Original Article

Agoraphobia with Panic Disorder in a Psychiatric Setting

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Abstract

Background: Agoraphobia diagnosis has largely remained unchanged, with its criteria based on persistent fear and avoidance of certain clusters of situations. The controversial diagnosis of Agoraphobia with or without a history of panic disorder has also been retained in classification systems; with the understanding that patients either generally have never fully met or meet the diagnostic criteria for panic attacks.

Case report: A 49-year old female presented to an outpatient Psychiatric clinic with a 12-year history of fear of enclosed spaces which was precipitated by an unstable relationship with a male partner who frequently assaulted, abused, and neglected her because she refused to terminate an unplanned pregnancy, she had for him. According to ICD-11, she was diagnosed with Agoraphobia with panic attacks, she was treated with Tab. Fluoxetine 20mg daily and Cognitive Behavioural Therapy and in the past two years she improved significantly with appropriate consistency in her follow-up visits.

Conclusion: This case report shines a beam of light on the very few reported cases of agoraphobia and its incapacitating course on those who suffer from it. In Nigeria, there is scanty literature on agoraphobia, for multiple reasons such as stigma, the embarrassing nature of the illness, and no disclosure of illness.

Keywords: Agoraphobia, Panic attacks, Cognitive behavioral therapy

Introduction

Agoraphobia is the fear of or anxiety regarding places from which escape might be difficult, rigidly avoiding situations in which it would be challenging to obtain help[1].It is a condition characterized by marked and excessive fear or anxiety occurring in response to multiple situations where escape might not be possible or help might not be available in situations such as being outside the home, being in crowds, or public transportation[2]. The individual will consistently be anxious about these situations due to fear of specific negative outcomes, either having panic attacks or other embarrassing physical symptoms.

A significant number of patients develop fear and avoidance of situations associated with previous panic attacks or fear situations where escape would be difficult or embarrassing, or where help might not be available[3]. A cluster of situations associated with agoraphobic avoidance from factor analytical studies includes typically – Public transportation (e.g. buses, trains, planes); riding in or driving a car, especially on heavily travelled roads, crowds (e.g. cinemas, a football match, large shopping centers), shopping (especially in supermarkets), particularly where one must stand in queues, bridges, tunnels, elevators, and other enclosed spaces.[3] These symptoms persist for several months and significantly cause distress or impairment in various of the individual's life.

Often the leading type of phobias accounts for up to 50-80% of the phobic population seeking professional help and about 2% of the general psychiatric population[4,5]. It is the most disabling of phobic disorders because it can significantly interfere with an individual's ability to function in work and social situations outside the home in severely affected patients. They develop a preference to be accompanied by a friend or a family member when leaving home, especially if their destination is crowded or closed-in.

Heritability for agoraphobia is about 60% and has the strongest and most specific association with genetic factors representing it proneness to phobia[6].Early onset Agoraphobia may constitute a familiar subtype and necessarily does not indicate increased clinical severity or disability, as opposed to other psychiatric disorders[5].

In Sub-African and Nigeria studies; there is a reported wide variation in the rates of mental disorders[7],with substantially observed lower Anxiety disorder rates owed to demographic factors, with specific phobia the most common disorder[7].

Often agoraphobia coexists with panic disorder, in that patients are afraid to leave the safety of home lest they experience a panic attack in a public place.

This article discusses a unique and severe case of agoraphobia after well-informed consent was obtained from the patient to proceed with this publication.

Case Presentation

Mrs. E. is a 49-year old married female accountant who presented in the outpatient psychiatric clinic of the University of Calabar Teaching Hospital accompanied by her daughter with chief complaints of Fear of enclosed spaces of 12 years duration. About 12 years before the onset of symptoms and presentation she reported being in an unstable relationship with her male partner for whom she became pregnant. She reported that this pregnancy was not planned and was undesired.

However, she insisted on keeping the pregnancy to the displeasure of her partner. Though not married, but co-habiting with him for 7 years prior to presentation, he constantly pressured her to have an induced abortion done, which she refused. Consequently, on several occasions, she had been neglected, assaulted, and abused (physically, verbally, and emotionally) by her partner for refusing to terminate the pregnancy.

During and following this incident, she subsequently developed an intense fear of enclosed spaces, especially places where she had no possession of the keys. Other occasions and examples include occasions when she visits the bank, where she will persistently insist the bank securities

does not allow the electronic door to the banking hall to be closed for her to be comfortable and relaxed, otherwise, she will become restless, agitated and will occasionally scream. She also couldn't travel in a plane, as she would start panicking and becoming breathless. She only feels comfortable when she owns the keys to any enclosed space, she finds herself in.

Other reported difficulties encountered include poor interaction with other people; very rare visits to places of family relatives and friends, especially outside the confines of her home.

She reported no history of persistent feelings of sadness, low energy, suicidal ideations or self-harm to suggest a depressive condition. No history of elated or irritable mood, increased energy, or inflated self-worth. There is no history of any hallucinatory experiences or experience of control by an external agent/force. No other form of treatment has been received by the patient since onset of this illness till this presentation.

She has no previous history of mental illness nor family history suggestive of symptoms of mental illness. There is a medical history of Hypertension diagnosed about 2 years prior to presentation and currently on prescribed oral antihypertensive with good drug adherence. No surgical history, nor known allergies. There is also no history of use of alcohol or any form of psychoactive substances before the onset of symptoms.

Her childhood history revealed no childhood emotional problems or abuse; Her sexual orientation is heterosexual, and her past relationship history is not contributory.

Currently, she is married and maintains a cordial relationship with her partner, however distant as her partner is based in another city, and not close to the patient. They have two children together, a 12 year old female and a 6-year old male both living with the patient. Pre-morbidly she describes herself as cheerful, her predominant mood is happy and enjoys singing as an interest of leisure.

Her Mental state Examination findings at presentation revealed a well-groomed and kempt woman with psychomotor agitation and restlessness. There were no abnormality in her Speech, mood was anxious, affect congruous with the mood and reactive; Attention and concentration (tested with serial 7's) was arousable and sustained; and had full insight to her condition.

A diagnosis of Agoraphobia (with comorbid panic disorder) using the ICD-11 diagnostic criteria was made. She was psycho-educated on the nature of the illness, treatment modalities available to ameliorate the symptoms and self-help strategies that could be employed to relieve symptoms and distress,

She was started on tablet Fluoxetine 20mg daily orally and was offered behavioral therapies such as Relaxation techniques, Music therapy, and weekly Cognitive Behavior therapy (CBT) for the next 4 months. The CBT was helpful and effective as it helped the patient become less afraid with fewer attacks.

She was seen monthly in the out-patient clinic for 6 months. She showed marked improvement within 1 month of commencement of treatment with reported significant improvement in her mood, behavior, and somatic symptoms with a reduction of anxiety to feared situations. She has sustained her follow-up visit afterward and has returned to her premorbid functioning. Additionally, she has shown significant improvement in her social interactions and occupational functioning two years later.

Discussion

Agoraphobia is considered the most disabling of phobias because it can significantly interfere with an individual's ability to function at work and social situations outside the home[1]. It is a condition characterized by fear of or anxiety about places where escape might be difficult and will vehemently avoid situations where it will be challenging to obtain help. Situations that may cause such anxiety to occur usually includes crowds, open spaces such as markets, shopping centers, and parks. Others

includes confined spaces such as offices, stores, public transportation, and so on. Interestingly, this is the case with our index patient.

Often, they usually opt for company by a friend, colleague, or family member when leaving home, especially when their destination is closed-in or crowded. In severe conditions, as it is with our index patient, affected patients will refuse to leave the house. A study by Habibeh and colleagues[8] found leaving home alone, being in a crowd, standing in line, and using public transportation as the most common agoraphobic situations.

Literature has extensively demonstrated the nature and relationship between Agoraphobia and panic attacks[4,8,9,10]. As was reported in this index patient, Agoraphobia may be accompanied by panic attacks, either in response to environmental stimuli or arising spontaneously. Nevertheless, some other patients with Agoraphobia may not have panic attacks.

Diagnostic classification systems like the International Classification Of Diseases 10th edition (ICD-10), the Diagnostic and Statistical Manual of Mental Disorders 5th edition (DSM-5), and more recently the ICD-11 have made changes and modifications to the case definition of agoraphobia and its relationship to panic disorder[2,6,11]. ICD-10 considers agoraphobia as a primary disorder with panic attacks being secondary, which indicates agoraphobia severity. In DSM-5, agoraphobia is separated from panic disorder and distinguished from specific phobia. In specific phobia, the feared situations are avoided because the individual believes escape might be difficult or help might not be available in the event of any distressing symptoms (such as incontinence) not just only panic; however, with panic attacks as severity specifier[12].

This case report depicts an agoraphobic lady with a disabling severity of irrational fear of leaving the confines of her home, avoiding crowds and public places or travelling away from home, and also developing a panic attack when in such situations, the common presenting feature in this case. It is also common for agoraphobics to become housebound, sometimes termed “housebound housewife syndrome”, however, not all patients are necessarily housewives. With a combination of psychotherapy and drug treatment, symptoms resolved significantly with a return to functioning. Two years gone, she has maintained active social participation and kept us the managing team updated on her progress.

Conclusion

Overall, this case report shines a beam of light on this rare but potentially intractable condition, its incapacitating effect on sufferers, and the successes that could be accomplished from the use of a combination of pharmacotherapy and psychotherapy and adequate follow-up care.

Consent

An informed consent was obtained from the patient for publication of this case report. A copy of the written consent is available for review by the Editor-in-Chief of this journal.

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Authors’ contributions

E.O. and G.A. conceived the study and participated in its design. E.O. and A.O. participated in the coordination and drafting of the manuscript. E.O. contributed to drafting the manuscript. E.O. contributed to revising the manuscript critically. All authors read and approved the final manuscript.

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Competing interests
The authors declare that they have no competing interests.

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