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Failed solution attempts in panic disorder with and without agoraphobia

Tentativas Fracassadas de Solução em Transtornos de Pânico com e sem agorafobia

Intentos de solución fracasados en Trastornos de Pánico con y sin agorafobia

Marcelo R. Ceberio[1]
https://orcid.org/0000-0002-4671-440X

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ABSTRACT

Panic disorders, both with and without agoraphobia, are among the most prevalent and impactful mental health conditions in contemporary society. These disorders are expressed through a constellation of organic and psychological symptoms, including cognitive, emotional, and interactional components. However, one of the most significant factors in symptom maintenance is not the symptoms themselves, but rather the "failed solution attempts" made by patients, their close relationships, and even some professionals. These attempts, though well-intentioned and aimed at reducing distress, paradoxically become counterproductive by reinforcing the problem, perpetuating it over time, and generating strong resistance to change. The present study aimed to identify, classify, and analyze these failed attempts within the framework of a systemic treatment protocol for panic disorders. Through a qualitative, descriptive, and exploratory research design, semi-structured interviews were conducted with a sample of 30 patients residing in Buenos Aires, Argentina. The analysis allowed for the categorization of failed solution attempts into four main groups: personal, those made by significant others, by professionals, and by affectively close individuals.

Keywords: support, disorders, panic, agoraphobia, failed attempts.

RESUMO

Os transtornos de pânico, com ou sem agorafobia, estão entre as condições de saúde mental mais prevalentes e impactantes da sociedade contemporânea. Esses transtornos se manifestam por meio de uma constelação de sintomas orgânicos e psicológicos, que incluem componentes cognitivos, emocionais e interacionais. No entanto, um dos fatores mais relevantes na manutenção do quadro sintomático não está apenas nos próprios sintomas, mas nos "intentos de solução fracassados" realizados pelos pacientes, por

[1] Laboratorio de Investigación en Neurociencias y Ciencias Sociales, Universidad de Flores, Universidad y Escuela Sistémica Argentina. marcelorceberio@gmail.com

seus vínculos próximos e até por alguns profissionais. Esses intentos, embora bem-intencionados e voltados para a redução do sofrimento, acabam sendo paradoxalmente contraproducentes, pois reforçam o problema, o perpetuam no tempo e geram fortes resistências à mudança. O presente estudo teve como objetivo identificar, classificar e analisar esses intentos fracassados dentro do marco de um protocolo de tratamento sistêmico para os transtornos de pânico. Por meio de um desenho de pesquisa qualitativa, descritiva e exploratória, foram realizadas entrevistas semiestruturadas com uma amostra de 30 pacientes residentes em Buenos Aires, Argentina. A análise permitiu categorizar os intentos fracassados em quatro grupos principais: pessoais, realizados por pessoas significativas, por profissionais e por indivíduos afetivamente próximos.

Palavras-chave: acompanhantes, transtornos, pânico, agorafobia, tentativas fracassadas.

RESUMEN

Los trastornos de pánico, con y sin agorafobia, constituyen una de las patologías contemporáneas de mayor incidencia y repercusión clínica en el ámbito de la salud mental. Este tipo de trastorno se manifiesta a través de una constelación de síntomas tanto orgánicos como psicológicos, que incluyen componentes cognitivos, emocionales e interaccionales. Sin embargo, uno de los factores más relevantes en la mantención del cuadro sintomático no reside únicamente en los síntomas en sí, sino en los "intentos de solución fracasados" que realizan los propios pacientes, su entorno cercano y algunos profesionales. Estos intentos, aunque bienintencionados y orientados a disminuir la sintomatología, resultan paradójicamente contraproducentes, ya que no solo perpetúan el trastorno en el tiempo, sino que, además, refuerzan las resistencias al cambio y complejizan el abordaje terapéutico. La presente investigación se propuso identificar, clasificar y analizar dichos intentos dentro del marco de un protocolo de intervención sistémico para los trastornos de pánico. A través de un diseño cualitativo-descriptivo de tipo exploratorio, se llevaron a cabo entrevistas semi-estructuradas a una muestra de 30 pacientes residentes en la ciudad de Buenos Aires, Argentina. Los resultados permitieron categorizar los intentos fallidos en cuatro grupos principales: personales, de acompañantes significativos, de profesionales y de personas afectivamente cercanas.

Palabras clave: acompañantes, trastornos, pánico, agorafobia, intentos fallidos.

INTRODUCTION: Panic Disorders

Panic disorder is one of the pathologies most frequently encountered in psychological clinical practice. Nearly 30% of the population will experience a panic attack at some point. Today, it is a commonly discussed topic. It seems that the accelerated pace of life in cities increasingly leads to this type of problem (Rispo, 2007). The stressful rhythm imposed by contemporary society drives the manifestation of symptomatic brakes, a response to the inability to set limits and endure situations bordering on pathology, often involving submission to excessive behavioural demands (Ceberio, 2014). Panic is generally defined as a disorder characterised by the recurrent presentation of panic attacks. Historically, it was considered a form of anxiety neurosis but was later defined as an anxiety state.

The term "panic attack" is typically used to designate the experience of a sudden onset of intense fear accompanied by physiological symptoms (Rodriguez, 2024; Delgado et al., 2021). The key characteristic of an anxiety or

panic attack is the isolated and temporary appearance of intense fear or discomfort, in the absence of real danger, accompanied by a wide range of somatic or cognitive symptoms (APA, 2002). The onset of a panic attack is abrupt, reaching maximal intensity rapidly (Yilmaz et al., 2025). The anxiety attack is accompanied by a feeling of imminent danger or death and an urgent need to escape (APA, 2022; Pinheiro, 2022; Ceberio, 2014, 2015; Chappa, 2006).

It involves the temporary or isolated appearance of intense fear or discomfort, accompanied by four or more of the following symptoms, which begin suddenly and reach their peak within the first 10 minutes (Carbajal-Burgos, 2023). The DSM-IV lists 13 symptoms to qualify a “Panic Attack,” which can be divided into “Neurovegetative Symptoms” (instability, dizziness, or faintness / trembling or shaking / sweating / paresthesias [numbness or tingling sensations] / chills or hot flushes); “Gastrointestinal Symptoms” (nausea or abdominal distress); “Emotional Symptoms” (fear of losing control or going crazy / fear of dying / derealisation or feelings of unreality or depersonalisation [being detached from oneself]); “Cardiovascular Symptoms” (palpitations, pounding heart, or accelerated heart rate / chest tightness or discomfort); “Respiratory Symptoms” (sensations of choking or shortness of breath / feeling of smothering).

Chappa (2006) adds that the subject not only experiences the sudden and unexpected onset of breathlessness, palpitations, sweating, trembling, and instability, but also perceives their surroundings as strange, altered, as if in a fog. They lack clarity of thought and feel on the verge of losing self-control (Helbig-Lang et al., 2012). In relation to these symptoms, we add that the person with panic disorder generally lacks clarity of thought and rational management, as their focus is permanently fixed on the probable appearance of fear. Consequently, they lose concentration and feel that they are “constantly” in the presence of an attack; that is, they suffer when they have the attack and suffer when they do not, because it is likely to occur. Many of these symptoms are accompanied by agoraphobic sensations, not as a pure syndrome, but as feelings of having no way out and feeling trapped with no escape.

Agoraphobia is a disorder involving significant fear or anxiety about being in places or situations from which escape might be difficult or embarrassing. It is especially related to intense fear of open or public spaces where crowds may gather, being outside home alone, being in a crowd, standing in a line, crossing a bridge, or travelling by public transport. Agoraphobia is often secondary to panic disorder, although agoraphobia without a history of panic disorder can exist DSM-5-TR (APA, 2022).

To this entire circuit, we must add that the panic attack is an experience of a maximum peak of fear and anxiety taken to the extreme, where both feed back into each other, generating a domino effect: fear of feeling fear, obsessive focus on fear and its symptoms, expectant and hypervigilant tension, permanent anxiety, uncertainty, panic. It is a sequence of emergency states in a process that devastates the person due to the constant stress it imposes. It must be remembered that not only does stress activate the same axis activated in panic, but also, panic itself is stressful, and stress encourages and further provokes the panic circuit.

Panic disorder with or without agoraphobia is, both in its presentation and development, a complex condition that can hardly be successfully addressed with therapeutic proposals that do not consider all the variables involved and their consequences (Mellado-Pastor et al., 2023). From this definition, it is easily deduced that panic is a form of fear and anxiety whose symptomatic manifestations are primarily somatic in nature.

A characteristic phenomenon of the panic attack is its omnipresence, as most patients with anxiety disorders, regardless of the specific type, have experienced panic attacks (Belloch et al., 1995). But its omnipresence is due to the person being in a state of permanent alertness, and this attitude renders them vulnerable: they fear the attack itself and also fear the periods between attacks, knowing one could potentially occur. The state of vulnerability generated by the underlying anxiety makes the person more susceptible to facing critical situations.

Wolpe and Rowan (1988) point out that the emergence of panic-specific sensations is a consequence of hyperventilation, with the attack resulting as an unconditioned response. Hyperventilation is the behavioural response to the feeling of suffocation. The sensation of breathlessness stimulates the automatic reaction of accelerating breathing, which overloads the system with air by reducing blood carbon dioxide levels, leading to nausea and dizziness (Ceberio, 2014).

The anxiety-fear circuit is crowned by a series of negative and catastrophic cognitive constructions, framed within “mental schemas.” These schemas are structures where the belief system, value scales, categorisations, family and sociocultural patterns, among other elements, are combined (Ceberio, 2011). They foster negative thoughts that reinforce the low self-esteem so characteristic of fearful individuals.

The tendency to continuously self-monitor, searching for any internal signal associated with panic, makes it more likely to perceive some sensation that re-triggers this vicious cycle (Schmidt et al., 2021). On the other hand, from an interactional perspective, a categorical rule of this disorder is: the more panic attacks occur, the greater the fear of having them again. The cognitive representation becomes entrenched as a mental schema and generates automaticity. Thus, the “fear of feeling the fear attack” emerges as the key effector that opens the floodgates to the symptomatic domino effect. Anticipatory anxiety produces intense fear, and this is what leads a person to increasingly avoid more situations, eventually even avoiding leaving home altogether, retreating into the “prison” of agoraphobia (Amarilla et al., 2022).

Human Problems and Solution Attempts

Within the field of phobic and panic disorders, one of the most clinically relevant aspects concerns the way individuals attempt to resolve their difficulties. The crux of the problem lies in how these attempts can, paradoxically, contribute to their maintenance and chronification. In the specific case of phobic conditions, it is observed that the proximity of the phobogenic stimulus is often the determining factor for symptom onset. Individuals with such disorders establish a personal safety perimeter—a threshold distance—within which they can function with relative calm. However, when this “comfort zone” boundary is crossed, a

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symptomatic response is triggered that compromises their daily functioning (Nardone, 2016).

In episodes of panic with agoraphobia, even a trivial situation—such as leaving home or entering an enclosed space—can act as a trigger for a catastrophic anticipatory cognitive sequence, followed by intense physiological reactions. Faced with this scenario, the individual attempts to control the situation using rational strategies, convincing themselves that they can manage what is happening and that nothing adverse will occur. This phenomenon is well-documented in current literature. For instance, Clark and Salkovskis (2021) explain that these catastrophic interpretations fuel a cycle of anxious anticipation and avoidance, turning even simple encounters into symptomatic triggers. Furthermore, a recent meta-analysis by García et al. (2023) indicates that individuals who attempt to rationalise their exposure without therapeutic support experience maintenance or even an increase in agoraphobic symptoms, due to the internal validation of their own fears.

However, this self-reassurance is underpinned by an implicit denial of the real fear: the person needs to convince themselves because, deep down, they profoundly fear the very thing they wish to avoid. As Ceberio (2018) notes, this cognitive process transforms into a negative reinforcement that amplifies the opposite effect: the more one tries to persuade oneself it won't happen, the greater the activation of fear. This type of strategy, aimed at reducing distress, frequently leads to the construction of “self-fulfilling prophecies.” As defined by Watzlawick (2015), Ceberio & Watzlawick (2025), and other authors (Nardone, 2025; Milanese, 2021; Gasalla, 2022; Laso Ortiz, 2015; Wurm et al., 2013), these prophecies arise from an anticipatory cognitive schema that, when enacted, ends up materialising in reality precisely what was intended to be avoided. Within this framework, behaviours aimed at suppressing the symptom ultimately contribute to its maintenance. The paradox lies in the subject deploying a repertoire of behaviours that, far from resolving the difficulty, increase its intensity and duration (Watzlawick, 2015; Ceberio & Watzlawick, 2025).

From a systemic-interactional perspective, it is argued that the so-called failed solution attempts constitute one of the primary mechanisms sustaining and reproducing the symptom (Weakland et al., 2010). Indeed, it is through these attempts, which seek to eliminate a difficulty, that the transition from a circumstantial challenge to an entrenched problem is configured. According to Watzlawick et al. (2018), it is precisely these ineffective solutions that transform a mere difficulty into a structural problem. This logical status change occurs when, failing to generate an effective resolution, the individual increases their investment in the same type of response, repeating the failed action with the expectation of a different outcome. This phenomenon not only fails to resolve the situation but consolidates it within the subject's personal and relational system.

Repeated actions that fail to achieve their purpose not only fall short of their resolutive goal but also end up becoming a constitutive part of the problem itself. The more one insists on applying the same failed formula, the more the problematic circuit is reinforced. In this way, solution attempts become generators of the very dysfunction they were originally meant to neutralise. Added to this is the fact that such behaviours—though ineffective in the long term—provide, in the short term, a measure of emotional relief: they act as fear attenuators or as preventive mechanisms against a panic attack. This momentary utility reinforces

their repetition, installing a perceptual-reactive pattern that fuels the persistence of the clinical picture (Nardone, 2020).

As these solution attempts are reiterated, the associated symptoms also intensify: anticipatory anxiety increases, feelings of lack of control are exacerbated, the sense of helplessness deepens, and self-esteem diminishes. This vicious cycle generates a progressive increase in distress, which in turn reinforces avoidant and defensive behaviours, restarting the cycle from its beginning. Thus, a pathological spiral is established where each attempt at resolution becomes another step in the consolidation of the disorder.

Conversely, the learning of effective solutions allows for their storage and subsequent transfer to similar situations, simplifying the approach to future problematic experiences (Watzlawick et al., 2018). However, when a previously successful strategy is applied automatically to a new situation, without assessing its pertinence or adjusting its implementation, it can become an obstacle to resolving the current conflict. In this framework, problems are conceptualised as the crystallisation of a “problem-behaviour” that persists over time, despite repeated conscious and intentional efforts to eliminate or modify it. This persistence pattern generates a self-perpetuating vicious circle: the greater the repetition of ineffective behaviour, the higher the probability that attempts to eradicate it also become ineffective or even counterproductive. What is configured, then, is a positive feedback loop (in systemic terms), in which the “erroneous” behaviour and the failed solution attempts mutually reinforce each other's presence and stability. Instead of extinguishing the symptom, these endeavours contribute to its entrenchment within the individual's behavioural repertoire.

Consequently, the objective of this research is to explain and group into categories the attempts that patients with panic disorder, with and without agoraphobia—apply in the belief that they are solving their problem. The possibility of inventorying these attempts would facilitate therapeutic interventions and increase understanding of the dysfunctional circuits structured around them. It follows that therapeutic intervention would not reside solely in eliminating the problem-behaviour, but in interrupting this dysfunctional cycle of maintained failed solutions. This implies identifying the feedback pattern, understanding the beliefs and cognitive structures that sustain it, and generating a break in the logic that perpetuates it. The aim is to foster new forms of action, more attuned to the current conditions of the environment, allowing the recovery of the adaptive flexibility lost in the repetitive attempt to apply an obsolete solution.

Symptom Maintenance and Chronification

The stereotyping of a solution runs counter to creativity. Conceptual schemas guided by logical-rational thought (which, on multiple occasions, proves insufficient) delimit a range too restricted to facilitate qualitative diversification. However, it is in the quantitative domain that a greater expansion of activities is manifested: the same strategies are insistently replicated, even when results do not lead to the intended goal and culminate in failure.

The symptom-problem manifests as an atypical behaviour, an unusual conduct that deviates from expected and operative patterns of response to

different situations. It can be conceived as a form of protest, becoming an explicit expression, a warning that some segment of the communicational system is functioning defectively. The symptom possesses an allostatic character (McEwen, 2006; Sterling, 2020). In this sense, it acts as an alarm signal which, if correctly interpreted, can guide the way toward the recovery of functionality. However, approaching the symptom solely from an interactional perspective offers only a partial view of the reasons underlying its appearance.

Interactional factors must be combined with unconscious, communicational, experiential, historical, biochemical, organic, endocrine, neurophysiological, cognitive, and emotional factors, all converging to constitute a bulimic, panic, anorexic, depressive, obesity, drug addiction, psychotic, obsessive-compulsive, couple, or family disorder, etc. (Ceberio & Kerman, 2014). Each of these factors operates in synergy with the rest, alternately potentiating and blocking final outcomes. In such complexity, structuring a moderately accurate hypothesis about the origin of the symptom becomes exceedingly difficult and utopian. The hypothesis formulated is a concatenation of premises that will depend on the distinctions drawn by the observer, in this case, the therapist (Spencer Brown, 1973).

The persistent reiteration of ineffective problem-solving strategies finds its basis in a matrix of thought anchored in the postulates of positivist sciences, whose hegemony has operated as a dominant sociocultural paradigm (Ceberio & Watzlawick, 2006). This traditional model of knowledge is characterised by linear, causalist, analytical, and reductionist logic, promoting the fragmentation of phenomena into constituent parts, with the illusion that their sum will allow access to a global understanding of the system (Onnis, 1999). Added to this is a binary cognitive structure, sustained by principles of logical opposition and univocal explanations (Morin, 1986, 1994), which consolidate a vision of reality as an objective and quantifiable entity.

In this context, the application of pre-established, learned, and automatised solutions imposes itself as the mode of intervention, even when such responses have repeatedly demonstrated their ineffectiveness (Ceberio, 2014). This logic, which responds to rigid and memorised schemas, is part of a classical epistemology that limits the emergence of innovative alternatives. The difficulty in generating effective solutions lies not exclusively in the lack of tools, but in the very structure of the cognitive model activated when facing a problem. The left hemisphere of the brain, associated with rational, logical, and analytical thought, tends to dominate in problem-solving situations, while the right hemisphere—linked to creativity, intuition, and emotionality—often remains relegated, even though its activation would be decisive in complex and uncertain contexts (Urréa, 2010).

The cognitive system organises not only contents but also procedures; that is, it configures information processing styles which, in many cases, prove dysfunctional when problems involve significant emotional and relational variables. As Rosal Cortés (2015) points out, human conflicts are rarely resolved through formal logic, given that they are fundamentally mediated by emotions, beliefs, and specific social contexts. Solution attempts are not merely individual acts but emerge from the interactive fabric of the relational system, making it essential to consider the totality of the context (Ceberio, 2011).

Within this framework, the interruption of dysfunctional patterns and redundant responses finds a privileged pathway in the use of paradoxical interventions. Particularly in conditions such as panic disorder, the efficacy of intervention correlates with the ability to generate responses that differ substantially from those previously attempted. From the perspective of second-order cybernetics, such responses can be defined as interventions that break with the homeostatic logic of the system, resulting in a structural crisis that allows for the emergence of new configurations (Watzlawick et al., 2018). This increase in entropy temporarily disorganises the symptomatic structure and permits a restructuring of the subject's perception and response schemas.

METHODOLOGY

Within the framework of implementing a systemic treatment protocol for panic disorders, a qualitative, descriptive, and exploratory research study was designed to identify the main solution attempts used by patients and their social environment (Hernández-Sampieri et al., 2023). Through semi-structured interviews (Flick, 2018) conducted with a sample of 30 patients with panic disorder during the first four months of 2017, the solution strategies employed were categorised into four groups: “personal attempts,” “attempts by primary companions,” “attempts by professionals,” and “attempts by affectively significant individuals.” The study enabled an understanding of how these failed efforts not only fail to resolve the symptomatology but, in many cases, contribute to its maintenance.

The sample comprised patients who had experienced symptoms of panic disorder with and without agoraphobia for between 1 and 10 years at the time of the interviews, presenting with recurrent attacks that, in the vast majority (87%), varied between one or two weekly or one or two monthly episodes. Ages ranged from 20 to 52 years, including both male and female participants; approximately 30% were medicated, and all resided in the city of Buenos Aires, Argentina.

In each case, a semi-structured systemic interview was applied, exploring not only the history and dynamics of the disorder in the individuals’ lives but also inquiring about the solution attempts they had made. The majority, 97%, were ineffective, with some providing only momentary relief. The collected material led to the construction of the four categories. The semi-structured intervention protocol is the one we have presented in other research (Ceberio, 2014, 2018, 2024 a and b) and which we reiterate on this occasion.

To obtain data for delineating personal characteristics in the period preceding the disorder and during its course, a first-interview design of a systemic and cognitive nature was employed. This interview model is based on the premises of the Palo Alto brief strategic systemic therapy model (Watzlawick et al., 2018; Watzlawick, 1976; Weakland et al., 2010). The questions serve merely as a guide and were by no means treated as a rigid, scripted interview text. The interview was categorised as semi-structured to allow for creative exploration by the researcher-therapist. Nevertheless, each researcher received directive guidelines aiming to unify the investigative approach (Jung et al., 2025).

A confidential and collaborative working atmosphere was created, facilitating the development of the interview in a warm and relaxed environment

(Andolfi, 1977). To secure the patient's commitment to treatment, an initial step was to build a relationship of trust and empathy with them; one way to achieve this was by accepting their fear as understandable and justified (Chappa, 2006). The brief strategic model emphasises creating a supportive and collaborative therapeutic context, avoiding any value judgments. The strategy to accentuate empathy involved 'speaking the patient's language' (Watzlawick, 1967; Haley, 1973) and focused on the description of symptoms and the most exhaustive detailing of the symptomatic picture. The therapist adopted the expert position (up position), ensuring their interventions carried greater status and credibility (Ceberio & Watzlawick, 2006) in the patient's perception. In this way, a strong alliance was forged with the patient, coupled with a positive attitude and confidence in the ability to resolve the problem.

For the interview process, a series of steps from the brief model (Watzlawick, 2018; Weakland et al., 2010) were delineated, allowing the professional to organise the material and operate as a guide for their work with this type of disorder. The steps begin with "problem focus" and continue with the "exploration of solution attempts." These steps are established through recursive and linear questioning. As a problem-solving model, the brief strategic model requires a clear definition of what the problem or problems are. The questions centre on specifying a description of what is happening to the person, both synchronically and diachronically.

In exploring solution attempts, a thorough investigation of all attempts was conducted. Not only were personal attempts recounted, but the interviewer encouraged reflection on attempts suggested by the environment, including friends, family, neighbours, among others. Also detected within this group was the relevance and power held by panic companions (PCs). Finally, solution attempts from other treatments and proposals from other professionals were explored.

In some cases, a successful solution that was not pursued could be observed (Kopec & Rabinovich, 2007; Rodero, 2025). This phase of the interview is very important, not only because it is the creative axis of the brief model, but because it reveals the cybernetic dynamic: erroneous attempts perpetuate the problem.

RESULTS AND DISCUSSION

Based on the responses, a diversity of four typologies of solution attempts was established. Some—around 8%—yielded positive results, demonstrating effectiveness. The vast majority, however, were failed attempts, which is precisely why patients reached this stage of the process with the disorder in full symptomatic expression, requiring psychotherapeutic attention. Table 1 presents the collected data.

Table 1.

Solution Attempts

PERSONAL	COMPANIONS	PROFESSIONALS	A.S.I.
Avoidance and flight The mantra “It won’t happen to me” Denail Ritualism Superstitions Vitamins and painkillers Psychotropic drugs Relaxation exercises Staying home Lying down and sleeping Pretexts and rationalisations Praying Thinking about other things	Siblings Husbands, wives Best friends Friends who have been through the disorder Mothers, fathers. Sometimes more fearful than the protagonist. Generally “do” things for the affected person. Attachment figures or resilience tutors	Prescription of medication and care from: General practitioners Neurologists and Endocrinologists Cardiologists and Gastroenterologists ENT specialists and Pulmonologists Psychiatrists and Psychologists Homeopaths Attendance at: Anonymous phobics groups Clairvoyants, tarot readers, witches Yoga Body therapists Flower therapists	Relatives, friends, neighbours, coworkers, etc. “Useful” advice (I have a doctor who treated my aunt...) Search for causes and reasons “Soothing” explanations The shepherd syndrome: “you can do it” Choice of companion

Regarding “personal attempts,” across the 30 cases, it was observed that one of the failed solution attempts (Ceberio, 2016) involves trying to face the fear by telling oneself that one can overcome it, that nothing will happen, that one is capable, and that nothing can go wrong. However, it was noted that the more one repeats this, the more the opposite effect occurs, as attempting to control bodily sensations actually intensifies them. The patient finds it difficult to understand what is happening to them and questions themselves repeatedly, increasing their uncertainty. The corollary of these numerous attempts is an increase in symptomatology, amplifying the initial anguish and fostering a growth in incapacity, helplessness, devaluation, and insecurity, which in turn trigger even more anguish and, fundamentally, anxiety (Cía, 2007).

In cases of panic disorders, the individual flees from wherever they are or avoids going anywhere other than their home. Those with panic disorder with agoraphobia try to flee from their current location or look for the emergency exit in a building, restaurant, or any public place, or sit near the exit door of a cinema (Pasto & Sevilla, 2000; Robins et al., 1984). Compared to social phobic disorders, they withdraw when there are more than four people present and avoid social gatherings, concerts, or any meeting that commits them to interact. Meanwhile, specific phobics flee when the boundary distance or comfort zone from the feared object is exceeded; they cross the street if they see a dog in their path, or pass cautiously if they encounter pigeons on a high-tension wire (Carrion & Bustamante, 2003; Haydu et al., 2016).

Faced with crises or the first symptoms, individuals experience an irresistible impulse to return home—or to their safe place—certain that doing so will make them feel better. This could even be a specific room within the house, such as the bedroom. This can be the initial trigger for the development of agoraphobia, as, upon discovering improvement when close to home, fear may increase proportionally with distance from it, fostering isolation (Chappa, 2006).

Indeed, Craske & Barlow (2001) demonstrated that agoraphobic avoidance is simply a way of coping with panic. This strategy is a trap, as it gradually leads the subject to increase avoidance until complete incapacity, since each avoidance confirms the danger of the avoided situation and primes the next avoidance.

It was also observed that patients resort to what we term “the mantra”: they repeat “It won’t happen to me,” both literally and metaphorically, as this wish underlies all attempted solutions. Others appeal to the mechanism of denial (“Nothing is wrong with me”), or sleeping as a form of momentary oblivion. In the same vein, they use pretexts and rationalisations as a way to justify the discomfort, denying the true essence, which is fear (“I have nausea because the food didn't agree with me,” “I feel dizzy because I have low blood pressure”). They may also turn to ritualism or superstitions: always taking the same route if using it previously did not trigger an attack, or using a particular garment or object if its presence seemed to ward off the distress (Ceberio, 2011).

Also observed was the use of vitamins or B12 complex, believing it strengthens the nervous system to solve the disorder; painkillers to address any of the symptoms (“I take paracetamol, or aspirin, or muscle relaxants... They make me feel good”); antispasmodics or digestive aids for stomach stitches or nausea; and psychotropic drugs, whether prescribed by general practitioners or psychiatrists. Others try relaxation and meditation exercises to learn to relax, attempting to erode the state of permanent tension and hypervigilant alertness. This is one of the attempts that proves effective.

Regarding “professional attempts,” the results also showed that patients had sought assistance from a multitude of professionals, as numerous as the sequence of symptoms afflicting them. Let us bear in mind that several symptoms are organic in nature (tachycardia, dizziness, nausea, sweating, choking, chest pressure, trembling, blurred vision, among others) pertaining to different medical specialties: General practitioners, Neurologists and Endocrinologists, Cardiologists and Gastroenterologists, ENT specialists and Pulmonologists, Psychiatrists and Psychologists, Homeopaths. As well as self-help groups such as Anonymous Phobics groups, or techniques like yoga, relaxation and breathing exercises, meditation, mindfulness. Also body and flower therapists. In the sample, particularly among long-standing patients, desperation sometimes led to recourse to magical and superstitious thinking. They attributed the causes of their panic to evil, supernatural, or magical origins, believing that “spells” had been cast on them, and they consulted witches, tarot readers, and clairvoyants to solve their problem (Sarudiansky, 2013; Idoyaga Molina, 1999). Uncertainty potentiates the original anxious symptomatology. The patient wanders from professional to professional, without finding a definition for their problem (Ceberio, 2011, 2014).

The suggestions from affectively significant individuals (A.S.I.) are those provided by friends, neighbours, acquaintances, co-workers, and relatives. These include doing things (errands, tasks, chores, etc.) that the person with panic should be doing themselves. The collected data revealed what we term “recommenders” of professionals, even when those professionals have nothing to do with the specialty relevant to panic (“He’s a doctor who’s an eminent figure! He cured my aunt’s diabetes”; “He’s a very good doctor; he's the one who treats Maradona for his addiction issues”).

It was also recorded that some prescribe “useful” advice, such as “Why don’t you drink some lime blossom tea at night,” “You must stop thinking,” “You’ll be fine, just relax,” “Try to go out,” “Have fun, go for a walk to distract yourself,” “Don’t eat too much and don’t drink alcohol,” “You’re an intelligent girl, how can you not be able to get in the lift!” There are those who play therapist and offer psychological interpretations in search of causes and reasons: “You’ve always been fearful, since you were little...”, “You don’t want to take responsibility, and with the attack you avoid facing the situation,” “There are other ways to ask for help!”

Others offer “Soothing” explanations (Bateson, 1976; Ceberio & Watzlawick, 2006) that explain a cause by the category into which the phenomenon is classified: “You’re a hypochondriac,” “You’ve always been somewhat phobic; you used to get scared when taking exams.” Meanwhile, there are the “encouragers” who deliver what we call the Church Pastor’s encouragement: “You can do it!” It can be understood that these statements trap the person in a dilemma, as they push them to face the fear without having an adequate strategy, which inevitably leads to failure. In addition to the helplessness generated by their disorder, the individual experiences an even greater sense of frustration when their immediate environment tells them what they should do, yet they are unable to accomplish it. Most interviewees expressed feeling misunderstood. Their social circle tends to minimise their suffering and anguish, perceiving their fear as absurd or unfounded. For this reason, those around them all too easily offer superficial advice or simplistic solutions that fail to address the complexity of the problem.

Finally, among all the A.S.I., the affected person chooses one or two individuals who become the primary companions on this painful journey involving the attacks. The tally from the 30 patients yielded some interesting results, leading to the decision to structure a separate data column from the general A.S.I. category. These companions are the ones who help, acting to protect the protagonist and provide them with security. The person turns to them when facing situations where an attack is likely to occur. The reasons leading the person with panic to assign someone this distinctive function lie in what John Bowlby (1969, 1958, 2014) clearly defined as “attachment.”

Although this figure is especially described in the first months and years of life, this relational model becomes systematised and constitutes a lifelong form of interaction. In adolescence or adulthood, people in critical situations always seek out reference figures with whom they feel protected and sheltered (Bowlby, 2014). This same conceptualisation is called “resilience tutors” by Boris Cyrulnik (2022), although it does not always refer to an attachment figure linked to a human being; it can also be an event, a circumstance, or a space. Nevertheless, in most cases, tutors are adults who act as identificatory references and affective models, interacting in ways that enhance the capacities of the resilient individual. The most striking aspect of this dynamic is that such a relationship can arise casually and ephemerally, without necessarily requiring permanence over time.

The idea of the attachment figure or resilience tutor gives meaning to the figure of the PC (panic companion) and allows the affected subject some capacity to navigate feared moments or situations. What was observed in the collected data is that PCs are very close relatives, mother, father, spouse, sibling, as Chappa (2006) notes or close friends, as well as people who have suffered from

the disorder themselves and with whom they identify. Barlow & Durand (2001) affirm that anxiety decreases if the person with the disorder considers a place or a person to be “safe,” or “strong,” “intelligent,” even when there is nothing that person could actually do if something bad were to happen.

PCs are generally more fearful than the affected person themselves (Ceberio & De la Cruz, 2023). They fear that the person will feel the fear of feeling the fear attack. Therefore, it is understandable that they sustain the person’s symptomatology. They are also described as “doing” what the protagonist should be doing: “I’ll go to the kiosk,” to which a companion's response might be “Let me go instead” or “Let’s go, I’ll come with you,” “Are you sure you’re going alone?” Errands, phone calls, interviews, supermarket shopping, and other activities install the person with panic in a comfort zone where responsibility and confronting their fears are not exercised. These are all expressions that demonstrate love and concern but, in parallel, remind the person with panic of their incapacity and their fears.

It is a slow process of social and personal impoverishment. An indicator of the degree of helplessness in patients with this type of disorder is observed in the telephone call requesting a consultation. When made by the companion, it reveals the degree of dependence, the comfort zone, the impossibility. A patient with panic who calls requesting treatment demonstrates a certain degree of autonomy and potential for change. The bond established is one of total asymmetry: someone commands, and the other submits. The protagonist develops a double game: they are managed by the PC, but at the same time, they have at their disposal a full-time protector-employee. In summary, the companion is one of the primary loci for the development of failed solution attempts.

All these attitudes, whether professional, personal, from affectively significant individuals, or from companions, destroy the protagonist's self-esteem: gradually, their social relations become impoverished, they lose their job, they abandon regular attendance at their studies, and their circle is reduced to some family members, a few friends, scant social life, and little room for pleasure.

CONCLUSIONS

A person suffering from panic disorder, after accumulating a series of fruitless personal efforts, reaches a phase where their vulnerability increases, making them more dependent on their environment. At this point, they begin to persistently turn to their close circle in search of answers to guide them toward recovery. These attempts were grouped into four categories: “personal initiatives, professional interventions, efforts from affectively significant individuals (A.S.I.), and the support provided by the panic companion (PC).”

We analysed who constitutes the patient’s environment and how their network of relationships is organised. This allows for an assessment of the degree of influence exerted by certain close figures, what messages they explicitly transmit, and how these contribute to perpetuating failed dynamics. Therefore, the exploration was not limited solely to the affected individual but also extended to those around them—relatives, friends, neighbours, and other close acquaintances—as this enabled an understanding of the structure of their

relational system, identification of the influence of key people, and recognition of how their interventions can reinforce the maintenance of the problem. As analysed in this development, solution attempts not only act as a support for the problem but also generate new complications arising from the original conflict. Their ineffectiveness makes them, in themselves, an additional obstacle. It is striking to observe how, in human systems, people tend to adopt a rigid repertoire of solution attempts and repeat them persistently, despite their evident ineffectiveness. What has been evidenced is that the majority of these multiple attempts end up aggravating the symptomatology, intensifying the initial anguish and fostering an increase in incapacity, helplessness, devaluation, and insecurity, which in turn further feeds back into the anguish. Although these actions are intended to reverse symptomatic behaviour, their effect is paradoxical: the individual ends up feeling misunderstood, perceiving that no one truly manages to put themselves in their place.

The person becomes subjected to the dominion of the symptom, in a position subordinate to it, which prevents them from changing the situation despite their efforts. This, in turn, intensifies the feeling of devaluation. Added to the original anguish is the anxiety provoked by the sense of helplessness in the face of the symptomatology and by the inability to meet the expectations of their affective circle (Beck & Emery, 1985). If the therapist does not thoroughly examine the attempted solutions, they run the risk of joining the chain of failed attempts. All these reasons justify the importance of the professional paying special attention to this analysis.

The way in which the notion of the problem is constructed directly influences the attempts to solve it. Therefore, it is not only a matter of modifying the strategies used, but also of transforming the perception of the problem itself. The logic underlying these solution attempts is often governed by rational thought and a problem-solving approach influenced by the principles of positivist science, which form the dominant sociocultural paradigm. However, these attempts do not depend solely on the individual but involve their entire relational system, which insists on addressing the problem in the same way, ultimately entrenching it further. It should be added that the problems derived from the original problema, the intensity of the problem’s appearance, its frequency, and the number of years living with the disorder, reinforce the problem and make its resolution resistentially even more complicated.

In summary, from the two points developed, it can clearly be seen that the person with panic disorder finds themselves at a crossroads between two fronts. On one hand, their internal voices telling them “It won't happen to me,” the trap of which lies in it being a denial of a prior affirmation. What appears in consciousness is the wish for the attack not to occur, but this wish is based on the prior fear of suffering a panic attack: it is the fear of feeling the fear attack. If one says “it won’t happen to me,” it is because there exists the prior belief that it could happen; otherwise, no one would express such a wish out of thin air. This is the evidence of the hypervigilant alertness of the person with panic. On the other hand, there are the external voices. Voices of incomprehension regarding the person’s symptoms. Voices that, with the best intentions, encourage through “You can do it,” dismissing or minimising the protagonist’s fears. This “encouragement” not only traps the protagonist by making them feel ridiculous (something so simple they cannot do), but also reflects their helplessness and

impossibility back at them, besides implicitly conveying a lack of understanding of their fears.

The maintenance of solution attempts, besides the systematisation of mental operations, offers momentary relief to the person suffering from panic disorder. But what initially is a learned way to escape fear, confirmed and reinforced by experiences and social relationships, becomes a spontaneous and uncontrolled reaction: a system of perception and reaction to reality, rigid and incapable of being modified by reason. However, one must not forget that the problem-behaviour must be considered in context, that is, maintained by actions among individuals within a system, who, by trying to resolve this difficult or troublesome situation, entrench it further. This is why the actions, attitudes, and thoughts of the individual's family/social nucleus must be taken into account. This crossroads shows the person with panic that if they listen within themselves, they find helplessness, and if they listen to their environment, they find helplessness. Each situational passage confronts them with these two forms of helplessness, which gradually undermine self-esteem and further perpetuate this symptomatic circuit.

All these manifestations, although well-intentioned on the part of both the environment and the individual themselves, seek to modify their behaviour. However, paradoxically, they generate the opposite effect. The affected person experiences a profound sense of being misunderstood and the impression that no one can truly put themselves in their place. They find themselves subjected to the dominion of the symptom, in a position of subordination to it, which prevents them from reversing the situation despite their attempts. As a result, to the initial anguish is added the anxiety provoked by the feeling of helplessness in the face of their suffering, as well as the shame or feeling of ridicule for not being able to meet the expectations of their close circle.

This panorama encompasses psychological, emotional, endocrinological, interactional, and social dimensions, constituting the complex scenario in which a person with panic disorders operates. Therefore, the implementation of treatments that can, in a short time, dismantle the intense and suffocating symptomatic chain of panic becomes essential. While the present study is limited to the categories of solution attempts in panic disorders, it is feasible to apply the same format in other research exploring different disorders. At the same time, it is possible to use the same methodology to replicate the model in other countries and compare results, given that a limitation of this research is that it is confined to the context of Buenos Aires.

REFERENCES

Amarilla, S., Bertone, R. M., Cano, M. E., Rivarola, M., & Paredes, C. (2022). *Validation of the Spanish version of the Body Vigilance Scale*. European Journal of General Medicine, 19(1), 1–6. https://doi.org/10.29333/ejgm/12141

APA (2002). *DSM-IV-TR: Manual diagnóstico y estadístico de los trastornos mentales. Texto revisado*. Masson.

APA (2022). *Diagnostic and statistical manual of mental disorders*. Fifth edition. Author.

Barlow, D. & Durand, M. (2001). *Psicología Anormal: Un enfoque integral.* International.

Bateson, G. (1976) *Pasos hacia una ecología de la mente*. Carlos Lohlé.

Beck, A. & Emery, G. (1985). *Anxiety disorders and phobias: A cognitive perspective*. Basic Books.

Belloch, A.; Sandín, B & Ramos, F. (1995). *Manual de psicopatología* (Vol. 2). McGraw-Hill.

Bowlby, J. (1958). The nature of the child's tie to his mother. *International Journal of Psychoanalysis* 39: pp. 350–73

Bowlby, J. (1969). *Attachment. Attachment and Loss*. Vol. I Hogarth.

Bowlby, J. (2014) *Vínculos afectivos*. Morata

Carbajal-Burgos, L. (2023). Abordaje de un caso con trastorno de pánico desde el enfoque de terapia breve estratégica. *KIRIA: Revista Científica Multidisciplinaria*, *1*(1), 46-55. https://www.revistasfiecyt.com/index.php/kiria/article/view/79

Carrion, O & Bustamante, G. (2003). *Ataques de pánico y trastornos de fobia y ansiedad.* Galerna.

Ceberio M R, Kerman B. (2014) *En busca de las ciencias de la mente*. UFLO.

Ceberio M.R. & Watzlawick P. (2006) *La construcción del universo. Conceptos introductorios sobre epistemología, cibernética y constructivismo*. Herder.

Ceberio M.R. (2014) “Los juegos del miedo. Hacia un modelo integrador en el tratamiento de los trastornos de pánico” en Medina, Raúl (2014) “Pensamiento sistémico”. Ed. UDG.

Ceberio, M. R. (2016) Querer y no lograr: Soluciones intentadas fallidas. *Revista Redes, 2.*

Ceberio, M. R. (2018) *Tratamiento de los Trastornos de Pánico: Uso de Prescripciones Paradojales y de Desviación como primer paso a reducir la sintomatología.* [Tesis doctoral. Universidad de Buenos Aires].

Ceberio, M. R. (2022). Querer y no lograr: Soluciones intentadas fallidas. *Revista REDES*, (35), 99–116. https://www.redesdigital.com/index.php/redes/article/view/131

Ceberio, M. R., & Watzlawick, P. (2025). *Conversaciones con Paul Watzlawick. Reflexiones sobre Cibernética, Constructivismo y Terapia breve*. Ediciones Morata.

Ceberio, M., & De la Cruz Gil, R. (2023). Acompañantes antipánico: ¿acompañantes terapéuticos?. *KIRIA: Revista Científica Multidisciplinaria*, *1*(2), 16-31. https://doi.org/10.53877/x87zmz67

Ceberio, M.R. (2011) *Dentro y fuera de la caja negra.* Psicolibro

Chappa, H. J. (2006). *Tratamiento integrativo del trastorno de pánico. Manual práctico*. Paidós.

Cía, A. (2007). *La ansiedad y sus trastornos. Manual diagnóstico y terapéutico*. Polemos.

Cía, A. H. (2002) *Trastorno de Ansiedad Generalizado*. Polemos.

Clark, D. A., & Salkovskis, P. M. (2021). *Cognitive processes in panic and agoraphobia*. *Journal of Anxiety Disorders, 82*, 102164. https://doi.org/10.1016/j.janxdis.2021.102164

Craske, M. & Barlow, D. (2001). *Panic disorder and agoraphobia*. En Barlow (Ed.) *Clinical handbook of psychological disorders: A step-by-step treatment manual* (3a ed., pp. 1-59). Guilford.

Cyrulnik, B. (2022) *Sálvate la vida te espera*. Debolsillo.

Delgado, E. C., De la Cera, D. X., Lara, M. F., & Arias, R. M. (2021). Generalidades sobre el trastorno de ansiedad. *Revista cúpula*, *35*(1), 23-36.

Flick, U. (2018). *An introduction to qualitative research* (6th ed.). SAGE Publications.

García, M. R., López, A. S., & Hernández, P. L. (2023). Estrategias no terapéuticas y su impacto en la agorafobia: Metaanálisis de intervenciones racionales versus control clínico. *Clinical Psychology Review, 102*, 102200. https://doi.org/10.1016/j.cpr.2023.102200

Gasalla, J. M. (2022). Confiando en la confianza. *Proyecto Hombre: revista de la Asociación Proyecto Hombre, (110)*, 4-9. https://proyectohombre.es/wp-content/uploads/2022/12/2-GASALLA-REV-110.pdf

Haley, J. (1973) *Uncommon Therapy: The psychiatric techniques of Milton Erickson, M D,* Norton. Versión cast. (1980) *Terapia no convencional: las técnicas psiquiátricas de Milton Erickson*. Amorrortu.

Haydu, V. B., Zacarin, M. R. J., dos Santos, A., Borloti, E., & Fornazari, S. A. (2016). Terapia de exposición de realidad virtual para el miedo y la fobia a conducir: una revisión de la literatura. *Avances en Psicología Latinoamericana*, *34*(1), 67-81. http://repository.urosario.edu.co/handle/10336/16034

Helbig-Lang, S., Lang, T., Petermann, F., & Hoyer, J. (2012). Anticipatory Anxiety as a Function of Panic Attacks and Panic-Related Self-Efficacy: An Ambulatory Assessment Study in Panic Disorder. *Behavioural and cognitive psychotherapy*, *40*(5), 590. https://doi.org/10.1017/S1352465812000057

Hernández-Sampieri, R., Fernández Collado, C., & Baptista Lucio, P. (2023). *Metodología de la investigación: Las rutas cuantitativa, cualitativa y mixta* (6ª ed.). McGraw-Hill Education.

Idoyaga Molina, A (1999): "La selección y combinación de medicinas entre la población campesina de San Juan (Argentina)". *Scripta Ethnologica*, XXI: 120-167. https://www.redalyc.org/pdf/148/14818345001.pdf

Jung, H. W., Jang, K. W., Nam, S., Kim, A., Lee, J., Ahn, M. E., Lee, S.-K., Kim, Y. J., Shin, J.-K., & Roh, D. (2025). *Digital Cognitive Behavioral Therapy for Panic Disorder and Agoraphobia: A Meta-Analytic Review of Clinical Components to Maximize Efficacy.* Journal of Clinical Medicine, 14(5), 1771. https://doi.org/10.3390/jcm1405177

Kopec, D. & Rabinovich, J. (2007). *Qué y cómo. Prácticas en psicoterapia estratégica.* Paidós.

Laso Ortiz, E. (2015). Terapia familiar en clave emocional, 1: breve revisión histórica. *Revista Electrónica de Psicología Iztacala*, *18*(2), 631-662 https://www.medigraphic.com/cgi-bin/new/resumen.cgi?IDARTICULO=69931

McEwen, B. S. (2006). Protective and damaging effects of stress mediators: central role of the brain. *Dialogues in clinical neuroscience*, *8*(4), 367. https://doi.org/10.31887/DCNS.2006.8.4/bmcewen

Mellado-Pastor, S., Del-Río-Sánchez, C., & Pastor-Morales, J. (2023). La influencia de la evitación experiencial y la fusión cognitiva en personas con diagnóstico de trastorno de pánico y agorafobia y TOC. Apuntes de Psicología, 41(2), 69–75. https://doi.org/10.55414/ap.v41i2.1548

Milanese, R. (2021). *El miedo engañoso de no estar a la altura: Estrategias para reconocer el propio valor*. Herder Editorial.

Morin, E. (1994) *Introducción al pensamiento complejo*. Gedisa.

Morin, E.1986) *El método. La naturaleza de la naturaleza*. Cátedra.

Nardone, G. (2016). *Miedo, pánico, fobias. La terapia breve*. Herder.

Nardone, G. (2020). *Más allá del miedo. Superar rápidamente las fobias, las obsesiones y el pánico*. Paidós.

Nardone, G. (2025). *El libro de las fobias y su curación*. Herder Editorial.

Pinheiro, J. D. (2022). Panic and Anxiety Disorder: Multifactorial Conditions. *Research, Society and Development*, *11*(7), e49011730122. https://doi.org/10.33448/rsd-v11i7.30122

Rispo, P. (2007). Como asistir a una persona con ataque de pánico. *Depsicoterapias.com.* http:/www.depsicoterapias.com/articulo

Robins, L., Helzer, J., Weissman, M., Orvaschel, H., Grunberg, E., Burke, J. & Regier, D. (1984). Lifetime prevalence of specific psychiatric disorders in three sites. *Archives of General Psychiatry*, 41, 949-958. https://doi.org/10.1001/archpsyc.1984.01790210031005

Rodero, B. (2025). *La ansiedad del esquimal: Una guía práctica para entender, afrontar y superar la ansiedad, el pánico y la agorafobia*. Arpa.

Rodríguez, A. (2024). Abordaje de pacientes con crisis de pánico en un contexto de medicina de empresa y salud ocupacional. *Revista Ciencia y Salud Integrando Conocimientos*, *8*(1), 63-70.

Rosal Cortés, R. (2015). Revalorización de los potenciales del hemisferio cerebral derecho. las imágenes en psicoterapia. *Revista de Psicoterapia*, *26*(101), 39-71. https://dialnet.unirioja.es/ejemplar/405102

Sarudiansky, M. (2013). *Itinerarios Terapéuticos y Pluralismo Médico en el Tratamiento de la Ansiedad en el Área Metropolitana*. Universidad de San Luis.

Schmidt, N. B., Norr, A. M., Allan, N. P., Zvolensky, M. J., & Gonzalez, A. (2021). *Examining body vigilance and anxiety sensitivity: Relations to panic disorder and health anxiety*. Behaviour Research and Therapy, 144, 103922. https://doi.org/10.1016/j.brat.2021 .103922

Spencer Brown (1973) *Laws of the form*. Bantam Books.

Sterling, P. (2020). *What Is Health?: Allostasis and the Evolution of Human Design*. MIT Press. https://doi.org/10.7551/mitpress/11472.001.0001

Urréa, H. (2010). El dominio de los hemisferios cerebrales. *Revista Ciencia Unemi*, *3*(4), 8-15.

Watzlawick P. (2015) “La realidad inventada”. Gedisa.

Watzlawick P., Weakland, Fisch R. (2018) *Change*. Ed. Norton & Company.

Weakland J., Fisch D., y Segal L. (2010) *La táctica del cambio*. Herder.

Wolpe, J. & Rowan, V.C. (1988). “Panic dissorder: a product of classical conditioning”, *Behav. Res. Ther*., 26: 441-450. https://doi.org/10.1016/0005-7967(88)90138-6

Wurm, S., Warner, L. M., Ziegelmann, J. P., Wolff, J. K., & Schüz, B. (2013). “How do negative self-perceptions of aging become a self-fulfilling prophecy?”. *Psychology and Aging*, *28*(4), 1088. https://psycnet.apa.org/buy/2013-35546-001

Yılmaz, S., Kabadayı, M., & Kubilay, D. (2025). A Review of Panic Disorder and Cognitive Behavioral Therapy. *Journal of Cognitive Behavioral Psychotherapy Research*, *14*(1), 61-72. https://doi.org/10.14744/JCBPR.2024.62723