

Case Report

A Strange Case of Agoraphobia: A Case Study

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ABSTRACT

Objective: To study a strange case of agoraphobia.

Method: Patient follows up.

Result: Agoraphobia irrespective of severity can be treated and decreased in intensity by psychiatric intervention and regular follow ups.

Conclusion: We report a case of an agoraphobic woman who was severely agoraphobic to an extent that she did not leave her bed for many years. Continuous and gradual psychotherapy eventually improved her condition. Twenty years later she was able to leave her room which we believe was a grand success for the doctors involved in her treatment. This case study suggests that agoraphobia can be a serious debilitating mental condition and gradual and patient treatment with regular follow ups can improve the patient's condition.

Keywords: Anxiety; Phobia; Agoraphobia; Anxiety disorders; Social phobia; Psychiatry

Introduction

Agoraphobia is an anxiety disorder characterized by uneasiness and fearfulness in situations, where the person perceives the environment to be unpredictable, dangerous or unsafe. These situations can include even the most wide open spaces such as shopping malls, airports, and parking lots. This feeling of chaos can also be triggered by social situations, where the person may not feel in total control or in unfamiliar spaces. Agoraphobia is defined in the DSMIV TR as "a subset of panic disorder, involving the fear of incurring a panic attack in those environments".[1] However, in the DSM5 Agoraphobia is actually classified as being separate disorder from panic disorder. Regardless of classification, these sufferers may go through immense obstacles and lengths to avoid situations where they feel helpless or uncomfortable, and in severe cases, may not even leave their home or sanctuary. Along with the feeling of uneasiness and discomfort, in unusual places, or large areas, people also feel as if they cannot be in certain areas, due to the possibility of not finding or getting help where help may actually be needed.[2,3]

According to the Anxiety and Depression Association of America (ADAA), about 6 million adults have a panic disorder.[4] The average time of onset is usually between ages 20 and 40 years, and more commonly effecting women than men.[5] Approximately 3.2 million or about 2.2% of adults in the US, from ages 18 to 54, suffer from agoraphobia.[6] Agoraphobia is one of the leading types of phobias, for which it accounts up to 60%. The best distinguishing age of onset cutoff of agoraphobia was found to be 27. Early onset agoraphobia might constitute of a familial subtype. As opposed to other psychiatric disorders, early onset in agoraphobia does not indicate for increased clinical severity and/or disability.[7] In this article we will discuss a unique case of agoraphobia which is mentioned below after taking a written consent from the patient.

Case Study

The case is of Mrs. E. L, who is a 91 years old woman at the time of initial evaluation, living with her husband of 60 years. She was seen through a home care program of Kent Hospital. Initial consultation was done in July 2008. We decided to write this case study after a written consent given to us by the patient.

Chief Complaint & History of Present Illness

The Patient Mrs. E. L had intense fear of falling and dying, along with fears of losing consciousness; not to be found in time; and might be buried alive. She had been home bound for the last 17 years. She had a fear that something bad will happen, if she will go out of her apartment. She stayed mostly in her bed, and did not even allow her husband to leave the apartment. She believed, that she might get hurt or buried alive if she leaves the safety of her bed. She also believed that she might not be found in time, should something bad happen to her. The patient was quite fearful of dying, thinking she may go to hell, although she could not describe anything that would make her deserve that fate. When her brother died in 1971, she managed to go to the hospital but did not want to go to his room to see him. Her niece reported that in the 1950s, when the patient's husband was working, she couldn't tolerate being home alone. It was unclear if the patient met the criteria for Panic disorder; however, her niece also reported she may sometimes have panic like symptoms. These include shortness of breath; tightness in her chest; palpitation; sweaty hands; tremors and sudden jolts of fear of dying. Her brother would pick her up and she would stay all day with his family until her husband returned from work to pick her up at the same time every day. Over the years, her condition worsened to a point where she even refused to step out of her apartment. As the time progressed, so did her agoraphobia, eventually forcing her to be confined to the corners of her bed. She was then provided with services such as a bedpan and sponge baths.

In 2008, during the month of July, Mrs. E. L called her husband, who was in the next room, like any other day. But this time she did not get a response from him. She immediately started having bad thoughts and ideas of what could have happened to him; so she called 911. This all took place from her bed. Instead of going to check up on his whereabouts in their own home, the agoraphobia took a drastic turn, which clouded her rational decision-making in the most critical time. The safety of her husband was jeopardized, yet she still could not leave her cloister of safety and comfort. Mrs. E. L denied feelings of depression, hopelessness and worthlessness. She also denied loss of concentration. She had no leisure activities and simply lied in bed. She did not listen to the radio or watch TV. She denied symptoms of mania or psychosis and also denied suicidal or homicidal ideation.

Psychiatric History

Treated at Butler in 1960 with ECT for depression and anxiety.

Medical History

Patient has a slight problem with hearing. Past history includes ectopic pregnancy in 1956, S/P bilateral oophorectomy; S/P cholecystectomy; Cataract for which she has refused surgery. After the initial assessment in 1998 she was found by the home care team to be very anemic and has been hospitalized and found to have colon cancer, which was surgically removed.

Mental Status Exam

The patient is an elderly white female who appears to be physically healthy and appears younger than her age. She was cooperative but seemed to be in distress, and sometimes even tearful. She also had a hearing problem, which was causing some difficulty in communicating with her. Her speech was of regular rate and volume. Thoughts were goal directed, but somewhat circumstantial and ruminative on the fear of leaving her bed and being alone. Her mood was anxious, but not depressed. She denied any symptoms consistent with obsessions and compulsions other than obsessive thoughts of fear of death. She was alert and oriented to time, place and person. Concentration and memory were intact. She denied any suicidal thoughts. Her insight and judgement was good, apart from her fear of being alone and excessive worries.

Initial Diagnosis

Axis I agoraphobia without panic disorder

Axis II None

Axis III Anemia, SP surgical resection of colon cancer, cataract

Axis IV Home bound for 17 years.

Axis V GAF 30

Treatment

Three years ago she was started on Sertaline (Zoloft) 25 mg PO qd. She tolerated the medication without any side effects. As time allowed, later on during the course of treatment, the medication was increased to 50 mg PO qd. Patient was also given behavioral therapy and exposure therapy and her home attendant was educated to carry out the proposed plan. Patient was encouraged in the beginning to leave her bed for few minutes to few hours. After a few weeks she was able to walk up to the living room. Slowly and gradually she was encouraged to go to a different room each day in the apartment. At one point she was escorted up to the front door of the apartment. Finally she managed to build enough courage and will power to step out of her apartment into the hallway; It took months before she was able to come down the lobby. Sertaline was subsequently titrated up until a dose of 150 mg pod qd. For few weeks she would only come to the stairs accompanied with her caregiver. She was continuously encouraged to gradually come out of her apartment. In July of this year after our home visit, she came down to the parking lot to see us off.

Follow-Up & Current Mental State Examination

Patient was regularly seen for the next three years. Her condition improved with no relapse in the severity. She was last seen in November 2011. She seemed to be at ease while having breakfast with her husband in the kitchen. Her speech was of normal rate and volume, although she had some paraphasic errors. Conversation was very difficult due to her hearing problem. She denied feeling depressed, upset or anxious home, however reported feeling afraid of going outdoors.

She reported being confused at times, but could not elaborate and provide specific details or examples of times where she was confused. Her thoughts and ideas were goal directed and coherent but somewhat disorganized. She denied any problems with appetite and sleep. There was no evidence of paranoia, hallucinations, delusion or other psychotic symptoms. The patient was only oriented to her name, but not to the day, month or year. She had a difficult time paying attention and concentrating. Insight was questionable and judgement was intact.

Current Diagnosis

Axis I Agoraphobia without panic disorder

Dementia of the Alzheimer's type, late onset, uncomplicated

Axis II None

Axis III Anemia, S/P surgical resection of colon cancer, cataract

Axis IV Home bound for 17 years

Axis V GAF 30

Current Treatment Issues

She was started on Aricpet 5 mg po qd and later on increased to 10 mg pop d. Maintain behavioral interventions. Continue to live in her apartment and to slow down cognitive decline.

Care Giver & Family's Response

The patient lived with her husband. The husband was very cooperative and helpful to the clinicians and her wife as well. Some other family members included some relatives; they were very empathic with the patient.

Discussion

Agoraphobia is a condition where people become troubled or bothered in unfamiliar environments or surroundings, where they believe that they have little or no control. Places which may spark this anxiety include open spaces like parking lots and malls, big crowds, and even traveling. Agoraphobia is often, but not necessarily in combination with a fear of social embarrassment, because usually these sufferers fear the onset of an acute panic attack; Together, agoraphobia and social panic attacks is called "Social Agoraphobia," which may be a branch of Social Anxiety Disorder. Fearing the onset of another panic attack, the sufferer is frightful and avoidant when it comes to going back to a location where a prior attack has taken place. Some refuse to leave their homes even in medical emergencies because the fear of being away from their safe haven is too much to handle.

Agoraphobics may also suffer from temporary separation anxiety disorder when certain individuals in their household leave temporarily. For example a parent, or spouse who may leave for certain errands for a short period of time, may be sufficient enough to induce some level of anxiety or a panic attack. Another common disorder that may be associated with agoraphobia is thanatophobia, the fear of death. The anxiety level of these persons often increases when contemplating the idea of eventual death, which may be done consciously or subconsciously, while connecting this idea of death to the epitome of separation from comfort and safety.

Agoraphobia patients can experience sudden and abrupt panic attacks when traveling to places where they may feel helpless and out of control or even get embarrassed. During a panic attack, Epinephrine, a vital hormone, is released from the Adrenal medulla in large amounts, which triggers the body's sympathetic nervous system, also known as the natural innate "Fight or flight" response. A panic attack is usually abrupt and spontaneous in onset, building to eventual maximal intensity within 10-20 min. Patients must fit a certain criteria of panic attacks, as mentioned in the DSMIV; The affected person must have "four or more of these symptoms within ten minutes of the beginning of an attack in order to meet the panic attack criteria" (DSMIVTR).These symptoms include, heart palpitations, sweating, shaking, shortness of breath, heart attack like pain in the chest, nausea, vomiting, chills or hot flashes, feeling of helplessness, and a sense of being out of control.

To this day, the exact cause of Agoraphobia is still unknown, but clinicians and therapists who have treated or tried to treat this disorder offer probable hypotheses. This condition has been associated with the presence of other anxiety disorders, stressful environment triggers, and even substance abuse. It is exceptionally difficult to study the brain and the underlying causes of psychiatric illnesses. The amygdala, a part of the brain's Limbic system, is responsible for the formation of memories; control of emotions; and the response to stressful stimuli. It has been implicated as a vital part of anxiety disorders. It is believed and hypothesized that the amygdala in patients with panic disorders is hypersensitive and acts as an internal suffocation monitor or alarm system when facing a trigger for an attack. This basically means that the patient's brain sends the body false signals that not enough oxygen is being received, causing the affected person to increase his or her breathing rate, also known as tachypnea, which is one of the hallmarks of an anxiety or panic attack. These attacks usually happen at unpredictable times, due to the propensity of the amygdala being in overdrive .Various external agents like drugs (Benzodiazapine)[8] and smoking tobacco are considered as the causes of agoraphobia, usually with panic disorder. The exact mechanism of tobacco induced agoraphobia (with or without panic disorder) is not well understood.[9] Attachment theory has also been described as one of the causes of agoraphobia.[10] Treating such a complex situation where many patients are not very cooperative could be clinically challenging. However, exposure treatment can be a useful way to treat patients with panic disorder and agoraphobia.[11]

The above mentioned case of the 91 year old woman perfectly fits into the definition of agoraphobia. She was properly managed with drug therapy and exposure therapy. Eventually the severity of the symptoms was reduced. Although she was not 100 percent phobia free, yet we believe it was a grand success to be able to see her leaving her room and eventually reaching the front door of her apartment. Case studies like the one mentioned above could play an integral role to help psychiatrists and psychologists understand that proper care and regular appointments by a licensed psychiatrist or psychologist can be helpful in reducing the severity of the symptoms of psychiatric illnesses irrespective of the severity of the condition.

Conclusion

We report a case of an agoraphobic woman who was severely agoraphobic to an extent that she did not leave her bed for many years. Continuous and gradual psychotherapy eventually improved her condition. Twenty years later she was able to leave her room which we believe was a grand success for the doctors involved in her treatment. This case study suggests that agoraphobia can be a serious debilitating mental condition and gradual treatment with regular follow ups can improve the patient's condition. We believe this is true for all severe psychiatric illnesses. Regular appointments and follow up with proper care and management can improve the mental health of the patients irrespective of the severity of their symptoms.

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