Panic Disorder Presenting in Primary Care

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The patient is a 38-year-old white woman, married for 10 years to an engineer. She has a 12-year-old son from a previous marriage and a toddler. She taught high school for several years before returning to school herself with the goal of becoming a medical researcher. Her past medical history is remarkable only for peptic ulcer disease. Her mother is being treated for hypertension and migraine headaches. The patient found out 4 years ago that the man she believed to be her father was, in actuality, her stepfather. She has never seen her biological father and was unable to provide paternal family medical information. Her family has described him to her as "an abusive alcoholic."

PRESENTATION OF THE PROBLEM

The patient has seen internists 5 times in the past decade secondary to complaints of intermittent dyspnea and palpitations. These episodes are described as being quite severe and occasionally accompanied by nonradiating chest pain. Two cardiac workups have yielded results within normal limits. She has also presented with similar symptoms to the emergency departments of 2 hospitals. Both emergency room visits involved symptoms that appeared while she was driving on the interstate, a feature fairly common in patients with panic disorder.

Previous outpatient psychiatric treatment had always been in response to an identifiable stressor such as career change or divorce. She had some improvement with venlafaxine and clonazepam treatment. However, she complained of feeling "out of it" when taking benzodiazepines and did not wish to take medications of that class again. She had no history of alcohol or illicit drug use.

On initial visit to her internist, her presenting complaint was stated as, "I want the 'depression' to be over." She was very discouraged about her marriage, children, and job and felt hopeless to make changes in these areas. For approximately 3 months, she had experienced increasing panic symptoms, with 7 panic attacks in the month prior to presentation. She also complained of fatigue, poor concentration, and loss of interest in previously pleasurable activities, such as sexual relations with her husband and socializing with friends. She was referred to the Department of Psychiatry and assigned to me for an intake evaluation.

PSYCHOTHERAPY

The patient presented to my office requesting both medication management and psychotherapy. She reported that she had not had a good experience with psychotherapy in the past, describing it as "stirring up too much." She said, however, that she was open-minded and motivated to make changes in her life to achieve a greater sense of well-being.

On examination, she was well groomed and somewhat anxious in appearance, frequently wringing her hands. She spoke very carefully, giving much thought to her choice of words. She described her mood as "pretty bad." Her affect was constricted. There were no psychotic symptoms nor suicidal ideas. The patient met DSM-IV criteria for panic disorder without agoraphobia as she reported a significant change in her behavior related to untreated panic. For example, she avoided exercising or driving alone for fear of having a heart attack or "losing it." Also, since she had previously experienced 2 or more major depressive episodes, she met criteria for recurrent major depressive disorder. Diagnostic criteria included depressed mood, loss of interest in previously pleasurable activities, fatigue, and feelings of worthlessness and guilt. We contracted for 10 weekly psychotherapy sessions; I believed that she would be an ideal candidate for brief cognitive therapy. Our approach included medication in addition to psychotherapy. She was started on treatment with paroxetine, 10 mg/day.

In psychotherapy, we first discussed the principles of the cognitive model, specifically the triple column technique whereby she would chart her automatic thoughts, the situations in which they occurred, and the associated feelings. We also discussed the concept of automatic thoughts, and she was able to give several examples without much prompting. Her first homework assignment was to use the triple column technique with an emphasis on panic-provoking situations. She seemed comfortable with

the notion of homework, which was not surprising since she had spent the majority of her adult life in school. I explained to her that her untreated panic and anxiety were most likely driving her depression.

One week later, she returned and reported that, in most cases, her panic symptoms came "out of the blue." However, when we examined the situations involved by using techniques such as role-playing, we found that all 3 recent panic attacks had occurred when she was alone. Her automatic thoughts had centered on the notion that no one would be available to help her. She also thought she "might be dying" when her panic symptoms did not remit after 5 minutes. We explored the probability of dying from a panic attack, a process referred to as *decatastrophizing*. Through the use of positive self-talk and cognitive retraining, she was given tools to avert panic symptoms without requiring the assistance of others.

Through the next several weekly sessions, it became clear that one of her fundamental cognitive errors was that of overgeneralization. A recurrent automatic thought was "Things never work out for me." This belief left her feeling sad and hopeless. She was, consequently, less likely to apply for career opportunities that she was interested in pursuing or to try new things in general. We evaluated whether she had objective evidence to support her belief. Further discussion involved looking at the numerous things that had indeed worked out well for her, including 2 graduate degrees with honors, 2 healthy children, a 10-year marriage, and the very real possibility of a career that would satisfy her lifelong dream of doing "hard scientific research." She also overgeneralized about her panic disorder, feeling that she would always have panic symptoms, despite our discussions reassuring her that effective treatments were available.

After identifying and challenging her recurrent cognitive error of overgeneralization, she became able to generate effective alternative responses, for example, "Sometimes, things do work out for me if I try hard." During the next few weeks, she was able to detect on her own that she had a tendency to make anxiety-associated self-statements, such as, "My panic is beyond my control." After learning to substitute more appropriate statements, such as, "I can now control my symptoms," she noted that her panic symptoms of tachycardia, dyspnea, sweating, and fear of losing control decreased. She no longer made negative interpretations of such symptoms as leading to a myocardial infarction. She also became more aware of events precipitating panic symptoms and was able to prepare herself physically and mentally to successfully avert panic attacks.

After 4 months (14 sessions) of treatment in which an ancillary goal was to empower the patient, she decided to apply for a higher paying job in which she felt her work would be more appreciated. She was hired immediately and given the responsibility of directing a division of research associates. She was able to parent her children more effectively and reported that she was now using cognitive therapy principles with her preadolescent son. When I saw her at a 1-month follow-up appointment, we reviewed her application of the cognitive method. She had been free of all panic symptoms for the previous 2 months. We have now completed a 1-year follow-up visit. She has continued to do well on her paroxetine dosage of 15 mg/day and discussed dosage reduction and discontinuation of medication in the upcoming year. Her primary care physician reported that she has not required benzodiazepines for anxiety and that she has had no further visits for panic-associated symptom evaluation.

Editor's note: Dr. Thomas is in her second year of Child Psychiatry Fellowship training after completing a 3-year residency in Psychiatry at the Medical University of South Carolina in Charleston. Through this column, we hope that practitioners in general medical settings will gain a more complete knowledge of the many patients who are likely to benefit from brief psychotherapeutic interventions. A close working relationship between primary care and psychiatry can serve to enhance patient outcome.

For further reading: *A Practical Guide to Cognitive Therapy.* 1st ed. by Dean Schuyler, New York, NY: WW Norton & Co; 1991. ISBN: 0393701050