

THE ROLE OF TRAUMATIC EXPERIENCE IN PANIC DISORDER AND AGORAPHOBIA

Suzanne M. Gassner, PhD

San Francisco Psychoanalytic Institute and University of California, Berkeley

Psychoanalytically oriented psychotherapy and psychoanalysis proper are widely considered by other clinicians to be inappropriate treatment modalities for patients with symptoms of agoraphobia and panic attack. The author presents a clinical hypothesis about the role of traumatic experience for these patients. The hypothesis is compatible with some ideas that have appeared in the clinical literature, and yet it has some distinctive features. Suggestions are offered as to some of the implications of this hypothesis for analytic treatment as well as for analytically oriented therapies that are integrated with psychopharmacological interventions and cognitive-behavioral approaches.

My major hypothesis is that patients who suffer from panic disorder oftentimes are people who were traumatized by being underprotected and emotionally neglected while they were contending with overwhelming catastrophic childhood experiences. These patients' psychopathology is rooted in (a) frightening unconscious beliefs and expectations, inferred from these experiences, concerning the relational dangers of both dependence and independence; (b) conflicts with regard to both separation anxiety and separation guilt; and (c) a vulnerability to affect states that they fear they cannot regulate. An extended case presentation describes the lengthy treatment of a patient who overcame her agoraphobic symptoms. The power of psychological factors to stimulate an incipient panic attack and its cessation is demonstrated via the presentation of a sequence of treatment hours.

In recent years investigators have made valuable advances in the study of the neurobiology of panic attacks. Unfortunately, these important findings have led some biological psychiatrists to treat the psychological determinants of such symptoms as mere epiphenomena. The purposes of this essay are (a) to present a trauma theory that explains why some patients acquire a heightened vulnerability to suffering in adulthood from panic attacks and agoraphobia; (b) to present the application of this theory to the lengthy

Suzanne M. Gassner, PhD, San Francisco Psychoanalytic Institute and Department of Psychology, University of California, Berkeley.

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Correspondence concerning this article should be addressed to Suzanne M. Gassner, PhD, 10 Crecienta Lane, Sausalito, CA 94965. E-mail: smgassner@aol.com

treatment of a patient who overcame her agoraphobic symptoms and relinquished her very constricted lifestyle; (c) to demonstrate the power of psychological factors to stimulate a panic attack and its cessation (illustrated through a sequence of treatment hours during which this patient experienced the panic symptom, as well as the therapist's intervention that was followed by the symptom's disappearance); and (d) to challenge the prevalent view that psychoanalytically oriented psychotherapy and psychoanalysis are not appropriate treatments for patients with a diagnosis of panic disorder.

A panic attack is an excruciating experience of terror. Patients experience a foreboding sense of disaster and physical symptoms that cause some to believe that their very physical survival is in question. Once having had this experience, patients become intensely motivated to do whatever they believe they can to spare themselves from reexperiencing additional episodes of overwhelming fear.

About half of panic-disordered patients develop the symptoms of agoraphobia. These are patients who believe they might be able to protect themselves from experiencing a recurrence of panic if they restrict their activity and use avoidant strategies such as remaining homebound. The treatment data as well as observations of others suggest that agoraphobic symptoms are secondary to the fear of having panic attacks or the fear of the physical symptoms themselves. In some patients, the two symptoms of panic attack and agoraphobia wax and wane together. In others, the agoraphobia may continue even though the panic attacks are reduced or cease altogether (Morrison, 1995).

The Role of Developmental Trauma in Panic-Disordered Patients

My major thesis is that an important factor in the psychology of many patients who suffer from panic disorder is a childhood trauma involving a family catastrophe whose impact was greater than what the child could cope with on his own. A significant aspect of the childhood trauma is that the parent(s) are unavailable to offer their child sustained, emotionally attuned, and reality-oriented help, the kind of responsiveness that would facilitate their child's capacity to process and master the intense emotions and associated disturbing convictions that these real-life ordeals inevitably generate. These needs go unrecognized, and instead during childhood these patients are forced, as best they can, to cope with problems and responsibilities that are way beyond their years. Despairing feelings accompany their experience of there being no help to be had. Oftentimes, they feel responsible for being on-call as a parental kind of caregiver long before they are capable of comprehending, not to mention providing, the kind of help that is required. The inevitable failure that results from being required to do what cannot be done is likely simultaneously to intensify a child's fear of independence, his vulnerability to humiliation, and the urgency of that child's normal attachment needs.

Sometimes parents are unable to offer a protective presence to their children at just those times when it is most needed, because the parents cannot face processing the intensity of their own children's suffering. Other times parents are emotionally unavailable to their children because they themselves are devastated by the magnitude of the losses they need to mourn, or the severity of their own or other family members' disabilities. Still other parents may be characteristically limited in their mentalizing capacity (Fonagy, 2001) and routinely fail to exercise a reflective function for their children.

Examples of the kinds of childhood catastrophes to which I am referring include home environments where (a) a parent is suffering from a prolonged illness or dies; (b) the parents are unavailable because they are preoccupied with another child who is seriously

ill or dying; (c) one or both parents are drug or alcohol addicted; (d) there is ongoing physical, sexual, or emotional child abuse; or (e) there is a long-term strain trauma such as occurs in families where there is serious, chronic family dissension.

Clearly, many children who suffer from catastrophic experiences of the kind I am describing do not subsequently develop panic disorder. At our current stage of knowledge we can only speculate about why this is the case. It appears that a genetic predisposition to anxiety is one factor. The child's prior relational history preceding the trauma is undoubtedly another factor of importance. There is much to be learned about the kinds of subsequent developmental experiences that parents and child-care professionals sometimes offer that help to protect the traumatized child from suffering the later emergence of panic and agoraphobic symptoms. Panic attacks and agoraphobic symptoms are clearly a multidetermined psychological disorder, and like other symptoms, there are undoubtedly many pathways to these manifestations of psychopathology.

In my review of clinical reports of patients who present with agoraphobia and panic attacks, I found that, independent of the authors' explanations for their patients' symptomatology, these patients typically suffered from childhood histories that involved abandonment and neglect. Almost all were victims either of sexual, physical, or emotional abuse (Milrod, 1995; Milrod, Busch, Cooper, & Shapiro, 1997; Stoeri, 1987) or of catastrophic family disorders, illnesses, or deaths (Beck, Laude, & Bohnert, 1974; Milrod, Busch, Hollander, Aronson, & Siever, 1996; Milrod et al., 1997; Pryer, 1999).¹ The parents of these patients were unavailable either because of their own serious illnesses (Diamond, 1985; Pryer, 1999; Silber, 1989) or because of deaths in the family (Deutsch, 1928; Diamond, 1985; Milrod et al., 1997; Pryer, 1999).² Characteristically, these clinical reports place a great deal of importance on the role of conflict over impulse expression or on a wide range of unconscious fantasies that were thought to be of central importance. Despite the reports of the patient's history of developmental trauma, relatively little emphasis was placed on the role of disturbed family interactions around dependence or independence in accounting for these patients' psychopathology.

On the basis of my reading of the clinical literature as well as my own clinical experience, I have concluded there are certain characteristic emotional struggles that characterize those patients who suffered from an absence of parental protection in childhood and who go on to develop panic disorder in adulthood. Such patients often feel frightened by emotional arousal and typically manifest intense anxiety in response to sexual and aggressive excitement as well as to strong affects generally. Relationships

¹I conducted a one-session course on panic disorder that 20 psychoanalytic psychotherapists attended, as part of a conference sponsored by the Extension Division of the San Francisco Psychoanalytic Institute. The participants were clinicians with whom I had had no prior contact. All had one or more patients who were subject to panic attacks. I was interested in offering this seminar as a means to compare and contrast what I assumed would be our various understandings of the psychodynamic and treatment issues. When I presented my hypothesis to the participants, namely, that childhood trauma involving parental neglect or inadequate protection was an important antecedent to panic attacks, to my surprise 100% of these clinicians confirmed that these kinds of childhood histories had been reported by the patient population they were treating. A majority of the patients were children of severely impaired alcoholics. Many others had reported having experienced some form of sexual exploitation. This informal survey seemed consistent with the clinical literature. There, too, case histories almost always described experiences of parental neglect or the unavailability of a parent to provide developmentally appropriate forms of protection.

²I was able to find only two case reports in which these kinds of catastrophes were not prominent features of the briefly reported childhood histories (Baumbacher, 1989; Isenstadt, 1980).

usually are experienced with intense ambivalence. These patients are likely to feel overly responsible, burdened, trapped, and enslaved by attachments—that is, to suffer from separation guilt (Asch, 1976; Modell, 1965; Weiss, Sampson, & The Mount Zion Psychotherapy Research Group, 1986) while simultaneously being highly vulnerable to separation anxiety. Such patients feel frightened by independence and feel shamefully needy in situations where they are called on to be self-reliant. Yet they also feel in danger of becoming self-sacrificing and emotionally enslaved by anyone who offers them care or the freedom to be dependent. This inability at a given point in time to enjoy either depending on another person or functioning independently is tormenting to themselves and challenging to psychoanalytic clinicians who try to have a therapeutic or analytic relationship with them.

The work of attachment theorists and researchers is highly relevant to this description of ambivalence that characterizes the relationships of adults who suffer from panic disorder. Ainsworth, Blehar, Waters, and Wall (1978) identified three types of attachment patterns in 1-year-olds—secure, avoidant, and resistant—and found that each pattern was systematically related to infant–parent interaction patterns. The kind of ambivalence I am describing panic-disordered patients as typically manifesting is what Ainsworth identified as the resistant form of an insecure attachment.

Ainsworth's work was highly influenced by Bowlby's formulations concerning children's attachment needs. Bowlby proposed that it is inherent in human nature to be powerfully motivated in childhood to seek proximity, care, and security from a person who is experienced as separate from the self (Bowlby, 1969, 1973). According to Stroufe (1997), the resistant type of insecure attachment pattern has been found to be "uniquely related to Anxiety Disorder classifications, as predicted from the chronic vigilance required to monitor an inconsistent caregiver" (p. 264). Drawing on Bowlby's work (Bowlby, 1988), a wealth of attachment theorists and researchers have been demonstrating empirically how deeply damaging separation and loss of loving attachments with reliable (parental) caregivers can be and the importance of disturbed attachment patterns and trauma to the development of later pathology (Biringen, 1994; Fonagy, 2001; Goldberg, Muir, & Kerr, 1995; Lyons-Ruth, 1996; Main, 1995; Main, Kaplan, & Cassidy, 1985; Trolnick, 1989; Zeanah, 1996). Limitations of space preclude my beginning to do justice to the rich and rapidly growing body of research derived from attachment theory that is demonstrating how profoundly normal development, psychopathology, and patterns of adaptation are affected by the reality of early caregiving experience.

Neurobiologists have amassed a good deal of evidence about the importance of neurophysiological factors in panic disorder (Cooper, 1985; Gabbard, 1992). For example, there has been reported a 31% concordance for panic attacks in monozygotic twins compared with 0% in dizygotic twins (Torgersen, 1983). Though not decisive, a higher incidence of panic disorder has been reported in panic patients' families than in the families of a control group (Crowe, Noyes, Pauls, & Slymen, 1983). Other evidence that supports a neurophysiological basis for panic disorder includes measurements of baseline autonomic activity and the investigation of brain neurochemistry.

Noteworthy is the empirical work of neuroscientists who have demonstrated the long-lasting impact of early traumatic relationships. Research findings suggest that such traumas can profoundly affect the functioning of the nervous system as well as alter the mind itself (Heim & Nemeroff, 2001; Nemeroff, 2004; Penza, Heim, & Nemeroff, 2003; Putnam & Trickett, 1997; van der Kolke, 1996). In other words, trauma leaves in its wake not only psychological but also long-lasting neurological sequelae. Therefore, often-cited evidence for the biological basis for panic attacks, such as the finding that panic attacks

can be induced by sodium lactate infusion in patients susceptible to such attacks but not in control patients, fails to address the question of cause and effect. The important work of these neurobiologists and psychiatrists suggests why there may be some correlation between an individual suffering developmental trauma in childhood and subsequently demonstrating a biological vulnerability to panic disorder in adulthood.

Freud's Views of the Role of Trauma in Psychopathology: A Brief Review

In Freud's earliest theorizing, the unconscious was conceptualized to be a storehouse of veridical memories of traumatic experiences that had not been abreacted. Freud viewed real experiences of sexual abuse as having a causative role in hysteria (Freud & Breuer, 1895/1961). Freud's early trauma theory failed to provide an account for how external trauma becomes internalized. In this sense his early ideas did not constitute a psychoanalytic theory of trauma. For the most part, Freud abandoned this trauma theory of the unconscious mind when he discovered that some traumatic experiences that patients reported were imagined or distorted. In Freud's second theory of the unconscious, neurotics were conceptualized to be people who remained infantile in their sexuality and cognition. The genesis of psychopathology was understood to be the result of these patients' fantasies rather than of experiences of repressed, unmastered traumas (Freud, 1900/1953a, 1905/1953b).

When Freud formulated his ego-psychological model (Freud, 1920/1955, 1926/1954), he included the role of trauma in some of his formulations. Trauma was now defined in terms of the helplessness and terror felt by the ego when it is overwhelmed. It was not until Freud formulated this later model of unconscious functioning that unconscious fears regained importance, this time conceptualized as the fears of childhood calamities (Freud, 1926/1954). Although Freud listed object loss and loss of the object's love as two such major calamities, he never applied this theory to panic disorder or agoraphobia. Contemporary theorists differ greatly in how much they view such fears as based largely on fantasy or on childhood perceptions of traumatic realities or on some combination of both (Brenner, 1982; Bowlby, 1988; Gassner, 2001; Stern, 1985; Weiss, Sampson, & The Mount Zion Psychotherapy Group, 1986).

Contemporary Relational Trauma Theories

My formulation concerning the nature of childhood experiences that are oftentimes antecedents to panic attacks is highly consistent with Stolorow and his colleagues' general understanding of relational trauma. Stolorow has emphasized the two phases of parent-child disruption which in combination are the sources of trauma. In the first phase, some very painful relational event occurs. Stolorow and Atwood (1992) emphasize that injurious childhood experiences in and of themselves are not necessarily traumatic. It is what fails to happen in the second phase that Stolorow defines as early developmental trauma. The central feature of early developmental trauma is

a breakdown of the child-caregiver system of mutual regulation—leading to the child's loss of affect regulatory capacity and thereby to an unbearable, overwhelmed, disintegrated, disorganized state. Painful or frightening affect becomes traumatic . . . when the requisite attuned responsiveness that the child needs from the surround to assist in its tolerance, containment, modulation, and alleviation is absent. (Stolorow & Atwood, 1992, p. 53)

Typically, an inherent feature of the family catastrophes I am describing is that no caregiver is available to provide the child with the urgently needed responsive milieu (Shane & Shane, 1990) in which validating attunement is provided.

Control-mastery theory (Sampson, 1994a; Weiss, 1993; Weiss, Sampson, & The Mount Zion Psychotherapy Research Group, 1986) emphasizes that psychopathology is rooted in the pathogenic beliefs that patients develop on the basis of traumatic relational experiences. These inferences, oftentimes unrealistic, frequently constitute rigidly held unconscious convictions that lock the patient's psychopathology in place. Many other contemporary relational analysts give importance to such unconscious anxiety-ridden expectations about the dangers of relationships. Examples of such related concepts include representations of interactions generalized (Stern, 1985), internal working models (Bowlby, 1988), unconscious organizing principles (Stolorow & Atwood, 1992), model scenes (Lichtenberg, Lachmann, & Fosshage, 1992), and cyclical psychodynamics (Wachtel, 1993).

What kinds of pathogenic beliefs and expectations might a child be likely to develop as a result of disturbed family interactions in which no primary caregiver is perceived to be capable of offering reliable, emotionally meaningful, protective responsiveness? I am suggesting that intense feelings of *both separation guilt and separation anxiety* become inherent unconscious experiences associated with subsequent intimate relationships. The pathogenic beliefs that panic-disordered patients are likely to develop involve the unconscious meanings of the dangers of forming emotional ties to others and of functioning independently. Examples of such beliefs and expectations are as follows: I am responsible for alleviating the suffering of the people I love; I would be disloyal to my family were I to function separately or independently from them; In this dangerous world there is nobody on whom I can depend; I do not deserve to receive help, care, or love; I am helpless to function on my own; I will always lack the capacity to function successfully and independently; I must avoid having strong feelings of any kind, because they will render me helplessly out of control.

On the basis of my observations across a number of cases, I have come to view separation guilt as an intrinsic aspect of the experience of perceiving one's parent to be incapable of offering parental protection. Oftentimes, panic-disordered patients simultaneously come to believe that they are in the wrong either to try to depend on others for help or to free themselves from others who need to depend on their help. As adults, such patients distrust their capacity to deal with reality should the demands be stressful ones. At such times, as soon as they move toward greater autonomy they feel frightened by fears of abandonment. As soon as they reach for a helpful interpersonal connection, they feel controlled, trapped, and suffocated.

Given the nature of these dilemmas, it is not surprising that many studies have found that panic-disordered patients are free of incapacitating anxiety symptoms until a significant, highly stressful life event triggers the onset of panic disorder (Dohrenwend, Krasnoff, Askenasy, & Dohrenwend, 1978; Faravelli, 1985; Last, Barlow, & O'Brien, 1984; Marks, 1970; Milrod et al., 1997; Roy-Byrne, Geraci, & Uhde, 1986; Solyom, Beck, Solyom, & Hugel, 1974). The reported life stresses typically involve loss or rejection, or a change in responsibilities that necessitates significantly more independent functioning. I expect that these are just the kinds of stresses that stimulate the dangers foretold by these patients' pathogenic beliefs and expectations with regard to the dual dangers of dependent and independent functioning.

Diamond (1985) rightly pointed to the need for any psychoanalytic formulation to explain why these patients are capable of experiencing a premorbid level of functioning

in which they are free from such overwhelming, debilitating fear states. My own view is that panic-disordered patients are suffering from a kind of posttraumatic condition. When a highly meaningful life event stimulates unconscious memories of prior agonizing experiences of trauma, there is a breakthrough of unconscious memories and emotions and a full resomatization reaction. These patients then reexperience an overwhelming sense of helplessness and aloneness against which they are unable to defend. It is my hypothesis that the kinds of highly stressful life events that trigger the onset of panic attacks are those that leave the patient feeling afraid or prohibited both from depending on others for help and from functioning independently while negotiating the demands of the external world.

Treatment Implications

What are the implications for treatment if it is true that patients who suffer from panic attacks oftentimes are people who as children were underprotected from catastrophic family traumas from which they could not escape, and who as adults were retraumatized by highly stressful current life situations? It seems clear that in order for such patients to make progress in treatment, priority must be given to their overarching need for therapeutic experiences that reduce their ever-present unconscious fear of further retraumatization.

J. Sandler introduced the safety principle in 1960 when writing about the conditions necessary for learning to occur. Later he elaborated on this theme and wrote,

the need to maintain a feeling state of safety (which is quite different from pleasure in direct instinctual gratification) is of enormous importance in learning and in development in general. The need to maintain safety gains dominance over the need to gain pleasure. (J. Sandler & Joffe, 1987, p. 262)

Weiss, Sampson, and The Mount Zion Psychotherapy Research Group (1986) further expanded on this idea in their formulations about the analytic process. They emphasized the importance of developing a treatment relationship that reduces the patient's unconscious fears of retraumatization.

My assumption is that those therapeutic interpretations and emotionally meaningful interactions that reduce patients' unconscious fears of retraumatization help the patient in three ways. They reduce the strength of the patients' fear-, shame-, and guilt-inducing pathogenic beliefs. Thereby they increase the capacity of patients to process these less intensely painful affects as information-providing signals. Such interventions also help patients become freer to lift defenses and experience previously warded off thoughts, memories, and affects that lead to the development of new insights about their pathogenic beliefs and grim transference expectations.

It strikes me that one of the potential unintended benefits that pharmacological and cognitive behavioral approaches offer, when helpful, is to provide patients with relationships in which they feel less in danger of being retraumatized. Panic patients may perceive such treatments as providing relationships in which they are neither being trapped nor in danger of abandonment. The therapist who exercises the role of an authority figure and directly offers concrete help offsets the patient's fear of abandonment. Because such treatment is characteristically time limited and typically does not involve the exploration of meanings, or of the nature of the therapist-patient relationship, the danger of feeling controlled by or responsible for someone with whom one is intimately related is also avoided. Although such treatments may usefully provide short-term, highly welcomed,

and urgently needed symptom relief, they do not address the underlying characterological and relational problems that predispose and usually predate such traumatized patients manifesting a vulnerability to these painful, debilitating symptoms.

Some psychoanalytic writers are beginning to explore the potential value of integrating psychodynamic approaches with both psychopharmacological treatments and cognitive-behavioral treatments (Wachtel, 1993). An outstanding example of this approach can be found in Milrod et al.'s (1997) manual *Panic-Focused Psychodynamic Psychotherapy*. The primary purpose of their manual is to help clinicians working with panic-disordered patients to make use of comprehensive therapeutic strategies. Interestingly enough, Freud introduced the recommendation that when working with phobic patients, and agoraphobic patients in particular, analysts need to intervene actively. Freud stated,

one can hardly master a phobia if one waits till the patient lets the analysis influence him to give it up. Take the example of agoraphobia. . . . One succeeds only when one can induce [patients] by the influence of the analysis to . . . go into the street and to struggle with their anxiety while they make the attempt. . . . It is only when that has been achieved at the physician's demand that the associations and memories come into the patient's mind which enable the phobia to be resolved. (Freud, 1917/1963, p. 166)

Perhaps some of the ways in which an exploratory therapy with panic patients might proceed is for such patients to be free not only to obtain medication but also to avail themselves of some of the skill training that a cognitive-behavioral therapy offers, such as breathing retraining, interoceptive and in vivo exposure, and other forms of psychoeducation. Such an integrated approach permits patients to split the transference and thereby offsets what some may experience early in treatment as the intolerable dangers associated with being highly dependent on just one therapist. Some panic-disordered patients may need not only an analytic therapy or full analysis but, early on, as a component of treatment, help that is oriented to resolving the presenting crisis and to teaching self-soothing and coping skills. *Pari passu*, such patients might also begin to obtain disconfirmation of their transference expectations of being both underprotected and trapped were the therapist to facilitate both the patients' procuring immediate relief from their incapacitating symptoms and the patients' exploration and mastery of the root causes for their problems.

Compton (1992) pointed out that Freud never published any clinical material on the analysis of agoraphobia.³ Compton concluded that "the agoraphobic syndrome, on a descriptive basis, constitutes an entity worth investigating as such. Furthermore, detailed case reports are required in order for us to formulate clearly the questions which need to be answered from a psychodynamic viewpoint" (Compton, 1992, p. 421). What follows is a case report that describes my treatment of a patient who presented with agoraphobia.

This descriptive case presentation is intended to serve several purposes. The detailed case history illustrates the kind of trauma that I am proposing increases a person's vulnerability to developing the symptoms of agoraphobia with panic attacks. Because this case report is intended to illustrate my point of view, I want to provide readers with enough of the treatment details that they can juxtapose their own clinical formulations as well as their own explanations about the treatment factors that may be curative.

This case illustration demonstrates how a psychoanalytic psychotherapy enabled a

³There is some evidence that Freud himself experienced periods in which he suffered from both a travel phobia and fears of dying, both symptoms, according to Breger (2000), "connected with the traumatic losses of his earliest years" (p. 136).

patient to achieve symptom relief and to resolve many of her underlying character problems. In addition, in light of the trend of some biological psychiatrists to treat the unconscious meanings of such symptoms as mere epiphenomena, this case report adds to the psychoanalytic literature that demonstrates the relationship of a patient's overall conflicts to her symptoms of agoraphobia and panic disorder.

Case Illustration

It was more than two decades ago that I met Jill, the patient who first stimulated me to develop my psychodynamic hypothesis concerning what the *DSM-IV* diagnostic code now defines to be agoraphobia and panic attack. At that time Jill, her husband, and her only daughter, Rebecca, had been living on the West Coast for 9 years. From the time Jill first decided to leave her East Coast home where she had always lived, she began suffering from agoraphobic symptoms. She was afraid to drive her car or to travel alone on buses or trains.

My first impression of Jill was of someone who was considerably older than her chronological age of 36. Her gray hair was long and unkempt; she wore no makeup. She dressed in jeans and T-shirts, and typically her clothing was too small, which called attention to her obesity. She presented as a depressed, deadened, drab, and frumpy individual. It was only after Jill and I had been working for several years on a once-a-week basis in a psychoanalytically oriented psychotherapy that I first learned that when she was 26 she had experienced a 3-month period of incapacitating panic attacks.

At that time, her psychiatrist began meeting with her daily on an outpatient basis and she was medicated. Jill was unable to remember what medications she was given but only that she felt heavily drugged, was frightened of medications, and that even while taking these drugs she still was suffering from anxiety. Although the first panic attack occurred in her home, she became severely agoraphobic and was unable to leave home except when accompanied by her husband. It became necessary for her to take a leave of absence from her secretarial job. She described her suffering as so severe that she pleaded unsuccessfully with the staff at Bellevue Hospital to hospitalize her.

Jill first sought treatment from this psychiatrist after ending her first marriage. Her father had chosen this doctor for her, and Jill believed that his treatment had been quite helpful to her, particularly during the period of her panic attacks. Many years later Jill discovered in a most startling manner that her father had come to oppose her treatment. It was only after her father had died that she first learned that father had disinherited her. Father's rationale was that she was in treatment with a charlatan who would take all of her money. It is noteworthy that the timing of the father's decision to disinherit Jill *followed* the patient's recovery from her panic attacks and the restoration of her capacity to function independent from father's care. All of father's estate was willed to her mother, who thus became quite wealthy. By all accounts mother routinely spent and lost all of this money at gambling casinos.

During most of the psychotherapy, I had very little information about the patient's relationship with her father. Early in treatment, I had learned that when Jill first became agoraphobic, she began having nightmares about the death of a parent, typically, her father. The only specific information that she did convey was that he went into rages unexpectedly and that when he was angry, he required her to write letters of apology to him, oftentimes for misdeeds that she considered totally trivial. He would refuse to talk to her until he had succeeded in extracting the required letters, letters that the mother saved

and carried around with her. This information left me with the impression that although Jill felt prohibited from maintaining a clear picture of who her father was, she actually had found him to be quite scary.

Jill spoke at length about her troubled relationship with her mother. The picture that emerged was one of a mother who had virtually no capacity to understand what her child was feeling. Jill's earliest memory, dating back to when she was 2 years old, was of being lost. She said that when she finally found her mother, her mother responded to her sobs with laughter.⁴ I would infer that this screen memory reflects Jill's early experience of feeling emotionally alone and both bewildered and humiliated by mother. Throughout Jill's treatment she continually described ongoing interchanges with her mother in which mother showed an extraordinary lack of sensitivity to what her daughter was feeling. The impression I was left with is that during the years we worked together, Jill was continuing to experience her mother as ignoring or profoundly missing the emotional import of her daughter's experiences, or as inappropriately responding to these experiences.

The patient reported two other events that occurred when she was 2 years old, which she claims to have experienced as life-threatening. She described an incident in which she almost drowned in the bathtub. Another time her mother gave her fish to eat and she was unable to stop choking on some of the bones. In retrospect, I find it noteworthy that this patient reported memories of two terrifying episodes in which, similar to her later reported experience of panic, she believed her physical survival was in jeopardy.

Jill also reported that mother neglected to prepare her for stressful events that she needed to be able to anticipate. Consistent with this view, Jill was badly frightened when she had her first menstrual period, because she had no information that prepared her for the event. She described watching her blood trickling down her legs and yelling for her mother to come. Her mother came in, said congratulations, and then slapped her. In response to Jill's bewilderment, mother explained that the slap was a part of the Jewish tradition. According to Jill, mother then complained about the blood that was dripping on the bedroom rug.

Jill reported that her mother saw the patient as against her from the very start. Childhood was filled with punishment episodes that took the form of one of her parents refusing to talk to her for weeks at a time. These periods must have been very difficult for the patient, made even more troublesome because she was an only child. I would infer that such experiences of shunning left Jill feeling profoundly isolated, distressingly alone, and profoundly in the wrong. If she were not a terrible child, how could her parents possibly seek to create such an unbridgeable gulf within the family?

I inferred that the combination of mother's perceived lack of empathy, her inability to help her child, and the parents' use of the silent treatment were highly traumatic for Jill, and that these factors left Jill feeling profoundly alone in the world. In addition, the little information I had about Jill's relationship with her father led me to think that Jill believed she was prohibited from thinking or functioning independently from father. I wondered whether Jill's pattern of dreaming about her father's death at the same time that she began suffering from agoraphobia—that is, when she moved cross country—reflected, among other things, her fear that leaving her father was tantamount to killing him.

During the course of the treatment, a number of related warded-off pathogenic ex-

⁴Sometimes parents' own incapacity to tolerate and regulate intense affects compels them defensively to laugh in reaction to their own children's intense suffering. This may be one factor that contributed to Jill's mother's seemingly profound misattunement.

pectations and beliefs gradually emerged. Jill had unconsciously been blaming herself for not being able to please her parents. She viewed the world as a very dangerous place, in part because she distrusted the willingness and ability of others to help her with her problems. She developed an exaggerated view of the difficulty entailed in trying new things or developing new skills. She characteristically responded to any emotional pain with a severely pessimistic view that things inevitably go from bad to worse.

I also observed that Jill held to a pathogenic belief that for a relationship to survive, one must not express anger. One obvious reason for this belief was that her parents did not tolerate, not to mention respond to, her distress if the emotion she expressed was anger. Instead, Jill reported, her parents countered her anger with severe threats and tantrums. These experiences are likely to have left Jill with an exaggerated fear concerning the destructive power of her own anger. But in addition, it is my impression that children who feel underprotected are particularly afraid of their anger. Jill, and other patients with similar anxiety disorders, have an urgent need to go to unusual lengths to avoid risking any momentary disruptions in the fragile relationships on which they depend.

The one arena in which Jill reported her mother's efforts on her daughter's behalf involved mother's eagerness to help Jill develop her considerable musical gifts. By the time Jill was 10, her parents and teachers were training her to become a professional opera singer. Unfortunately, Jill felt exploited by her mother's investment in her performances.

During Jill's grade school years, she invested heavily in her relationships with her teachers and experienced numerous successes, despite suffering from some social isolation. Each year she characteristically became the teacher's pet, and she received the highest grades in her class. She also persisted in her musical studies and made considerable progress.

It was when the patient reached adolescence that her life changed dramatically. From then on Jill reported a history of being an underachiever. At this time she refused to continue at the prestigious music school that she had been attending, she gained a great deal of weight, and she lost the ability to absorb and retain information that she wished to memorize. She had told her parents that the reason she refused to continue studying music was that she resented how overly invested they appeared to be in her achieving fame as a Metropolitan Opera star. Later, she confided to me that the main reason she had discontinued her musical training was that her memory problems had become so severe that it had become impossible for her to continue performing. Completing her schoolwork had become such a struggle that she relinquished her earlier plans to attend college.

Jill married shortly after graduating from high school but was dissatisfied with her sexual relationship. She reported that when they attempted intercourse, she experienced numbness in her vagina. During most of Jill's second marriage, to Henry, things did not go much better.

At the time when Jill's first and only child was born, a number of adverse life events occurred. Henry had been very happy about his wife's pregnancy, and Jill stated that during that time their sex life had greatly improved. However, shortly before the patient delivered, Henry was seriously injured in a car accident. Although he achieved a complete recovery, he refused to drive a car thereafter. Worse yet, Jill almost died in child birth, and for a while it was not clear whether their baby girl was going to survive. In the aftermath of these events, Henry lost practically all interest in sex. In those rare instances when Henry initiated sexual contact, Jill became symptomatic and once again experienced vaginal numbness. Jill claimed that this symptom was a reaction to her husband's no longer showing interest in foreplay or in her feelings and sensual needs.

The Course of the Treatment

When I first met Jill, she viewed herself as unable to seek employment because of her fears of traveling by herself by car or relying heavily on public transportation. Jill complained about her mother's disinclination to offer the family any financial help during their time of need. I was initially struck by how profoundly guilty Jill appeared to be about functioning independently from her mother. I interpreted her agoraphobic symptom as well as her striking lack of success in school, music, or other career endeavors to reflect in part her guilt to function more separately from mother. During the first 6 years of the treatment, Jill slowly but consistently took steps to become more independent. Often she withheld information from mother about her successes. When she did share a triumph with mother, mother was reported not to show interest but rather to shift the focus of conversation to mother's concerns. The patient often experienced depression in response to mother's disinterest but seemed unable to relinquish the hope that mother would change.

The sequence of successes that the patient ever so slowly achieved was as follows. First, she began coming to the therapy sessions by herself. Then she began volunteering to run a fund-raising program for her daughter's music school. Next she began to earn a small amount of money doing public relations work for the music school. It took 2 years of work before Jill overcame her guilt about leaving the program director "in the lurch" in order to find a position where she could earn more money. Eventually Jill obtained a secretarial position at school, and despite experiencing great anxiety, she began working there on a half-time basis. Over time she became comfortable enough to work full time, and she became the school's administrative assistant. Then Jill did research to learn what loans were available for low-income families that would enable her family to purchase real estate. She arranged to purchase a small home and did much of the work to renovate it. After a number of years, she initiated a successful effort to sell this home and was able to replace it with a middle-class suburban residence.

Early in the treatment our relationship was at times stormy. For example, in an early hour the patient was in the middle of a story in which she was boasting about a success, when I called time. The next session the patient began the hour saying,

You are the worst therapist I have ever had. People don't just leave other people in the middle of a story. I took it as a slap on the hand when you said we could continue talking about this next time. I left feeling my words were stuck in my mouth. Were you trained in school not to move a muscle in your face?

She continued explosively to vent her anger for about a half hour and then apologized. I made inquiries about her apology and tried to demonstrate a calm, steady interest in what it was that she was feeling. In response, she talked about her fear that I wouldn't like her. Jill then began to tell me more about her mother's techniques for fighting back. She described mother as picking out one phrase from all of what had been said and using it in a way that distorted her real meaning. Jill reported feeling that when she was around mother, she always had to stay on guard. I viewed the patient's ability to become angry at me as a progressive transference enactment. I had inferred that the parents' intolerance for their daughter's anger, and her father's rages in particular, had discouraged her from assertive or independent functioning and contributed to her own misregulated expressions of anger. Both her angry outbursts and her periods of inhibited aggression appeared to be outside of her conscious control. I saw myself working to help her overcome her pathogenic conviction about how endangering to her object ties her anger actually was. Following this and many similar angry outbursts, new material characteristically followed.

During the first 6 years of treatment, Jill routinely opposed my efforts to receive payment in a timely fashion. Instead, she developed a pattern of building up a debt. She provided many different excuses for why she could not pay and complained bitterly about my lack of trust in her. We were able to explore the multitude of meanings it had for me to investigate an accumulating bill. During each such cycle, the patient eventually paid the full amount owed.

In the earliest payment drama, the patient complained that I did not care about her if I put pressure on her to pay the bill. As I demonstrated that I would continue to assert myself and not be ruled by worry about her, she demonstrated an increased freedom not to be ruled by mother's complaints. Through this kind of reenactment as well as the earlier upset with me for ending the hour on time, the patient seemed to be asking whether I would take responsibility for her suffering. I came to understand that Jill had unconsciously felt chronically responsible for her parents' unhappiness and, more generally, for the unhappiness of those people with whom she was currently relating.

At times Jill would turn passive into active and make promises about making payments that I subsequently did not receive. In these dramas she gradually made clear that she envisioned that I was feeling needy, greedy, and hungry. Jill came to realize that this was how she chronically had felt toward mother, who tantalized her with promises of financial help but who proved to be capricious and unreliable. Jill frequently alternated between feeling she was being cruel not to pay her bill and feeling I was taking advantage of her by requiring her to pay her bill.

At times Jill encouraged me to view her as someone who was irresponsible and not able to manage her own money. I understood this stance to be a transference enactment, one in which she conveyed a need to be dependent on me. At other times I noticed that she appeared to be asking to have a special illicit tie to me that would leave her indebted and obligated. This seemed like an invitation that she and I strike a deal, albeit one that would burden her with even fewer rights to function independently, and no rights to express angry or hostile feelings and fantasies. I repeatedly interpreted how the patient had created a dilemma in which I could oppose her independent functioning by allowing her to build up the bill, or by requiring her to stop accumulating a growing bill, something she claimed was the equivalent of forcing her to stop treatment. This too would mean that she was not allowed to solve her problems and become more independent. At such times I conveyed my confidence that she could resolve the dilemma; I stated my sense of how important it was for her to work out a solution. I believe that through these transference enactments, the patient gained conviction that I would not be hurt, nor would I punish her, for her growing capacity to function separately and independently.

It was striking how difficult it was for Jill to come up with realistic solutions to the problem of how to pay her bill. At times she acted much like the mother she had been describing to me, showing me no empathy and insisting on a stance instead that everything was for her and nothing was for me. At one point Jill decided that now that she was allowing herself to drive a car, she needed to have a new car. Given her fears about driving, how could I possibly expect her to drive a used car? At times like these I insisted on payment, despite tears and threats to quit treatment. Jill responded with a sense of incredulity that I would expect her to take a mundane job rather than nourish her grandiose fantasies of a job that would fulfill her ambitions. During these episodes, Jill conveyed alternating feelings of things being either too much for her or beneath her.

During the last 2 years of treatment, Jill took a number of progressive steps. I was aware that there was a shift in our relationship and that she was relating to me in a more collegial and spontaneous way. She changed the way she wore her hair and began taste-

fully to use some makeup. Both her appearance and her manner seemed transformed. She was now making herself quite appealing. During this time she also began to investigate a variety of realistic career advancements and began to plan to do the additional study that would be necessary. Jill enrolled in college classes and began doing creative writing. Years later I learned that Jill had become an accomplished writer who enjoyed traveling across the country on national book tours that promoted the sales of her work.

Jill's Panic Attack During a Treatment Session

The sequence of three therapy hours that I am herein presenting illustrates the patient's struggle to feel neither neglected nor entrapped in her relationship with me. When I responded to an uncharacteristically urgent plea for help by making myself more available to her, this triggered an incipient panic attack. Only when I retracted my offer was Jill able to gain control over the overwhelmingly intense anxiety that had been set off. These hours further illustrate the significance of this patient's presenting symptoms of agoraphobia and of her earlier panic attacks.

It was in the first of these three hours that I learned of Jill's heretofore undisclosed history of panic attacks. In this hour Jill joyfully described her housewarming party, the first large, successful party that she had ever given. During most of the hour I supported her experiencing her excitement and pride in this major achievement. As a seeming afterthought, Jill told the following story during the last few minutes of the hour.

Her boss had given her a letter to type, which listed at least 10 undesirable behaviors that one of the teachers in the school had to change if he hoped to be retained. This was a teacher about whom Jill had complained bitterly because he often made what she considered to be sexually degrading and humiliating comments. He also had a pattern of touching her in ways that she considered to be inappropriately familiar and laughing in response to her complaints. Jill described how happy she had initially felt when she saw her boss's letter but said that immediately thereafter she became somewhat anxious and began having heart palpitations. When I asked her how she understood the heart palpitations, she responded that it had something to do with feeling so happy. I commented that it sounded like she forbade herself from rejoicing at a disliked coworker rightfully being called on the carpet. She responded with a sense of mystification, "Yes, and this is someone I hate." I then said that she seemed to prohibit herself from hating anyone. She replied, "If I hate everyone I won't have anyone. It's my parents. I couldn't hate both of them." Or else you would be all alone, I replied. The patient cried and then said, "I couldn't hate my father when I was small. I have tried so hard to hold on to happy memories. I didn't start hating him until I was older." With this, the hour ended.

Later that evening Jill called and said that she had become very anxious at the end of the hour. She felt a need to talk more to me about her parents and wondered whether I would be willing to schedule an extra hour. In 8 years of once-a-week work, she had never made such a request. I agreed to arrange another appointment. The only way I could fit in the additional hour was for her to see me at a different office. Accepting the hour would mean she would have to drive at night to a new location, something we both knew she would be anxious about doing, but she chose nonetheless to proceed in this way.

When Jill arrived for the next hour, she announced that she was having heart palpitations. When I asked her about this, she told me about her history of panic attacks. At age 26, Jill had married for the second time. Her husband had been serving in the National Guard and had been away from his bride for the weekend. The afternoon that he was expected to return she had her first panic attack. It was very intense; she thought she was

having a heart attack and would die. When I asked her how she had felt anticipating her husband's return, she said the panic attack was preceded by feelings of excitement and happiness.

Because of the intensity of her symptoms, her therapist at the time decided to see her on a daily basis. Jill was unable to get to the therapist's office except by taxi, accompanied by her husband. During this period, the couple moved in with her parents. The ostensible reason for this was that her parents lived considerably closer to the therapist's office than did the couple themselves. As I heard this I recalled knowing that during the first year of Jill's first marriage, she also had ended up moving back to live with her parents.

Jill then brought forth a new memory. She described an incident when she was around the age of 2 in which she had bent over to pick something up, causing her behind to stick up. Her parents thought this was very funny and took a photograph. She could not understand what made it funny. She again told me about not just her mother but her grandmother, too, routinely laughing if something upset her to the point of tears. Jill went on to describe how it was immediately after she had moved back to her own apartment that her father changed his will and disowned her, because of her supposed "addiction" to therapy.

As the hour was drawing to a close, the patient conveyed ambivalence about whether she wanted to meet again before her regularly scheduled appointment. She tried to reassure both of us that she did not feel she was falling apart. I responded that I had agreed to see her again not because I was worried about her, but rather because I thought it was important that she had allowed herself to pay attention to what she had been feeling and to ask for something that she was wanting. She continued to convey ambivalence about when next we should meet, and I suggested we plan the next session to be at our regular time. Subsequently I received another phone call from her, in which she said that although she was anxious to see me, she could not come in at the regular time because of a particular work obligation. This, too, had never happened before. I rescheduled her next appointment for 2 days past the regular meeting time.

During the next hour, Jill commented that she had continued feeling anxious and had been having many thoughts about her father. When she was younger she remembered she had thought there was nothing he couldn't do. She recalled a time when her teacher needed lots of cardboard and her father, who was in the printing business, supplied the whole class. She also recalled a time in the second grade when she lost her report card and came home upset. To her surprise, her father comforted her and said everything would be all right. When she reached the ninth grade, she stopped attending the music school because of feeling very tense. She found herself unable to remember anything. Jill said that she felt things were coming to a head and that there was something very important she needed to remember. Jill said that she felt the implication of my questions was that she had been sexually abused.

Although much of what Jill had told me was suggestive of this possibility, nothing she reported had been definitive. Therefore, I had adopted a technically neutral, open-ended exploratory stance and had avoided directly suggesting such a possibility. She continued,

As far back as I can remember, I felt uncomfortable if my father touched me. I remember in my teens when he would dance with me, it felt very odd, and yet I liked it. I remember that my father had heart palpitations. I could almost see his heart pumping. When I was in my teens he used often to say things about when he died, I was going to get this or that. And I would always say you're not going to die. But I can't remember anything sexual.

I responded, "We don't yet understand the meaning of your feeling so anxious last week when you saw that your boss was laying down the law to this teacher who you felt made such inappropriate sexual advances and comments." Jill replied, "I can't remember anything about that or what caused the palpitations last week." She wondered whether it would be possible for me to hypnotize her. Jill again repeated her assertion that she could not remember anything sexual her father did that was inappropriate. I commented that several months earlier she had told me that he routinely went around the house with the fly of his pajama bottoms open, thus exposing himself to her. Jill replied, "I just remembered, he used to go to the bathroom in front of me; but I don't think he did anything deliberate." I asked her whether she felt he was oblivious to whatever impact he was having on her. Yes, she said, seeming quite relieved. I then returned to her question about wanting hypnosis and wondered whether she was experiencing a sense of wanting some change in our working relationship. I told her that for some people, coming more frequently made it safer to remember more. I added that I thought from what she had told me that she might not feel any more comfortable coming more frequently, and that more frequent sessions might even make her less comfortable. Jill responded that she would be willing to associate to words, if I would give her words. "I wonder why now. Why am I remembering now? It seems like the more angry and stuck I feel in my marriage, the freer I am to remember. I am very anxious now."

The time for the hour to end was just about up. "I am beginning to feel tingling in my feet and it is moving up my body. That's just what happened with my first panic attack." At this point it was obvious that Jill had become intensely anxious. I asked, "When did you start feeling anxious?" Jill responded, "Something about your mentioning the possibility of my coming more often." I said, "I don't think your coming more often is a precondition for your remembering. Right now I don't think we should change anything." After a few moments Jill responded, "The tingling stopped. I just need to cry." She began to sob. "Also, I don't tell you about all these thoughts I have about you. That I need to take care of you. But then I can't take care of myself." I replied, "I think you're afraid if you come here more often, it would be for me. That just won't work. It's important that we stick with our once-a-week schedule. Let's stop here today." Jill seemed much calmer and asked, "Will you be in town if I need to talk to you later in the week?" I responded, "Yes, I won't be going away."

The Course of the Treatment Following This Sequence of Hours

Following these hours, Jill immediately began working for a period of over a year to overcome her conflicts about seeking a divorce. I was surprised by how dramatically her focus had shifted to the task of preparing for a divorce, and I assumed that something had been processed unconsciously that had left her feeling freer to leave an unsatisfactory marriage.

As best I could understand the therapy process, although she had felt prohibited from separating from her father, at this point in the treatment she felt emboldened to leave a relationship from which she was wishing to become independent. Eventually she mustered the courage to divorce her husband, and she began having more emotionally and sexually fulfilling relationships with men.⁵

Jill and I both continued to believe that she needed more help to recover deeply buried

⁵Some theoretical positions would lead to the a priori assumption that Jill's grim beliefs about how destructive it would be to separate from first her father and later her husband were based on

memories that she had been unable to access. Although she anticipates that she may seek more psychotherapy and/or psychoanalysis at some future time, the financial responsibilities of being single, combined with her spending part of her working time as a self-employed writer, precluded her continuing in treatment. My own impression was that the treatment was interrupted, not only because Jill was too frightened and guilty about remembering more about her relationship with her father and the events in adolescence that led to her impaired memory function but also because she had gained from her treatment a newfound excitement about functioning autonomously. The fears that had been expressed by her agoraphobia had been overcome.

Discussion

My description of Jill's childhood history has emphasized the central importance of a pattern of experiences that left her feeling underprotected and alone in a world in which she routinely experienced an absence of both parental protection and meaningful emotional responsiveness. It is hard to imagine any family situation in which there is simply a pure case of such neglect. Rather, underprotection takes many different forms. It may be the concomitant of parental loss, intrusion, sadism, emotional malattunement, or subtle or overt family craziness.

Jill developed a number of pathogenic beliefs and expectations based on this trauma. She felt distrustful and undeserving of relationships with people on whom she could depend. Simultaneously she developed a burdensome, exaggerated, omnipotent sense of responsibility to care for, protect, and comfort first her parents, and later, any of the people who became part of her interpersonal world. She had entered treatment viewing herself as incapable of functioning effectively when faced with a crisis, and she feared being overwhelmed by the intense feelings that highly stressful events inevitably engender.

Jill's pathogenic beliefs and expectations concerning the dangers of dependence and independence were expressed in the sequence of the three therapy hours that I summarized. Even at a time of great emotional distress, Jill was uncomfortable receiving my offer of greater availability. Instead, my willingness to consider just the possibility of increasing the frequency of sessions in this 8-year once-a-week treatment immediately stimulated an incipient panic attack and consciously manifested separation guilt. Her only verbal association was to say, "I don't tell you about all these thoughts I have about you, that I need to take care of you." It may be that one of the paternal transference meanings of my offer was that I was seducing her and exploiting her needs primarily because of my own neediness. To accept my availability, she feared, would be to subordinate her autonomy to *my* needs. Her unconscious conviction was that nothing I offered could truly be for her. Yet as soon as I retracted my offer of availability, even though her panic subsided, concomitantly her separation anxiety increased. Thus she envisioned the danger once again of being without the availability of help.

Steven Stern's (1994) conceptualization of contemporary psychoanalytic theory, which relies heavily on the work of Racker (1968), Bollas (1979), J. Sandler (1976), and Winnicott (1971), emphasizes how transference-countertransference communications include not only patients' repetition of their past destructive relationships but also their evocation of their needed new, more facilitating relationship. What was striking in my

her own aggressive and perhaps murderous wishes. However, at no point in the treatment did she report fantasies consonant with this theoretically based assumption.

work with Jill, however, was that her pathogenic expectations were organized in such a fashion that the very provision of the needed relationship *simultaneously* was experienced as my repeating the old, endangering, traumatic relationship. To depend on others is only to be once again trapped in an exploitative relationship with someone else who must be appeased, placated, and needed. Exploration of the obstacles to her freely exercising her autonomy uncovered fears that once again, she would be alone in the world, required to handle emotionally demanding realities that would overtax her capacities. The possibility of counting on someone else for help or for self-sufficiency did not bring her peace of mind.

To a large extent, I believe Jill worked in treatment by turning passive into active and repeated her pathological relationship with her parents by reversing roles. At various times she sent confusing messages, went on tirades, complained that I could not do anything right, acted hurt, became obtuse, was tempted to cheat me financially, made promises she broke, and held me responsible for failing to satisfy her.

Therapeutic responses to such interchanges require that the therapist become accustomed to being steadily off-balance. I believe there is no clear rule for how to provide a patient with a sense of protection while avoiding taking omnipotent responsibility for that patient. But I think that the analytic therapist or analyst need not be impaired by the double-bind (Bateson, Jackson, Haley, & Weakland, 1956) aspects of the relationship. Instead, part of what I think the therapist needs to offer is what Harold Sampson (1994b) has called "treatment by attitudes." These are the case-specific attitudes that can help reduce a given patient's chronic unconscious fears of being retraumatized (Weiss, 1993; Weiss et al., 1986). These attitudes also help to disconfirm the patient's pathogenic beliefs and expectations and thereby strengthen her capacity for relationships. The kinds of attitudes that I think a therapist needs when working with this kind of patient include respect for the patient's need to have a steady, calm, assured, nonworried, noncatastrophizing, separate, and available therapist. Obviously, like all treatments, one also needs to have empathy for one's patient and be as emotionally attuned to the unconscious meanings of the patient's struggles as is possible.

At this time it remains unclear to what extent Jill's relationship with her father involved some form of sexual exploitation. As seen in the reported treatment hours, there is evidence that Jill continues to repress memories of sexual advances. Within but one week, Jill no longer could remember her reaction to learning that a hated coworker's job was in jeopardy and that his inappropriate sexual behavior was being confronted. There are many hints that the relationship with father had a forbidden, sexually overstimulating character. There also are hints that she believed father was opposed to her becoming more separate from him and to her having a sexual relationship with someone else.

What is clear is that Jill experienced her capacity to become more self-sufficient from her father as endangering her relationship with him. So, for example, her father disinherited her just when her first treatment led to her gaining control over her panic attacks. This treatment success freed her to leave her parents' home and to resume living independently with her husband. It also is clear that Jill continues to repress memories of illicit sexual advances and her hatred of a man who makes such advances. I can only speculate about whether the onset of the patient's first panic attack was stimulated by feeling that her excitement about being reunited with her husband, who was returning from National Guard training, signified a sexual betrayal of her father and expressed a forbidden disloyalty.

Of course it is a major developmental milestone when anyone achieves sexual fulfillment with their spouse. But just how prohibited was it for Jill, a patient who remembers

observing her father's heart palpitations when he danced with her? It is obvious that Jill had profoundly significant sexual conflicts that became manifest in early adolescence, when she became obese and lost the capacity to remember what she needed to be able to learn. It seems to me that Jill may also have experienced the expression of her sexuality as a kind of double bind. Might it be that she not only inevitably felt damned to be sexually involved with her father but also felt damned were she not to be sexually involved with her father? Jill's fears of sexual behavior appear to have been a significant concomitant of some of her panic attacks.

This case report demonstrates how interpersonal communications can both trigger and stop a panic attack. This description of Jill's therapy is just one of a number of writings in our literature that describe the efficacy of psychoanalytically oriented treatments for patients suffering from panic disorder with agoraphobia (Abend, 1989; Isenstadt, 1980; Lane, 1994; Malan, 1979; Mann & Goldman, 1982; Milrod, 1995; Milrod et al., 1996; A. M. Sandler, 1988; Sifneos, 1972; Silber, 1989; Stoeri, 1987; Vanggaard, 1989).

In combination, these studies offer some impressionistic data that challenge the conclusions of the National Institute of Mental Health (1991)—namely, that the only two treatments that have shown efficacy for this disorder are cognitive-behavioral therapy and certain medications. Certainly, formal outcome studies are needed. In addition, the more that we as psychoanalytically informed clinicians can learn about how to understand the underlying causes and meanings of these disorganizing symptoms, the more we can further increase the efficacy of our treatments.

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