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Intensive weekend group treatment for panic disorder and its impact on co-occurring PTSD: A pilot study

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ABSTRACT

This pilot study examines the feasibility, acceptability, and potential effectiveness of delivering an intensive weekend group treatment for panic disorder (PD) to Veterans returning from deployments to Iraq and Afghanistan with co-occurring posttraumatic stress disorder (PTSD). The treatment program lasted 6 h each day and was delivered by two experienced therapists. Patients received core components of panic treatment, including psychoeducation, cognitive restructuring, and interoceptive exposure. The interoceptive exposure exercises directly targeted anxiety sensitivity, a psychological construct also implicated in the maintenance of PTSD. Eighty-nine percent of patients who expressed interest in the treatment attended a baseline evaluation, and 63% of those who were study eligible initiated treatment. Treatment retention was high, with all 10 patients who initiated treatment completing the program. Veterans reported finding the treatment and delivery format highly acceptable and reported high levels of satisfaction. Panic symptoms improved significantly following the treatment and were maintained at a 7-month follow-up, with 71.4% of the sample reporting being panic free. Co-occurring PTSD symptoms also improved along with symptoms of anxiety and depression. Preliminary findings suggest that brief and intensive group treatments for PD/PTSD are a promising method of delivering cognitive behavioral therapy that may rapidly improve symptoms. This innovative treatment delivery format also may be a cost-effective way of increasing treatment engagement through increased access to quality care.
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1. Introduction

Panic disorder is frequently comorbid with PTSD in civilian and Veteran populations (Barrera, Graham, Dunn, & Teng, 2013; Craske et al., 2006), and the two disorders share symptom overlap in domains such as hypervigilance, autonomic arousal, and avoidance (Teng et al., 2013). The high rate of co-occurrence is attributed in part to shared underlying pathology across the two disorders, including constructs such as anxiety sensitivity (Zvielli, Bernstein, & Berenz, 2012). The effectiveness of cognitive behavioral therapy (CBT) for the treatment of panic disorder (PD) and posttraumatic stress disorder (PTSD) is well established (Barlow, 2002; Norton & Price, 2007; Olatunji, Cisler, & Deacon, 2010; Tolin, 2010), but practice guidelines do not specify a recommended course of treatment for individuals with both disorders (American Psychiatric Association, 2009; National Institute for Health and Clinical Excellence, 2011).

In an effort to streamline treatment for individuals with comorbid disorders, recent research efforts have begun to investigate the efficacy of a single course of CBT in reducing both primary and co-occurring disorders (e.g., Norton et al., 2013). Studies of CBT treatments for panic disorder have reported that 21–57% of patients with comorbid anxiety and depression diagnoses experience reductions in the severity of these co-occurring disorders to subclinical levels (Tsao, Lewin, & Craske, 1998; Tsao, Mystkowski, Zucker, & Craske, 2002, 2005). Additionally, a study of CBT for panic disorder among Veterans with comorbid PTSD reported significant reductions in anxiety sensitivity at post-treatment (Teng et al., 2008).

Despite the effectiveness of CBT for panic disorder and its potential to reduce symptoms of comorbid PTSD, relatively few

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individuals receive this evidence-based psychotherapy (Young, Klap, Shoai, & Wells, 2008). Among Veterans seeking care within the Department of Veterans Affairs (VA) healthcare system, for example, only 28% of Veterans diagnosed with panic disorder received psychotherapy in the year following initial diagnosis, and on average they received only two sessions (Barrera et al., 2014). These data are supported by studies from the broader literature highlighting the frequency of premature treatment withdrawal among individuals who are able to access CBT for anxiety disorders (Arch & Craske, 2009).

The delivery format of CBT may be one factor related to treatment access and attrition, given that a standard course of CBT for anxiety typically requires 12–20 weekly sessions each lasting 60–90 min. This standard delivery format typically requires missing work or school to attend multiple therapy sessions, and is problematic for individuals who must travel long distances to access treatment services and/or arrange for childcare (Stecker, Fortney, Hamilton, Sherbourne, & Ajzen, 2010). An additional drawback of standard CBT delivery is that, although a small subset of patients may experience rapid treatment gains (Norton, Klenck, & Barrera, 2010), some patients do not experience significant relief from panic symptoms until completing a full course of treatment, which typically lasts between 3 and 5 months (Otto et al., 2012).

To address these concerns, recent efforts focused on improving patient access and treatment retention have examined the adaptation of CBT using novel delivery methods such as brief or intensive individual therapy formats. Brief therapy formats offer a smaller dose of treatment (i.e., fewer intervention hours), whereas intensive formats retain the standard treatment dose (12–20 h) while modifying the delivery into a condensed time frame. Preliminary data for these delivery formats appear promising, with studies of brief cognitive and cognitive behavioral interventions for panic disorder demonstrating significant decreases in panic symptoms following 4–5 sessions of weekly therapy (Clark et al., 1999; Craske, Maidenberg, & Bystritsky, 1995). Studies of intensive CBT for panic disorder also show significant improvements in panic symptoms following 20–24 therapy hours delivered over 6 days (Britan, Morissette, Speigel, & Barlow, 2008) and 9 therapy hours delivered over 2 days (Deacon & Abramowitz, 2006). The rapid improvement in symptoms and large effect sizes resulting from intensive CBT occurred despite limited opportunities for between-session practice, and were comparable to those reported in trials of standard 12-week CBT for panic disorder (Addis et al., 2004; Barlow, Gorman, Shear, & Woods, 2000). These studies highlight the remarkable effectiveness of brief and intensive CBT formats in reducing panic symptoms in a shortened timeframe; however, the effect of these interventions on comorbid disorders such as PTSD remains unknown.

Although fewer studies have evaluated intensive PTSD treatment delivery formats, similar rates of improvement were reported in a small feasibility study of intensive individual cognitive therapy for PTSD, which included up to 18 h of therapy delivered over 5–7 working days, showed that the intervention was well tolerated and resulted in an 85.7% remission rate of PTSD at post-treatment (Ehlers et al., 2010). Treatment gains were comparable to those reported in a trial of standard cognitive therapy for PTSD delivered in a weekly session format (Ehlers, Clark, Hackmann, McManus, & Fennell, 2005), but occurred in a much shorter time period.

Although these novel individual formats improve accessibility for patients, few practice settings afford the option for therapists to devote 9–24 h a week to a single patient. Thus, the time-intensity and cost of these interventions may pose feasibility and logistic issues for clinicians who manage full caseloads. Intensive group interventions offer an alternative approach that maximizes resources by providing treatment to multiple individuals simultaneously. In comparison to standard individual CBT, group CBT for panic disorder has been shown to be more cost-effective while resulting in comparable symptom improvement (Roberge, Marchand, Reinharz, & Savard, 2008).

The present pilot study describes a group-based intensive CBT intervention for panic disorder based on the empirically supported Panic Control Treatment protocol (Barlow & Craske, 1994; Craske, Barlow, & Meadows, 2000). The intensive panic control treatment (IPCT) used in this study allows core treatment components (psychoeducation, cognitive restructuring, and interoceptive and in vivo exposure) to remain intact, while condensing the delivery format to two consecutive days. Though PTSD was not a focus of the IPCT intervention per se, it was expected that the impact of these core treatment components on anxiety sensitivity would generalize to symptoms of PTSD as well. Accessibility difficulties posed by the standard 12-week delivery format were addressed by providing the treatment over one weekend in order to accommodate individuals who were unable to attend weekly therapy due to disruption of regular work hours, travel distance, and schedule conflicts. The weekend IPCT treatment was offered to returning Veterans from the Operation Enduring Freedom and Operation Iraqi Freedom conflicts, a patient population that has proven particularly challenging to engage in mental health treatment (e.g., Zinow, Britt, McFadden, Burnette, & Gillispie, 2012). Similar to the weekend drill experience familiar to Veterans, this format encouraged camaraderie and peer support. The primary goals of this study were to investigate the feasibility of providing the intensive 2-day treatment over one weekend and to assess treatment acceptability and satisfaction. A secondary aim was to evaluate degree of symptom improvement. We hypothesized that participants would find the intensive group treatment delivery format to be a satisfactory and acceptable form of treatment, with preliminary support for improvement in panic and PTSD symptoms, as well symptoms of anxiety and depression.

2. Method

2.1. Participants

Service members recently returning from deployment to Iraq and Afghanistan were recruited from a large Veterans Affairs hospital through a specialty outpatient treatment program for Veterans with PTSD and related anxiety disorders. Inclusion criteria consisted of a current diagnosis of panic disorder and PTSD. Exclusion criteria included current (1) substance dependence, (2) diagnosis of bipolar disorder or psychosis, and (3) severe depression with active suicidal ideation/intent. Patients taking medications for anxiety-related problems were included provided they were on a stable regimen of medications for a minimum of 4 weeks prior to treatment.

Veterans were referred by their mental health providers or by responding to brochures placed in clinic waiting areas. Patients completed a 2-h screening appointment to be assessed for study eligibility and baseline data collection approximately two weeks before treatment. Participants completed a post-treatment assessment approximately two weeks following treatment, and a follow-up assessment approximately seven months after treatment. This study was approved by the local Institutional Review Board and VA Research and Development Committee.

2.2. Materials

Measures assessed (1) feasibility and acceptability of the intensive 2-day treatment and (2) preliminary outcomes. Outcomes were assessed using self-report measures to parallel the provision of real-world care and to maximize study feasibility. To ensure that patients in the study met criteria for panic disorder and PTSD, a