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Panic-Focused Psychodynamic Psychotherapy in a Woman with Panic Disorder and Generalized Anxiety Disorder

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Abstract

Panic-focused psychodynamic psychotherapy (PFPP) is a 24-session, twice-weekly (12 weeks), manualized psychoanalytic psychotherapy with demonstrated preliminary efficacy for panic disorder (PD).^{1,2} Given the substantial morbidity and the health care utilization of the PD population,^{3,4} coupled with the sizable proportion of such patients who do not respond (or respond inadequately) to alternate treatments (cognitive-behavioral therapy [CBT] and drug therapy),^{5–7} PFPP may offer clinicians an additional tool for their therapeutic armamentarium. It may also facilitate a rapprochement between academic psychiatry and psychodynamic perspectives, and a reassessment of the role of psychodynamic therapy as part of the educational experience of residents in training—an experience that has diminished over two decades.

Keywords

panic disorder; psychodynamic therapy; residency education

CASE HISTORY

Ms. A, a 55-year-old, married Hispanic mother of a teenage daughter, presented to the Psychotherapies for Panic Disorder research protocol for treatment of lifelong symptoms of anxiety. She was randomized to receive 24 sessions of PFPP.¹

Ms. A described long-standing, frequent panic attacks: bouts of intense anxiety with palpitations, shortness of breath, tingling, hot flashes, and a fear of suffocating. These symptoms occurred out of the blue or could be triggered by angry calls from her husband or thoughts about her 19-year-old daughter's increasing independence. On the Anxiety Disorders Interview Schedule Lifetime Version⁸—a structured interview that assesses for

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current and past episodes of anxiety, mood, somatoform, and substance abuse disorders—she met DSM-IV criteria for panic disorder without agoraphobia (severity, 6/8), generalized anxiety disorder (GAD) (5/8), and specific phobia—dentist (4/8).

Past History

Ms. A had a traumatic childhood characterized by repeated verbal abuse from her mother (a prostitute) and repeated sexual molestation by two neighbors from age seven through eleven. An absent, alcoholic father heightened her experience of feeling unprotected by her “monster” mother. Ms. A said, “I always felt out of control, without any balance or stability; my mother couldn't give that to me.” Ms. A left college without graduating, subsequently met her husband (a plumber), and after many years and much ambivalence (in part resulting from her pervasive anxiety and panic attacks), became pregnant with her daughter. She never worked full time, although she held some part-time jobs. Despite being in “talk therapy” for many years for chronic low self-esteem and relationship problems, her anxiety symptoms had never improved.

In sum, at presentation Ms. A suffered from panic disorder without agoraphobia, GAD, and specific phobia. Her Structured Clinical Interview for DSM-IV Axis II Personality Disorders⁹ was significant for obsessive-compulsive, avoidant, and depressive personality traits, although she fell short of meeting criteria for any personality disorder.

PFPP Phase I: Identifying and Articulating the Underlying Dynamics of Panic

In the initial phase of PFPP, therapists explore stressors, feelings, and emotional meanings of panic attacks, with the goal of identifying and articulating the underlying dynamics. For example, in session 3, Ms. A described panic attacks that she experienced while visiting a dentist for a root canal treatment. In an effort to get better care, Ms. A chose an “out-of-network” dentist who was more costly than the dentist who accepted her insurance. When she learned that the tooth might be lost, she berated herself for having spent money on herself. The feeling of being out of control and the worry about the integrity of the tooth unleashed a barrage of self-blame—something that the therapist drew to her attention. She linked her tendency to self-blame to her childhood: “I don't blame myself on the surface for what happened, but I must blame myself somewhere inside because I tried to make everything right, and I couldn't do that as a child.”

The therapist told her that it seemed she was blaming herself as her mother had blamed her, effectively turning her anger at others against herself. She responded that she was certainly angry with the dentist for not being able to save her tooth but that she had not been aware of that anger until the moment that the therapist mentioned it. “Maybe my anger is an issue for me; is it ‘mad’ anger or justified anger?” The therapist suggested that her confusion about her angry feelings—and her terror in the face of her intense anger—were sources of her vulnerability to panic.

Ms. A began session 4 as follows:

I assumed because I was angry and couldn't do anything about it that it wasn't an important emotion. But I realize it was important. There's been this pattern from my

childhood of not being able to do anything about my situation, so I'd be frustrated, and I would eliminate the emotion, though not on purpose.

The primary interpretive line that the therapist pursued at this point was that Ms. A's anxiety was tied to her violent childhood experiences, leaving her terrified that her own anger might go out of control, especially in important relationships. She could bury her anger or, as with the dentist, turn it on herself, blaming herself. The therapist articulated two contradictory images that Ms. A had of herself when angry.

Therapist: Perhaps you have two views of anger—one a destructive anger as you felt your mother's anger was, and the other an impotent or helpless anger you felt as a child. In either case, you could be left feeling out of control and vulnerable to panic.

Ms. A: I have to find that spot somewhere in the middle . . . There's that violent anger I abhor and the passive anger I fall into as convenient . . . though not consciously.

Ms. A's conscious awareness of her conflicts over her angry feelings coincided with a marked reduction in her panic symptoms between sessions 4 and 5.

PFPP Phase II: Addressing Panic Vulnerability

Addressing vulnerability to panic in PFPP involves further identification and exploration of the underlying dynamic conflicts, along with the articulation of those conflicts as they emerge in the transference. For Ms. A, conflicts about experiencing anger were important. In session 7, Ms. A likened her anger to a “volcano” ready to explode, which reminded her both of her mother being out of control with her rage, and of herself as a child who, at times, wished her mother dead. Acknowledging her death wishes was important in helping Ms. A to understand the power of her ongoing fantasies, which were contributing to her current panic. She became aware of the fearful fantasy that if she expressed her anger, she would destroy others. Insofar as she imagined her anger to be linked with destruction, healthy assertion in the context of important relationships also became fraught with the terror of loss and abandonment. Awareness of the origins of her intense fears helped her to assert herself more comfortably with her daughter and husband. She became more in touch with her deep yearning for love and more aware of how her angry feelings complicated the gratification of that desire.

Ms. A: I never had the approval I needed as a child . . . I could never please my mother, and I felt if I couldn't please her I was bad . . . I used to think, what could I do to make her love me? I felt—and it comes into the present—if I show too much anger, I won't get love.

Therapist: So, that anxiety still exists for you now.

Ms. A: Yes. Maybe now I fear if I get angry that I'll lose my husband's love. I won't. We've been married for 25 years. We love each other. But I still feel constrained to show anger towards him . . . He's not my mother, but sometimes he reminds me of her.

Ms. A's growing capacity to see how past events cast a shadow on her present life led to improvement in her "reflective function."¹⁰ For example, she could see how her feelings of being a "bad girl" derived from her experience of being abused and that those feelings did not indicate anything about her current feelings as a wife or about her perception of husband's feelings toward her. Her improved reflective capacities were manifest in her growing awareness that her husband frequently became angry when he felt anxious—something she had not previously recognized. A growing understanding of these factors increased her confidence in lovingly disagreeing with him about matters of importance without the need to entertain her habitual fears of the relationship's disruption.

Ms. A: Life is causing me anxiety, *the way I see life*, because I'm afraid of life. I realize I don't have to be afraid of it, and I may not have the anxiety anymore!

PFPP Phase III: Termination

Ending treatment was painful for Ms. A since she viewed the therapist as an idealized figure. The awareness of the therapist as a new object fueled her mourning for the absence of a loving parent throughout her childhood, while allowing her to revise her earlier views of her mother—that is, seeing her as "monstrous but *not* a monster," as a disturbed woman who had herself been the victim of sexual abuse in her own childhood.

Ms. A's panic attacks returned during the termination phase, when the transference meaning emerged in a dream (session 23):

Ms. A: A dog jumps out a window [of Ms. A's childhood apartment], fractures its leg, and is transformed into a child who is calling for "Ma" ("I never called my mother that."), and no one answers.

In her associations to this dream, Ms. A described herself as a "feral child" who had been helped with therapy to develop into a person. But now she felt abandoned. The therapist suggested he might be the "Ma" in the dream because Ms. A felt uncertain how she would move forward when the treatment ended. Ms. A responded to the transference interpretation with diminished anxiety (although her affective expression appeared muted), acknowledging that she would miss the therapist.

Nine months after treatment ended, Ms. A returned for several booster sessions, as was permitted by the protocol. She had been panic free but noted a recurrence of panic attacks upon returning home from an extended vacation. In exploring the determinants of her panic attacks, she connected returning home from the trip to being sexually abused as a child. She spoke with shame about the pleasure she felt as a young girl being shown "affection," although this experience also contributed to her sense of "badness." Shame was a factor in avoiding this topic in her therapy proper, she now told the therapist. The therapist's compassion and nonjudgmental attitude toward this revelation brought significant relief and a resolution of her panic recurrence.

During the final meeting Ms. A harbored some feelings of anger toward the therapist, while also expressing gratitude and affection. Experiencing ambivalence felt new to her.

Ms. A: Now I know how to say goodbye to somebody I care about and feel angry at. Oh my goodness! I didn't know that I *could* do that . . . I didn't know *how* to do that.

The therapist suggested that treatment had helped give form and texture, through language, to an affect that felt overwhelming—a process that had also made her more secure in tolerating her feelings and hence less vulnerable to panic and its recurrence. At the time of discharge from the protocol (several months after the booster sessions), her Anxiety Disorders Interview Schedule severity scores were PD, 3/8; GAD, 0; and specific phobia, 1/8. Ms. A experienced a resolution of her GAD.*

QUESTIONS TO THE CONSULTANTS

1. How does PFPP compare with, and contrast to, CBT and medication as an approach to panic disorder?
2. How might the study of neurobiology aid in our understanding and further development of the psychodynamic approach?
3. Given the demonstrated efficacy of PFPP as a psychodynamic treatment for panic disorder (and potentially other disorders), what are the implications for residency education?
4. Could this treatment be employed for a broader range of anxiety disorders?

RESPONSES OF THE CONSULTANTS

Franklin Schneier, MD

First-line treatments for panic disorder are CBT and pharmacotherapy, based on their established and roughly comparable efficacy in numerous randomized, controlled trials.^{11–13} PFPP has shown promise in a single, small, randomized, controlled trial.¹ Each of these approaches differs in theoretical basis, but they share potentially important common elements, starting with the offer of a diagnosis-specific treatment plan in the context of a therapeutic relationship. High responsivity to such nonspecific elements of treatment, combined with fluctuating natural course and relatively high rates of placebo response,¹⁴ suggest the need for caution in inferring causality of change for any individual case. How would the best-established treatments for this patient differ from PFPP?

In CBT,^{15,16} assessment of the cycle of fears, feelings of arousal, and avoidance behaviors that make up PD, along with the assessment of stressors, is supplemented by self-monitoring through the use of a daily diary. The therapist offers a cognitive-behavioral conceptualization of panic disorder, incorporating examples specific to the patient and corrective information about both the nondangerous nature of anxiety and the paradoxical role of avoidance behavior in maintaining anxiety.

*The case history was prepared by Larry Sandberg, MD.

The CBT therapist might hypothesize that this patient's childhood history of repeated exposure to dangerous verbal and sexual abuse, along with her associated feelings that she was “out of control,” taught her to react to her own emotions as if they were truly dangerous. Therapist and patient would collaboratively test whether her beliefs about losing control or suffocating were accurate or whether they are perhaps better understood as examples of catastrophic thinking and risk overestimation. Such cognitive biases might amplify initially subtle arousal responses to her reported panic triggers (an angry call from her husband or thinking about her daughter's independence) into full-blown panic attacks. A CBT formulation would consider the likelihood that this patient avoids attending to her own preliminary somatic signals of anxiety. Such avoidance might be reinforced by the temporary relief that it offers, albeit at the high cost of missed opportunities to regulate arousal before it escalates to the unmanageability of a panic attack.

CBT interventions address arousal symptoms, unhelpful cognitions, and avoidance behaviors. The therapist would instruct this patient in techniques such as breath retraining and progressive muscle relaxation that reduce somatic arousal while building tolerance for normal fluctuations in physical state. Cognitive-restructuring exercises help the patient redirect negative internal dialogue (“I feel so out of control that I'm going to explode”) to coping-focused self-talk (“My heart is beating fast, but that is probably because I'm feeling angry about the way my husband just spoke to me. I'll let him know that bothered me.”). For this patient, effective cognitive restructuring may involve addressing deeper erroneous beliefs or schema related to her low self-esteem.

An important component of CBT treatments for anxiety disorders is exposure to fears, in the service of mastery or habituation. In PD a key target of exposure is interoceptive; that is, feared bodily sensations. This patient might be taught to practice hyperventilating to elicit symptoms of dizziness or running in place to elicit tachycardia. Goals are to replicate symptoms and practice new coping techniques to manage and tolerate feared stimuli. Other triggers, such as thinking about her daughter's independence, could be incorporated into exposure exercises utilizing cognitive coping strategies. Homework assignments reinforce and generalize what is learned in sessions.

Medication management of PD is based on evidence that treatment blocks panic attacks, reduces anticipatory anxiety and avoidance behavior, and improves functioning. Selective serotonin reuptake inhibitors are the first-line class of medication for panic disorder—based on their safety, tolerability, and efficacy for associated symptoms such as depression, relative to other efficacious classes of medications. These latter include high-potency benzodiazepines, tricyclic antidepressants, serotonin-norepinephrine reuptake inhibitors, and monoamine oxidase inhibitors.^{11–13,17} Whether these medications act primarily on panic attacks or a broader array of symptoms is not clear.

Beyond the direct effects of medication, good management includes careful psychoeducation addressing attitudes and fears about medication use in this somatically preoccupied population. Encouraging patients to call about any concerns during the early phase of treatment may help prevent premature discontinuations. Emphasizing that medication is intended to facilitate a patient's active efforts to overcome avoidance

encourages patient-directed exposure that may enhance response and discourages excessive attribution of improvement to medication, which may contribute to risk of relapse when treatment is discontinued.¹⁸

The establishment of efficacious and efficient CBT and medication treatments for PD may be considered one of psychiatry's greater advances over the past three decades, but many patients do not respond fully to these treatments, in which context PFPP offers a promising alternative. Key issues for the utility of PFPP—such as its efficacy relative to CBT, and identifying moderators that might predict differential response to treatments—are under study. The hypothesized mechanisms of PFPP would suggest that patients with developmental factors and intrapsychic conflict that seem particularly relevant to their PD symptoms might respond preferentially to PFPP. Alternatively, both PFPP and CBT may act through a final common pathway; both the interpretation of developmental issues and conflicts in PFPP and the cognitive restructuring in CBT may enhance coping strategies and enable persons to reengage with avoided emotions and situations, facilitating new learning that these stimuli can be safe.

If both PFPP and CBT in their own ways facilitate emotional growth, their effects have the potential to be persistent. Medication appears to be effective, however, only while it is being taken, and it carries the risk of adverse effects, which is a relative disadvantage. The combination of medication and PFPP has potential advantages and disadvantages. For example, if medication is highly effective, its symptomatic relief may reinforce a patient's belief that the disorder is “biological” and may decrease patient motivation to put effort into the explorations of PFPP. However, some highly symptomatic patients may be better able to engage in PFPP after their symptoms have been reduced by medication, and partial responders to PFPP might similarly benefit from adjunctive medication treatment.

Andrew Gerber, MD, PhD

Until recently, most pathophysiology models for panic disorder divided roughly into three non-mutually exclusive groups.^{19–24} In the “fear circuitry” or suffocation-alarm model (Model 1), the normal anxiety reaction of the brain is believed to be overactive and thus to respond overzealously to triggering by non-life-threatening events, leading to panic attacks (e.g., in Ms. A's case, calls from her husband, thoughts about her daughter, or normal somatic sensations and affective responses to these or other events). This hypersensitivity may be a consequence of an abnormality in the fear circuitry within the limbic system or a deficit produced either through kindling of pathologic brainstem nuclei that support respiration or through other overwhelming sensory inputs.²¹ In an alternative model (Model 2), the central pathology is hypothesized to consist of abnormal or insufficient activity in circuits that control or modulate fear circuitry, such as the prefrontal cortex. Minor anxiety episodes are insufficiently limited and thus progress into panic attacks.²⁴ In the third model (Model 3), panic attacks are seen as responses to implicit stimuli that remain outside of awareness; bringing them into awareness would be a more adaptive response. Limbic structures, such as the amygdala, are recruited in response to these stimuli, but without the benefit of top-down attenuation, which, in part, requires conscious awareness.^{24,25}

Busch and colleagues²⁶ have recently proposed an integrated model of PD that views the mechanisms in each of the above models as part of a single interdigitating system. This integrated model is supported by data from neurobiological research that has detected abnormalities in the coordination of brainstem, sensory, limbic, and frontal control systems.^{19,20,26,27} Some researchers have suggested that individual treatment modalities target specific systems: serotonergic or noradrenergic medications may reduce limbic or brainstem activity, whereas psychotherapy may boost top-down frontal control or bring implicit (and thus difficult to modulate) stimuli into greater awareness.^{20,28–30}

Structural and functional neuroimaging studies of PD have most commonly reported abnormalities in temporal lobe structures—including the hippocampus, parahippocampus, and amygdala—consistent with the notion of overactive fear circuitry.^{31–35} Animal studies suggest that these structures support the generation of negative affects, such as anxiety and fear, as well as the association of these affects with episodic or autobiographical memories.^{36,37} Other anatomical and functional imaging studies suggest that top-down control mechanisms based within the prefrontal cortex either respond inadequately to consciously perceived threats (as suggested in Model 2) or fail to respond because threatening stimuli are not consciously perceived, even though those stimuli still activate subcortical components of fear circuits that operate outside of conscious perception (Model 3). Clinical studies may support an integrated model, but they are too limited to draw conclusions at this time.^{38–44} To date, all but one of the neuroimaging studies of psychotherapy for PD have analyzed the effects of CBT, medication, or interpersonal psychotherapy. Beutel and colleagues⁴⁵ studied nine patients undergoing a short-term inpatient version of PFPP and report normalization of frontolimbic activation patterns on an fMRI task, similar to what had been reported with regard to other treatments. Further neuroimaging research is needed to clarify whether the brain changes brought about by PFPP are indeed the same as those by other treatments. Depending on these results, more specific hypotheses could then be tested with regard to the mechanism and timing of action in PFPP versus other treatments. For example, one might test whether conscious awareness of interpersonal triggers of anxiety directly leads to normalization of brain circuitry or whether it enables a gradual process in which the patient practices new behaviors or exposes him- or herself to previously avoided stimuli.

Ms. A's PFPP treatment demonstrates many instances when the therapist helps Ms. A to become aware of unconscious affective stimuli that trigger her panic. For example, she learns about the intensity of her anger and how frightened she becomes of it. She understands that this reaction is due, in part, to the few options that she had during her traumatic childhood to deal with the anger itself and the external events that caused it. Based on our understanding of the pathophysiology of panic outlined above (in particular, Model 3), we understand that this intervention, at the neurobiological level, helps Ms. A become aware of these affects and body states. The awareness allows her to further and better recruit control mechanisms in the prefrontal cortex to regulate the anxiety before it turns into a full-fledged panic attack. As the therapy progresses and Ms. A identifies elaborate underlying fantasies concerning her own rage and internal “badness,” what we describe clinically as an improvement in reflective function¹⁰ takes place. Neurobiologically, we would say more diverse and effective control mechanisms are gradually developing to handle Ms. A's

thoughts and feelings—most of which require reinforcement through conscious awareness. Some of the control mechanisms are closely tied to internalized representations of the therapist;⁴⁶ it is therefore not surprising that in the context of termination, and to some extent after therapy has ended, symptoms recur. However, the patient's prognosis is good if she consciously applies what she has learned to her interactions with others, hence strengthening her control mechanisms. Her underlying vulnerabilities, as highlighted in pathophysiology Models 1 and 2, may have changed; the control mechanisms that are described in Model 2 can normalize with practice and in an improved interpersonal environment.

Neurobiological research naturally complements current clinical research and writings, and will hopefully lead to further ideas on tailoring interventions to individual pathology. For example, through brain imaging we may be able to identify a range of risk factors in the development of PD: perhaps Group A has a more vigorous amygdala and hippocampus-mediated signaling system; Group B, a weaker frontal cortical control system; and Group C, abnormalities in the system that allows conscious awareness of anxiety-provoking stimuli to build needed regulatory processes. Such deficits are roughly analogous to the three models outlined above. Similarly, research into therapeutic processes may reveal that the most effective intervention differs according to each patient's vulnerabilities: perhaps medication is most useful for Group A, exposure or CBT for Group B, and PFPP for Group C. More likely, the various vulnerabilities sit on a continuum, and combined therapies need to be tailored to the relative vulnerabilities of the individual patient. Each of these hypotheses must be tested, and alternatives explored, before customized treatments can be realized.

Eve Caligor, MD

I would like to approach this case from a training perspective to consider the potential role of manualized, evidence-based psychodynamic treatments in psychotherapy training during residency. In 2001, the Residency Review Committee for Psychiatry introduced competencies in psychotherapy, requiring that programs demonstrate that residents have achieved competency in brief therapy, CBT, combined psychotherapy and psychopharmacology, psychodynamic therapy, and supportive therapy. Since these requirements were introduced, the psychodynamic psychotherapy competency has been controversial.⁴⁷ It is not the value of psychodynamic *principles* that is at issue; few have argued against the utility of familiarizing residents with core psychodynamic concepts, such as the roles of unconscious mental processes, transference, and countertransference in psychological life or the ongoing impact of developmental relationships in shaping current subjective experience. Rather, the controversy surrounds training in psychodynamic *treatment* per se.

Psychiatric educators who oppose the requirement for training in psychodynamic psychotherapy emphasize the difficulty of teaching and learning psychodynamic treatment, the significant allocation of time and resources required to do so, the limited evidence base for psychodynamic treatments compared to cognitive-behavioral therapies, and the difficulty of evaluating clinical competency in psychodynamic therapy.⁴⁷ Many of these objections are

addressed, however, by training in psychodynamic psychotherapy that focuses on manualized, evidence-based psychodynamic treatments.

By definition, manualized psychotherapies are directed toward treating well-defined diagnostic entities or clinical problems, based on a clearly described model of pathology. Therapeutic techniques are clearly delineated, as are the procedures by which one can rate therapist adherence to the treatment manual. Manualization is the first step toward systematically studying a treatment, developing randomized control trials (RCTs), and ultimately establishing an evidence base. It is generally accepted that RCTs, although not without limitations when it comes to psychotherapy outcome research,⁴⁷ carry the highest level of scientific evidence in evaluating treatment interventions. The current case presentation demonstrates the clarity and specificity of PFPP in its delineation of phases of treatment, psychological conflicts relevant to panic disorder and how to address them, use of the transference, and managing termination in a therapeutically productive manner.

Manualized, evidence-based psychodynamic treatments, such as PFPP for PD or transference-focused psychotherapy for borderline personality disorder, can be used to great advantage by psychiatric educators for training residents in psychodynamic therapy. These treatments have been studied in RCTs^{2,48–50} and target clinical problems and disorders that commonly present in residents' caseloads. Psychotherapy manuals provide clear and specific explanations of how to do therapy, which is embedded in a model that explains the rationale for the intervention (though such explanations are no substitute for the experience of qualified supervision). By going beyond teaching theoretical principles to systematically demonstrating how these principles are operationalized in clinical practice and by providing opportunities to understand the trajectory of a psychodynamic treatment from start to finish, training in manualized psychotherapy helps residents to traverse two of the most challenging hurdles along the road to psychotherapy competency. First, adherence rating scales could be modified for use as supervisory and evaluative tools—most effectively, in the setting of reviewing residents' recorded clinical work. Second, the model of group supervision through the use of recorded treatments (used for training therapists in the RCT of PFPP) could be adapted; by exposing trainees to a series of treatments, both residents' and supervisors' time would be efficiently used. This model of psychotherapy training would not necessarily require a large panel of dynamic supervisors—a significant benefit for programs having a limited psychodynamic faculty.

Pioneering courses in PFPP and transference-focused psychotherapy taught in our residency training program at New York University have been well received by residents and have led us to novel approaches to psychodynamic training during residency. An especially promising training model that we have been developing introduces general psychodynamic principles and clinical constructs to PGY-2 residents, and provides didactic courses in manualized psychodynamic treatment in PGY-3 (using the treatment manual as a text). In PGY-4 a clinical elective is offered; residents are assigned suitable patients, have their therapy sessions videotaped, and participate in group supervision. In sum, manualized, evidence-based psychodynamic psychotherapies offer opportunities to develop models of psychodynamic psychotherapy training during psychiatric residency—models that are pedagogically sound, resource friendly, and clinically rich.

Concluding Comments: Fredric Busch, MD, Barbara Milrod, MD, and Larry Sandberg, MD

Due to long-standing disagreement in the field of psychoanalysis on the most basic research questions, such as whether or not psychoanalytic treatments could or should be subjected to systematic study, the field of psychoanalysis has been slow to develop an adequate research base. However, since our research group's presentation in 1996 of a clinical case of PFPP,⁵¹ we have developed a manualized, well-operationalized, psychoanalytic approach to the treatment of DSM-IV panic disorder with or without agoraphobia: PFPP.¹ This form of treatment is the first manualized, dynamic psychotherapy to demonstrate efficacy for an Axis I anxiety disorder.² The case presentation included here is an excellent clinical demonstration of this manualized approach, in which it is possible to pinpoint core psychodynamic conflicts and focus on them in a 24-session, 12-week treatment. Dr. Caligor discusses how such manualized approaches may aid in residency education in psychodynamic psychotherapy. Dr. Gerber's comments focus on neuroanatomical connections and the role that they may play in our current understanding of how psychodynamic psychotherapy might work. Further studies evaluating the efficacy of PFPP and its functional neurological impact are in progress.⁵²

Dr. Schneier describes standard, first-line treatment approaches to PD. It is to be hoped that future research will clarify which approaches and combinations are most helpful for which patients. The goal of tailoring treatments to individual patients has gained more urgency, given rising public health costs of untreated and partially treated psychiatric illness and the many patients who do not respond completely to our current treatments. It is possible that a focus on vulnerability to panic, as well as improved appreciation of comorbidity in tailoring initial treatment, can help to reduce overall disease burden.

In this regard it is notable that Ms. A experienced a resolution of her generalized anxiety disorder in addition to her PD. Some common dynamisms can be observed across a range of anxiety disorders, and our clinical work suggests that various anxiety disorders, anxiety-associated mood disorders,^{53,54} and anxiety disorder–associated personality disorders⁵⁵ may also improve in the course of PFPP. Work on the unconscious dangers that Ms. A experienced as a result of her wrathful fantasies connected to her husband, her daughter, her mother, and eventually also her therapist, coupled with her greater articulation and tolerance of these emotions, likely led to reduced vigilance associated with GAD. We have recently written a manual that describes operationalized dynamic treatment for an extended range of anxiety disorders⁵⁶—PFPP-XR—using the approach that has been so successful in PFPP. A pilot feasibility study will begin to assess the transdiagnostic impact of PFPP-XR, as we strive to further clarify the optimal role of psychodynamic treatment for the treatment of anxiety disorders.

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