

A One-Session Treatment Protocol for Panic Attacks

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Abstract

This article describes in detail a one-session treatment protocol for panic attacks as well as the results of two small studies of its efficacy. The treatment protocol, typically completed in 75 - 120 minutes, uses an innovative approach that combines the identification of bodily sensations and specific thoughts as the precursor or “starter” of the panic attack process. The exact treatment approach is described in detail. The results of two small studies using the protocol are analyzed. The results showed that a single session using the treatment approach produced a statistically significant, immediate decline in the reported number of panic attacks that were sustained over time. These results were achieved in two separate sets of subjects utilizing different facilitators. Descriptive information regarding the sample is also provided.

Keywords

Panic Attacks, Treatment, Anxiety Disorders

1. Introduction

This article discusses an innovative treatment approach that utilizes the identification of bodily sensations and specific thoughts to treat panic attacks in one session. The emergence of new treatments for panic attacks has been negligible in recent years (Stirman, Toder, & Crits-Cristoph, 2010). As studies of multiple methods of the treatment of panic attacks all report a significant number of subjects, 29% - 48%, who do not experience a lessening of symptoms, the need for an approach such as the one described in this article is clear (Milrod et al., 2007).

There were two major questions asked in this research project. The first was would the intervention result in a decrease in panic attack frequency? The second question was whether a study with a new facilitator with differences in age, gender and personality style would yield similar results?

Treatment for panic attacks that meets the requirements for Panic Disorder is usually based on Cognitive-Behavioral Treatment (CBT) approaches (Gloucester et al., 2014). The other most common treatment approach is biologic which is comprised of medications designed to lower anxiety. With CBT, the clients' exaggerated thought responses related to bodily experiences that are interpreted inaccurately have been shown to precede a panic attack. Fear of triggering anxiety has also been associated with the onset of a panic attack. Therefore CBT addresses the distorted reactions, beliefs, and sensitivity to the onset of a panic attack. Treatment is usually short-term, comprised of 20 - 24 sessions. Gloucester et al. cite several CBT studies which show that 50% - 80% of clients with Panic Disorder, with or without Agoraphobia, demonstrated improvement. But 5% - 30% of the subjects had a recurrence of symptoms within 12 - 24 months after ending treatment, and the great majority of the subjects had a reduction in panic attacks, without complete remission of the symptoms (White et al., 2012). In the White et al. study, half of the subjects received follow-up CBT for a minimum of 28 - 31 weeks and a maximum of 60 weeks. The subjects who were in the treatment group had a 5.2% relapse rate in comparison to the control group which had an 18.4% relapse rate.

Teachman, Marker, and Clerkin (2010) studied how clients with Panic Disorder attributed physical sensations to mean the onset of a serious medical condition such as a myocardial infarction. They stated that it is the thought process that leads to a panic attack rather than the physical sensation itself that can create panic attacks. This was seen as supporting the efficacy of the CBT approach to Panic Disorder. They assessed four CBT models: "1) Catastrophic misinterpretations and overall panic symptoms...; 2) Catastrophic misinterpretations and panic attack frequency...; 3) Catastrophic misinterpretations and panic-related distress/apprehension...; and 4) Catastrophic misinterpretations and panic-related avoidance" (p. 967). As expected a reduction in catastrophic misinterpretations led to a reduction of symptoms in all four models; however this study did not include long-term follow-up to examine whether the initial results held up over a significant period of time.

Relaxation training, including meditation, has also been studied as an alternative to medication in the treatment of anxiety in both the clinical and non-clinical population (Pagnini, Manzoni, Castelnovo, & Molinari, 2009). This approach has shown initial positive results and is currently being researched in more detail; however the initial results seem more effective with subjects who do not qualify for a diagnosis of panic disorder. Additionally, Strohle et al. (2005) found that aerobic exercise reduced the number of panic attacks in healthy adults.

The approaches discussed above require multiple therapy sessions to achieve results, and some regression was noted in many subjects (citations). The treatment method described in this article, the Rhythmic Integration Panic Protocol (RIPP), achieved sustainable results in one to two sessions.

A chance occurrence led to the development of the RIPP Project. The first author of this article observed a woman on an airplane beginning to have a panic attack and intervened. He utilized a theory of the process of change he had developed called Rhythmic Integration (Robbins, 1990) and combined this with his knowledge of the meaning of body movements acquired in his training as a somatic bioenergetic psychotherapist. He employed techniques developed out of this background. Specifically, he observed the confluence of the utterance of an emotionally charged statement and the display of unusual body movements that coincided with the utterance. This confluence was described as the "starter" and became a central component of the protocol described below. The woman's panic symptoms subsided and there was no return of them during the balance of the trip. Some-time later he began the RIPP Project, a qualitative study that replicated the results with multiple subjects. This article is a reporting of that study.

2. Method

2.1. Overview of Project

The above protocol was studied utilizing two separate groups of subjects. Group I was facilitated by the first author, the developer of the protocol. Positive results with this group led to the formation of Group II. This second group was facilitated by a different clinician to determine if the initial findings were replicable and not tied to a particular facilitator. The design for both studies used a before and after small n model where repeated measures of panic frequency were gathered.

2.2. Participant Screening

The determination of whether subjects met the DSM-IV diagnostic criteria for panic attacks (American Psychia-

tric Association [APA], 1994) was done by licensed master's level clinicians using a screening instrument developed by the first author. To qualify for a panic attack the individual had to have at least four symptoms. The range of symptoms comprising the participant's panic attack was from 4 to 20.

Group I consisted of five subjects, three of whom were female and two were male. Group II consisted of eight subjects, seven of whom were female and one male. The age range for all subjects was from 20 - 45. All but one of the subjects had had some form of therapy prior to entering the study.

The majority of the subjects called for treatment based on having read articles or heard radio interviews about the panic project. Subjects also were referred by clinicians who had unsuccessfully tried more traditional forms of treatment with their clients.

In the initial telephone interview the interviewer obtained demographic and information from the client and provided a summary and rationale of the intervention's background, direction, and goals. If the subject seemed interested, a following telephone call done by master's level clinicians would obtain information to determine if the subject met the criteria for the study. These criteria included information about symptomatology and frequency of panic attacks, previous therapeutic experience, etc.

2.3. Procedure

The subjects each attended one treatment session which was set in the first author's office for both groups. For both studies the data were gathered over several months. The first study was facilitated by Ronald Robbins, PhD, clinical psychologist and the second study was facilitated by Ann-Marie Jensen, LCSW Licensed Clinical Social Worker. Both facilitators were trained in body-oriented psychotherapy techniques. The facilitators were of different ages, gender, and personality style.

If the client was deemed to have multiple panic attacks, as defined by the RIPP project screening instrument, they were asked if they had any questions. Questions were answered, and if agreement to follow directions was obtained, the first session was scheduled. The typical session was from 75 to 120 minutes, with most lasting less than 90 minutes, and moved through the following steps:

2.4. Treatment Protocol

1) Greeting and Contract: In the first step the client and the facilitator greet each other as equals. The rationale for the intervention being based in the body is explained. The subject is then asked again: "Do you want to have markedly fewer panic attacks, perhaps no more panic attacks?" If the subject answers affirmatively, he is told "For that to happen now, all you need to do is follow the directions given. They will be respectful, safe, and not against any fundamental values you hold. Will you commit to that?" They were also told that "Our method does not induce panic attacks, and to date no one has had one in a session." Once a clear commitment has been given then the next step of the process begins. If the commitment is not made, the reasons for it are discussed in an attempt to allow agreement. If this is unsuccessful, the protocol may not be followed and the subject no longer qualifies to be part of the study.

2) Therapist's Identification of the Starter: Once the commitment is made, the relationship changes in that the facilitator is now giving directions which the client has agreed to follow. The facilitator leads a relaxation process aimed at assisting the client to ease muscular tension, enter a dreamy state, and soften the critical aspect of the ego to allow her to experience a memory. Once this state is achieved, the facilitator asks the subject to imagine the memory of a specific panic attack and to talk about it as if it is happening now. The facilitator listens to the description and looks for the starter which is a combination of an emotionally charged sentence accompanied by a particular kind of unusual body movement (see below).

3) Starter Characteristics and Further Identification: Starters reveal body movements that would be seemingly dangerous if allowed to continue and/or done more extremely. Examples of these types of movements include rolling the eyes up so that the pupils are no longer visible which cuts off vision, and holding the chest in a frozen position which cuts off breathing. In clients with a history of panic attacks, the researchers found that these body movements and an emotionally charged statement or reaction had already been paired. Therefore the facilitator can ask the person to repeat the charged statement as many times as necessary, and each time it will automatically result in the movement. The facilitator can use this pairing to assist the subject in becoming aware of this unconscious body movement. This stage ends when the facilitator has clearly identified the unconscious body movement and the associated sentence.

4) Subject's Identification of the Starter: Once the starter is identified by the facilitator, then the subject is asked to say the charged sentence and the facilitator interrupts the process by asking what the person just did with his body. This leads to some disorganization so that the subject is no longer in the relaxed state and is being asked to do two things that do not fit together naturally. This is repeated as many times as is necessary for the subject to become consciously aware of the body movement. This stage ends once a repeated awareness of the presence of the starter is reported by the subject.

5) Strengthening Awareness of the Starter: The next stage is designed to strengthen the conscious awareness of the starter by the facilitator and subject experimenting with the movement. They may exaggerate the movement, name the movement, or do the movement rapidly or in slow motion, etc. The purpose is to allow the subject and the facilitator to heighten awareness of the movement whenever it happens.

6) Topics of Psycho-education: The subject now becomes excited about the ability to notice the movement and is more open to taking in more information about the process. The facilitator becomes inspired to learn more about the subject's full panic picture. Several types of psycho-education take place during this phase. The subject learns how the fight, flight, or freeze response can be triggered without thought (i.e., physiological responses designed to help with survival are set off without the presence of actual danger). Therefore, the situation is misread by the primitive areas of the brain which react with a host of emergency responses that are intended to support survival. However, there is no real danger present. The emergency responses become symptoms of panic. For example, readiness to run from danger becomes rapid breathing and increased heart rate. In light of this, it's reasonable that one of the symptoms of the panic attack is to think: "I'm going crazy!" It's reasonable, too, that in response to a rapid heartbeat, feelings of choking, and detachment from oneself, fears, and thoughts of dying occur in many subjects.

Other topics often considered during this phase of the session are: How can panic attacks occur while sleeping? How can a panic experience become tied to the environment in which it first occurred leading a sufferer to phobically avoid returning to the setting?

Classical conditioning is explained to the subjects. This stage ends when the subjects begin to reflect on what this means especially to their situation. Inspired, the subject asks: "How can this information help me to change my suffering from frequent panic attacks?" One question leads to others. The doorway opens to a period of analysis.

7) Analyzing: Once the subject begins to analyze his or her own situation, other questions arise. Some typical ones are presented along with their answers.

Question: Are the feelings that come with the starter like the feelings of a panic attack?

Answer: Yes, you notice that they are but with markedly less intensity. The feelings are a shadow of the feelings of panic.

Question: Does the starter's appearance mean an attack will necessarily come?

Answer: No, often the starter will resolve itself on its own. Later in the session specific ways to resolve the starter before an attack occurs will be given.

Questions: Will I always have to be conscious of the starter when it happens?

Answer: No, we will work together to weaken or eliminate the link so that the starter either does not occur at all, or if it happens it is less likely to lead to a panic attack. If it does you will experience that attack differently due to your understanding of what is happening and your ability to stop it using the tools we will give you later in the session.

Question: So what do I do next?

Answer: This is what we will work on now.

8) Solidifying Work: The facilitator advises that change can occur. It will take solid hard work but it can be done. The subject is asked to tell a memory of another panic attack, again "as if it is happening now". This time when the subject catches the starter he or she is to keep repeating it until *on its own* the sentence loses its charge and is no longer accompanied by the starter.

After a few repetitions there is invariably resistance. For example, subjects may consciously suppress the body movement, or they may focus on the reactions of the facilitator rather than on their own. They may say they want to stop because the repetitions are boring. They may say they feel a change in the charge before they actually do.

If they do or say any of these things subjects are informed that some people may need to repeat the charged sentence up to 100 times in order to achieve the result. This, although factious, puts the process in perspective.

Indeed the whole session only lasts 120 minutes. It is hard but not that hard. This reality usually dissolves the resistance with all subjects. They resumed the task and a fuller level of involvement is clearly seen. When necessary for clarity, subjects may be asked to rate the strength of the charge that accompanies the body movement on a scale of 1 to 10, 1 being no charge and 10 being the strongest charge they have had with any panic attack. Once the report of the charge has been reduced to at least a 1 or 2 the facilitator acknowledges the subject's progress. At this point subjects are typically excited about their ability to do something to change the effect of the starter. To further understanding a metaphor of the starter being similar to the starter of a car is used. The starter starts the car but it needs more to move. Similarly with panic attacks the starter readies the subjects for panic to develop but more is needed in the form of catastrophizing sentences or images, or hyper-excited emotionality. If the subjects are able to catch the starter, they can stop the process before the panic attack erupts. Therefore, the subjects are able to see that if the starter can be identified the panic can be avoided.

9) Achieving a Difference: Once the subject obtains the awareness that the starter can be interrupted to prevent a panic attack from occurring, work begins to make this a reality. In this stage clients learn techniques to utilize in the real world that allows them to identify and interrupt the starter even when experiencing a high level of emotion.

In modern society, most people have tension in the head and neck area. The first step in the process is to teach clients images that relax these body zones. It is essential to relax these areas first in order for the subject to make effective use of subsequent images that will be given to effect the tensions related to their starter.

The client is asked to sit upright in a straight backed chair. The facilitator then asks permission from the client to touch the client's head. After permission is granted the facilitator puts one hand on the client's forehead and cups the back of the skull with the other hand and gently rotates the head in all directions. When areas of tension or jerky movements occur, the facilitator repeats the movement that causes it, and asks the client to be aware of what they are sensing. This raises the client's awareness of their tension. Then the facilitator tells the client, "we are going to now work with your imagination in a different way." The facilitator asks the client to close his or her eyes and imagine a horse. The client is asked to tell the facilitator about the horse. This intervention identifies any difficulties the client has working with images, and helps those who protest saying they do not visualize, accept the fact that they imagine even if they do not see anything in their mind's eye.

Once the client is comfortable using the imagination, the facilitator works successively with three images adapted from the work of Todd (1937) and Sweigard (1974) which is designed to relax the tension in the head and neck. The first image asks the client to imagine the neck lengthening upwards. The second image is imagining a cap or shawl sliding smoothly in a continuous movement over the top of the head and down to the eyebrow. The third image is imagining the head as a helium balloon floating straight upwards.

After the client completes the work with the three images, the facilitator asks for permission to again touch the head, moves it in the manner previously described, and asks the client how what is now being experienced is different from what was felt before. The result of this entire process should be an awareness of less constriction, greater ease, and freedom of movement. When the easing of tension does not occur it is invariably because the client rejects the image for some idiosyncratic reason (i.e. "I am not sure what a 'shawl' is"). In such cases, a new image is given, one that suggests the same line of movement. When this is accepted, the desired easing occurs.

The client is now ready to address the specific body tension that activates the starter which has led to the beginning of a panic attack. For example, the eyes roll up into the head. The image could be of the muscles in and around the eyes melting like butter. A different starter might be the chest held in a locked position interfering with the ability to breathe. With this the client might be asked to imagine the ribcage collapsing towards the center of the chest cavity. The use of these images leads to an immediate change in how the client is feeling. When asked to describe the change, the client will report an easing of the tension. With the ability to imagine, the image comes an awareness that the client can now respond in a way that prevents the starter from moving into panic. The client has now achieved choice and autonomy. They can choose whether to have a panic attack or not.

10) Final Phase: The final phase of the protocol calls for a review of the entire session. The facilitator asks the client to describe what has happened. Following this the facilitator provides a review. During this review the facilitator ensures that the client remembers how to identify the starter, how to use the images to ameliorate the starter, and reminds the client of the necessity to practice this for several days until he or she becomes adept at using it whenever it is needed.

3. Results

Two separate studies were conducted. Study 1 had five subjects and Study 2 had eight subjects for a total sample size of 13. **Figure 1** shows the results of reported panic attacks for both studies. **Figure 1** shows that the month prior to the intervention the number of panic attacks ranged from 5 to 26 and the average was quite high (9.6 for Study 1 and 17.6 for Study 2). Following the intervention, the number of panic attacks dropped off precipitously for both study groups (less than one on average for both groups). No matter how many symptoms the participant had the results were the same: large drops in panic attack frequency. The one exception was a participant who had a history of only three panic attacks prior to the intervention. In this case, the number of panic attacks dropped to zero. Despite the small sample size, the statistical analysis was quite robust. Overall, the decline in panic attacks was statistically significant: $F(4, 40) = 35.52, p < .001, MSE = 39.26, \eta^2 = .75$. The main effect for the comparison between the different study groups was not significant [$F(1, 10) = 1.93, p > .20, MSE = 3.14, \eta^2 = .16$] and the interaction between time and study group was not significant [$F(4, 40) = 3.25, p > .08, MSE = 39.26, \eta^2 = .25$]. When contrasting the number of reported panic attacks one-week prior to the intervention with the number of attacks one week after the intervention, the difference was highly significant [$F(1, 10) = 32.89, p < .001, MSE = 59.29, \eta^2 = .77$]. All contrasts between the other post-intervention reports (one month, six months, and one year) were not statistically significant ($p > .5$).

Both study groups reported the number of symptoms they experienced prior to the start of the intervention. The first study group reported 12.6 (SD = 4.4) prior symptoms and the second group reported 11.9 (SD = 2.4). The difference in reported symptoms between the two groups was not significant: $F(1, 11) < 1.00$. In addition, there was no significant correlation either between the number of symptoms and the number of prior panic attacks ($r = -.08, p > .8$) or between symptoms and number of panic attacks one year later ($r = .23, p > .4$).

The participants in Study 2 were also asked a series of background questions related to a) did they experience any balance problems, b) were they on any psychotropic drugs, c) were they currently in therapy, d) had they been in therapy prior to the study, and e) had any relatives experienced panic attacks? **Table 1** summarizes the results from these questions.

Table 1 indicates that all of the subjects were taking psychotropic drugs and the majority was either currently

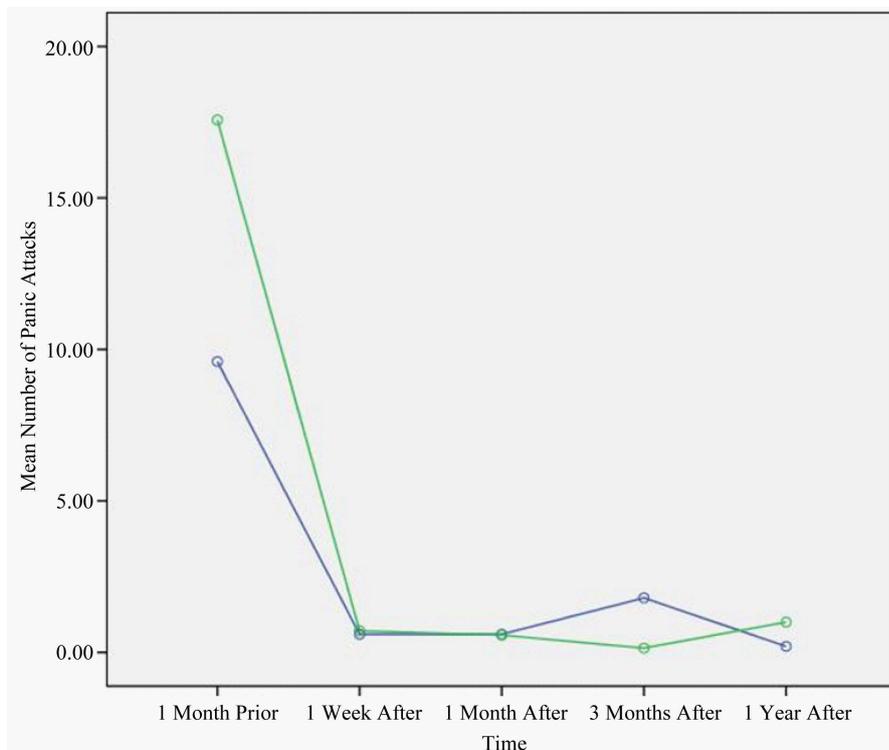


Figure 1. Mean number of reported panic attacks before (1 month prior) and after (1 week, 1 month, 3 months, and 1 year) the intervention.

Table 1. Responses from Study 2 for background questions.

Balance Problems	Psychotropics	In Therapy	Previous Therapy	Relatives with Panic Attacks
No	Yes	Yes	Yes	No
Yes	Yes	Yes	Yes	Yes
No	Yes	No	No	No
No	Yes	Yes	Yes	No
Yes	Yes	No	Yes	
No	Yes	Yes	Yes	No
No	Yes	No	Yes	Yes
Yes	Yes	No	Yes	Yes
37.5% Yes	100% Yes	50% Yes	87.5% Yes	43% Yes

in therapy or had been in therapy prior to the study. About a third had balance problems and over 40 percent of those who responded had relatives who had experienced panic attacks.

4. Discussion

The intervention described in this article clearly produced significant results. Study 1 and Study 2 both show large drops in panic frequency when the number of attacks in the month prior to the study and the number of attacks in the month after the study are compared.

The low level of attacks was maintained when follow-up data were collected during the year after the intervention.

The two major questions asked in this research project were: Would the intervention result in a decrease in panic attack frequency and would a study with a new facilitator with demographic differences yield similar results in the reduction of panic attack frequency. The answer to both of these questions was yes. This seems to indicate that the effect was created by the intervention itself.

4.1. Limitations

The small size of the sample limits the generalization of the study in ways that will be discussed below in the Implications section. Given the consistent effects observed, it is doubtful if a larger number of participants would have altered the findings in any meaningful way. If there had been more participants we could have studied multiple other aspects, such as the effect of gender, age, ethnic background, or having another psychiatric diagnosis.

Another limitation is that the Study 1 subjects were not asked the additional questions posed to the Study 2 subjects. Study 1 can be considered a pilot study (proof of concept). Once it was discovered that the intervention was effective, Study 2 was designed to replicate the effects and provide data about additional variables that describe the sample (e.g., a history of relatives with panic attacks or the use of psychotropic drugs, etc. (see [Table 1](#)).

The most serious limitation of both studies was the lack of a control group. This has implications for future research.

4.2. Implications

The results of this study support the fact that treatment of panic attacks can be successful in one session. Clinicians treating clients for multiple issues can help the client eradicate panic attacks quickly and then move on to other presenting problems. Mentioning this panic treatment to clients may prompt them to report a history of panic attacks when they come for treatment for other issues. Additionally, because this approach is a single session format, acute health care settings could refer to practitioners who use this model.

Given that one of the important characteristics of this study is that success is attained in a single session, the

authors suggest that future research should continue to focus on that goal. A single session sets a standard of simplicity and elegance in research design that can counterbalance much current research which tends to involve costly mega studies with thousands of subjects and multiple locations, researchers and administrators.

Replicating the study described in this article with larger sample sizes and control groups would allow for greater generalization. Controlling for co-existing psychiatric disorders can contribute to understanding the application of this intervention. Including a pre- and post-test battery of psychological tests in future research could assist in assessing whether this approach affects the symptoms of other anxiety-based disorders.

5. Summary and Conclusion

In summary, the treatment approach described in this article demonstrated successful use of a powerful method to eliminate the occurrence of panic attacks. There were two major questions asked in this research project. The first was would the intervention result in a reduction in panic attack frequency? The second was whether a study with a new facilitator with differences in age, gender, and personality style would yield similar results in reducing panic attack frequency? The answer to both of these questions was yes. The affirmative answer to the second question seemed to indicate that the effect was created by the intervention itself and not by other variables such as the age, gender, or personality of the therapist. Suggestions for future research have been made and can contribute to further validation and extension of the use of the treatment protocol. The authors believe that utilizing this approach to treat panic attacks can be extremely beneficial to clients with those symptoms and encourage clinicians to try the method described in the article.

Within the constraints of publication space, an attempt has been made to give as full a presentation of the protocol as possible. Where questions remain unanswered, please email the first author, Ronald Robbins PhD, at rhythmicintegration@gmail.com and place "Panic project request" in the subject line to receive more information.

References

- American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.). Washington, DC: Author.
- Gloucester, A., Klotsche, J., Gerlach, A., Hamm, A., Strole, A., Gauggel, S., & Wittchen, H. (2014). Timing Matters: Change Depends on the Stage of Treatment in Cognitive Behavioral Treatment for Panic Disorder. *Journal of Consulting and Clinical Psychology*, 82, 141-153. <http://dx.doi.org/10.1037/a0034555>
- Milrod, B., Leon, A., Busch, F., Rudden, M., Schwalberg, M., Clarkin, J., & Shear, K. (2007). A Randomized Controlled Clinical Trial of Psychoanalytic Psychotherapy for Panic Disorder. *The American Journal of Psychiatry*, 164, 265-272. <http://dx.doi.org/10.1176/ajp.2007.164.2.265>
- Pagnini, F., Manzoni, G., Castelnuovo, G., & Molinari, E. (2009). The Efficacy of Relaxation Training in Treating Anxiety. *The International Journal of Behavioral Consultation and Therapy*, 5, 264-269.
- Robbins, R. (1990). *Rhythmic Integration: Finding Wholeness in the Cycle of Change*. Barrytown, NY: Station Hill Press.
- Stirman, S., Toder, K., & Crits-Cristoph, P. (2010). New Psychotherapies for Mood and Anxiety Disorders. *Canadian Journal of Psychiatry*, 55, 193-201.
- Strohle, A., Feller, C., Onken, M., Godemann, F., Heinz, A., & Dimeo, F. (2005). The Acute Antipanic Activity of Aerobic Exercise. *American Journal of Psychiatry*, 162, 2376-2378. <http://dx.doi.org/10.1176/appi.ajp.162.12.2376>
- Sweigard, L. (1974). *Human Movement Potential: Its Ideokinetic Facilitation*. New York, NY: Harper Row Publishing.
- Teachman, B., Marker, C., & Clerkin, E. (2010). Catastrophic Misinterpretation as a Predictor of Symptom Change during Treatment for Panic Disorder. *Journal of Consulting Psychology*, 78, 964-973. <http://dx.doi.org/10.1037/a0021067>
- Todd, M. E. (1937). *The Thinking Body: The Study of the Balancing Forces of Dynamic Man*. Brooklyn, NY: Dance Horizons.
- White, K., Payne, L., Gorman, J., Shear, K., Woods, S., Saksa, J., & Barlow, D. (2012). Does Maintenance CBT Contribute to Long-Term Treatment Response of Panic Disorder with or without Agoraphobia? A Randomized Controlled Clinical Trial. *Journal of Consulting and Clinical Psychology*, 81, 47-57. <http://dx.doi.org/10.1037/a0030666>