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Sometimes things that seem easy turn out hard.
Other times, the hard seems easy.

Jeannie did not know what to make of the sudden end of her panic attacks. They had come often. They were horrible events with body uproar and wild fantasies of dying—racing heart, trembling, choking feelings. When her panic attacks occurred at work she would flee to an empty room and call in a colleague. She would cling desperately to her, both emotionally and psychologically, until the feelings subsided. When at home, Jeannie would disappear to a place in the house where she could shield her family from what was happening to her until she felt better. Hiding the shame she felt about her uncontrolled behavior was all she could do to get back to her routine.

Jeannie had known, and learned to anticipate, these attacks for over seven years. She estimated their occurrence at three times a week, although at times they were less frequent. They ripped apart her sense of who she was. They were a vivid tear in her personal being. Though it is estimated that panic attacks strike as many as 10–15 percent of us in our lifetimes, most of us get by without having them develop into an ongoing frequent pattern.[1] If the panic attacks take over, however, as in Jeannie's case, the chances of them ending without treatment is unlikely. Untreated, there is little reason to expect panic attacks to simply go away.

It was only by giving great support that Jeannie's colleague was able to move her enough beyond her anxiety and convince her to participate in a one-session intervention that offered the possibility of relief. The one session was part of a research program named The Rhythmic Integration Project on Panic. The project was formally studying and systematizing a method that had already shown a capacity to rapidly reduce, and typically eliminate, panic attacks.

Jeannie arrived at the session in obvious distress. Within ninety minutes, her panic attacks were gone. It all seemed too easy. What did it mean? Suddenly years of suffering and inner elaboration of the panic experience stopped. For Jeannie it was quite a before-after experience: "Who is it that is me?" she questioned.

Three months after the intervention, during a follow-up contact, Jeannie expressed her ongoing amazement about what had happened, but she was still grappling with the magnitude of the change and how to make sense of it. Her voice lowered as she spoke about the experience, "No one would believe it. I can't tell anyone. It seems so crazy—or like some kind of miracle."

Jeannie was not the only one to experience what seemed to be a personal miracle. When events occur in unexplainable ways and have profoundly desirable effects, they are apt to be called miraculous. But what Jeannie and other treated panic sufferers couldn't explain is explainable. In fact, it is an outgrowth of a carefully conceived and measured process with a clear rationale. The intervention that proved so helpful is a systematic integration of Bioenergetics and other body-oriented psychotherapies.[2]

The balance of this chapter will present clinical and research background material about panic attacks, as well as the rationale and study results of a process undertaken by The Rhythmic Integration Project on Panic to rapidly reduce the frequency of panic attack occurrence.

Background

It seems every level of analysis has been undertaken in our attempt to understand panic—except the obvious. There has been examination of chemical imbalances, measurements taken of oxygen levels,[3] hypothesizing of gene markers, and speculation about neurological and brain processes.[4] Even cholesterol levels[5] have been considered. Therapists have stressed the importance of patients' inner lives and childhood experiences.[6] In behavioral treatment, personal imagery has been stimulated, sensations noted, and emotions aroused to the point of flooding. Family dynamics have been probed, and cognitive thoughts and logical patterns have been closely examined and changed.

Observable body movements have been largely overlooked. It is a new variation on the story of the Blind Men and the Elephant. The blind men at least tried to perceive directly what was before them. They touched and felt the physical—the leg, the ear, etc. One touched the tail and thought the animal was rope-like. Another contacted the side and likened it to a wall. Only able to know a piece of what was before them, they couldn't comprehend a whole view.

In studying panic attacks, modern science does less than the blind men. It forsakes simple direct observation in favor of high-tech instrumentation and systematic inner probing through questions and verbal report. Sophisticated and well-researched techniques have replaced the natural human perceptive ability to open the eyes and observe. Though researchers rarely look to find and follow clues from the observable body, individuals who suffer from panic attacks are likely to know their body cues, having carefully observed their own bodies in panic reactions.

Panic sufferers don't have the perspective of seeing from the outside. They focus on the physical from the vantage point of within, often exaggerating their thoughts and emotions. "Research has shown that individuals with panic disorder are preoccupied with certain bodily sensations, such as heart palpitations, dizziness, or a sense of unreality. In particular, they attribute more threatening meanings to bodily sensations than do persons with other anxiety disorders."[7,8]

People with panic attacks also differ from those who suffer from other kinds of anxiety disorders in the amount of attention they give to their own physical sensations. They attend "vigilantly." They are trying to see something, but are seemingly unable to get it. This might suggest that research efforts directed toward helping sufferers might approach understanding and treatment by taking a look, from an outside view, at observable physical behavior. This, however, has not been a focus of research in the field.

The neglect of the directly observable is curious in light of how panic attacks have been defined for clinical purposes in the DSM-IV (p. v).[9] Of the thirteen listed panic disorder symptoms, ten involve clear physical sensations. These physical sensations, vividly sensed by the sufferer may or may not be accompanied by cognitive experiences. Thoughts of losing control, going crazy, or dying are common occurrences for people suffering from panic attacks.

Though there are some exceptions, the research literature that focuses on the psychological treatment of panic attacks is heavily weighted by approaches concerned with changing irrational cognitions associated with the attacks. The importance of this emphasis grows out of society's emphasis on the significance of our thoughts and René Descartes's universally known philosophy, "I think, therefore I am." A strong cognitive and cognitive - behavioral establishment in academia also furthers it. Solid and extensive work on panic treatment has developed in these quarters. A number of studies have shown that panic attacks can be successfully treated in fairly reasonable time periods.

In these studies,[10] summarized by A. Arntz and colleagues, between 75–90 percent of panic-ridden subjects become panic-free after following a course of cognitive therapy designed to address their symptoms. The treatment times of the studies varied between eight to twelve sessions, sometimes involving homework that called on subjects to do personal work between sessions. These results were significantly better than those obtained by

subjects who were put on a waiting list for future treatment, or for placebo treatments such as progressive relaxation or supportive help.

The Rhythmic Integration Project on Panic demonstrates the possibility that treatment can be effective in even less time, often in just one session. Its effectiveness originates from the original idea of intervening at a point in the panic process before panic-arousing thoughts creep in precognitively.

Support for the fact that panic attacks are initially precognitive comes from several sources. Historical meanings, diagnostic descriptions, research findings, and theoretical writings support the idea that the mind's thoughts do not play the primary role in the arousal of panic attacks. This is a concept that often seems counterintuitive to sufferers, as their thoughts, anticipation, and attempts to avoid are usually a major part of their experience.

A review of the history of the word panic identifies its early usage in English or French as having occurred in the sixteenth and seventeenth centuries: "the so-called 'panique terrors' or 'terreur panique:' Sudden Foolish Frights, without any certeine cause … (England, 1603)." The review concludes, "Many of the original meanings of the word "panic" seem relev ant to the phenomenon — its sudden and groundless appearance, 'out of the clear blue sky.'"[11] In order to be diagnosed as clinically suffering from panic it's required that the individual have at least one panic attack that is unexpected[12]—or unanticipated. H. Waring, who collected data from panic sufferers as part of general medical practice reported that, "Nearly all patients stated that their first attack caught them unawares (97 percent)."[13] These observations strongly suggest that thoughts, cognitions, are not the catalyst to panic attacks. Something else comes first.

D. Klein, a major researcher and theoretician in the field, also presents a strong case for the source of panic attacks being a non-cognitive event.[14] He argues that the anxiety that occurs during a panic attack significantly differs from that which occurs just prior to the attack. Klein based his argument on data that showed that two classes of psychiatric drugs, trycyclics and benzodiazipines, produced different results in relation to panic and anxiety. Trycyclics reduced panic attacks, but they did not affect anticipatory anxiety. Benzodiazipines reversed the situation; they reduced the anticipatory anxiety, but not the attacks. It appeared to Klein that there were two kinds of anxieties.

Klein's thinking is further elaborated in relation to the attacks themselves: "It is only after a series of such extremely unpleasant experiences that the person develops a 'secondary anticipatory anxiety' between panic attacks, often referred to as 'free floating anxiety.' Klein went on to hypothesize that panic attacks, and anticipatory anxiety, were basically different psycho-biologically. He believed that anticipatory anxiety, with its stimulation of worry and catastrophic thoughts had "followed, not p receded, panic attack."[15]

A further case can be made for arguing that fearful anticipation, and the arousal of worry and distressed thinking, may be the result rather than the cause of panic attacks. In the vast majority of instances, expectations that an attack will occur are not followed by the symptoms.[16]

Additionally, sufferers often have no explanation for what caused their first attack,[17] and between 20–40 percent of those suffering panic attacks, who have been seen in general medical rather than psychiatric settings do not have fearful cognitions associated with them.[18]

The Role of the Directly Observable

In relation to panic attacks, directly observable body signs have not often been a central scientific concern, nor have they played a large role in developing treatment methods. There are, however, several notable exceptions: Applied Relaxation, Breathing Retraining, and Eye Movement Desensitization and Reprocessing (EMDR). Each of these treatment methods grew out of scientific work. None of these methods emerged directly from the extensive clinical psychotherapeutic work done in the context of Body Psychotherapy. Here the body is

carefully observed in individual sessions, typically in private treatment over an extended period of time. What is seen is worked with to gain understanding of the person and their functioning and in finding ways to change. Often the aims are spoken of in general terms: increased well-being, self-awareness and control, more feeling, and a fuller understanding of one's personal history.

The clinical field of body psychotherapy lacks the rigor of the scientific approach. It does not typically focus on removing specific and scientifically measurable symptoms, but it allows for a greater freedom range in looking at an individual and in dealing with what the client presents. It has a large and extended field of direct client experience on which to draw on for understandings.[19]

Interestingly, the three scientifically related methods that will be discussed as having a relationship to observable behaviors deal with variables that have been important in the approaches of body therapy. Where relevant, touchpoints drawn from the body therapy school of Bioenergetics[20] will be mentioned.

In Applied Relaxation,[21,22] people are taught to quickly progress to a state of relaxation and then instructed how to use the relaxation to cope, counteract, and eventually eliminate anxiety reactions. This method has been taught over a twelve-week period and studied in relationship to its effect on the frequency of panic attacks. The study utilized homework between sessions. Individuals were asked to relax fifteen to twenty times a day while doing natural activities such as talking on the phone, looking at their watch, and responding to prearranged cues.

As the facility to move quickly to relaxation developed, participants began to apply it during panic-provoking moments. At the end of treatment, 65 percent of the participants were panic-free. At a follow-up session one year later, 82 percent were panic-free.[23] They were encouraged to continue practicing relaxation on a regular basis.

A second form of directly observable bodily behavior studied in relation to panic attacks is disturbed breathing patterns. This is often an important part of body-oriented psychotherapy. Bioenergetic therapists, for example, are specifically trained to develop sensitivity to shifts in breathing patterns (i.e., when abdominal breathing is replaced by chest breathing). Disturbances such as shallow or held breathing or erratic rhythms are seen as indicators of therapeutic intervention. Practitioners use their observations to deepen breathing and to raise the individual's level of excitement in order to bring unconscious memories into awareness where they can be explored. Deep breathing is also used to vivify and strengthen emotional experience.

The method of Breathing Retraining, as described by R. Ley,[24] was designed from a source other than the field of Body Psychotherapy. Therapists and doctors took note of shifts in breathing patterns that occurred specifically during panic attacks. They observed that the symptoms of panic resemble those of hyperventilation.

Ley forwards a method of breathing retraining for panic sufferers. It involves sensitizing clients to their breathing difficulties by teaching respiratory mechanics and the physical and psychological effects of hyperventilating. Clients are also taught to control the panic effects of hyperventilation by slowing their rate of respiration, breathing through their nose, and using their diaphragm rather than their chest.[25]

Ley argued that hyperventilation was the central cause of panic attacks. Research and review, however, has not supported this. In studies where people with panic disorder voluntarily hyperventilated, panic attacks were not reported, although the symptoms were felt to be similar.[26]

There is a stronger argument against the idea that hyperventilation is the key cause of panic attacks. Many sufferers do not hyperventilate during panic attacks. Since hyperventilation can be part of a panic attack, but does not have to be, it can't be the central factor in the existence of an attack. Disturbed breathing patterns are still an important factor, however.

L. Papp and J. Gorman[27] suggest that Breathing Retraining can serve as a viable treatment for those panickers who do hyperventilate. Results from recent studies also indicate benefits for those who do not hyperventilate; perhaps this is a result of correcting other breathing distortions.[28] L. Lum[29] specifically makes the point that chest breathing may be a mechanism which heightens the possibility that a panic attack will occur, while not leading to hyperventilation.

The real crux for Breathing Retraining as a method lies in the question of whether or not it reduces panic attacks. Ley's results [30] show subjects dropped on average from 1.89 to 1.43 panic attacks per day following eight sessions of Breathing Retraining. This is statistically significant and demonstrates that the method can play a role in reducing panic attacks. However, the reduction found is relatively small, and the technique might not have been powerful in actual terms for any particular individual. Two of the sixteen subjects actually experienced an increase in panic attacks.

The technique of Eye Movement Desensitization and Retraining (EMDR)[31] has been applied to and researched for a variety of anxiety disturbances, including panic attacks.

This third observable body process that has resulted in the development of a treatment method focuses on the eyes. Bioenergetic practitioners observe and work with the eyes and their surrounding musculature. The eyes are noted for signs of aliveness, emotional expression, and character attitudes. In a poetic metaphor, they are seen as "the windows of the soul."

EMDR developed from a personal discovery by its originator, F. Shapiro. While remembering some her own traumatic memories, she noted that as her eyes spontaneously shifted from side to side. She experienced a decrease in the emotional charge that she was feeling. She developed a treatment method that was initially based on the observation that these kinds of eye movements could lessen the experience of painful emotional memories.

Shapiro first applied her method to people who suffered from traumatic stress disorders. As they recalled troublesome memories, they were instructed to follow her finger as it moved from side to side. They were then asked to report their thoughts, sensations, and emotions. The process was repeated until clients reported that their level of discomfort had dropped significantly. Next, clients were instructed to form a positive thought about themselves or their trauma and work with it until there were signs that the thought was accepted.[32]

Shapiro's first study reported dramatic results.[33] It reported improvements from single sessions in clients who suffered from posttraumatic stress disturbance to the point of no longer suffering from the disorder. Shapiro's work came under strong scientific criticism for a variety of reasons and from a number of sources (see end notes 31–34). It has been argued that she was the sole practitioner in her study. It has been pointed out that the one-session results have not been replicable by other practitioners, while other methods have been more effective. It has been stated that the extensive claims of success in treating a variety of anxiety problems by EMDR practitioners are said to lack sufficient scientific support. Most importantly, studies have shown that factors other than the eye movements could have been responsible for the changes reported. In fact, Shapiro eventually abandoned eye movements as the necessary variable in her method. She began using other techniques, such as alternately tapping the sides of the body or using audio tones while arousing memories of the trauma. Though Shapiro's original eye movement intervention continues as a technique, its centrality has given way to a more general technique of bilateral stimulation that involves alternately stimulating both sides of the body.

Shapiro's method is now characterized as "an integrated form of therapy incorporating aspects of many traditional psychological orientations."[34] These include using imagery, behavioral desensitization, cognitive restructuring, rating inner experiences, and keeping a journal. EMDR treatment is now spread out over a three-session application (or more) rather than the one-session approach originally thought sufficient. For people with multiple traumas, it is suggested that several months of sessions may be necessary.[35]

The posttraumatic stress disorder application of EMDR has been applied in the treatment of panic disorder. Here it can be measured against a clear criterion, the reduction or cessation of panic attacks. Research evaluation has measured the efficacy of the technique—whether attacks are reduced, if eye movements are important, and how it fares in comparison to other methods that involve desensitization and cognitive therapy.

Research by U. Feske and his colleagues[36] found that six sessions of EMDR significantly helped people reduce panic attacks. Subjects went from an average of 3.6 attacks to .96 attacks in a two-week period. Feske's extended results led to the question of whether eye movements mattered or not. After three months it was found

that there was no difference in the results of the EMDR group whose eye movements followed the therapist's moving finger as they recalled traumatic memories and a second group who provided an eye experience that was not believed to have an effect: EMDR without eye movements. Here subjects were aided to hold their eyes steady by focusing on a therapist's stationary finger while recalling and reporting the traumatic memories.

In fact, both these groups did significantly better than an untreated control group. Feske suggests that EMDR's eye technique was not critical because the stationary eyes yielded the same result as laterally moving eyes. The possibility is forwarded that a different factor, the repetition of traumatic memories that was common to both groups, may have been the crucial factor causing the results. The argument suggested is that the memories aroused associated feelings. By repeating them a number of times the subject gradually lost sensitivity to them, until they no longer aroused traumatic feelings. Desensitization, not eye movement, was the critical factor.

This explanation may not suffice for body therapists. They might argue that both rapid and fixated eye movements would lead to observable changes in the body's natural dynamics. They are both, so to speak, body techniques. Both introduce a means of physical control while memories are recited. Both fall under the general goal of helping people gain self-control. The experimental control of the client's eyes as they recalled memories may well have been the important factor in producing the result. Control rather than desensitization may be what's relevant for change. With greater self-control the traumatic memories no longer result in highly intense and disturbing emotional recall.

The Rhythmic Integration Project on Panic emerges from a clinical viewpoint that looks directly at the movement and structure of the physical body. It grew from a background that emphasized the importance of body experience in the therapeutic process.

Rhythmic Integration intervention consists of two major components. It works to find what it calls "The Body Starter," and to make the client aware of it. Then the client is guided through a series of steps designed to change their physical expression so that panic attacks don't occur.

Rhythmic Integration looks for the spontaneous body movements that provide the physical beginning of a panic attack. The word "Starter" is carefully chosen. Often the literature uses the word "trigger" in relationship to a panic attack. Trigger provides the metaphor of a gun—pull the trigger, the bullet is fired. The response is instantaneous. For panic attacks, a trigger has been thought to be an encounter with a location, an event, a thought, or a physical sensation. Once the moment is triggered, it is suggested, the panic explodes. But in reality, often the so-called triggering response occurs, and no panic attack follows: "I was sure I'd have a panic attack but nothing happened." Starter evokes a different metaphor—the starter of a car. A starter gets the engine to turn over; but it will take engaging the gears and pumping the gas for the car to really get going.

In panic attacks, the Starter readies the organism for panic, but it is not enough to get it going. It is the first observable physical event in a process that may lead to an attack. If the person is aware of their Body Starter, the physical aspect of the panic process can be shut down before it gets moving. Even better, if the Starter doesn't occur, if there is no first physical event, there is no chance for a panic attack—without a start a process can't occur.

Telling an individual that panic attacks often begin with a Body Starter is typically met with disbelief. People with panic attacks are quite aware of the role of their thoughts in the process. Many have developed cognitive strategies, "self-talk," to try to anticipate, modify, or control their symptoms. Some blame outside situations for their plight. They come up with avoidance possibilities to stay away from scenes similar to those where attacks have previously occurred. In the individual's mind, these strategies are creative coping mechanisms devised to meet the challenge of panic attacks. People are often invested and proud of their solutions, even though they are usually not effective in preventing attacks.

Our clinical experience has shown that the disruptive movement pattern, the Body Starter associated with the beginning of the panic attack, is outside the person's immediate awareness until it is clearly and repeatedly

pointed out to them as it occurs. The statement that a physical movement starts panic seems to put the body in charge. Thought and consciousness are secondary. This very idea is typically an affront to the person's meaning system. It's often first met with defense—"I don't believe it," or "Doesn't everyone do that?"

In about half the cases, after the person perceives and accepts their Body Starter, there is a spontaneous report that someone in their family, or a friend, has previously noted the movement and commented on it (i.e., "My husband teases me about that," or "I remember my mom asking me why I move like that?").

A Body Starter that some people use appears to be the same one that Shapiro personally discovered—spontaneous eye movement. Shapiro had tried to stimulate a response in her clients by having their eyes follow her finger as it moved from side to side. This is an imprecise method. It does not guarantee a spontaneous movement as Shapiro experienced it.

There is a somewhat similar technique described in the literature of body psychotherapy[37] that has the client's eyes tracking a moving penlight as it moves in varied directions. The aim is to break through chronic muscle holding. After a while, the greater part of a session, the eyes may lose track and spontaneously go from side to side of their own accord. Often at this moment a powerful emotional catharsis accompanied by significant memories occurs. Therapists experienced with this eye-tracking method know from experience that the spontaneous movement and its aftermath may not occur. Spontaneity is a key aspect of the Body Starter. In the Rhythmic Integration Project there is no attempt to experimentally induce it. Rather the facilitator watches for the natural occurrence of the movement as the client speaks about their panic. As it occurs in the flow of conversation, and it inevitably does, it is brought to the client's attention before identifying it as the Starter.

In the intervention session, once the Body Starter has been identified, a process of change needs to be undertaken in order to make a difference. Rhythmic Integration (RI)38 follows a model based on the early physical and psychological developments humans undergo. As our bodies mature, new psychological potentials become available and new experiences occur. RI describes seven stages that make up the Cycle of Change,39 as well as the body dynamics and psychological outgrowths of each. The stages are named for their respective psychological process: Dreaming, Creating, Communicating, Inspiring, Analyzing, Solidifying, and Achieving.

Treating Panic

Working to help a person change their use of the Body Starter involves moving through the Cycle of Change and dealing with any stopping points that might occur. The session calls for considerable skill on the part of the practitioner. Body movements must be registered and evaluated. Each stage of the change process must be negotiated. The aim is to have the intervention completed within ninety minutes. Difficulty arises from any of a variety of resistances that may emerge to deflect or stop progress. These must be perceived by the therapist and efficiently worked with until the entire process is completed.

To concretize this, consider the following example: Early in the session the therapist requests memories of panic episodes. Help is provided to enable the client to activate a Dreaming quality that underlies this type of memory recall with heightened physical and emotional responsiveness. Already at this beginning point, resistance can arise which can stop and/or end the course of change if not successfully brought to the surface and addressed.

Case Study

Mary was excited to be in the study. She had experienced several panic attacks a week for the past seven years. Yet near the beginning of the session she stated that she couldn't evoke memories of any of the attacks. As having a memory was crucial to the Dream Phase of the process, little could be done.

Instead of remembering, Mary kept talking about how she felt during her attacks—trembling, rapid heart, desperate fears of losing control, etc. She was very dramatic in her presentations. Specifics of an incident, however, were lacking. Attempts to awaken them proved unsuccessful for over half the session.

Finally, she spontaneously revealed, "The truth is, I don't want to remember specifics." She had vowed to herself beforehand that she would prevent an attack in the session at any cost. Her strategy was to not remember—not to allow scenes of the past to emerge. Without the scenes, she reasoned, she would not have the sensations and emotions that accompanied them. She could be secure that nothing uncontrollable would happen.

Her strategy went a step further. She focused her eyes on a spot on the wall in front of her as she talked. She knew from the past that this kind of focus prevented anything from starting. In fact, her plan supported the thinking of the research. Her focus allowed her to control her movements, preventing her Starter from occurring. In her everyday life she couldn't alw ays focus and control her thoughts, prevent her Starter. In everyday life she was often caught unawares, unable to control her Starter, and experienced panic attacks.

Once she had revealed the reasons for not remembering, the resistance to the process could be addressed. Mary was reassured that the method did not involve having a panic attack in the session. She was able to give up her defense and remember an event that led to the discovery of her Body Starter and set her on the way to pursue the course of change. Mary was able to let down her guard and proceed. Her panic attacks stopped occurring and she has remained panic-free.

Let's continue to examine the course of change beyond the stage of Dreaming, to give an overview of the change process. Each of the stages of the Cycle of Change is capitalized to highlight it. During the Dreaming phase, the Body Starter becomes outwardly observable (the eyes, for example, moving from side to side). As the therapist directs attention to the Starter, the situation changes for the client. They move beyond memories and begin to tell their story while working toward awareness of their Body Starter.

This is a naturally awkward time. The client is doing two things at once: recalling their attacks and noticing their movements. They are split between two tasks, two pieces, and are noticeably in a state of physical tension because of the disjunction. It's a bit like the challenge of the childhood game of tapping your head while rubbing your stomach. The tension that arises serves as an impetus for a Creative moment to bring back a sense of unity. Different approaches are tried. To get there requires allowing both fragments to exist until something new occurs, something bigger takes over, and the separate pieces blend into one harmonious and new response.

As the session proceeds, the client and therapist, through joint observation and back and forth Communicating, make the experience of identifying the Starter easily observable for them both. Eventually the Starter, previously unconscious, becomes an integrated part of the client's conscious experience. The therapist and client then work through the dynamics of Inspiration, exploring the hopes and despairs that accompany the panic attack experiences.

The next stage involves the client Analyzing their situation closely in order to become aware of the link between different parts of their specific memories and the occurrence of the Body Starter. During high-charged moments of their story they will take notice of the Starter.

The individual will be asked to recall several panic situations and work with them until they can tell their story without it being accompanied by the movement of the Body Starter. When this has been Solidified, the change aspect of the session concludes by working physically to Achieve a way for their body to have a fluid way of expression without arousing the physical dysfunctions that mark the Body Starter.

Rhythmic Integration Project Results

The complete cessation of panic attacks, which occurred within a week for four of our five subjects, was profound for them. It was experienced as a stunning change. Panic attacks are extremely powerful experiences. To limit them, sufferers quickly develop an elaborate inner dialogue to understand and develop strategies. The experience of ending panic attacks after only a 90-minute session is hard to believe.

Figure 1 shows the dramatic reduction in attacks for all participants, though not all of them experienced immediate ongoing cessation. Those patients who did not report complete cessation were all panic-free for the month prior to the one-year follow-up.

Panic Frequency Before and After Intervention

Subject	Month Prior	Week After	1 Month After	2 Months After	3 Months After	1 Year After
Client A	3	0	0	0	0	0
Client B	18	0	0	0	0	0
Client C	5	3*	0	0	0	1
Client D	3	0	4*	0	2	0
Client E	20	0	0	1	7*	0
Total Attacks	49	3	4	1	9	1

* Explanations of disparities are outlined in the following paragraphs.

It is interesting to consider what happened to those who did not cease their panic attacks immediately. In the routine one-week follow-up call by a staff member of the project, Client C reported having had three panic attacks in the first week after the session. Review of a videotape of the intervention revealed a second Starter, a choking response, that hadn't been identified in the session. The study was designed to provide participants additional support if there were signs of difficulty. For Client C, two more panic attacks occurred in the several days leading up to the therapist's phone call, at which point the problem was addressed. Drawing on what occurred during the interventions, the interaction took only five minutes. In subsequent follow-up calls over the following year Client C reported no further attacks.

Client D experienced a burst of attacks the week before she was to undergo major surgery. This was to be the last of a series of surgeries that she had undergone as a result of an injury. She attributed the injury to the beginning of her panic attacks. She reported that in her stress she had completely forgotten to make use of her Starter. After her operation, she was given a one-hour session to reinforce her learning. A year later she reported no attacks.

The experience with Client E was particularly instructive. It demonstrated the psychological complexities that can come into play around treatment. A middle age man, Client E had suffered with a history of frequent panic attacks since early adolescence. Initially, after participating in the project, he dropped to no panic attacks. However, the very day he was contacted for his two-month follow-up he had an unexpected attack while exercising— "It came out of nowhere." Though early results had brought a two -month period of dramatic and unexpected change for him, he became convinced the method didn't work. He was angry and ready to give up on it. There were seven more attacks over the next days before the outbursts subsided, and his rate again dropped to zero.

Client E's experience makes evident that the method does not necessarily prevent the Starter from occurring. Nor is it certain that when it does occur that it will not escalate into an attack. It is possible, however, and seemed to ring true for all the participants, that over time awareness of the Starter fades into the background; the body learns how to take care of itself without conscious effort.

This study, as are many studies that begin to research a new method, was small and simply designed. There were five subjects, one therapist (the author), and a critical variable measured over time—the number of panic attacks reported. Still, the dramatic nature of the change after the intervention, in people with long histories of frequent panic attacks, is sufficient to show that the intervention was significant by research standards.[40]

Meanings

This is the first research study of this method. The results are strong enough to conclude that the one-session Rhythmic Integration intervention made a significant difference in the occurrence of panic attacks. The findings are further supported by similar results in experiences that took place in teaching, and clinical applications that were done before or outside the design of this study.

Certain generalities are important to note: The size of the sample was small; panic attacks are often associated with other emotional difficulties (i.e., depression, night terrors, agoraphobia, specific and social phobias, etc.); knowledge of how broadly, and under what conditions the results will be upheld, will also necessitate further study.

Another reason for caution about the method's applicability is fundamental. It arises from the fact that one therapist saw all subjects. Should the results be attributed to the method, or the therapist? A second study, currently in process, addresses this question under supervision of another therapist. The one-month follow-up results, collected at the time of this writing, again show a high level of success: eight subjects went from having a combined total of 146 attacks (mean=16, median=20, mode=20) to a combined total of six attacks. Five subjects became panic-free. The three others saw reductions in the number of attacks by 82 percent, 90 percent, and 95 percent respectively. The results at the time of this writing offer strong evidence of the effectiveness of the method. Follow-ups will continue. Also, a manual and training module are being developed which will lay the ground for further research and clinical application.[41]

The method suggests that the role of the body and its observable movements are highly significant in affecting the occurrence of panic attacks. Can this thinking be applied to other anxiety categories with similar results? The field of Bioenergetics and body-oriented psychotherapies has found that along with psychological improvement comes more fluidity of motion in the body. In considering the mind-body connection the reverse is also seen as true—a more natural flow pattern results in improved psychological functioning. The method used here demonstrates that changes toward natural movement patterns can be made in a systematic and rapid way.

Finally, there is the disbelief factor. Even experiencing the cessation of panic attacks after having them for years is not enough to negate the disbelief in those who have undergone the change. It takes time for the mind to accept the fact that the body's movements are a stimulus for attacks, that the mind may have a less critical role than previously thought. If the results prove to be widely applicable and frequently reported, the view that body movements play a key role in initiating panic attacks can become part of a consensus of understanding—believed as part of commonplace knowledge.

With a different belief system permeating society, panic attacks can move out of the murky arena of emotional disease to be understood more simply as a reaction started by a physically disruptive body movement. The mystique, and the shame that accompanies this malady, would be over. Like a golfer who works to eliminate a hitch in his swing, the sufferer of panic attacks might simply train themselves to break the troublesome link between disruptive movement and charged emotions. Their bodies then would flow more smoothly and avoid

setting the physical conditions that can start a process headed toward inner uproar and the life-limiting experiences that accompany panic reactions.

Endnotes:

4/4/2004 ERRATA CORRECTED P 10: "1 Year After" column Subject C should read 1, not 0 as published.

1. J. Gorman, *Understanding Panic Disorder Finding Hope, Gaining Control*, pamphlet from Freedom From Fear, Stanton Island, NY (a Pfizer, Inc. publication, 2000).
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    http://www.eabp.org/correction.htm
20. Author Ron Robbins is an International Trainer in the method of Bioenergetics. For further description of it see Alexander Lowen, *The Language of the Body* (New York: Collier Press, 1958).
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41. Contact Information - www.panicproject.com or 845- 485-7171