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Response to Commentaries on:
Paradoxical Intention (PI) Combined With Hypnosis in the Rapid Treatment of Anxiety Disorders: The Cases of "Fran" And "Emily"

But Does It Work in Theory? and The Case of Simone: Paradoxical Intention in a Case of Post-Traumatic Panic Disorder

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ABSTRACT

I gratefully acknowledge the thoughtful and perceptive comments and criticisms of Roberg and Buerger (2026) and of Cassiello-Robbins and Bullis (2026) in response to my case studies on the therapeutic use of Paradoxical Intention (PI) with "Fran" and "Emily "(Hamberg, 2026). Both commentaries note that the theory underlying the current Cognitive Behavior Therapy (CBT) approach to panic disorder is not habituation, as I had proposed, but the Inhibitory Learning Model (ILM). In line with Toulmin's (1953) view of theories as conceptual maps, I argue that the advent of a new theory does not necessarily render an older or alternative theory incorrect or obsolete. Rather, different theories can be seen as equally valid maps of the phenomena under consideration, e.g., a street map of San Francisco versus a topographical map of the city, and thus have differential pragmatic value depending on the use to which they are put. Habituation would seem clearly useful in the traditional desensitization situation, while ILM would seem more useful in accounting not only for the effects of CBT for panic disorder but also for the effects of Paradoxical Intention (PI) procedures like the ones I used in the cases of Fran and Emily. Roberg and Buerger are correct in pointing out some points of similarity between PI and CBT, especially in my flight phobia case of Emily. While Cassiello-Robbins and Bullis argue that PI and CBT are more similar than dissimilar, I present a view emphasizing their differences.

Key words: paradoxical intention; hypnosis; hypnotherapy; panic disorder; agoraphobia; aviophobia; Cognitive Behavior Therapy (CBT); United Protocol; case study; clinical case study

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INTRODUCTION

On the campus of my local neighborhood Great University, students wear t-shirts with the University's name on the front, as usual; on the back, something less usual: "That's all

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well and good in practice, but how does it work in theory?"—a wry undergraduate commentary on the intellectual habits and predilections of the professoriate. I am grateful to Roberg and Buerger (2026; referred to as R&B below) and to Cassiello-Robbins and Bullis (2026; referred to as C-R&B below) for the thought-provoking commentaries on my case studies on the therapeutic use of Paradoxical Intention (PI) with "Fran" and "Emily "(Hamburg, 2026), which brought this item of collegiate humor to mind. Both articles are heavily freighted with theoretical argumentation. And so they raise, implicitly but inevitably, the perennial question, what is the relationship between theory and practice in psychotherapy?

The two commentaries traverse much the same landscape, so I will respond to them together, thematically, rather than serially. On points that are made by one commentary but not the other, they will, of course, be dealt with separately.

HABITUATION VERSUS INHIBITORY LEARNING

Neither Fran's treatment nor Emily's included desensitization via exposure. Nevertheless, because I attributed the desensitization occurring in the interoceptive exposure of CBT treatment to habituation, both commentaries include extensive discussion of the putative mechanisms underlying exposure treatment. Both fault me for adhering to an outmoded theory to explain what happens in desensitization. C-R&B list disadvantages of habituation as a method of understanding and as a guide to treatment: It sometimes doesn't produce lasting change; clients and even therapists will be hesitant to deploy it for fear that "it will be too distressing to be helpful" (p. 52), and some clients do not habituate but can be helped in other ways, by being taught to tolerate their anxiety and cope with it

Both offer the more up-to-date theory, the Inhibition Learning Model (ILM). As C-R&B put it:

> [I]nhibitory learning focuses on the learning that an individual obtains by engaging with the emotion-provoking stimulus. In inhibitory learning, reduction of emotional distress or intensity is not required for exposure to be effective. Instead, what matters most is that the individual learns something about their ability to tolerate the stimulus and associated emotions, regardless of change in the intensity of the experience (p. 51).

R&B put it this way:

> Rather than focusing on reducing fear during exposure (habituation), ILM focuses on creating and strengthening new safety learning that inhibits the retrieval of old fear association" (p. 37).

Neither commentary offers evidence that exposure motivated by ILM is superior to, or even different from, exposure based on a habituation model of desensitization. Indeed R&B

admit that while the explanation of how exposure works have changed over the past 20 years, "the intervention and impact remain the same" ((36).

Let us consider how habituation and ILM compare in accounting for the therapeutic process in a simple, indeed paradigmatic, case—the desensitization for a man with a lifelong fear of heights (cited in my original article on the case studies of Fran and Emily in Hamburg, 2026, (p. 22). Every time I opened the window a bit more, the client experienced a transient fear response that abated after a few moments. I think we can all agree that, if the client had been hooked up to a polygraph, we would see that each of his fear spikes was mediated by physical changes associated with the autonomic nervous system's response to threat: increases in heart rate, blood pressure, skin conductance, and so on. And I think the most plausible explanation for the repeated abatement of this responding is habituation, once the stimulus (the window at whatever degree of openness) loses its novelty. Habituation in this case is manifest, and potentially measurable.

This is not to say that habituation was the only thing happening in this situation. The client has a cerebral cortex and can be presumed to have been experiencing all sorts of cognitive changes in this process, including changes in self-efficacy, the replacement of old fear memories with new safety memories, etc. What is more, it is conceivable that these cognitive changes could have occurred in the absence of habituation and resulted in the same outcome—leaning out the window at the end of 90 minutes.

Following the philosopher of science, Steven Toulmin (1953, Chapter 4), I subscribe to the view that theories are distinct from the phenomena they attempt to account for. In other words, a theory is a map that is more or less useful in helping us understand a particular phenomenon, but it is not a literal, one-to-one picture or true copy of reality. Thus, theories are not mutually exclusive. One theory is not truer than another when they both map different aspects of the phenomenon. A road map of the United States is no more true than a topographical map; they are just useful in different ways.

In line with this view of a theory as a map, for me habituation maps onto the acrophobia desensitization more easily than ILM does. I can well believe that ILM maps onto the fear-reduction process in interoceptive exposure better than habituation does. (I will add, though, that an advantage of habituation is that it is easier to explain to clients than ILM, for example: "You know how when you walk into a kitchen where garlic is cooking, you smell it but after a minute or two you don't—you just get used to it? That is habituation, a property of our central nervous system, and that is what we're going to use to rid you of your phobia.")

OUTCOMES

Both R&B and C-R&B question my estimate of an 80% success rate. I strongly agree with them that ideally I would have collected systematic quantitative data on the outcome of my clients, and that this should become the universal standard in future best practice. In lieu of not having such data, at the request of the *PCSP* journal editor, I provided a subjective estimate of my success with PI cases. (The estimate may have been either an overestimate or an underestimate.)

I do not agree with C-R&B's assessment of my degree of success with Emily. They suggest that the success was only partial because after treatment she was still taking a Xanax tablet in advance of flights. In response to this, it should be noted that before treatment she would sometimes take not just one Xanax before the flight but an additional one during the flight if she felt that the effects of the first were wearing off. But even two Xanax tablets were not enough to keep her in-flight distress within tolerable limits. They were ineffective and so she resorted to psychological treatment.

After treatment, Emily experienced less anticipatory anxiety — "I don't check the weather ahead of time or worry about where I am seated"— and much higher tolerance for turbulence — "Turbulence doesn't cause me to white knuckle." The two major treatment objectives were met, and the client attributed that attainment to the treatment — she even talked to a friend about it — and not to the benzodiazepine. From a practical clinical perspective, I count that as unqualified success even if the client continues to take a pre-flight Xanax as some kind of psychological insurance.

AREN'T WE ALL DOING PRETTY MUCH THE SAME THING?

Both sets of commentators claim that what I was doing with Fran and Emily was less distinct from conventional CBT treatment than I think it is. They base this claim on a post-hoc reinterpretation of my procedures in CBT terms and on what they see as actual correspondences between what I did and what they would do. C-R&B go a step further and claim that their Unified Protocol (UP) approach actually incorporates elements of PI in a variety of ways. Here, I will deal with the two commentaries separately.

Specific Responses to R&B's Comments

R&B cite my statement about dealing directly with fear of the panic attack itself rather than dealing just with the physical manifestations of the attack as a point of correspondence between the PI approach I use and CBT. They point out that CBT approaches indeed focus on the client's fear of attacks by using psychoeducation, cognitive restructuring, and defusion. However, in CBT these methods are employed to change the client's relationship with the

experience of a panic attack. In the PI approach, focusing on the fear of the panic attack is aimed at averting attacks rather than making them more tolerable.

R&B are correct in pointing out that both the PI approach and CBT involve exposure. But again that exposure in PI is in the service of demonstrating that the client can avert panic attacks in increasingly challenging environments rather than an attempt at detoxifying their experience of panic. In any case, they are correct in that both approaches involve in vivo exposure to bolster the client's confidence about being away from a "safe" environment. Exposure as I employ it in PI definitely has its origins in CBT.

R&B observe that the directive in PI for panic attacks, to try to make the feelings worse, "echoes the ACT process of creative hopelessness" (p. 39)." I am not knowledgeable enough about ACT per se to comment fully on this. However, if the effort in ACT is to detoxify negative experiences by having the client refrain from any attempt to control negative thoughts and feelings, then it is distinctively different from the PI directive to make the incipient panic attack symptoms worse. From a PI perspective, trying to control those incipient symptoms is a critical link in the chain leading to a full-blown attack, and so the directive to make the symptoms worse is intended to avert an attack altogether rather than to help the client cope with it somehow. As I understand the term, it is the opposite of acceptance.

As I have said, anxiety desensitization, by habituation or any other mechanism, plays no part in PI. R&B note that the PI approach in this way mirrors ILM because what is presumed to be happening is corrective learning rather than habituation. I totally agree with this. What Fran's PI exposure in increasingly challenging situations did was create an ever-expanding set of safety signals. I further agree with R&B that what PI can be interpreted as doing is creating "distance between the individual and their physiological sensations" (p. 40). If this is what ACT attempts to do, then in this way at least PI resembles ACT.

R&B correctly observe that the PI of Emily's treatment "appears structurally different from the intervention used for Fran" (p. 41). Indeed, it might have been more accurate for me to say that Emily's treatment was PI-inspired. The PI essence of her treatment was to attempt to engineer a positive, welcoming attitude toward the occurrence of turbulence that might interfere with, or at least mitigate, her dread of it. R&B speculate that the PI directive for Emily was a distraction intervention. To the extent that Emily was absorbed in her book, she might have been distracted from the turbulence. But as they also note, she was given an explicit directive to pay attention to turbulence and its disruptive effects. I can agree with R&B that the PI attempted to facilitate "a transformation in Emily's associative learning: in place of linking the sounds and movements of the plane to…fears of the plane crashing, Emily learns to associate the stimuli with the lesser threat, frustration that her reading was being disrupted. A tradeoff, we imagine, most aviophobes would gladly accept" (p. 42).

I join R&B in wondering if hypnosis added anything to the treatment. It is certainly possible that the PI directive itself—to read the book only during turbulence—combined with the psychoeducation provided by the two books about aviation Emily had read would have been sufficient. Two ideas, one from CBT and one from hypnosis, motivated my use of hypnosis. The CBT-derived idea was that imagining the flight experience as it was described in the hypnosis might function as covert rehearsal, and in itself have an anxiety-reducing effect. The idea from hypnosis is my belief, after almost 40 years of using it, that the combination of the highly concentrated state that is hypnosis and the repetition of suggestions that the client regards as in her best interest allows her to be influenced by them. In short, I used hypnosis because I thought it would make a good outcome more probable; and I believed that the small amount of cost and effort involved for the client in using it made it all the more worth trying.

R&B admit that they are not trained in hypnosis and so they cannot confidently explain how it works. I am trained and experienced in hypnosis and I cannot confidently say how it works—especially in the treatment of pain, one of the two applications (anxiety/fear being the other, of course) in which I employ it (Hamburg, 2017). I am always skeptical when I use hypnosis, but it works enough of the time and so I persist.

Parenthetically, I should add that there was no contradiction between using PI for Fran's panic attacks and hypnosis aimed at anxiety reduction, for her anxiety about long car trips. Although that anxiety may have derived from her experience of panic, that anxiety was distinct from panic, that is, it was residual. We can think of Fran's panic attacks as the shadow, and the trip anxiety as the penumbra—related but different, one subsidiary to the other. By the time I hypnotized her, Fran knew how to avert panic attacks; however, she was also just nervous about taking a long trip, and so a straightforward anxiety-reducing tactic seemed appropriate.

Specific Responses to CR&B's Comments

C-R&B claim that the PI approach is not as distinct from their approach, the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders (UP), as I contend it is. My view is that the two approaches are very different in their tactics, in their objective in the treatment of panic attack disorder, and more generally in their guiding conception.

C-R&B argue that what I did with my clients can be explained by their theory. As mentioned above in my allusion to the thinking of the philosopher Steven Toulmin, it is possible that the UP theory can be as valuable a map to explain what I did therapeutically as was my IP conceptual map. On the other hand, C-R&B point to exposure as a common feature of UP for panic disorder and the PI used with Fran, but the comparison only highlights the differences. C-R&B state that if they had been treating Fran, they would have her

> engage in exercises to specifically induce the physical sensations she was distressed by. For example, she might drink seltzer quickly to induce nausea. She might also breathe through a thin straw to produce shortness of breath and chest tightness…By inducing these physical sensations on purpose, she would learn that these sensations are tolerable and she can navigate the experience of them (p. 55).

This is interoceptive exposure, which is designed to detoxify the experience of panic not by habituation, in their view, but by changing the client's psychological relationship to it. There is a stark contrast between such interoceptive exposure and exposing the client not to the experience of a panic attack but to the situation in which an attack occurs so that the client can learn to interrupt the sequence of events that leads to a panic attack and thus avert it. Again, as I see it, both what is done to the client and for what purpose are distinctively different in the two approaches.

More importantly, the guiding conceptions underlying the two approaches are different. UP presumes that individuals presenting with panic disorder require:

> motivational enhancement; … psychoeducation about the function of emotions and teaching patients to break down their experience into thoughts, sensations, and behaviors; … [help in understanding] the short- and long-term consequences in order to identify ineffective behaviors that are maintaining their symptoms; … [training in] mindfulness skills… to increase emotion awareness; … [training in] emotion-focused mindfulness exercises; … [training in] cognitive flexibility skills;"… [training in how to] engage in alternative actions for ineffective behaviors; … [and training in the] ability to tolerate strong emotions [in general] (pp. 53-54).

On the other hand, PI, at least as I practice it, does not presume that people suffering from panic disorders are deficient in all these respects and require such comprehensive rehabilitation. It presumes that they just need to learn how to interrupt the sequence of events that leads to panic attacks and thus avert them.

C-R&B claim that PI is embodied in UP in many ways, but none that they cite meets the definition of PI as I understand it. If PI means anything it means doing the opposite of what would be expected to make things better with the expectation that doing that opposite thing in itself will make things better. What C-R&B point to as examples of PI are in my mind simply tactics to help clients approach anxiety-provoking stimuli, to aid in anxiety desensitization. My view is that simply inducing someone to encounter an anxiety-provoking stimulus is not PI; it is just desensitization.

Contrary to my observation that PI is relatively rare, C-R&B claim that it pervades our culture, that it is in fact ubiquitous. To demonstrate this, they quote the lyrics of the song, "I Whistle a Happy Tune" from the classic American musical, *The King and I.* If the lyricist, Oscar

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Hammerstein II, were alive today and we could ask him what his song means, I believe he would say something like this: "The song means what it says—that if you're afraid you can pretend not to be, fool other people, and eventually fool yourself so that you're not afraid anymore." At no point was either Fran or Emily directed to pretend they were unafraid. And I have never seen the directive to pretend in any of the PI literature. If C-R&B are saying that PI reduces to having the client pretend, then I contend that they fundamentally misunderstand PI.

Finally, it should be noted that—their numerous other objections notwithstanding—none of the Commentators took exception to the moment-to-moment description of the phenomenology of a panic attack, as depicted in the Panic Attack Time Line (PATL) in the original article (p. 9). If that description is accurate, as they seem to implicitly acknowledge, then the logic of trying PI as a first line treatment approach for panic attacks is further strengthened.

PRACTICE, RESEARCH, AND THEORY

In its first six decades, psychotherapy was dominated by psychoanalysis and the major function of theory typically was to substitute for data as psychotherapy's foundation and justification. With the advent of behavior therapy and then cognitive therapy and then cognitive behavior therapy, with their empirical approaches, that all changed. Three decades into that new era, Davison and Lazarus (1994) discussed the complementary and cross-pollinating roles of clinical work and research in advancing psychotherapy as an empirically-based practice. They identified clinical work as the domain in which new techniques were invented and provisionally tested. Evaluative research served to put these techniques on an empirical basis, and then further refine them. And this dialectic then led to a more detailed understanding of the new procedures, i.e., advances in theory. Clinicians who followed these developments were influenced by them. (I remember a particular instance of this influence: reading a review article in the mid-1970s, by Isaac Marks [1975] of research on anxiety desensitization. One conclusion emerging from this research was that the crucial factor in desensitization was not how stimuli were presented — by a graduated hierarchy or by starting at the top of the hierarchy, i.e. flooding — but simply by exposure time. I remember being struck by that finding at the moment I read about it, and I know it has influenced me ever since.)

I acknowledge that ILM offers a more comprehensive and satisfying account of anxiety desensitization in a variety of contexts than habituation does. C-R&B's arguments suggest that ILM could potentially give a more articulate account for what happened in Fran's therapy than I did. But in my view a more pressing question is whether PI-based procedures are as effective and more efficient in the treatment of panic disorder compared with ILM-based, UP procedures as I propose they are, as illustrated in the cases of Fran and Emily. A controlled trial of PI versus UP in panic disorder would yield the answer and is certainly doable. If the results of such a study, carried out by an unbiased investigator, proved UP to be superior to PI then I would have

to admit that PI's effectiveness in my use of it was probably due to the non-specifics of therapy as I practice it. If the results proved IP to be equal or superior to UP, that would compel practitioners of UP to re-evaluate their treatment method and the theory that underlies it. (Of course, another possible outcome is that PI and UP are distinctively suited to different types of clients with anxiety problems.) I would like to think that by specifying my therapeutic procedures in enough detail for them to be replicated, even manualized, I have contributed what I can to advancing evidence-based psychotherapy.

POSTSCRIPT

The case study of "Simone," in Appendix 1, is relevant to the foregoing discussion as another individual case illustrating my use of the PI timeline in Figure 1 of my target case studies of Fran and Emily (Hamburg, 2026). As can be seen, once Simone's presenting problem of panic attacks was resolved through procedures including PI, an underlying problem surfaced, that of existential despair. For treating this, I did not rely on any particular approach to therapy. Rather, I drew on the well of our common humanity**.**

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APPENDIX 1: PARADOXICAL INTENTION IN A CASE OF POST-TRAUMATIC PANIC DISORDER: SIMONE

The Client

Simone was an 84 year-old married woman, referred to me by her primary care physician. She was of medium height, slender, and walked and sat with posture that was remarkably erect for a woman of her advanced years. That she was well-to-do was evident from both her conservative but expensive clothing and from her home address. Otherwise, she was hard to place. Her name was French but her very slight accent in English sounded German. Her face was a kind of Necker cube in my perception, sometimes looking Hispanic to me, sometimes Asian, sometimes African-American. (Much later, I found out that she was of mixed Carribean, European, and Asian ancestry and that she had been born, raised, and educated in Zurich, Switzerland.)

Simone's long life was studded with achievement: two masters degrees, one of them in theology; ordination into the ministry of her Protestant denomination; founder of a successful business that eventually had 50 employees. Her husband—her second, who accompanied her to each session—a few years her junior, had recently sold a successful business of his own. My impression was that Simone and her husband were happy with each other. Simone had children by her first marriage. She mentioned that she wished they were doing better. (I never inquired further about Simone's children because I judged that her feelings about them were unrelated to her presenting problem.) She reported that her mental health had been good in general but that she had been hospitalized sometime in her mid-thirties for depression. (Likewise, I did not inquire about this decades-old depressive episode. It was significant of course. But I felt it had occurred too long ago to have any connection with her current problem. Inquiring into it at the outset would be a waste of time. If at any point later it seemed relevant, I could inquire into it then. In the event, the hospitalization never seemed relevant and I never inquired into it.)

One day, about four months before Simone and I met, she experienced sharp pain in her chest and some difficulty breathing. She immediately went to see her primary care physician, who admonished her for not immediately going to the emergency room of her hospital and directed her to go straight there from his office. She was admitted, diagnosed with acute pericarditis, and released after a few days under the care of a cardiologist. About a month later she had another attack—which changed her diagnosis from acute pericarditis to recurrent pericarditis—was admitted to the hospital again, treated, and released. Her first visit with me was about two months after that.

Her presenting complaint to me was that she experienced episodes of "tension and stress in my chest," which caused her "pangs of anxiety." Even though her primary care physician and cardiologist assured her that her pericardium was healthy, every instance of the chest sensations

caused her mortal fear; they were a signal to her of another attack of pericarditis, or maybe even a heart attack. And when she was not having an episode of chest tension, she was preoccupied with worry about the next one.

Treatment

Session 1. A Preliminary Diagnosis

After the initial interview I wrote this to Simone's doctor:

> I guess the best way to describe her situation is post-traumatic anxiety. She has become hypervigilant about sensations coming from her chest; and whether or not she feels anything at the moment, she can have a surge of anxiety if her mind is not otherwise occupied. I asked [Simone] if she had read anything about pericarditis, and she said she hadn't. This was surprising because these days I would have expected someone of her high intelligence and educational level to have already read at least what the Mayo or Cleveland Clinic had to say about it. I interpret her not having done so as an index of phobic avoidance. [Simone] also admitted to being a worrier in general, which makes this situation all the more difficult.

Force of habit temporarily blinded me to the salience of panic attacks in her anxiety. For many years, I have treated post-traumatic anxiety—whether as a result of a road or boating accident, an assault, or torture—with hypnosis. Since Simone's anxiety was post-traumatic in origin, my first thought was to treat it with hypnosis. It did not occur to me to instead focus on the panic attacks and treat them directly. At the end of the first session, I told Simone my initial impression and asked her to read my 2006 hypnosis article (Hamburg, 2006). I also asked her to begin composing a list of reassuring propositions; propositions which, if she believed them deep in her bones, would allay her fears about a recurrence of pericarditis. Finally, I assigned her a CBT book on combating worry (Leahy, 2005).

After the session, I realized that I had to ask her in greater detail about her frightening chest episodes. My notes say,

> Next ask her in detail re this: quality and severity of any pain, how long it lasts per incident, how many times per day, and when, e.g., during or after working out. [Despite her persistent anxiety about her heart, Simone had resumed her daily exercise routine which included both cardio and resistance exercises.]

Session 2. Changing Course

We next met twenty days later. First, I got clarification on some of the details of her anxiety attacks. They happened only when she was at rest and not otherwise occupied, typically with reading or something on TV. They never happened during or after exercise.

Following up on the homework, Simone reported that she had started the book about combating worry. Then she said that she had begun reading the hypnosis paper but had to stop because it scared her. At that moment I realized that we would not succeed with hypnosis because she was too skittish about it to allow herself to enter into a hypnotic state. We had to change course.

The obvious alternative was to treat Simone's anxiety attacks as if they were manifestations of an ordinary panic disorder, even though they were not. Her panic attacks were manifestations of a post-traumatic anxiety disorder and differed from ordinary panic attacks in three important ways. For one thing, the only physical aspect of her panic attacks was a tight, sharp pain in her chest. There was no dizziness, lightheadedness, shortness of breath, tingling, sweating, or nausea. Second, there was not even an incipient pattern of agoraphobic avoidance, since the attacks happened only in the evening, when she was at home and at rest. Most importantly, the cognitive component of her attacks was not a generalized fear of losing consciousness, falling down, having a heart attack, or even dying. It was the specific fear that the pain in her chest signaled a recurrence of her pericarditis.

Despite these differences from ordinary panic attacks, her subjective experience during an attack mapped nicely onto the Panic Attack Timeline of Figure 1 featured in my target article in this issue of *PCSP*, the case studies of Fran and Emily (Hamburg, 2026). Simone would feel the tight, painful sensation in her chest coming on, try to make it go away, realize that she could not, and then go into a panic. Since the phenomenology of Simone's attacks was so similar to that of ordinary panic attacks, it was reasonable to expect that hers would also be amenable to paradoxical intention.

I this told Simone that, since hypnosis was anxiety provoking for her, we would try an alternative approach. I drew the Panic Attack Timeline from my target article and gave Simone the same presentation I gave to Fran in my 2026 target article. Simone considered it a plausible account of what she experienced and was willing to try paradoxical intention. Then I asked her if I could leave the consulting room for a few minutes to give her an opportunity to feel the chest pain, if she could become aware of it, and then try to make it worse. She stretched out on my couch, and I left the room. When I returned to the room a few minutes later I found, to my dismay, that Simone was very upset. She had indeed been able to summon up the pain and she had tried to make it worse. The pain had subsided but had not entirely disappeared by the time I returned. Simone found this experience to be very frightening.

Needless to say, this was not what I was hoping to find when I returned to the consulting room. I spent some time trying to calm her down. But then I did something I never do with ordinary panic attack clients but that I do use with clients suffering from hypochondriacal anxiety: I issued a challenge. I said to her something very close to this, "Either you do have

pericarditis or you don't. So the next time you have an attack of this pain, you must make a decision about whether or not it means you are having a recurrence of pericarditis. If you decide the pain means that you are having an attack of pericarditis, then you must do as your doctor advised for that—call 911 and get to an emergency room. If you can't get yourself to make that call, it means that deep down you don't think you are experiencing pericarditis. And in that case you must just let go of the thought that you do have pericarditis."

Issuing such a challenge does two things. First, it changes the symptom from something the client must endure, or at best cope with, to something they must make an affirmative decision about. Their role vis-à-vis the symptom is changed from one of passivity to one of agency. Second, such a challenge forces the patient, in colloquial terms, to put their money where their mouth is. The challenge can also be interpreted as a paradoxical directive in that it instructs the client to enact their symptomatic behavior, in the hope that it will extinguish that behavior and the emotions motivating it. Simone agreed to try paradoxical intention in response to the chest pain, and she accepted the challenge.

Session 3. Some Improvement, Some New Information, and Reinforcement of the Challenge

The third session took place just six days later. From my notes:

> Pt [patient] improved. Pain is less intense, more of an ache than a sharp pain. And seems to happen less freq[uently]. And pt not as intimidated by it. At night when wakes up w[ith] it, tries to make it worse but when can't just stays w[ith] it, her mind wanders and then it's gone.

This was heartening; a great deal of improvement in a short time. And as with Fran in my 2026 target article and other panic attack people who follow the PI directive, the improvement began as soon as Simone started following that directive.

Since Simone was improving, I took the opportunity to speculate with her about how the panic might have come about. First, I pointed out that countless events occur in our bodies every second. We can sense some of them, but only if we direct our attention to them. For example, Simone was not feeling her feet in her shoes until I mentioned it. Generally, we are habituated to most of the sensations our body makes available to us—which is a good thing, since that habituation prevents those sensations from interfering with all the things outside our body that we must attend to in carrying out our daily lives. However, Simone's traumatic experience of pericarditis *sensitized* her awareness of sensations in her chest, causing some of them to amplify and trigger a panic attack.

Then I gave Simone a directive that I should have given in the previous session. I asked her to consult her cardiologist and (a) ask him if she currently was suffering from pericarditis;

and (b) if there was any harm in trying to make her panic symptoms worse. She said she would do that.

At the very end of the session Simone told me something important that either she had told me before and I had forgotten somehow, or that she had not initially told me. This was that sometimes during panic attacks she experienced not only chest pain but also difficulty breathing. I told her that the PI response to that would be not to breathe slowly and deeply but rather to hold her breath. Simone agreed to try that.

Session 4. A New Treatment Focus Emerges.

By our next session, two weeks later, Simone felt cured of her panic disorder. She was still having episodes of chest pain, but they were not frightening to her and she could handle them. She had not yet contacted her cardiologist, but she did not feel endangered by making the symptoms worse, not even holding her breath when she was short of breath. I thought our work was over but then Simone presented another, more complicated issue—existential despair. It was summed up by her question, "Why am I still here?" What Simone meant by this was why was God keeping her alive despite the fact that she had the variety of physical discomforts and medical issues that accompany advanced age.

What was interesting to me was that Simone felt this way despite living a full and rewarding life. Her marriage was happy, she was active in her local community, and she was on the board of directors of a major national environmental group. But all of this was not enough to stave off the despair. It occurred to me that none of those involvements gave her a way to anticipate the future positively on a day-to-day basis. I have come to believe—based on my life experience and reflections as a psychotherapist—that without an activity—something to *do*—to create that positive anticipation from day to day, life for people Simone's age (and mine—I am not much younger), can look very much like an empty corridor with a door marked "Death" at the end of it. In my own personal lexicon, such death-defying activities are termed "life-giving."[1] I thus asked Simone what she most liked doing. She said that she had always liked to write, and added that a friend of hers had suggested that she spend some time writing every day. Then either I asked her or she volunteered that she had played the piano as a youngster but had not played in many years. In this, I realized, we had struck psychotherapeutic gold. Playing a

[1] When I was a little boy, my family would occasionally go to the beach in the summer. There, old (i.e. the age I am now) ladies in black bathing suits that were modest in the extreme would wade into the water just far enough so that when a wave came in it would reach no higher than their knees. At that moment they would bend down, scoop up some seawater and splash it on their shoulders. And they would say in Yiddish, the language of the Eastern European Jews, "Oy, seeze eh mikhayeh, seeze eh mikhayeh!" which translates to "It's such a great pleasure!" The Hebrew root from which mekhayeh derives is *khayeem,* the Hebrew word for "life". The word mikhayeh in Hebrew (accented on the first syllable rather than the second, as in Yiddish, means "life-giving." I have always found it touching that the sensitive and clever soul(s) seeking a Yiddish word for pleasure settled on this one.

musical instrument and practicing diligently assures that, no matter what your level is, you will be playing a little better tomorrow than you did today. Every day at the end of your practice, you can plan what you will practice tomorrow that will enable you to play better yet. This provides a powerful way to anticipate the future positively on a daily basis.

I asked Simone if she had ever considered taking up the piano again. She said she had considered getting an electronic keyboard but that she was afraid her husband would be bothered by the noise. Simone was evidently unaware that it was possible to practice silently on a keyboard because you could listen through headphones. I gave her this information and she visibly brightened up. She said she would look into piano lessons. I recommended a brand of electronic keyboard that was favored by professional pianists.

Session 5. Continued Improvement

Our next session occurred three weeks later. Simone was still having attacks of chest pain but they were less frequent and she considered them "minor." She had arranged to start piano lessons at a high-quality music school in her upscale community. It was just a mile away from her house and she was looking forward to riding her bike to it. Simone talked about how things were different for her now that she was 84. Since our last session she had been to New Orleans and Palm Springs, but she wasn't as interested in traveling as she had been—in contrast to her husband who was still interested in traveling. She also complained that she felt less able to juggle several tasks at once. She had been asked to deliver a sermon at her church, felt she could not refuse, and now felt the pressure of having to prepare it.

I explained to Simone that in order to further decrease the frequency of her attacks we had to find a way to lower her overall anxiety level. To that end I did two things. I taught her meditation which she indeed found relaxing. (A copy of what I say to clients to teach mediation is shown in Appendix Table 1. I also sent Simone a sound file of my 20-minute hypnotic induction, which doubles as a relaxation tool, and asked her to listen to it at home. We agreed that stressors like the pressure of the sermon did not help her anxiety level and that she had to be more careful about making commitments that could be stressful for her.

Overall, Simone sounded a bit depressed. Just to check, I administered the Beck Depression Inventory (Beck, Steer, & Garbin, 1988). The scoring categories are: "none or minimal depression is < 10; mild to moderate depression is 10-18; moderate to severe depression is 19-29; and severe depression is 30-63" (Beck et al., 1988, p. 79). Simone scored 13. I concluded that for practical clinical purposes, then, Simone was non-depressed.

Session 6. Final session

Our last session did not occur until five weeks later because of Simone's travel schedule. (She and her husband were still doing a lot of foreign travel even though, as mentioned above,

her taste for it had diminished.) Her condition was improved overall compared to the previous session. In the entire interval she had experienced only two attacks, which she characterized as "very minor." She said that she just waited them out. She wondered why she'd had them. She had finally met with her cardiologist and he had reassured her that the "tools" she had acquired in therapy were safe to use. She was meditating regularly and finding that beneficial. Simone said, "I feel in control."

However, Simone had still not listened to the hypnotic relaxation recording. She was afraid of getting lost or stuck in a hypnotic state. I assured her that she could never get lost or stuck in a hypnotic state and described the classic experiment (Orne & Evans, 1966) on that. In the experiment, the hypnotist hypnotizes a group of people and then leaves the room. Sensing that nothing further is happening, eventually all of the hypnotized people open their eyes and they leave the room. I suggested that Simone listen to the recording together with her husband the first time, both of them with their eyes open and with no attempt to enter into a hypnotic state, just so she could find out what was on the recording. Then she could make an informed decision on whether she wanted to listen to it again or not.

At the end of the session Simone talked about how excited she was about beginning her piano lessons in a few weeks. She said that her aspiration was to improvise jazz on the piano. I assured her that this was well in the realm of possibility, once she had recovered her piano technique. I also recommended that she read two books. The first was the book I had used more than 50 years before to learn to improvise (Coker, 1987). The second was *Never Too Late: My Musical Life Story* by the educator, John Holt (1991). The book is an inspiring account of the joys, and trials, of taking up an instrument late in life. Simone agreed that she was free to call me at any time for any reason, and with that the treatment ended.

Follow-up

Four and a half months later, I wrote Simone an email informing her of her balance after Medicare reimbursement. I took the opportunity to ask her how she was doing. Several days later, she wrote back:

> 1. Your check is in the mail today.
>
> 2. Thanks again for all the good work you did with me. My anxiety attacks are less frequent. I employ the exercises you taught me as well as the meditation. I think I am in control.
>
> My piano lessons are super duper. My teacher is wonderful and patient. I find it's not as easy to learn as an old person vs. a young person. But I welcome the challenge and consider it a blessing. This summer I took lessons twice a week and practiced 5 days a week. This fall I am taking lessons once a week and practice 5 days a week. The music school is a

wonderful place to be. There are so many sounds of good music. 12 practice rooms all but two equipped with grand pianos. The other two have older uprights.

We are traveling the end of this month for 3.5 weeks. Iceland, Ireland, Portugal, finally Spain. We have rented a small house in Barcelona to extend our stay by one week. Exhausting but should be enjoyable. When I return I'll start my fall semester of music lessons. You have assisted me in ordering my steps in a new direction and I am so grateful.

Hope you are well.

Oops, pericardium is still around but I'm taking meds for it. I'm feeling healthy and good.

Reflections on My Suggestion to Simone to Take Up Piano Playing to Combat Her Existential Despair

The tactic of recommending that Simone take up the piano again can be theorized, post hoc, in numerous ways. For example, after Simone's case was over, I looked into whether Viktor Frankl (1969), one of the developers of existential therapy (and coincidentally the progenitor of PI), had proposed my type of suggestion based on his logotherapy theory and found that he had.

That the piano-playing recommendation helped Simone with her existential despair does not mean that another totally different approach could not have been as helpful, maybe more helpful. Another therapist, maybe many others, would not have chosen to look away, as I did, from Simone's evidently problematic relationship with her children; they would have focused on it. And by helping Simone understand the relationship with her children and come to terms with it in a different way—maybe even do something about it such as reach out to them—such a therapist might have achieved as deep or maybe an even deeper, more life-changing result than I did.

My understanding of how I was thinking when I made the suggestion to Simone of taking up the piano again is that this recommendation emerged from my outlook at this point in my life. It might not have occurred to me, say, 40 years ago. Back then I was too busy raising my daughter, developing my psychotherapy practice, too preoccupied, to play music very much. My orientation to music was more as a listener than as a player. With more time now, day to day, but much less time than 40 years ago, when I look at the big picture, my outlook is different. I still listen to music—more to classical than jazz these days—but, because I feel a greater sense of urgency about everything now, I play a lot more—whenever I can. Playing is my major preoccupation now, so it stands to reason that it would have occurred to me to recommend it to Simone. In any event, I am happy that this aspect of my personal life contributed to inspire me to encourage Simone to take piano lessons.

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Appendix Table 1: Script for Meditation for Simone

As you know, different cultures the world over have more or less independently developed their own approaches to meditation. They vary from each other in different ways. Some are frankly religious, some are not. The kind I teach you will obviously not be religious. Some approaches involve verbiage of some sort—repeating a prayer, or a special word or phrase, a "mantra." Some don't. The kind of meditation I teach you will not involve verbiage. But when you survey all these diverse approaches to meditation and ask what they have in common you find that what they have in common is an attempt to quiet the person's mind by focusing their attention on their breathing. There are many different ways to focus on your breathing. I like the one I am going to teach you because it sort of gives you a target.

Now please recline back, make sure your head is supported by a cushion or pillow—that head support is very important so you can relax the muscles of your neck and your upper back—and close your eyes. As you breathe easily and naturally—this is no kind of deep breathing exercise, just breathe in whatever way is easy and natural for you—we can compare the in-and-out motion of your breathing to the back-and-forth motion of a swing. So what does the swing do? It arcs out in one direction until it reaches its furthest point of travel in that direction, stops instantaneously, reverses direction, reaches it's furthest point of travel in that direction, stops instantaneously and reverses again. The two points in your breathing cycle that correspond to the two end points in the travel of the swing are: the point at the end of the inhale, where the exhale meets the inhale—find that point and tell me when you have—[wait for the client to so

signal] and the point at the end of the exhale where the exhale meets the inhale. Find that point and tell me when you have. [Then, after the client has so signaled:] Some people like to imagine a swing when they meditate but you don't have to. You can just look directly at your breathing.

Now I'm going to leave the room for three minutes to give you a chance to try this. And even in that short span of time—and probably sooner rather than later—a moment will come when you realize your mind has wandered, that you've stopped focusing on your breathing and started thinking about something else. Whenever you sense that's happened, just let go of the thought that's intruded and return to where the inhale meets the exhale. Even in a short three minutes, that's going to happen repeatedly: Repeatedly you're going to notice that your mind has wandered, repeatedly you're going to have to let go of the intruding thought and return to your breathing. The fact that this happens repeatedly does ***not*** *mean that you are not good at meditation or doing it wrong. That repeated process of noticing the intruding thoughts, letting go of them, and returning to your breathing* ***is*** *meditation. Do you have any questions at all about what I've said? [After any questions have been answered:] I am going to leave the room to give you a chance to meditate in private, and then we'll talk about it.*

[Then after returning to the room:] OK, tell me about what you experienced. [Once the client's experience has been processed continue with:] Now let me tell you about meditation in this country. It came to this country with the Beatles. Towards the end of their life as a group, they had a friend, an Indian dude called The Maharishi. He meditated, and so they meditated—and meditation became a "thing." At the same time, research was done showing that meditation just like what I taught you caused greater decreases in physical indices of stress—heart rate, blood pressure, skin conductance, that is, sweating, than did the simple instruction to sit in an easy chair and relax. Trained meditators meditate for a half-hour or more at a time. But you don't have to meditate that long to experience a benefit. Set a timer for three minutes, so you're not wondering about elapsed time. If three minutes seems too long, set the timer for two minutes; if it seems too short, set it for four minutes. I think you will find that just five minutes of meditating can be not only relaxing but restorative—almost as if you had taken a half-hour nap. You can meditate at any time of day with one exception: the research found that the effects of meditation were less if the person had a full stomach. So it's better to meditate before meals than after them.