

Chapter 2

Psychodynamic Treatment of Panic Disorder

Clinical and Research Assessment

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Introduction

Both pharmacological [1–3] and cognitive-behavioral treatments [4–6] of panic disorder have been found to be effective in treatment. Despite this progress, not all patients respond or are able to tolerate these treatments [4–8]. Relapse is frequent if medication is discontinued before a prolonged maintenance phase [9–12]. Questions remain about the long-term effectiveness of these interventions [4, 13]. In studies of “routine care,” generally a poorly defined mix, patients frequently demonstrate persistent symptoms and problems functioning [14]. Little systematic data are available about whether or not these treatments are effective in treating impairments associated with panic disorder, such as occupational dysfunction, relationship difficulties, and diminished quality of life [15, 16]. Given the high morbidity and health costs of this disorder [17–20], it is important to continue to develop the most effective treatments for panic disorder and its related impairments.

Psychodynamic psychotherapy has been a commonly practiced, but poorly studied intervention for panic disorder. The potential value of this treatment is based on the notion that panic patients have a psychological vulnerability to the disorder associated with personality disturbances, relationship problems, difficulties tolerating and defining inner emotional experiences, unconscious conflicts about separation and autonomy, negative emotions such as rage at important loved ones, and conflicted aspects of sexuality. Theoretically,

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psychodynamic treatments could have a greater impact on psychosocial impairment associated with panic, as cognitive-behavioral and psychopharmacological treatments do not focus on this domain. This might in theory lead to a reduction in vulnerability to panic recurrence [21]. The limited research on psychodynamic treatment of panic disorder is described below.

Psychodynamic concepts as they relate to panic disorder will be outlined, followed by a psychodynamic formulation that weaves together neurophysiological and psychological vulnerabilities to panic. Our research group developed this psychodynamic formulation for panic disorder based on psychodynamic theory, systematic psychological assessments, and clinical observations to guide treatment interventions [21–23]. The theory and interventions were used to develop a manualized description of a approach to panic disorder, panic-focused psychodynamic psychotherapy (PFPP) [23], to be employed for clinical and research purposes.

Psychodynamic Concepts in Panic Disorder

The Unconscious

According to psychoanalytic theory, symptoms are based at least in part on unconscious fantasies, conflicts, and affects [24]. For instance, clinical and research observations suggest that panic patients have particular difficulty with angry feelings and fantasies toward close attachment figures, such as wishes for revenge [22, 23, 25]. These wishes are felt to represent a threat to attachment figures, which triggers overwhelming anxiety. Oftentimes patients are not fully aware of the intensity of these affects, or of the vengeful fantasies that accompany them. Becoming conscious of these aspects of mental life and rendering them less threatening are important components of psychodynamic psychotherapy for panic disorder.

Defense Mechanisms

Fantasies and affects that are experienced as dangerous can be avoided through the triggering of defense mechanisms, unconscious mental processes that disguise the fantasies or render them inaccessible to consciousness [26]. Clinical and research observations indicate that panic patients employ particular defenses: reaction formation, undoing, and denial [27]. Reaction formation and undoing play a particular role for panic patients, in that they often unconsciously attempt to convert angry affects to more affiliative ones, diminishing the threat to an attachment figure. In reaction formation, a threatening feeling is replaced by its opposite; oftentimes in panic patients negative feelings are replaced by concern and efforts to help others. In undoing, an unconscious

negative affect or fantasy is typically taken back in some way. Denial represents a nonrecognition of the presence of a particular feeling, conflict, or fantasy, such as a patient reporting he was not angry even after someone had done something hurtful to him. In a psychoanalytic treatment, it is helpful to bring these defenses to the patient's attention, as they maintain the patient's avoidance of the emotions that give rise to physiological symptoms. For instance, a patient who follows the statement "I hate him" by "But I really love him," an example of undoing, is often trying to avoid the intensity of his angry feelings.

Compromise Formation

From a psychoanalytic perspective, psychic symptoms represent a compromise between a conflicted wish and the defense against that wish [24]. Teasing apart the components of this compromise formation can help to elucidate the meaning of the symptom and unconscious elements that trigger it. Thus panic symptoms can include the wish to be dependent and cared for, a denial of negative aspects of core relationships through a focus on anxiety or bodily symptoms, as well as an unconscious expression of anger in the coercive pressure on others to help. Psychoanalytic theory also considers fantasies and dreams, as well as central aspects of people's choices, such as career and sexual partners, to be influenced by compromise formations, encapsulating both wishes and defenses.

For example, Busch et al. [28] describe an 18-year-old girl who had the onset of panic while driving to her eighteenth birthday party celebration. She became unable to drive and had to wait several hours to be picked up by her mother. It emerged in psychotherapy that she associated this birthday with her "independence," and an associated wish to rid herself of her parents and siblings, with whom she was intensely furious. The panic attack was a compromise between several wishes and defenses. It represented her conflicted wish for autonomy in that a heretofore basic skill, driving by herself, was rendered impossible due to intrusion of terrifying fantasies of danger and her own fantasized inadequacy. In addition, her murderous wishes were guiltily redirected toward herself: she was now immobilized and helpless. Panic became a punishment for her aggressive fantasies of autonomy, by tying her evermore to her frustrating family.

Self and Object Representations

In systematic assessments, patients with panic disorder have been found to have views of their parents as controlling, temperamental, and critical [29, 30]. These become internalized expectations of others' behavior. In addition, because of their temperamental predisposition to fearfulness, panic patients often view

others as being essential to their safety and well-being. Recognizing these perceptions of the experience between self and others can help patients understand the irrational dangers they perceive in their relationships.

Traumatic and Signal Anxiety

Freud distinguished between two types of anxiety: “traumatic” and “signal” anxiety [31]. In traumatic anxiety, related to panic attacks, the ego is overwhelmed by threats from internal dangers. Signal anxiety, on the contrary, can be viewed as an appraisal system in which small doses of anxiety alert the ego to psychologically meaningful dangers, such as potential disruptions in attachment, or threats that might be expected to be experienced from vengeful feelings. Signal anxiety can trigger defenses that act unconsciously to ward off potential dangers. In PFPP, the therapist helps the patient to reappraise the degree of actual danger he is in based on reality, rather than on compelling fantasies.

Transference

In the course of treatment, conflicts that the patient experiences with others will necessarily reemerge in some form in the relationship the patient develops with the therapist. For example, a panic patient may feel that the therapist would not be able to tolerate her anger and become judgmental or rejecting. This phenomenon, referred to as transference, can provide essential, direct access to intrapsychic conflicts and self and object representations that underlie panic symptoms. The therapist is active in utilizing aspects of the emergence of the transference to help the patient to better grasp his central conflicts.

Psychodynamic Formulation for Panic Disorder

Busch et al. [21] and Shear et al. [22] developed a psychodynamic formulation for panic disorder based on neurophysiologic predispositions, psychological findings, and psychoanalytic theory. The formulation posits that certain individuals are susceptible to the onset of panic disorder due to a predisposition to anxiety, associated with a fearful temperament described by Kagan et al. [32]. Because of their anxiety, children with this predisposition tend to develop a fearful dependency on others, feeling that parents must be present at all times to provide a sense of safety. In addition, the dependency on others is a narcissistic humiliation for these children, because feelings of safety often require the caregiver’s presence. This fearful dependency can develop from a biochemical vulnerability, or from the experience of inadequate and/or traumatic early

relationships with significant others, usually parents or other caregivers. In either case, significant others are perceived as “unreliable,” prone to abandoning and rejecting the child.

In response to perceived rejection or unavailability, and due to the narcissistic injury of dependency, the child becomes angry at his close attachment figures. This anger is experienced as dangerous, as the associated fantasies could potentially damage the relationship with the people upon whom the child depends, increasing the threat of loss and fearful dependency. Thus, a vicious cycle of fearful dependency and anger can occur. The vicious cycle gets triggered again in adulthood, when the individual experiences or perceives a threat to the integrity of important attachment relationships. Signal anxiety and defenses are triggered, such as undoing, reaction formation and denial, in an attempt to reduce the threat from whatever anger the patient actually experiences. Due to the degree of threat and disorganization engendered by these fantasies, as well as immaturity of the signal anxiety mechanism, the ego becomes overwhelmed and panic levels of anxiety result. Panic attacks further avert conscious acknowledgement of anger and compel attention from others.

This formulation of the origins of fearful dependency is based on limited current knowledge. Although it has been of clinical value in the development of PFPP, further elucidation is necessary to determine the ways in which neurophysiological factors interact with psychological vulnerabilities to panic onset [33]. Gorman et al. [34], for example, describe an oversensitive fear network, with a central role played by the amygdala, stimulation of which has been found to produce panic-like reactions in animals. The amygdala receives input from brainstem structures and the sensory thalamus, pathways likely involved in immediate responses to danger, and cortical regions, which allow for slower processing of data. The authors suggest that psychotherapy may act by increasing the impact of cortical projections over automatic panic responses. Alternatively, Panksepp [35] focuses on a brain PANIC system, linked to separation distress and attachment, with a circuitry that partially overlaps with that described by Gorman et al. [33]. Additional studies (e.g., [36–39]) are providing data to further delineate the neurophysiology of panic and elucidate the relationship between the danger response and attachment systems in the brain and psychological factors.

Relatively recent developments in psychoanalytic theory suggest another component of the process of panic onset and persistence. Mentalization describes the ability to understand oneself and others with regard to motives, desires, and feelings [40]. Panic patients may experience a diminished capacity for aspects of mentalization as regards their anxiety. Rudden et al. [41] have noted a specific lack of access to feelings and fantasies surrounding panic experiences. This lack of mentalization reflects patients’ capacity to deny or unconsciously block access to frightening areas of intrapsychic conflict. Greater introspective access to these fantasies and emotional states helps to relieve these dangers.

Panic-Focused Psychodynamic Psychotherapy

PFPP is a specific manualized form of psychoanalytic psychotherapy [23] that has been subjected to clinical trials and has been found to be efficacious [42]. As opposed to more traditional open-ended psychodynamic psychotherapy and psychoanalysis, PFPP focuses on panic symptoms and the dynamics associated with panic disorder. Material in the sessions other than panic symptomatology is ultimately connected to the dynamics of panic. The treatment follows the overall course of identifying the meanings of panic symptoms, calling attention to defenses that inhibit awareness of panic-specific disavowed feelings, conflicts, and fantasies, and, once made conscious, rendering these feelings less threatening or toxic. Psychoanalytic techniques of clarification, confrontation, and interpretation are employed in this process. Unlike more structured manualized therapies for panic disorder, the three phases of PFPP (Fig. 2.1) are not necessarily sequential, and may occupy differing amounts of time between patients. In outcome studies that have been conducted thus far, PFPP is a twice weekly, 12 week (24 session) time-limited psychotherapy.

Phase I

In phase I of PFPP, the therapist works to identify the specific content and meanings of the panic episodes. In addition, patient and therapist examine the stressors and feelings surrounding the onset and persistence of panic attacks. The patient's developmental history is reviewed to delineate specific vulnerabilities that may have led to panic onset, such as particular representations of parents, traumatic experiences, and difficulty expressing and managing angry feelings. The therapist's nonjudgmental stance aids the patient in articulating fantasies and feelings that may have been unconscious or difficult to tolerate, such as vengeful wishes or abandonment fears. The information is used to identify the presence of intrapsychic conflicts surrounding anger, personal autonomy development, and sexuality. The goal of this phase is reduction in panic symptoms.

Phase II

Phase II seeks to address the dynamics that lead the patient to be vulnerable to panic onset and persistence. As noted, these typically include conflicts surrounding anger recognition and management, ambivalence about autonomy, fears of loss or abandonment (i.e., separation anxiety), and conflicted aspects of sexual excitement. These dynamics are addressed as they emerge in the patient's feelings and fantasies about relationships in their present and past, and in the transference relationship that develops with the therapist. The meanings of symptoms and the employment of defenses also continue to play a role in

Description of Panic-Focused Psychodynamic Psychotherapy

Phase I: Acute Panic: Panic symptoms carry psychological meanings and panic-focused psychodynamic psychotherapy works to uncover unconscious meanings to achieve relief.

Format:

A. Initial evaluation and early treatment:

- 1) Exploration of circumstances/feelings surrounding panic onset.
- 2) Exploration of personal meanings of panic symptoms.
- 3) Exploration of feelings/content of panic episodes.

B. Common psychodynamic conflicts in panic disorder:

- 1) Separation and autonomy.
- 2) Anger recognition; management, and coping with expression.

C. Expected responses to phase I:

- 1) Panic relief.
- 2) Reduced agoraphobia.

Phase II: Panic Vulnerability: To lessen vulnerability to panic, core unconscious conflicts must be understood and altered. These conflicts are often approached through the transference.

Strategy:

A. Addressing the transference.

B. Working through—demonstration that the same conflict emerges in many settings.

C. Expected responses to phase II:

- 1) Improved relationships.
- 2) Less conflicted and anxious experience of separation, anger, and sexuality.
- 3) Reduced panic recurrence.

Phase III: Termination: Termination permits re-experiencing of conflicts directly with the therapist so that underlying feelings are articulated. Patient reaction to termination must be addressed for minimally the final third (1 month).

A. Re-experiencing central separation and anger themes in the transference with termination.

Expected responses:

- 1) Possible temporary recrudescence of symptoms as feelings are experienced in therapy.
- 2) New ability to manage separations and autonomy.

Fig. 2.1 Description of panic-focused psychodynamic psychotherapy

identifying underlying dynamisms. Improved understanding of these conflicts helps to interrupt the vicious cycle described above, reducing vulnerability to panic recurrence.

Phase III

The termination phase provides an opportunity to work with the patient's conflicts about anger and personal autonomy as they emerge in the context of ending treatment. Patients are actively helped to focus on the experience, and to articulate their feelings about loss directly with the therapist. Increased awareness and understanding allows for better management of these feelings and the capacity to avert the development of more severe panic states. An ability to

express anger in ways that feel less threatening is often an important development of the treatment. Increased assertiveness and the capacity to communicate about conflicts in relationships improve psychosocial function and reduce panic vulnerability.

Treatment Indications

Psychodynamic psychotherapy has typically been thought to be indicated for patients who enter treatment with a particular set of qualities: verbally skilled, psychologically minded, and curious about the origins of their symptoms. These qualities are identical with the qualities that have often been described as being good prognostic indicators for psychoanalysis [43]. Panic patients, however, with their tendency to experience conflicts and affects in their bodies, have limited verbal access to their intrapsychic life and may be frightened to pursue underlying emotional origins of their problems. In our studies, we have found that patients without these skills regularly obtain relief of symptoms from PFPP [44, 45].

Engaging the Patient

Several factors enable PFPP to work as a short-term treatment, and as an intervention that can help people with little exposure to psychotherapy. In early sessions the therapist focuses on exploring the circumstances and feelings preceding panic onset. This is usually what preoccupies patients most as they start their therapy. Patients become engaged in treatment as they begin to recognize the relationship between their symptoms, the circumstances in which symptoms began, their feelings surrounding panic, and their developmental history.

Ms. A was a 43-year-old married woman with two children who described the onset of panic attacks 1 month prior to consultation. She presented with primary *Diagnostic and Statistical Manual of Mental Disorders* (DSM)-IV panic disorder and mild depressive symptoms not meeting criteria for a specific disorder. She recalled a series of panic attacks just after leaving home for college, but these had resolved spontaneously. At first, Ms. A described her panic as having emerged out of the blue. However, on exploration, the therapist learned that the initial panic attack occurred after an intense conflict with her 15-year-old daughter, the older of two siblings. Ms. A struggled with how to manage her daughter and saw herself as unable to set limits. She experienced limit setting as “too mean.” Ms. A quickly grasped that her panic was likely

related to these conflicts. She brought up that she was “not very assertive” and always had difficulty confronting others.

Following this initial link of the onset of symptoms to family conflicts, Ms. A became very curious about the sources of her problems. The discussion about her daughter reminded her of her difficulties with her alcoholic father, who was often explosively enraged. The therapist wondered if Ms. A had been frightened of expressing any disagreement with him.

Ms. A responded: “Yes, I think I was scared of that. I’m always trying to be nice to people. I think that will get them to like me. But I’m not sure that it’s really helping my daughter to do that.” Ms. A was describing reaction formation, in which her anger toward others was converted into becoming “too nice.” She then noted: “I realize I should be setting better limits. Yesterday when I stood my ground with her I felt so much better.”

This information, presented in the first two sessions of Ms. A’s treatment, already provided valuable insights into the origins of her panic disorder: the conflict with her daughter, difficulties with her management of limit setting, and her fears of getting angry, and engaged her interest in exploring the symptoms further.

The Transference

As treatment progresses, the therapist has more opportunities to explore conflicts as they emerge in the transference. Oftentimes, these occur in the context of angry feelings or separation fears from the therapist.

In a later session, Ms. A complained about an incident with her daughter, in which her daughter had demanded that her family wait for an extended period until she was ready to leave on a family outing. Although the therapist explored the tensions with her daughter in his usual manner, Ms. A left feeling the therapist was unsupportive and viewed her as a “bad mother.” She became anxious after the session. That evening she asked her husband to comfort her, but he responded that he had had a stressful day and wanted to read the paper. At that point, she had a panic attack. In the following session, therapist and patient were able to determine that she was quite angry at her therapist and her husband, and that her discomfort with being angry at people she depended on triggered the attack.

Working Through and Termination

Working through involves identifying the presence of central conflicts in various areas of the patient's life, allowing increased understanding of the ramifications of these central, organizing unconscious conflicts.

For instance, Ms. A realized her unassertiveness was organized around several central developmental experiences: fear of her temperamental father, fear of her sister who was more aggressive and bolder than she, and identification with her mother, who was also unassertive and never confronted her father about problems. Each of these formative developmental situations helped to elucidate the patient's worry that asserting herself would lead to disruptions in her relationships. She felt that being the "nice girl" maintained others' interest in her and was the only way to keep her attachments safe.

As she became more aware of some of the fantasies underlying her fears, Ms. A became more active in "testing" her concerns and behaviors with others. The impact of the shift toward better limit setting with her daughter, and a continued firmer stance on her part, led to a reduction in her daughter's temper tantrums and demanding expectations of her. Ms. A realized that she similarly yielded to her mother's and sister's demands and expectations. She recognized that rather than obtaining the caring and concern she sought, "being nice," allowed others to continue to behave toward her in demanding and hurtful ways. Increased comfort with her anger allowed Ms. A to recognize that her mother was "not a nice person," something that had been difficult for her to tolerate without feeling guilty and anxious. Her criticisms included that her mother was often self-centered, with little actual interest in Ms. A's children.

One day when her sister called and stated in her typical manner: "Mom needs someone to go to the doctor today and I'm working," Ms. A did not respond with her usual ready agreement, but stated that she had plans and could not go. Her sister reacted angrily and hung up on her. Initially Ms. A felt guilty. When her guilt was explored in therapy, it emerged that she feared her anger would damage others in a significant way. And yet she knew that her mother would make some other arrangement to get to the doctor. As her guilt was discussed more openly in therapy, Ms. A felt relieved, freer, and less anxious about being more assertive. She became increasingly aware of her reflexive tendency to be "too nice" and became more assertive in most of her relationships.

Termination provides an important opportunity for examining central conflicts underlying panic directly with the therapist. Anger and fear of losing the relationship with the therapist often intensify at this point, highlighting

conflicts that emerged earlier in treatment. In PFPP in research studies, patients were typically pleased about the progress they had made, but often had difficulties expressing disappointment and frustration with the therapist about ending treatment [44, 45].

Research on Psychodynamic Treatment of Panic Disorder

Few systematic studies using manualized psychoanalytic treatments have been done in populations with panic disorder. Wiborg and Dahl [46] conducted a randomized, controlled trial of a manualized form of psychodynamic psychotherapy in addition to clomipramine, in comparison with clomipramine alone. The 3-month weekly psychotherapy combined with medication reduced relapse rates at 18 months compared to patients treated with clomipramine alone (9 vs. 91%).

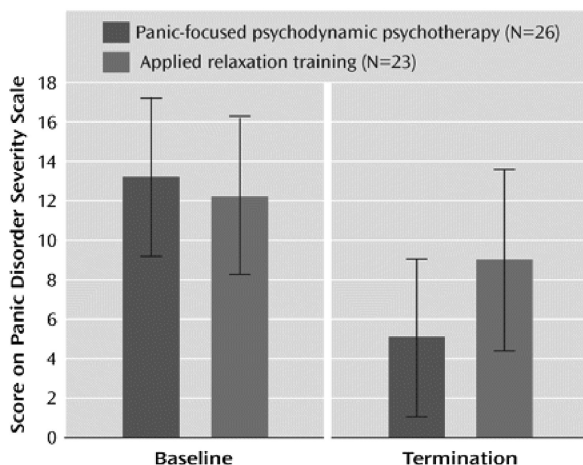
An open trial of PFPP was conducted by our research group [44, 45]. Of 21 patients with primary DSM-IV panic disorder who entered the trial, 4 patients dropped out. Of the remaining 17, 16 patients achieved standard remission criteria of their panic and agoraphobia [47]. Significant psychosocial function improvements were noted. All of the therapeutic improvements were maintained at 6-month follow-up. Notably, the eight subjects who also met DSM-IV criteria for major depression at study entry experienced relief of these symptoms as well. Although not a randomized controlled trial, the study suggested that PFPP could provide significant relief of panic disorder.

Recently, our research group completed a randomized controlled trial [42] comparing PFPP to applied relaxation therapy (ART) [48], a treatment for panic disorder that is less active than cognitive-behavioral therapy (CBT) [49], in 49 patients. This study was the first to demonstrate efficacy of a scientifically testable psychodynamic psychotherapy for panic disorder.

Patients entered the study if they met DSM-IV criteria for primary panic disorder with or without agoraphobia, in addition to having at least one panic attack per week. Patients on medication agreed to not change the dose or type of medication throughout the study period (15% of the sample). To gain study entry, patients had to agree to stop all nonstudy psychotherapy. Patients were included if they had severe agoraphobia, comorbid major depression, or personality disorders as comorbid conditions. Exclusion criteria were psychosis, bipolar disorder, and substance abuse (6 months remission necessary).

Patients were symptomatically assessed at baseline, at treatment termination, and at 2, 4, 6, and 12 months after treatment termination by independent raters, blinded to study condition and therapist orientation. The primary outcome measure was the Panic Disorder Severity Scale (PDSS) [50] (Fig. 2.2); other domains monitored were psychosocial function with the Sheehan Disability Scale (SDS) [51], depression, with the Hamilton Depression Rating Scale (HAM-D, [52]) and general nonpanic-related anxiety the Hamilton Anxiety

Fig. 2.2 Panic Disorder Severity Scale as primary outcome measure



Rating Scale (HAM-A, [53]). Response was defined as a 40% reduction from baseline PDSS score in keeping with standard definitions in the field [47].

PFPP and ART were provided as 24-session, twice-weekly (12 weeks) treatments. ART includes a rationale and explanation about panic disorder, progressive muscle relaxation (PMR) techniques, cue controlled relaxation, and exposure. PMR involves tensing and relaxing particular muscle groups, with therapist suggestions of deepening relaxation. Twice daily homework was assigned. An exposure protocol was included, using relaxation as an active technique to combat emerging panic.

PFPP therapists ($N = 8$) were PhD psychologists or MD psychiatrists who had completed at least 3 years of psychoanalytic training. They received a 12-h course in PFPP, and had at least 2 years of experience with psychodynamic treatment of PD.

ART therapists ($N = 6$), were PhD psychologists or MDs after psychiatric residency, had a 6-h course in ART, and at least 2 years of clinical experience treating panic disorder with ART and CBT. Supervisory experience of both groups of therapists included monthly group supervision and individual supervision as needed.

All psychotherapy sessions were videotaped for adherence monitoring. Adherence to study therapy protocol was assessed based on three videotapes from each treatment using the PFPP Adherence Rating Scale (available from the authors) and the ART Adherence Scale [54]. Both groups demonstrated a high level of adherence to the manualized treatments.

There was a significantly greater proportion of men in the ART group compared to the PFPP group (47 vs. 15%; two-tailed Fisher's exact $p = 0.03$). No other significant demographic or clinical differences were found between the two treatment groups (see Table 2.1). Importantly, no significant baseline differences were observed between randomized groups in severity of PD, PDSS score [50], the SDS [51], the HAM-D, [52], and HAM-A [53] (Table 2.2). PFPP

Table 2.1 Clinical and Demographic Characteristics

Variable	Panic-Focused Psychodynamic Psychotherapy (N = 26)		Applied Relaxation Training (N = 23)	
	Mean	SD	Mean	SD
Age at entry (years)	33.4	9.6	33.5	8.5
Severity of panic disorder (range: 1–8)	5.7	0.8	5.8	0.8
Comorbid axis I disorders	2.2	1.4	2.4	1.6
Panic duration (years)	8.4	9.8	8.8	9.6
	%		%	
Gender (male)	15		47*	
Moderate to severe agoraphobia	69		86	
Comorbid major depression	19		26	
Psychotropic use	19		17	
Axis II diagnosis	42		56	
Cluster B diagnosis	11		21	

**p* < 0.05

had a significantly higher response rate than ART (73 vs. 39%; *p* = 0.016) using definitions that are standard in the field (a 40% decrease in the total PDSS score from baseline) [47], and a significantly greater reduction in impairment of

Table 2.2 Change in clinical severity measures pre- and posttreatment^a

Variable	Panic-focused Psychodynamic Psychotherapy (N = 26)		Applied relaxation Training (N = 23)		Analysis			Effect Size ^b
	<i>N</i>	%	<i>N</i>	%	<i>t</i>	df	<i>p</i>	
Responder status	19	73	9	39	5.74 ^c	1	0.016	–
	Mean	SD	Mean	SD				
Panic Disorder Severity Scale baseline	13.2	4.0	12.2	4.0				
Panic Disorder Severity Scale termination	5.1	4.0	9.0	4.6	3.30	47	0.002	0.95
Sheehan Disability Scale baseline	14.7	8.8	14.6	6.0				
Sheehan Disability Scale termination	7.3	7.8	12.7	6.4	2.54	46	0.014	0.74
HAM-D baseline	15.9	7.3	14.2	6.3				
HAM-D termination	9.0	5.6	11.5	6.7	1.84	47	0.071	0.53
HAM-A baseline	16.0	6.9	16.0	6.0				
HAM-A termination	8.9	5.7	11.1	6.4	0.54	47	0.588	0.16

^aGroup comparisons on change in scores pre- and posttreatment. *N*'s vary because of missing data. (One applied relaxation training subject did not complete the Sheehan Disability Scale correctly posttreatment.)

^bCohen's *d* is the between group effect size.

^cChi square test.

psychosocial function on the SDS ($p = 0.014$). Significant differences were not observed between the two treatments in the HAM-D ratings of depressive symptoms ($p = 0.07$), or in nonpanic anxiety on the HAM-A ($p = 0.58$).

Thus, in this first randomized controlled trial of a manualized psychoanalytic treatment as a sole intervention for panic disorder, PFPP demonstrated efficacy. Treatment was well tolerated: only two of 26 subjects dropped out of the PFPP condition (7%), in comparison with 8 dropouts from the ART condition (34%). The dropout rate for PFPP was unusually low for an RCT of panic disorder patients in the United States. Patients generally responded well to treatment, even though, due to the inclusion of severe agoraphobia and comorbid depression, they were relatively sicker than panic patients in other major panic outcome studies [47, 49, 55–57]. Although PFPP performed comparably to clinical trials of CBT and medication, these treatments were not directly compared in this study. A study is currently in progress comparing PFPP directly with CBT.

Conclusion

As panic disorder remains a significant public health problem, it is important to continue to develop and assess therapeutic interventions for this illness. PFPP is a useful alternative treatment for panic and addresses aspects of the disorder that are not likely to be addressed by other, better-tested treatments. Further studies of comparative efficacy of treatments should help to determine which interventions, or series of interventions, are most helpful for panic patients.

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