Psychotherapy for Panic Disorder

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Although medications and panic-focused cognitive behavior therapy are considered standard treatments for panic disorder, other types of psychotherapy may also be helpful. Many patients with panic disorder have some residual underlying vulnerability, as suggested by the continued occurrence of symptoms. These patients may benefit from a more broad-based psychotherapy, as might those in whom comorbid symptoms occur. Some patients are unable or choose not to participate in a structured prescriptive treatment requiring homework. Our psychotherapeutic approach to treating panic disorder, called emotion-focused treatment, targets identifying and managing negative emotions, especially as they relate to common psychological themes of fear of separation, fear of constriction, and the need for interpersonal control. *(J Clin Psychiatry 1997;58[suppl 2]:38–43)*

Patients with panic disorder can be treated effectively with either medication or cognitive behavior therapy, which were endorsed as standard treatments at a National Institutes of Health Consensus Development Conference.[1] Efficacy has been documented for several different classes of medication, including tricyclic antidepressants (imipramine, clomipramine),[2–4] high-potency benzodiazepines (alprazolam, clonazepam),[5,6] and serotonin selective reuptake inhibitors (fluoxetine, fluvoxamine, paroxetine, and sertraline).[7,8] However, only one type of psychotherapy—cognitive behavior therapy focusing on fear of bodily sensations associated with panic attacks—has been proved effective.[9–11] Other forms of psychotherapy have not been well tested and are considered less effective. Why then discuss psychotherapy for panic disorder?

There are several reasons why other types of psychotherapy might be useful for patients with panic disorder. First, although short-term treatment has a high success rate, symptoms commonly continue to occur in patients treated with medication[12] or cognitive behavior therapy.[13] This less favorable long-term outcome suggests an underlying diathesis that is not fully treated using standard symptom-focused approaches. In particular, psychological dysfunction, in addition to fear of bodily sensations, may contribute to ongoing vulnerability to panic attacks. Several researchers[14–17] have noted that agoraphobic persons are plagued by both fear of abandonment and fear of constriction and that they have an intensified need to control their interpersonal environment to avoid feeling alone or trapped. Since high levels of interpersonal control are difficult to achieve, the agoraphobic individual has a chronic sense of uncontrollability. Barlow[18] suggests that a sense of uncontrollability underlies negative emotions, including panic, and further posits that the sense of uncontrollability has its origins early in life.[19]

Several authors have noted that patients with panic disorder have difficulty identifying and managing a range of negative emotions. Guidano[15] states that "agoraphobics are generally convinced that it is possible to exert direct control over one's own emotions. As a consequence, every state of autonomic arousal that does not seem subject to self-control through 'will-power' is not considered to be of an emotional nature, but rather a symptom of a physical or psychic illness"[15(p216)] and further that "when precipitating events are as clear-cut as in the case of most agoraphobics, most…patients are usually able to admit there must be some connection. Agoraphobics usually fail to do so."[15(p213)] Thus, psychotherapeutic intervention should focus on the patient's concerns about feeling lost, abandoned, trapped, or constricted; the loss of interpersonal control needed to avert these possibilities; and the cognitive style of avoiding the negative emotions associated with these concerns. In our psychotherapeutic approach, we target emotion regulation, especially as it relates to interpersonal control and to fears of being abandoned or trapped.

A second reason for using psychotherapeutic strategies other than panic-focused cognitive behavior therapy concerns readiness and receptivity. Some patients find it difficult or undesirable to participate in a highly structured prescriptive treatment. Although a skilled therapist may be able to overcome this barrier, having a range of techniques

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and strategies with which to treat the patient with panic disorder is desirable. Moreover, the treatment we suggest here may be particularly useful when combined with medication since, unlike the cognitive behavior approach, there is no need to evoke panic attacks.

A third reason for using other psychotherapeutic approaches is comorbidity. Most patients with panic disorder have other anxiety or depressive symptoms or coexisting disorders.[20] A treatment that also targets these associated symptoms might provide improved sense of well-being. Focusing on the sense of uncontrollability is an example. The treatment we devised, which focuses on recognizing and managing negative emotions, is another such strategy.

We recently conducted a study[21] comparing cognitive behavior therapy targeting fear of bodily sensations with nondirective psychotherapy. Our results suggested that a different, less structured treatment might be useful, particularly if the treatment includes information about panic disorder and daily monitoring of panic attacks. In this paper, we describe and discuss this less structured psychotherapeutic approach, now called emotion-focused treatment for panic disorder.

EMOTION-FOCUSED TREATMENT FOR PANIC DISORDER

Reports in the literature and observations made during our earlier work with patients with panic disorder led us to consider emotion regulation as a potential treatment focus. Several studies indicate a high prevalence of alexithymia in patients with panic disorder.[22] This condition is characterized by a failure to identify emotional reactions and a tendency to focus on behavioral self-observation to describe a feeling. For example, an alexithymic person might say, "I started to yell so I guess I was angry." Other studies document a defensive style, which suggests that patients with panic disorder cope with negative emotions by avoiding them.[23] Guidano[15] writes that in "dealing with emotions connected to variations in affectional balance, the overcontrolling attitude is intensified to the point of making the individual 'blind' to certain personal emotional experiences."(p147) Chambless et al.[24] assert that patients with agoraphobia tend to deny and misattribute symptoms of anxiety and other affects, so effective problem-solving does not occur and somatic symptoms become the focus of attention.

Our own observations support these reported findings. For example, using the Anxiety Sensitivity Index,[25] we found that patients with panic disorder endorse a high need to control their emotions. In addition, we have often found that negative emotions act as panic triggers. When describing the onset of panic, patients frequently deny any relationship with other thoughts or emotional situations. However, if the therapist continues to focus on the situation in which panic occurred, clear inciting events typically are reported. For example, one patient stated, "I woke from sleep. I wasn't dreaming. I felt afraid and didn't know why." On minimal further questioning, the patient revealed that she was dreaming about her ex-lover. She awoke feeling very lonely and empty. As she thought about the dream, she became angry with her ex-boyfriend and experienced a panic attack. Another patient reported, "I was going to church. I enjoy church a great deal and look forward to going. All of a sudden I felt very nauseous and started to panic." When the therapist asked her to elaborate on the situation that morning, she revealed it was Easter weekend. Her fiancé was at work and her family was out of town. The patient knew no one at the church and felt alone and resentful. This feeling of loneliness caused an empty feeling in her stomach and she felt nauseous. This triggered the panic attack. A third patient told the therapist, "I was at work. It was pleasant, maybe a little boring. For no reason at all I felt very afraid." This patient disclosed that she was involved in a stormy relationship with a man she did not trust. The night before the panic attack, this man stood her up for a date. She was enraged and frightened, got little sleep, and thought of little else the next day. A fourth patient reported, "I was having a pleasant conversation with my son and his friend. I had a few palpitations. Right after my son left, I had a bad panic attack. I have no idea why." This patient was worried because her son was going on a plane trip. She had recurrent upsetting thoughts of the plane crashing, and she had tried hard not to think about it. She commented, "I guess if I think about it then I'll *really* have a bad panic attack."

These examples illustrate the difficulty these patients have in thinking about negative emotions. Our observations are similar to those of Guidano,[15] Nemiah,[16] and others who described a tendency for patients with panic disorder to deny a relationship between the onset of a symptom (or of the disorder) and an emotionally meaningful situation or thought. We concluded that patients might benefit from a treatment that helps them identify distressing situations and the thoughts and specific feelings evoked by these situations. We planned to help the patient consider ways (other than avoidance) of coping with the negative emotions. In addition to working with specific emotional episodes, we focused on fears of feeling lost or trapped and the ensuing overcontrolling interpersonal behaviors.

Description

Emotion-focused treatment for panic disorder begins with a generic intervention common to all documented effective panic disorder treatments—a period of monitoring the panic attacks and educating the patient about panic disorder. We give the patient a handout we developed called *Facts About Anxiety and Panic Attacks*, which is similar to the handout distributed to patients attending

sessions for panic control treatment.[26] This handout answers questions about anxiety and panic, such as when it occurs, its physical effects, risk factors, and treatment options. The handout also describes the physiology of emotions and suggests that emotions can trigger panic attacks. The therapist reviews this information with the patient and explains the rationale for emotion-focused treatment.

Patients monitor panic attacks throughout the treatment, just as they do for both medication and cognitive behavior therapies. However, emotion-focused treatment differs from cognitive behavior therapy in that it focuses on other emotional reactions in addition to panic. It also differs in method. There are no homework assignments, and session content is not defined and standardized. Using an individualized approach, we determine the content of the discussion through focused reflective listening and systematic exploration of the circumstances and details of reactions to events the therapist considers important.

Focused Unfolding of Panic Attacks

A primary objective of emotion-focused treatment is to ensure that the patient identifies and accepts emotional reactions and can cope with them effectively. Therapists use focused unfolding—a modification of Rice and Dsprtis' five-step procedure for evocative unfolding[27]—to accomplish this goal. With focused unfolding, the therapist identifies an unexplained emotional reaction (including a panic or limited symptom episode) and encourages the patient to elaborate on the details of the reaction. The therapist helps the patient identify stimuli that provoked an emotion; any thoughts, images, or physical sensations associated with the emotion; and the specific ways the person coped with the emotion.

The therapist then explores the general relevance to the patient's life of this type of response pattern. This approach allows the patient to reexperience and examine, as fully as possible, a problematic emotional reaction. Patients are encouraged to reconsider the meaning of the triggering situation and to evaluate their own strategies for coping with difficult emotions. Helping a patient realize there are options for interpreting situations that evoke distressing affects, and alternative ways of managing these affects, produces an increased sense of control.

Patients with panic disorder are sensitive to feeling out of control of relationships and to feeling abandoned or trapped because of this. As a result, they are likely to interpret ordinary minor interpersonal problems as threatening and to react to such events with negative emotions. Moreover, fear of abandonment may trigger a feeling of shame. Fear of being trapped may lead to anger, and the need to manipulate and control others may be associated with guilt. However, patients often suppress such painful feelings. Disavowal or avoidance leaves little possibility of processing an emotion. The patient may experience unacknowledged, unwanted emotional reactions as a vague dysphoric affect, often accompanied by unexplained bodily sensations and attributed to some physical disturbance. The focused unfolding procedure is used to identify hidden shame, guilt, fear, or anger and thereby lessen the sense of helplessness caused by automatic, poorly articulated emotionality. Identifying the vague dysphoria makes it less frightening, more controllable, and less likely to provoke a panic episode.

The six steps of the focused unfolding process are described below.

Step 1: Reflect the primary reaction. The therapist must first identify and reflect on an unexplained emotional reaction. In emotion-focused treatment, all panic attacks and limited symptom episodes are considered unexplained emotional reactions and frequently serve as the focus of exploration in the initial phase of treatment. If no panic symptoms have occurred, other indications of an unexplained emotion are targeted. An emotional reaction may be described by the patient as an explicitly unexplained feeling, such as "I began to feel irritable and angry, but I couldn't tell you why. There wasn't any reason." Sometimes, the therapist observes that an emotion is present because of the nature of the situation described, even when the patient does not directly mention it. For example, when a patient described her boyfriend's abusive taunts, her voice conveyed her outrage, even though she did not mention she felt angry. An uncomfortable physical sensation, such as "I had this strange wobbly feeling" may be a manifestation of a hidden emotion.

Emotional reactions described in vague terminology, such as "I was upset" or "I didn't like what he said," or unexplained behavior, such as "I turned and walked out of the room. I don't know why I did that," may represent an unrecognized emotion. An interpersonal disturbance that is mentioned and dropped or otherwise not well explained may signal an uncomfortable emotional reaction. For example, a patient stated, "My husband and I weren't getting along," then changed the subject. Another patient was more explicit: "I never see my grandchildren any more. It makes me sad and I'd rather not talk about it." Positive interpersonal comments that are vague and global may indicate an effort to suppress a negative feeling, especially if they seem out of context. For example, a patient who was silent for awhile and then, changing the subject, said, "My boss is fine." Other similar comments by the patient may indicate an emotionally important event and should be pursued.

The therapist begins the discussion by reflecting the patient's statement: "You were watching TV and suddenly felt your heart racing," "You began to feel irritable and angry," "You had a wobbly feeling," "You were upset," "You walked out of the room," "You and your husband were not getting along," "Your boss is fine." This intervention focuses the patient's attention, identifies the therapist's interest, and encourages the patient to elaborate on the statement.

Step 2. Encourage the patient to recall and envision the scene in which the reaction occurred. After reflecting the patient's comment, the therapist listens for other cues with the goal of defining the emotion and the triggering stimulus as specifically as possible. The preferred method of eliciting the description is through 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 strategy encourages the patient to recall the situation without structuring the attentional processes. It also facilitates the activation of a wider array of associated ideas and a freer expression of these ideas. For example, this patient said she did not think she was reacting to the television. She had a very upsetting phone call from a friend of her deceased mother earlier that morning. She now recalled that she was not paying attention to the television but was thinking about how lonely she felt since her mother's death and how she felt no one understood her anymore. She experienced a pain in her stomach that she always got when she thought about her mother. She had thought the pain meant she was very ill and would require hospitalization. Her husband, who already was under stress at his job, would then be responsible for caring for her children and foster children. She imagined that he would not withstand this pressure and would also become ill. As she thought about this grim scenario, she became frightened and her heart began to pound.

The following is an example of identifying and exploring an unexplained emotional reaction not related to panic, but indicated by a vague description of a negative feeling. A patient reported that her week had not been too good and that she was upset. When the therapist reflected the feeling, "You were upset," the patient replied, "I get this feeling whenever I have to do something I don't want to do. It's a kind of tense, angry feeling." She continued, "My boss is a hard-driving man who doesn't take other people's needs into consideration. He told me to do a report, and I didn't really know exactly what he wanted in the report. Besides, he had already asked me to do two other things. I didn't know which should take priority."

In another example, a patient commented, out of the blue, that his boss was fine. The patient had earlier indicated that he had problems at work. This led the therapist to suspect that the vague statement about the boss might represent an unacknowledged emotional reaction. The therapist drew attention to the remark, saying "Your boss is fine." The patient responded by elaborating, "Well, sort of. I mean I think he's basically OK, and I don't like to complain, but sometimes he really makes me mad. He isn't fair. He expects me to perform perfectly and he doesn't seem to know what I have to do. He doesn't want to answer questions, even when I really need some answers." The patient continued with a litany of complaints against his boss. Then he stopped and commented sheepishly, "I guess I'm sort of angry with my boss. I hadn't realized that."

Step 3. Elicit detailed descriptions of the quality of the internal emotional reaction and the nature of the eliciting stimulus. When the therapist provides a reflective intervention, describing the scene of the initial reaction, the patient often responds with a detailed description of the quality of the internal response and the nature of the eliciting stimulus. However, if patients do not spontaneously elaborate, the therapist encourages them to do so. The therapist might comment on the description of a scene during which an unexplained panic attack occurred. For example, in response to a patient's report of a panic episode while falling asleep, a therapist might say, "You were lying in bed, trying to get to sleep, and suddenly you felt short of breath." The patient may then respond, "I was tired. Nothing was on my mind." The therapist continues, "Nothing was on your mind when you began to feel short of breath." The patient might now say, "Well, I guess I was worried about whether I could function if I couldn't get to sleep. 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. I think she resents me because I have a life outside of work. She doesn't seem to trust me. My job is important to me. Maybe I shouldn't go home on time. I'm starting to feel short of breath. Whenever I think about work, I get this feeling. Now that we're talking about this, I remember I was worrying about my job 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. My heart started to race and I felt very hot and shaky. I had to get up and get some fresh air."

There are different variants of this process. Essentially, the therapist continues to reflect elements of the emotional reaction and surrounding situation until the patient fully describes both the stimulus and the response. If this is no longer productive but the therapist considers the description incomplete, it usually indicates that the patient's feelings are very intense or the therapist does not seem empathic. Strategies for managing these situations are outlined in a manual we developed for emotion-focused treatment.

Step 4. Identify idiosyncratic personal meanings of the stimulus and qualities of familiarity and repetitiveness of the response. After the emotional reaction has been fully elaborated, including the specific nature of the stimulus and the quality and sequence of the response, the therapist returns to a discussion of the stimulus to further explore its personal meaning. Here, the themes of fear of being controlled or constricted, fear of being ignored or abandoned, and fear of loss of interpersonal control begin to appear. The behavior of others might seem to be placing an unreasonable demand on the patient, even when this is not the case. Patients may feel they will be accused of wrongdoing or must accommodate another or bear the

consequences. A situation in which loneliness is evoked often leads patients to believe that no one really cares about or understands them.

The procedure for elucidating these meanings can be illustrated by further work with the patient who reported a tight feeling in her stomach, which was then determined to be a manifestation of anger triggered by her boss' behavior. The therapist noted, "Your boss asked you to prepare a report and you weren't clear what he wanted." The patient continued, "Yes. I felt very frustrated. I didn't know what to do, so 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 go away for the rest of the day. I had to stay home from work the next day too." Listening to this, the therapist recognized that the boss' actual behavior didn't fit with the patient's earlier description of him as uncaring about the needs of others.

The therapist returned to the initial problem, saying, "When your boss gave you the assignment did you feel you couldn't ask him to clarify what he wanted?" The patient confirmed this, "Right. He expects me to read his mind. It's so unfair." The therapist underscores this, with slight surprise, "You believed he expected you to read his mind!" The patient, slightly defensive, initially reasserts, "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." The therapist continues to focus on this idiosyncratic interpretation by repeating, "You were *certain* he expected you to read his mind and you felt you must do this or suffer the consequences?" The patient considers this for a few minutes, before continuing, "I know I get the feeling very strongly that I must do whatever he wants." Thoughtful now, she adds, "He reminds me so much of my father." She goes on to describe the situation in her childhood home where her father was a tyrant with both her mother and the children. The patient was often frightened by his angry outbursts, especially those directed at her mother, who seemed unable to defend herself. The patient ended this discussion by saying, "Maybe I see my father in all men. My boss is really pretty different. He's kind of disorganized and maybe he doesn't realize he hasn't made his priorities clear to me."

Step 5. Explore the generalizability of the stimulus-response paradigm and consider its importance. The generalizability of the stimulus-response paradigm is related to its thematic content. The reluctance of the patient discussed in Step 4 to question or challenge others, and her interpretation of the behavior of her disorganized boss as demanding and demeaning, reflected both a general tendency to fear being abandoned if she confronted, disagreed with, or displeased someone and resentment about feeling controlled by an admired male authority.

The therapist had formulated previously predominant themes for this patient as fear of arguments or disagreements, fear of too much interpersonal distance, and feeling alone and abandoned. These themes were based on reports of the patient's feelings about her relationship with her current boyfriend and her childhood experiences.

The therapist encourages the patient to think through her response to the situation with her boss. The therapist clarifies, "When your boss doesn't communicate clearly, he reminds you of your tyrannical father. Then you feel like you can't say anything or he will fire you." The patient considers this and concurs, adding, "I think I am almost always afraid of confronting people. I feel if I don't do what someone else wants, they won't want me around."

Step 6. Explore strategies for managing the emotional response. After the various aspects of the targeted emotional reaction have been fully specified, the therapist focuses on the way the patient managed the reaction. The therapist acknowledges the pain involved in experiencing the distressing affect and the need to find a way to lessen the pain. The patient should not feel criticized for the reaction but should feel understood.

Applying this step to the patient discussed above, the therapist reviews the discussion, including the patient's perception that her boss was making unreasonable demands on her, her conviction that all successful men want to make women their slaves, and her feeling that it is futile to stand up to her boss. The patient's solution was to bury her resentful feelings. When she thought about this, the patient responded, "I guess I could have asked exactly what he wanted me to do. I could ask him to set priorities if I can't do all the things he asks." The therapist supports this, saying, "You don't like feeling resentful and helpless, and if you think you can get through to someone, it's not too hard to think of different ways to manage the resentment." The patient experienced considerable relief from this discussion, since her relationship with her boss had preoccupied her for several months and had caused her considerable pain.

Emphasis on particular steps in the focused unfolding procedure can vary with each patient. Some patients need more focus in the first steps—identifying, naming, and acknowledging feelings. Others need more help in finding ways to cope with overwhelming and uncomfortable affect, which involves the later steps. As the therapy proceeds, the therapist determines which steps are most important for the patient.

CONCLUSION

Emotion-focused treatment for panic disorder is a newly developed intervention with some early support for its efficacy. This treatment involves a psychoeducational component similar to that of other effective treatments and includes daily panic monitoring. However, emotion-focused treatment differs from cognitive behavior therapy in several ways. The sessions are not conducted according to a specific prescribed sequence but focus on emotionally relevant material identified by the therapist in response to the patient's report of symptoms and other problems. Treatment also focuses on broadly defined emotional reactions, rather than a specific panic-inducing mechanism.

Emotion-focused treatment uses a focused unfolding strategy to help the patient recall thoughts and feelings related to panic attacks. This strategy is also used to identify and explore unexplained emotional reactions not necessarily related to panic, but nevertheless avoided by the patient. The patient is helped to explore idiosyncratic personal meanings to emotional stimuli, specifically those related to themes of fear of abandonment, constriction, and interpersonal control. The patient and therapist explore ways to manage troubling emotions.

We believe this treatment may be effective for patients with untreated panic disorder. However, perhaps more promising is the use of emotion-focused treatment as an augmentation strategy for patients receiving medication and cognitive behavior therapy. It has the added benefit of targeting general anxiety and depressive symptoms and addressing psychological problems that may contribute to long-term vulnerability to panic attacks.

Drug names: alprazolam (Xanax), clomipramine (Anafranil), clonazepam (Klonopin), fluoxetine (Prozac), fluvoxamine (Luvox), imipramine (Tofranil and others), paroxetine (Paxil), sertraline (Zoloft).

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Discussion

Interpersonal Therapy

Dr. Jefferson: Interpersonal therapy can be effective for persons with eating disorders or depression. Is it also effective for those with panic disorder?

Dr. Shear: Interpersonal therapy focuses on identifying interpersonal problems. When questioned about their interpersonal problems, 90% of patients with panic disorder deny they have any problems or they pick the problem that is least upsetting to them because they do not like to think about their emotions. For this reason, interpersonal therapy is less successful in patients with panic disorder. One of my colleagues in Pittsburgh who is fully trained as an interpersonal therapist believes this type of therapy does not work for anxious patients, although these patients do respond to cognitive behavior therapy.

Emotion-Focused Treatment

Dr. Barlow: It seems to me that emotion-focused treatment for panic disorder is every bit as prescriptive as cognitive behavior therapy, although you refer to it as a nonprescriptive approach. Although emotion-focused treatment is individualized, the procedure is clearly outlined. Also, emotion-focused treatment lacks the formal cognitive restructuring that is part of cognitive behavior therapy. However, your treatment seems to incorporate an extension of the cues for panic beyond the strictly interoceptive or somatic cues to ones that are more interpersonal. We should also consider that we may diminish panic attacks, as well as their somatic cues, by helping patients arrive at alternative interpretations of their emotions.

Dr. Shear: I agree that emotion-focused treatment, panic control treatment, and many other effective psychosocial therapies are specifically outlined programs. They are individualized within the program, but basically there is a framework of things that must be done and one of them is interoceptive exposure. Evidence indicates that patients do better with therapists who are skilled enough to follow the manuals and ensure that essential components are covered. Patients do less well if therapists veer from the manual and follow what their clinical experience tells them to do. This is a tough lesson for psychotherapists to learn.

Dr. Barlow: Patients basically are arriving at their interpretations of emotions through an indirect route. It may make a difference in the sense of control, but is it really an etiologic factor or is it a consequence of the panic attack?

Dr. Ballenger: Emotion-focused treatment appears to be a more systematic form of psychodynamic therapy for panic disorder. A typical psychodynamic therapist may focus on areas that probably are not useful and may even be bothersome. Emotion-focused treatment emphasizes the actual problems related to panic disorder and what would help the patient improve.

Dr. Shear: Let me emphasize that patients with panic disorder do not want to talk about their emotions. If you ask, "What do you think might have triggered your panic attack?" they invariably say, "Nothing, it came out of the blue." You can get an explanation only in a more indirect way. To me, this is an indication that they are trying to avoid the emotions, rather than trying to avoid the explanation.

Dr. Marshall: Maybe they have learned the traditional explanation—that panic attacks are spontaneous. This has been played up in the lay press.

Dr. Jefferson: For which patients would you consider emotion-focused treatment a first-line therapy?

Dr. Shear: As Dr. Barlow pointed out, patients come to the office with strong preferences for specific types of treatment. Some patients have heard about cognitive behavior therapy and want the instructions, breathing retraining, and other aspects of this program. Others say, "No talking. I've talked forever already and it's not going to help." These patients want antipanic medication. Still others do not want to learn about breathing retraining or take medications. They know something is bothering them and they want to talk about it. These patients are probably candidates for emotion-focused treatment. So I tend to select patients for this program based on their treatment preferences.

Dr. Charney: What are the advantages of emotion-focused treatment over panic control treatment or drug therapy?

Dr. Shear: Compliance with emotion-focused treatment may be better than that with panic control treatment since there is less homework, which makes it less time-consuming for the patient. On the other hand, panic control treatment is a more direct approach to the panic attacks. Some patients really like the homework because it makes them feel that they are accomplishing something. The advantage of psychotherapeutic programs over medication is avoidance of side effects.

Dr. Jefferson: Are there advantages for the patient's interpersonal life, since you focus more on relationships?

Dr. Shear: Yes, emotion-focused treatment may have advantages in terms of quality of life. We focus directly on maladaptive lifestyles.

Dr. Rosenbaum: With emotion-focused treatment, you may identify an ongoing provocation in the patient's life. If a patient is having problems at home, for example, that may be driving the illness, regardless of the etiologic

model. When you improve that, you may be removing a risk factor for worsened panic attacks or persisting disorder.

Dr. Barlow: With panic control treatment, however, the focus is on the panic attack itself. The therapist recognizes that the patient hyperventilates when he fights with his wife, but then moves on to other things.

Dr. Jefferson: Can emotion-focused treatment be used in group therapy or is it strictly geared to individual therapy?

Dr. Shear: Emotion-focused treatment is still in such an early stage that we have not explored the possibility of group therapy. I would guess it could be done though, just as we do with panic control treatment.