

Support Person (Co-Therapist) in the Therapy of Panic Disorder

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Abstract

Objective: This study evaluates: a) the natural course and severity of panic disorder using psychometric testing, and b) the efficacy of using support person (co-therapist) in the treatment of panic disorder.

Method: Twenty-six outpatients were assessed with the Burns Anxiety Inventory, Diagnostic Anxiety Questionnaire, Hillview Panic Inventory, and Beck Depression Inventory. The patients were divided into two groups: 13 patients have been treated without involvement of the support person (control group), and 17 patients have been treated with help from the support person. The patients were also taught to write the Daily Panic Record form and the support persons (co-therapists) were instructed about therapy procedures provided by the therapist. All involved patients were re-assessed with the same psychometric instruments after three and six months of the treatment.

Results: The results on initial assessment were similar in both groups. As therapy progressed, both groups show a reduction in anxiety and depression after 3 months of treatment. However, it was evident that patients in the experimental group (with support person) had much better progress in last 3 months of the treatment than those in the control group.

Conclusion: Accepting that the exposure is the most effective treatment of panic disorder, we hypothesised that the therapy with a help from the support therapy should be more effective. We found that 54% of the patients in experimental group were panic-free after 3-months, and 86% after 6-months treatment. However, those who did not have help from support person, only 21% were panic-

free after 3-months treatment and 33% after 6-months treatment.

Key words: Panic disorder; Co-therapist; Exposure therapy; Therapeutic alliance

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INTRODUCTION

As an individual experience, panic disorder is an extreme form of anxiety or “terror” that tends to occur in a life-threatening situation, especially when it is unclear whether aware of any escape for patient is available. The DSM-5 describes the concept of panic disorder as a period of intense fear or discomfort that is accompanied by at least four out of 13 somatic or cognitive symptoms and it shows the recognition of cognitive, psychological, and behavioural dimensions of panic disorder. These elements have been recognised for a long period of time but in same stage, due to dominance of behavioural theories, it has not been paid enough attention to the evidence of somatic symptoms that occur in the panic disorder, such as palpitation, sweating, nausea, or dizziness (APA, 2013).

DSM-5 listed 13 symptoms and specified that at least four must be present to label the event a true or “full-blown” panic attack. Clinical experience tells us that different individuals may experience different combinations of symptoms and that the patient may report a slightly different mix of the symptoms from one panic attack to another. The most reported physical symptoms are: palpitations, chest pain, sweating, trembling, hot and cold flushes, shortness of breath, and paresthesia. Patients also report a fear of dying, losing control, or going crazy. DSM-5 diagnostic criteria describe a discrete period of

intense fear or discomfort, in which four (or more) of 13 recognised symptoms of panic attack developed abruptly and reached a peak within ten minutes.

There is a general agreement that fear occurs when a patient feels that he/she is directly threatened with “dangerous, perhaps life-threatening event”. Consistent with this view, the fear is an alarm reaction, an intense push to escape from a potential danger in which the organism is mobilised, both physically and psychologically, for an action (fight or flight response). When fear occurs in the absence of any real threat, the fear reaction is called a “false alarm” of the panic attack. Panic attack occurs following a period of stress in individuals who possess a “biological vulnerability” to experience surges of fear in the absence of any specific trigger (APA, 2002; Barlow, 1993). Following the stressful life events, some individuals are assumed to be more vulnerable to having panic attack than others, just as other people might develop essential hypertension in response to the stress (Barlow, 2002; Rapee, 1996; Salkovskis, 1996; Zepinic, 1997a). Probably, the factors that contribute to this vulnerability include genetically inherited predispositions to experience of panic attack.

As the fear is leading problem in panic disorder, the clinical experience found that systematic exposure (desensitisation) to frightening stimuli reduces pathological fear markedly. This approach conceptualised pathological fear in term of stimuli-response (S-R) association, and viewed treatment as entailing the severing of these associations. The exposure *in vivo* became a central ingredient in the treatment of panic disorder accompanied with or without agoraphobia. However, the physical symptoms in panic disorder often mislead patients to seek a treatment not with professionals in mental health but in other areas of medicine because of being overwhelmed by the physical symptoms.

Exposure therapy, specifically *in vivo*, is the most recognisable and recommended therapeutic approach to the panic disorder (APA, 2002; Barlow, 2002; Clum, 1989, Shear & Weiner, 1997; Zepinic, 1997a). The therapy focuses initially on assimilated uncontrolled dysfunctional beliefs and assumptions that something catastrophic will happen. It is common 12-session therapy which appears to be effective. At 3- and 6-month follow-ups the clinician checks the therapy progress and makes further therapeutic strategy (Zepinic, 1997a). The therapy begins with education about panic attacks and then introduces exposure to feared environmental reminders of the attack, although it may occur suddenly without any warning sign. The exposure therapy is a coping skills treatment that includes education, skills building for relaxation, cognitive restructuring, and behaviour rehearsal (such as covert modeling and behaviour exposure) in order to reduce avoidance of feared stimuli (Barlow, 1993, 2002; Mersch, 1995).

Therapeutic alliance is an essential factor in exposure therapy as it is the overall bond between the therapist and patient evolving during the process of therapy (Gelso & Carter, 1994; Horvath & Luborsky, 1993; Norcross, 2011). Although there is not a single definition of the therapeutic alliance it could be seen as an agreement on tasks and goals, role investment, empathic resonance, mutual affirmation and a therapeutic bond. In clinical practice a stronger alliance is seen as an important factor for more effective treatment outcomes, including an exposure-based treatment. In an attempt to better understand the relationship between therapeutic alliance and treatment efficacy it is important to explore patterns of alliance during therapy (Zepinic, 2012). However, it is possible that alliance breaks down because of the patient’s vulnerability and sensitivity in regard of the therapy demands. These could make tension between the therapist and the patient. The therapist should be understandable to the patient’s sensitivity and once when challenges were navigated or resolved, the relationship is then restored.

1. THE METHOD

1.1 Subject

The purpose of this study was to conduct a controlled trial with sufficient power to compare treatment effective in treating panic disorder using a support person (co-therapist) and an ordinary approach of the *in vivo* exposure therapy. The therapy was specifically designed to challenge dysfunctional cognitions and it was hypothesised that co-therapist will play positive role in helping the patient for coping skills to resolve symptoms more effectively than the clinician alone.

The subjects in this study were 26 outpatients (16 women and 10 men), age 20-51 (mean age = 29, *SD* = 7). Patients were divided into two groups: 13 patients who had been treated without any involvement of support person (*control group*), and 17 patients treated with help from the support person (*experimental group*). None of the patients in this study had previously been admitted to psychiatric hospital due to their mental problems (disorder).

The majority of patients reported a long-standing history of panic disorder (mean = 3.2 years). Twenty patients reported having previous treatment because of panic disorder or generalised anxiety, four patients reported being treated by a neurologist due to reported vertigo, dizziness, and nausea, two patients had been treated by a cardiologist due to the heart palpitations, trembling, or shaking, and seven patients had been treated by family doctor in particular to resolve physical symptoms (chest pain, fainting, shortness of breath, or trembling).

All patients were informed about the procedure of this study which includes an initial assessment

using psychometric testing, and review with the same instruments after three and six months of systematic exposure treatment (desensitisation). However, four patients from the experimental group left the study before the six-month evaluation was due, thus only 13 patients have been followed to the end of the therapy.

1.2 Inclusion Criteria

Patients were accepted for this study if they met the following inclusion criteria: a) primary diagnosis of panic disorder, b) at least six months suffering from a panic disorder, c) having at least one panic attack per week within the last four weeks, d) voluntarily seeking treatment, e) older than 18 and younger than 55 years of age, f) no evidence of any organic or psychotic disorder, epilepsy, alcohol or drugs dependency, personality disorder, or the intellectual deficiency, g) no medical contraindication for the exposure therapy (e.g. cardiovascular disease, asthma). In addition, as an exclusion criteria was that the participants cannot be in any abusive relationship and must have known the support person for at least 6 months.

1.3 Assessment

The comprehensive instruments were used to assess the symptoms and severity of the panic disorder in accordance with the guideline for a standardised assessment. The measures included the assessment of panic attacks and apprehension, self-reported symptoms, and overall day-to-day functioning. All patients were screened with the following instruments: Burns Anxiety Inventory, Diagnostic Anxiety Questionnaire, Hillview Panic Inventory, and Beck Depression Inventory.

Each treatment started with pre-treatment session when the therapist and patient made acquaintance, the *Daily Panic Record* form was introduced, and arrangements were made about the sessions and measurements including description of a *support person* (co-therapist) role. All patients that participated in this study were re-assessed after three and six months of the treatment.

1.4 Support Person

The support person was chosen by a patient presumably because he/she has been trusted and encouraging to the patient. Every support person received brief instructions about how he or she can help and what he or she should do if the patient avoids the recommended exposition. The key role of the support person was to reduce patient's avoidance, encourage and support patient to follow the given instructions and rational goals of the therapy (Arntz, 1996; Emmelkamp, 1986; Shear, 1997). After discussing the meaning of the co-therapist role, the patients are given the assignment of writing a detailed account of the panic attacks, including sensory details, thoughts and emotions during and after the attack (Zepinic, 1997b).

They were encouraged to write their emotions as their account and read it back to themselves before being

analysed in the presence of the therapist and co-therapist. They are also encouraged to identify problematic patterns of cognition that have come to represent outcomes of the panic attack and their style of responding. During therapy session with the presence of the therapist and co-therapist, the patients were asked to review the impact statement to reflect their current beliefs and evaluate gains made in treatment and areas on which the patients wish to continue working (Zepinic, 1997a).

In essence, the therapy included four components: education-rationale, cognitive control retraining, behavioural exposure, and imaginary exposure. The co-therapist provides a rationale for *in vivo* and imaginary exposure in the context of avoidance reduction and habituation of conditioned negative emotional response (Resick, 2002; Zepinic, 1997a). When the patient was unable to expose him/herself to the particular situation, the support person had a role of support and encouragement. The level of control depends on the intensity of avoidance and the patient's inability to control own behaviour and recognise negative automatic thoughts. Patients were advised to follow instructions given by the support person and not refuse request to repeat rituals in specific situations for reassurance. On the other hand, support person was instructed not to accept the patient's avoidance because of reported and expected difficulties including the occurrence of somatic symptoms associated with a panic attack, particularly in public situations.

Support person was also required to keep records about the patient's behaviour during exposure and to record reported symptoms that the patient has experienced. During weekly appointment with the therapist, the patient attended together with the support person to analyse symptoms and reactions during the exposure (Barlow, 2002 Rapee, 1996; Salkovskis, 1996; Shear 1997). Support person was instructed to support patient throughout the entire therapy but four patients requested to continue treatment without support person after 3-month treatment because of good progress and "capacity to expose themselves" without help of the support person (Zepinic, 1997a). However, they stayed in the therapy and mostly relied on the clinician's requirements during the therapy but were not included in the final 6-months re-assessment as a part of the study.

2. TREATMENT PROCEDURE

The two therapeutic groups were equal in terms of overall number of hours but different in number and length of session. The exposure therapy was based on the hypothesis that panic attack is a result of a *vicious cycle* involving a fear of imminent physical and/or psychological disaster arising from the misinterpretation of a certain bodily sensation and/or psychological experience. The treatment was designed to break the vicious cycle of panic by providing corrective information and experiences that

result in the re-attribution of unpleasant psychological affective phenomena in non-pathological and less threatening sources to the patient. In the experimental group, the support person had to encourage the patient to overcome panic during exposure.

In both groups, every patient needed to self-monitor his/her panic symptoms and keep recording the *Daily Panic Record* form, which was reviewed at the weekly appointments. In the experimental group it was mutual identification of reported symptoms from both the patient and the support person. It was, in particular, important to properly identify physical symptoms in patient's worst panic attack and which situation or place they avoid because of fear of panicking, embarrassment or humiliation.

The patient's description of a panic attack illustrated the misery of dramatic variations of "intense, unpleasant, and strange experience". We classified these manifestations in four categories:

- (a) Qualitatively different reactions from previous experience, distorted and unreal loss of normal sensations in the patient's extremities or in the interior of their body (feelings of heavy or weightless body experience of peculiar sensations or the paraesthesia in upper or lower limbs).
- (b) Frightening aspect of panic such as loss of controls that the individual has always taken for granted (struggle to retain or regain voluntary control over focusing, concentration, attention, and action, difficulty in focussing extends into a sense that they are losing consciousness, difficulty framing thoughts or pursuing a consistent logical line in the thinking or reasoning).
- (c) Confusion and disorientation.
- (d) Automatic suppression of reasoning powers (frightening ideas, losing control, choking), and feeling of being engulfed by uncontrollable anxiety (this feeling has been described as "unendurable pain" and "the worst imagined experience").

The therapy aimed to measure the perceived credibility of the provided treatment asking patients treated by using co-therapist after 3- and 6-months to explain: (a) how logical this type of treatment seemed to be, (2) how confident the patient is that the treatment will be successful reducing panic attacks, (c) how confident the patient is that co-therapist will be supportive in solving other personal problems, and (d) how confident is the patient to recommend to others this type of the treatment. This evaluation was rated on a 6-point scale ranging from *not at all* (1) to *extremely* (6).

Although panic attack has been described as "spontaneous" we have trained the patients to monitor their anxiety by their identification of an "inexplicable" physiological sensation (such as faintness or palpitation) followed by frightening automatic thoughts as a prelude

to an attack. As patients have a specific fear during the attack their danger is real and plausible. Their attention has been fixated on anxiety, a status of feeling peculiar, and loss of control with minimum introspection to identify unrealistic feelings (e.g. the fear of dying is activated by unexpected physical sensations for which they had no benign explanation). They interpreted the physical distress as a sign of a devastating physical disorder and became more anxious and symptomatic (APA, 2002; Barlow, 1993; Clum, 1989). Their panic attacks seem to signify helplessness in the face of serious danger (Rapee, 1996; Zepinic, 1997a). The sense of helplessness appears to be the result of an internal mechanism leading a patient to believe that he/she is trapped in a dangerous situation or overwhelmed by an internal derangement (Rapee, 1996). The fear of own vulnerability interacts with physiological and affective responses to produce a vicious cycle.

In panic attack, the crucial devastating factor is the inability to control mental, physical, and affective symptoms. When the anxiety becomes so intense that the patient believes that he/she cannot control him/herself and that it will not subside spontaneously, the patient starts to catastrophise and requires help. Although the attack is often described as "spontaneous" the patients usually report some "alarm system" for forthcoming panic attack.

Patients were instructed to identify and describe the main body sensations associated with the occurred panic attack, negative interpretations using rating scale (0-100), and description of rational response (rate beliefs of negative sense 0-100). The *Daily Panic Record* form was used to provide information about: a) the data of the time of onset, b) the duration of the panic (from the onset of the symptoms to the beginning of their reduction), c) whether the panic was cued or uncued (with the description), d) the maximum severity using scale from 0-100, e) the list of each of the 13 described symptoms in DSM-V. The panic attack was considered if more than four symptoms occurred and severity was evaluated using 6-point scale (none, minimal, some, average, a lot, extreme).

3. INITIAL ASSESSMENT

Using psychological instruments, self-monitoring system, and clinical interview, we recognised the symptoms of panic disorder that reflect over-activity of the cognitive, affective, and behavioural system. Among the physical symptoms, the most recognisable symptoms were: a) inability to relax 94.1%, b) tense 84.5%, c) unsteady 71.3%, d) frightened 70.1%, e) raising heart rate 68.4%, f) weakness all over 65.1%, g) difficulty catching a breath 54.3%, h) nausea 46.1%, i) fainting or dizzy feeling 41.3%, k) feelings of choking 38.1%, m) sweating 32.5, n) fear of dying 29.4%. The most common reported physical symptoms "inability to relax" appears to represent an overmobilisation of all symptoms and incorporates anxious feelings and mind blocked. Other

reported symptoms (tense, weakness) reflect mobilisation or activation of parasympathetic and/or sympathetic system such as sweating, face flushed, rising heart rate, nausea, feeling of choking.

Among the psychological symptoms we identify the most common: a) difficulty concentrating 84.1%, b) fear of losing control 81.0%, c) inability to control thinking 74.1%, d) confusion 71.3%, e) fear of being rejected 68.4%, f) mind blurred 64.1%, g) inability to recall things 54.3%, h) broken sentences 54.1%, i) stuttering 24.1%.

Avoidance behaviour has been recognised in many ways: a) going away from home 89.6%, b) driving on freeway 76.4%, c) being too far from a safe place 64.5%, d) social parties/functions 63.4%, e) being alone 56.4%, f) sitting in a group of people 42.3%, g) using public transport 41.4%. Avoidance behaviour is usually a result of patient's fear of panic attack at an unsafe place, humiliation or embarrassment in front of the others. These feelings, accompanied with symptoms of uncontrolled motor activity (trembling, shaking), make patient significantly socially withdrawn and isolated.

The initial assessment confirmed type of symptoms and their severity as well as difficulties that patients experience. During the clinical interview we recognised three types of safety behaviour: a) avoidance of situations, which the patient expects, will provoke a panic attack (e.g. avoiding huge shopping centres or too crowded places, restaurants), b) escape from the situation at the time of a panic attack (e.g. patients explain that they have never experienced a heart attack because they left situation just in time), c) subtle avoidance behaviours carried out during the panic to prevent the fear-arousing situation.

The patients reported cognitive distortions that could be summarised in four groups: a) catastrophising; tendency to dwell on the most extreme negative consequences conceivable, assuming that a situation, in which there is any possibility of harm, constitutes a highly probable danger. b) personalisation; they often react as though external events are personally relevant and are indications of a potential danger. c) magnification and minimisation; patients are told to focus on signs of danger or potential threat to the exclusion of other aspects of the situation. The patients tend to emphasise any aspect of a situation that might be seen as dangerous and minimise or ignore the non-threatening or rescue factors in a situation. d) overgeneralisation; the patient's view of a time-limited situation as lasting forever (that panic attack will never end), and assume that because a particular problem has occurred previously, it is bound to re-occur frequently or assume that if they had any difficulty in a particular situation that shows the situation is dangerous.

4. THERAPY RESULTS

Before starting therapy, the therapist tried to help a patient to identify specific fears, and if possible, idiosyncratic

meaning of symptoms. In order to accomplish this, we elicit as precise a description as possible of a typical panic attack. We tried to identify in what situations symptoms occurred, exactly what sensations, emotions, thoughts and imaginings were associated with a panic attack. The patients were also asked to recognise what they thought was the worst thing that could happen and how strongly they believed in it. In particular, the patient should recognise how dangerous the attack was and to recall whether there is anything "special" about their breathing during the attack (gulping air, breathing through the mouth). Together, the therapist and patient explore the possibility of how hyperventilation may occur in numbness, tingling, nausea, dizziness, and other sensations.

All patients were informed that already prescribed antianxiety/antidepressant medication would not be changed during the treatment, including type and doses of medication. The patients were re-educated about the panic attack and the operation of a vicious cycle in which symptoms lead to fear. As it is known, the patient's key belief is that during the panic attack he/she will "lose control" and act foolishly or uncontrollably. The patients were taught that, although physical symptoms, emotions, or thoughts appear to be "out of control"; it is unlikely their behaviour will be the same.

They were instructed to respond in simple ways such as giving themselves a command during the next attack (raise arms, walk a few steps), and observing whether they follow it. In such situation a support person has a dominant role to encourage the patient to do the recommended steps, to handle the panic attack, and to expose him/her to a particular situation that the patient usually avoids. As patients were to allow them to maintain contact with the fear-inducing situation, place or object, the fear diminished entirely. By exposing themselves to a particular situation they have used the threshold method and systematic self-desensitisation.

In principle, the patient had to identify all the things, places and situations that he/she avoided. Therapy started with instructions to expose to a simple task and has a contact with mildly fear-provoking situation with repetition of this procedure as much as needed until reaching a tolerable fear. In experimental group, support person accompanied the patient in all provoking situations and encouraged patient to repeat exercise until no anxiety was evident. The major goal of a treatment was to give the patients the confidence to face a situation, place or thing that they had been avoiding through real-life exposure and good therapeutic alliance (McLaughlin, 2014). As we know that real-life exposure can be dangerous for a patient, we instructed the support person in how the patient may behave and what should be done to encourage him/her to reduce anxiety and avoidance to make it easier to move faster up the hierarchy of the exposure (Zepinic, 1997a).

Psychometric testing using the same instruments revealed the result differences between two groups:

Patients treated with no support person

	BAI	BDI	HPI
Initial assessment	65.8	25.2	32.6
After 3-month treatment	54.1	19.0	27.1
After 6-month treatment	3.4	14.1	25.6

Patients treated with a support person

	BAI	BDI	HPI
Initial assessment	65.4	26.0	32.4
After 3-month treatment	42.3	15.1	23.2
After 6-month treatment	16.3	9.4	8.5

The results on initial assessment were similar in both groups confirming criteria for panic disorder and accompanied symptoms. Both groups show reduction in anxiety and depression after three months of treatment, which continued until the end of treatment. However, it was evident that patients in experimental group (with support person) had much better progress in last three months of treatment than those in control group. We presume it was a result of given precise instruction and encouragement from the support person during the treatment.

SUMMARY

The results of this study should have good generalisability to treatment of panic disorder. Without any doubt, *in vivo* desensitisation is the most useful therapeutic model in treating a panic disorder (APA, 2002; Clum, 1989; Shear, 1997; Zepinic, 1997a). For the therapy plan it is important to identify how much the fear interferes with the patient's life and daily functioning, and how patient recognises the fear as reasonable or unreasonable, the level of disturbed thinking, negative automatic thoughts, and dysfunctional assumption.

With a gradual exposure the patients expose themselves initially to the "target" stimulus and vary the amount of time during which they expose themselves. The exposure has been a practical procedure in which the patient (a) can tolerate exposure to the avoided "target" situation, place or object at least briefly, and (b) has complete control over amount of the time during which he/she exposes to the dreaded target. Exposure is by definition a gradual procedure and the patient should not torture him/herself, but experience a reverse effect of increasing sensitivity to the fear-inducing stimuli.

Accepting that the exposure is the most effective treatment in panic disorder, we hypothesised that in therapy using help from a support person, treatment would be more effective. This assumption was based on two considerations: (a) proposed combinations of treatment (exposure, encouragement, company of

trusted person) would support a patient to do more frequent exposure to the "phobic target" situations, and (b) in a particular avoidance situation the support person controls patient's response to expose instead to leave. The test results supported our hypothesis that in treating panic disorder using help from support person the patients achieved benefits in two areas: (a) they could tolerate exposure to the "phobic target" situations or object in more confident manner, and (b) they have complete control over the amount of time during which they exposed themselves to the dreaded targets.

We have found that 54% of patients in experimental group (with support person) were panic-free after 3-months and 86% after 6-month treatment. However, the patients without help of a support person had only 21% of them panic-free after 3-month treatment and 33% after 6-month treatment. We also found that panic-free patients had improved self-esteem, optimism, motivation, and increased social activities. There was decrease in pessimism, self-dislike, and withdrawal.

Although therapist also taught the patients in control group how to deal with exposure, the progress results confirmed that many of them had been unable to do it at a desired level. What we can conclude from this study is that, as was hypothesised, an exposure *in vivo* using help from support person is superior to the exposure *in vivo* by patient alone (Zepinic, 1997b). The results on testing and self-report in this study confirmed that the treatment with co-therapist was successful to resolve a panic disorder. Exposure therapy, including the homework assignments as a comprehensive framework of therapy, with a support person was helpful in reducing the frequency and the severity of the panic attacks.

Panic disorder, as an individual experience, is an extreme form of anxiety with periods of intense fear or discomfort that is accompanied by somatic or cognitive symptoms. This can be a "terror" in those situations when availability "to escape" is not possible (Arntz, 1996; Clum, 1989; Mersch, 1995). Consistent with this view, the fear is an alarm reaction, an intense push to escape from a potential danger and in which the organism is mobilised, both physically and psychologically, for the action (fight or flight response). Exposure therapy is well known suggested treatment to panic disorder (APA, 2002; Barlow, 2002; Rapee, 1996; Shear, 1997). However, it is common that patient with panic disorder is unable without a support to respond properly and escape of being overwhelmed by fear.

Twenty-six outpatients, divided in two groups (13 had been treated without involvement of a support person, and 17 had been treated with a help of support person) participated in this study. The majority of patients reported

a long-standing history of panic disorder and many of them have been treated by different specialists due to physical complaints (heart palpitations, vertigo, chest pain, dizziness, shakiness, etc.).

The symptomatology of panic disorder with all patients was assessed by the following instruments: Burns Anxiety Inventory, Diagnostic Anxiety Questionnaire, Hillview Panic Inventory, and Beck Depression Inventory. Their symptoms were re-assessed after three months and six months of treatment. Accepting that the exposure therapy is the most effective treatment, we hypothesised that therapy with a help from support person will be more effective than without such help.

We found that 54% of patients in group where patients have been treated with help from support person were panic free after three months and 86% of them after six months of treatment. However, the patients treated without a help of support person only 21% of them were panic free after three and 33% after six months of treatment. These results confirmed effectiveness of a support person in treating panic disorder when exposure therapy is introduced.

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