Psychological treatment process for a woman suffering from panic disorder

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Abstract

This paper describes how a patient was helped with her feelings of wanting to escape from everything, including her symptoms of agoraphobia. She was considered to lack psychological mindedness. As soon as we started psychotherapy, she was angry with me because she could not understand how she could be cured by talking with me. She could not identify her negative emotions or regulate her emotions. Gradually, she began to be aware of her loneliness, which she could not express to others. After two years of treatment, I had to take a sudden break from therapy for personal reasons unrelated to the patient. When I returned to the office about two months later, I realized that she was blaming herself to hide her true feeling of sadness. During psychotherapy, she was able to experience emotions that she had denied for a long time. An ability to maintain instability and conflict in her mind may have developed during her trusting relationship with me.

Keywords: defense; self-blame; psychological mindedness; persecutory guilt

Psychological mindedness has been seen as an important trait for maintaining therapeutic relationships and for gaining benefits from psychotherapy. Appellbaum (1973) first proposed and defined psychological mindedness as ‘A person’s ability to see relationships among thoughts, feelings, and causes of his experiences and behavior’. This definition has four components 1) the ability to see relationships and to learn their meanings and causes, 2) the goal of learning the meanings and causes of behavior, 3) the causes of experience, and 4) ability, which refers to a person’s present and future capacity for psychological thinking. After Appellbaum presented this definition, some studies have been conducted on the definition and construction of psychological mindedness (Coltart, 1988, Conte & Ratto, 1997; Hall, 1992). Conte, Ratto, Karasu (1996) added a new dimension to psychological mindedness and concluded that psychological mindedness involved self-understanding and an interest in the motivations and behaviors of others. Shill and Lumley (2002) stated that reduced psychological mindedness could contribute to a tendency for somatic symptoms. They viewed psychological mindedness as a mediator of psychological stress. The studies have shown that psychological mindedness is an important factor for obtaining benefit with every form of psychotherapy (Berry et al., 2008; Bietal & Cecero, 2003; Bietal et al., 2004, 2005 Kronstrom et al., 2009; MacCallum & Piper, 1990; Nyklicek & Denolett, 2009; Nyklicek et al., 2010).

This report describes the psychotherapeutic process in a woman who had a strong desire to escape from everything and could not identify negative emotion. She seemed to lack of psychological mindedness at the beginning of our psychotherapy. However, during psychotherapy, she was able to experience emotions that she had denied for a long time. Eventually, she could understand that she was a human being and honest. I will discuss the elements of the relationship between the patient and the therapist that could promote her ability to identify her stress and stressors.

Case: A 45-year-old woman

Case introduction and her complaint

Mrs. A was married with two children: a girl in high school and a boy in junior high school. She and her husband lived with her parents-in-law. She had been helping her husband with his office work for one year when psychotherapy commenced. Her father-in-law died soon after psychotherapy commenced, and her husband took over his father’s job.

She presented at the clinic where I had been working for about half a year when she was 43 years old. She began suffering from panic disorder with agoraphobia when she was about 36 years old. While she was washing dishes at her friend’s house, she broke into a cold sweat and was taken to an emergency hospital. She felt better the next day. She thought that she became better because

she had slept for half the day. When she was 39 years old, when she got up in the morning, she felt nauseated, listless, and unmotivated. She became bedridden throughout the morning, and was unable to take part in any activity. However, she was able to eat in the afternoon, and therefore decided not to go to the hospital. When she was 41 years old, she went to a restaurant with her family and had a sudden panic attack. She went to a physician and was prescribed tranquilizers. However, her symptoms of panic disorder did not improve. She consulted a few physicians, but was disappointed when no one could help her. She read a medical book and realized that she suffered from a mental disorder. She asked her physician whether she suffered from a mental disorder and her physician agreed that this was a possibility. She came to the clinic where I worked after she visited a mental health clinic. Psychotropic medication prescribed by a psychiatrist at the clinic somewhat improved her symptoms. She did not take her medication regularly. She only took a tranquilizer when she worried that she might experience agoraphobia. However, she was still unhappy with the improvement in her symptoms. For example, she still could not get onto a train alone. She started psychotherapy to overcome her agoraphobia and began weekly 45-minute psychotherapy sessions after providing her written informed consent.

History

During her childhood, her parents were busy. A housekeeper came to her home to care for her and her younger sister. She said that she was not lonely and did not experience periods of solitude because she spent time with the housekeeper.

When she was an elementary school student, she preferred to monopolize her teachers' attention. However, she felt that she could not monopolize her parents' attention. When she was about 11 years old, she caught a cold and had a fever for a month. This was the first time that she noticed how much her mother worried. When she complained of pain in her knee, her parents would always take her to the hospital. The patient thought that physical or mental pain, no matter how minor, was unacceptable. Hence, the patient said that she could not allow panic attacks or even another physical illness to occur. The patient had known her mother- and father-in-law since she was a child, and her parents and her husband's parents knew each other. During her childhood, she envied her future husband's family, since many enjoyable things seemed to take place in their house every day. She said that when she married her husband, she felt as if she truly became a daughter to his parents, and she quit her job as a nursery school teacher after getting married.

Assessment

Projective tests, including the Rorschach ink-blot test and Sentence Completion Test, indicated that

the patient's primary thought process was easily aroused. These tests also indicated that she found it difficult to identify specific types of emotions, particularly negative affectivity accompanied by poor introspection. She could not understand why she worried so much. Her lack of initiative made it difficult for her to adapt to a new environment, which led to a loss of self-confidence. On the other hand, despite being very passive, she tried to present herself as being different from others. She had an immature harsh superego. Since very minor stimuli often resulted in the rise of negative feelings, she used vague fantasy and hopes of happiness to overcome these feelings. Since she claimed to not have any response to card IV of the Rorschach test, I speculated that she could not bear her need for other people.

She stated that she could not express her feelings about her panic disorder in words. She felt uneasy because she could not understand what she was feeling, and she was unaware of why she felt worry and fear. Most of her fear was due to this state of unknowing. She was afraid of feeling as if she were floating in the air when she was having a panic attack. These statements regarding her panic attacks were similar to the description of autistic-contiguous anxiety reported by Ogden (1989).

Course of treatment

At the outset of therapy, she was angry with me because she could not understand the usefulness of counseling or how talking could cure her illness. She said that she could not find any topics to discuss during our sessions. She became frustrated when I did not respond as she thought I should. The patient was frequently angry with her family members because her husband would not do as she told him and she said that she could not control her children in the way she wanted in childhood.

She also complained about doctors; she disliked doctors who made her feel uneasy, and she felt that doctors were always trying to make her rely on them. She thought that it was the duty of doctors to make her feel comfortable. This episode revealed the patient's need to control other people.

She wanted to escape from both her symptoms of panic disorder as well as from situations that she could not escape. She demanded that I tell her that she should not "escape" from her symptoms. On the other hand, she truly wanted to escape. She really wanted to recover, but constantly said that she would never be cured. She frequently stated that she really disliked things that were vague, and that she preferred things to be black and white. She said that her family often said to her that many things could not clearly be delineated, and that most things were not black and white. Although she appreciated her family's comments, she could not tolerate things that were vague and disordered.

She really disliked the swaying in her mind between one thing and another. For example, when she saw leaves trembling through the window of a train, she became fearful that her symptoms would appear. She also feared dizziness for the same reasons; perhaps, for the patient, dizziness was a "swaying" of her mind.

During most of our sessions, she blamed herself for various things and talked about her fear, anger, and anxiety about her symptoms. I often mentioned that she was too hard on herself or blamed herself too much. However, her stories did not change.

She sometimes seemed to exhibit symptoms of panic disorder while waiting for a session in the waiting room and even while we were talking. However, when I asked about her feelings at that time, she said that she did not understand.

Since her father-in-law died, she had to work as an assistant to her husband, as was strongly recommended by her mother-in-law. The patient would have liked to reject her mother-in-law's recommendation, but felt that she could not. She seemed to fall into a conflictual situation.

At the 18th session, which was before the New Year's holiday, the patient tried to give me a bead ring she had made. Although I did not accept the gift, I asked her how she felt about giving the ring to me. She said that she was not thinking of me so much, but that people around her were pleased when she gave them similar gifts. She may have wanted to please me, and she must have been disappointed when I did not accept her gift. However, she did not speak about her feeling of disappointment even though I carefully observed her painful emotion when she talked.

At the 28th session, she complained that her mother-in-law, who she truly loved, could not understand her suffering. Her mother-in-law said that the patient should enjoy dizziness. As soon as the patient said this, she said that I could not understand her suffering. Since I gave no advice, she thought that she would cure herself. From this session onward, she continued to ask me for advice. Just before the 46th session, the patient heard that her psychiatrist had been hospitalized for cardiovascular disease. The patient discussed her remorse about her daughter during most of this session, indicating that she thought that she and her daughter were similar and selfish. She disliked her daughter's behavior. She did not mention the hospitalization of the psychiatrist. She cancelled her next session. At the 48th session, she did not express any worry even when I asked her about her feelings regarding her psychiatrist's absence. However, when she talked about the difficulty she had dealings with her son's self-reliance, she said that it made her feel sick and she took a tranquilizer. She told me that she wanted to go home, because it was not possible to lay down in the room. I said that the fact that her psychiatrist was absent may have made her anxious. She denied this. Her worry for her psychiatrist's absence was that she could not ask her psychiatrist whether or not she could take her medicine. However, her psychiatrist had always said that she could take medicine any time

she felt that she was in a bad situation. Since she was having a small panic attack, she asked me for permission to go home in the middle of our therapy session. I denied her permission and continued talking with her, and she eventually became calm. In our next session, she was angry with me. She had been eager to return home when she had had a panic attack in the middle of psychotherapy. I replied that I could not permit her to leave in the middle of psychotherapy, but she could choose whether or not she came to psychotherapy. The patient said that she did not want to make this choice. She wanted to depend on other people to determine her behavior. At the 54th session, she remembered that she always had some trouble or pain somewhere in her body. When her husband was hospitalized because of a broken leg in the week of the 66th session, she went to the hospital to visit him. She felt that she disliked every hospital. She recalled her heart beating fast when she talked with a nurse at the first mental clinic she attended when she was around 41 years old. At the 68th session, she said that when she had a panic attack on the highway at night, she remembered my office, but not me. She was relieved when she recalled the atmosphere of the therapy room in the car. She said that she would sometimes recall me at that time. I began feeling uncomfortable about what she said during her sessions. Although I hoped that she would remember me when she suffered from a panic attack, at the same time, it felt strange. I wondered if she was intentionally being sarcastic, but it did not seem that she was. From this later perspective, this may have been her way to approach me.

At the 71st session, she played a joke on me. When she came to my office, she seemed to be depressed. The week before this session, her son had received the results of his high school entrance exam. I had worried about the results. She seemed to be depressed when she started to tell me about the results, and I began to gasp. Then she laughed and said her son passed the examination. At the next session, she said that she could not share her suffering with me because she thought that I did not have the same experiences as her. After this session, she indicated that she wanted to cancel our meetings. At the 86th session, she said that because I did not suffer from panic attack disorder, she felt alone in the therapy room. She said that I drew a line between her and me to be calm by myself. I replied that she drew a line between us by thinking that I drew a line. She said that I did not think of her when she was not at a session. She also thought that I could easily live without thinking of her every day. We gradually began talking about our relationship. The day before the 92nd session, she went to a fortune-teller because she was alone and felt that nobody supported her. She said that she was in real pain, but could not express these feelings. She used the expression “an attitude that she should not be having” to describe her painful feelings toward her husband. At the 98th session, she mentioned that she disliked the quiet times between us during therapy. She worried about what I was thinking. I asked her whether she thought that I would not say anything if she did not say

anything during that time. The patient thought that I would not help her if she stayed quiet for 45 minutes. At the 109th session, she stated that she wanted to be raised by a mother like her mother-in-law. She disliked noticing her own characteristics, which were similar to her parents' scolding behaviors. At the next session, she told me that her young sister cried when her family of origin had gathered together at her parents' home the week beforehand. Her sister had thought that she did not want to become like her mother. However, her sister became just like her mother, who was always angry. I suggested that she did not want to forgive her mother, but she denied this. However, she said that the way her mother scolded her was not good. She said that if she hung her head and was silent, her mother stopped scolding her. She thought that, even though she did not want to become like her mother, she was becoming increasingly similar to her mother. She implied that her mother scolded her more than her sisters. However, she did not explain what she had experienced in childhood. She seemed to feel that she was responsible for being scolded by her mother.

At the 114th session, I phoned the patient to tell her I would need to take a break for a while. I did not tell the patient anything about how long I would be gone or the reason for my break. She said that she understood. Ultimately, I had to take a 2-month rest. Before our sessions resumed, I phoned her to say that I was returning to the office and made arrangements for our next session. At the 121st session, when we started the sessions again, I told the patient that I was pregnant. She said despite that she had also experienced an increased risk of miscarriage, twice, she was worried that my sudden break was due to a serious illness. She blamed herself, since she could not imagine any positive reason for my break, even though she could see physical signs that I was indeed pregnant on the day that the sessions resumed. At the beginning of my sudden break, she indicated that the idea of a break was pleasing to her. During our meetings, she had to face a side of herself that she did not want to see. She stated that she was conflicted between wanting to go to therapy and not wanting to go to therapy. At the 122nd session, she blamed herself as usual. When I heard what she said, I felt tired. I said many times that she was very hard on herself, but she did not change her story, even when I would have to take a rest for my delivery. I was very irritated and worried. I said that her strict attitude was not helping her weak self to cope with severe situations. I explained a concrete mechanism for her self-blame and said that she must change her attitude toward herself. The patient realized that her strict attitude was not helpful, but she could not agree with my suggestion. She felt that if she was not strict toward her weak self, she might be much more spoiled so that her symptoms would persist. At the 123rd session, the patient said that she felt guilt whenever she took medication because she did not want to allow herself to escape from the current situation to a place that was much easier. She did not think that she suffered from panic disorder. She felt that she was broken and could not be repaired. Even if she was glued together by medication, her cracks

would still remain. She said that she could not escape from sadness. She said that the feeling of sadness replaced the thought that she was ruined and the thought of being unable to go back to being cheerful caused sadness. To avoid recognizing her sadness, she scolded and encouraged herself. She wished that she could return to her cheerful self, and thus she did not permit herself to take medicine. She said that only people who suffered from the same disorder could understand her suffering. On one hand, the patient hoped to share her sadness with me and was comforted by me. On the other hand, she hoped to escape from having to be treated by me. I was in a very difficult situation between her two hopes. While I felt her painful feelings, in fact, I did not understand why she was sad at that time. At the next session, she started to talk about her guilt about taking medicine. She rarely took her medicine, since she almost forgot about her illness in daily life. She complained that she turned around and around in the same place. She realized that her way of coping with her timid self was not constructive. Since her parents did not praise her, she did not trust that praise was useful. She thought that she could not accept praise indiscriminately. She thought that her parents did not love her, and they were very strict with her during her childhood. After this session, we talked about her way of thinking in terms of black and white. She found that she did not think that she liked dichotomized thinking, and said that she felt comfortable with grey. She said that she could not control others because she was not able to control her own symptoms. After these sessions, she stated that she had some trouble in her body such as a headache. Moreover, she said that she would give up on curing her psychiatric disease and that no one understood her feelings. I speculated that she was thinking about my maternity leave, but I said nothing about it. I was afraid that she would lose her feeling of loss about my maternity leave if I mentioned an earlier, similar, situation in which she described her anger toward her mother. At the end of the session, she asked me whether I liked myself or not. This was the first question she had asked me. She also realized that her previous assumption, that others must think the same way she did, was incorrect. She realized that she disliked the way that she showed anger, but did not dislike herself and discovered that she was an honest person. At the 131st session, she said that she had asked her daughter the same question she had asked me. She had thought that her daughter might dislike herself as well. However, her daughter said she neither liked nor disliked herself. She thought that most people were the same as her daughter and me. She hoped that her mind would always be stable, but knew that the human mind was not always stable. She said that this was extremely human. However, she disliked wavering and preferred to be stable. She said that the fact that she disliked uncertainly meant that she denied being human and might be immature. She liked people who are able to openly express their feelings. She realized that she disliked her way of expressing anger.

I had to suddenly stop our sessions earlier than expected due to circumstances at my workplace

immediately after the 131st session. While this was outside of my control, I felt guilty about stopping our sessions. I speculated that she might not be able to fully mourn the separation from me. I just hoped that she would not be injured further.

Discussion

Complicating factors and barriers to care

The patient grieved about suffering from panic attack disorder, since she did not maintain a perfect image of herself. This statement showed her extreme way of thinking. I realized that most things that she grieved about not being able to do were things that she preferred not to do before she suffered from panic attack disorder. For the patient, suffering from panic attack disorder was terrible, but, in fact, it was important, since she could escape from things that she preferred to avoid. Thus, she frequently said that nobody could cure her. The results of projective tests indicated that she found it difficult to identify specific types of emotion, particularly negative affectivity. However, the panic disorder made her realize her feelings. Perhaps more accurately, her panic attacks made her realize her negative feelings. Whenever she faced this fact, she could not "consent" to lose her perfect image. From the time she was born, she had not been perfect. She might know this fact, so she frequently said that nobody could cure her.

Freud stated that people suffering from melancholia did not blame themselves, but rather blamed introjected objects in their minds (Freud, 1957;1999). While this patient did not suffer from melancholia, the phenomena in her mind were the same as those described by Freud. She stated that her mother was too strict toward her in childhood and she disliked this attitude. However, her strict attitude toward herself was similar to her mother's attitude toward her and people around her. She was both the introjected strict mother and the fearing child. I stated that she could not forgive her mother, but she denied this. She both loved and disliked her mother and sometimes a child and sometimes her mother. However, she disliked her mind swaying in such a manner. This reflects a true schizoid mechanism. Kano (2002) clarified the characteristics of the patient with schizoid mechanism from the point of view of the clinician's transference phenomena. He stated that a psychotherapist could not sympathize with such a patient's guilt, since this kind of patient tended to vividly experience the fear of guilt with a masochistic quality. Grinberg (1964) built on Klein's view and divided guilt into two types: persecutory and penitential. Persecutory guilt originates in an immature ego, whereas penitential guilt is associated with a mature ego. Persecutory guilt is not a true one but is a defensive mechanism. The patient's persecutory guilt concealed her sadness as she stated in her session (Hasui, Igarashi, Nagata, and Kitamura, 2007). Moreover, this defense helped

to conceal her distrust from her. This type of guilt is troublesome and will not contribute to enriching the mind. This defense would also be useful for creating distance from the therapist. The present patient did not know how to share her feelings with others and the therapist. Even though she wanted to share her feelings, she maintained her distance from others when they got closer because she did not know to share her feelings or she feared being hurt. Therefore, she felt anger at herself, me, and people around her. By utilizing guilt, she was in a state of hopelessness.

Termination of the treatment

During my break, she had various feelings about me (Lax, 1969). She said that she had only one bad fantasy of me during the sudden break. I did not ask her about the bad fantasy, but I speculated that she thought that I suffered from some disorder. She said that she never imagined that I was pregnant, even when she saw my pregnant body, and she had experienced two pregnancies herself. People with lack of psychological mindedness have been reported to be characterized by an inability to fantasize. For the patient, fantasy had only negative connotations. The patient in this report did not explain her experience of being scolding by her mother. Since this experience may have been traumatic, she may not have fully developed an ability to fantasize. Her experience with only negative fantasies inhibited the arousal of any fantasies. Her traumatic experiences with her mother may have also contributed to her distancing herself from others. However, my increased risk of miscarriage stimulated her ability to fantasize.

At the same time, our therapy style changed to a kind of time-limited arrangement. She had to have known that I would be leaving in the near future. This knowledge of my imminent leaving may have made her more aware of my existence, and as a result, she was able to identify with me. Since she was able to experience emotions that she had denied for a long time during our psychotherapy, her ability to tolerate instability and conflict in her mind may develop. Such a sudden event does not necessarily have a negative impact on the relationship between a patient and a therapist. In a close relationship, since a sudden absence may arouse a patient's fantasies and emotions, a patient may become aware of their emotions and fantasies.

Our relationship had become close before I took a sudden break. However, it took a long time for me to realize why she did not change what she said. She frequently said that I could not understand her feelings, and I was motivated by her saying this; I felt that I had to understand her feelings. At that time, when I would have liked to discuss her feelings, she refused to cooperate. Thus, she seemed to be an unpleasant person. Nonetheless, since she was honest and spoke as openly as she could, she was a preferable person. In fact, she had several close friends and I speculated that she was liked by other people. She had a lack of psychological mindedness, but was not cold and

hoped to have relationships with other people. In the present case, I almost enjoyed talking with the patient during sessions. The patient may have also enjoyed talking with me. Instead of a harsh, scolding mother, she introjected and identified with me who did not scold her. A positive relationship between the patient and the psychotherapist is needed to help counteract the arousal of only negative fantasies. In warmth condition, she had many fantasies of me. She realized that she disliked the way that she showed anger, but did not dislike herself and discovered that she was an honest person. Because she was able to experience emotions that she had denied for a long time during our psychotherapy, her ability to keep the instability and conflict in her mind may develop.

References

Appellbaum S A. (1973). Psychological-mindedness: word, concept, and essence. International *Journal of Psychoanalysis*, 54, 35-45.

Berry K., Shah R., Cook A., Geater E., Barrowclough C., Wearden A. (2008). Staff attachment styles: A pilot study investigating the influence of adult attachment styles on staff psychological mindedness and therapeutic relationships. *Journal of Clinical Psychology*, 64, 355-363.

Bietal M., Cecero J J. (2003). Predicting psychological mindedness from personality style. *Journal of Clinical Psychology*, 59, 163-172.

Bietal M., Ferrer E., Cecero J J. (2004). Psychological mindedness and cognitive style. *Journal of Clinical Psychology*, 60, 567-582.

Bietal M., Ferrer E., Cecero J J. (2005). Psychological mindedness and awareness of self and others. *Journal of Clinical Psychology*, 61, 739-750.

Coltart N.E. (1988). The assessment psychological-mindedness in the diagnostic interview. *British Journal of Psychiatry*, 153, 819-820.

Conte H R., Ratto R., Karasu T B. (1996). The psychological mindedness scale. Factor structure and relationship to outcome of psychotherapy. *The Journal of Psychotherapy and Practice and Research*, 250-259.

Conte H. R., Ratto R., (1997). Self-report measures of psychological mindedness. In McCallum, M., Piper, W. E (Eds.), *Psychological mindedness. A contemporary understanding*. (pp.1-26). London: Lawrence Erlbaum Associates Publishers.

Freud S. (1957/1999). *Mourning and melancholia*. London, Hogarth Press.

Grinberg L. (1964). Two kinds of guilt: their relations with normal and pathological aspects of mourning. *International Journal of Psychoanalysis*, 45, 366-371.

Hall J A. (1992). Psychological mindedness: A conceptual model. *American Journal of Psychotherapy*, 46, 131-140.

Hasui C., Igarashi H., Nagata T. and Kitamura T. (2007). Guilt feeling and its multidimensionality: Empirical approaches using Klein's view. *American Journal of Psychotherapy*, 21, p. 117 - p. 142

Kano R. (2002). *Jusho jinkaku shogai no rinsho kenkyu* [The clinical research of severe personality disorders.] Kongo Shuppann, Tokyo. Japan.

Kronstrom K., Salminen J. K., Hietala J., Kajander J., Vahlberg T., Markkl J., Rashi-Hakala H., Karlsson H. (2009). Does defense style or psychological mindedness predict treatment response in major depression? *Depression and Anxiety*, 26, 689-695.

Lax R F. (1969). Some considerations about transference and countertransference manifestations evoked by the analyst's pregnancy. *International Journal of Psychoanalysis*, 50, 363-372.

McCallum M. & Piper W E., (1990). The psychological mindedness assessment procedure. *Psychological Assessment*, 2, 412-418.

Nyklicek I., Denolett J. (2009). Development and evaluation of the balanced index of psychological mindedness (BIPM). *Psychological Assessment*, 21, 32-44.

Nyklicek I., Poot J., van Opstal J. (2010). Psychological mindedness in relation to personality and coping in a sample of young adult psychiatric patients. *Journal of Clinical Psychology*, 66, 34- 45.

Ogden T H. (1989). On the concept of an autistic-contiguous position. *International Journal of Psychoanalysis*, 70, 127-140.

Shill M A., Lumley M A. (2002). The psychological mindedness scale: Factor structure, convergent validity and gender in a non-psychiatric sample. *Psychology and Psychotherapy: Theory, Research and Practice*, 75, 131-150.