

# [Panic disorder essay](https://assignbuster.com/panic-disorder-essay/)

Introduction Substantial research has aimed to elucidate the most effective method for practitioners to formulate a patient’s diagnosis. Engel (1977) proposed a bio psychosocial model to be used by a practitioner to investigate the many dimensions of a mental disorder and arrive at a fully comprehensive approach to treat the patient. Engel proposed that in order to properly diagnose mental disorders, practitioners should consider biological, social, psychological and behavioural dysfunction of the presenting illness.

Additionally, Nurcombe and Fitzhenry-Coor (1987) direct practitioners to address all facets pertaining to the patient, in order to ascertain a detailed picture of the patient and the disorder, and improve the formulation of the patient’s diagnosis. Specifically, assessment of the patient should include the patient’s health history, underlying personality constitution, collection of symptoms and perpetuating factors as well as prognostic potential.

Clearly the process of correctly identifying a presenting mental health issue in a patient includes ascertaining its cause, and involves the health practitioner developing clear diagnostic and reasoning skills (Vickery, Samuels & Ropper, 2010). Nurcombe and Fitzhenry-Coor’s (1987) method incorporates the biopsychosocial elements of the patient, and can be referred to as the seven P’s; predisposition, precipitation, pattern, perpetuation, presentation, prognosis, potentials.

The ideology underpinning this reasoning is a deviation from the unitary theory of placing the root of dysfunction at a single cause, and has been found to improve the accuracy in provisional diagnosis of trainee professionals in clinic (Nurcombe and Fitzhenry-Coor’s, 1987). Vickery, Samuels & Ropper (2010) use the model of heuristics to highlight some of the critical errors that many practitioners are prone to.

They discuss many of the common faults that occur with the use of short cuts such as becoming attached to a provisional diagnosis despite new data that may not support it, being influenced by the ease of recalling past cases and not adjusting diagnostic probabilities with new data. They aim to reduce the bias that is intrinsic in the heuristics of diagnosing mental disorders by increasing awareness and implementing certain behavioural strategies, potentially avoiding many of the pitfalls a practitioner can fall into when making a provisional diagnosis. The objective of this paper was to apply

Nurcombe and Fitzhenry-Coor’s (1987) diagnostic and reasoning skills in order to investigate the case study of patient Joan, and assess any psychopathology that may be present. As per Nurcombe & Fitzhenry-Coor’s (1987) recommendations, the case study of Joan was assessed from a behavioural, social, biological and psychological perspective, to ascertain the most accurate provisional diagnosis possible as per Axis 1 of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR; American Psychiatric Association [APA], 2000).

A differential diagnosis was presented, including a discussion of the process taken to obtain a provisional diagnosis. This paper concludes with a discussion of Joan’s prognosis and an analysis of some treatment strategies. Joan is a 22-year-old University student presenting with panic attack symptoms of nausea, sweating and palpitations, indicating an overactivity of the autonomic nervous system (Li, Chokka and Tibbo, 2001). Joan appears uncomfortable with social interaction and requires a close companion nearby to attenuate anxiety feelings.

Panic attack symptoms have occurred four times over a three month period, and have caused significant distress as Joan fears that a medical disorder may be causing them. Symptoms are causing considerable disruption to occupational and social functioning, however no depressive symptoms are noted. A full case history for Joan is provided in Appendix A. According to the DSM-IV-TR (APA, 2000), the practice of differential diagnosis can be worked through in the following seven steps, ruling out plausible diagnoses until a provisional diagnosis has been obtained. Ruling out a malingering or factitious disorder

Clinical assessment of a patient relies heavily on the provision and assessment of client information and, unlike other fields in the medical model, is often without a significant amount of supportive medical data (Miller, 1970). Ruling out the intentional fabrication of physical or psychological symptoms is therefore an essential first step in reaching an accurate provisional diagnosis. Joan’s initial reluctance to communicate with her psychologist could be misconstrued as attempted malingering, however other behaviour patterns were not consistent with malingering.

There appeared to be no incentive gained from fabricating symptoms, which indicated that Joan’s diagnosis was not likely to be malingering. Further, Krahn, Bostwick and Stonnington (2008) argue that patients suspected of factitious disorder or malingering resist psychological attempts to investigate their concerns and may be reluctant to comply with testing. Joan willingly attended an appointment with her General Practitioner to ascertain a cause for her symptoms, and shared personal information such as her substance use with her psychologist, suggesting that Joan was not suffering from a factitious or malingering disorder.

Ruling out a substance aetiology Joan uses cannabis to attenuate her anxiety feelings, which could indicate substance induced anxiety disorder, however her level of substance use was not fully apparent. Substance induced anxiety disorder was initially considered as a provisional diagnosis, however DSM criteria (APA, 2000) for disorders with substance induced aetiology state that the disorder can be attributed to the substance if the psychological disturbance resolves itself within a month of substance cessation.

Joan’s symptoms occurred upon cessation of cannabis use suggesting a substance aetiology (Budney, Novy and Hughes, 1999) however her symptoms persisted for three months, indicating that Joan did not have a substance induced anxiety disorder. The DSM-IV (APA, 2000) indicates that substance induced anxiety disorders occur in substance withdrawal states whilst other anxiety disorders occur during periods of abstinence. Research with both animals and humans indicate that the most prevalent response to cannabis withdrawal is irritability, insomnia, restlessness and decreased appetite (Budney, Novy & Hughes, 1999; Cottler et al. 1995). These withdrawal symptoms were not consistent with Joan’s psychological and somatic symptoms, further suggesting that her symptoms were not caused by substance withdrawal. Van Os et al. (2002) demonstrated that individuals with an underlying predisposition to mental illness who are abusing cannabis have a significantly greater risk of experiencing psychotic symptoms than those with no predisposition. Hathaway (2003) demonstrated that cannabis use is significantly related to panic attack episodes, with 40% of weekly cannabis users reporting the occurrence of at least one panic attack related to their substance use.

It is a matter of debate whether cannabis causes the psychotic symptoms or if individuals abuse the substance because of the underlying presence of a disorder (Khantzian, 1985). Although it is difficult to completely rule out a substance induced aetiology due to the lack of information in Joan’s case study, the duration and nature of Joan’s symptoms suggest against a substance abuse aetiology, and suggest that she may be using the substance to cope with an underlying mental disorder. Rule out an etiological general medical condition

It could be ascertained from a recent medical examination that Joan did not have an Anxiety Disorder Due To a General Medical Condition. Joan’s history of cardiac surgery as a child could indicate a possible cardiac cause of anxiety, which, if not previously investigated by her Doctor, should be considered. A more thorough case history would be required to completely rule out physical causes for her current symptomology, including Joan’s family history to highlight any genetic predispositions.

A thyroid screen should be ordered as panic attacks can be a common symptom of hyperthyroidism and a respiratory and cardiac check-up could be considered due to the rise in comorbidity of both conditions with panic disorder (Simon & Fischmann, 2005). Determine the specific primary disorder Nurcombe and Fitzhenry-Coor (1987) describe a method of arriving at a diagnosis through the process of investigating salient cues and inferences, assessing a pattern of behaviour to form a hypothesis and consequently a treatment plan.

Joan’s health history had only been provided for the past three months, making it difficult to ascertain salient cues that would predict the cause of her current symptomology. It is inferred from her case history (See Appendix A) that Joan suffers from anxiety, possibly due to the university stressors and relationship difficulties mentioned. Therefore, the diagnosis of an anxiety disorder appears applicable.

Unmanageable anxiety may have been a catalyst for her initial cannabis use as she mentioned that it helped her to relax, indicating a lack of intrinsic stress management; a perpetuating factor that may drive her disorder. The acute “ fear of fear” (Roy-Byrne, Craske & Stein, 2006) that many people suffering from panic attacks experience is a perpetuating factor in the maintenance of high anxiety levels. The presence of a Social Phobia was considered due to Joan’s fear and avoidance of certain social situations. Although Panic Attacks are not typically associated with Social Phobia (APA, 2000), the two disorders o share similar characteristics of an overactivity of the Autonomic Nervous System (ANS) with Noradrenaline system dysfunction resulting in some of the symptoms Joan is experiencing such as sweating, shaking and insomnia (Li, Chokka & Tibbo, 2001). The diagnosis of agoraphobia is differentiated from Social Phobia when anxiety about being in a social situation is due to the fear of panic attack, not the fear of the being in a social environment itself (APA, 2000). Furthermore, it is typically those with agoraphobia, rather than those with social phobia, that prefer to have a companion present in social situations (APA, 2000).

In short, Joan is avoiding certain places for fear of an attack being triggered, not because of an inherent fear of specific places. This suggests Agoraphobia rather than Social Phobia. Joan’s experience of intense and irrational fear elicited a consideration of Specific Phobia; however Joan’s panic attacks are unexpected and have occurred in differing environments, suggesting that Joan does not specifically fear one object or place, but rather fears the experience of the panic attack itself.

Panic attacks due to Generalized Anxiety Disorder (GAD) was also considered due to the insomnia, sweating, palpitations and panic attacks suggesting arousal of the ANS that is present in an anxiety disorder (World Health Organization, 1994). According to the DSM-IV-TR (APA, 2000), additional diagnostic features have been added to the diagnosis of GAD and they now must occur for more than six months to be considered as a disorder and must include at least three other related symptoms such as fatigue, muscle tension, difficulty concentrating and irritability, none of which Joan detailed in her case history.

Nurcombe and Fitzhenry-Coor (1987) propose that the diagnostic process requires consideration of the physical and psychosocial aspects of a cluster of symptoms. Joan’s collection of symptoms indicates that she is having recurring panic attacks. Panic attacks are defined by the DSM-IV-TR (APA, 2000) as short periods of extreme fear or distress accompanied by palpitations, derealisation, shortness of breath, sweating, trembling, and a fear of losing control or dying. The incidence of comorbidities with Panic disorders is very high, with studies showing that the occurrence of another anxiety disorder can be as high as 63. % in individuals suffering from panic disorder with agoraphobia (Goldenberg et al. , 1996; Keller et al. , 1994; Tsao, Lewin & Craske, 1998). According to the DSM-IV-TR (APA, 2000), diagnostic criteria for panic disorder with agoraphobia consists of repeated unanticipated panic attacks with at least one of the attacks followed by at least one month of concern and anxiety about the attack or its consequences, and / or a change in behaviour associated with the attacks.

Panic Disorder has been differentiated from Panic Attacks due to the unexpected nature of the attacks and the fact that they are not situationally bound to any one place (APA, 2000). The presence of agoraphobia is very commonly seen with panic disorder (Roy-Byrne, Craske & Stein, 2006) and is the provisional diagnosis for Joan, due to a number of observations. Joan displays anxiety about being in situations where she may have a panic attack for fear that it may cause her embarrassment.

She also requests that her partner Nevin accompany her to places where she is worried about the possibility of an attack. Joan has also begun avoiding situations in which she has previously experienced a panic episode, such as university and the corner shop, further supporting the addition of agoraphobia to the diagnosis. Based on the information given the provisional diagnosis is 300. 21 Panic Disorder with Agoraphobia. This is differentiated, in short, from the other anxiety disorders due to the unpredictable nature of the attacks, duration of the disorder and the presence of agoraphobia.

Differentiate Adjustment Disorder from Not Otherwise Specified (NOS) Joan’s symptomology conforms to the cluster of symptoms know as Panic Disorder with Agoraphobia and therefore is not classed as an Adjustment Disorder or Not Otherwise Specified. Should there be no presentation of panic attacks, Joan’s complaints of intermittent nausea, sweating and palpitations may fit into a Not Otherwise Specified category due to the milder nature of the symptoms.

Using cannabis as a tool to cope with stress may indicate an inability to cope with stress suggesting Adjustment Disorder, however the severity of her symptoms coupled with the panic attacks suggests a mental health aetiology. Establish the boundary with no mental disorder For a set of symptoms to warrant a classification of a clinical disorder they must be negatively impacting on functioning in occupational, social and other realms of the patients life (APA, 2000).

Joan’s quality of life is being significantly impaired by her experience of panic attacks. Her university qualification is in jeopardy and she is restricting her outings to those in which her partner Nevin can accompany her to alleviate her fear of having a panic attack. If the symptoms were to go on as they are, Joan’s quality of life would continue to be seriously disturbed, indicating that her current symptoms are clinically significant and warrant thorough attention from a health professional.

Although a provisional diagnosis of Panic Disorder with Agoraphobia is the most likely cause of Joan’s mental health issues, it has been demonstrated that nearly 70% of people with anxiety disorders suffer with an additional mental health issue (Sanderson, Di Nardo, Rapee & Barlow, 1990), therefore further information such as a history of anxiety or depressive episodes or substance abuse issues should be elicited from her to completely rule out the concurrent existence of some of the differential diagnosis aforementioned. The diagnosis made is only provisional and may change should further data be obtained.

More information pertaining to the duration and frequency of her cannabis use should be elicited to demonstrate whether the panic attacks occurred within withdrawal periods of cannabis use as the diagnosis of substance-induced panic attacks may be more accurate if this is so. Information pertaining to her past medical history would be of interest to ascertain if there may have been a significant past trauma as this may explain the cause of her ANS overactivity and direct the diagnosis towards another origin such as Post Traumatic Stress Disorder. Prognosis

Patients with Panic Disorder seek medical attention more than any other mental health issue (Boyd, 1986). The limits on discussing Joan’s prognosis lay in the lack of data in her case study, namely the level of her cannabis use. The association of the disorder with other issues such as drug and alcohol abuse make adequate intervention essential to a good prognostic outcome (Barlow & Shear, 1988). Research on the prognosis for people with Panic Disorder with Agoraphobia has produced mixed findings with no intervention often resulting in a poorer prognosis alongside that of major depression (Schapira, Kerr & Roth, 1972; Wittchen, 1998).

Although it has been demonstrated that panic disorder has a high comorbidity with other disorders, with adequate treatment strategies the prognosis can be good if a correct and timely approach is taken. A combination of cognitive and behavioural therapy appears to be the most successful approach for ameliorating the symptoms of Panic Disorder, with studies indicating an average of three out of four people are symptom free after three months of treatment (Anthony & Swinson, 1996; Chambless & Gillis, 1994; Clum, Clum & Surls, 1993) as opposed to only one out four in the control groups (Gould, Otto & Pollack, 1995).

A range of follow up studies demonstrate that the effects of cognitive behavioural therapy are also long lasting (Pelletier, Gauthier, Bouchard & Cote, 1995) and that it is superior to pharmacological interventions for compliance and long term treatment gains (Barlow, Otto & Pollack, 1998). Pharmacological intervention has also been shown to have reduced effectiveness over time where cognitive behavioural therapy was successful at maintaining the treatment gains experienced (Barlow, Otto & Pollack, 1998). This may be due to the educational nature of cognitive behavioural therapy.

Joan fears a serious medical disorder and she is anxious that she may lose control during a panic attack, resulting in the Agoraphobic behaviour. Education and practical instruction of the management of these fears is a crucial step in maintaining treatment gains in the long term (Rabatin & Keltz, 2002). It can be concluded after reflecting on the literature that Joan will have the greatest chance of continued success with the support of a therapist who can educate her in the management of Panic Disorder with Agoraphobia coupled with a focus on the use of cognitive behavioural techniques to help attenuate her anxiety levels.

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