MINDFUL PANIC: INTEGRATING CBT AND PSYCHODYNAMIC THERAPY
WITH MINDFULNESS TO IMPROVE RELATIONSHIPS WITH PANIC

by

MARIAN A. SMITH

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Abstract

Although cognitive behavioural therapy (CBT) is currently the first line of treatment for panic disorder, many individuals experience less than adequate post-treatment relief and continue to experience substantial levels of anxiety, fear of panicking, avoidance and reduced quality of life. Many continue to seek alternate treatment to cope with their fear. Much of the research on panic disorder reveals that a more comprehensive treatment approach is needed to offer clients a better therapeutic fit and increased efficacy of treatment. The author proposes a model combining CBT and psychodynamic therapy with Buddhist concepts and mindfulness meditation. Drawing on her own experience with various treatment approaches as a client and as a therapist, the author outlines the importance of mindfulness practice for the growth and development of therapists as well as clients. The dynamic and flexible treatment model is adaptable to individual clients and their changing needs over time and stresses the importance of awareness, connection, action and compassion. Clients who continue to experience panic attacks post-treatment are offered a practical and empowering method to work with them. This integrated therapeutic approach thus offers clients the opportunity to improve their relationships with anxiety and panic and to no longer allow these states to define them.
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Introduction

My interest in the topic of panic stems from my own experiences with panic attacks, as well as the experiences of several family members across three generations. At the age of 14, my world changed overnight. While swimming from one island to another, I suddenly felt overwhelmed by a deep sense of dread. It was a cold eerie moment where time slowed and I felt like I was being sucked down into a dark, bottomless pool. I panicked and began fighting for breath and for my life, until my feet finally touched ground. That night, I lay in bed trying to make sense of what had happened to me. I was aware of how close to death, and to nonexistence, I had come. I thought about how every day all over the world people die; countries are at war, bombs drop, and civilians have no control. Although I had made it through my close call in the water, I became acutely aware of my own helplessness in the face of death. As I reflected on my fragile mortality, the same cold terror washed over me for the second time that day, only this time, there was no water to get out from. And no matter how I twisted and turned, I couldn't shake it. It was as though a silent scream was emanating from my core. I didn't feel like I would live through the experience intact.

For the next four years, panic attacks came and went until the start of my last year of high school when they began to increase in both intensity and frequency. I began going for behavioural therapy treatment and no longer felt the huge burden of carrying my terror alone. I felt relieved when my behavioural psychologist seemed to understand what I experienced. He viewed me as an ideal client: highly motivated, intelligent, with close interpersonal relationships, numerous skills and interests and assured me that I would be "cured" after 10 sessions. That never happened. Nor did it happen with subsequent cognitive behavioural therapy (CBT) at Queen's University or at the University of British Columbia. Even when a doctor prescribed several Xanax a day and I was working and studying through a fog, I still experienced panic.

Ever in search of relief and understanding, I embarked on a course of psychodynamic therapy. It was a relief to be able to speak openly about the profound sense of disconnection and disintegration that I experienced during panic. My therapist had the capacity to be very present and compassionate with me in a way I had never experienced.
with a CBT therapist. I felt less like an irrational being in need of being fixed, than a being in pain in need of a compassionate co-investigator.

A few months into psychotherapy, I took part in a Buddhist loving-kindness retreat and began attending a weekly mindfulness meditation group. That was 15 years ago and the combination of meditation practice within the supportive context of a psychotherapeutic relationship helped me to face my terror. While meditating, I experienced a sense of peace unlike any I had known before. At times, I also experienced lightness and warmth, feelings of expansiveness and connectedness with other beings and with all of life. I also experienced the coming and going of numerous mind states and sensations and, for the first time since that initial panic, believed that I would not get stuck there, forever drowning in the maelstrom of my endless fear. I began to think and feel that maybe I could stand it.

I remember how tremendously freeing it was for me to hear the first teaching of Buddhism--life is suffering. A palpable release swept through my body and a gradual attitudinal shift began to grow. I had previously thought that my life should be easier, that I must be doing something wrong or there must be something wrong with me that I need to fix. . . Hearing that life is suffering helped me to let go of thinking that I shouldn't have to deal with these states of terror. It's just what is. It is already here as part of my experience. I might as well stop fighting with it, accept it, and pay attention to it.

I also remember thinking that if life is suffering, then clearly I'm not the only one who is suffering. Feeling isolated and disconnected are a major part of panic. It's very connecting to know that everyone suffers to some degree, even when it isn't apparent. To know that intellectually is one thing, but to know it experientially, to see it, hear it, and feel it while sitting in a meditation hall among countless others, is quite another. Seeds of compassion were slowly ripening.

Mindfulness meditation provided me with welcome periods of ease and peacefulness. Learning to accept states of high anxiety in myself and to witness them, without identifying with them, was a revolutionary practice for me. Mindfulness became an anchor I could drop down periodically, lending me comfort and rejuvenation. As my practice deepened over the years, even though I still experienced panic attacks, I no longer waged war with myself for my "weakness". I also began to recover more quickly
from the panic, both emotionally and physically. With the ongoing practice of *metta* or loving-kindness (a Buddhist concentration meditation frequently practiced with mindfulness), I became gentler and more loving toward myself. Being compassionate with myself was a radical departure from my reactive anger and deep disappointment in myself for not having "gotten over this yet".

At times, I still experience feelings of terror, as well as frustration, disappointment and loss. I grieve for numerous lost opportunities and misunderstandings and there are still some situations that I continue to avoid. But, instead of feeling like my soul is being painfully sucked from my body (as I did at 14), and instead of snapping a thick rubber band against my wrists (as behavioural therapists had me do to stop anxious thoughts and feelings), I am more likely to stroke my cheek, tune in to my breath and my connectedness with the ground beneath me, remind myself that this is a passing state, and offer myself soothing words.

Although cognitive behavioral therapy gave me some useful skills, it was not enough. Psychotherapy helped me to understand my struggle and to grow with the support of another. Buddhist psychology and its meditation practices gave me a practical way of working with my fearful states, and greatly enhanced the quality of my life.

When I use the term *psychotherapy* in this paper, I am referring to non-directive therapy that considers psychodynamic concepts where appropriate and where the relationship between the therapist and the client is primary. Psychodynamic psychotherapy recognizes the importance of unconscious forces in mental life and acknowledges that exploring the past is helpful in understanding the present. When I refer to CBT therapy, I am referring to those approaches associated with the work of Beck (1988), Beck and Clark (1997), and Craske, Brown and Barlow (1991).

**Construction of Disorder**

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, APA, 4th Ed., 1994), years later, would categorize my existential struggle as panic disorder. However, as Raskin & Lewandowski (2000) note, "the DSM-IV is a cultural construction, rooted in the social mores of Western society in general and North American psychiatry and psychology in particular" (p. 36). As humans, we grapple with the unexpected and try to
make sense of it in order to help decrease our anxiety around the unpredictable and our "not knowing" (Anderson & Goolishian, 1992). This leads to the human tendency to categorize, yet as Kutchins and Kirk (1997) note, "far too often, the psychiatric bible has been making us crazy--when we are just human" (p. 265). Caplan (1995) states: "I cannot say that I have found it either personally or professionally useful to classify anyone as normal or abnormal" (p. 44). Personally, I have not resonated with parts of the DSM-IV definition, nor found it helpful in understanding and working with my own panic attacks. However, I realize that some individuals who experience recurrent panic attacks may find the DSM-IV definition or diagnosis viable at some point in their process. Not surprisingly, the quantitative research literature reviewed here uses the DSM-IV diagnosis of panic disorder as the criterion for participation in their studies. Yet, because I believe that personal realities are constituted by one's constructions of events (Raskin & Lewandowski, 2000), and in order to emphasize that "panic disorder" is a construction, I will usually refer to participants as "people who have recurrent panic attacks" or "individuals who struggle with panic." I also believe that using this terminology expands the possible meanings that individuals give to their anxiety and panic states. Moreover, it allows for viewing behaviours that are classified by some as mental illness, as meaningful actions "made to happen by sentient, intelligent human beings" (Szasz, 1974, p. 201). This terminology also allows for envisioning a continuum that includes people who panic to greater and lesser degrees and who are looking to improve their relationships with anxiety and panic. Most importantly, using the term "people who panic" versus "panic disorder" leads to less identification with panic and thus, more possibility for change.

**Historical Background on the Experience of Panic**

Panic attacks are not a recent phenomenon and have been referred to by different names over time and across cultures (Gelder, 1986). In addition, a variety of biological explanations have been proposed over the last two decades, including mitral valve prolapse (Pariser, Pinta, & Jones, 1978), hypoglycemia (Gorman, Martinez, Liebowitz, Fyer, & Klein, 1984), vestibular dysfunction (Jacob, Moller, Turner, & Wall, 1985), and thyroid disease (Fishman, Sheehan, & Carr, 1985). However, none of these explanations has been confirmed (Fishman, Sheehan, & Carr; Gorman et al., 1984; Rachman & Maser,
Some researchers suggest that people who experience recurrent panic attacks have a low threshold for physiological arousal which could be inherited (Eysenck, 1967; Barlow, 1988) or may result from prolonged stress, such as from panic attacks (Klein, Ross, & Cohen, 1987).

Studies using antidepressants in the 1960s were the first to suggest that panic can be dissociated from generalized anxiety and agoraphobia (Klein, 1964). Findings related to antidepressant effects as well as sodium lactate and caffeine-induced panic (Pitts & McClure, 1967; Udhe et al., 1985) helped to form the basis for a biological explanation of panic episodes. However, according to Margraf, Ehlers, & Roth (1986), there is no unifying explanation of these biological findings.

Evidence for the role of psychological factors in panic attacks emerged during lab interviews in the 1970s (Beck, Laude, & Bohnert, 1974). Participants expressed fear over the significance of their distressing symptoms; attributed their distress to a variety of causes; believed themselves to be in danger of going crazy, dying or passing out; and often reported feeling a confusing rush of thoughts during a panic (Beck, Laude, & Bohnert, 1974).

**About "Panic Disorder", According to the DSM-IV**

According to the Diagnostic and Statistical Manual of Mental Disorders (APA, 1994), "the essential feature of panic disorder is the presence of recurrent, unexpected panic attacks followed by at least one month of persistent concern about having another panic attack, worry about the possible implications or consequences of the panic attacks, or significant behavioral change related to the attacks". An unexpected panic attack is one that is not associated with a situational trigger. It consists of "a discrete period of intense fear or discomfort that has an abrupt onset, reaches a peak within ten minutes, and is accompanied by at least four of 13 somatic or cognitive symptoms" (APA, 1994, p. 394). At least two unexpected panic attacks are required for diagnosis of panic disorder and most individuals have considerably more. Situationally predisposed panic attacks are common (i.e. attacks that are more likely to occur but are not invariably associated with the situation), whereas attacks that occur almost invariably and immediately on exposure
to a situational trigger are less common. The frequency and intensity of panic attacks vary widely for individuals with panic disorder.

Characteristic attributions regarding the implications or consequences of panic attacks include fear of having a life-threatening illness, of "going crazy" or losing control. Although some individuals deny being fearful of having another attack, anxiety over having another attack can lead to avoidance behavior and agoraphobia, the fear of leaving familiar surroundings (APA, 1994). In the latter case, panic disorder with agoraphobia is diagnosed.

Agoraphobia that occurs in the context of panic disorder, essentially involves anxiety about being in situations where escape might be difficult or in which help may not be available in the event of having a panic attack or panic-like symptoms (APA, 1994). The anxiety often leads to a pervasive avoidance of a range of situations such as being home alone or being away from home alone, riding in an elevator, bus or airplane, crossing bridges or being in a crowd.

Many individuals with panic disorder report feeling constant or intermittent anxiety that is not focused on any particular situation or event. Some may be excessively apprehensive around daily experiences, often related to health issues or separation from loved ones (APA, 1994). A common consequence for many individuals struggling with panic disorder is a sense of demoralization, accompanied by feelings of discouragement, shame and unhappiness due to the difficulties they experience in carrying out their day-to-day activities (APA, 1994).

Individuals with panic disorder are especially vulnerable to depression. In fact, major depressive disorder occurs in 50%-65% of these individuals and precedes panic disorder in one-third of those with both disorders (APA, 1994). The lifetime, worldwide prevalence for individuals with panic disorder (with or without agoraphobia) is 1.5%-3.5% (APA, 1994). One-third to one-half of these individuals in community samples also have agoraphobia although that rate is much higher in clinical samples. Panic disorder without agoraphobia is diagnosed twice as often and panic disorder with agoraphobia three times as often in women as in men.
Life with Panic: Daily and Long-term Struggles

Without treatment, people who experience recurrent panic attacks tend to continue to do so, with negative, long-term consequences (Keller et al., 1992; Kendall & Southam-Gerow, 1996). Even with treatment, panic attacks tend to recur across the lifespan (Hoffman & Spiegel, 1999; Ollendick & King, 1998). The American Psychiatric Association (1998) recently concluded that cognitive behavioural treatment (CBT) and psychopharmacology should be first-line treatments for panic disorder. A review of the panic disorder treatment literature on CBT and psychopharmacology (Gould, Otto and Pollack, 1995) reveals that the criterion for a positive outcome is no longer meeting the diagnostic criteria for the disorder, as laid out by the American Psychiatric Association (1994). Yet, Kazdin (1997) notes that those who no longer meet the criteria for a diagnosis of mental disorder often suffer significant impairment and poor prognoses. This is substantiated by Hoffman and Spiegel (1999), who reviewed the evidence for the clinical efficacy of CBT for people with panic disorder and found that posttreatment panic-free scores are generally higher than those based on global measures of improvement.

Candilis et al. (1999) found that individuals with panic disorder experience quality of life disruptions in several areas of their lives. Their mental and physical health scores are significantly worse than those of the general population. If they have an additional anxiety disorder (such as generalized anxiety disorder or social anxiety disorder), they tend to have more body pain and worse social functioning than most individuals. Similarly, in a study using CBT with people who panic, Klosko, Barlow, Tassinari, and Cerny, (1990) note that although there is a decrease in general anxiety at post treatment, these individuals still experienced substantial anxiety. In another study, Barlow and Cerny (1988) note that there is considerable room for improvement in at least 50 percent of those who struggle with panic. Two additional studies found that many participants continued to take medication at post treatment and follow-up, and some who were assessed at follow-up were seeking alternative psychological treatment (Craske, Brown, & Barlow, 1991; Beck, Sokol, Clark, Berchick, & Wright, 1992). Brown and Barlow (1995) discovered that when they assessed individuals at one-year post treatment instead of at one month, as in previous studies, the success rate dropped from 57 percent to 21
percent. Moreover, it is significant that in 1997, Beck and Clark, two major CBT proponents, concluded that cognitive therapy is a necessary, but not a sufficient component of anxiety treatment.

Thus, despite improvements experienced by some of those who have received CBT, therapists need to be able to offer more powerful treatments to those who experience less than adequate relief through CBT alone. A lower quality of life, including fear of future attacks and avoidance appear to impact even those who are considered panic-free after treatment. Thus, longer-lasting treatment is needed to help these individuals deal with their anticipatory anxiety and any future attacks. Some researchers (Klosko et al., 1990) suggest that greater therapeutic efficacy may arise from combining treatments. (For an in-depth review of the literature on panic disorder, see Appendix A).

An Adjunct Treatment: Meditation

As there is no definitive cure for panic disorder (Anxiety Disorders Association of British Columbia, 2001), finding effective ways to help individuals manage symptoms of high anxiety is important. In a time of multiple cutbacks to the health-care system, cost-effective treatment techniques need to be considered as an adjunct to other treatment and for ongoing anxiety management. In recent decades, meditation has become more prevalent both as a self-management tool for anxiety and as an addition to psychotherapy (Delmonte & Braidwood, 1980; Kutz et al., 1985). In fact, the American Psychological Association delivered a position statement in 1977 suggesting that "meditation may facilitate psychotherapeutic process" and strongly recommended research "to evaluate the possible specific usefulness of meditative techniques"(p. 720). Since that time, several studies (Boswell & Murray, 1979; Delmonte, 1985; Miller, 1993; Schwartz, Davidson, & Goleman, 1978) have suggested a link between various meditation practices and a reduction of symptoms of anxiety.

In a review of more than 50 studies on meditation and anxiety reduction, Delmonte (1985) found that those who are drawn to meditation tend to experience higher than average levels of anxiety. The literature suggests that individuals with high levels of anxiety tend to have a low frequency of practice, but that those who practice meditation regularly tend to show significant decreases in anxiety (Fling, Thomas, & Gallagher,
However, Delmonte's review was largely limited to a type of meditation known as concentration meditation, where individuals focus on a single object, such as a mantra or the breath, as in Transcendental and Zen Meditation.

Another type of meditation called "mindfulness meditation" has been steadily gaining in popularity in North America over the last two decades (Epstein, 1999; Kornfield, 1993). Mindfulness meditation is also known as *Vipassana*, a Sanskrit term meaning *insight*, and both terms are used interchangeably with Insight Meditation. Mindfulness meditation is rooted in ancient Buddhist traditions and includes aspects of both concentration and mindfulness. Most simply, to practice mindfulness is to practice attending to whatever is happening right now, observing it, and letting it go.

Mindfulness meditation practice is designed to cultivate greater awareness or mindfulness in everyday life (Kabat-Zinn, 1990; Kornfield, 1993). Mindfulness involves an "experiential exploratory stance toward whatever mind-object presents itself in a given moment, with the intention of deepening one's understanding of the nature of the mind, and growing in wisdom towards eventual liberation from suffering" (Miller, 1993, p. 170). Within a single period of meditation, an individual's attention may shift from the breath to physical sensation, to thought, and to emotion, depending on what is in the foreground in each moment. From this place of "choiceless awareness" (Krishnamurti, 1973), mindfulness strengthens and the meditator is increasingly able to embrace the present moment, and not just while meditating. According to Miller (1993), "the increasingly direct contact with the present moment often reduces stress, fear, anxiety, and dysphoria, as these mind states are often associated with some past experience which distorts the present moment reality" (p. 170).

One of the most frequent developments reported by meditators is "a growing ability to adapt easily to a large range of fluctuating experiences. This is noted as a growth of equanimity and calmness in the face of extreme bodily and mental changes" (Kornfield, 1979, p. 54). Insight into the ever-changing nature of body and mind states can develop with regular practice and may be helpful for individuals who are experiencing a wide range of frightening symptoms leading up to and during a panic attack.

In contrast to the large number of studies on concentration meditation practice and anxiety, few studies have been conducted on the relationship between anxiety and
mindfulness meditation. Kabat-Zinn and his colleagues (Kabat-Zinn et al., 1992; Miller, Fletcher & Kabat-Zinn, 1995) conducted studies on individuals dealing with generalized anxiety and/or panic and discovered that, after eight weeks of meditation, participants reported a reduction in both their symptoms of anxiety and in the severity of their panic attacks. They also reported a decrease in the avoidance of triggering situations, a result that has not been reported with CBT alone (Goldberg, 2001). These significant improvements appear to be enduring for those who continue to practice meditation.

The effects of a mindfulness meditation program were also studied on individuals involved in long-term private psychotherapy (Kutz et al., 1985). Some of the participants were dealing with anxiety disorders. According to participant and therapist ratings, the mindfulness meditation program produced significant improvements in the clients' well-being. The greatest change was in the area of decreased depression and anxiety. Eighty percent of the participants rated the daily experience of meditation as the most valuable factor responsible for their reported change. Therapists believed that the clients' ability to calm themselves led to a sense of mastery in controlling their anxiety outside the meditation session, which served to further defuse their anxiety.

Qualitative studies on mindfulness with individuals without recurrent panic (Kornfield, 1988) suggest that this practice involves more than a process of simple relaxation. Individuals report changes in perception with important learning in relation to the experience of terror (Kornfield, 1988).

Current Theoretical Orientations and Models

Treatment Theories

Both pharmacological and cognitive behavioral treatments (CBTs) were endorsed as effective interventions at the 1991 National Institute of Health Conference on panic disorder and, by 1998, the American Psychological Association concluded that both
therapies should be first-line interventions for panic disorder. However, pharmacology and CBT differ in their theories regarding the etiology of panic disorder.

Pharmacotherapy is based on the assumption that panic disorder is caused or maintained by pathological physiological and biochemical factors in the brain. Medication targets neurotransmitter activities that have been implicated in the pathogenesis of panic disorder including norepinephrine, serotonin and GABA-BZ (Heninger, 1994). In a review of the pharmacological literature (Gould, Otto, & Pollack, 1995) concluded that the greatest amount of data supports the efficacy of antidepressants and high potency benzodiazepines. Medications are assumed to target panic and anxiety in particular, assisting the individual to enter feared situations with less dread and a greater sense of control. Situational exposure is sometimes assigned along with pharmacotherapy.

Cognitive behavioral theory posits that panic is mediated by the fear of symptoms of anxiety (Barlow, 1988; McNally, Riemann & Kim, 1990). High levels of anticipatory anxiety are thought to be maintained by the catastrophic meanings individuals give to their panic sensations, which in turn cues a panic attack (Gould, Otto, & Pollak, 1995). Meanings that individuals give to symptoms of anxiety and panic include "I'm losing my mind", "I'm dying", and "I won't be able to control my actions." According to Gould and his colleagues, each attack strengthens the perception of danger and leads to a phobic response to the symptoms. After experiencing a number of attacks, an individual becomes sensitized to small signals of arousal and responds to these with conditioned fear, thus eliciting another attack. Agoraphobic avoidance can then arise and habituation does not take place (Gould et al.).

Psychodynamic theory differs from the basis of both pharmacotherapy and cognitive behavioral therapy. Freud (1966) viewed phobias as an unconscious externalization of an internal fear. An individual is thus able to protect herself from perceived danger by fleeing the feared object or place. Horney's (1950) concept of basic anxiety is defined as a "feeling of being isolated and helpless in a world conceived as potentially hostile" (p. 18). According to Horney, a person who has been insufficiently nurtured as a child will lack a basic sense of security and will experience basic anxiety. Panic is experienced when the individual's strategies to restore basic security are blocked or fail (Goldberg, 2001). At
bottom, what the individual really fears is the disintegration or dissolution of the self (Kohut, 1977, p. 102). Indeed, some of the symptoms of panic, such as the fear of losing control, going crazy and dying, relate to this "fear of nothingness" (Kierkegaard, 1944) and dissolution. According to Goldberg (2001): "Whatever the source of the threat to basic security, after experiencing a panic attack, the attack itself becomes a threat. The symptoms associated with panic such as dizziness, shaking, and confusion make the individual feel he is disintegrating and falling into nothingness" (p. 149). After experiencing a panic attack, an individual becomes fearful of experiencing another attack and will go to great lengths to avoid re-experiencing panic (Chambless & Goldstein, 1982).

A Psychodynamic Model

Weiss, Sampson, and the Mount Zion Psychotherapy Research Group (1986) proposed a psychodynamic dual cognitive system whereby behaviour is guided by both "Automatic Functioning" and "Higher Mental Functioning". During Automatic Functioning, an individual's unconscious processes are ruled automatically by the pleasure principle. The pleasure principle refers to the basic human tendency to avoid pain and seek pleasure and is especially salient in the first years of life. When "Higher Mental Functioning" is predominant, an individual unconsciously appraises danger and safety and decides at the unconscious level whether to repress or experience unconscious content. In the case of psychopathology, the sources of danger are assumed to be unconscious, pathogenic beliefs that are usually rooted in early traumatic experiences. Weiss and his colleagues show that individuals bring previously repressed material to consciousness when they unconsciously decide that they may safely experience them.

Empirical Support for the Psychodynamic Model of Panic

Some empirical evidence for this model can be found in an extensive case study by Weiss and his colleagues (1986). In this case, the client held pathogenic beliefs that she would cause harm to her family if she were independent and successful. She began to act in an independent manner to unconsciously evaluate whether the therapist would react similarly to her parents. Since the therapist did not react in the way she perceived her
parents to react, she changed her pathogenic beliefs. She gained insight into her irrational beliefs and was able to bring out content that she had previously repressed. The client became more relaxed, less driven and more able to enjoy life.

A Cognitive Model

Clark proposed a cognitive model for panic in 1986. Clark submitted that an individual experiences panic due to a predisposition to interpret bodily sensations as catastrophic. Clark (1986, 1989) outlined a sequence of events that results in a vicious cycle that culminates in a panic attack. The stimulus can be external, such as a location in which an individual has experienced a panic attack, but more often the stimulus is internal, such as thoughts, images and bodily sensations. If the stimulus is perceived as a threat, apprehension develops. Apprehension is associated with a range of physical sensations and if these are interpreted in a catastrophic manner, the apprehension increases. This in turn produces increased bodily sensations, creating a vicious cycle, which results in a panic attack. Clark (1986) proposed that both the perception of bodily sensations and the ensuing catastrophic interpretation may be unconscious processes, which would explain the occurrence of spontaneous day and nighttime panic attacks (Barlow & Cerny, 1988).

During the 1970s and 1980s, CBT focused on agoraphobic avoidance of feared situations and stressed relaxation and cognitive skills (Mavissakalian, Michelson, Greenwald, Kornblith, & Greenwald, 1983). However, since the late 1980s, treatment has focused on trying to eliminate panic attacks and the fear of symptoms tied to an attack (Barlow, Craske, Cerny, & Klosko, 1989; Beck, Sokol, Clark, Berchick, & Wright, 1992; Margraf, Barlow, Clark, & Telch, 1993). An important component of this treatment is interoceptive exposure, which involves helping individuals to repeatedly re-create the somatic symptoms of their panic attacks in order to decrease anxiogenic responses to symptoms. For example, an individual who hyperventilates during an attack would be asked to hyperventilate in the therapist's office and at home, in order to normalize the symptoms and reduce catastrophizing. Interoceptive exposure is combined with cognitive restructuring activities such as Socratic questioning, self-monitoring and behavioral homework. Most of these more recent CBT programs also included a breathing retraining
component or muscle relaxation training, and if agoraphobia is present, a graduated exposure to feared situations (Gould, Otto, & Pollak, 1995).

A Cognitive Information Processing Model

More recently, cognitive behavioral therapists have focused on information processing models in order to enhance understanding of the cognitive basis for anxiety disorders (Goldberg, 2001). In 1997, Beck and Clark proposed a three-stage information processing sequence as the cognitive model of anxiety and panic.

Stage I, initial registration. At this stage, rapid, automatic and involuntary recognition of the stimulus occurs. Beck and Clark (1997) claimed that anxious individuals have an orienting mode that is biased toward negative and personally relevant information.

Stage II, immediate preparation. Activation of the primal mode occurs whose function is to ensure survival by searching out safety and minimizing danger. The primal mode tends to be rigid and reflexive and decreases the capacity for constructive thinking. The primal mode involves both automatic and controlled information processing and also expresses the earliest phase of meaning assignment to the perceived threat. Because automatic information processing is still involved at this stage, it may occur without conscious awareness with the exception of the resulting threat appraisal. According to Sternberg (1999), individuals can be taught to become aware of their automatic thinking.

Stage III, secondary elaboration. Controlled processing is fully active here and is relatively slow, effortful and capable of analysis and synthesis (McNally, 1995; Sternberg, 1999). At this stage, individuals can evaluate their coping resources, yet are still contaminated by the primal mode. Clark and Beck (1997) outlined three possible outcomes: (a) Anxiety may increase due to dominance of the primal mode which prevents a more realistic reappraisal of the situation, (b) anxiety may decrease with reappraisal causing individuals to diminish their perception of the threat and upgrade their ability to cope, or (c) anxiety may diminish as the primal mode prompts defensive behaviors such as escape and avoidance.

According to Goldberg (2001), Clark’s original cognitive model (1986, 1989) fits the current information-processing model. When individuals become hypervigilant of their
bodily sensations, the primal mode is activated. When individuals engage in avoidance behaviors that can maintain their misinterpretations of physical sensations, both the primal mode and controlled information processing are at work.

**Empirical Support for the Cognitive Model of Panic**

In order to test the information processing model, many studies have employed the Stroop Task (Williams, Matthews, & MacLeod, 1996) to see if individuals who panic show any bias. Participants are shown a series of words with a range of emotional significance and are asked only to name the colour in which the word appears. A number of studies have shown that individuals with panic have a delay in responding to panic-related words, including those related to various catastrophes, fear and body sensations (Ehlers, Margraf, Davies, & Roth, 1988; Hope, Rapee, Heimberg, & Dombeck, 1990; McNally et al., 1994). However, in the study by Ehlers et al. (1988), the difference in Stroop interference between panic participants and those in the control group was relatively small. A more recent study (Lundh, Wikstrom, Westerlund, & Ost, 1999) showed that participants who panic exhibit delays in the Stroop task when panic-related words were presented subliminally as well as supraliminally. This finding provides support for the automaticity of selective attention to negative and personally relevant information, in the sense that this process is unconscious and involuntary (Goldberg, 2001).

Overall, there is some support for the first stage of Beck and Clark's (1997) information processing model whereby an automatic and involuntary orienting occurs toward negative and personally relevant information (Goldberg, 2001). There is also some support for the primal mode of thinking in stage II, which involves a blend of automatic and controlled information processing. For example, one study showed that individuals with panic disorder tend to have more catastrophic thoughts such as those related to death and loss of control, compared to individuals with Generalized Anxiety Disorder (Breitholz, Johansson, & Ost, 1999). Another study found that when participants with panic disorder were biologically challenged with carbon dioxide inhalation or lactate infusion, cognitive procedures helped prevent the participants from misinterpreting the sensations and blocked their panic attacks (Sanderson, Rapee, &
Barlow, 1989; Clark, Gelder, Salkovskis, and Anastasiades, 1991). In addition, in participants who were panic-free at six-month follow-up, Clark et al. (1994) found a positive correlation between misinterpretation of bodily sensations and later relapse.

**Toward a More Comprehensive Model**

*Psychodynamic concepts.* In order to provide a more comprehensive understanding of panic disorder, Goldberg (2001) suggests expanding Beck and Clark's (1997) cognitive model to include psychodynamic concepts. In Goldberg's expanded model, threats to "Basic Security" (Horney, 1950) lead to panic because they imply dissolution of the Self. Goldberg claims that this would explain why panic could occur even in the absence of physical sensations. The construct of "Basic Security" can also explain why catastrophic interpretations are specific to those physical sensations that are associated with anxiety. (For example, a leg cramp is not usually anxiety-provoking whereas a rapid heartbeat can trigger panic for some.) As the sense of "Basic Security" can vary with circumstances and over the life span, panic and avoidance reactions also vary with time. Goldberg proposes that those lacking a sense of "Basic Security" develop strategies in an attempt to restore it, such as entering a feared situation in the company of a close friend. When these strategies are threatened, panic occurs. Panic attacks also become a further threat to "Basic Security," “leading the individual to engage in certain types of thinking and behaviour which tend to perpetuate the panic" (Goldberg, p. 154). Goldberg posits that addressing the pathogenic beliefs of people who panic may help to improve therapeutic outcomes of CBT.

**Linking Psychotherapy and Buddhist Psychology**

Just as CBT therapist Carlos Goldberg (2001) advocates extending our understanding of panic through psychodynamic concepts, many psychotherapists are observing the benefits of incorporating Buddhist psychology into therapy (Epstein, 1995; Bennett-Goleman, 2001; Kornfield, 1993; Kutz et al., 1995; Miller, 1993). Both the concepts of Buddhist psychology and the practice of mindfulness meditation are valuable in
understanding and working with panic states (Kabat-Zinn et al., 1992; Miller, Fletcher, & Kabat-Zinn, 1995). Mindfulness meditation involves observing one's thoughts as they arise and pass away from moment to moment, without getting caught in the content. Witnessing the arising and passing away of one's irrational thoughts can lead to insight into one's pathogenic beliefs and enhance therapeutic outcomes for individuals experiencing recurrent panic attacks.

**Buddhist Psychology**

As far back as the early 1900s, William James predicted that Buddhism would be the psychology of the future (Epstein, 1995). James was aware of the psychological dimension of Buddhism whose object is to question the nature of the self and to offer a means to end self-created mental suffering. The Buddhist view of suffering holds that the causes of suffering are also the means of release and that it is believing in our faulty perceptions that causes our suffering. Suffering can, however, be transformed through changing the way we relate to it. In the short term, we do not escape it, but we can gain a clear perception of ourselves and of the entire range of the human experience. This is important. However the long-term goal of the practice is to end all such suffering by realizing the true nature of existence, which is egolessness.

From a Buddhist perspective, suffering occurs because we are afraid to experience ourselves directly. Fearing this experience of ourselves is, in itself, suffering and is rooted in habits of dualistic perception arising from ignorance. This is similar to the psychoanalytic view wherein Freud (1914/1958) submitted that the client must have the courage to "direct his attention to the phenomena of his illness" (p. 152) and reconcile with material that has been repressed. If parts of ourselves are cut off, denied, and not assimilated, they become "black holes that absorb fear and create the defensive posture of the self, unable to make satisfying contact with the world" (Epstein, 1995, p. 19). However, when these parts are tolerated or accepted and integrated, our defensiveness lessens and compassion arises.

Within Tibetan Buddhism, sentient beings are believed to cycle endlessly through six different realms of existence in their round of rebirths. The opportunity to escape an endless round of rebirths is believed to be possible through an awakening of the mind
while in the Human Realm. In this worldview, extreme forms of anxiety and panic belong to the Hell Realms, which are depicted as places in which beings are tortured by their anxiety. However:

They do not recognize their torturers as products of their own minds... They believe themselves to be tortured by outside forces over which they have no control. At the same time that they are completely dominated by their rage or anxiety, they are cut off from those same emotions. They do not see that those unwanted forces are their own, and they are therefore imprisoned in a cell of their own making. (Epstein, 1995, p. 22).

Fortunately, Buddhism teaches a way to work with these powerful forces, by training the mind through meditation.

Similarity between Psychodynamic and Buddhist Concepts

_Narcissism and no-self_. One of the most distinctive tenets of Buddhist psychology is known as "no self", the claim that there is no particular substantive agent doing the experiencing. Epstein argues that this Buddhist stance actually approximates psychodynamic thought as exemplified in psychoanalyst W. R. Bion's declaration that true thoughts "required no thinker" (Bion, 1970, p. 105). Bion believed that psychotherapists are better off not identifying with their insights. Thus, both schools uphold the importance of the elimination of narcissism, that considerable amount of self-centeredness we retain into adulthood.

One of the first teachings of Buddhism is the inevitability of loss, disease, death, and decay. As hard as we try, we cannot keep up the illusion of our self-sufficiency. Buddhist psychology explains thus why a sense of pervasive unsatisfactoriness is present throughout life in the experience of those still attached to ideas of a "true self". From birth, we are vulnerable to unfathomable anxiety, which later shows up as feelings of futility or unreality (Epstein, 1995). Similarly, according to Rank (1978), what we fear is life and this fear is rooted in a separation anxiety. Thus, we fear what has already happened, but we also fear the loss of our individuality in death (Epstein). "Between
these two fear possibilities, these poles of fear, the individual is thrown back and forth all
his life, which accounts for the fact that we have not been able to trace fear back to a
single root, or to overcome it therapeutically" (Rank, p. 124). This is difficult for many to
hear; yet the wounds to our narcissism can be overcome, through letting go of the belief
in a "self" that needs protecting (Epstein, 1995). From the Buddhist standpoint,
strengthening our sense of self and security only adds to our mental suffering. Buddhism
teaches that happiness is available to us if we can only overcome our own narcissism.

To put the same thing a different way: As humans, we long for a sense of security,
and part of this centers around the desire for a solid self. The developing mind deals with
this desire by imposing a false coherence on itself. It then becomes infatuated with an
image of itself and grasps for an identity, making itself into something other than what it
actually is (Epstein, 1995). According to Epstein, the ego attempts to preserve the illusion
of security and runs back and forth between emptiness and fullness, looking for refuge (p.
70).

While psychoanalysis has approached core existential insecurity through the effects
of anxious/insecure parenting on children, Buddhism posits that it is impossible to know
ourselves satisfactorily, no matter what parenting we received. Since the observer always
affects what is observed, we as subjects can never satisfactorily know ourselves as
objects (Epstein, 1995). Buddhism deals with this through encouraging a "not knowing"
state of mind (Kornfield, 1993). Doubts about the self are viewed as an inevitable part of
the maturational process and Buddhism recommends exploring and accepting it as a way
to resolve it.

**Transitional Objects and Bare Attention.** According to Winnicott (as cited in Phillips,
1988), a young child may become attached to a primary transitional object such as a
blanket or toy that helps her to tolerate intense emotions, such as being alone and away
from parents. The child’s feelings for her mother or her primary caretaker spill over into
the object, which is used for self-soothing and to reduce anxiety. Transitional objects act
as a substitute, and bridge the representation of mother. For example, when mother is
away, the child may choose to sit in her mother’s chair, which offers her comfort. This
action also affirms that the child is becoming aware that she is an individual, separate
from external love objects. Transitional objects also provide a constancy that helps the
child to hold herself when faced with being alone. Similarly, bare attention can be a constant that is not disrupted by intense emotion. The meditator is said to be like a bridge, undisturbed by the stream rushing below (Epstein, 1995). The meditative space offers "a refuge where the fixed beliefs in a separate self that must be protected and defended can be temporarily suspended" (Epstein, 1995, p. 124). Mindfulness meditation gives us the space in which to challenge our instinctive identification with our emotions.

**False self and non-duality.** Psychoanalyst D. W. Winnicott submitted that, in order to deal with a parental environment that is not resilient enough to support our falling apart, we impose a coherence on ourselves— a "false self" (as cited in Phillips, 1988, p. 124). This false self is a primitive form of self-sufficiency in the absence of nurture. When a mother prematurely withdraws her nurturance from her children, they lose touch with their bodies and retreat to the thinking mind, which becomes the sense of self. Children use this false self to protect themselves and to gain favor. Winnicott believed that it was the rigidity of this false self that led to one's pervasive sense of dissatisfaction.

Within Buddhism, the suffering of the false self is born out of attachment to the extremes of self-sufficiency and emptiness. We develop the grandiose self in order to comply with parental demands and the empty self is that part of us that feels alienated and insecure, aware of the love it never received (Epstein, 1995), or never received enough of. The Buddhist approach encourages us to view these polarities as non-dual and to bring them to our awareness in order to release their unconscious hold.

**Similarity between CBT Concepts and Mindfulness Meditation**

CBT was the first therapy to offer clients a systematic approach with which to separate thoughts from emotion (Witt, 2002). It treated thoughts dispassionately and objectively, as something to be verified or disputed. As Segal, Williams and Teasdale (2002) note, CBT implicitly supports the notion of changing one's relationship to thoughts by gaining some distance from them. Mindfulness has the explicit objective of seeing thoughts as mere thoughts and breaking one's identification with them. Despite this similarity, mindfulness meditation does not instruct individuals to test the accuracy of their thoughts, list their dysfunctional cognitions or dispute their negative thoughts
In mindfulness programs for stress reduction (Kabat-Zinn, 1990) and depression (Segal, Williams & Teasdale, 2002), instructors emphasize viewing phenomena as simple phenomena. Thoughts are merely thoughts, not facts, and feelings are just feelings. One does not have to believe them or act on them. As one meditation teacher remarked, "if you have a thought, think nothing of it" (Ed Brown, personal communication, January, 2004); we are not our thoughts or our feelings (Kabat-Zinn, 1990).

Mindfulness meditation also shares with CBT the "self-regulation and retraining of attentional habits" (Goleman, 1976, p.123) through deconditioning habits of perception, cognition and response (Bogart, 1991). Mindfulness produces a change in one's internal state, and like CBT, lessens the need to control the environment (Bogart, 1991). From a cognitive viewpoint, Delmonte (1985) proposes that meditation allows us to suspend our habitual, logical-verbal construing and its related automatic defenses, which in turn lead to broader perspectives and consciousness. Other researchers have found the attentional training of meditation useful in increasing the range and clarity of the observing self (Diekman, 1982; Epstein, 1995) and in facilitating behavioural change (Boals, 1982; Johnson & White, 1971, as cited in Bogart, 1991). Diekman submits that, as motivations of the object self recede, we gradually dis-identify with automatic sequences of thoughts, feelings and fantasy. The intensity of our usual affect, obsessional thinking and automatic response patterns is redirected by the observing self to training the mind toward more constructive behavior and emotion (Diekman, 1982; Goleman, 2003).

From a Buddhist perspective, a destructive emotion is one that obscures the mind from seeing things as they are and impairs our freedom by generating a sequence of thoughts that compels us to act in a biased manner (Goleman, 2003). Constructive emotions, however, are seen as grounded in sound reasoning and involve a correct appreciation of things as they are. As with CBT, mindfulness training leads us to become more alert to cues of threats and helps us to constructively respond rather than automatically react in situations of arousal (Kabat-Zinn, 1990). In addition, with mindfulness meditation, we practice becoming attentive to when our minds have wandered from our point of focus, which increases our sensitivity to the present moment.
and allows us to interrupt maladaptive behavioral sequences (Schapiro & Zifferblatt, 1976).

Concentration aspects of meditation can also desensitize the meditator to anxious thoughts and images as these compete with our attention on the breath. Both meditation and CBT are based on increasing awareness through self-observation and self-monitoring of thoughts, emotions and body sensations. Although both employ labeling of thought content and body sensations, in meditation this noting is background or "only 5 percent noting, 95 percent being with the experience" (James Baraz, September, 1990, personal communication). Thought content is much more foreground in CBT where it is tracked, recorded, and analyzed.

Dissimilarity between Therapy and Mindfulness Meditation

While content is important in CBT and psychodynamic therapy, in mindfulness meditation, it is viewed as unimportant. During meditation, we do not attend to the meaning that might attend the content of our experience. As Epstein (1995) notes:

By not identifying with, not holding on to, and not being embarrassed by whatever arises, the meditator moves from a narrow focus on the content of her experience to an ever-widening focus on the process itself. Thoughts and feelings, stripped of their associated pride or shame, gradually lose their charge and come to be seen as just thoughts or just feelings (p.124).

The meditator can, however, note recurring themes and become curious about these outside the meditation process itself. The client can then bring this material into therapy for deeper joint exploration.

The Therapeutic Aspects of Meditation Practice

Mindfulness. As mentioned earlier, the essential technique of meditation is bare attention, which is also referred to as mindfulness. Bare attention is defined as "the clear and single-minded awareness of what actually happens to us and in us at the successive moments of perception" (Thera, 1962, p. 30). To sit with bare attention, we observe the body, mind and emotions as they are, without changing them as we would in CBT. Paying attention in this way is believed to be healing in and of itself and to lead to the
development of insight. Across all Buddhist schools, the instructions are the same: "pay precise attention, moment by moment, to exactly what you are experiencing, right now, separating out your reactions from the raw sensory events." (Epstein, 1995, p.110). The technique of paying attention is a constant throughout one's meditation practice, only the objects of awareness change. We begin by paying attention to the breath and then open up to body sensations, feelings, and thoughts. With more experience, we bring our awareness to more and more subtle phenomena including consciousness and the felt sense of "I". For example, we gradually let go of all objects of attention and become aware of simply being, fully aware of whatever there is within the sphere of our attention.

While sitting in this place of choiceless awareness, the meditator's boundaries become more diffuse. The meditator has the felt sense of having clung to certain thoughts, opinions and roles for her sense of self, but as she lets go of the process of constantly trying to construct and protect an identity, she begins to question who is the "I" doing the experiencing. When sitting without grasping, the meditator begins to see that what she has identified as "me" are simply processes, phenomena that have no substance and are continually changing. She begins to realize that there is no specific entity in anything. This is a difficult concept to grasp and, as Khema (1984) notes, in order to know it, you must experience it. If one accepts and bears the fright that there is really nothing to hold on to and goes through it, one comes to complete and utter relief and release (Khema). All the burden of looking after our sense of "I" and protecting it, and all the fears around it, are no longer necessary.

Some people mistake mindfulness meditation for techniques of concentration meditation, which can offer feelings of relaxation. Relaxation training is common in CBT and is a useful therapeutic skill. However, Buddhism teaches that concentration does not solve the problem of the emotions, because the emotions are never understood as empty in their own right (Epstein, 1995). It is mindfulness that teaches a different way to be with feelings. The Buddhist concept of emptiness is helpful in understanding that things do not exist in the way we imagine. For example, the emotions that upset us and seem so real do not actually exist in the way that we envision; as Epstein notes, "they do exist, but we can know them in a way that is different from either expressing or repressing them" (p.101). Through mindfulness, we can learn to recognize our misconceptions around our
emotions, thereby changing our experience of them. We learn to hold our thoughts, feelings and sensations with increasing equanimity, and when we do not identify and react to them, we can see them more clearly.

**Loving-Kindness.** Loving-kindness or *metta* is a Buddhist meditation practice of relatedness and connection. The literal Pali translation of metta is "loving kindness" or "friendliness" (Warder, 1974). While mindfulness is a practice of moment-to-moment concentration, loving-kindness is a practice of fixed concentration. Rather than anchoring in the breath and bringing awareness to the experience of each moment, the meditator repeats certain phrases in order to cultivate a feeling of loving-kindness toward ourselves and others. One of the phrases is "may I be peaceful and happy" (Salzberg, 1995, p.?). As we practice, we come to see that all beings share this wish for themselves and this universality becomes a place of connection. When we understand that everyone basically wants to be happy and that their actions are guided by this desire, we also cultivate compassion for others. Thus, loving-kindness is a practice of opening to unconditional love and heartfelt care and concern for ourselves and others (Salzberg, 1995).

The practice of loving-kindness teaches us that we don't have to obsessively follow states of mind such as anxiety and fear. Instead, we can let go of them as though dropping a burden (Salzberg, 1995). We learn to abandon unskillful states that cause suffering, not out of fear or contempt, but as we learn to truly love ourselves and bear witness to our burdens, we watch them simply fall away. Meditation teacher Sharon Salzberg advocates that if we want to find reliable happiness, we need to shift from "trying to control the uncontrollable cycles of pleasure and pain, and instead learn how to connect, to open, to love no matter what is happening" (p. 12).

According to Salzberg (1995), the Buddha taught metta meditation as an antidote to fear. Cultivating a sense of love that is not attached to desire and does not have to pretend that things are other than they are, overcomes the illusion of separateness. In this way, "metta overcomes all of the states that accompany this fundamental error of separateness-fear, alienation, loneliness, and despair—all of the feelings of fragmentation. In place of these, the genuine realization of connectedness brings unification, confidence, and safety" (Salzberg, p. 21).
Loving-kindness practice is a useful adjunct to mindfulness as it encourages us to embrace all parts of ourselves and relieves us of the need to deny those aspects we dislike. When we feel love, our minds are expansive and can open wide enough to include both its pleasures and its pain, in full awareness. We do not have to feel betrayed by our fear or overcome by it; we can connect with that part of ourselves that is undamaged, regardless of the situation. By not identifying with the forces of fear, we realize these torments are only visitors and do not reflect on who we really are. We come to see our fear and panic as states that arise from past conditioning and do not need to criticize ourselves. Instead, our challenge is to see these states for what they are. Finally, metta reminds us that we are already whole, just as we are (Salzberg, 1995).

The Usefulness of Mindfulness for Therapy

As the literature review reveals, CBT is the first line of treatment for individuals who panic and it is beneficial for many to a degree. However, many feel the need to seek additional treatment as panic attacks continue to challenge them over the lifespan. Many seek psychotherapy in order to better understand themselves, the origins of their terror, and the beliefs that are tied to their fears of disintegration. Psychotherapy is also useful in helping us identify our core feelings of emptiness, yet it does not offer a way out of this emptiness (Epstein, 1995; Rank, 1978). Epstein posits that Buddhist psychology, however, offers a practical method that provides more than the "relative relief" of psychotherapy (p. 7), noting that it promises freedom from narcissistic craving, from a false sense of self, and from the endless desire to be other than where we are at any given moment. It also offers an effective cognitive technique for the development of self-awareness (Kutz et al., 1985) and provides insight into the nature of the self.

Buddhism posits that as we open to emptiness, we will feel more real. We fear our own lack of solidity and that is why we defend it so strongly (Epstein, 1995; Goldstein, 1991). In opening up to our most private feelings without fear, Buddhist meditation promises genuine liberation over a permanent sense of isolation (Epstein, 1995). Mindfulness helps us to open to the intensity of emotions we are afraid to feel. It provides a protective distancing that enables us to create and maintain an observing ego through which we can confront emotions that were previously avoided because they were
unpleasant or overwhelming. Once these emotions are permitted to surface, they are made conscious and their subversive power begins to lessen (Kutz et al., 1985).

The practice of mindfulness thus allows us to be a detached observer of our mental habits and distortions (Kutz et al., 1985). The meditator is able to perceive the distinction between a mental object and its related emotion. For example, we note an image or thought arising and then we notice the feeling provoked by that stimulus. The meditator learns to note the feeling as somewhat separate from herself, noting "there is fear" rather than "I am afraid". Learning to separate in this way allows the individual to recognize that fear arises from within, in various shapes and forms without provocation. The meditator has not moved or opened her eyes in 30 minutes, her external environment has not changed and yet several themes that are central to her life may have arisen. She begins to see the process whereby she automatically rationalizes her thoughts and emotions in relation to external stimuli.

In addition to enhanced perception, meditation leads to greater conceptual and intuitive flexibility that continues beyond the meditation itself (Kutz et al., 1985). We broaden our perspective as our cognitions become more plastic and as we begin to forge connections between previously unrelated psychic material. We also become more emotionally receptive during meditation, which at times can lead to the awareness of repressed material (Epstein, 1995; Kutz et al., 1985; Miller, 1993). This material can then be brought into the therapeutic milieu.

Along with our increased perception and cognition, a heightened emotional state emerges and provides a feeling of centeredness. Feelings of inner trust and serenity begin to grow, leading to a defenselessness that allows a range of emotion to emerge. In meditation, emotions cannot be disowned or transferred as in therapy; "the fear has to be contained within the sphere of one's own vulnerability. There is very little to cling to; nothing remains but what is at hand. One's loneliness, even one's very existence, is threateningly close. All that matters is not being dead or disintegrating into nonexistence" (Kutz et al., 1985, p. 8). One client related such an experience from her meditation:

At first I wanted to deny the fear in my usual fashion. But, feeling a centre of inner serenity while meditating, I let myself go. It was devastating. I felt lost and abandoned forever. But soon after, I knew I was still sitting there and felt that
place inside me that told me I was not going to vanish. I could continue to sit and
watch my fears until the pain gradually dissolved. Experiencing and not reacting
or running away was a new experience to me" (Kutz et al., p. 8).

Through the practice of mindfulness, the client learns to create a container for herself and
her fluctuating, sometimes powerful emotions.

**Advantages of Combining Mindfulness Meditation with Therapy**

According to Kutz et al. (1985), a central advantage to combining mindfulness
meditation in therapy is that it intensifies the therapeutic process. It allows clients to
continue observing and reflecting on their process on a daily basis outside sessions, at no
cost. In addition to increasing the frequency of introspection, meditation also improves
the quality of the therapeutic process by providing an additional means to work with
one's challenges. Over time, the client may become aware of repetitive themes, which
may tie into her panic attacks and may benefit from mindful co-investigation.

Combining meditation and psychotherapy is also "technologically compatible and
mutually reinforcing," according to Kutz et al. (1985, p. 11). It doesn't threaten the
therapeutic relationship or dilute transference (Epstein, 1995; Kutz et al.). In addition, the
practice of mindfulness helps to instill a sense of personal responsibility in that the client
comes to see herself as the "writer-director of her own dramas" (Kutz et al., p.6). She is
unable to project or disown those feelings that she observes arising within herself during
her meditation. These observations begin to transfer to therapeutic process whereby the
client begins to own her resistances and projections.

Perhaps the greatest advantage to providing the client with the tools of mindfulness
practice is that it empowers the client. Mindfulness meditation gives her a practice with
which to ground herself in her daily life, a practice that has enhanced the quality of life of
countless others (Kabat-Zinn, 1990). The practice of loving-kindness helps the client to
be gentle and compassionate with herself in her process and helps her to feel more
connected to herself, to others and to life itself.

**Meditation "doesn't do it all" (Kornfield, 1983)**

While I have stated that both CBT and psychodynamic therapy alone are not
sufficient in working with recurrent panic, neither is meditation. Both Buddhist
psychologists Kornfield (1983) and Goleman (1976) contend that meditation does not specifically address the treatment of specific fears or phobias but that it deconditions general or diffuse anxiety. However, Goleman also notes that meditators’ responses to stress situations may be more adaptive than those of non-meditators due to an increased ability to let go of stress. One researcher noted that "meditation may facilitate more rapid, spontaneous recovery from negative reactions" (Jackson, as cited in Hall, 2003, p. 4) and another posits that meditation's focused attention leads to mastery over instinctive, compulsive reactions (Odanjoyk, as cited in Bogart, 1991).

Despite all the apparent advantages of combining mindfulness meditation with CBT and using this meditation as an adjunct to psychodynamic therapy, there are no guidelines for the therapist who wants to bring all of these approaches together into one therapy.

What is being proposed here is an integrated therapeutic model for the treatment of recurrent panic. This model integrates CBT and psychodynamic concepts with those of Buddhist psychology and the practice of mindfulness and loving-kindness meditation.
SECTION II
Toward an Integrated Therapeutic Model

As is evident from the literature review (see Appendix A), addressing panic attacks strictly through CBT may be inadequate for some clients and may not improve their quality of life. Many continue to avoid anxiety-provoking situations and go on to seek alternate therapies. CBT can provide useful techniques for many, although it may not address deeper issues underlying panic. CBT may also be experienced as disempowering by clients as it is more about teaching rationality and correcting errors in thinking than joining with the client and meeting her where she is. Within a psychodynamic approach, clients may experience a sense of connection with the therapist, feel understood, and gain insight into issues surrounding their panic attacks, yet may have difficulty facing panic situations.

By combining CBT and psychodynamic therapy with Buddhist psychology and meditation, clients are offered a more holistic experience whereby their panic is understood and approached from multiple perspectives, including exposure to feared situations. The integration of these three therapeutic approaches addresses multiple dimensions of experience, including cognitive, emotional, physical and spiritual. CBT mostly addresses cognition, psychodynamic is largely concerned with affect, and mindfulness is rooted in spiritual tradition that provides practical training for addressing physical as well as cognitive and emotional aspects of being. For example, mindfulness meditation uses the breath and posture to synchronize body and mind.

Who is the model for?

This model will be of interest to therapists who are meditation practitioners themselves or who are interested in mindfulness as an aspect of psychotherapy in order to assist clients in addressing high levels of anxiety and panic without psychosis. Although Linehan (1993) has found aspects of mindfulness useful in working with clients diagnosed with borderline personality disorder, I do not address this population here.
Method

An investigative and experimental method. According to the Dalai Lama, "in a way, the methodologies of Buddhist thought and science are essentially similar" (as cited in Goleman, 2003, p. 38). Both go through a self-correcting process in the pursuit of truth and Buddhism strongly encourages investigation and experiment, stating that these are more important than simply taking the Buddha's words at face value (Goleman, 2003). In keeping with the methodology of Buddhist psychology, I have personally investigated and experimented with the practices outlined here. I do not believe that there is one "right way" to be prescribed for all people. However, I offer the following model as a suggestion for improving relationships with panic. Therapists can investigate and experiment with these views and practices as part of their own process of being with difficult mind states and offer them to clients as they see fit.

In my own experience with CBT, I felt like I had to fit the therapy—and it often didn't fit. Although I would practice the techniques ad nauseam, I still panicked frequently and experienced a lot of anticipatory anxiety, fearing future attacks. To my knowledge, the therapist never once questioned the choice of therapy. As Linehan (1993) notes, there is an implication that, if the client doesn't improve, it is the client's fault. However, if the therapist is willing to be consistently on the client's side, she must be willing to adapt her therapeutic approach and honour what is best for the client. Thus, although CBT is reportedly the first line of treatment for panic, CBT research is also the most highly funded and the most measurable (Michael Mahoney, personal communication, November, 2003), outside pharmacotherapy. It only makes sense to have several ways of approaching a challenge in order to increase the opportunity for a good therapeutic fit with a range of clients. Moreover, since "problems cannot be solved at the same level of consciousness that created them," (Einstein, 1933) meditation offers a tool to access other levels of consciousness from which to approach one's challenges.

Outline of the Model

The therapeutic model can be envisioned as a creative tapestry-in-process, whereby the foundational, lengthwise threads make up the warp and the flexible cross threads form the weft. Buddhist psychology informs the model and can be viewed as the warp to the
well of the therapeutic process. Within Buddhism, there are three basic characteristics underlying all phenomena: suffering, impermanence and no-self (Kornfield & Goldstein, 1987). These characteristics form the enduring framework of the model while the foreground interweaves mindfulness and loving-kindness practice amongst elements of CBT and psychodynamic therapy toward an integrated whole (see diagram on following page). The tapestry is unfinished, as mindfulness and loving-kindness practice is ongoing and becomes part of one's life. However, leaving the tapestry unfinished also reflects the possibility that a client may choose to end therapy and return months or years later with a different focus. For example, a client may have benefited from CBT and mindfulness at one stage in her life and later, become aware of the subtle circumstances under which her panic occurs and want to explore this more deeply through a psychodynamic approach. Another might notice that she was using her meditation practice to repress her anxious feelings and thus, was unable to be with the intensity of her fear whenever it arose. Later, she may feel ready to open up to the breadth of her experience. Finally, leaving the tapestry unfinished allows for changes in the model as it becomes refined through practice.

The therapeutic stance is derived from CBT, psychodynamic therapy and Buddhist psychology. In CBT, the client-therapist relationship is usually viewed as a means to an end and the therapy itself is outcome-oriented (Arnkoff, 1995; Beck & Weishaar, 1995). In psychodynamic therapy, the client-therapist relationship is central, as is resolving the complexities of its dynamics. The often-unconscious dynamics of transference are rooted in both the client's and the therapist's past and working through the transference is seen as intrinsic to successful therapeutic outcome (Egan, 2002). In Buddhist psychology, both meditation and therapy are process-oriented and the primacy of the client-therapist relationship lies somewhere between that of CBT and psychodynamic approaches.

This model, too, takes a middle ground. The therapeutic approach is client-centered and process-oriented, encouraging therapist and client to set a clear intentionality over being attached to a particular outcome. The client-therapist relationship is very important, as is the client's relationship with herself through her meditation practice. Both client and therapist work to maintain a balance between letting go of specific expectations and the
willingness to believe that important changes can occur through mindfulness practice (Segal, Williams & Teasdale, 2002)) and mindful therapy.

Before proceeding with the model, I would like to acknowledge that from the outset, I have had two reservations about creating it. One is that I do not believe in any recipe or formula for working with a particular challenge; the other is that I do not think that therapists should use mindfulness meditation practices in therapy without having at least one year's experience in meditating daily (and preferably, many more than that) as well as a commitment to ongoing practice. There is so much depth to the practice, with limitless layers of understanding that, even after 16 years of mindfulness practice, I still consider myself a beginner. For this reason, the model begins with the practice of the therapist. From there, I outline what can be learned from mindfulness practice, which forms the necessary ground for therapists to work with their own anxiety as well as that of their clients. I then proceed to address working specifically with anxiety and panic, followed by guidelines for the therapist to weave mindfulness into treatment with aspects of CBT and psychodynamic therapy. I conclude with some cautionary notes regarding the use of meditation in therapy.

Main Elements of the Model

There are four main elements in this integrated model that form the basis for improving people's relationships with panic. They arise in therapy out of the interweaving of Buddhist psychology and meditation practice, CBT and psychodynamic therapy:

1. Awareness (of what is happening in each moment without a story attached, of where we get caught).

2. Connection (with a caring presence, with others who struggle, and to knowing ourselves more deeply).

3. Action (toward being in the world, even when experiencing extreme fear).

4. Compassion (toward oneself in one's struggle, allowing oneself to rest and care).
Integrated Therapeutic Model

Key

MM = Mindfulness Meditation
L-KM = Loving Kindness Meditation
CBT = Cognitive Behavioural Therapy
PDT = Psychodynamic Therapy
Background framework: Buddhist concepts

As mentioned earlier, within Buddhist psychology, the following characteristics are believed to underlie all phenomena: (a) suffering, (b) impermanence, and (c) no-self (Goldstein & Kornfield, 1987). These concepts are explored more deeply here, in order for the therapist to increase her understanding of their pervasiveness and how they bring her and those she works with, to greater acceptance and letting go.

Suffering. In order to deeply understand suffering, we must be able to see it in ourselves. Mindfulness practice helps us to connect with it directly and immediately. When we remove our daily distractions and pay attention, we see that many moments of our day contain frustration, irritation, judgment, disappointment, fear, loneliness, hunger, restlessness, sleepiness, boredom, physical discomfort or pain. It is important to familiarize ourselves with these states and see them clearly, as these moments of suffering drive many of our actions.

Dissatisfaction is pervasive in our lives and so is our drive to avoid it. Underlying this dissatisfaction is a hunger for connection, happiness, and comfort that is rooted in a fundamental, existential pain (Goldstein & Kornfield, 1987). We spend much of our lives distracting ourselves from this raw, painful place inside of us with our relentless hunger and avoidance.

Within Buddhist psychology, the source of suffering is attachment, which includes craving, grasping and aversion. Craving takes us out of the moment and puts us in a painful place where we are desperately wanting something that we don't have, believing that this will bring us happiness. This could be anything, a house, a relationship, a certain job, good health or a peaceful mind. Grasping involves clinging to what we have or feel in any given moment. Those who experience intense anxiety and panic often desperately want moments of calmness to last. Yet, nothing is worth grasping because nothing lasts, and so we suffer when it changes. Individuals who have recurrent panic often come to see panicking as part of their identity, which can negatively affect their self-esteem, their beliefs about themselves in the world and their ability to cope and to change. Mindfulness practice can be especially freeing for these individuals as they come to see that panic is not who they are.
Aversion is wanting things to be different. Yet, the more we want things to be other than they are, the more we suffer. A lot of energy goes into trying to avoid experiencing unpleasantness and we may even believe that we can't stand it, especially when it comes to the extreme unpleasantness of panic states. It can become difficult to separate out the actual experience from our judgments about it. Mindfulness meditation offers us a practice in which we can make this separation.

Impermanence. As we begin to see how we relate to suffering, we also become aware of its impermanence. According to Kornfield (1995), "no state of mind, no feeling, no emotion actually lasts more than 15 or 30 seconds before it's replaced by some other one" (p. 99). This concept can come as a great relief to those who panic, as their terror feels unendurable and each moment, interminable. It is also a useful concept for those for whom anxiety precedes panic. Through mindfulness meditation, these individuals learn to gradually increase their awareness of subtle, early signs of anxiety, name this state and observe it change. For example, as they look closely, they see that anxiety is no longer present; it has been replaced by another feeling, perhaps by restlessness or self-pity. They observe this for a while and notice it turn into anger, or maybe frustration, then thinking, and finally, relief.

It is easier for all of us to be with a difficult emotion knowing it is going to change. Bringing clients' attention to the fact that all things change—from rivers and tides, to trees, mountains, people and relationships— opens up the possibility of beneficial change occurring for them (Groves & Farmer, 1994). Discussing change helps to shift emphasis away from static concepts of personality and a solid view of the self and toward a more fluid nature where clients see themselves as making choices (Groves & Farmer, 1994; Mahoney, 2003?).

No-Self. As Kornfield (1995) notes, there is no "self" to whom experience happens, no "self" that is separate from the flow of experience. In order to keep the sense of self or I, we continually fabricate thoughts and plans and automatically string them together to form a sense of a solid self. But when we are quiet and the mind settles, as in meditation, there begins to be some spaciousness between those thoughts. As our thoughts begin to disappear, we may become anxious and afraid, feeling as if we are disappearing. And so the mind becomes active again, grasping at thoughts, plans and opinions. According to
Kornfield, "our sense of self is created by our thought process and by the habit of grasping in the mind. If we are not caught up in all our thoughts about our experience, there is simply experience in each moment" (p. 145).

Through meditation, we begin to see how sensations, thoughts and sounds arise and pass away of their own accord. We do not ask for these thoughts to arise, nor do we control them. Similarly, there's no enduring or possessable self controlling our senses; we are simply a flow of the changing processes of our bodies, feelings, perceptions, reactions and consciousness (Kornfield, 1995). From a Buddhist view, identification with these processes is false and is the cause of our suffering. People who panic are used to identifying with the thoughts and feelings that accompany a panic attack and mistakenly take them to be their true self. Opening to the sense of no-self, however, can lead to feelings of humility, interconnectedness and liberation.

It is only when we recognize and accept the characteristics of suffering, impermanence and no-self, that we can become free and truly know peace. But we are constantly running, afraid to look at the difficulties of our lives directly. We are afraid that we will be overwhelmed by our fear, sadness, pain, attachment and greed, and we think that we have to keep our dark side under control (Kornfield, 1995). But these mind states arise from the mistaken belief that there is a separate self that we need to defend and make complete and secure. We think that we are surviving because of our cleverness and heroic efforts when we are actually surviving in spite of them (Andrew Feldmar, September, 1991, personal communication). Through meditation practice, we open to trusting that we can be with things just as they are—unsatisfactory, impermanent and without self. We don't need to exhaust ourselves by putting up a false self, trying to fill a constant neediness and constantly running from our fear. We can let be.

**Foreground of Model**

The weft of the therapeutic model is made up of the therapist's and the client's mindfulness and loving kindness meditation practice as it weaves through the basic Buddhist concepts. The weft is also comprised of aspects of both CBT and psychodynamic therapy that alternate with each other as well as with mindfulness and
loving-kindness practice as they are integrated into the conceptual framework. (See diagram on page 24.) Although the diagram depicts a specific order of alternating practices and therapies along the vertical axis, these are guidelines meant to be adapted by each therapist in each client interaction. For example, some clients who are highly self-critical may benefit from focusing mostly on loving kindness in their meditation, for a period of time. Others may not relate to that particular practice, yet connect with feelings of compassion toward themselves through mindfulness meditation or through psychodynamic therapy. Thus, each client-therapist tapestry is uniquely and flexibly woven according to each client-therapist interaction and according to the client’s needs at that point in time.

**Why Does the Therapist Need to Meditate?**

When therapists are dedicated practitioners of mindfulness and loving-kindness, they bring this energy into the therapy session. They are engaged in an ongoing practice that includes facing their demons and their intense emotions without moving to hide them or push them away. They continually face themselves and their process in their daily practice of self-awareness. The practice increases the likelihood that they will notice when they are not being present for themselves or with their clients’ process. In addition, practice in loving-kindness helps therapists to be more open to the client in her struggle and enables them to extend heartfelt compassion and deeply connect with the client. Mindful therapists bring a calm and grounded presence, as well as practice in being attentive, alert, nonjudgmental, curious and compassionate. They do not need to know the "answers" and can sit with the clients’ questions, thereby providing a more balanced meeting ground than is found in therapies that call for an expert.

Another reason for therapists to meditate is that, through meditation, they cultivate complete acceptance of themselves as they are. They learn to tolerate discomfort. They also learn that meditation isn't just about feeling good, that even experienced meditators experience psychological and physical pain (Chodron, 2001). As they learn to relax and be tender with themselves, meditation becomes a transformative process where they begin to let go of harmful patterns. As they learn to let go, they are more able to support their clients in doing the same.
As therapists, we first benefit from practicing being fully present for ourselves. If we are not fully present, Thich Nhat Hanh (2002) submits that we are usually running, running out of fear of losing our relationships, our employment, our homes, our money, our health and our sanity. People who panic often fear disconnection of a spiritual, psychic, or physical nature and are running from moments where they feel profoundly disconnected and alone. Meditation practice directly addresses this disconnection by reminding us to connect with this moment, this breath, this feeling, this conversation. As we ourselves become more aware and learn to face our demons and weaken our self-destructive patterns, those we work alongside will sense the quality of presence we bring to our sessions. As Thich Nhat Hanh notes, "to practice means to use our intelligence and our skills to make nourishment and transformation possible in ourselves, engendering nourishment and transformation in the people around us" (p.117).

What Therapists Learn through Meditation Practice

Mindfulness meditation helps to cultivate numerous qualities of mind that provide a grounding for working with fear and panic, be they our own or our clients'. With regular practice, we learn to (a) stay, (b) be in the body, (c) tolerate discomfort, (d) be patient and gentle, (e) see clearly and (f) have humility. Although these qualities are cultivated in meditation, they gradually begin to extend into how we live our lives and practice therapy.

Staying. In meditating every day under all sorts of conditions, we learn steadfastness. We learn to be able to stay present with ourselves whether we are in a good or a bad mood, whether we are feeling ease or pain, whether we feel our meditation is going well or not. Even if we feel like bolting out of boredom, agitation or pain, we acknowledge the urge and observe it as thinking, without judging it. Chodron (2001) notes that we all discover an inherent restlessness when we meditate and, if we manage to stay rather than run from the room, we learn not only about ourselves, but what it is to be human. All of us would rather dwell in the security of our fantasies and memories rather than stay with the nakedness of our present experience.

Learning to stay is also important because many of us make ourselves so busy that we don't know how to stop. "But if we have not stopped, if we have not learned to
concentrate, then we cannot look deeply" (Thich Nhat Hanh, 2002, p. 110). Mindfulness meditation allows us to stop, calm ourselves and really be present for our lives. Moreover, the stopping allows us to look deeply into ourselves and to accompany our clients in doing the same. As we learn to stay with our emotions in the most challenging situations of our own lives, we come closer to being able to stay with clients who are experiencing intense emotion and difficulty. We also come closer to understanding what it might be like for a client to stay present during extreme anxiety or panic.

**Being in the body.** We begin our meditation by attending to the sensation of our feet making contact with the ground, the weight of our bodies on the chair or the cushion, the alignment of our spine through to the top of the head, and the placement of our hands and arms as they make contact with our bodies or the chair. Through this process of grounding through the body, we bring ourselves into the room and into this moment. We then turn our focus to the breath and how we experience it in our bodies, attending to it as though we are feeling it for the first time. In this way, we learn to cultivate an observing stance toward the natural processes that occur spontaneously in our bodies. As various body sensations arise, we note them, and if they are the most salient aspect of our current experience, we open to them with a gentle curiosity. We learn to allow a full range of sensations and to observe how we get caught in our attachment and our aversion to them. In addition, as we become more steadfast in our practice, we find ourselves to be more in our bodies. Being in our bodies helps us to be more grounded in the present and decreases the likelihood of spinning out in our thoughts. Practicing this skill helps us to be more grounded in our interactions with our clients and enables us to model and teach this skill so our clients can use it throughout their day and increase the likelihood of being able to call upon it during intense anxiety.

**Tolerating discomfort.** When we meditate, we try not to make any volitional movements with small amounts of discomfort. In so doing, we are able to observe the arising of a type of fear, in this case our fear of experiencing pain or discomfort. We learn that we don't have to act on it simply out of habit, but can learn to decondition ourselves. Goldstein (1990) suggests we ask ourselves, "Is comfort the measure of what I do?" In committing to mindfulness practice, "We discover that we can face not only personal difficulties but even 'heaven and hell', as the Buddha put it, and survive" (Kornfield,
It is only in learning to face our own hell that we can expect our clients to face theirs. Furthermore, although therapists do not necessarily discuss this experience in words, clients feel instinctively safe and supported in the presence of one who is willing to face her own hell. It also makes it easier for clients to discuss their own experience of hell. They see that their therapist is not immune to being with their own intensely challenging thoughts and emotions.

*Being patient and gentle.* Some meditation teachers liken the training of our minds to training a puppy to pee on newspaper (Chodron, 2001; Kornfield, 1993). Both our minds and puppies benefit from being repeatedly and patiently handled with gentleness and caring. Through practice, we learn to tend to all that arises with compassionate awareness. And, "once we can name [our inner] demons as they come and go, our heart can hold them more lightly" (Kornfield, p. 104). Thich Nhat Hanh (2001) suggests that we do this by acknowledging our habits of mind, including anxiety, with humor. Hahn recommends that we smile as we breathe in and out with the phrase "Oh, my dear little habit energy, I know you are there!" (p. 112) As we become increasingly patient and gentle with ourselves, we are more likely to feel this way toward our clients. Again, modeling this behavior in interactions with our clients helps them to learn another way of meeting what is difficult to accept themselves.

*Seeing clearly.* In meditating, we learn to name our experience. This is the first step in allowing us to bring wakeful, conscious attention to our difficulties as well as our pleasures. "Mindfully naming and acknowledging our experience allows us to investigate our life, to inquire into whatever aspect or problem of life presents itself to us" (Kornfield, 1993, p. 84). We gradually begin to notice what brings about particular experiences and thus can respond to them more skillfully. According to meditation teacher Chodron (2001), "we won't be free of self-destructive patterns unless we develop compassionate understanding of what they are" (p. 25). Bringing conscious attention to our clients' difficulties helps us to see what conditions may be causing them anxiety. Bringing conscious attention to how we are as therapists and enables us to observe where we may and may not be helpful to our clients.

*Humility.* Meditation practice also brings a sense of humility. In practicing meditation with others, we soon learn that no matter how motivated we are to remain present, we all
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grapple with wandering mind and physical challenges. We all struggle with a range of emotions and find ourselves caught up in memories and fantasies more than we care to admit. We realize that no one is exempt from suffering and that everyone is worthy of attention and care; We know firsthand how much effort it takes to be present at the best of times and that we are asking our clients to be present in moments that feel like hell. Finally, we open to seeing and admitting our own shortcomings as therapists and touch in to the incredible honour of walking alongside our clients on our journeys.

**Working with our Anxiety, Fear and Panic**

The therapist needs to learn to work with her own anxiety and intense fear, regardless of whether or not she experiences panic. Fear and anxiety are part of life and thus, practice in working with them is ongoing. Once the therapist has some experience facing these in herself, she is more able to witness and work with them in others.

According to meditation teacher Goldstein (personal communication, September, 1990), the most important quality that we need to cultivate is to recognize fear in our minds when it arises. A good place to practice this is during meditation, when we have slowed the pace of our lives and have some quiet in the mind. In recognizing fear, we also need to come to a place of acceptance because if we are afraid to feel it, we never get to a place of going beyond it. Instead, we become caught up in it and contract. Goldstein counsels us to be with our fear the way we would be with a child who was afraid. We wouldn't blame the child or feed her fear; we would be present, loving and caring. This allowance and caring gives space for the fear to begin to decondition, little by little.

We can also learn to investigate the nature of the fear itself. Instead of solidifying our fear and ourselves as a fearful person, we can practice opening to the feeling and looking very carefully at the nature of fear. In so doing, we make an interesting discovery. We learn that fear is just a mind state like any other mind state, such as boredom or sadness. We begin to see that fear is a conditioned state that is essentially empty. It has no substance or power other than what we give it. Of course, as Goldstein (personal communication, September, 1990) notes, it takes a very balanced mind to understand the transparency of fear and this takes practice. But once we understand it, we are never quite
hooked in the same way; it may still arise and we may still get caught, but we come to a
different understanding of it.

Another way to work with fear is to counter anxious and fearful feelings with their
opposite, in an effort to quickly balance them out. From a Buddhist perspective, the
opposite of fear is love. Practicing loving-kindness and compassion for oneself and others
helps to dispel fear. If we are really caught in the fear and don't have the strength to face
it directly, or if we are experiencing intense fear that feels overwhelming, Goldstein
(personal communication, September, 1990) proposes that we can change channels.
Through practicing loving-kindness, it becomes obvious that fear is just a conditioned
state arising because of certain conditions (see Salzberg, 1990, *Loving-Kindness*, for
instructions on this meditation). As we change the conditions, fear abates. Of course, the
more we practice connecting to feelings of love and compassion, the more we can call
upon them in times of suffering. In using this practice in the face of fear, we are
combining the distraction technique of CBT with a conscious opening of our heart
through a form of Buddhist meditation.

**Weaving It All Together: An Integrated Approach to Therapy**

Therapy typically begins with establishing rapport and eliciting information from the
client regarding the occurrence of panic in her life and her relationship to it. Some clients
report experiencing anxiety building before finding themselves in a full blown panic
attack, whereas others describe being suddenly and unexpectedly overwhelmed by panic,
and still others experience a mixture of both types of onset.

The therapist might then discuss the Buddhist view of the universality of fear and
suffering, thereby normalizing their occurrence in life while validating the extreme
discomfort of experiencing panic. The therapist can bring in as little or as much Buddhist
content as she wishes, in accordance with the client's interest. Buddhist concepts and
practice can be presented as an aspect of the ancient wisdom traditions, mindfulness-
based stress reduction (MBSR), or as a scientific practice that encourages
experimentation and investigation. Basically, an early message to impart to clients is that
they don't have to fix anything or make anything go away, but may want to start paying attention to aspects of their life of which they have been previously unaware.

Although the client is seen individually, she is strongly encouraged to enroll in a meditation (or MBSR) group at the same time. Therapists can explain that studies show that practicing mindfulness meditation helps to decrease the frequency and intensity of panic attacks over the long term, empowers the client and can also increase her quality of life (Kabat-Zinn et al., 1992; Kutz et al., 1985; Miller, Fletcher and Kabat-Zinn, 1995).

Meditation groups are held in major cities and in numerous small towns across North America. Where an individual cannot make it to a group, a series of guided meditation tapes can be ordered (see Appendix B). Therapists can also schedule a portion of each individual session for instruction and practice. Being in a group with others who experience stress and anxiety helps clients to feel a sense of belonging, experience the universality of suffering and helps support them in their ongoing meditation practice. However, most of the participants that clients will encounter in meditation groups will be dealing with a variety of challenges and not necessarily panic. Therefore, one of the roles of the therapist is to help clients who experience panic to understand how mindfulness meditation practice benefits them, and to help them adapt the practice to their particular concerns and integrate it into their lives.

In the first session, therapists spend a few minutes with the client following the breath (see Kabat-Zinn, J., 1990, Full Catastrophe Living for instructions). Generally, meditation teachers (personal communication, Baraz, September, 1984; personal communication, Wilson, July, 1992) teach that following the breath at the abdomen tends to help people “be in their bodies” and be more grounded, whereas following the breath at the nose can encourage people to “be in their head.” However, if following the breath at the abdomen causes the client anxiety, there are a variety of options. One is to simply follow the breath as it passes through the nostrils. Another is to vary awareness of the breath at the abdomen on one breath and at another touch point on the body for the second breath (such as the hands or feet). After the meditation, the therapist elicits feedback on the experience, modeling a spirit of genuine curiosity and inquiry.

Beginning each therapy session with a few minutes of meditation allows clients to become more aware of a different mode of being. It allows them to move into “being”
mode rather than "doing", and helps them to focus on the present moment. Also, it is helpful to ask the clients for feedback immediately following the meditation in order to bring their attention to the moment before they delve into their experience of the past week. The therapist does not give the clients any "answers;" She is more likely to offer a few suggestions while encouraging them to experiment and see what is helpful for them. In this way, the meditative process provides clients with an experiential problem-solving base for learning, one where they come to see that they are the experts on themselves.

**Avoidance.** The therapist and the client determine whether the client has been avoiding particular places and situations, and if so, which patterns of avoidance are most problematic. They agree to work on the avoidance behaviours that are most seriously interfering with the client's life. Thus, while for one person the inability to get to work may be problematic, for another it might be staying at home alone. Therapists attempt to help clients' balance accepting whatever is happening in each moment with taking action toward expanding their world of experience.

**Interoceptive Exposure.** For clients who are fearful of the somatic sensations experienced during a panic attack, therapists may introduce interoceptive exposure (Barlow & Craske, 1990). This is a CBT technique that involves purposely reproducing the internal sensations of panic in a safe setting in order to desensitize clients. For example, clients who feel dizzy during a panic attack and fear passing out might practice spinning in circles. Those who feel as though they are suffocating can practice breathing through a straw. Clients come to see how these sensations arise, that there is no mystery to them, and that they pass away. They can observe the thoughts that tend to accompany their feared sensations and, without needing to argue against them, come to see the transparency of these thoughts.

Mindful observation requires less striving than the CBT technique of coaching oneself with such messages as "I can control it" and doesn't place added pressure on the client to control feelings she cannot control. She learns to surrender to them and observe them from a safe distance. The therapist remains present during these exercises and can remind the client of her mindfulness tools. Valuable learning can take place through interoceptive exposure whereby clients come to see that the body sensations arise from their own doing (i.e. spinning, hyperventilating) and that the accompanying feelings and
catastrophic thoughts are simply created in their own minds in response to certain physical sensations.

*Homework.* As is common with CBT, homework is assigned each week; however, the intention behind the assignment is different from that in CBT. In CBT, there is an assumption that there is something wrong with the client that needs to be fixed whereas in mindfulness meditation, the assumption is that clients need to go and sit and open to what is, and accept it.

Clients are asked to practice following the breath for 5-10 minutes each day, gradually increasing the duration each week until they are meditating 45 minutes or an hour each day. Also, from the first week, clients are encouraged to bring mindfulness to a daily activity of their choosing. For example, they may elect to pay close attention to preparing or eating a meal or washing the dishes. It is beneficial to initially choose an activity that is emotionally neutral and observe what happens when mindfulness is brought in. This daily exercise helps to ground clients in what are often viewed as the mundane activities of their day, encouraging them to pay attention at times when they usually operate automatically. Many will likely find that most moments and activities are not so neutral in tone when they are fully present for them.

*In Vivo Exposure.* Regular exposure is also assigned and clients are encouraged to be in the world without retreating, being curious and observing their reactions. An important role of the therapist is to encourage regular meditation practice, an activity that requires persistence and discipline, as it is not always pleasant. However, people experiencing recurrent panic are often motivated to do whatever it takes to move toward a centre of calm and the therapist can be a powerful model in this regard. The therapist’s modeling of complete acceptance of themselves and their clients as well as their grounded and compassionate nature will go long way toward motivating clients to practice. Clients are encouraged to balance being and doing, and to stick with their practice even when it is difficult. They are also encouraged to voice to their difficulties and resistance and come to see how these are part of their process. With continued practice over time, clients are taught to broaden their attention from focusing on the breath to include body sensations, sound, thoughts and emotion.
Working with the Body

Body Scan Meditation. In order to help clients develop a greater awareness and acceptance of their bodies, therapists may choose to teach clients the body scan (Kabat-Zinn, 1993) meditation in the second or third session. (See Kabat-Zinn, 1993, Full Catastrophe Living for a full description of the body scan). Developing a greater awareness of their bodies will help clients to better deal with their emotions. The body scan is a guided meditation in which detailed awareness is systematically brought to each part of the body. Some clients who panic are hypervigilant of their body sensations and are reluctant to engage in an exercise that will increase bodily awareness. However, these clients are often hyperaware of physical sensations related to anxiety while being oblivious to others and lack the flexibility of mind to move their attention to more neutral sensations or to their bodies as a whole. In addition, critical judgments or catastrophic stories frequently accompany certain bodily areas and sensations. Clients are encouraged to attend to each area of the body only for the minute they are directed to do so and to acknowledge any thoughts that arise and just observe them, softly allow them, and let them go as they move on to the next area of focus. Clients learn to keep their attention focused over a sustained period of time and begin to develop concentration, calmness, flexibility of attention and mindfulness.

Embodying Emotion. Therapists help clients become aware of how people’s bodies literally embody their emotions and respond to their thoughts. At times, clients may be unaware of their thoughts or emotions and find their shoulders hunched, their chests tight, or their stomachs in a knot. Yet what happens in the body also affects the mind; their bodies can be part of a feedback loop that maintains certain states. For example, heightened body tension can make them feel more anxious, stooped posture can make them feel like they are already beaten and encourage them to retreat in fear. Yet, the simple act of bringing awareness to their bodies changes their experience, and is powerful practice.

In addition to attending to body posture, therapists can direct the client’s attention to the breath as a way to bring mindfulness into a session. Kornfield (1998) notes that individuals often hold on to the out breath when they are anxious, which only increases anxiety; by asking clients to pay attention to this holding, the anxiety is often released or
they are able to get in touch with the energy or excitement that is being held back. Unlike cognitive behavioral therapy, they are not asked to change the breath or control it, but just to pay attention. In this way, the client is not made to feel that they are doing something wrong, nor that the therapist is an expert who tells them how to do it right. Simply bringing awareness to their breath changes it.

Bringing attention to the body is helpful for clients who often try to think their way out of their troubling feelings. This is common for people who panic. They try to figure out why they panicked, what triggered them, and how they can prevent it from happening again.

An alternative is to bring awareness to manifestations of emotions as physical sensations or felt senses in the body. In time, this allows a shift of the centre of gravity of attention away from "being in the head," toward an awareness of the body. It offers the prospect of coming at emotion from a fresh perspective, honing in on a new aspect: "how am I feeling this in my body." (Segal et al., 2002, p. 111).

Helping clients to pay attention to and “be in their bodies” thus provides an additional place from which they can observe and relate to their thoughts and feelings.

Clients may report difficulties in meditation related to problems staying awake or physical discomfort and therapists can encourage them not to worry about them or let them take control. Similar reactions arise in daily life anyway and this is a place to learn to handle them without letting them rule their lives. Working with difficulties also provides an opportunity to relate to thoughts and feelings as mind states rather than identifying with them.

Walking Meditation. Walking meditation is a very useful practice and is essentially a meditation in motion (see Appendix E for full instructions). It helps to bring awareness to the body in motion and is especially helpful for clients to help them ground themselves. When feeling too agitated or anxious to sit and watch the breath, moving mindfully can help clients to settle and to anchor themselves in the moment. Some find it helpful to slip off their shoes to increase their sense of connection with the earth, focusing on the muscles of their feet, the transfer of weight, and the sense of balance. Another exercise that can help clients to come into their bodies and ground is balancing on one foot and breathing into their dynamic centre of balance (see Mahoney, 2003, for full instructions).
Thoughts

Through their meditation practice, clients often realize that they live much of their lives on automatic pilot, going through most activities of the day without being present for them. When they are on automatic pilot, they are less likely to notice fragments of negative thinking that may be connected to patterns of anxiety and panic. However, by the time these thoughts and feelings come into their consciousness, they may be too strong to deal with easily. For this reason, teaching our clients to become aware of when they are on automatic pilot and intentionally stepping out of it is an important first step. According to Segal et al. (2002), the wandering mind can be particularly hazardous when one's mood is sinking and associations and memories are likely to be negative. Being aware of this stream of association helps us to be able to intentionally disengage. Clients may be lessening the richness in their lives by not being present for what is pleasant and may be missing opportunities to take skillful action by not being aware of unpleasant thoughts creeping up on them. They gradually learn that deliberately bringing awareness to their experience changes it; it may enrich it or make them aware of things that had previously gone unnoticed. Although they cannot control what comes into their minds, they can choose how they respond.

Once our clients are beginning to work with thoughts in their practice, it may be helpful to remind them that we're not trying to create a specific state of mind, since all states are always changing anyway. Nor are we asking them to turn off their thoughts. We are simply presenting them with an alternative way to relate to their thoughts: "seeing them as they are, simply, streams of thinking, events in the mind, rather than getting lost in them" (Segal, 2002, p. 134). In so doing, they learn how to work with their minds and bodies to see how they get trapped by their fears and wants and how they can directly experience freedom.

Without analyzing specific thoughts, the therapist encourages clients to observe how certain thoughts and feelings feed off each other and create negative spirals. For example, the thought "what if I panic?" may lead to increased heart rate, leading to the thought "I'm losing control," to feeling dizzy and "unreal", to imagining that they have lost touch with reality and are utterly alone, and so on. By increasing their skills of observation and awareness, clients come to realize the seductive pull of habitual patterns of racing
thoughts that take them out of the moment. Therapists can assist in highlighting how this process happens and challenge them to catch themselves earlier in their spirals. Learning to disengage from old habits of mind is one of the core skills of mindfulness practice. Unlike with CBT, clients learn to let go of the need to respond to the content of thoughts or to reassure themselves through denying their validity. Clients are reminded that thoughts are only thoughts. They can be present with them but they don't have to believe them or act on them in their usual ways. The more individuals are aware of how their attention moves about and how they get caught, the more they experience choice.

As with many things, it is helpful to start small. It may be easier for clients to see how they get caught by working first with thoughts unrelated to panic. For instance, they may begin with observing a thought like their favourite food is in the kitchen. Although their normal habit may be to get up from whatever they are doing and go and eat the food, they realize they are free to simply observe the thought without being compelled to act on it. It can be very freeing for clients to experience having a choice in whether to react, or to respond. Reacting would entail getting up automatically and eating the food, perhaps without even being aware of it. Responding from a place of mindfulness means they are aware and take responsibility for their choice. Clients are encouraged to observe their thoughts and reactions both while meditating and throughout their day, gradually opening up more to thoughts that cause them anxiety.

Therapists assist in observing and normalizing some of the clients' sources of suffering, including craving, grasping, and aversion. In the context of anxiety and wanting to avoid experiencing another panic attack, the client naturally craves a sense of security, calm and groundedness. She clings to comfort, safety, home and what is known, and has an aversion to anxiety as it can precede panic and resembles some of its symptoms. And so she avoids places where she feels panic and/or disconnection.

When anyone experiences the terror of a panic attack, they understandably want to be anywhere and feeling anything but what they are feeling. The feeling of wanting to flee the situation is so incredibly strong because we are all evolutionarily wired to run from danger and seek safety. In this case, where there is no actual danger, the client needs to override her wiring and get some distance from her racing, chaotic thoughts and electrified body. This is not easy. The client has to go against her most basic instincts.
It is important for therapists to continually validate the courage and discipline that it takes to stay, over and over again, in the face of terror and ride out the storm. It is highly likely that clients do not get this validation elsewhere. They are often deeply ashamed of having difficulty doing what is so easy for most people that they live alone with their fear and thus, their successes as well. Clients will at times be exhausted and therapists need to encourage them to practice good self-care.

Therapists also need to engage the client in discussing barriers to practice and to normalize the challenges in maintaining their commitment. Maintaining a meditation practice is hard work and there will be times when clients feel like quitting, especially if they feel like they are not seeing immediate "results". Practice requires patience, gentleness and loving kindness toward oneself and toward the experience of anxiety and panic. It mindfulness practice also entails working gently at one's limits without pushing too hard to break through. As Kabat-Zinn (1990) notes, breakthroughs will come with bringing in energy that embodies a spirit of self-discovery. It is natural to encounter resistance to meditation practice and to being with uncomfortable states. The best way to work through resistance is not bulldozing our way through, but by working gently at its edges, if only for five minutes a day.

Working with Feelings and Reactivity

Buddhism teaches that it is possible to learn a new way to be with one's feelings (Epstein, 1995). When we sit in meditation, we are made aware of the bare workings of our day-to-day minds. It is not long before we become aware that our minds are in a state of reactivity much of the time. We identify with our reactions, experiencing ourselves as victims of a frustrating outer world or an overwhelming inner one. We notice that we are constantly judging our experience, liking or disliking it and trying to get more or less of it. This is just what the mind does; it is not personal (Kabat-Zinn, 1990; Kornfield, 1993).

As we practice, we gradually learn to separate our reactions from the actual events around us; we move from identifying with our fear to being able to observe it with the same dispassionate interest as anything else. The practice allows us to contain our difficult emotions and reactions rather than running away from them. In sitting with nonjudgmental awareness, we allow space for our reactions without completely
identifying with them. We become our own caring witness, holding the space that helps us to contain our anxiety, without being anxiety. We also begin to see that everything changes, moment to moment. We start to witness the impermanent nature of phenomena. Anxiety arises and panic occurs, accompanied by a whole stream of frightening thoughts and images, and then passes away. As we practice staying with our painful emotions, we build tolerance (Kabat-Zinn, 1990). In meditation, we practice staying with all emotions, physical sensations, whether pleasant or unpleasant. As we practice being with boredom, restlessness, grief, intense physical pain, we are training ourselves to stay present during difficult moments, which is useful when anxiety rapidly escalates to panic. We practice being with low levels of anxiety and gradually move to more intense levels. It is extremely difficult to stay present during a panic attack, but the more we practice outside of a panic state, the more we are likely to be successful. It requires a great deal of discipline, strength and courage to stay present in one's body and mind when powerful sensations, thoughts and images threaten to overwhelm and urge one to immediately escape a situation at all costs as impending disaster, disintegration or death seem to await.

Epstein (1995) suggests that most people don't really understand the extent to which our emotional states are physical experiences (Nisker, 1998). The most common defensive strategy is to move away from physical sensations and go to the mind to figure out how to manage the situation (Winnicott, cited in Phillips, 1988). With the autonomic arousal arising during a panic attack, we will commonly look to the outer environment to search out safety cues. However, in jumping too quickly into thought, we become distanced from critical aspects of ourselves. Through mindfulness and therapy, we have a practice ground to experience the complexity of our emotions and our physical being, allowing our emotions to become more understandable and tolerable.

**Bridging Mindfulness and CBT: Wise Mind**

A useful concept to introduce to clients is borrowed from Linehan's (1993) dialectical treatment. Linehan suggests to clients that we essentially have three states of mind, including reasonable mind, emotion mind and wise mind. We are in "reasonable mind" when we are thinking rationally, whereas in "emotion mind" we tend to distort the facts to achieve congruency with the intensity of feeling we are experiencing. However, when
we are in "wise mind," we are integrating "reasonable" and "emotion mind" and adding an intuitive knowing which goes beyond what is received though our senses and doesn’t rely on intellectual analysis (Linehan, 1993).

Clients can connect with a sense of "wise mind" through following their breath at the belly. After a time of focusing their attention in this way, Linehan suggests leading clients to settle into their physical centre at the bottom of their inhalation. With practice, clients develop a centre of calm from which they can respond when anxiety is escalating and cognitions are "hot". In those moments, they cannot logically analyze what is happening and their intense emotions are affecting their perceptions. By letting go of these familiar modes of knowing, they can learn to refocus and drop into "wise mind". Some examples of wise mind include the sense of calm that follows a crisis or a period of intense upheaval, the experience of suddenly getting to the heart of a matter, and the feeling of grasping the whole picture rather than individual parts; it is a “feeling that comes from deep within rather than from a current emotional state” (Linehan, 1993, p. 215).

Another helpful way to access wise mind is to ask clients if they know that place inside of themselves that knows that everything is okay and to tune in to that place. It can also be helpful for clients to ask themselves what they know to be true in their wise mind (Linehan, 1993). For example, if a client is feeling fearful about traveling a certain distance from home for fear of panicking and going crazy, she can tune in to what she knows to be true. She knows that she is not in any true danger, that she has panicked before, that the panic has always ended and that she has never gone crazy. This is similar to the CBT approach of challenging one's irrational beliefs except that the knowing is generated from one's physical centre.

**Taking stock.** Clients may find that as they increasingly tolerate a range of painful emotions, that their panic attacks begin to wane or that their relationship with panic has improved in that they are less identified with it. They may begin to realize that the awareness of anxiety and terror itself is not anxious or afraid (Kabat-Zinn in Brantley, 2003) and this awareness itself is their anchor. Armed with their tools to help them with any future panic attacks, they may choose to end therapy at this point, knowing that they
can return for a refresher or to examine any issues that may have arisen. Some, however, may recognize a need for something more in their therapy.

**Weaving in Elements of Psychodynamic Therapy**

Over time, some clients may begin to see patterns in their mind states and may want to explore these at a deeper level with the therapist. Some may experience conflict between different parts of themselves; some may wish to explore issues in their family of origin. In addition, through listening attentively to clients, therapists may come to see that some individuals may be operating from certain illogical beliefs that they may have unconsciously adopted as children. The therapist then begins to reflect to clients the ways in which their unconscious may be contributing to their anxiety and panic.

Memories of forgotten events can sometimes surface during meditation or in the therapy session. Some of these may be of a traumatic nature while others may be about "nothing happening when something might profitably have happened" (Winnicott, 1974, p. 106). From a psychodynamic viewpoint, clients benefit from recalling and integrating memories of both trauma and neglect. However, non-traumatic memories of neglect are more often recorded in the body than in verbal memory and need to be re-experienced in order to make sense of them (Epstein, 1995). Non-traumatic memories often present as feelings of emptiness, alienation and low self-worth with clients reporting more diffuse body sensations than those who have experienced a specific trauma (Epstein, 1995). As clients attend to sensations in the body through meditation, their practice can help to highlight areas in need of more therapeutic attention.

Therapists assist clients to stay with their uncomfortable physical feelings by remaining present to them and by asking questions that help them to gently touch sensations in the body. Therapists ask clients to close their eyes, follow their breath and tune into the area of discomfort. They inquire about the temperature, texture, colour and size of the area. The therapist might ask them if they can soften around the edges of it and allow it as much space as it needs. Chronic holding patterns in the body can be with us from childhood, yet often remain outside of our awareness. However, when one's attention is concentrated, areas of contraction in the body become particularly visible,
especially those places where fear has taken hold. Although the trauma has passed, clients come to realize how they have kept it alive in their bodies.

Both psychotherapists and meditation teachers stress remembering, however, in the case of meditation, it is remembering in each moment to return to the present. Freud (1958) saw that "studying whatever is present on the surface of the patient's mind," (p. 147) could be important in terms of making sense of an individual's history. While Buddhism does not place importance on the individual or on past revelation, memories are often important to attend to in order to integrate them therapeutically (Epstein, 1995).

According to Freud (1958), we rarely remember or experience the traumatic events of childhood and are much more likely to repeat behaviours in an attempt to repair or deny the original deprivations. Perhaps incidences of panic may be reliving some preverbal awareness of acute vulnerability or of premature disconnection, resulting in feeling intolerably alone. However,

"What is ultimately therapeutic for many people is not so much the narrative construction of their past to explain their suffering, but the direct experience, in the therapist's office, of the emotions, emotional thoughts, or physical remnants of emotional thoughts with which they are stuck. The feelings peek out of the silences and manifest their presence when the room becomes quiet" (Epstein, 1995, p.193).

The therapist creates an environment in which it becomes safe to experience feelings from an earlier time that were unsafe or not allowed. Helping them to work through their defenses against an unbearable hollowness or lack of connection, the therapist helps them to directly experience the terrifying emptiness that they are constantly fighting against. By reminding them to bring moment-to-moment awareness to these feelings over and over again, a gradual desensitization takes place whereby clients accept their losses and begin to make choices that nourish.

*Identification with pain and no-self.* An important step in assisting clients to stop repeating an earlier troubling experience is to address their identification with emotional pain. They may strongly identify with the story of someone who was emotionally abandoned and thus, identify with the associated feelings of terror as being who they are. Once the difficult, estranged feelings of the past are made present, clients come to realize
that the feelings are coming from their own being (Epstein, 1995). For instance, it is not
the current separation from a loved one that caused their recent panic attack, but it may
have triggered their own internal sense of disconnection. Through their meditation
practice and therapeutic process, clients begin to see that they write and direct their own
dramas (Kutz, et al., 1985). Gradually, clients learn that their terror is not them and that
they are so much more than their panic attacks.

Transference and countertransference. Transference and countertransference refer to
the reciprocal impact that the client and the therapist have on each other during the course
of psychotherapy (Lindy & Wilson, 1994). Clients often unconsciously relate to the
therapist in ways that mirror their own personal history, bringing unresolved,
unassimilated, and unconscious aspects of past events into the present. The therapist
needs to be attuned to the ways clients relate to her emotionally and behaviourally,
including casting the therapist in symbolic roles, such as that of a parent. Clients’
projections are therapeutically valuable as they gradually come to realize that the
projections belong to them and not to others. A similar process occurs in meditation
whereby clients strengthen their ability to observe and own their projections, thus
complementing and furthering the therapeutic process.

The therapist must also be aware of her own countertransference toward the client,
noting any emotional responses that arise from their reciprocal relationship during
therapy. The therapist’s meditation practice, in addition to ongoing supervision, helps her
to be aware of her own issues and be attentive to her reactions in relation to the client.
For instance, the mindfulness practice of noting when we find ourselves judging helps us
to note when we are judging and thus, distancing from our clients rather than connecting
with them as they are. Countertransference reactions are unavoidable and integral to a
therapist’s work; however, therapists need to be mindful of moments when these
reactions cause them to leave the therapeutic role and no longer connect empathetically
with their clients. According to Lindy and Wilson (1994), countertransference responses
can impede clients’ telling of a story, reproduce defenses from an earlier traumatic period
or bring out complementary elements of a traumatic memory that are too painful to
remember. It is very important to the therapeutic alliance to work through reciprocal
transference reactions, particularly for clients who experience intense feelings of
disconnection and danger due to panic. Clients need to be able to check out to their assumptions and name what is in the room. As transference is resolved and clients experience greater self-awareness, they become able to relate to the therapist as a normal human being and both parties are able to experience a greater empathic connection (Douglas, 1995).

The need to grieve for loss. Many individuals who have lived with panic for a long time have suffered a lot of loss over the years due to the numerous ways it has affected their lives. As clients begin to experience more quiet through their practice, they may also connect with their grief over lost opportunities related to health, family, relationships, travel, career, and over a lack of spontaneity in their lives, in general. Rather than distract or deny their experience, the practice encourages them to allow their feelings to be there. In times of grief, clients may benefit from practicing a compassionate meditation for themselves. This is practiced much like loving-kindness meditation, except that we connect with such phrases as, "I care about this pain" and "I care about this loss."

Practicing with Panic during Therapy

Once the therapeutic alliance is strong, most clients feel a sense of safety in the presence of the therapist, and do not panic during a session. However, in order to practice facing their intense anxiety, the therapist can suggest to clients that they intentionally bring to mind thoughts or images associated with their panic attacks. This is similar to the covert rehearsal of CBT, however the method of addressing the client's response is different. Once the client is experiencing anxiety, the therapist assists her in creating space around her fear. One way to create this space is to simply allow fear to be present, to acknowledge it and accept it. To do this, the therapist guides the client in taking an observing stance, using her breath as an anchor and getting some distance from the fear. The client is asked to note the fear without personalizing it. For example, she notes, "there is fear" or "there is anxiety", rather than saying "I am afraid" or "I am anxious".

The therapist then gently reminds the client to let go of the negative thoughts and to try to connect directly with the underlying energy in her body. Just as in meditation, the client practices letting go of any story line that may be arising (such as, "I am really losing it this time. I can't stand it. This is even worse than...") and leans into the energy
that she usually struggles against. In so doing, she trains in opening her fearful heart to the intensity of her own energy and learns to abide with her acute emotional distress. The therapist guides her to be curious about the size and shape of her changing emotions and body sensations. How big is the anxiety or restlessness? Allow the energy more space. Don't push it back.

One analogy that many meditation teachers use is to think of the intense emotion as being like a teaspoon of salt in a lake instead of in a bucket. When we expand the field of our awareness, we soften around the edges of our difficulty and allow it as much space as it needs. Another possibility is to think of panic as being like a wild horse in a stall; when we give it a wide pasture, it runs freely. Similarly, when we try to hold back our feelings, they buck and kick at our insides; yet, when we are spacious and allow the energy to be present, it runs through us more freely.

This process sounds simple, and yet is anything but easy. It is literally like driving in winter and suddenly hitting a patch of black ice. You lose all control of the steering and find yourself accelerating toward the edge of a steep cliff. In a fraction of a second, your heart is in your mouth and all of your instincts are simultaneously screaming at you to save yourself and veer away from the abyss. But then, somewhere inside your being, a small but steady voice says that you must turn into the skid, toward the abyss, in order to survive...Mindfulness involves opening to that small voice, over, and over, and over.

After practicing turning into the skid and opening to her terror in the company of the therapist, the client gradually practices on her own, first in a safe place and then, in the situations she fears. If the client is unable to get in touch with her intense anxiety in the counselling room, the therapist can accompany her into a feared situation and use the same techniques noted above.

From a Buddhist perspective, our fear is bottomless, and the way to transform it is to create enough space around it so that it can come and go on its own. Once the client learns that she can abide with her intense anxiety and panic, she gradually begins to give it less energy in relation to the rest of her life, grasps it less, and lessens her identification with it. Over time, she discovers that her anxiety is not who she is. She sees that it is just a collection of strongly conditioned patterns of thoughts, feelings and body sensations to which she has given a lot of power to run her life (Kabat-Zinn, 2003). Little by little, the
client realizes that she is larger than the habits that hijack her mind and body and that her “awareness of her anxiety and panic is not anxious at all” (Kabat-Zinn, 2003, foreword, xi).

**What to Do during a Panic Attack**

Although clients come to learn that thoughts and emotions arise and pass away, some states are more convincing than others. The intensity of fear that accompanies a panic attack is almost indescribable (Brantley, 2003). Making and keeping contact with such a noxious experience is extremely challenging as our natural tendency is to react or dissociate.

Some suggestions that the therapist can offer include:

- Stop. Stay where you are.
- Feel your feet making contact with the ground.
- Breathe with your experience.
- Be aware of what is happening and note it ("Panic is happening. That's all... no big deal... it passes.")
- Note each body sensation ("My heart is beating fast, there's pressure in my head and chest.")
- Note your thoughts simply as thoughts without believing or reacting to them. If you feel yourself getting lost in them, come back to the breath and increase your attention to it.
- Gently stroke your hand or cheek using whatever loving-kindness phrases you connect with ("May I know that I am safe, may I be peaceful.")
- Look at other people and try to tune in to a sense of connectedness with them.
- Breathe in and out with the phrase, "I am here, I am home." Thich Nhat Hanh (2002) suggests a similar phrase that helps to invite us to be fully present and reminds us that we are at home wherever we are.

Clients may find it helpful to write down those suggestions that are most meaningful to them and carry them on a cue card on their person for those moments when they most
need them. As they become more confident with facing fearful situations and staying present, they may notice that they are leaving the cue card at home.

General Steps for Clients

All of the above suggestions are not very useful without a regular practice to provide an anchor, a familiar and accessible place in which to ground oneself. Generally, clients are encouraged to:

1. Lay a groundwork—establish a daily mindfulness and loving-kindness practice. (It helps to calm the nervous system, create a habit of being curious and increases one's tolerance for staying with difficult thoughts, emotions and sensations.)

2. Ensure support for regular practice through group meditation. (It helps to keep motivation and discipline alive and nurture a sense of connectedness.)

3. Notice any emerging patterns and whether they need to make changes in their lifestyle and/or look more deeply into certain issues. (It helps clients to see the larger picture and to be accountable for the choices they make.)

A Word of Caution regarding Meditation: No Escape

As mentioned earlier, meditation practice is simple, but not easy. Sometimes, meditators can unwittingly use the practice to escape and repress their difficult emotions. This can even be the case with long-term meditators. The therapist thus has an important role in supporting clients to be, as much as possible, with their emotional pain rather than push it away. According to Trungpa Rinpoche (as cited in Chodron, 2001), emotions are a combination of thoughts and self-existing energy and our emotions cannot escalate without accompanying thoughts. As we note "thinking, thinking" and let go of the thought, it is important to be aware of whether there is an energy of wanting to push away thoughts that frighten us. Initially, there most likely will. However, with practice, we learn to let go of our internal conversation, and notice an underlying energy remaining. There is nothing harmful about that energy and our practice is to stay open to it. We can let the energy energize us and allow us open to our inner wisdom. As Kabat-Zinn (2003) notes, anxiety can be a great teacher and the lessons to be learned are profound. Yet,
transformation only occurs when we move toward our emotional distress without being critical of our experience (Chodron, 2001).

Before beginning meditation, clients should be notified that previously forgotten memories can sometimes surface during meditation practice. Of course, this can also occur during the course of various types of therapy, either within the session or outside. Combining meditation and therapy can make the therapeutic experience more intense for clients and bring in a wider range of material as clients become more self-aware through their daily meditation practice (Kutz et al., 1985).

**Strengths, Limitations and Future Directions**

One of the strengths of the model can also be viewed as one of its limitations. Notably, there is no discussion of spirituality, even though Mindfulness meditation and Buddhist psychology are deeply rooted in spiritual traditions. There are several reasons for this. Firstly, spirituality is difficult to define and has so many different meanings for different individuals that it was beyond the scope of this thesis to bring it into the model. Secondly, since clients have diverse individual and cultural backgrounds, they also have different frameworks for spirituality. Not defining spirituality in my role as a therapist or meditation teacher allows clients to bring their own meanings to their own experiences. Thirdly, some clients have an aversion to notions of spirituality. In teaching MBSR, I've observed that while some clients describe their experience as being spiritual, there are many who say they are drawn to the practice because it is not described as spiritual. Thus, although clients often experience increasing connectedness, acceptance, ease, compassion and love, not naming these phenomena as spiritual increases accessibility for those who are adverse to any notions of spirituality or to anything that may be perceived to be at odds with a particular religious faith.

The model is also limited in that it will appeal to only a small, but growing, niche of therapists. It requires a lot of training and knowledge on the part of the therapist in CBT, psychodynamic therapy and Buddhist psychology, in addition to flexibility and practical wisdom in integrating these with each other in treatment. Furthermore, use of the model demands a lot of discipline in terms of ongoing daily meditation practice and not everyone will be motivated to maintain this commitment over time.
In order to test the model, it would be useful to have several meditation practitioner-therapists use it in their practice for at least six months and have a researcher review the cases. The researcher could interview clients before beginning therapy, at six-months and again at 18 months in order to track changes over time, as their meditation practice develops. Clients could be asked questions related to their level of avoidance, self-esteem, hope, life satisfaction, identification with and attitudes toward their panic attacks. Interviewing therapists at the six-month mark for their perceptions regarding the client would provide an additional, informative perspective. Clients could also be questioned regarding their perception of the intensity, duration and frequency of their panic attacks although this data would not assume primary importance. Future studies of therapists’ use of the model could also explore clients’ experiences of spirituality and its perceived influence on their quality of life and their relationship to the experience of panic.

Conclusion

Both the therapists’ and the clients’ meditation practice converge to assist clients in becoming aware of all of their arising sensations, thoughts and emotions, and in allowing and naming them. Clients may need to be reassured that it is normal to initially feel more anxiety as they pay more attention to the fearful mind. Therapists support clients in naming and being with the subtle nuances of a range of emotion, including such painful ones as sadness, loneliness and despair. As clients begin to stay more present for their pain, they build tolerance for staying present during intense anxiety and panic and not abandoning themselves.

What clients ultimately learn is that, if they try to change an emotion by eliminating it, they might feel better in the moment, but they remain bound to that very emotion by either holding on to it or pushing it away. They realize the need to work through their emotions by coming to terms with their inescapability. When they can bring bare attention to their fear or terror, they bring a quality of acceptance that allows simultaneous letting go. In essence, they begin “Naming the demon and making friends with it” (Kornfield, 1995, p. 92).
In staying present to their unpleasant thoughts and emotions, not just those related to fear, clients may be able to decrease the likelihood of getting to a place of panic. Yet, in order to transform the habit of being fearful and panicky, clients have to learn to recognize it every time it appears, as running from their fear only makes their pain more intractable. This ongoing recognition also allows them to defuse small amounts of anxiety without attaching catastrophic interpretations to them (Segal et al., 2002).

A mindfulness approach to therapy "does not provide a solution to anyone's problems"(Segal et al., 2002, p. 127). For some, panic attacks may dissipate or end, while others may continue to have panic attacks across the lifespan and yet, learn to relate to them differently (Howie Cohn, personal communication, July, 2004). They no longer need identify with these states or allow them to affect their self-worth. They learn to work with panic when it arises and gradually open to the gifts that arise from their experience. For, in their willingness to stay present with their own pain, they become increasingly able to sit with others' pain without shutting them down and increasingly open to a breadth of compassion that was previously unknown to them.

From a Buddhist standpoint, it is an individual's perspective that determines whether a given experience perpetuates suffering or is a vehicle for awakening (Epstein, 1995, p. 204). Experiencing recurrent panic can lead to a subsequent sense of humility and wonder through witnessing an extreme range of mindbody feeling. Extreme fear without fixation involves a deep experiencing of our vulnerability as humans on many levels of this realm. Through frequently moving up close to a sense of ultimate disconnection (psychic, spiritual, and physical), these individuals experience a tender reverence and gratitude for each "return" to life-connectedness, for each breath and each moment. Living with panic attacks presents a constant challenge to live consciously, compassionately and lightheartedly, letting awareness provide a calm bridge above the stormy waters of the mind.

As therapists, we bring the tools of mindfulness into therapy to offer clients a way to break identification with their powerful emotional responses through the power of awareness (Epstein, 1995). In conjunction with their meditation practice, we support them in creating an internal environment for themselves in which any feeling can be
experienced, without having to express it or feel overwhelmed by it. In the process, we are called to bear witness to their ongoing commitment and immense courage.
References


Appendix A

Panic Disorder Treatment Literature

Quantitative. Klosko et al. (1990) compared a form of behavior therapy called panic control therapy (PCT) with alprazolam, a medication placebo, and a wait-list control group. Fifteen men and 42 women with a mean age of 37 completed the study. Each had a primary diagnosis of panic disorder that was rated by a clinician within a range of "definitely disturbing or disabling" to "very severe" and experienced an average of 2 panic attacks a week in the two weeks prior to treatment. Most of the participants exhibited only mild agoraphobic avoidance, however several with moderate to extensive avoidance were also included. Results on measures of panic attacks and generalized anxiety show that PCT was significantly more effective than the placebo and wait list on most measures, however, the alprazolam group did not differ significantly from PCT or placebo. Although this study illustrates the relative effectiveness of two different treatments for panic disorder, using panic-free status as a measure of therapeutic success may be overly optimistic (Barlow & Cerny, 1988), especially given that the researchers only conducted a two-week follow-up. Klosko et al. (1990) suggest that a greater problem than the panic attacks themselves may be severe anxiety over the possibility of a future attack. Generalized anxiety scores (as measured by the Hamilton Anxiety Rating Scale) dropped by only 10 points across all conditions, suggesting that substantial anxiety continues to be a real problem for this population. Klosko et al. (1990) suggest that future research needs to address ways of making treatments for panic attacks more powerful, efficient and longer lasting and also needs to consider combining treatments for greater efficacy.

In a study that attempted to measure longer lasting effects of treatment, Craske, Brown and Barlow (1991) divided 41 adults with panic disorder into 3 treatment conditions: 1) progressive muscle relaxation ®, 2) interoceptive exposure and cognitive restructuring (E & C), and 3) relaxation, interoceptive exposure and cognitive restructuring (COMB). Participants were assessed at six months and 24 months following treatment completion through semistructured diagnostic interviews, self-report inventories, and self-monitoring. The combination of exposure and cognitive
restructuring resulted in 81 percent panic-free participants at 24 months, compared to 43 and 37 percent in the COMB and R groups, respectively. However, when end-stage functioning is also considered, only 50 percent of the panic free participants scored high on this index two years post-treatment. Thus, when clinical ratings of severity are included, results indicate more psychopathology than when panic frequency alone is considered. The researchers suggest that continued agoraphobic avoidance may be responsible for lower scores on endstate functioning. Craske et al. concluded that eliminating panic alone may not result in eliminating agoraphobic avoidance as well.

This research highlights the importance of looking at the whole of the person and considering their quality of life, not just the frequency of panic attacks. Results must be interpreted with caution due to the fact that at follow-up, some participants were using alternative treatments. Clearly, even when receiving some benefit from cognitive behavioral therapy, it is not sufficient and individuals still seek relief through other sources.

In a later study with a longer-term follow-up, Brown and Barlow (1995) assessed the outcome of CBT on 63 individuals with panic disorder. When a traditional cross-sectional method of assessing panic frequency was used, the researchers noted that the results paralleled those of earlier studies. However, in examining outcomes over a longer period of time, Brown and Barlow found that a large proportion of participants sought additional treatment during follow-up because of less than adequate response to CBT, yet further treatment did not result in further clinical improvement. Clearly, CBT does not yield positive outcomes for all individuals living with panic disorder and many feel the need to seek additional ways of coping with their ongoing frightening symptoms.

Gould, Otto and Pollak (1995) compared the effectiveness of pharmacotherapy, cognitive behavioural, and combined pharmacotherapy/cognitive behavioural treatments in a meta-analysis of 43 controlled studies conducted between 1974 and 1994. The researchers selected only those treatment outcome studies of individuals with panic disorder (with or without agoraphobia) that employed a control group and random assignment to conditions. All three treatments were found to be more effective than control conditions and cognitive behavioural treatments resulted in the highest effect size (ES = 0.68) compared to pharmacotherapy (ES = 0.47) and combined treatments (ES =
Cognitive behavioral treatments (CBT) also yielded the lowest attrition rates (5.6%) relative to pharmacotherapy (19.8%) and combined treatments (22.0%) and yielded relatively large overall effect sizes with high panic frequency and a high percent reporting panic-free at post treatment. However, effect sizes for CBT may be higher than those for pharmacotherapy because CBT studies use wait-list rather than pill-placebo controls.

Varying combinations of CBT interventions were employed in the studies reviewed by Gould et al. (1995), and included components of relaxation training, exposure, communication skills, cognitive restructuring, interoceptive exposure and guided coping. Meta-analysis revealed that CBT interventions that included a combination of cognitive restructuring and exposure appeared to be the most effective. According to the researchers, studies that combined exposure with pharmacotherapy do not appear to be as effective as those using strictly CBT interventions; however, there are relatively few studies that combined medications with the most current and comprehensive CBT programs.

Because many participants in control conditions are given treatment at post-treatment, it is impossible to obtain a "controlled" effect size at follow-up. The researchers thus measured effect sizes by utilizing a within-groups procedure. Long-term outcome analysis suggested that CBT interventions were the most successful at maintaining treatment gains at six months or longer with an ES = 0.06 compared to pharmacotherapy (ES = -0.46) and combined treatments (ES = -0.07). However, these differences were not statistically significant as sample sizes were small. These results must further be interpreted with caution as participants in all but one study were no longer taking medication at three-month follow-up and "slippage" in treatment effects is likely lower in naturalistic pharmacological studies where participants stay on their medication.

Although these posttreatment CBT scores look statistically impressive, Gould et al. (1995) note that panic-free scores are generally higher than those based on more global measures of improvement. For example, Telch, Lucas, Schmidt and Hanna (1993) studied 37 individuals with panic disorder and agoraphobia for the purpose of comparing the effectiveness of three treatment conditions: pharmacology, CBT and combined pharmacology and CBT. Participants with similar Beck Depression scores were randomly
assigned to one of these three conditions and pre and posttest measures were collected through self-report, behavioral and physiologic modalities. Between-group comparisons demonstrated that the combined treatment group was the only one to show a significant decrease in panic attacks. However, while 85% of the participants were panic-free at posttreatment, only 63% met a stricter criterion when general anxiety and avoidance behavior were considered. In addition to general impairment in life functioning (Kazdin, 1997; Telch et al., 1993), longitudinal data reveal that many individuals with panic disorder have a fluctuating posttreatment course, with periods of symptom relapse (Hoffman & Spiegel, 1999).

Candilis et al. (1999) assessed the quality of life of 73 individuals with a primary diagnosis of panic disorder, without current substance abuse or contributory medical illness. Participants had a mean age of 35 with above average education, 57% were female, and all were entering an outpatient anxiety disorders program in Massachusetts. Participants completed the Medical Outcomes Study Short Form Health Survey (MOS SF-36; Ware & Sherbourne, 1992), and clinicians completed the Hamilton Anxiety Scale (Hamilton, 1959) and Clinical Global Impression Scale (Guy, 1976). The researchers compared the quality of life scores of the participants with established general population norms as well as norms for individuals with chronic medical conditions and major depression. Candilis and his colleagues found all SF-36 mental and physical health subscale scores to be significantly worse in patients with panic disorder than in the general population. Moreover, relative to participants with panic, significantly poorer functioning was found for a subgroup of panic patients with comorbid anxiety disorders (generalized anxiety disorder, social phobia, post-traumatic stress disorder: N = 55) with regard to body pain and social functioning. Similarly, significantly poorer functioning was also found for participants with comorbid depressive disorders (N = 54) in the area of social functioning and mental health.

Because most persons with panic disorder present to primary care settings, the analysis of this sample from a mental health clinic may limit generalizability to other clinical or community populations. Candilis et al.'s (1999) findings are important in that they describe a range of impairment among individuals who panic, thereby suggesting that greater attention be paid to the psychosocial and physical challenges affecting these
individuals' quality of life. Meditation may well be an avenue through which individuals struggling with panic can work to improve their quality of life.

Qualitative. Frommer, Moellering and Tress (1995) conducted psychotherapeutic interviews with 12 individuals suffering from phobias or panic disorder. The transcripts were reviewed for the participants' biography, subjective theories regarding their illness, and subjective description of their personality. Qualitative content analysis revealed that these individuals characterized their own personality as normal while simultaneously "feeling misunderstood, exploited, excluded, and isolated" (p.38). Unfortunately, since the full article is only available in German, I am unable to review the methodology.

A case study by Wetchler (1999) illustrates the use of narrative therapy with a 45-year-old female with panic disorder without agoraphobia. The therapy was conducted over five sessions across four months in a conjoint couple format. Susan and Fred had been married 21 years and sought marital therapy six years earlier with Wetchler and now viewed themselves as good communicators in a strong and enjoyable relationship. The therapist did not feel that a systemic approach was appropriate because the relationship appeared to be "running smoothly" and because research on the relationship between panic disorders and interpersonal relationships are inconclusive (Rosen, 1996). Wetchler also felt that the co-constructive nature of narrative treatment was more appropriate than CBT because having a sense of control over one's life is a central issue in panic disorder. According to Wetchler, "placing the client in charge of her recovery promotes more self-efficacy than teaching the client to resolve her problem" (p. 23).

Susan's work as a business executive involved a fair amount of travel and she began having panic attacks on business trips and during meetings. Wetchler (1999) asked the couple externalizing questions in order to help them separate the problem from themselves, become aware of times they have control over the problem and 2) take a stand against it (White & Epston, 1990). At the time of starting therapy for anxiety, Susan had been experiencing panic attacks for two years and her GP had put her on SSRIs. Both Wetchler and the couple continued to use Susan's term "anxiety attacks" rather than panic disorder. Wetchler suggests that using the DSM-IV term would not have helped Susan and might have made her view the therapist as the expert instead of herself. The therapist also asked Susan what she did to successfully fight off anxiety attacks, which allowed her
to focus on her own competency. Wetchler suggests that discovering her own self-efficacy is more powerful than having the therapist provide his own perspective.

Over the course of treatment, Susan reported feeling an increased sense of competency and security as she began to anticipate and prevent most of her attacks. Her husband congratulated her on her competency and expressed feeling more relieved, as she was taking better care of herself. Although Susan continued to experience panic attacks, she reported that they were less frequent and shorter duration. She began to view her attacks as "acute, manageable incidents". A follow-up at four months revealed that Susan continued to actively strategize to prevent panic attacks through adhering to a program of self-care, calling her husband when traveling, and responding to anxiety cues. On the whole, Susan reported that her symptoms had mostly dissipated.

This case study illustrates a primary assumption of narrative therapy, namely that people feel a greater sense of control over their lives when they discover and apply their own solutions to life challenges (White, 1995). Because people with panic attacks often feel a decreased sense of self-esteem, increasing a sense of competence is important toward incorporating a greater positive sense of self (Wetchler, 1999; White, 1995). While the client showed significant improvement in only five sessions, these results must be interpreted with caution. Wetchler notes that the results could be due to client-specific variables, such as an absence of agoraphobia or depression (which often co-occur with panic attacks) and having a strong marital bond. Results could also be due to a prior positive relationship with the therapist, the medication, the therapy itself, or a combination of all of these variables.

Angle (1999) studied 8 college students diagnosed with panic disorder with agoraphobia using qualitative in-depth interviews for the purpose of examining the nature and scope of their college experiences. All but one of the participants suffered with either chronic anxiety or panic attacks for over one year before seeking any counselling. Common experiences among the participants revealed that all of the students experienced difficulties in the classroom, had concerns with the physical college setting, and had encountered significant anxiety-related barriers that impacted their choice of future jobs or career. While all of the participants reported that counseling was helpful, all reported still having difficulty with chronic anticipatory anxiety and occasional panic attacks.
Unfortunately, the study's methodology cannot be critiqued, as this section of the thesis is not available.

**Meditation Studies**

*Quantitative.* Later research addressed the effectiveness of a mindfulness meditation-based stress reduction program on individuals with generalized anxiety disorder and panic disorder, with and without agoraphobia (Kabat-Zinn et al., 1992). For this pilot study, Kabat-Zinn and his colleagues took Vipassana meditation out of a spiritual retreat context and moved it into an urban outpatient hospital setting, creating an eight-week program of weekly two-hour classes and one full day of meditation. The 22 participants were mostly female, married, averaging 38 years of age and diagnosed with an anxiety disorder having a mean duration of 6.5 years. Participants were assessed at several points during the program through structured interviews using the Hamilton Rating Scale for Anxiety, the Hamilton Rating Scale for Depression, the Fear Survey Schedule, and the Mobility Inventory for Agoraphobia. Repeated measures analysis of variance resulted in both statistically and clinically significant reductions in symptoms of anxiety and depression at the end of the eight-week program and at three-month follow-up. Improvement was observed both in the patients' self-ratings and in the interviewer's ratings of anxiety and depression. Participants who continued to experience panic attacks both during and after the intervention noted a decrease in the severity of these attacks. The results of this study must be interpreted with caution due to the small sample size and the lack of a randomly selected control group. However, given the marked decreases in anxiety, in-depth interviews with this population on their experiences of anxiety during and after the mindfulness meditation program would be an interesting focus for future research.

A follow-up study (Miller, Fletcher and Kabat-Zinn, 1995) was conducted on 18 of the original 22 participants of Kabat-Zinn et al.'s (1992) study in order to analyze long-term effects of mindfulness meditation on individuals with anxiety disorders. Ongoing practice was maintained by a majority of the participants three years later and repeated
measures analysis showed that treatment gains were maintained on anxiety, panic, depression, and mobility scores.

The effects of a mindfulness meditation program were also studied by Kutz et al. (1985) on individuals involved in long-term private psychotherapy. The 20 participants had a mean age of 38, averaged 3.7 years in psychotherapy and had a variety of diagnoses including personality disorders, anxiety and obsessive neuroses. Participants continued seeing their therapists during the 10-week program and both parties completed questionnaires and rating scales before and after the intervention, as well as at six-month follow-up. According to both participant and therapist ratings, the mindfulness meditation program produced significant improvements in psychotherapy clients' well-being. The greatest change was in the area of decreased depression and anxiety. Eighty percent of the participants rated the daily experience of meditation as the most valuable factor responsible for their reported change. Qualitative data from the therapists corroborated this finding with therapists adding that the clients' ability to calm themselves led to a sense of mastery in controlling their anxiety outside the meditation session, which served to further defuse their anxiety. The most salient strength of the study relates to the role of the therapists who evaluated the intervention without being familiar with it, without having any personal investment in it, and without being involved in its administration.

A more recent study examined English and Spanish-speaking patients' healthcare use in a Connecticut inner-city health centre, after participating in a mindfulness-based stress reduction program. Roth and Stanley (2002) used a 1-group, pre-post design to compare the frequency of patient visits and type of diagnosis (i.e. acute, chronic or routine), a year before and after the program. Most of the participants were female with a mean age of 45. Of the 47 patients for whom a full year of data were available, a significant decrease was found in the number of chronic care visits and all 36 Spanish-speaking participants showed an additional decrease in total medical visits. In addition to the absence of a matched control group, this study is limited in that only primary care visits were examined and therefore, visits to mental health providers or complementary therapists were not recorded. Despite these limitations, the results of this study suggest that a mindfulness meditation program may be a cost-effective intervention for adults with
chronic illness, and more specifically for inner-city individuals of low socioeconomic status, largely Hispanic, and primarily Spanish-speaking populations.

Recent neurological testing by a team of researchers headed by Davidson (as cited in Goleman, 2003) has not yet been formally published, yet shows that different meditative states produce different results on the mind and body. Davidson's group recently measured brain activity in a monk who had been meditating for over 25 years. While the monk meditated on compassion and loving-kindness, the researchers noticed a dramatic increase in activity in the left middle frontal gyrus. Activity in this area of the brain relates to such feelings as happiness, enthusiasm and alertness. Conversely, high activity in the same site on the right side of the brain appears in people experiencing intense anxiety, and individuals experiencing both sadness and anxiety show the highest levels of activity on the right side. The preliminary results of Davidson's study show that concentration meditation enabled the monk to close himself off to external stimuli. He experienced positive neurological changes, as well as a decrease in heart rate and blood pressure. Furthermore, his heart rate and blood pressure remained low even in situations where he was challenged by an angry person or looking at a disturbing film of a badly burned body. Apparently, his years of meditation practice helped him to not only maintain his centre but to feel a degree of love and compassion that was beneficial to his own health.

In another experiment in Davidson's laboratory (as cited in Goleman, 2003), the monk meditated in an open state (as in advanced stages of mindfulness practice) and a loud gunshot-like sound went off near his ear. The monk responded in a manner thought to be evolutionarily impossible. Not only did he suppress the normal, "involuntary" startle reflex, but his facial muscles did not move at all. According to Goleman, the larger someone's startle response, the more intensely they tend to experience upsetting emotions. The monk's response while practicing open, mindful meditation suggests an advanced ability to maintain calmness and equanimity.

Since the data from these experiments has not yet been formally published, it is not possible to critique the study. However, the implications of the research are intriguing as the results suggest that everyone has the capacity to shift their moods to some degree and to change the ratio of brain activity in the middle frontal gyrus. Davidson's researchers
imply that practices such as meditation can help us shift neural activity further to the left to improve our frame of mind.

Qualitative. In order to supplement the paucity of phenomenological data on mindfulness meditation in the West, Kornfield (1979) conducted a phenomenological inquiry into individuals' experiences following a period of intensive mindfulness meditation. Descriptions were collected from 100 participants in a two-week retreat and from 63 students in a three-month retreat through simple questionnaires and student-teacher interviews held every two days. Sixty students in the three-month program also completed extensive follow-up questionnaires several months after the retreat, recording how they perceived themselves as being changed or unchanged by the experience. In analyzing patterns of information provided by the students, Kornfield concluded that "mindfulness meditation is much more than a process of simple relaxation.... Although profound relaxation is reported by students at times, usually this meditative relaxation is perceived as only one among many spontaneous and often dramatic changes in perception and experience" (p. 51). Periods of strong fear become common as concentration and mindfulness deepen and are usually resolved as students surrender to the fear. Kornfield noted that some of the students' most important learning took place in relation to the experience of terror. Several months after the three-month retreat, students reported positive, long-lasting changes in terms of increased openness, equanimity, and a relaxed attitude toward life. Kornfield's work significantly deepened understanding of the range and frequency of the experiences of mindfulness meditators. However, the researcher did not specifically target the subject of anxiety and did not record whether any of the participants suffered from high levels of anxiety at the start of the retreat.

Although Roth and Stanley (2002) show that individuals who participate in a mindfulness meditation program seek a decreased frequency of medical care for chronic health concerns, the researchers do not address the topic of anxiety in particular. Kabat-Zinn et al.'s (1992) and Miller, Fletcher and Kabat-Zinn's (1995) studies on clinically anxious individuals showed treatment gains in both panic and anxiety, yet both studies were quantitative in nature and did not examine the in-depth experience and meaning of participants' anxiety. Kutz et al. (1985) include some qualitative data in their study of
anxious clients in psychotherapy, but the data is limited and does not specifically address panic disorder. At this point in time, we still know little about how anxious individuals who regularly practice mindfulness meditation experience changes in their ability to cope with and manage their symptoms of high anxiety and panic.

Summary of the Literature Review

In reviewing quantitative studies on panic disorder, it appears that many individuals with panic disorder derive some benefit from cognitive behavioral therapy. However, while panic frequency decreases with CBT for many individuals, fear of panicking and avoidance may not decrease. Substantial levels of anxiety continue to be a problem for many of these individuals resulting in a reduced quality of life. Many experience less than adequate relief from CBT and continue to seek alternate treatment to cope with their fear. The effects of panic disorder are pervasive and challenging, affecting individuals emotionally, socially, environmentally, and physically (Angle, 1999). Those who suffer from an additional anxiety disorder or from depression face additional challenges related to body pain and social functioning. Some researchers have suggested that future research needs to focus on finding more powerful and longer-lasting treatments and on combining treatments for greater efficacy.
Qualitative studies reveal that although people with panic disorder view their personalities as "normal", they often feel misunderstood and isolated. Many feel a decreased sense of self-esteem and decreased control over their lives, yet can experience a greater sense of competency and control when they discover and apply their own solutions to their challenges.

Quantitative studies on mindfulness meditation on individuals with panic disorder report a marked decrease in anxiety, as well as decreases in the severity of panic attacks and in the avoidance of triggering situations. These significant improvements appear to be enduring for those who continue to practice meditation. Recent unpublished neurological studies suggest that meditation can help in calming and improving one's frame of mind.

Qualitative studies on mindfulness meditation on individuals without panic disorder suggest that this practice involves more than a process of simple relaxation. Individuals experience changes in perception with important learning in relation to the experience of terror.

These different lines of inquiry contribute to our understanding of some of the issues that people with panic disorder face, including the limits of CBT and how mindfulness meditation has lessened some of clients' symptomatology. However, there are some gaps in the literature. While some researchers recommend combining treatments for greater efficacy, there are presently no guidelines for bringing mindfulness meditation and Buddhist concepts together with CBT and psychodynamic therapy to address any challenge, let alone recurrent panic.