations in which they may feel either alone and unable to

get help or trapped and unable to escape if a panic attack occurs. Typical agoraphobic situations include being alone, traveling far from home, taking public transportation, being in crowded public places, and going over bridges or under tunnels. Recently, other types of panic-related phobic avoidance have been reported—for example, fear of situations in which frightening bodily sensations are evoked, such as physical exercise, watching exciting movies or sports events, and drinking coffee, and fear of social situations in which the panicking individual might feel embarrassed or trapped.

HISTORY AND DEVELOPMENT

In 1895 Freud described a syndrome called anxiety neurosis, characterized by spontaneous anxiety attacks, nearly identical with *DSM-III* panic disorder (Freud, 1895/1962). However, the modern diagnosis of panic disorder was not recognized until 100 years later when it appeared in *DSM-III* (APA, 1980). Freud (1926/1959) was very interested in anxiety, and understanding anxiety has remained a central interest of modem psychodynamic clinicians and theorists. Bowlby, a major modern psychodynamic theorist, was also interested in the panic/agoraphobic syndrome. Bowlby drew attention to the strong evidence supporting a primary instinct for attachment and hypothesized that separation anxiety, a form of pathological attachment, figures importantly in the pathogenesis of agoraphobia (Bowlby, 1973). Nevertheless, psychoanalytic views that differ from current neurobiologic and learning theory explanations have not been incorporated into the panic disorder models that guide most research and clinical work.

Instead, identification of panic disorder is credited to psychopharmacological researchers working in the 1960s (Klein, 1964). These investigators observed that an antidepressant medication, imipramine, unexpectedly led to improvement in severe, hospitalized agoraphobic patients. Exploration of this effect led to the identification of unexpected

panic attacks as the basis of agoraphobia. The modern history of panic disorder is thus interwoven with the growing new field of psychopharmacology. Documentation of efficacy of pharmacologic treatment followed quickly, and a recent NIH consensus development panel on the treatment of panic disorder (Wolfe & Maser, 1994) endorsed medication treatment as a standard, adequately proven treatment strategy.

A second line of important panic disorder treatment research grew out of behavior therapy studies of phobias. Having successfully treated phobic symptoms using exposure strategies, behavior therapists turned their attention to the more important clinical problem, agoraphobia. Initial efforts to use exposure to agoraphobic situations were moderately successful, but there was a need for further improvement (see Barlow, 1994). This led to identification of panic as a core symptom of agoraphobia and to strategies for targeting panic directly. Panic was conceptualized as a conditioned fear of bodily sensations, and exposure to the feared sensations was the hallmark of the behavioral treatment. This treatment has now been expanded to include a cognitive component in which sensation fears are augmented by catastrophic misinterpretation. Thus, cognitive-behavioral therapy for panic is targeted at breaking the link between bodily sensations and fearfulness, using both exposure and cognitive strategies. Efficacy of this approach has been documented, and like medication, cognitive-behavioral treatment was endorsed by the NIH consensus development panel.

In general, psychodynamic research has been slow to get under way, and psychodynamic thinkers have not shown a focused interest in the understanding or treatment of panic disorder. The NIH consensus development panel noted that, as yet, there have been too few outcome studies to allow evaluation of this form of treatment.

Models of Panic Disorder

The two prominent schools of treatment present different models of panic disorder. The neurobiologic model postulates a defect in brain function, possibly involving the mechanism that mediates response to cues of separation (Klein, 1981) or to suffocation (Klein, 1993). Panic is thought to occur because a deranged sensor fires sporadically, with or without a trigger. Neurobiologic studies suggest a variety of neurotransmitters (noradrenaline, GABA, serotonin) may have a role in panic vulnerability. Imaging studies point to the involvement of the parahippocampal areas. In the neurobiologic model, anticipatory anxiety and phobic avoidance, as well as other psychological disturbances, are seen as secondary to the experience of panic. Treatment is targeted at blocking panic through raising pharmacologically the sensor's threshold. Medication is considered the treatment of choice (Fyer & Samberg, 1988).

The cognitive-behavioral model postulates a different mechanism.

Chambless and her colleagues observed that fear of fear is common in agoraphobics (Chambless & Goldstein, 1981), and Clark (1986), Beck (1988), and Barlow, Craske, Cerny, and Klosko (1989) developed a more specific theory that fear of bodily sensations explains the occurrence of the sudden, rapidly escalating sense of panic in agoraphobics. Panic is thought to occur because bodily sensations provoke catastrophic fearfulness, by a process of conditioned fear response and/or cognitive misinterpretation. In this model, physiologic abnormalities are seen as secondary to behavioral disturbances such as hyperventilation. Unlike the neurobiologic model, anticipatory anxiety is a predisposing trait for panic episodes. Studies confirm that panic patients report high levels of fear of bodily sensations (McNally & Lorenz 1987; Apfeldorf, Shear, Leon, & Portera, 1993), and studies of memory and attentional processes show cognitive biases that support the interoceptive sensitivity model (Cloitre, Shear, Cancienne, & Zeitlin, 1994). Treatment is accomplished using strategies to correct cognitive misinterpretations and/or strategies to extinguish reactivity to interoceptive cues.

DYNAMIC ISSUES IN PANIC DISORDER

Since psychoanalysis has roots in neurobiology, learning theory, and evolutionary perspectives, psychodynamic thinking provides a unique, integrated model of anxiety (Michels, Frances, & Shear, 1985). However, a modern psychodynamic theory provides an explanation of the etiology and pathogenesis of panic somewhat different from that provided by current neurobiology or learning theory. In general, a psychodynamic model hypothesizes a relationship between current psychological functioning (including symptoms), early experiences, and ongoing psychological traits. Both biological and psychological contributions to symptom formation are postulated. We recently proposed a psychodynamic model of panic disorder based on a series of clinical interviews and a set of observations in the literature (Shear, Cooper, Klerman, Busch, & Shapiro, 1993). Interviews of panic disorder patients revealed themes of early life anxiety and shyness, unsupportive parental relationships, and a chronic sense of being trapped and troubled by frustration and resentment. Reports in the literature document that panic patients describe frightened, controlling, or critical parents (Arrindel, Emmelkamp, Monsma, & Brilman, 1983; Heckelman, Spielman, & Shear, 1992; Parker, 1979; Silove, 1986), and most report feelings of inadequacy and/or self-reproach. Aggression is threatening and unwanted, and reaction formation has been identified as a common defense mechanism, possibly more common in panic patients than in other anxiety

disordered patients (Pollack & Andrews, 1989; Busch, Shear, Cooper, Shapiro, & Leon, 1992). Personality traits of dependency, avoidance, fearfulness, neuroticism and introversion, and low assertiveness have been observed (Brodbeck & Michelson, 1987; Chambless, Hunter & Jackson, 1982; Chambless, 1985; Emmelkamp, 1980; Fischer & Wilson, 1985). The onset of panic exacerbates these problems, but there is evidence that psychological disturbance occurs prior to the onset of a panic disorder (Faravelli, Webb, Ambonetti, Fonnesu, & Sessarego, 1985; Garvey, Cook, & Noyes, 1988) and persists after amelioration of panic symptoms (Katon, 1978).

These observations led us to propose that fearfulness and neurotic traits represent a risk factor for, as well as a reaction to, the onset of panic episodes. This idea was supported by reports that children of panic disorder patients show evidence of high physiologic reactivity and behavioral inhibition in response to unfamiliar situations (Rosenbaum et al., 1988), and that these children are predisposed to childhood anxiety disorders (Biederman et al., 1990). Studies of nonhuman primates (Soumi, 1987) document the existence of a similar subgroup of high reactive individuals who appear to be socially submissive and more fearful than normal individuals. Moreover, there is evidence that both constitutional factors and rearing experiences contribute to the high reactivity in primates. Similarly, both genetic and developmental factors seem to contribute to panic diathesis in humans. Panic disorder is common in family members of panic patients, and

this association is thought to be genetically determined (Weissman., 1990). As noted, panic patients remember parents who were critical and/or controlling, suggesting that the object world may be generally viewed as threatening and that establishing a comfortable degree of dependence-independence is difficult. Avoidance by the inhibited child of the unfamiliar would result in less opportunity to learn to predict threats accurately or to develop maximally adaptive defensive and coping strategies. Thus, inborn fear of unfamiliar situations, augmented by frightening, over-controlling parental behaviors, would predispose to problems in finding a comfortable distance from others. We have observed that some panic-vulnerable individuals are separation-sensitive and overly reliant on others, while others are suffocation-sensitive and overly reliant on a sense of independence. In both instances, object relations are characterized by weak self and powerful other representations.

A consequence of dominant, easily activated fantasies of being alone and abandoned, or of being trapped and suffocated, is a tendency to react with strong negative affects to psychological challenges interpreted as threatening separation or entrapment. Moreover, negative effects, however activated, are likely to be threatening and thus engender anxiety. This "secondary" anxiety acts to augment affect intensity and to promote escape and avoidance mechanisms. The result is a tendency to avoid acknowledgment of these negative feelings and their triggers in an effort to

ward off painfully intense emotions, which nevertheless often figure prominently in the mental life of panic patients. Avoidance of negative effects, especially anger, results in shifting attention to the somatic aspect of the emotion. This begins a vicious cycle, well described by cognitive psychologists, in which dysphoric physiologic symptoms generate fear, leading to more physiologic symptoms and more fear, ultimately culminating in a panic episode. However, the origin of dysphoric bodily sensations is different.

This psychodynamic model is consistent with the current neurobiologic model in postulating differentiation of panic from other forms of anxiety. However, it differs from current neurobiologic theory regarding the issue of panic onset. In the neurobiologic model, panic episodes occur spontaneously; in other words, they lack psychological content. The dynamic model, like the cognitive-behavioral model, holds that panic is triggered by frightening thoughts, images, and sensations. However, from a dynamic perspective, frightening fantasies that trigger panic are related to fears of being trapped by and/or separated from powerful others and/or of being weak and out of control. Furthermore, triggering thoughts and images may be unconscious. In this model, minor physical sensations provoke panic because they originate from an overly threatening negative affect that escape/avoidance strategies are inadequate to control. As Bowlby (1973) suggests, fearfulness in panic/agoraphobic patients results from a chronically impaired sense of

safety, due in large part to insecure attachment. Complementary effects of constitutional characteristics and developmental experiences contribute to attachment problems. Patterns of object relations, ego strengths and weaknesses, and defenses typical of these patients maintain fear and inadequate control of negative emotions.

Impairment of autonomy, self-worth, and self-confidence increases sensitivity to threat. There is a bidirectional relationship between the ability to regulate anxiety and an individual's sense of well-being and effectiveness. The better the anxiety-regulating mechanism, the higher the self-esteem, and the higher the self-esteem, the better the anxiety-regulating mechanisms. Faulty anxiety regulation consequently leads to loss of self-confidence, worsening of anxiety regulation, further erosion of confidence, and so on. Moreover, low autonomy and low self-confidence are often associated with distortions in object relations. Thus, in general, poor anxiety regulation, diminished self-esteem, and troubled relationships occur simultaneously and exacerbate each other.

Two models of etiology and pathogenesis proposed by prominent panic researchers can be linked to this psychodynamic model. One is Donald Klein's theory (1981), which also proposes an etiologic role for dysfunction in separation and/or suffocation anxiety mechanisms. We provide a psychological explanation for vulnerability to separation and suffocation,

while for Klein the disturbance is in hardwired neurophysiologic systems. A different theory, proposed by David Barlow (1991), focuses on the importance of a learned sense of uncontrollability in panic pathogenesis. We agree that impairment in the sense of controllability contributes importantly to the feelings of inadequacy associated with distorted object relations. Learning about predictability of threats and developing realistic self-confidence in coping with threat provide the underpinnings of confidence in the controllability and safety of the world. The fearful, inhibited child has less opportunity to learn these skills.

Symptomatic treatment of anxiety states can have a highly beneficial effect, improving self-esteem and interpersonal relationships. For some patients, further psychological benefits follow naturally. However, ongoing disturbances in emotion regulation may underlie anxiety proneness and persist following symptomatic treatment. If so, the patient will continue to be vulnerable to anxiety, as well as other psychological disturbances. Psychological treatment directed at correction of this problem might enhance the durability of remission.

Emotion-Focused Treatment

Amelioration of panic symptoms can unquestionably be achieved using any of a variety of approaches. Each includes the presentation of a model of

symptom formation and a rationale for the treatment strategy chosen. As mentioned above, medication and cognitive-behavioral treatment were endorsed by an NIMH consensus development panel in the fall of 1991. The principles and practice of these approaches can be found in relevant references (Craske, 1988; Fyer & Samberg, 1988).

Cognitive-behavioral treatment for panic was designed as a highly specific intervention targeted at correcting cognitive errors and promoting habituation of reactivity to interoceptive cues. Efficacy of this treatment, in comparison with a wait list control, is now well established (Craske, 1988; Craske, Brown, & Barlow, 1991). Moreover, the response obtained with this intervention appears to be similar to, or even greater than, the response with medication (Clark, Salkovskis, Hackmann, Middleton, Anastasiades, & Gelder, 1994). However, there is little information regarding the specificity of this treatment. We undertook a study to compare cognitive-behavioral treatment with a psychotherapy intervention, utilizing a psychoeducation component followed by a nonprescriptive, empathic, reflective listening approach. Our prediction that the highly directive and specific psychotherapy would be superior was not supported. Instead, we found the two treatments to be equally effective (Shear, Pilkonis, Cloitre, & Leon, 1994).

Systematic review of the empathic listening treatment was conducted at weekly study meetings. These discussions, along with the dynamic model

outlined above, formed the basis for the treatment we present here. However, although it is derived from a psychodynamic model, emotion-focused treatment (EFT) is not a strictly psychodynamic treatment. It differs from standard psychodynamic approaches in that it does not emphasize interpretation of unconscious material, nor does it focus on linking early experiences with present symptoms. Discussion of transference is not prohibited but is unlikely to play a prominent role in this treatment. Instead, EFT is centered on discussion of problems in the present. Interventions target fear and avoidance of negative effects and their triggers. In the context of a supportive, empathic relationship, the patient is helped to clarify and accept emotional reactions, to identify triggers of these emotions, and to explore new ways of managing disturbing emotionality. This work leads to an increased sense of internal control, as well as better controllability of the external world. The resultant increased self-confidence diminishes sensitivity to fears of being abandoned or suffocated by others. EFT also incorporates a psychoeducational component, similar to that utilized in another recent dynamically informed treatment, interpersonal treatment of depression (Klerman, Weissman, & Rounsaville, 1984), but different from most other psychodynamic approaches.

Description of the Treatment

There are two major components of emotion-focused treatment for

panic disorder. The first is a psychoeducational component: information about panic disorder is provided, and the hypothesized role of emotions is explained. The informational segment of the treatment removes blame from the patient for having symptoms and provides accurate information about physiologic changes during panic. Cooper (1985) notes that patients treated with a combination of medication and psychotherapy benefit from being presented with a model of symptom formation that does not hold the patient fully responsible for the dysphoria and affective intensity they experience. We explain to the patient that anxiety is a normal reaction, necessary for an optimally adaptive organism. The problem experienced by patients with panic and other pathological anxiety states is that the reaction is triggered too easily, too often, and/or too intensely, in response to stimuli that are not associated with a high degree of actual danger. The reason for this heightened reactivity is not fully understood. However, there is evidence that both constitutional factors and learned responses play a role. These processes are outside of the control of the individual.

The second component of this treatment is the identification and clarification of emotional reactions and their consequences. The principle technique in EFT is empathic reflective listening. The development of a solid rapport with the patient is essential for any effective treatment, and reflective listening is a particularly effective strategy for developing rapport. In addition, skilled use of reflection serves to communicate empathy. Reflective

comments are used to guide further elaboration of the components of emotional reactions, their triggers, and responses. The EFT therapist utilizes reflective listening to identify and clarify emotional reactions that the patient may not acknowledge. The therapist attempts to fully elucidate triggers, individualized interpretations of the triggers, the specific quality of the ensuing emotion, and the response to the emotion. A modification of a technique called focused evocative unfolding, developed by Laura Rice (Rice & Saperia, 1984; Laura Rice, personal communication, 1990), involves systematic exploration of the quality of a targeted unexplained emotional reaction and the context in which the reaction occurs.

TREATMENT GOALS

The overall goal of the treatment is to ameliorate panic disorder by targeting panic symptoms directly and focusing on better identification, acceptance, and management of a range of negative emotions. The treatment is conducted in an 11-session acute phase, followed by a 6-session, monthly maintenance phase. The acute phase is divided into initial, middle, and termination subphases. The goal of the initial phase of treatment is to provide information about panic, anxiety, and other emotional reactions and to explain the rationale for the treatment. The middle phase of treatment is aimed at identifying and working with emotional reactivity by encouraging the patient to identify, re-experiencing , and think through specific problematic emotional reactions. The presence of a supportive, accepting therapist facilitates reevaluation of the meaning of affect-provoking stimuli and of the strategies used to cope with difficult emotions. The termination phase is used to discuss reactions to ending treatment, to review the progress of the treatment, and to help the patient consolidate gains. The maintenance phase is used to troubleshoot and continue this work.

THEORY OF CHANGE

Both of the active ingredients of this treatment, the psychoeducation and the emotion-focused components, contribute to improvement. Like all treatments that ameliorate panic, we provide more accurate information about the physiologic underpinnings of panic and emphasize that a panic episode, in and of itself, is not dangerous. This is quite reassuring for patients who have been frightened that they are losing their minds or that something is seriously wrong with them physically. The rational model of panic and the experience of monitoring and focusing on the panic episodes provide a sense of control and predictability.

The central focus on emotion is unique and therefore responsible for therapeutic effects more specific to this treatment. Systematic detailed exploration of emotional reactions, their triggers and context, and the response to them helps the patient to feel less frightened of his or her feelings and less buffeted by external events. Better understanding of panic and other unexplained emotions leads to improvement in self-confidence and self-esteem and less vulnerability to the vicissitudes of relationships with others. Better control of emotions lowers sensitivity to threats in general, and panic in particular. Panic attacks often occur in response to a feeling of being pressured or treated unfairly by someone whom the patient is fearful of losing, but the patient ignores the feelings of annoyance and hurt. The

therapist helps the patient to recognize these feelings. We find that the patient's response to this recognition is surprise and relief.

The ability to identify and manage emotions frees the patient to be more exploratory and assertive in the world, further enhancing self-esteem. Their view of others as powerful, critical, and not necessarily trustworthy is modified. An increased sense of reliability and stability in relationships improves the patient's tolerance of changes and losses in interpersonal relationships, decreases vulnerability, and diminishes susceptibility to anxiety.

TECHNIQUES

As noted above, therapists use a modification of Laura Rice's technique of focused evocative unfolding to clarify unexplained emotional reactions. The therapist works with a specific reaction, such as an unexplained panic attack, and encourages exploration of the stimulus and the process by which the reaction was triggered; the thoughts, images, and physical reactions associated with the reaction; and behavioral and/or cognitive coping responses that follow. In this process, the generalizability and broader relevance of the stimulus response and coping patterns are brought to light.

There are six aspects of the focused evocative unfolding procedure used in this treatment: (1) exploration of the primary reaction; (2) elucidation of the setting and context in which the reaction occurred; (3) confirmation of the specific quality of the internal emotional reaction and the nature of the eliciting stimulus; (4) identification of the idiosyncratic personal meanings of the stimulus and of the qualities of familiarity and repetitiveness of the emotional response; (5) clarification o* the generalizability of the stimulus-response paradigm and its importance; and (6) identification and exploration of the response to the primary emotional reaction.

Emotional reactivity can be understood using a stimulus-response paradigm. Certain stimuli elicit a fairly universal emotional reaction. However, personal idiosyncratic interpretations often mediate the reaction to

a stimulus and account for the specific quality and/or intensity of the emotional response. For panic patients and others, the experience of a negative affect often results in a secondary response of guilt, shame, or fear. The secondary reaction augments the intensity and the dysphoria of the initial emotion, and this augmented negative affect promotes more powerfully the use of disavowal or avoidance-type mechanisms in dealing with the original stimulus and/or the original reaction. In this way, unacknowledged and unwanted emotional reactions are experienced as a vague dysphoric feeling, accompanied by unexplained bodily sensations. The sensations become a focus of attention and a source of anxiety and are further augmented. The focused unfolding procedure facilitates identification and acceptance of feelings that have been hidden, diminishing the secondary augmenting reactions engendered by these emotions. Identifying a "nameless fear" makes it less frightening, less uncontrollable, and less likely to provoke a panic episode. Successful use of focused unfolding breaks the pattern of the sense of helplessness engendered by automatic, poorly articulated emotional reactions. A more complete description of focused unfolding follows, illustrated with clinical vignettes.

Exploration of the Primary Reaction

A central aim of the focused unfolding procedure is to clarify and explore an unexplained emotional reaction. An unexplained emotional

reaction is one in which the therapist judges that the patient has experienced a negative affect without knowing its cause. "Spontaneous" panic attacks are an example. Puzzlement may be explicitly stated by the patient: "I don't know why I felt that way." The patient may provide a shallow, unconvincing explanation. Other unexplained emotional reactions may be expressed as having no feeling, or as an unconvincing positive feeling in the context of describing a distressing situation.

Unexplained emotional reactions typical of panic patients include:

1. Unexpected, "spontaneous" panic or near-panic episodes.

2. Uncomfortable physical sensations ("My stomach was upset all day," "I had this strange wobbly feeling," "Whenever I am with her, I get a feeling of unreality").

3. Feelings described in vague terminology ("I was upset," "I felt a kind of nameless dread," "I didn't like what he said").

4. Emotional states that are explicitly unexplained ("I was having a bad day; I don't know why," "I was just irritable and angry, for no reason").

5. Unexplained behavior ("I just walked out of the room; I don't know why I did that," "I didn't tell him I wasn't coming; I don't know why").

6. Interpersonal disturbance that is mentioned and dropped or

otherwise not well explained ("My husband and I weren't getting along; I went to my sister's house and we watched TV," "I never see my grandchildren anymore; it makes me sad and I'd rather not talk about it").

7. Out-of-context positive interpersonal comments that are vague and global ("I wasn't in a very good mood when I left for work this morning, but my boss is fine," "I was anxious when my husband left for work; my husband is a good man").

This list is not meant to be comprehensive. There may be other comments by the patient that catch the therapist's attention as indicative of an emotionally important event.

The therapist noting one of these types of communication proceeds to simply reflect the patient's statement: "Your stomach was upset," "You had a wobbly feeling," or "You were upset." Such an intervention focuses the patient's attention, underscores the therapist's interest, and encourages the patient to elaborate on the statement. This begins the process of focused unfolding.

Elucidation of the Setting and Context in Which the Emotional Reaction Occurred

After reflecting the unexplained reaction, the therapist then listens for other cues in order to further define the emotional reaction and triggering stimulus. We usually elicit the description using a reflective technique. For

example, the therapist might reflect, "You were sitting alone watching TV when all of a sudden you noticed your heart beating very fast." This technique invites the patient to recall and attend to the situation without structuring the attentional processes. We wish to facilitate activation of a wide array of associative material and a free expression of the material.

For example, Ms. Smith reported a panic episode one morning, while watching TV with her husband. She noted that she was having a perfectly good day and this feeling came out of the blue. Her heart began to race, and she felt very frightened. She experienced tingling of her hands and feet and felt slightly dizzy. Her stomach was in a tight knot. She added that her relationship with her husband was a good one, but he was under stress at his job and she had been worrying about him. She told the therapist she wondered if this worry had triggered the panic attack but added that she did not really think it did. After the therapist reflected that the patient's heart began to race, the patient remembered feeling very frightened. She remarked that she didn't think she was reacting to the TV. She then remembered a very upsetting phone call from a friend of her mother's earlier that morning, and she thought this call was probably still on her mind. The patient described the phone call and then began to elaborate on her feelings about her mother's death, her loneliness, and her feeling that no one understood. She then thought about her panic episode and recalled that the sense of fear and heart palpitations had been preceded by a pain in her stomach that she always got

when she thought about her mother. She feared that the pain meant she was very ill and would require hospitalization, which would involve abandoning her children and leaving responsibility for their care to her husband, who was already under stress at his job. She feared, in turn, that he would not withstand this pressure and would also become ill.

Another patient, Ms. Jones, is a 40-year-old woman who was having problems at work and with her mother, whose health was deteriorating from illness. She described a panic episode: "I woke from sleep. *I wasn't dreaming.* I went to the bathroom, returned to bed, and noticed a strange feeling in my stomach. I felt afraid and didn't know why. Suddenly my heart was beating very fast, and I was very frightened. It lasted about 10 minutes. I got up and read a book and eventually calmed down and went back to sleep." The therapist identified the primary reaction as the strange feeling in the patient's stomach, and reflected to the patient the scene she described of herself lying in bed feeling a strange feeling in her stomach. The patient then elaborated: "It was a hollow feeling, a lonely feeling—I may have been thinking about being all alone, my mother's illness, no one to talk to. I think I was missing John [a very close friend who had died many years earlier], I remember I had just had a dream in which John and I were together. It's a dream I sometimes have, and it seemed very real. It was as though he were really alive and with me. I think when I woke up and thought about that dream and John, I was very aware that he was gone and I felt very lonely. I felt sad and resentful.

Why wouldn't he let me be with him while he was dying? He went back to his family when he got sick, and I wasn't able to go to the funeral."

The therapist can also conduct a focused unfolding procedure for other types of unexplained emotions. For example, in the course of reporting about her past week, a patient commented that her boss was fine. The patient had earlier indicated that she had problems at work. This information led the therapist to suspect that the vague statement about the boss might represent an unacknowledged emotional reaction. The therapist simply reflected, "Your boss is fine."

The patient responded by elaborating: "Well, I think he means well, but sometimes he isn't really fair. He expects me to perform perfectly, and he doesn't seem to have a good idea of what is entailed in my job. He's very busy, and he doesn't have time to answer questions." The patient continued with a litany of complaints against her boss. Then she stopped and commented sheepishly, "I guess I'm sort of angry with my boss. I hadn't realized that."

Confirmation of the Specific Quality of the Internal Emotional Reaction and the Nature of the Eliciting Stimulus

The therapist reiterates the emotional reaction and the context in which it occurred in order to further clarify the stimulus and response. For example, the therapist reflected the onset of a panic episode and the scene in which the

panic occurred: "You were lying in bed, trying to get to sleep, and suddenly you felt very short of breath." The patient recalls, "It was pretty late, and I was tired. Nothing was on my mind." The therapist reflects, "You were tired and trying to go to sleep, and nothing was on your mind when you began to feel short of breath." The patient considers this: "Well, I guess I was worried about whether I could function if I couldn't get to sleep *[pause],* I have this job, which hasn't been going that well. I can't seem to please my boss, no matter how hard I work. She is a workaholic with no children. I think she resents me because I am married and pregnant. She doesn't seem to trust me anymore *[silence].* My career was always important to me. Maybe I shouldn't have gotten pregnant *[silence],* I feel a little short of breath. Lately, whenever I think about being pregnant, I get this suffocating feeling *[silence].* Actually, I'm pretty sure that's what I was worrying about when I started to feel short of breath in bed the other night. Then I got frightened that I would have a panic attack and that these panic attacks would never go away. I wouldn't be able to work or to take care of my child. My heart started to race, and I felt very hot and shaky. I had to get up and go downstairs for some fresh air."

Identification of the Idiosyncratic Personal Meanings of the Stimulus and of the Qualities of Familiarity and Repetitiveness of the Response

The procedure for elucidating these meanings can be illustrated by further work with Ms. Green, who reported a tight feeling in her stomach that

was then determined to be a manifestation of an angry feeling triggered by her boss's behavior. Having established the link between the bodily sensation and the emotional reaction, and the trigger of the emotional reaction, the therapist returned to reflect on the stimulus, saying, "Your boss asked you to prepare a report, and you weren't clear on what he wanted." The patient continued: "Yes. I felt very frustrated, but I didn't know what to do. I decided to just do the report. I was sitting at my desk working on it when I felt this awful tight feeling in my stomach. I was certain I must have an ulcer and I would get terribly sick and have to go to the hospital. I tried very hard to continue to work, but I just couldn't concentrate. The pain was getting worse. I finally had to stop and went to tell my boss that I wasn't feeling well. He was very nice and said I looked pale and maybe I should go home. I didn't really want to leave, but I felt I didn't have a choice. I went home, but the feeling didn't really go away for the rest of the day. I had to stay home from work the next day too."

Listening to this elaboration, the therapist recognized that the patient had probably made an idiosyncratic interpretation of the boss's request, and the following discussion ensued:

> Therapist: You felt you had to prepare the report even though you didn't really know what your boss wanted in the report?
>
> Patient: Yes. I know he wanted me to do that. He just expects me to read his mind. It's so unfair.

Therapist: You believed he expected you to read his mind.

Patient: I know he does. I know about people like him. My father was like that, and my ex-boyfriend, and the first boss I had. If you don't do what they want, no matter how unreasonable it is, they get very angry and critical. Most really successful men make women in their lives their slaves.

Details of the idiosyncratic interpretation were now clear, and the therapist reflected, "You were certain he expected you to read his mind, and you felt you must do this or suffer the consequences." The patient silently considered this statement for a few minutes. She then thought aloud, "I know I get the feeling very strongly that I must do whatever he wants," indicating she was beginning to make a distinction between her feelings and the reality of the situation. The therapist reinforced this distinction by reflecting, "You get a strong feeling." The patient now added, "He reminds me so much of my father," and went on to describe the situation in her childhood home. Her father was a tyrant boss with both her mother and the children.

The patient was frequently frightened by his angry outbursts, especially ones directed at her mother, who seemed to be helpless to defend herself. She ended this discussion by saying, "Maybe I see my father in all men. My boss is really kind of different. He's pretty disorganized, and he probably doesn't realize he hasn't made his priorities clear to me."

Another example of an idiosyncratic reaction is provided by a patient who described an unexplained panic episode while watching TV with his wife.

Further discussion led to a recognition that the panic episode had occurred after the patient had tried to talk with his wife about an important interaction with a coworker that he had experienced that day. She was preoccupied and did not pay attention to him, and he became enraged, his heart began to beat wildly, and a full-blown panic attack ensued. After the anger was identified, the therapist returned to the original situation and reflected, "You wanted to tell your wife about your day, and she wasn't listening." The patient now responded, "She makes me so angry. She doesn't pay attention to me, and she doesn't pay attention to anyone. I know she does this with the children too. She is just like my aunt. She is going to ruin our children."

The therapist recognized an idiosyncratic interpretation of the wife's behavior and explored further the idea that the wife didn't ever listen and was just like his mother's sister, whom the patient intensely disliked. His parents often argued about this aunt, and her father would angrily complain, "She's a good-for-nothing leech! She is full of crazy ideas and never listens to anyone!" The therapist reflected the patient's view of the similarity between his wife and his aunt, leading him to now report marked differences between his shy, somewhat preoccupied, highly organized wife and his uneducated, brash aunt, who was loud and unpleasant and never listened to anyone else. He recognized that his wife's problems were very different from his aunt's, and this enabled him to feel more empathic with his wife, less anxious about her behavior, and less angry with her. He now commented that he thought he

frequently overreacted to women who seemed not to be listening.

Clarification of the Generalizability of the Stimulus-Response Paradigm and Its Importance

The generalizability of an emotional stimulus-response paradigm is related to its thematic content. For example, Ms. Green, whose familiar reaction of interpreting the behavior of her disorganized boss as demanding and demeaning toward her reflected a general tendency to fear confrontation and disapproval and the feeling of humiliation and subjugation evoked for her when she admired a man and wished to please him. In working with this patient, the therapist reflected the patient's new recognition: "When your boss doesn't communicate clearly, he makes you mad and reminds you of your tyrannical father. Then you feel you can't confront him or he will fire you." The patient concurred. The therapist waited, and the patient remarked, "I think I am almost always afraid of confronting people. I feel that if I don't do what someone else wants, they won't want me around."

Ms. Jones, who awoke from sleep with a strange feeling in her stomach, was feeling demoralized at a job she had held for years. She felt she had worked hard to improve herself and had achieved a position of some standing. But now younger people were in charge, and although they did not know the field as well as she did, they did not have the proper respect for her. She felt angry about this and wanted to walk away and leave them in the

lurch. On the other hand, she was frightened that she would lose her job and not be able to find other employment. She said, "I keep feeling like I am between a rock and a hard place." She recalled that her friend John had helped her through a similar difficult time at work many years earlier. She had been missing him quite a bit. She also explained that her mother had been a great support to her throughout her life and had been the one person in her lower-class family who had encouraged her and had faith that she could succeed. Her father, on the other hand, was an alcoholic who was frequently verbally abusive and favored her sister. After learning that the patient's panic attack occurred following a dream about John, the therapist reflected, "You miss your friend a great deal." The patient agreed and described how unfair it was that she couldn't even go to John's funeral. When she thought about it, she felt very angry. It seemed like she was always getting pushed around and she was helpless to do anything about it. She said, "When you stand up for yourself, you get criticized for being selfish. If you make people mad, they retaliate. The best thing to do when you are mistreated and you feel angry is to try to ignore it—try to forget about it."

The generalizable stimulus-response paradigm identified in a focused unfolding procedure reflects the thematic pattern of unexplained emotional reactions typical for that patient. Common themes related to unexplained emotional reactions in panic disorder patients include fear of too much interpersonal distance, of feeling alone, and of being abandoned; fear of

feeling controlled or trapped, with too little interpersonal distance; fear of and/or guilt about anger and assertiveness; fear of the disapproval of others; fear of or guilt about selfishness or greed; fear of submissiveness; guilt about wishes for independence and success coupled with chronically low self-confidence; shame about wishes to be close and dependent; fear of weakness, helplessness, uncontrollability.

Panic patients frequently experience and/or report emotional reactions related to these themes using physical or bodily metaphors. For example, fear of interpersonal control was expressed by one patient as a feeling of being pressured. Fear of distance or separation was expressed by another patient as a sense of unreality. Guilt or shame about dependence/independence might be experienced as feeling small.

A common way for the therapist to detect a thematic concern is by its noticeable absence in the content of what the patient is saying and/or its overt disavowal by the patient. For example, Ms. Brown was careful to avoid acknowledging that she ever experienced anger. She would describe her boyfriend's abusive behavior in great detail, but in a bland manner. The therapist reflected the patient's hostility, which was evident from the content of her report, along with her discomfort about feeling angry, which was evident from her avoidance of mentioning or expressing this reaction. By the end of the treatment, the patient had acknowledged how angry she felt

toward her boyfriend and had taken action to end her relationship with him. She told the therapist, "You taught me the word *anger."*

Sometimes the disavowal of an obvious emotion is direct. One patient insisted that he was never afraid of being rejected. Another patient stated that she was independent and needed help only when she had panic attacks. In these cases, the therapist identified the "missing emotions" and reinstated them in the patient's vocabulary. This is accomplished by reflecting the patient's statements using emotional vocabulary. For example, the patient who denied fear of interpersonal rejection reported a panic episode that occurred in an interaction with his boss. Further discussion revealed that his boss had recently chosen someone else for a promotion and the patient had felt rejected and hurt. Just before the panic episode, the boss had made a request of the patient. The patient experienced a surge of resentment associated with the thought, "Why should I go out of my way for him? He just takes advantage of me. I can never please him anyway." The therapist reflected, "You felt pretty angry when he asked you to do that special report." The patient responded, "Yeah, I guess I really wanted his approval, and I was hurt when he didn't promote me." The theme of shame about wishes to have the approval of others became a focus of the treatment.

Identification and Exploration of the Response to the Primary Emotional Reaction

After the stimulus-response characteristics of the targeted emotional reaction have been fully specified, the therapist focuses on how the patient manages this reaction. The therapist accomplishes this through a reflective intervention, acknowledging the pain involved in experiencing the distressing affect and the need to find a way to lessen the pain. It is important that the patient not feel criticized for the reaction he or she has had, and that he or she feel understood. This facilitates examination of the coping strategy and its rationale and at the same time permits exploration of alternative solutions to the problem of controlling distressing affect.

For example, in working with Ms. Jones who had just recognized that her panic episode occurred in reaction to distressing feelings evoked by her dream about her friend John, the therapist commented, "You had a disturbing dream that led you to feel very sad, resentful, and lonely. You then tried to put it out of your mind." The patient responded, "Well, he's dead now, and there's nothing else to do except try to forget it." The therapist then reflected, "Your friend is dead, and you feel you must forget your feelings." The patient then said, "Maybe I want to forget. It's too painful to think about him and feel lonely and angry and helpless." The patient then paused and reflected on this: "Maybe I've never let myself really say good-bye to John. Maybe I've been too mad at him and his family to give him that respect *[pause].* It's also a kind of guilty feeling. What if I found someone else? I feel it wouldn't really be fair to him. Maybe it would make him mad." She said it's easier just to put it out of

her mind whenever she has a spontaneous thought about him. The therapist reflects: "These feelings are too difficult. The only way to cope with them is to put them out of your mind." This leads the patient to consider, "Do you think there's something else I could do?" The therapist reflects the question: "You're wondering if maybe there could be another way of handling this situation." The patient responds, "I don't know." The therapist encourages further thoughts about this: "You're wondering if it's possible to find a solution to situations like losing your friend, where you feel angry and guilty and afraid. A way that might not leave you feeling so helpless. But you're not sure there's anything to do but tell yourself, 'Forget it.'" The patient agrees and elaborates: "I guess *[pause].* I wonder if I could ever feel there was someone else who could care for me as much, someone who would understand me.... I really need another friend like John *[pause].* Maybe John would want that for me too."

The therapist working with Ms. Green, the patient whose perception was that her boss was making unreasonable demands upon her, reflected that perception to her, leading the patient to add that she felt that all successful men want to make women their slaves, a conviction that made her feel it was futile to stand up to her boss. Her solution was to bury her feelings. The patient thought about this and responded, "I guess I could have asked what exactly he wanted me to do. I could ask him to set priorities if I can't do all the things he asks." The therapist reflected, "You don't like feeling resentful, but if

you think you can get through to someone, it's not too hard to think of different ways to manage the resentment."

In each of these cases, the therapist used a sequential unfolding process to identify a difficult negative affect. The therapist then encouraged discussion of the affect, its origin, and alternative ways to think about both the stimulus for the affect and the response to it. Throughout the treatment, this process is used to identify negative emotions, discuss them, and reevaluate stimuli that trigger the reactions. Responses to emotions are also identified and considered.

TRAINING

The administration of this treatment requires general training and experience in the use of psychodynamic psychotherapy and/or in experiential psychotherapeutic techniques. The therapist who uses this treatment should also be familiar with panic disorder patients and skilled at differential diagnosis. In addition, the therapist should receive some specialized, supervised training experience, as outlined below.

Our training procedures include careful reading of the treatment manual and an opportunity to review the principles and techniques described in the manual with one of the authors or someone else trained to administer the treatment. This is accompanied by study of case examples and listening to or watching taped treatment sessions. We pay particular attention to ensuring that the therapist is familiar with the psychoeducational principles. Techniques for managing resistance are included in the manual, and the prospective therapist studies this information. To complete training, the therapist conducts at least two supervised cases while being monitored on adherence to treatment procedures. An adherence monitoring form is included with the treatment manual.

EMPIRICAL EVIDENCE FOR THE APPROACH

Emotion-focused treatment is not yet empirically well validated. However, there is preliminary support for its efficacy, based on results of studies using supportive, nondirective treatment as a control therapy and on case reports of the usefulness of psychodynamic treatment. A prospective controlled study of EFT is under way, but results are not yet available. In the absence of that data, it is helpful to know that treatment approaches using nondirective empathic support appear to ameliorate symptoms and that case reports document some utility in more classic psychodynamic treatment. We see these approaches as more similar to EFT than the direct, symptom-targeted strategies used in cognitive-behavioral treatments. For this reason, we will highlight some reports available in the literature here.

Case Reports in Psychoanalytic Literature

Mann (1973) reports a case of a housewife disabled by agoraphobic symptoms whose dependency and lack of assertiveness were seen as central to symptom formation. The report includes a detailed description of a brief therapy, focused heavily on transference interpretations, that produced virtual recovery. Sifneos (1972) also describes a psychodynamic treatment in some detail. The patient was a young mother, employed part-time as a fashion model, who complained of frigidity and agoraphobia. A treatment focused on guilt feelings about sexual pleasure and guilt about her aggressive,

competitive feelings toward her mother produced remission that was sustained at seven-year follow-up. Milrod and Shear (1992) summarized tentative generalizations from case reports of successful psychodynamic treatment: Initial management of panic symptoms appears to have occurred through the establishment of a relationship with the physician and the patient's knowledge that a treatment would begin. In some cases, the patient's family was contacted during the early phase of treatment in order to educate them. After a therapeutic relationship was established, the patient began to acknowledge and discuss upsetting feelings that seemed to have contributed to the onset of panic symptoms. In the middle phase of treatment, patients' central conflicts were identified and explored. Therapists used transference interpretations to elucidate the meaning of panic symptoms, as well as of other identified problems. In these cases, treatment with psychodynamic psychotherapy resulted in disappearance of panic and a sense of greater overall psychological stability.

Previous Studies of Supportive/Nondirective Treatment

Klein, Zitrin, Woerner, & Ross (1983) reported similar results with either systematic hierarchical desensitization or supportive psychotherapy in agoraphobics, and Borkovec and Matthews (1988) reported an equivalent outcome with cognitive-behavioral treatment and a nondirective reflective listening treatment in a mixed group of subjects with panic or generalized

anxiety. As noted above, we reported the results of a study comparing cognitive-behavioral therapy with a panic-focused, affect-processing treatment very similar to the one described in this chapter (Shear, Pilkonis, Cloitre, & Leon, 1994). Post-treatment and six-month follow-up assessments revealed a good response to both treatments. We observed a high rate of panic remission and significant improvement in associated symptoms in each group. A replication study is currently under way, along with a comparison with an inactive control.

In summary, we present the background and methods for a brief emotion-focused therapy intervention for panic disorder patients. This treatment is derived from psychodynamic principles but is not, strictly speaking, a psychodynamic psychotherapy. Efficacy of this treatment has some early empirical support, but full confirmation of its efficacy and effectiveness in comparison with other active treatments awaits further study.

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