

Cognitive-Behavioral Intervention in Panic Attacks. A Case Study.

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Abstract

The following is a case study of a thirty-five year old female accused panic attacks, the patient being referred to the psychologist by a psychiatry specialist. The client was diagnosed with panic attacks and anxiety and followed medical treatment for 6 months; also the psychiatrist made the recommendation of following a psychotherapeutic intervention.

Keywords: *panic attacks, anxiety, Cognitive-Behavioral Therapy, psychological instruments*

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I. INTRODUCTION

Thirty-five year old female accused panic attacks, the patient being referred to the psychologist by a psychiatry specialist. The client was diagnosed with panic attacks and anxiety and followed medical treatment for 6 months; also the psychiatrist made the recommendation of following a psychotherapeutic intervention.

The client was raised in a family of average socio-economic status. She is the second child, having an elder, 39 years old brother – graduate of the Law school, presently a lawyer. The parents are living, both retired from professional activity. The patient describes her father as “quite weak”, and the mother as expressing a difficult behavior. The parents seem to have had serious conflicts rarely, but intensively manifested.

The anamnesis shows that the educational style practiced by the parents was one of triggering shame, guilt addressed by the client in relationship with other people, fact supported by information offered in the clinical interview: “My symptoms come from my childhood, from my mother’s and teachers’ pressure; I could say that I did not chose my profession because I didn’t have much of a choice. It has always been my mother’s dream and she always pushed me to become an accountant, because it is a suitable job for a good girl”.

The patient also states that, in the present she cannot reposition herself in position with the mother who always intervenes in raising her child, stating that she cannot do it and also with her husband who apparently wishes to make modifications regarding the locative situation, but does not act on the aspect, taking advantage of his parents in law he lives with.

She remembers and talks about herself as being an “anxious” person ever since she’s known herself. Even from the primary school she often got worried regarding the fact that she could be spoken to by parents or teachers or she could obtain law grades at school.

Clinical history

The first signs emerged during the high school graduation exam, while in time, they diminished. However the signs repeated with greater intensity, three years after the patient got fired from the former workplace.

For six months she did not have a place to work and asserts that she felt like she was depending on her husband because he earned little money and most of the expenses were supported by her parents. The described states appeared as feeling sweaty, easily crying, hyperventilating, asthenia, headaches, hypoprosexia, next to sensations of suffocation and feeling like fainting – each time she went to a job interview.

Also, the client emphasized that the anxiety states, suffocation, irritability and problems regarding attention brought her difficulty in maintaining work tasks.

In the family tableau described by the patient we find feelings of inadequacy – “I cannot find my place anywhere, I always feel like I am an outsider”; feeling helpless – “When things seem to work well, I think it is only temporary and I am afraid of tomorrow, from a financial point of view”; underestimating capacities of problem solving – “ I am not feeling capable of managing each day of my life”; “I try to adapt”, “I think of myself as a dependent person when it comes to everyday life”. “I don’t trust my capacity of solving all problems which interfere, especially at the workplace”; she is always defensive, trying to protect herself from others – “I feel that I shouldn’t let the guard down in the presence of other people, because they will hurt me”. The depression and anxiety scales utilized show clinical symptomatology, as intensity is concerned.

II. PSYCHOLOGICAL EXAM

The client assessment was conducted using the following psychological instruments:

- The Hamilton Anxiety Scale – 14 items – which showed a global score of 42, specific to major anxiety (>41): anxiety: frequent emotional states of uncertainty regarding the future – from restlessness, feelings of insecurity, irritability, apprehension to terror impossible to control; tension: incapacity to relax, nervousness, corporal tension, shaking, incapacity to rest and fatigability, insomnia (Maier, Buller, Philipp, & Heuser, 1988).
- Structured clinical interview for clinical personality disorders of DSM-IV-TR – Axis II showed elements of avoidant and dependent personality, although they do not meet the criteria for personality disorder diagnosis (Samuel, & Widiger, 2008).

As a result of structured clinical interview for clinical disorders for DSM-IV-TR Axis I, it was detected that the patient’s symptomatology meets the criteria for generalized anxiety disorder. As a result of the evaluation interview, of the applied tests and based on obtained information, the following resulted: the patient presents evident sadness, cries easily, experiences a state of generalized anxiety with panic attacks which resulted in a state of depression.

Hence the positive diagnosis presents the following coordinates: anxiety and excessive worry present in most of the days, for at least 6 months connected to a series of events of activities.

Axis I: Generalized anxiety, according to DSM-IV (clinical disorders);

Axis II: No personality disorders identified;

Axis III: Several allergic states, without significant disorders (general medical conditions);

Axis IV: Stress caused by workplace conflicts, economic difficulties, lives with her parents – without the possibility of moving out, conflict with parents).

Axis V: global functioning index (GAF): 55.

The psychological intervention objectives were the following: ameliorating/managing symptoms related to panic attacks; ameliorating symptoms with the purpose of optimizing purpose of the behavior; removing feelings of incapacity, worthlessness, guilt; lack of appetite for life, decreasing irritability and increasing energy; removing obsessive thoughts regarding failure and personal image she considers to be scanty; better interpersonal relationship with parents and building an assertive training for a better interpersonal communication.

III. BUILDING THE THERAPUTIC INTERVENTION PLAN

The examination confirms the presence of generalized anxiety disorder, as the client presents behaviors of social isolation developed especially through expected interactions, more than through symptoms contingent to events (DSM-IV-TR, 2000).

The main obstacle in the present intervention was total disclaim of the symptomatology by the client. The dependence schemes bring her back to criticizing others in situations generating anxiety, expecting for others to change. During the intervention the client understood that the change of behavior and cognitions is owed to her.

Another effect of this problem is the difficulty of the client to think of a list of personal objectives, finding it difficult to visualize her objectives, placing them to an extreme compared to the present behavior and looking for real solutions. “I want to be indifferent, like my other colleagues, and not care... but even if I would do so I wouldn’t actually change anything”. Lack of hope was the second obstacle in the therapeutic intervention, presenting a form of learned helplessness: “anything I do, it always has a bad result”. When it was combined with the belief that people want to purposefully humiliate her, the inner discourse changes to “Anything I do, I still get humiliated”.

This is why, in the intervention programming, these two aspects were primarily sighted. Further in the process, clear objectives were negotiated with the client in order to proceed with techniques and methods on the cognitive, behavioral, biological and emotional levels.

On a cognitive level, cognitive restructuring techniques were applied, especially the intervention of cost-benefits type (“If it feels this way, what good does it bring you to think this way?”) or metaphoric and especially procedures of stress inoculation (analysis of the distress situation – identifying the internal dialogue – stopping it – replacing it with a functional dialogue).

On a behavioral level the technique of successive approximation through shaping or chaining was applied because many of the behaviors which required action were not present in the patient’s repertoire (Borkovec, & Costello, 1993). After finalizing the modulation, a plan of negative and positive strengthening was built (Beck, Emery, & Greenberg, 2005; Beck, 2011).

The technique known as chaining, just as shaping, is used in order to help the client learned behaviors and things that would not come up by themselves and for this reason are hard to increase as frequency (Martin, & Pear, 2015). In general the chaining is used for those behaviors which suppose an impossibility of determining because the task lasts too long or is complex. Thus in practice, the chaining means that the task is divided in smaller tasks which refer to guiding the client and helping him completing the tasks.

On a biologic level, the client was proposed to learn effective procedures of relaxation, afterwards being exposed to different anxiogenic situations through progressive desensitization (Morris, Davis, & Hutchings, 1981; Wells, 1990).

All mentioned techniques were accompanied by scenarios of hypnotic induction of guided imagery (Holdevici, & Crăciun, 2015), along with different interventions regarding the axis of time (for instance “changing personal history”, “reimprinting”, “activating resources”, etc) along with an assertive abilities training.

IV. RESULTS

Between sessions, homework was prescribed in order to be conducted daily, including: daily outdoor walk program – being accompanied – for at least 30 minutes up to bibliotherapy – recommendation of the book “Feeling Good: The New Mood Therapy” by Burns; from building a program for daily activities (with the purpose of installing an anxiolytic effect – reducing the impact and incidence of contingent events and imprinting a constant rhythm to avoid states of agitation) up to going over solved problems and providing rewards (Beck, 2011).

The client formed a valid daily activities program even after finishing therapy (as an anxiolytic strategy) (Zinbarg, Craske, & Barlow, 2006). The idea was proposed that starting that point she could consider she was following a psycho-physical recovery program and that the tasks she has to conduct are necessary to maintain the change obtained through therapy.

By the end of the intervention, a diminishing of symptomatology was observed and the client referred to positive states regarding its course. Problems were discussed regarding possible relapses and a series of cognitive-behavioral strategies were established in order to prevent anxiety and anxious relapse.

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