PANIC-FOCUSED PSYCHODYNAMIC PSYCHOTHERAPY-EXTENDED RANGE

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Abstract

Panic Focused Psychodynamic Psychotherapy (PFPP) is a 24 session, twice weekly treatment that has been manualized and has demonstrated efficacy in a randomized controlled trial in the treatment of panic disorder. The treatment has recently been extended to address additional DSM-IV anxiety disorders and Cluster C personality traits and disorders. The manualized approach identifies a set of dynamisms that contribute to panic onset and persistence involving intrapsychic conflicts about separation, autonomy, anger and guilt. The treatment aims at increasing patients' recognition and understanding of these dynamics through exploration of the meaning and circumstances of their panic attacks, related intrapsychic dynamics, developmental factors, and the transference. The termination of treatment is particularly important in working through conflicts surrounding separation and autonomy. This article describes the formulation and psychotherapeutic approach in greater depth, and a case example is provided to demonstrate the treatment. We then provide a summary of the research.

Introduction

Panic-focused psychodynamic psychotherapy (PFPP), one of the very few psychoanalytic psychotherapies that meets Evidence-Based Medicine criteria, works to identify core psychodynamic conflicts associated with DSM-IV panic disorder and agoraphobia, and delineates approaches for addressing these dynamics (Milrod et al, 1997). PFPP has been manualized and subjected to randomized controlled trials as a 12 week, 24 session psychotherapy. PFPP demonstrated efficacy for panic disorder (MIlrod et al, 2007; Subic-Wrana, et al 2010). Recently, our research group has extended this psychoanalytic treatment intervention to specifically address a range of DSM-IV anxiety disorders and anxiety- related cluster C personality disorders, as operationalized in our Manual of Panic Focused Psychodynamic Psychotherapy eXtended Range (PFPP-XR) (Busch et al, 2012). The new manual identifies dynamics that appear prominently in various DSM-IV individual anxiety disorders, as well as those that are common to a range of anxiety disorders (ie. it is a transdiagnostic treatment). In this article, we shall describe a psychodynamic formulation for panic and other anxiety disorders, provide an overview of PFPP-XR, and present a case demonstrating PFPP-XR.

A Psychodynamic Formulation for Panic and Anxiety Disorders

Busch et al (1991), Shear et al (1993) and Milrod et al (1997) articulated a psychodynamic formulation for panic disorder. According to this formulation, a combination of neurophysiological vulnerabilities and key developmental experiences contribute to psychological predispositions to panic disorder onset and persistence. Children with these vulnerabilities feel particularly threatened by separation and develop a sense of fearful dependency on caregivers, who are experienced as unreliable or rejecting. Normal strivings for autonomy become a source of anxiety and conflict because of their association with separation and symbolic loss of the primary care

object. The child becomes fearful of angry feelings due to the fantasy that these feelings threaten permanent disruptions of the essential primary relationships, and experiences guilt about wishes and fantasies of hurting parents. Defense mechanisms such as denial, reaction formation and undoing are employed unconsciously, in an attempt to diminish the fantasy that the threat, resulting from angry feelings and fantasies, but the risk of the conscious emergence of these wishes and fantasies leads to persistent anxiety and guilt. In addition, the capacity to mentalize (to conceive of behaviors and experiences as deriving from internal mental states, Fonagy & Target, 1997) is disrupted by avoidance of feelings. This interferes with normal development of ego capacities. In adulthood, threats to attachments trigger regression and a surge of anger and anxiety that cannot be readily identified or managed, leading ultimately to panic. The resulting panic attacks can form a piece of the guilty atonement as punishment for angry fantasies.

Patients with other DSM-IV anxiety disorders have core sets of fantasies and conflicts that overlap in varying degrees with those commonly seen in panic disorder per se. They typically view themselves, especially during periods of intense anxiety, as inadequate, incapable, and in need of another person for survival, sometimes in the form of a phobic companion. Greater personal autonomy and anger at close attachment figures can both feel threatening and as though they both can potentially disrupt relationships. In addition, specific conflicts can be more prominent among patients with individual DSM-IV anxiety disorders. For example, patients with social phobia often struggle with conflicted grandiose fantasies and exhibitionistic wishes, which can stem from efforts to compensate for a core sense of inadequacy. Grandiose fantasies can lead to feelings of disappointment in actual social situations, fuelling anxiety. Exhibitionistic fantasies can trigger guilt and fears of punishment. In generalized anxiety disorder, patients feel the need to maintain a constant state of vigilance, unconsciously living in fear of the emergence of conflicted feelings and fantasies.

PFPP-XR

Rather than a traditional psychodynamic psychotherapeutic approach, PFPP-XR like PFPP, focuses on the circumstances and dynamics surrounding panic attacks or severe anxiety events that are central to the patient's anxiety disorder (Milrod et al, 1997; Busch et al, 2012). Although sessions begin in an open ended manner, and the therapist helps the patient to explore themes that emerge throughout treatment, the focus on anxiety and its ramifications is addressed consistently. Links to seemingly unrelated emergent themes are connected to anxiety symptoms and their underlying psychological significance. This time limited treatment demands a more rapid focus on conflicts and fears surrounding anxiety events and separation than would be necessary in open ended psychodynamic psychotherapy.

PFPP-XR is divided into roughly 3 phases, although the content of these phases may vary significantly between patients. In the initial phase, therapeutic focus is on exploration of the circumstances, feelings, and thoughts surrounding anxiety and panic symptoms, as well as on the underlying fantasy-meanings of symptoms. The therapist addresses patients' lack of reflectiveness and awareness about the meaning of feelings

and about the significance of events. A preliminary psychodynamic formulation about the meaning of the patient's anxiety is made by the therapist and presented to the patient during this period, usually within the first few sessions. This formulation typically involves themes and conflicts surrounding separation, anger, conflicted aspects of sexuality and guilty self-punishment through anxiety symptoms.

In the second phase of therapy, the therapist works with the patient to further identify conflicts and developmental factors relevant to prominent anxiety symptoms. The intensification of the transference during this phase allows the therapist to highlight relevant conflicts as they emerge in the relationship with the therapist. The goal is to reduce anxiety vulnerability through increasing reflective function (Fonagy & Target, 1997) with improved identification of conflicted feelings and fantasies, and increased tolerance of affects and ability to reflect on emotions and their meaning.

In the termination phase (phase 3) the therapist must explore the patient's (necessarily) mixed feelings about termination for at least the final third of treatment. Conflicts and fears surrounding attachment and separation typically emerge in the context of the patient's upcoming separation from the therapist. The impending end of treatment allows these fears and conflicts to be articulated verbally, and understood and tolerated in the context of the transference. This exploration increases the patient's capacity to manage separation, anger and guilt, in ways that may be protective after therapy ends.

Studies of PFPP

In an open clinical trial, 21 patients with primary DSM-IV (American Psychiatric Association 1994) panic disorder with or without agoraphobia were treated with PFPP (twice weekly; 24 sessions) (Milrod et al. 2000, 2001). Sixteen of 21 patients who entered experienced remission, defined by multisite panic disorder study criteria (Shear and Maser,1994) of panic and agoraphobia. Patients with comorbid major depression experienced remission of depression (N=8). Patients were found to have substantial improvements in symptoms and psychosocial function (within-group ES=2.08 in the primary outcome measure, the Panic Disorder Severity Scale [PDSS]; Shear et al. 1997). Gains were maintained at 6 month follow up.

Milrod et al. (2007) conducted a randomized controlled trial of 49 patients with primary DSM-IV panic disorder with or without agoraphobia, diagnosed with the Anxiety Disorders Interview Schedule (Brown et al. 1995), in which patients were randomized to either PFPP or Applied Relaxation Therapy (ART) (Cerny et al. 1984). Patients entering the study who had been receiving medication (18%) agreed to keep the dose and type of medication constant. Patients were not permitted to enter the study while in another psychotherapy. The study included patients with severe agoraphobia, comorbid major depression, and personality disorder comorbidities and excluded patients with psychosis, bipolar disorder, and substance abuse (6 months remission necessary). PFPP and ART were conducted twice-weekly with 24 sessions. ART included a three-session cognitive rationale and explanation about panic disorder (Cerny et al, 1984), progressive muscle relaxation techniques and *in vivo* exposure to situations triggering anxiety. ART does not include interoceptive exposure, the most active component of PCT (Craske & Barlow, 1988). Adherence ratings were performed on three sessions

from each treatment as per protocol, which indicated high adherence to both manualized treatments.

The treatment groups were matched on demographic and clinical variables, except that the ART group contained a higher proportion of males (47% vs. 15%; two-tailed Fisher's exact text, P=0.03). PFPP had a significantly higher response rate than ART (73% vs. 39%; P=0.016), with "response" defined as a 40% decrease in the total PDSS score from baseline (Barlow et al. 2000). Subjects in the PFPP condition experienced significantly greater improvement in panic disorder symptoms as measured by the PDSS (P=0.002), and psychosocial function as measured by the Sheehan Disability Scale (Sheehan, 1983) (P=0.014). No significant between-group differences were found with symptoms of anxiety and depression, as measured by the Hamilton Depression Rating Scale (Hamilton 1960) (P=0.07) and the Hamilton Anxiety Rating Scale (Hamilton 1959) (P=0.58). It should be noted that this was a sample of patients with relatively low overall comorbidity with major depression (20%). PFPP is the first psychoanalytic treatment to demonstrate efficacy for treatment of an Axis I anxiety disorder (DSM-IV-TR panic disorder and agoraphobia). PFPP was well tolerated, with a 7% (2 of 26 subjects) dropout rate. The strong response to treatment occurred despite inclusion in the study of patients with severe agoraphobia and comorbid major depression, making for a relatively sick and, thus, possibly more generalizable group of panic disorder patients, compared with some other outcome studies focusing on patients with panic disorder (Barlow et al. 2000; Craske et al.1991; Clark et al. 1994; Fava et al. 1995; Marks et al. 1993). At the time of this writing, a study is in progress comparing PFPP directly to Cognitive Behavioral Therapy (CBT) and ART (B. Milrod and J.P. Barber, National Institute of Mental Health R01 MH070918/01).

Moderator analyses in the completed, small PFPP RCT found that patients with Cluster C personality disorder comorbidity (SCID-II; First et al. 1994b), experienced more profound response to PFPP than patients who did not have Cluster C comorbidity. (Milrod et al. 2007a). This finding suggests that Axis II/ Cluster C disorders may moderate response to PFPP, such that this comorbidity, frequently making treatment more complicated, may impart an advantage in this modality.

Rudden et al. 2006 examined Reflective Function in conjunction with this study, along with panic-specific reflective functioning (PSRF), a measure of awareness of the link between underlying emotional experience and anxiety symptoms. PSRF improved significantly from baseline to posttreatment in patients treated with PFPP, but not in those treated with ART. However, in this underpowered pilot study the degree of change in PSRF did not correlate with degree of change in panic severity on the PDSS. PSRF is being examined as a potential mediator and moderator of change in symptoms in the current two-site study described above.

PFPP-XR Case Example

Phase I:

Mr.C, a 54 year old divorced accountant, father of a 7 year old son, presented with severe and persistent panic attacks with agoraphobia. In addition to panic disorder with agoraphobia, Mr. C was diagnosed on the ADIS-IVL (Brown et al, 1995) as having

comorbid generalized anxiety disorder (GAD), social phobia, and obsessive compulsive disorder (OCD). He also met criteria for avoidant, borderline, and obsessive compulsive (OCPD) personality disorders on SCID II (First et al, 1994). Although he had always been prone to anxiety in the past, his panic attacks had begun about 6 months prior to entering the Psychotherapies for Panic Disorder study in the context of several stressors.

The attacks occurred most often in the context of his interacting with difficult clients whom the patient described as threatening or aggressive. These clients, who had recently entered his practice, typically tried to push the patient to do things he did not feel comfortable with or he felt were not ethical. For instance, one client pressured him not to report some of his earnings, or to push legal limits in an attempt to save taxes. Even though he anxiously refused to behave unethically, Mr. C began obsessively to question himself at these moments as to whether he had done something wrong or not, or whether he might get "in trouble" for his behavior. He feared that his unwillingness to yield to his clients' demands would lead them to quit and find another accountant. He particularly obsessed about "gray areas," in which he felt there might be uncertainty as to the correct course of action. He noted that despite his fears, he was more careful in his professional behavior than many of his colleagues, and tended to be overconscientious. These symptoms were consistent with his comorbid diagnoses of OCD and OCPD. When he entered PFPP, Mr. C at first acknowledged experiencing little anger toward these clients, although he did admit he felt "frustrated."

At the same time that Mr. C struggled with these difficult clients, he also had come into increasing contact with his father, who was aging and needed a greater amount of support and services. As he felt with his clients, Mr. C worried that his father would bully him into providing things that he felt were inappropriate, such as insisting that Mr. C purchase him a car when his doctor had recommended against driving. Mr. C had a long history of feeling bullied by his father, and he recalled that his father had always been insistent that his view and approach were correct both with family and friends. If the patient did not do what his father asked, his father became enraged or sullenly withdrew. Although Mr. C felt that his mother had been warmer than his father, he was also angry at her for not having intervened more when he was younger and clearly having problems at home and school when growing up. This included the fact that Mr. C had been painfully shy with children who were not close friends, and had struggled with school work. As an adolescent Mr. C was rebellious; he stayed out late drinking, although he was rarely reprimanded. He reported that this behavior led his father to "give up on him," which made him feel rejected and hurt. Thus Mr. C had found little effective means of expressing his anger. He felt frustrated, alone and anxious throughout much of his adolescence.

As the context of Mr. C's panic attacks were further explored, elements of his family background emerged that added to the understanding of their origins. Mr. C reported that when he was a baby, his father had left his mother for another woman. His mother became depressed and had difficulty functioning and was unable to take care of him for several months, requiring Mr. C to be placed in the care of relatives when he was about 6 months old. Eventually his father returned to live with his mother when he was 14 months old, and his parents reconciled. This history contributed to his chronic rage at

his father for his treatment of others, particularly his mother, and added to his fear that his father might reject or abandon him again.

Mr. C initially minimized his anger, but it became increasingly clear that he was furious at his clients, just as he was at his father, but had difficulty acknowledging or expressing it for fear that it would lead to rejection or "getting into trouble." Addressing his state of mind as he was panicking it became increasingly clear that he was wrestling with feelings of fury, including having fantasies of striking out physically when feeling bullied or pressured. His panic led him to feel ineffective and unable to express his frustration. He acknowledged that his father never tolerated anyone's anger: he yelled or angrily withdrew in response. Ultimately Mr. C recognized that part of his problems with schoolwork had been an indirect expression of his anger, what he had come to recognize in retrospect was a refusal to perform well in part unconsciously intended to provoke his father's rage. Later in adolescence his anger was expressed in fights in which he attempted to show other boys how "tough" he was. In Mr. C's mind, this represented an conscious identification and attempt to connect with his father. Patient and therapist identified how Mr. C's panic attacks and other persistent anxiety symptoms functioned to prevent his acknowledging or expressing angry feelings, prevented him from viewing himself as threatening. His anxiety also provided direct punishment for his rage toward others. In sessions 7 through 9, the therapist and Mr. C developed an initial formulation that Mr. C experienced and reacted to his clients as if they were his father. He felt bullied by them and pressured to do things he felt were wrong, but was fearful that any attempt to address these concerns would lead to a disruption in these relationships. At the same time, Mr. C was drawn toward and repelled by the moral ambiguity expressed in his father's and client's attitudes, creating further anxiety and conflict. At the end of the first phase of treatment, in response to these clarifications, Mr. C experienced a significant reduction in his panic attacks, although he still struggled with anxiety when talking with difficult clients, followed by preoccupations that he had done something wrong. This preoccupation appeared to be triggered by conflicts about aggressive fantasies toward clients.

Phase II

In phase II, another fear that emerged as a contributor to Mr. C's panic and anxiety was that he would make a significant error on one of his returns, causing potential problems with clients or authorities. This concern related in part to a conflicted wish to create trouble for his clients, an unconscious provocation as he had begun to recognize mimicked the pattern with his father. The conflict also triggered feelings of inadequacy and weakness that he had struggled with throughout much of his life. He felt particularly inadequate about his intellectual and social skills, areas in which he believed his father excelled. In high school and college Mr. C had made efforts to compensate by responding aggressively to those who he felt might bully him, first through physical fights, and later by acting intellectually superior. He referred to himself as a "pseudointellectual", viewing himself as unable to match his father's intelligence. In therapy, however, he began to question his father's intellectual skills, recognizing that his father might have bullied others to accept his views, rather than presenting superior arguments or being respected.

His feelings of inadequacy were also associated with longstanding social anxiety, fearing that he would perform poorly with others and be humiliated. In response to his underlying sense of inadequacy, he developed persistent grandiose fantasies of having an intense impact when he was speaking to a group, after which he fantasized about receiving accolades. Unfortunately, his anxiety made public speaking highly conflictual, and he was recurrently disappointed when he was presented with these opportunities. The therapist worked to help Mr. C understand that his fantasies of grandeur served to unconsciously compensate for his chronic low-self-esteem and shyness, and to recognize that they were unrealistic, and actually interfered with his being better able to utilize his more than adequate social capabilities. In addition, these expectations were linked to idealized fantasy identifications with his father, who seemed to the patient to a make a very positive impression on others. However, as his therapy progressed and his reflective capacities improved, Mr. C began to question his father's social stature. He made inquiries of friends and family that confirmed that his father was known for his tendency to bully others. The patient's new awareness of his idealized expectations of himself, and his shifting view of his father's abilities helped him to feel less threatened in social situations.

Mr. C was concerned about a sense of loss of control, particularly as it involved his anger, of which he was gaining increasing recognition in therapy. He became aware of intensifying rage in himself as his more aggressive clients or his father pushed him to take steps he was unwilling to take. He feared that if he expressed his anger he would do so in a hurtful way, such as telling them to "go to hell," leading to further problems and conflict. Therapist and patient identified that Mr. C feared yet also partly wished to be a bully in the same way his father was. Also, his sense of not being in control in these situations was associated with a feeling of vulnerability linked to being in a passive position and being bullied by others. Mr. C found himself in a state of constant vigilance due to the threatened emergence of these frightening fantasies. As he identified and was able to tolerate his fears of being a bully and being bullied, he became less generally anxious. He began to feel more comfortable setting realistic limits with others, as in telling his clients: "I'm not willing to do this. It could get both of us into trouble".

An opportunity to examine these conflicts emerged in the context of the transference. Mr. C was about to describe his father's behavior from many years before, and then suddenly said he would not do so with the study camera on "because people could get into trouble." After much exploration about his mistrust of the therapist and the research study staff, without a shift in the patient's attitude, the therapist turned off the camera for 10 minutes of the session. The story the patient revealed clearly demonstrated his father's insensitivity to his mother, but did not remotely present a risk to anyone. After discussing this "secret" incident, the patient reluctantly accepted that he had been overly wary. Mr. C's fears of retribution and betrayal by the therapist highlighted the intensity of his fear of his father, as well as his conflicted feelings and fantasies about his underlying wish to get revenge on his father for his bullying (i.e., the idea that his father would get "in trouble"). The pattern also indicated his expectation of being bullied by the therapist, a transferential fantasy that came to the fore in the termination phase. Further concerns regarding mistrust of the therapist, and fears that the therapist would harm him in some way were articulated further in the termination phase.

Mr. C's personal life was both affected by and added to his anxiety. He lived with his ex-wife, Julia, and their 7 year old son. He felt frustrated about continuing to live with Julia, whom he did not love. After his divorce 5 years before, he lived on his own and had a relationship with a woman whom he found more intellectually stimulating. In exploring why Mr. C returned to his ex-wife, he revealed that he felt guilty about his son living without his father (as he had done briefly, as an infant), and that this had led him to the decision to return. The chronic frustration he experienced with Julia added to his sense of dissatisfaction, anger and anxiety, as he felt trapped with her. Julia was irresponsible about money and was constantly in debt, and the patient felt it was necessary to bail her out repeatedly. Although he got along well with his son, he felt extremely guilty about expressing any anger at him.

Mr. C struggled with pressures about responsibility and was typically overconscientious. He felt he had to limit his own life by moving back with Julia to take proper care of his son, so as not to repeat the abandonment he felt in relationship to his own father as a child. He could not identify a way that he felt was "right" for him to move on to another relationship and still pay adequate attention to his son. As with his son, Mr. C was preoccupied with doing things the "right way", leaving him in a nearly constant state of feeling extremely burdened by his responsibilities. The patient reported that he charged his clients less than what was appropriate, and often took care of an elderly woman, a former client, doing things for her that were not part of his job, and did not charge her. Exploration revealed that he believed it was necessary to take on these responsibilities in order to maintain relationships and be accepted by others. It emerged that this was also a form of reaction formation in which he suppressed his anger at others and instead focused on caring for them, undoing of his sense of being a bully. However, this type of 'caring', in which he arranged to feel undervalued by others, unconsciously increased his sense of unfairness and his rage and anxiety. His understanding of the fears that led to his overconscientiousness contributed to the change in his attitudes and behaviors associated with the resolution of his OCPD. For example, as he recognized that he was frightened unnecessarily about "getting into trouble," he began to check his work less compulsively. He felt less compelled to act out the bullying/punishment scenario that he struggled with internally. In addition, his understanding that his heightened sense of responsibility was warding off angry feelings and worries about rejection helped him to set better limits on what he agreed to do for others.

At the end of phase II, Mr.C's anxious preoccupation with his clients had diminished, and he was less worried about making errors or inadvertently doing something unethical. He was able to get openly angry at his father about his bullying. He felt worried and guilty after yelling, but relieved when he observed that his father was "behaving better" the next time they met. He felt more confident socially and noted a reduced need for vigilance about his own feelings and behavior, a core component of his generalized anxiety disorder.

TERMINATION

As termination approached, Mr. C's therapy became increasingly focused on his relationship and feelings about the therapist. In session 18, an incident occurred in the

transference that led to additional examination of the core dynamics of his anxiety. Mr. C described a conflict about whether or not to cancel the next session. He was concerned that the therapist would be angry at him because he had canceled other sessions, and had been reminded by the therapist that treatment in the Psychotherapies for Panic Disorder protocol was meant to occur twice weekly. The therapist responded in a neutral fashion, saying that it was important to explore Mr. C's conflict. However, Mr. C reacted to the therapist's comment by describing the therapist's tone as angry and critical; he felt negatively judged for possibly missing a session, and pressured not to do it. The therapist responded that he did not agree that his reaction was judgmental, but that the behavior Mr. C was attributing to him sounded very similar to his father's bullying that he had been describing. Mr. C recognized that this was true. The therapist wondered whether Mr. C might also experience others as behaving aggressively, when in fact they had not been so aggressive. At this point, Mr. C acknowledged his own intense anger at the therapist, something which he had previously denied.

When Mr. C became calmer, he was able to look at this incident in the context of the conflicts he experienced about being responsible. He had thought he might have to cancel his session because he needed to take care of elements connected with the sale of his father's house. However, he believed the therapist would be angry at him if he openly told him his priorities. As in other situations, Mr. C felt pressured to yield to others' needs: he felt torn between what he perceived as his father's and his therapist's demands. However, he then felt angry about being put in this position, and feared his anger would trigger his getting punished, or could disrupt the therapy. His ability to openly acknowledge his anger at the therapist for the first time and recognize that he would not be judged or rejected helped relieve some of his fears of expressing anger. This transferential experience further diminished the anxiety he experienced with his clients when he felt pressured by them, as he felt safer experiencing and expressing his anger. His increased understanding of the conflicts underlying his acute sense of responsibility that he experienced in therapy with the therapist helped to reduce the pressure he felt to yield to clients' demands.

In session 20, Mr. C became angry at the therapist for the brief duration of treatment and claimed he had never been told about it. The length of treatment was clearly explained by the research staff at the outset of the treatment, it appeared on the consent form that he signed, and the therapist had brought it up twice. Nonetheless, Mr. C complained that he was being unfairly treated, and that it was wrong for people with anxiety problems to be subjected to time-limited therapy. He subsequently revised this view when he looked over the material in the consent form, and then recalled being clearly told about the treatment being time-limited. He realized again that when he expressed anger, he feared he was being a bully like his father, adding to his sense of danger and subsequent anxiety. He did not have a model for modulated expressions of anger and feared the therapist would reject him. At the same time, here at treatment termination, his anger was being employed to ward off feelings of sadness in losing the therapist and ending treatment. In exploring these feelings, Mr. C began to feel less threatened by this loss. He became increasingly articulate in directly expressing his anger in other situations outside of the therapy. For example, he said to a client: "If you want someone who will do this, get another accountant." Mr. C's opportunities to explore fears of bullying and being bullied, as well as his guilt and sense of

responsibility in the transference allowed for further articulation, tolerance, and a less conflicted expression of these feelings. Mr. C's panic attacks, social phobia, GAD, OCD, and borderline, avoidant, and obsessive compulsive personality disorders all improved significantly in the course of the treatment.

Conclusion

PFPP has been shown to be a promising alternative approach for treatment of panic disorder. Preliminary evidence suggests that this treatment may be particularly valuable for patients with comorbid cluster C personaltiy disorders, although these results have yet to be replicated. Clinical experience suggests that that PFPP may treat a broader range of anxiety disorders, as demonstrated in the above case example, and we have expanded our articulation of our treatment manual to address these related transdiagnostic anxiety disorders (PFPP-XR). Further research will determine the impact of PFPP-XR on other anxiety disorders and cluster C personality disorders. Further research is necessary to determine for which patients this approach may be most effective in comparison with medications and CBT, and what treatment or combination of treatments work best for whom over the long term.

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