

TREATMENT OF PANIC

Bernard Rosenblum

In this discussion I will be looking at the therapeutic response to an acute episode of panic, which occasionally occurs in therapy or which may stimulate a person to seek therapy. Such an episode is to be differentiated from the long-term, ongoing process of working with an individual's general tendency to have moderate degrees of anxiety, although the acute and long-term processes may be connected.

I have experienced three categories of individuals with an acute episode of marked anxiety or panic.

1. The person who comes to therapy in a state of anxious collapse with little or no integrated ego structure intact. This is a fairly rare experience, and usually occurs with borderline, schizophrenic, schizoid, or oral-schizoid characters. These categories of patients are not capable of effective emotional discharge work for some time, and require a good deal of support, clarification of attitudes and needs, reality testing, and work on trust.

An example is a 48-year-old, divorced woman who came for therapy with a background of several months of debilitating panic attacks. She had no idea why these episodes occurred. With detailed questioning, it was revealed that they began when her 18-year-old daughter, her only child, left home to attend college. The patient had poured a large part of her needs and emotions into her relationship with her daughter, with little pleasurable connection to her work, friendships, or sexual relationships. The departure of her daughter seemed to leave her with an empty and misdirected life, and she did not have enough ego structure to face this dilemma in a conscious way. Panic ensued.

2. The person who starts therapy with a panic attack, but has some degree of ego structure, as well as work and social functioning. In this situation, the patient can sometimes tolerate, and may need, some early body-emotional work.

3. The person who has been in therapy for some time and has progressed to deeper levels of emotional functioning. The episode of marked anxiety and/or panic represents a strong charge of childhood conflict which the person is ready to face, but fears. Bioenergetic emotional work is essential in this type of patient, as will be illustrated in the case discussed below.

The very anxious or panicky individual is fearful of several things: of the collapse of his or her ability to function and have normal relationships to the world and to people; of overwhelming internal emotions, impulses, and fantasies; of a loss of sense of self-integration, boundaries, and self-worth. There is a sense of impending disaster with a corresponding feeling of powerlessness and lack of perspective on what is really happening. Childhood feelings of helplessness and aloneness lurk under the surface. Trust in the world and one's own resources have been severely shaken. Frequently there is a fear of "going crazy" or dying.

Severe anxiety episodes are precipitated by the confluence of three factors: a life circumstance that the individual perceives on some level as a threat to his sense of self and ongoingness; internal conflicts that are triggered by the external situations and are symbolically related to it; and a poorly-functioning ego structure.

Recently, a 38-year-old patient, Betty, called me in a state of near panic. It started shortly after she entered one of the studios in the building where she works, and found her boyfriend telling a female co-worker of his upcoming marriage with Betty. Betty was pleased with the conversation, and shortly returned to other job duties. When she did, she began to feel panic, fearing that she would lose her boyfriend. On the surface, this was strange, in that she had just witnessed him confirming their relationship to another person.

The background to the episode is complex, but interrelates meaningfully. Betty had been in therapy a couple of years, and had progressed to a degree of release of emotion and armor, with strengthening of her sense of self. But there remained a tendency to go out of contact, deny her stronger aggressive needs and emotions, and take care of other people. In body-language terms, she had remaining eye and throat blocks, respiration still tended to be shallow, and she would draw back out of guilt and fear of either reaching out or hitting out and screaming fully. There was

always a braking effect when she approached the greatest intensity of emotion. In Ellsworth Baker's system of diagnosis, she could be described as hysteric in that she would respond to emotional threat by withdrawing and freezing, or by talking quickly and "hysterically." There was minimal body armor, which made it hard for her to feel safe with strong feelings, as she had not yet fully developed a sound ego structure and orgasmic capacity.

At 38, the patient has never been married. She and her boyfriend, with whom she has been living for four years, are both in the entertainment field. A precocious, talented, and beautiful woman, she has had male companionship since adolescence, including several long-term relationships with passionate but unstable men. Two of these men died, one during his relationship with Betty. When she was in her 20s, both her parents died at a time when she was beginning to resolve old conflicts with them. She has become sensitized to tragedy and loss.

As a child and adolescent, she could not reconcile her "warm, passionate, Jewish family" and the existence of a paranoid schizophrenic brother who, on intermittent occasions, attacked her sexually. Her parents did not want to hear her complaints, as that would have necessitated sending the son to a mental institution. Betty was forced to repress her legitimate terror, pain, and rage at her brother's destructive behavior in order to avoid loss of love and a terrible sense of guilt and responsibility. When she began therapy, she was very adept at taking care of other people, often to the denial of her own needs and feelings.

Another important factor forming the background for her panic episode was the early relationship with her present boyfriend. He introduced her to cocaine which produced "paranoid attacks" in which she felt that everyone had hidden, hostile intentions. For instance, she felt her boyfriend gave subtle hints of connections to other women and, at the same time, denied such connections. After they both stopped using cocaine, she came to feel that he was more trustworthy.

A final preceding ingredient was her recent therapy experience. Not long before the panic episode, she had finally begun to express the powerful rage and hatred toward her brother which she had so forcibly repressed.

In summary, her recent decision to marry aroused deep feelings of vulnerability, including those connected with the unresolved conflicts and emotions from her childhood. Her first expressions of rage and hatred toward her brother elicited the deepest childhood fears of loss and of punishment by her parents. This emotional upheaval stimulated fears of lack of support and love from her boyfriend associated with the earlier days of their relationship, were also connected to the childhood terror of guilt and abandonment.

In the context of the concept of our study, Betty had strengthened her ego through therapy and life experience, with simultaneous diminishing of superego controls, thus permitting the outpouring of childhood id experience. For her, the latter would include: need to depend on her parents' love and support, anger and resentment at their betrayal, and finally, powerful negative feelings toward her brother. Since she had transferred some degree of parental need onto her boyfriend, a transfer which was reinforced by the upcoming marriage, his person became "cathected" with fears of parental abandonment of the patient as a child.

The important aspects of the treatment of an acute episode of extreme anxiety and/or panic are as follows:

1. ***Immediate and sustained support.*** The panicky person feels totally at a loss and without resources to extricate him/herself from an overwhelmingly threatening situation. Persons in this state may do almost anything to overcome the intolerable anxiety and need immediate attention. I will see a patient that day, either skipping a meal or canceling a session with another patient. Some persons can wait until the evening. Usually, the worst edge of the panic decreases as soon as patients know that the therapist will see them very soon. The presence, skills, and caring of the therapist helps the person to overcome a sense of dissolution and abandonment, and the patient can begin to relax.

The person in panic needs to see the therapist as often as needed (whether it be daily or just two or three times a week) until the extreme symptoms diminish to tolerable levels. My patient Betty needed to see me for only one extra session during the week of her panic attack before the panic disappeared. In fact, she felt deeper and stronger afterward.

2. **Ventilation.** The individual in this situation has an urgent need to verbalize in detail his worst fantasies, fears, and body sensations. Often the person is besieged with extreme and "irrational" fantasies and impulses which had previously been repressed. The patient needs to know that the therapist is not shocked, critical, or threatened, and feels at ease in the situation.

The patient needs to "ramble" and free associate, but at the same time feels reassured when the therapist can aid him/her to begin organizing the discordant material, as to both time sequence and effect on the internal life.

Though ventilation is usually helpful for a while, the therapist occasionally observes the patient becoming increasingly frantic. In this case, the therapist needs to either: 1) stop the frantic monologue, elicit what the patient fears at the moment, and then give reassurance and beginning understanding; or 2) have the person lie down on the therapy couch, cease talking, breathe easily with the therapist's hand softly touching the chest, diaphragm, or stomach. Soft physical touch is often most reassuring in such situations, sometimes more than verbal responses. As we know, the very anxious person is breathing shallowly or hardly at all. Easy deepening of the breathing helps, but not forced or deep breathing.

3. **Understanding.** The person who is frozen with fear or terror, as in panic, is not able to see or understand clearly the general process that is occurring. It is too overwhelming and mystifying. The nervous system is overloaded, and the mind held by extreme fantasies and possibilities. Impending calamity does not make sense, and the individual feels victimized by unreasonable forces.

The beginning calming effect of what has already occurred in the therapy session allows disturbed individuals to open their psychological/emotional/bodily eyes and look at what is really occurring. An absolutely necessary ingredient for the resolution of extreme anxiety is the patient's ability to make sense of the whole process; this understanding allows the person to feel that there is a way out of the dilemma. Power is now beginning to be restored, whereas before one felt powerless.

The following need to be clarified:

a) Why the panic began at that particular time; or, in other words, what deeper unconscious meaning did the triggering cause have for the patient and how is that related to the patient's underlying

conflict? Further, some idea of the emotional process the person is presently undergoing allows an understanding of how a comparatively small occurrence can trigger such profound emotional consequences.

In this clarification process, it is more effective if patients come to their own realizations of these emotional connections than if the therapist simply points them out. Frequently, a combination of both occurs; the therapist helps the person realize these connections with contactful questions and probing, always avoiding intellectualization.

For example, my patient Betty needed to understand that she was facing both childhood fears of parental loss as well as loss of her boyfriend because she is now stronger, more vulnerable, more independent (through the commitment to marriage), and experiencing greater aggression toward her brother in therapy. Further, these present processes challenge the underlying fear that her internalized parents will abandon her if she is more demanding and assertive with them about her brother, thereby revealing her true vulnerability. Finally, as a stimulating or triggering cause, hearing her boyfriend relate the soon-to-occur marriage brought a sense of reality to facing her greatest needs in an intimate relationship.

All of these connections need not be made, and not all in one discussion, but some idea of the general process has to occur for the patient to begin to relax.

b) After seeing more of the connections of the general emotional picture, the person necessarily has to feel there is a way through to the other side. What can be done now? Again, if patients grasp that on their own, the situation is more grounded. With my patient, she now realizes she has to take care of her own needs and feelings more completely and realistically than she had in the past. She feels instinctively that she has to risk more fully her vulnerability and aggression.

4. **Emotional release.** In the previous three phases, there is necessarily a release of some degree of tension and emotion. However, the deeper source of the panic is childhood terror, rage, hatred, grief, and frustrated longing for love; these are most effectively evoked by directed body-emotional work.

The degree of strong emotional work that can be helpful to a person in panic varies considerably. In the case of someone starting therapy in a state of anxious collapse, with very limited ego functioning, strong emotional work is inadvisable. With the second example described above, the person who begins therapy with better ego functioning, some beginning moderate couch work can be helpful. In this case, the therapist must proceed slowly and see how it goes. If one respects the understandable fears and limits of opening up emotionally at the beginning of therapy, the work is usually most effective.

Finally, in the case of a person who has been in therapy for a period of time and has developed good ego functioning and trust in the therapist, strong emotional release is certainly called for. My patient Betty felt calmer knowing that she was able to see me very soon; after some releasing and clarifying discussion, she was able to go to the therapy couch and let go more completely than she ever had before. She expressed her rage and hatred of her brother more fully than she had before the attack of panic. Only by living through the panic was she able to enter more completely into the emotional domain of deepest childhood conflict. Since then, she has been taking a fuller responsibility and involvement in her true desires and core self.

Essential to effective handling of panic is the therapist's calm and confidence that caring, sustained effort, understanding of energy-emotional dynamics, and timely release of depth emotion are the basics in resolving a large majority of panic episodes for our coworkers, patients.

Bernard Rosenblum, M.D., has been a Reichian therapist for many years. He is Director of the Center for Reichian Energetic Therapy.

