THE EFFECTIVENESS OF SHORT-TERM INTENSIVE COGNITIVE-BEHAVIORAL THERAPY ON SYMPTOMS SEVERITY OF PATIENTS WITH PANIC DISORDER

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***Submitted* 12/09/2018*; accepted* 24/02/2019**

ABSTRACT

Background: Panic disorder (PD) is defined as a sudden rise in extreme fear or drastic distress appearing at a maximum level within minutes. Cognitive-behavioral therapy (CBT) is the psychological treatment of patients with chronic PD. Despite more effectiveness and preferable cognitive behavior therapy in the treatment of PD in comparison with pharmacotherapy, a considerable percentage of patients do not benefit from it due to too many and long sessions per week. Accordingly, this study aimed to examine the effectiveness of a group short and intensive (4 days) program of CBT on symptom severity in patients with PD with or without agoraphobia.

Patients and Methods: In the present clinical trial, the patients attended the author's private clinic in Duhok city were consecutively screened for eligibility criteria. Of them, 40 patients diagnosed with PD with or without agoraphobia were randomized assigned into experimental (n=20) and control group (n=20) by a random digit number generated by a computer. The patients assigned into the experimental group received one-month intensive CBT; four two-hour sessions along with their regular medications; and the patients in the control groups received their regular treatments only. The symptom severity was assessed by the Panic Disorder Severity Scale (PDSS) in both groups following the course completion.

Results: The patients in both groups of the study were comparable in age, gender, education, marital status, physical activity, history of child abuse, and occupation before starting and after finishing the course (P>0.05). The study showed that the severity and frequency of panic symptoms were significantly lower in the experimental group compared to the patients in the control group.

Conclusions: The study suggests that the short-intensive CBT programs can be effective to reduce the panic symptoms in patients with PD.

Duhok Med J 2019; 13 (1):44-55.

Keywords: Panic Disorder, Cognitive Behavior Therapy, Symptom.

Panic disorder (PD) is defined as a sudden rise of extreme fear or drastic distress appearing at a maximum level within minutes. This situation occurs periodically with the recurrent condition[1]. Approximately 2.5% of people develop the PD within their life[2]. The commencement time of PD is in adolescence or early adulthood, which affects female and male populations despite being common in children and older people. Females are more affected by PD than male populations[1].

Cognitive-behavioral therapy (CBT) has confirmed to be a psychological treatment of patients with chronic panic disorder[3]. The patient needs between 12 and 15 CBT sessions and is designed to be conducted

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on a weekly basis and it has been shown to associate with the substantial decrease in PD symptoms[4]. This treatment is more effective and cost-effective compared to pharmacotherapy[5]. In addition, it is more desirable and preferable to patients with PD [6].

Despite more effectiveness and preference of CBT in comparison with pharmacotherapy, a considerable percentage of patients do not benefit from it due to too many and long sessions per week. In particular, those patients living in rural and far areas would not be successful to attend these types of psychotherapy sessions. The effect of brief and intensive CBT technique has been the main focus of a few authors in the medical literature. For example, Deacon and Abramowitz et al [6] recruited ten patients in a brief and intensive CBT instead of weekly CBT in a hospital-based anxiety disorders clinic in the USA. They showed a large and clinically significant reduction in PD symptoms, anxiety sensitivity, body vigilance, anxiety, and depressive symptoms following a one-month CBT course. Most of their patients (60%) achieved panic-free and normative levels of symptoms following the CBT sessions. The brief and intensive treatment was suggested as an effective tool to deliver CBT for patients with PD.

In addition, Manfro and Heldt et al[7] confirmed that CBT is an effective therapeutic technique in patients with PD, whether as the first line therapy or as a strategy in patients not responding to medications or as a combination therapy.

The CBT with respect to the number and duration of session per week is faced with obstacles in patients with lack of sufficient time and those seeking an immediate decrease in panic symptoms. Moreover, few studies focused on CBT technique within the short and intensive session to the patients with panic disorder[8].

The study aimed to examine the effectiveness of a short-term (4 days) intensive course of CBT on symptom severity of patients with panic disorder with or without agoraphobia.

MATERIALS AND METHODS

Study Design and sampling

The current study was a randomized controlled trial of the effectiveness of a short and intensive CBT (4 days) in 40 patients with a panic disorder of both genders aged between 20 and 35 years old. The patients visited the private clinic of the psychiatrist in Duhok-Iraq were consecutively and systematically screened for the diagnosis of PD. A previous random digit number generated by a computer (chosen by SPSS-Statistical Package for Social Sciences software) was used for recruitment of the patients in either experimental or control groups. The SPSS software has the possibility to take a random sample of the entered cases. In this regard, 40 consecutive numbers were entered in the software. Accordingly, the cases were separated into two random groups. The cases of one of them were assigned into the interventional and other to control group.

A total of 40 patients diagnosed with panic disorder whether with or without agoraphobia were included in this study. Half of them (n=20) were assigned in experimental and half (n=20) in the control group in a random way. The patients were recruited in the experimental group

received the regular medications along with one-month intensive CBT treatment and the patients in the control group received the regular medications only. The study was held between May and July 2018.

Inclusion and exclusion criteria

Patients aged 18 years and older of both genders and regardless of socioeconomic and demographic characteristics were eligible to be recruited into the study. The patients with an untreated disorder of substance use, diagnosed with psychotic disorder, previously involved in psychotherapy sessions, or with a different depression and anxiety disorders were not included in the study. The entire CBT course was implemented by the clinician.

Data collection and measurement

The socio-demographic characteristics of patients, including age, gender, occupation, education level, living area (urban, rural), marital status, smoking, history of child abuse, psychological stress, and physical activity was collected through a direct interview before study commencement and recorded in a predesigned questionnaire. The following items were considered for physical activity: walking, running, exercise, cycling, climbing, and biking.

The diagnosis of panic disorder was performed according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). The panic disorder is considered an anxiety disorder in DSM-5 [1]. It is recurrent unexpected panic attacks. Sudden onset of intense fear or intense discomfort reaching a peak within minutes is called a panic attack. The diagnosis of panic disorder was established in line with the following criteria:

A: Recurrent unexpected panic attacks, and during which time four (or more) of the following symptoms occur;

Note: The abrupt surge can occur from a calm state or an anxious state.

1.Palpitations, pounding heart, or accelerated heart rate, **2.**Sweating **3.**Trembling or shaking, **4.**Sensations of breath or smothering shortness, **5.**Choking feelings**, 6.** Pain or discomfort in the chest, **7.** Nausea or abdominal distress, **8.** Feeling dizzy, unsteady, light-headed, or faint, **9.**Chills or heat sensations, **10.**Paresthesias, **11.**Derealization or depersonalization, **12.**Fear of losing control or "going crazy.", **13**.Fear of dying.

Note: Culture-specific symptoms (such as tinnitus, neck soreness, headache, uncontrollable screaming) may be seen. Such symptoms should not count as one of the four required symptoms.

B. At least one of the attacks followed by 1 month or more of one or both of the following: **1.** Persistent concern or worry about additional panic attacks or their impacts, (e.g., losing control, having a heart attack, "going crazy"), **2.**A significant maladaptive change in behavior related to the attacks (e.g., behaviors designed to avoid having panic attacks, such as avoidance of exercise or unfamiliar situations).

C. The disturbance is not related to the physiological impacts of a substance (such as as., an abused drug, a medication) or other medical conditions (e.g., hyperthyroidism, cardiopulmonary disorders).

D. The disturbance is not better described by another mental disorder (e.g., the panic attacks do not occur only in response to

feared social situations, as in social anxiety disorder: in response to circumscribed phobic objects or conditions [1].

In the present investigation, agoraphobia was defined as anxiety about locating in embarrassing situations or unavailable assistance upon the panic occurrence in association with panic disorder [9].

In order to make an easier comparison with the previous studies on PD, both types with and without agoraphobia were included in this study.

Assessment of symptom severity

To assess the overall severity symptoms of PD patients in both the control and intervention group, the Panic Disorder Severity Scale (PDSS) was used in the study. The control and intervention groups were assessed through the PDSS questionnaire by the psychiatrist following one-month CBT sessions only[8].

Ratings were generally done for the past week, to allow for a stable estimation of panic frequency and severity. The PDSS rating scale has the range from 0 to 4, where 0=none or not present; 1=mild, occasional symptoms, slight interference; 2=moderate, frequent symptoms, some interference with functioning, but still manageable; 3=severe, preoccupying symptoms, substantial interference in functioning, and 4=extreme, pervasive near constant symptoms, disabling/incapacitating. The PDSS has good interrater reliability, construct validity, and internal consistency [10].

Intervention

The patients assigned to the experimental group were provided informed consent and the study purposes. Four two-hour sessions of brief and intensive CBT was established in accordance with the 12-session protocol developed by Telch and Lucas et al [11]. However, the 12 sessions were applied over one month (one week consecutive) in four sessions. In order to apply the intervention in a better way and organize the patients, the patients in the experimental group were divided into five groups. Each group included four patients and was instructed for two hours per day over 4 days/week at the silent place in the private clinic of the author after completion of the regular patient visit.

The sessions presented to the patients included four two-hour sessions face-to-face psychiatrist with patients in a group working. In these sessions, the patients were instructed about the role of catastrophic beliefs in the development of anxiety-related sensations of the body and their role in the development of panic attacks. The primary aim of CBT was defined as assisting patients to obtain more accurate beliefs on the dangerous panic-associated body sensations. Maintenance factors were described in safety-seeking and avoidance behaviors. The cognitive, behaviors and physiological characteristics of the flight-or-fight response were explained to the patients. The emphasis was given to the unpleasant and the harmless inherence of the body sensations that a patient has a fear. Gradually, the patients were trained to identify their "threat forecasts" to establish cognitive reconstruction and evaluate the evidence for their panic attacks and severity. Accordingly, the psychiatrist and patients reviewed each of the panic-associated threat forecasts, such as heart attack and suffocation. The severity of each forecast was estimated through the experiences of the patients of each threat forecast.

Following the rationale of exposure, patients were asked to participate in some various interoceptive exposure exercises; such hyperventilation, running in the hall, spinning chair (one by one for each patient). The exercise was repeated until the patients report that the exercise was not dangerous anymore. The exercises were framed as behavioral experiments and assisted them to find their own threat forecasts.

Finally, the therapist in colligative with patients framed a hierarchy of fear including feared and/or avoided agoraphobic situations. The psychiatrist assigned a number of interoceptive exposures to the application at home.

Each patient was asked to complete the highest feared item on his or her hierarchies. The myths of recovery were discussed with the patients. An individualized relapse prevention plan was designed for each patient, including detailed continued exposure exercises. The behaviors must be avoided in everyday life and safety seeking behaviors that should be eliminated were trained to the patients.

Examples include completely avoiding situations in which the threat might occur (Escaping the situation). Subtle avoidance behaviors such as breathing techniques; seeking reassurance from loved ones or professionals to ensure that the fears are unwarranted. A common safety behavior is when a person with agoraphobia attempts to entirely avoid a crowded place such as a mall or a public bus. If the affected person does end up in a crowded area, then the person may tense his or her legs to prevent collapsing in the area.

Examples of safety behaviors for panic disorder include "checking pulse" and "avoiding stressful encounters; Carrying rescue medication, water, food, inhalers, having to have another person accompany to certain places (being alone); losing control of one's vehicle while driving (avoid driving).

Avoidance of external activities, situations, or objects: e.g., enclosed spaces, certain foods, restaurants, avoidance of certain bodily reactions: e.g., exercise, saunas or steam rooms and fear to close the door of bathrooms and checking: e.g., location of exits, location of bathrooms, one's pulse or blood pressure.

STATISTICAL METHODS

The frequency and percentage were performed for categorical variables, mean, and standard deviation for continuous characteristics of the patients. Mann-Whitney U-test and Pearson Chi-square statistical tests were performed on a comparison of baseline aspects of the patients between two study groups. The difference of panic symptoms between the patients in experimental and control groups was examined in an independent t-test. The level of 0.05 was considered a statistically significant difference. The Statistical Package for Social Sciences version 25:00 (SPSS 25:00 IBM) was used for statistical analysis. The effect size (Cohen's d) was measured by the G*Power 3.2.19 statistical software. The panic severity of the five cases of the patients was measured for sample size determination (Mean: 18.0 and SD: 4.5). The power 0.95 and alpha error 0.05 was considered and it was estimated that severity reaches to the mean: 4.5 with SD: 2.3. The total sample size obtained for the study was 16 for both groups. The sample

size was extended to compensate for the loss to follow up patients and missing information.

RESULTS

The study showed that the patients in control and experimental groups were comparable in age (30.0 vs. 33.50 years, respectively; P=0.40) and gender (85.0 and 73.7 males, respectively; P=0.451). In addition, the patients in both groups were comparable in education (P=0.620), marital status (P=1.00), history of child abuse (P=1.00), physical activity (P=0.465), and occupation (P=0.681). However, more patients in the control group were a smoker (65.0%) compared to 35.0% in the experimental group (P=0.027), see **Table** 1.

Table 1: Comparison of Baseline Characteristics between Patients in Experimental and Control Groups

General Characteristics	Study Groups		P-value (Two-sided)
	Control (n=20)	Experimental (n=20)	
Age (Year)	**30.0 (9.0) Range: 21-35**	**33.50 (6.75) Range: 20-35**	**0.40***
Gender			**0.451*****
Male	**17 (85.0)**	**14 (73.7)**	
Female	**3 (15.0)**	**5 (26.3)**	
Education			**0.620*****
Illiterate	**3 (15.0)**	**1 (5.0)**	
Primary School Graduate	**9 (45.0)**	**9 (45.0)**	
Intermediate School	**1 (5.0)**	**1 (5.0)**	
High School Graduate	**0 (0.0)**	**0 (0.0)**	
Institute	**3 (15.0)**	**4 (20.0)**	
College	**1 (5.0)**	**4 (20.0)**	
Post Graduate	**3 (15.0)**	**1 (5.0)**	
Marital Status			**1.00*****
Single	**5 (25.0)**	**4 (20.0)**	
Married	**15 (75.0)**	**16 (80.0)**	
Smoking	**13 (65.0)**	**6 (30.0)**	**0.027****
History of Child Abuse	**7 (35.0)**	**7 (35.0)**	**1.00****
Physical Activity	**4 (20.0)**	**6 (30.0)**	**0.465****
Occupation			**0.681*****
Unemployed	**7 (35.0)**	**8 (40.0)**	
Unskilled Worker	**0 (0.0)**	**1 (5.0)**	
Semi-Skilled Worker	**5 (25.0)**	**3 (15.0)**	
Skilled Worker	**3 (15.0)**	**2 (10.0)**	
Clerical, Shop-owner,	**0 (0.0)**	**1 (5.0)**	
Farmer	**5 (25.0)**	**3 (15.0)**	
Semi-Profession	**0 (0.0)**	**2 (10.0)**	
Profession			

*Mann-Whitney U-test, **Pearson Chi-square, and *** Fishers' exact tests were performed for statistical analyses.

The study showed that the overall symptoms of panic disorder were lower in the experimental groups compared to the control group; 3.90 vs. 14.90; P<0.0001. The patients in the experimental group had limited attacks and symptoms/week; 0.55 vs. 2.55; and low distressing and frightening attacks; 0.55 vs. 2.10, respectively. Similarly, the experimental arm of the study had lower worry and

feeling anxious about the next attacks; 0.95 vs. 2.25, respectively. The places or situations that the patients avoided, or felt afraid of because of fear of having a panic attack were fewer in the experimental patients; 1.00 vs. 2.25. In addition, the patients in the experimental arm have fewer activities that must avoid feeling afraid due to panic attack consequences; 0.55 vs. 2.30, respectively (Table 2).

Interestingly, the panic symptoms and attacks altogether have a lower effect on the patients' responsibility at home; 0.15 vs. 1.80 and less interference in their social life compared to the patients in the control arm 0.15 vs. 1.65, respectively, see **Table 2**.

Table 2: Comparison of Panic Symptoms and Attacks between Experimental and Control Groups

General Characteristics	Study Groups		P-value (Two-sided)	Effect Size (Cohen's d)
	Control (n=20)	Experimental (n=20)		
Total Score	**14.90 (3.95)**	**3.90 (1.33)**	**<0.0001**	**3.16**
Panic frequency	**2.55 (0.759)**	**0.55 (0.510)**	**<0.0001**	**2.98**
Panic distress (uncomfortable, frightening)	**2.10 (0.641)**	**0.55 (0.510)**	**<0.0001**	**2.64**
Anticipatory anxiety	**2.25 (0.639)**	**0.95 (0.224)**	**<0.0001**	**2.31**
Agoraphobia	**2.25 (0.851)**	**1.00 (0.000)**	**<0.0001**	**1.47**
Interoceptive fear	**2.30 (0.801)**	**0.55 (0.510)**	**<0.0001**	**2.49**
Work interference	**1.80 (0.616)**	**0.15 (0.366)**	**<0.0001**	**3.07**
Social interference	**1.65 (0.489)**	**0.15 (0.366)**	**<0.0001**	**3.40**

Independent t-test was performed for statistical analyses.

The difference in panic symptoms and agoraphobia was examined between the patients with under high school education and those with high school and higher level in the experimental group in **Table 3**.

The study did not show a substantial difference of the total panic symptoms (P=0.275) and the sub-panic symptoms (P>0.05) between the patients in the experimental and control groups.

Table 3: Comparison of Panic Symptoms between the Patients with Different Education Levels on the Experimental Group

Panic Symptoms	Under High School (n=11)	High School and Above (n=9)	P-value (Two-sided)*
Panic Frequency	**0.55 (0.52)**	**0.56 (0.53)**	**0.966**
Panic Distress	**0.55 (0.52)**	**0.56 (0.53)**	**0.966**
Anticipative Anxiety	**0.91 (0.30)**	**1.00 (0.00)**	**0.341**
Agoraphobia	**1.00 (0.00)**	**1.00 (0.00)**	**n.a. (no difference)**
Interoceptive fear	**0.64 (0.51)**	**0.44 (0.53)**	**0.420**
Work interference	**0.27 (0.47)**	**0.00 (0.00)**	**0.082**
Social interference	**0.27 (0.47)**	**0.00 (0.00)**	**0.082**
Total PDSS	**4.18 (1.72)**	**3.56 (0.53)**	**0.275**

*Independent t-test was performed for statistical analysis.

DISCUSSION

The author's aim in conducting the present study was to examine the effectiveness of one-month short and intensive CBT intervention in patients with panic disorder. The study confirmed the impacts of a short-term intensive CBT on panic symptoms and frequency.

Less attention has paid to the short and intensive CBT programs for patients with PD in the literature. Deacon and Abramowitz applied a short-term and intensive CBT program (9 hours, contact of patients with a psychiatrist) through two consecutive days. The assessments at pre-intervention and one-month follow-up showed the significant reduction in anxiety and depressive symptoms, PD symptoms, anxiety sensitivity, and body vigilance. Interestingly, 60% of the patients were panic-free following the treatment and the assessment showed the normative levels of symptoms following course completion Deacon and Abramowitz[12].

The patients with PD attend the treatment in medical settings where pharmacotherapy is the dominant therapy modality[13]. The patients like immediate improvement and recovery may find out the CBT duration too long and turn to medication therapy to obtain a more immediate reduction in panic symptoms. Particularly, the patients live in rural areas have difficulties to access the long CBT programs.

Although, several approaches have been suggested to eliminate the time between the patient and therapists such as by using self-help books, Internet-based treatment, or computer-guided self-exposure[14], traditional CBT is the best intervention for patients with PD[15]. Hence, it is so important to consider the efficacy of the short and intensive CBT programs in patients with PD as therapist-assisted exposure is the crucial part of a CBT course.

The studies have shown the comparison results between the brief, exposure-based CBT and standard-length CBT protocols[16] and the favorable outcomes were obtained in the master of few days[17, 16]. Hence, the brief and intensive CBT courses can solve the barrier of the long duration contact between patients and therapist. The successful implementation of a 2-day, intensive, exposure-based CBT intervention has been reported on a 38-year-old woman with severe and intractable panic symptoms and agoraphobia even after one year period. The case had unusual and highly distressing symptoms of fainting such as vasovagal syncope Deacon[18].

CBT uses a variety of procedures to recover the patients, such as education, cognitive restructuring, diaphragmatic breathing, interoceptive exposure, and in vivo exposure. It could be more efficient through de-emphasizing or eliminating the procedures that have little efficacy, like breathing retraining[19] and cognitive restructuring[20, 21].

In accordance with Deacon[18], the interoceptive exposure was delivered to the patients in a long duration until it did not need a coping mechanism by the patients. In addition, the interoceptive exposures were applied in line with the patients' experiences rather than fixed ones in advance without inflexible adherence to a manual.

The study could be applied to patients with PD with different education level as it was shown in the results section. Therefore, not necessarily the patients must have a higher level of education to take advantage of the short and intensive CBT courses. The previous studies have approved that the post-treatment or follow-up outcome is predicted by baseline frequency and

duration of panic episodes and anxiety level[22-24].

The strong point of the study must be traced in the randomization of the patients into either experimental or control groups. In addition, the intervention was implemented over the one-week interval for each patient, provided the required time to practice the instructions at home as well. Moreover, the study author implemented the intervention and assessment and the exercises were practiced in front of the therapist (psychiatrist). However, the study was not exempt from the weaknesses. The weak point of the study may back to this aspect that the author did not measure the other comorbidities in these patients due to time pressure. The present study showed that the short and intensive CBT programs can be effective in the reduction of panic symptoms and frequency in patients with PD.

CONFLICT OF INTEREST

The authors declare that there are no any conflicts of interest.

ETHICAL ASPECTS

The scientific approval of the study was obtained from the scientific committee of College of Medicine –the University of Duhok and ethical approval from the Scientific Research Division-Duhok General Directorate of Health registered as reference number 10052015-4 on 17th April 2018. The current study had not any harm to the patients, as the investigator did not stop their regular medications. The guarantee was given to the patients for the confidentiality of their personal information.

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پوختە

کارتێکرنا چارەسەریا دەروونی – تێگەهی و رەفتاری یا کورت لسەر نیشانێن تێکچونا بزدیانێ

پێشەکی: : تێکچونا بزدیانێ دهێتە ناسین وەکو پەیدابونا ترسێ یان گۆشتنا ژ نشکێفە کو کێمتر ژ چەند خولەکان ب ئاستەکێ هەری مەزن دگەهیت. چارەسەریا دەروونی – تیگەهی و رەفتاری یا کورت بو نەخوشێن تووشی تێکچونا بزدیانێ سەرەراری کارتێکرنا زوورا بەرچاف یا چارەسەریا دەروونی – تێگەهی و رەفتاری ل هەمبەر چارەسەریا ب دەرمانان. بەلێ گەلەک ژ نەخوشان ژبەر درێژبوون و گەلەکیا ژمارەیێن رونشتنێن دەروونی مفا ژ ئەڤێ رێکێ وەرناگرن. لەورا ئەڤ ڤەکۆلینا بەردەست کارتێکرنا کورسەکێ کورت (٤ روژی) یا چارەسەریا دەروونی – تێگەهی و رەفتاری یا کورت لسەر دژواریا نیشانێن تێکچونا بزدیانێ هاتە ئەنجام دان.

ڕێکێن ڤەکۆلینێ: ئەڤ ڤەکۆلینا ل بەردەستدا، 40 نەخوشێن هاتین دەست نیشان کرن و ناسین ب تێکچونا بزدیانێ بتنێ یان دگەل ترسا گورەپانێ ژ لایێ ڤەکۆلەری ڤە لگور (DSM-5) بشێوەیەکێ هەرەمەکی (عشوائی) ل گروپێ ئەزموونی (20 نەخوش) و گروپێ کونترول (20 نەخوش) هاتن دابەش کرن. نەخوشێن گروپێ ئەزموونی بو دەمێ ئێک هەیڤ ب رێکا چارەسەریا دەروونی تێگەهی و رەفتاری یا کورت لگەل دەرمانان سەرەدەری ل گەل وان هاتە کرن. بەلێ نەخوشێن گروپێ کونترول ب تنێ بریکا وەرگرتنا دەرمانان سەرەدەری لگەل وان هاتە کرن. کورس بو دەمێ ئێک هەیڤ پێکهاتی ژ ئێک دانیشتنا دوو دەمژمێری ل هەر حەفتیەکێ دا بوو. نیشانێن تێکچوونا بزدیانێ لهەر دوو گروپان ب پیڤەرێ دژواریا نیشانێن تێکچونا بزدیانێ هاتن هەلسەنگاندن و پیڤان.

ئەنجام: نەخوش ل هەر دوو گروپێن ڤەکۆلینێ ل تەمەن، رەگەز، ئاستێ خواندنێ، رەوشا خێزانی، وەرزش کرن، دیروکا توشبونا زەبر و گۆشتنا زاروکینیێ، کار و پیشە وەک هەڤبوون. ڤەکۆلینێ خویاکر کۆ دژواری و ژمارەیا نیشانێن تێکچونا بزدیانێ ل گروپێ ئەزمونی ب شێوەیەکێ بەرچاف لهەمبەر گروپێ کونترول کێمتر بوو.

دەرئەنجام: ڤەکۆلینا بەردەست خویا کر کو چارەسەریا دەروونی – تێگەهی و رەفتاری یا کورت لسەر نیشانێن تێکچونا بزدیانێ کارتێکەرە.

پەیڤێن سەرەکی: تێکچونا بزدیانێ، چارەسەریا دەروونی – تێگەهی و رەفتاری – سەرەدەری و نیشان

الخلاصة

تأثير العلاج المعرفي السلوكي المكثف والقصير المدى على شدة اعراض المرضى المصابين باضطراب الهلع

الخلفية والأهداف: يعرف اضطراب الهلع بانه نوبات هلع غير متوقعة من الخوف المفاجئ والشديد مع الكرب العنيف التي تصل ذروة الذعر خلال دقائق معدودة. وبالرغم من ان العلاج المعرفي السلوكي هو العلاج المفضل والاكثر تأثيرا في معالجة المرضى المصابين باضطراب الهلع الا ان هناك نسبة معتبرة من المرضى لا يحبذون هذا العلاج بسبب كثرة عدد الجلسات وكذلك طول المدة الزمنية للجلسات النفسية التي تستغرق خلال الاسبوع. تهدف هذه الدراسة الى معرفة مدى تأثير العلاج المعرفي السلوكي المكثف والقصير المدى (4 ايام) على شدة اعراض المرضى المصابين باضطراب الهلع.

المواضيع و طرق البحث: في هذا الاختبار السريري تم اخذ عينة مؤلفة من (40 فردا) مريضا والذين تم تشخيصهم باضطراب الهلع مع او بدن رهاب الساحة من قبل الباحث وفق الدليل الاحصائي للاضطرابات العقلية للجمعية الامريكية (DSM-5) حيث تم تحديدهم بصورة عشوائية الى مجموعتين متساويتين كل منهما تتألف من (20 فردا) مريضا مصابا باضطراب الهلع. المجموعة الاولى الضابطة (20 فردا) التي استلمت العلاج الدوائي لوحدها خلال فترة الدراسة المحددة بشهر كامل والمجموعة الثانية الاختبارية (20 فردا) والتي استلمت العلاج الدوائي اضافة الى اخذ اربعة جلسات جماعية اسبوعية لمدة ساعتين كل اسبوع من العلاج المعرفي السلوكي المكثف والقصير المدى خلال المدة نفسها (شهر كامل). وفي نهاية الفترة المحددة انفا تم تقييم وقياس مدى تأثير العلاج المعرفي السلوكي المكثف والقصير المدى على بشدة اعراض المرضى المصابين باضطراب الهلع وفق مقياس شدة اعراض اضطراب الهلع (PDSS).

النتائج: كان المرضى في كلتا المجموعتين متجانستين ومتقارنتين من حيث العمر والجنس والمستوى الثقافي والحالة الزوجية والنشاط الجسمي وتاريخ التعرض للكرب في فترة الطفولة وكذلك المهنة ($P>0.05$) حيث اظهرت الدراسة بان شدة الاعرض وتكرار حدوث النوبات في المجموعة الاختبارية كانت اقل من الاهمية الاحصائية مقارنة بالمجموعة الضابطة.

الاستنتاجات: اظهرت الدراسة بان برنامج العلاج المعرفي - السلوكي المكثف والقصير المدى يمكن ان يكون فعالا ومؤثرا لتخفيف من شدة اعراض اضطراب الهلع لدى المرضى المصابين بها.