

COGNITIVE BEHAVIOR THERAPY AS EFFECTIVE TREATMENT FOR FAST REMISSION OF PANIC ATTACKS WITH AGORAPHOBIA : A CASE STUDY

MEHWISH MURSALEEN¹, UZMA ALI²

¹PhD Fellow, Institute of Clinical Psychology, University of Karachi.

²Associate Professor, Institute of Clinical Psychology, University of Karachi.

CORRESPONDENCE: MEHWISH MURSALEEN, Email: mehwishmursaleen@gmail.com, Contact: 0333-3193739

ABSTRACT

This case study indicates the efficacy of Cognitive Behavior Therapy in optimizing treatment outcomes for Agoraphobia and panic attacks. Treatment of a 46-year-old female patient was carried out over a 7 month period in a clinical routine setting of a psychological clinic at Institute of Clinical Psychology, University of Karachi, Pakistan in 2013-14. She suffered from severe Agoraphobic and Panic symptoms which hampered her social and family functioning. For her treatment Cognitive Behavior Therapy techniques including Cognitive Restructuring, De-catastrophizing Continuum and Systematic Desensitization were applied during 8 sessions. Pre, Post-treatment and follow-up evaluations were established to check out agoraphobic severity. A drastic decrease in the severity of Agoraphobic Avoidance, Panic and associated symptoms through both objective and subjective reporting indicated that Cognitive Behavior Therapy is an effective mode of treatment for Agoraphobia with Panic Attacks. Moreover, full remission was maintained at 5-months follow-up.

KEYWORDS

Cognitive behavior therapy; Agoraphobia; Panic Attacks; De-catastrophizing continuum.

INTRODUCTION

Agoraphobia with panic attacks is categorized as an anxiety disorder in which person avoids places and situations because in case of a panic attack help might not be accessible. Panic attack is described as an intense anxiety attack leading to physiological and affective symptoms along with fear of having additional panic attacks. It causes impairment in individual's psychosocial functioning so that individual becomes home bound and dependent on others. The course of this disorder is chronic and chances of full remission are very low unless treated¹.

To treat agoraphobia and panic, both pharmacological and psychological approaches have been developed. Studies comparing these treatments indicate that cognitive behavioral therapy (CBT) is more effective than long-term pharmacological treatment. Specific strategies have been devised which base on CBT model. Majorly cognitive restructuring serves to modify client's misinterpretations of bodily sensations to accurately perceiving them as ordinary bodily states. Secondly exposure to feared situations either in imagination or in vivo, serves to invalidate the learned experience of agoraphobic avoidance and individual becomes able to face them without being anxious. Moreover, home-work assignments serve as opportunity to test what they have learned in clinical settings and modifies their patterns to gain control over life.²

THE CASE REPORT

A 46 years old married female, 3rd born among 2 sisters and 1 brother, presented with complains of palpitations, pounding heart, sweating and chills, shortness of breath and numbness in limbs along with fear of getting faint and this condition reached to peak within 15minutes. Moreover, nausea and abdominal distress led her to vomit excessively. She avoided crowded situations and leaving home alone due to fear of having additional attacks. In addition, she developed some depressive symptoms, lack of appetite and sleep disturbance. Her first anxiety symptoms appeared after witnessing an accidental death of a young boy (two years back) in relatives' family, after which she became apprehensive for occurrence of such an accident with her own son. Two years later she abruptly experienced her first panic symptoms. She had a family history of epilepsy and depression. After her first panic attack client became fearful that she might have developed any heart disease and may die of heart attack. 3 months back she was having almost three panic attacks within a day. She started remaining anxious all the time then she went to doctor and intensively investigated but all her results were within normal limits. Although she was prescribed some anxiolytics, but didn't recover her symptomatology. She approached psychological clinic for psychotherapy where her diagnostic interview was conducted with the help of Intake form of Institute of Clinical Psychology. Standard psycho-diagnostic tools were used including: Human Figure Drawing Test (HFD)³, Thematic Apperception Test (TAT)⁴ and Rorschach Inkblot Test (ROR)⁵. Client was diagnosed as having panic attack with agoraphobia (300.01)

according to DSM-5.

Written consent was taken from client to voluntary participate in study assuring confidentiality and the right to terminate treatment at any time during the period of study.

To measure severity, intensity and frequency of Panic and Agoraphobia, three scales were used which are: Agoraphobic Cognitions Questionnaire (ACQ)⁶, Mobility Inventory for Agoraphobia (MIA)⁷ and Panic Disorder Severity Scale (PDSS)⁸ (Shear et al., 1997). In order to utilize the selected scales in research, permission was taken from the concerned authors. The pre-test subjective reporting and all questionnaire scores indicated high level of anxiety regarding panic and social avoidance (refer Table-I, Chart-I, II & III).

Client was introduced with cognitive behavior therapy and treatment was carried out over 2 & ½ months during which 8 therapy sessions were taken on weekly basis. The treatment mainly comprised of Psycho-education about her symptoms and Cognitive behavioral interventions including cognitive restructuring, de-catastrophizing continuum, and systematic Desensitization.

After 2 ½ months of treatment, client recovered from panic attacks and agoraphobic avoidance and she remained symptom free at 5 months of follow-up (refer Table-I, Chart-I, II & III).

DISCUSSION/ THERAPEUTIC OUTCOME

In current study psycho-education in initial sessions produced insight in client regarding psychological nature of her problem rather than believing on observed physical symptoms.

Cognitive restructuring helped client to challenge her thoughts and beliefs of illness, panic and death through evidence based Socratic Questioning. She was able to recognize a high occurrence of her automatic negative thoughts related to panic, heart attack or death in relevance to very low occurrences of such events in actual.

Through de-catastrophizing continuum, she realized about her rating of a minor bodily sensation as higher as if she is going to die of panic attack. This was the point in therapy where she recovered from panic attacks by monitoring her own thoughts and changing them to adapt healthy patterns.

Further reduction in her agoraphobic avoidance was brought about through systematic desensitization. She formulated a rating of anxiety provoking situations ranging from low to higher level of anxiety and step by step she faced them in imagination while it was conditioned with a relaxed state. With the help of homework assignments step-by-step she was able to face situations in reality. And, at the end of treatment she was able to deal her life without the help of therapist.

Thus, it is suggested that CBT is not only helpful in reducing symptoms of panic and agoraphobia but its outcomes remain stable in long run.

In light of the above findings, it is proposed that mental health professionals in our culture would find better results if they consider CBT techniques while treating patients with mental disorders particularly those suffering from Agoraphobia and Panic attacks.

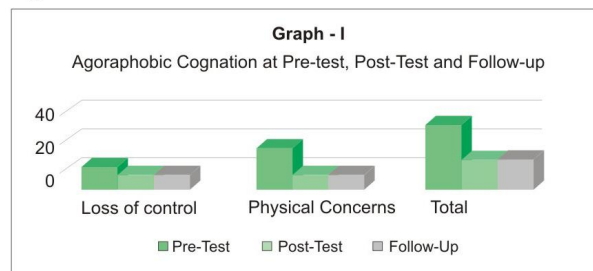
Table-I

The table showing Questionnaire Raw scores or Composite scores for Pre-test, Post-test and 5-month Follow-up

	Pre-test Scores	Post-test Scores	Pre-Post difference	Follow-up Scores
AQ				
Loss of Control	11	7	4	7
Physical Concerns	20	7	13	7
Total	31	14	17	14
MA				
Avoidance-alone	4.708	1.958	2.75	1.192
Avoidance-Accompanied	3.82	1.782	2.038	1
Panic Frequency	21	2	19	0
Panic Severity	4	1	3	-
PSS	3.71 (Markedly ill)	0.28 (Normal)	3.43	0 (Normal)

AQ=Agoraphobic Cognitions Questionnaire, MA=Mobility Inventory for Agoraphobia, PSS=Panic Disorder Severity Scale

Figure-I



REFERENCES

1. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. VA: American Psychiatric Association, Arlington, 2013.
2. Galassi, F., Quercioli, S., Charismas, D., Nicolai, V., & Barciulli, E. Cognitive Behavioral Group treatment for Panic Disorder with Agoraphobia. *J Clinical Psychol*: 2007;63(4):409-416.
3. Machover, K. Personality projection in the drawing of the human figure. IL: Charles C Thomas, Springfield, 1949.
4. Murray, H. A. Thematic Apperception Test manual. MA: Harvard University Press, Cambridge, 1943.
5. Exner, John E. The Rorschach: Basic Foundations and Principles of Interpretation, Volume 1. NJ: John Wiley & Sons, Hoboken, 2002.
6. Chambless, D. L., Caputo, G. C., Bright, P., & Gallagher, R. Assessment for fear of fear in agoraphobics: the Body Sensations Questionnaire and the Agoraphobia Cognitions Questionnaire. *J Consul Clinical Psychol*: 1984;52:1090-1097.
7. Chambless, D. L., Caputo, C. G., Jasin, S. E., Gracely, E. J., & Williams, C. The Mobility Inventory for Agoraphobia. *Behav Res Ther*: 1985;23:35-44.
8. Shear, M. K., Brown, T. A., Barlow, D. H., Money, R., Sholomskas, D. E., Woods, S.W. et al. Multicenter collaborative panic disorder severity scale. *Am J Psychiatry*: 1997;154:1571-5.



Figure-2

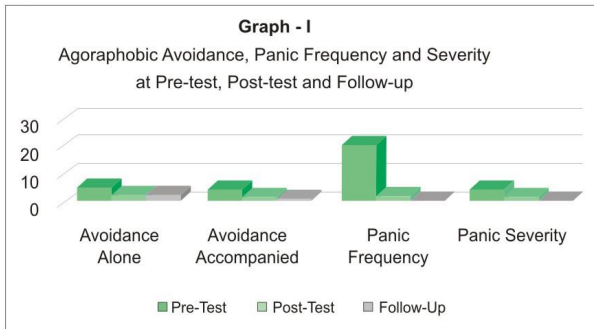


Figure-3

