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Five-Sessions of Cognitive Behavioral Group Therapy in Patients with Panic Disorder: A Preliminary Study

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Abstract

The present study was designed to examine the relationship between panic severity and symptomatic outcome following brief cognitive-behavioral group therapy (CBGT). The sample consisted of 15 outpatients suffering from Panic Disorder who underwent CBGT. Panic severity was assessed by the Panic Disorder Severity Scale (PDSS), and Beck Depression Inventory (BDI), Beck Anxiety Inventory (BAI), Body Sensations Questionnaire (BSQ), Agoraphobic Cognitions Questionnaire (ACQ) and Health Anxiety Inventory (HAI) were administered to the patients by the study team at baseline, after the second and 5th session, post-treatment and first month. At the end of 5 sessions, a significant decrease was observed in the severity of panic disorder, depression and anxiety values, body sensations and health anxiety levels and this decrease was maintained at 1 month. According to our results, our 5-session protocol seems to be a fast and effective option in the treatment of panic disorder.

Keywords: Panic disorder, Cognitive Behavioral Therapy, Treatment outcome, Group therapy, Body sensation

Öz

Panik Bozukluk Hastalarında Beş Seanslık Bilişsel Davranışçı Grup Terapisi: Bir Ön Çalışma

Bu çalışma, kısa bilişsel-davranışçı grup terapisi (BDGT) sonrasında panik şiddeti ve semptomatik sonuç arasındaki ilişkiyi incelemek için tasarlanmıştır. Polikliniğe başvuran ve panik bozukluk tanısı konulan 15 hastaya, BDGT uygulandı. Panik şiddeti Panik Bozukluğu Şiddeti Ölçeği (PDSS) ve Beck Depresyon Envanteri (BDI), Beck Anksiyete Envanteri (BAI), Beden Algılamaları Anketi (BSQ), Agorafobik Biliş Anketi (ACQ) ve Sağlık Anksiyete Envanteri (HAI) ile değerlendirildi. Hastalara çalışma ekibi tarafından başlangıçta, ikinci ve 5. seanstan sonra, tedavi sonrası ve birinci ay sonunda uygulandı. 5 seans sonunda panik bozukluğu şiddeti, depresyon ve anksiyete değerleri, beden duyumları ve sağlık anksiyetesi düzeylerinde anlamlı bir azalma gözlendi ve bu düşüş 1.ay sonunda korundu. Sonuçlarımıza göre, 5 seans protokolümüz, panik bozukluğunun tedavisinde hızlı ve etkili bir seçenek gibi görünmektedir.

Anahtar Kelimeler: Panik bozukluk, Bilişsel davranışçı terapi, Tedavi sonucu, Grup terapisi, Beden duyumları

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INTRODUCTION

Panic Disorder (PD) is a disorder that occurs suddenly and consists of intense anxiety, physical and cognitive symptoms and is characterized by the presence of attacks and concerns that the attacks will recur; a disorder that causes impairment in functionality (Association, 2013). In a study conducted with 43,093 people, Grant et al. (2006) found that the lifetime prevalence of PD was 5, 1% (Grant et al., 2006). In the research of Mental Health Profile of Turkey, the prevalence of PD in the last 12 months was found to be 0.4% (Kiliç, 1998).

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Drug therapy and/or cognitive behavioral therapy (CBT) is commonly used in the treatment of PD. Many studies for PD have proven the efficacy of drug therapy. However, it is known that in many patients complaints may recur while drug treatment is in progress or after treatment is discontinued. According to the long-term study of Katschnig et al., 31% of the individuals recovered, 45% felt better but their symptoms persisted, 24% experienced the same symptoms or worsened 4 years after drug treatment (Katschnig & Amering, 1998). CBT becomes a priority choice when it can be applied due to the lack of side effects, the applicability to the patient group who do not want drug treatment (Otto, Pollack, Penava, & Zucker, 1999) and the reporting of more permanent effects in the long term (Nadiga, Hensley, & Uhlenhuth, 2003).

Many research results are showing that Cognitive Behavioral Therapy (CBT) is effective in the treatment of panic disorder (Bruinsma, Kampman, Exterkate, & Hendriks, 2016; Butler, Chapman, Forman, & Beck, 2006; Otto et al., 2012). In a meta-analysis by Gould et al., published between 1974 and 1994, studies comparing controlled CBT and pharmacological agents were examined; both treatments and combinations have been reported to be effective in the short term, but with more positive results in favor of CBT. In addition, follow-up studies have shown that patients receiving CBT maintain long-term well-being after treatment (Gould, Ott, & Pollack, 1995). In the light of these findings, it can be said that CBT may be more effective in maintaining the favor condition of panic attacks symptoms.

CBT identifies individuals the negative thoughts and behaviors and affects them on the process with change related to the danger and aims to reduce long term dysfunctional anxiety. According to the CBT formulation, panic disorder cycle begins with the first attack occurring in some way catastrophizing and the misunderstanding of bodily sensations afterward (Clark, 1986). While catastrophized and misinterpreted stimuli are usually the normal consequences of conditions such as situational changes in blood pressure, stress, fatigue, the individual perceives these symptoms as precursors of very poor results. These misinterpretations include thoughts of fainting, suffocation, heart attack and loss of control which come to a person quite convincing at that moment.

When misinterpretations emerge, the safety and avoidance behaviors towards coping develop and these behaviors provide the basis for the continuation of the process by strengthening (Clark, 1986). Some safety behaviors may exacerbate symptoms. For example, taking deep breaths due to fear of suffocation can cause hyperventilation. On the other hand, the failure to realize the expected catastrophe may be attributed to the conduct of safety behaviors and as a result, safety behaviors may reinforce false beliefs (Salkovskis, 1991). In the CBT approach, the nature of panic attacks and the cycle of panic attacks are explained to patients with panic disorder within the field of psychoeducation.

While cognitive behavioral protocols aim to restructure cognitive catastrophic beliefs; it is aimed to eliminate behavioral avoidance and abandonment of safety seeking behaviors. Behavioral change also means testing catastrophic beliefs from the perspective of behavioral testing. Hereby, cognitive change gains an experiential quality.

Although CBT has been reported as an effective treatment for PD, it has been generally applied individually. However, it is also known that there are many curative aspects of group-based therapies. As a matter of fact, it is possible to provide a well-structured group environment for PD, to take role models of group members to control symptoms and to benefit from treatment (Dannon, Gon-Usishkin, Gelbert, Lowengrub, & Grunhaus, 2004). In addition, group therapy is a preferred treatment because it is less costly (Roberge, Marchand, Reinharz, & Savard, 2008).

In this study, the results of panic disorder treatment will be discussed with a 5-session group treatment protocol. The preliminary results of this study, which we think will contribute to the literature, will be discussed because this is the first study we know about cognitive behavioral group therapy (CBGT) in Turkish society and because of the short protocol based on 5 sessions.

METHOD

Sample and Procedure

In this study, a standard protocol was determined for 5 sessions of therapy (Table-1).

Participants between the ages of 18-65 who applied to T. C. SBU Ankara Dışkapı Yıldırım Beyazıt Training and Research Hospital between March 2019 and May 2019 were included in the study.

During the policlinic examination, a 5-session treatment protocol was initiated with the volunteers of the patients

Table 1: Content of sessions

Session No	*Session content*
1. Session	Each patient sharing him- or herself and his or her symptoms in the group environment. Explain the treatment process and treatment goals for each patient. Form a therapy contract. The strategies used by the group members to date and the results of these (long term and short term). Introduction of cognitive behavioral model. Cognitive behavioral formulation of panic disorder. Practice: Partial or full. When an attack occurs, the individual should note the "trigger" "catastrophic thoughts" and "return to safety" behavior as soon as possible after the attack is over. If there is no attack, write down "thoughts" and "avoidance behaviors" that come to your mind when you are worried.
2. Session	Emotional control of group members: Brief summary of last week (attacks, anxiety levels in general). Summarizing last week and practice control. Explaining autonomic nervous system. The role of catastrophic belief in the attack - highlighting the role of behavior in the change of belief. Intra-session interceptive exposure (exposure to all group members (with hyperventilation?)). Explanation of Theory A and Theory B on panic symptoms. Practice: All members make a panic provocation similar to the one in the session and raise their anxiety to 50% and note the results. Patients will be able to note their thinking and behaviors according to Theory A and Theory B.
3. Session	Emotional control of group members: Brief summary of last week (attacks, anxiety levels in general). Summarizing last week and practice control. Individual review of belief in catastrophe; emphasizing the relationship between change in belief and behavior; Behavioral testing model. To discuss the narrowing repertoire of the individual in relation to behavior according to Theory A in daily life (social life, work life, hobbies). Practice: Continuing panic provocations, extending anxiety and attack periods. Plans to divide avoidances into 4 steps in the context of the development of one's repertoire in living spaces and to develop a living space related to the first step (no avoiding); conducting a behavioral experiment. Evaluation before and after the event. Testing expectations.
4. Session	Emotional control of group members: Brief summary of last week (attacks, anxiety levels in general). Summarizing last week and practice control. To look over concepts such as internal avoidance and external avoidance. Evaluating the effect of attention focusing on the body on anxiety. Practice: Determination of ongoing safety seeking behaviors and avoidances; classifying concerns as "mild", "moderate" and "difficult" in the absence of these behaviors.
5. Session	Emotional control of group members: Brief summary of last week (attacks, anxiety levels in general). Summarizing last week and practice control. Review of the 4 sessions. Discussion of strategies that work and which do not work; preparations for prevention of recurrence. A one-month plan for individuals on ongoing avoidance and safety behavior. Study on intolerance to emotion and intolerance to uncertainty.

diagnosed with panic disorder according to DSM-V. There were 8 patients in the groups and the sessions were limited to 60-75 minutes. Sociodemographic data form, Panic Disorder Severity Scale (PDSS), Beck Depression Inventory (BDI), Beck Anxiety Inventory (BAI), Body Sensations Questionnaire (BSQ), Agoraphobic Cognitions Questionnaire (ACQ) and Health Anxiety Inventory (HAI) were administered to the patients by the study team. The practice period of the scales lasted between 30-45 minutes and was conducted by other researchers. Medical treatment of the patients was not intervened but attention was paid on the fact that the patients taking the drug treatment had been using the same dose for at least 4 weeks. Exclusion criteria included psychotic disorder, bipolar disorder, alcohol and substance addiction, mental retardation and dementia comorbidities. The diagnosis of panic disorder and evaluation of exclusion diagnoses were performed by clinicians with at least 2 years of clinical experience. First complaints when policlinic examination of the patients must be panic symptoms. In addition to the patients presenting with complaints of panic disorder, patients with anxiety disorder and depression were

also included in the study. The primary outcome variable of the group research was the severity of panic disorder symptoms. There were no cognitive behavioral interventions specific to other areas during the therapy process. Before the beginning of the sessions, after the second session, after the 5th session and one month after the end of the therapy period, the scales were reapplied to the patients and the process was evaluated. 1 patient was not included in the evaluation because she could not attend the sessions after the 1st session due to her job; 15 patients were evaluated. Local ethics committee approval was obtained for this study.

Data Collection Tools

Sociodemographic data form: A form prepared by the research team to obtain general information of the participants such as age, gender, marital status, drug treatments, and family history. This form also includes some questions aimed at contributing to the development of the protocol.

Panic Disorder Severity Scale (PDSS): Developed in 1997 by Shear et al., each of the seven items in the scale regulated according to DSM-IV measures the frequency of panic attacks, distress during panic attacks, anticipatory anxiety, agoraphobic fear / avoidance, fear / avoidance of panic-related somatic symptoms, impairment of functionality (Shear et al., 1997). The Turkish adaptation of the scale was made by Monkul et al. (Monkul et al., 2004). Shear et al. (Shear et al., 2001) found that the scale had a cut-off score of 8 for panic disorder.

Body Sensations Questionnaire (BSQ): Developed in 1984 by Chambless et al. to measure fear of physical arousal and/or panic symptoms (Chambless, Caputo, Bright, & Gallagher, 1984; Moore, 2001). The scale consists of 17 items, a 5-point Likert-type score, and the total score ranges from 17 to 85. High scores are related to the severity of the individual's fear of physical sensations.

Beck Depression Inventory (BDI): It was developed by Beck et al. in 1961 and consists of a 21-item self-report scale that evaluates emotional, somatic and cognitive symptoms. The scale was scored on a 4-point Likert scale. It was revised by Beck in 1984. The Turkish validity and reliability study was conducted by Hisli (Hisli, 1989).

Beck Anxiety Inventory (BAI): In 1988, Beck et al. developed a 21-item scale to measure anxiety symptoms. The 4-point Likert-type will be scored, the total score ranges from 0 to 63 points. The Turkish validity and reliability study of the scale was conducted by Ulusoy et al (Ulusoy, 1993).

Agoraphobic Cognitions Questionnaire (ACQ): It was developed by Chambless et al. in 1984 to determine disastrous thoughts. The scale was developed in accordance with information obtained from patients and therapists (Chambless et al., 1984). The Turkish validity and reliability study was conducted by Kart et al. (Kart & Türkçapar, 2013).

Health Anxiety Inventory (HAI): It was developed by Salkovskis et al. (Salkovskis, Rimes, Warwick, & Clark, 2002) to assess health anxiety. It is a self-report scale consisting of 18 items. The first 14 items question the mental state of the patients and the last 4 items evaluate the assumptions about how their mental state could have been with the assumption of a serious illness. The validity and reliability study of the Turkish version of panic disorder patients was conducted by Karapıçak et al. (Karapıçak, Aktaş, & Aslan, 2012).

Statistical Analyses

The data were evaluated with SPSS 15.0 for Windows Evaulation Version (statistical package for the social sciences) statistical package program. The socio-demographic information of the patients with nominal characteristics are shown in percent. Numerical variables are shown with mean and minimum maximum values, and categorical variables with number and percentage. Wilcoxon test for binary comparison was used when comparing the changes according to time periods. In the interpretation of all results, p value <0.05 was considered statistically significant.

RESULTS

11 male and 5 female patients were included in our study. The youngest age was 21 years, the highest age was 48 years and the mean age was 33.80 (±7.29) years. 4 patients were single and 11 patients were married. The years of education were at least 8 years and at most 18 years and the mean education year was 12.06 (±3.59). The mean duration of complaints was 12 months. All of the patients had been admitted to the emergency department, cardiology, and pulmonary diseases at least once, and 9 patients had applied to other departments with these complaints. 6 patients were not receiving medical

treatment and 9 patients were receiving the same dose of treatment for at least 4 weeks. 3 of 9 patients were also receiving benzodiazepine treatment. At the end of the therapy, the patients had discontinued their benzodiazepine treatment. At the end of the therapy process, patients were asked questions about the process. The most common answer to the question "What is left in your mind about psychotherapy?" was to think about the relationship between our thoughts and our feelings and behaviors and to understand the working mechanism of the sympathetic nervous system. The answer to the question "What was the most useful information?" was the exposure experience during the session. When asked the question "What were the positive effects of the group process?" they reported that other people also had these symptoms, they understood that they were not alone and that there was a positive competitive environment during the implementation plans. When asked the question "What were the negative effects of the group process?" they reported that it was strained to hear other symptoms in the first week but they also reported that this negative effect had disappeared over time.

Table 2 shows the comparison of the scores of the PDSS scale applied to the participants at different times. There was a statistically significant difference between the measurements at different times ($p<0.01$). Accordingly, PDSS measurements decreased significantly until the 3rd measurement and there was no significant difference between 3rd and 4th measurements.

Table 3 shows the comparison of Beck Anxiety Inventory scores applied to participants at different times. There was a statistically significant difference between the measurements at different times ($p<0.01$). Accordingly, Beck Anxiety measures decreased significantly until the 3rd measurement, and there was no significant difference between the 3rd and 4th measurements.

Table 4 shows the comparison of Beck Depression Inventory scores administered to participants at different times. There was a statistically significant difference between the measurements at different times ($p<0.01$). Accordingly, Beck Depression measures decreased significantly until the 3rd measurement, and there was no significant difference between the 3rd and 4th measurements.

The comparison of the scores of the Body Sensations Questionnaire, applied to the participants at different times, is given in Table 5. There was a statistically

Table 2: Comparison of the scores of the PDSS applied to the participants at different times

	SCALE SCORE				
PDSS (n=15)	*Med*	*Min*	*Max*	X^2	*p**
1. measurement	18[a]	13	20	42.2	<0.01
2. measurement	9[b]	4	13		
3. measurement	3[c]	1	7		
4. measurement	3[c]	1	9		

* Friedman test
Med: Median, **a, b, c:** The difference between the groups with median letters is significant (Post hoc: Wilcoxon Test)

Table 3: Comparison of Beck Anxiety Inventory scores applied to participants at different times.

	SCALE SCORE				
BAI (n=15)	Med	Min	Max	X^2	p*
1. measurement	21[a]	5	57	36.0	<0.01
2. measurement	16[b]	2	39		
3. measurement	7[c]	0	14		
4. measurement	8[c]	1	19		

* Friedman test
Med: Median, **a, b, c:** The difference between the groups with median letters is significant (Post hoc: Wilcoxon Test)

Table 4: Comparison of Beck Depression Inventory scores applied to participants at different times.

	SCALE SCORE				
BDI (n=15)	Med	Min	Max	X^2	p*
1. measurement	14[a]	3	39	31.9	<0.01
2. measurement	7[b]	0	40		
3. measurement	4[c]	0	16		
4. measurement	4[c]	0	22		

* Friedman test
Med: Median, **a, b, c:** The difference between the groups with median letters is significant (Post hoc: Wilcoxon Test)

Table 5: Comparison of Body Sensations Questionnaire scores applied to participants at different times

	SCALE SCORE				
BSQ (n=15)	Med	Min	Max	X^2	p*
1. measurement	38[a]	20	60	33.1	<0.01
2. measurement	22[b]	18	45		
3. measurement	20[c]	11	31		
4. measurement	22[b,c]	11	36		

* Friedman test
Med: Median, **a, b, c:** The difference between groups with median letters is significant (Post hoc: Wilcoxon Test)

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significant difference between the measurements at different times ($p<0.01$). According to this, Body Sensory measurements decreased significantly until the 3rd measurement and there was no significant difference between the 2nd and 3rd measurements and the last measurement.

The comparison of the scores of the Agoraphobic Cognitions Questionnaire administered to the participants at different times is given in Table 6. There was a statistically significant difference between the measurements at different times ($p<0.01$). Accordingly, the 1st and 2nd agoraphobic measurements were significantly higher than the 3rd and 4th measurements.

Table 7 shows the comparison of Health Anxiety Inventory scores administered to participants at different times. There was a statistically significant difference between the measurements at different times ($p<0.01$). Accordingly, the Health Anxiety Inventory measures decreased significantly until the 3rd measurement and there was no significant difference between the 2nd and 3rd measurements and the last measurement.

Table 6: Comparison of the scores of the Agoraphobic Cognitions Questionnaire administered to the participants at different times.

	SCALE SCORE				
ACQ (n=15)	Med	Min	Max	X^2	p*
1. measurement	22[a]	14	48	27.4	<0.01
2. measurement	21[a]	14	32		
3. measurement	15[b]	11	26		
4. measurement	16[b]	11	27		

* Friedman test
Med: Median, **a, b, c:** The difference between groups with median letters is significant (Post hoc: Wilcoxon Test)

Table 7: Comparison of the scores of the Health Anxiety Inventory administered to the participants at different times.

	SCALE SCORE				
HAI (n=15)	Med	Min	Max	X^2	p*
1. measurement	21[a]	6	31	24.8	<0.01
2. measurement	15[b]	3	29		
3. measurement	10[c]	4	24		
4. measurement	12[b,c]	4	29		

* Friedman test
Med: Median, **a, b, c:** The difference between groups with median letters is significant (Post hoc: Wilcoxon Test)

DISCUSSION

In this study, the data of 15 patients with different age groups and different educational degrees were evaluated.

According to the results of our study, the scale scores of the patients decreased during the 5 sessions on the severity of panic disorder scale and this gain was preserved in the first month. It was observed that the number of panic attacks and expectation anxiety decreased and functionality increased. Again, according to the results of our study, depression and anxiety scores of the patients decreased during the therapy process and this gain was maintained during the first month follow-up. In a study reviewing the studies in the literature between 2000 and 2015, it was reported that as in our study, the severity of PD, the frequency of panic attacks and the increase in the social and occupational functionality of the patients were increased with CBGT (Başaran & Sütcü, 2016).

When these studies were examined in terms of session contents, it was seen that the basic techniques consisted of psychoeducation, exposure and cognitive restructuring (Başaran & Sütcü, 2016). In another study, it was reported that the number of panic attacks decreased, the levels of anxiety and depression decreased and CBGT was significantly more effective when compared with the waiting list and gains were maintained in the 2-year follow-up (Rosenberg & Hougaard, 2005).

It was observed that the body sensation of the patients decreased significantly during the therapy and there was no significant difference between the measurements in the 2nd week and after the 5th session and the measurements in the 1st month follow-up. This suggests that the first cognitively changing field in the group therapy process is related to body sensations. Giving information about the early autonomic nervous system and changing the physical catastrophes seem to be related to this result. In the following period, this change was preserved. In other words, it seems that individuals have produced more realistic, appropriate and functional thoughts about their body sensations.

In terms of agoraphobic cognitions, there was no significant difference between baseline and post-session evaluation, but there was a significant decrease after the 5th session following cognitive restructuring and this gain was maintained at 1-month follow-up. Despite a significant decrease, the scale scores are still high. Agoraphobic cognitions can be expected to decline further in the long term as

avoidance from the outside world decreases. The fact that these scores remain relatively high may be decisive for the long term process.

In our study, the measures of Health Anxiety Scale decreased significantly during the therapy and there was no significant difference between the follow-up after the 2nd session, the 5th session and the 1st month follow-up. Decrease in total scores related to health anxiety has emerged since the first two sessions. The fact that health anxiety and body sensation scores decreased early and remained relatively stable suggested that cognitive interventions had a response to belief.

Patients with pure agoraphobia were not included in this study, but after the initial evaluation, patients expressed more agoraphobic complaints, especially when they learned avoidance and safety-providing behaviors and in a sense were able to more clearly interpret what avoidance and safety behaviors actually serve in their lives. Agoraphobic cognitions were intervened from the third session. In addition, body sensations, focus of attention on the body, health anxiety and cognitions about the effects of anxiety have been discussed in the last 3 sessions. In the first session, the model was explained and in the second session, the sympathetic nervous system was explained and in fact a psychoeducation-weighted process was managed. At the end of the second session, the patients experienced theoretically learned symptoms and experienced a significant decrease in symptoms by exposure. After the second session, they were focused on cognitive interventions. Catastrophic thoughts were discussed from the third session, the effect of body attention on anxiety was discussed and the effect of safety and avoidance behaviors was explained. Two basic theories about the symptoms of panic disorder are discussed. According to the first theory, "these symptoms are a sign of something very bad (heart attack, fainting, choking and percussion) and I need to intervene urgently (such as going to the emergency room, taking medication, seeking relatives)". According to the second theory, "these symptoms are symptoms of panic disorder and make you feel bad but do not harm". As a result of the cognitive interventions made on the basis of these two theories, it was discussed according to which theory the patients behave and what the long-term effects of the chosen theory were (such as the solution to the disease?, what kind of results did they have in their social and professional lives?). In panic disorder, even if patients hold the first theory in the background when there are no symptoms, the first theory somehow comes to the forefront when symptoms occur. The second theory was introduced as a new guideline for the patients and it was aimed to make the intellectual knowledge experiential through hierarchical exposure plans, applied to each individual separately. Cognitions such as health anxiety, agoraphobia, and body sensations begin to recover after symptoms occur; this can be interpreted as an expected result.

Concerning the short CBGT of panic disorder, it may be useful to interpret several previous trials. Clark et al. (Clark et al., 1999) presented evidence of the effectiveness of a short version of CBT for panic disorder, with this short CBT was found to be equivalent to a more comprehensive treatment program and was superior to a 3-month waiting list condition. Treatment gains were maintained at a 12-month follow-up evaluation. In the second session, their interoceptive exposure occurs and forms the core of the treatment, consistent with the theory of changing these fears is the critical part of treatment (Smits, Powers, Cho, & Telch, 2004).

At the same time, studies have been examined suggesting that existing CBGT protocols contain components that are not necessary for a response to treatment. Unlike our study, Schmidt et al. (Schmidt et al., 2000) suggested that respiratory retraining is not an essential element in the treatment response to panic disorder; in a 12-week trial, skipping this training resulted in no reduction in response to treatment. Relaxation training has similarly been proposed to offer no additional efficacy and may even disrupt longer-term responses, because it has been suggested that it may inadvertently teach patients to try to control anxiety responses rather than directly learning not to fear of it (Otto, Powers, & Fischmann, 2005; Schmidt et al., 2000). For example, Craske et al. (Craske, Brown, & Barlow) found that CBT for panic disorder was associated with trends towards weaker treatment gains when it included relaxation interventions compared to CBT without a relaxation component. If these preliminary findings are appropriate, removal of breathing retraining and relaxation training emerges as prominent candidates in increasing the effectiveness of CBT for panic disorder.

When the CBGT processes related to panic disorder are examined in the literature, it is seen that the sessions vary between 5-14 sessions and the duration of the sessions varies between 60-150 minutes. The shortest intervention program we could reach was Rufer's protocol of 5 sessions; each session consisted of 2 meetings and a total of 150 minutes (Rufer et al., 2010).

One of the limitations of our study is the low number of participants and as a preliminary study; it is useful to interpret this with larger groups.

This protocol can be seen as a time and cost gain due to its short duration and the possibility to reach more than one person at the same time and it can be suggested as an option in routine treatment. In this sense, it can be said that the 5-session protocol is the shortest known CBGT protocol for panic disorder. Our study will make a valuable contribution to the literature as it is the first study we know about cognitive behavioral group therapy (CBGT) in our country, as well as it consists of a short protocol with 5 sessions.

Ethics Committee Approval: The study was approved by the Local Ethics Committee.

Informed Consent: Informed consent was obtained from all individual participants included in the study.

Peer-review: Externally peer-reviewed.

Conflict of Interest: The authors declare no conflict of interest.

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