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*Case report* ■

# Case of Panic Disorder with Agoraphobia - Continuum Through Cognitive-Behavioural Therapy

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## SUMMARY

**Panic disorder is characterized by spontaneous and unexpected occurrence of panic attacks, the frequency of which can vary from several attacks per day to only a few attacks per year. Panic disorder is usually qualified with the presence or absence of agoraphobia. Panic disorder with agoraphobia is an anxious disorder where repeated attacks of fear and anxiety appear at places and situations out of the family surrounding, places where the escape is difficult and where someone would be helpless, as for an example crowded places, passing over bridges, traveling by public transport, walking in an open space. Depressive episodes, as well as obsessive-compulsive procedures, can also follow this condition.**

**A female person aged 25 years presents with a classical panic disorder with an agoraphobia and a classic and secure behaviour. She also suffers from dysthymia and a chronic fluctuating mood and low self-confidence. The patient gets panic attack when travelling by public transport in the morning when going to work, in a restaurant, in a supermarket, in a disco, when walking in an open space. The symptomatology started half a year before going to the psychiatrist, after several close persons died.**

**A short description of CBT. CBT is based on the cognitive model of an emotional answer and aspects of stoic philosophy. CBT is based on an idea that our thoughts cause emotions and different behavior, so that we can change the way of thinking, and after that feelings/behaviour unchaged situations. CBT uses Sokrates method and some techniques from psychodrama, as well as relaxing techniques. Giving «homework» and keepingg a diary is also a very important part of this therapy. Seven therapeutic sessions of a cognitive-bihavioural psychoteraphy in a combination with the antidepressants (one session weekly) were performed.**

**Cognitive-behavioural therapy is a leading therapy in dealing with agoraphobia and panic attacks. In combination with SSRI, it gives excellent results in reduction of the symptomatology.**

**At the end of the treatment, the mental state was significantly improved. The patient came in contact with her beliefs and the basic models developed in childhood, and learned how to cope with negative thoughts, feelings and maladaptive behaviour.**

***Key words:*** **panic attacks, agoraphobia, CBT (cognitive-behavioural therapy), SSRI (selective serotonergic reuptake inhibitors)**

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## INTRODUCTION

Panic disorder with agoraphobia is an anxious disorder where repeated attacks of fear and anxiety appear at places and situations out of the family surrounding, places where escape is difficult and where someone would be helpless, as for example a crowded place, passing over bridges, traveling by public transport, walking in an open space. It is followed by a turbulent vegetative and body symptomatology. During the episode, patients have the urge to fight or escape and have a sense of impending doom (as though they are dying from a heart attack or suffocation). Other symptoms may include headache, cold hands, diarrhoea, insomnia, fatigue, intrusive thoughts, and ruminations.

A panic reaction is a learned behavior, and accordingly, it is a subject of correction. It is more present in females than in males. The panic attacks must be associated with more than one month of subsequent persistent worry about having another attack, consequences of the attack, or significant behavioural changes related to it. The frequency of the panic attacks can vary from several attacks per day to only a few attacks per year. Panic attacks can occur in other anxiety disorders (1).

Panic disorder can lead to a significant hindrance in lifestyle. Many people with agoraphobia are unable to travel alone or be in crowds or malls or on public transportation. Individuals with panic disorder also may face problems with employment and depression. In addition, persons with panic disorder are at much higher risk of alcohol abuse and suicidality than the general population (although some studies suggest that panic disorder itself is not a risk factor for suicide in the absence of other risks, such as affective disorders, substance abuse, eating disorders, and personality disorders (2, 3).

## CASE REPORT

A girl 25 years of age presents with a panic disorder and agoraphobia with a classical secure behavior. Also, dysthymic behavior with a chronic volatile low mood and low self- confidence is diagnosed. The patient gets panic attacks while traveling by public transport to work, in a restaurant, in a supermarket, in a disco, while walking in an open space.

The symptomatology appeared half a year before visiting psychiatrist, after several close persons died (grandfather, first cousin, aunt). A maladaptive behavior appears when traveling by taxi, and not by public transport, she does not go to supermarkets, she avoids restaurants, open places. All this is followed by turbulent vegetative symptomatology (faster breathing, hands sweating, faster hearth beating).

### Description of sessions

*First session*

In case of panic disorder with agoraphobia, CBT is a symptom-oriented therapy. At the beginning, the therapist explains to the patient what the normal body reactions are and symptoms associated with stress and anxiety. That will help her to reduce some catastrophic fears connected with the wrong thoughts.

Everyone who is “caught“in a life-threatening situation experiences an activation of the sympathetic nervous system when the body is flooded with adrenalin. The sympathetic nervous system prepares the organism for an individual reaction-to fight or escape. The hearth and the lungs work faster to supply the body with oxygen and glucose, and the muscles fill with blood to fight or run. During a panic reaction, hyperventilation can cause nausea and dizziness.

*Experiment*

Hyperventilation is tested in an office so that the patient can see that the symptoms are the same as those appearing during panic attack. The therapist also explains some possible therapy-related problems. For homework, he suggests keeping a diary - a symptom diary for self-monitoring (Table 1).

*Second session*

*Breathing technique*

We taught the patient that artificially caused hyperventilation is followed by the symptoms similar to those during panic attacks. We instructed her how to practice abdominal breathing and techniques of a progressive muscular and mental relaxation, and told her to practice them at home twice a day.

*Third session*

Review of the diary and cognitive restructuring. Detection of automatic thoughts and getting an idea of the principal persuasion of the patient.

***Table 1.*** *Diary of self-monitoring*

| | Situation | Automatic thought | Body symptoms | Feeling (%) | Behavior |
|---|---|---|---|---|---|
| 1 | **Traveling by bus** | I'll be sick, faint, I'll be ashamed | Faster heart beating,dry mouth, heath, hands sweating and trembling | 90% fear | I listen to the radio |
| 2 | **At work** | | | | |
| 3 | **In a café** | | | | I speak loudly not to think about fear |
| 4 | **In a restaurant** | | | | I run out |
| 5 | **In a super-market** | | | | I rush to put everything in the cart and go out |
| 6 | **In a disco** | | | | I stand next to the exit where there is no crowd |
| 7 | **Open space** | | | | I walk fast |
| 8 | **In a theatre** | | | | I sit on the back seats |
| 9 | **At a hair dresser** | | | | I read a magazine not to think |
| 10 | **At the beauty parlor** | | | | |
| 11 | **At a weeding** | | | | I dance near the table so that I can sit if I get a panic attack |

*Fourth session*

We ask the patient which problem or a situation is the most difficult for her.

We work with a situation in a restaurant when the patient can not withstand more than a few minutes and most of the time she runs out. We pose Socrates type of questions and apply the principle of a drop-down arrow.

Th: When it happened - what did you think?
P: That I'll be sick and I'll faint.
Th: And how will you faint?
P: So, just like that…
Th: And what if you get a panic attack?
P: Well, I'll be ashamed.

With this we came to the **key thought.**

The patient continues:

- I'm a mannerly girl. My father is a famous person. The company knows me as a successful and mannerly, simply strong. I must not show myself in a poor light. Simply, I'm always the best, loved and appreciated. I should be the best." With this, we came to the **primary rule.**

Now we come to the basic scheme that is a scheme number four-a fear from losing control (limits).

*Fifth session*

Now we tell the patient to draw a table of facts "for" and "against" an alternative thought and a percentage of expressing her feelings.

The patient marks them by ordinal numbers. It appears that there are more facts "for" than "against" so that we make a reconstruction of the automatic one:

- It's nothing frightening and shameful, now I know how to breathe and control myself. This lead to the fear reduction by ten percents. We introduced a therapy with SSRI-Paroxetine of 20 mg and increased it to 30 mg after two weeks (4).

*Sixth session*

Respecting the patient's choice, we work with another situation: the situation of traveling by bus. She has not been using a bus for a longer period of time; she goes to work by taxi, but she can not stand it financially. We ask her to tell us something connected with her experience with traveling by buses, in order to come to

some specific situation. She recalls the situation at the bus stop when she was with her friend and saw her aunt, but she did not want to say hello to her, and she pretended that she did not see her. Her aunt died several weeks after.

With Socrates type of questions and a drop down arrow we make a reconstruction again. Regarding the basic though " I'll be sick " we get a second automatic thought "I'll stay alone", a second scheme of the person appears, which goes in addition to the scheme number 3 (orientation toward the others-the patient fears to lose other people's love and feels guilty for the aunt).

*Experiment*

Psychodrama with an "empty chair "and visualization of the aunt.

Th: Tell her all what you did not tell her before she left…

We achieved catharsis and reduction of the feeling of guilt in the patient and we gave her a homework to try travelling by bus alone gradually, starting from one station at the beginning.

*Seventh session*

We work in vivo desensitization in a supermarket, in the presence of the therapist. Previously, we reminded her about the breathing technique. The exposition finishes successfully. We give her an assignment related to the frequency and going to the supermarkets.

## DISCUSSION

Cognitive behavioral therapy (CBT) is a psychotherapeutic approach-a talking therapy. CBT aims to solve the problems concerning dysfunctional emotions, behaviours and cognitions through a goal-oriented, systematic procedure. Treatment is sometimes manualized, with specific technique - brief, direct, and time-limited treatments for specific psychological disorders. CBT is used in individual therapy as well as group settings, and techniques are often adapted for self-help applications. Some clinicians and researchers are more cognitively oriented (e.g. cognitive restructuring), while others are more behaviourally oriented (in vivo exposure therapy). Other interventions combine both (e.g. imaginal exposure therapy). Cognitive-behavioural therapy is based on the idea that our *thoughts* cause our feelings and behaviours, not external things, like people, situations, and events. The benefit of this fact is that we can change the way we think/ feel/act better even if the situation does not change. Cognitive-behavioural therapy provides normalization and start functioning in different situations in everyday life. Cognitive-behavioural therapy is the leading therapy for dealing with panic disorder with agoraphobia, and in combination with SSRIs antidepressants gives excellent result in the reduction of symptomatology (5-10).

## CONCLUSION

The patient came into contact with its core beliefs and patterns developed in childhood and learned how to deal with negative thoughts, feelings and behaviour, so that her condition was significantly improved.

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# SLUČAJ PANIČNOG POREMEĆAJA SA AGORAFOBIJOM - KONTINUUM KROZ KOGNITIVNO-BIHEJVIORALNE TERAPIJE

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**Sažetak**

**Panični poremećaj se karakteriše spontanim i neočekivanim pojavama napada panike, sa frekvencijom koja može da varira od nekoliko napada dnevno na samo nekoliko tokom godine. Panični poremećaj obično se kvalifikuje uz prisustvo ili odsustvo agorafobije. Panični poremećaj sa agorafobijom je poremećaj gde se pojavljuju ponovljeni napadi straha i anksioznosti na mestima i u situacijama koje su daleko od kuće, gde je bekstvo teško, kao na primer gužva, prolazak preko mostova, putovanje javnim prevozom, hodanje na otvorenom prostoru. Depresivne epizode, kao i opsesivno-kompulsivni postupci isto tako mogu pratiti ovo stanje.**

**Osoba ženskog pola od 25 godina ima klasični panični poremećaj sa agorofobijom i klasičnim bezbedonosnim ponašanjem. Takođe, pati od distimije i hroničnog fluktuirajućeg raspoloženja i niskog samopouzdanja. Bolesnica dobija napade panike kada se ujutru vozi gradskim prevozom na posao, u restoranu, u supermarketu, u diskoteci, kada hoda na otvorenom. Simptomatologija je prisutna pola godine pre javljanja psihijatru, a posle smrti nekoliko bliskih osoba.**

**Kratak opis KBT-a: KBT je bazirana na kognitivnom modelu emotivnog odgovora i aspektima stoičke filozofije. KBT je bazirana na ideji da naše misli prouzrokuju emocije i različita ponašanja, tako da možemo da promenimo način razmišljanja, a zatim osećaje/postupke u nepromenjene situacije.**

**KBT koristi Sokratov metod i neke tehnike iz psihodrame i relaksacione tehnike. Zadavanje ,,domaćeg rada" i vođenje dnevnika isto tako je vrlo bitan deo ove terapije.**

**Urađeno je sedam terapeutskih sesija kognitivno-bihejvioralne psihoterapije u kombinaciji sa antidepresivima (po jedna sesija nedeljno).**

**Kognitivno-bihejvioralna terapija je vodeća terapija u rešavanju agorafobije i paničnih napada. U kombinaciju sa SSRI-ma daje izvrsne rezultate u redukciji simptomatologije.**

**Na kraju lečenja je značajno poboljšano mentalno stanje. Bolesnica je došla u kontakt sa svojim uverenjima i osnovnim modelima razvijenim u detinjstvu i naučila kako da se izbori sa negativnim mislima, osećanjima i maladaptivnim ponašanjem.**

***Ključne reči:*** **napadi panike, agorafobije, KBT (kognitivno-bihejvioralna terapija), SSRI (selektivni serotoninski riaptejk inhibitori)**