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Identifying and treating agoraphobia

MHPN WEBINAR

Tuesday 19th March 2024

Tonight's Panel

Caroline Johnson
General Practitioner

Peter McEvoy
Clinical Psychologist

Lisa Lampe
Psychiatrist

Facilitator:
Prof. Steve Trumble
General Practitioner

The webinar platform

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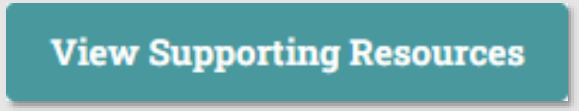

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(i.e. slides, case study and panel bios).

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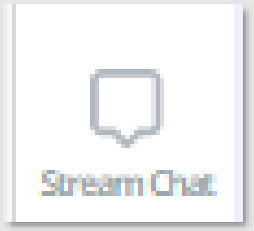

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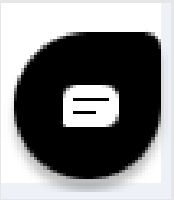

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Learning outcomes

The webinar will provide the audience the opportunity to:

- Identify comorbidities and the biological and environmental factors that increase the risk of developing agoraphobia.
- Discuss how to identify, assess and diagnose agoraphobia.
- Evaluate therapeutic approaches suitable for treatment of agoraphobia
- Discuss the importance of collaboration and appropriate referrals when providing care to people living with agoraphobia.

Help-seeking

- First port of call (with respect to the health system)
  - How will Stella present to the system?
  - Where is Stella at from a developmental perspective?
  - Is Stella seeking help or is someone bringing her to help?
- Engaging Stella in care
  - Access
  - Affordability
  - Appropriateness
  - Efficacy/effectiveness/efficiency
  - Tipping points?

Caroline Johnson

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Assessment

- Time-limited but holistic assessment
- Able to assess thoroughly for physical DDx (but maybe not in a standard 15 minute appointment)
- What 'type of anxiety' does Stella have and does it matter?
- GPs will generally use a formulation approach, but the assessment may be quite non-linear (the benefits of continuity of care) and it may not be documented neatly in one place.

Caroline Johnson

Management

- Dimensional versus categorical perspectives to diagnosis (and how this impacts on Stella's management plan)
- Pay heed to Stella's explanatory models!
- Psychoeducation
- Talking therapies: When? Where? Why? By whom?
- Medications: perfecting the sales pitch….

Caroline Johnson

Interprofessional work

- Sharing ideas and approaches with colleagues is valued
- Sending someone like Stella to any GP to 'get a plan' is unhelpful, but there is a better way…..
- Tips for engagement:
  - With Stella
  - With Stella's family and friends
  - With the GP

Caroline Johnson

Recovery

- Treatment for agoraphobia works….and then it doesn't…..and then it does…..
- What do people do when they don't feel treatment is helping?
- Monitoring as a therapeutic process?

Caroline Johnson

A Clinical Psychologist's perspective

Assessment

- Problem and life impacts (in Stella's words)
- History of panic attacks: onset, changes, persistence, frequency, intensity
- Describe an example in detail (validation/empathy+++)
- Medical review completed?
- Co-occurring problems (e.g., depression, social anxiety): temporal relationships
- Lifestyle factors (e.g., sleep, diet, exercise, secure housing)
- Protective factors (e.g., social supports, work, dependents)
- Other interventions (e.g., prn medication)
- Psychometric measures (e.g., Anxiety Sensitivity Index, Panic Disorder Severity Scale, Agoraphobic Cognitions Questionnaire, Bodily Sensations Questionnaire)

Peter McEvoy

Assessment

Predisposing:

- Family history: heritability ~43-48% for PD, 61% for AG (see Wittchen et al., 2010)
- Parenting/modelling: overprotection, lack of warmth, authoritarianism (correlational).
- Significant life events in childhood (retrospective)
  - e.g., separation, death of parent
- Temperament
  - Non-specific: behavioural inhibition, neuroticism
  - Specific: anxiety sensitivity (belief that anxiety symptoms are harmful)

- Can’t change these, but can work on what was left behind (e.g., beliefs, coping strategies)

A Clinical Psychologist's perspective

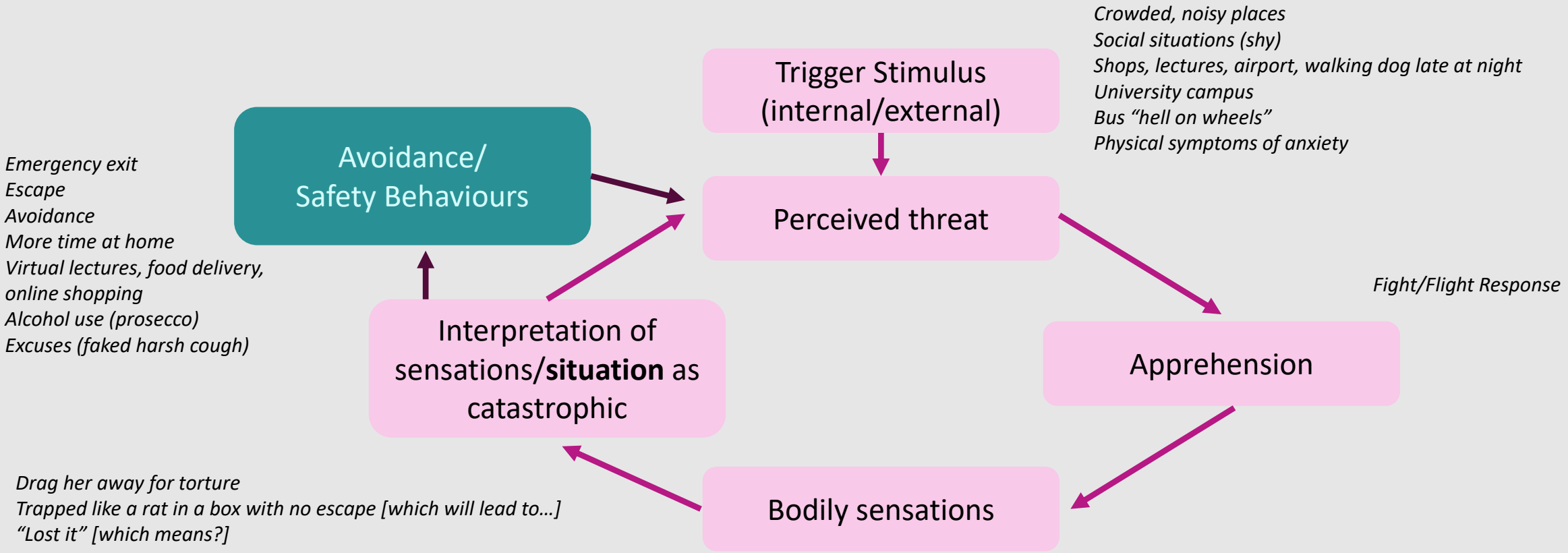
Individualised case formulation (7 Ps)

- Presenting problem
- Predisposing factors
- Precipitating factors
  - Distal: at which times symptoms/avoidance/impacts have escalated and why?
  - Proximal: what triggers anxiety/panic/avoidance on a daily basis?
- Perpetuating factors
  - Cognitive content: helpful for differential dx and identifying function of avoidance
  - Cognitive processes: attention, interpretation, memory, metacognitive awareness/distancing
  - Behaviours: avoidant coping (becoming more generalised?)
  - Emotions: terror, dread, panic, anxiety
  - Physiological symptoms: e.g. heart racing, breathlessness, sweating, blushing
- Protective factors (e.g., social supports, appropriate help-seeking, insight)
- Potential obstacles
- Plan

Peter McEvoy

A Clinical Psychologist's perspective

Cognitive model of agoraphobia (Clark, 1986)



Peter McEvoy

A Clinical Psychologist's perspective

Cognitive Behaviour Therapy

- Psychoeducation (via individualised case formulation)
- Cognitive restructuring
- Behavioural experiments (challenge cognitive mis-appraisals)
  - Introceptive exposure (‘de-couple’ sensations from cognitions)
  - In vivo exposure (generalise learning)
  - Abstain from avoidance/safety behaviours (to optimise new learning)
- Possibly de-arousal strategies (relaxation, slow breathing, but depends on the function)
- Routine outcome monitoring (session by session)

Peter McEvoy

A Psychiatrist's perspective

- Reference to feeling shy – could it be social anxiety disorder?
    - Up to 40% of people endorse shyness (not unusual that new social environment like University could cause a transient increase)
    - Highest rates in younger people
    - Shyness not abnormal
- Key concerns appear to be physical symptoms – makes panic/agoraphobia more likely
- Alcohol use – what level?

Lisa Lampe

Key diagnostic pointers

- Panic attacks can occur in any anxiety disorder
- What are the main fears? (e.g. negative evaluation vs catastrophic physical/mental outcome; being "trapped")
- Associated avoidance (panic → agoraphobia)
- AGE:
  - anxiety disorders usually present in the teens or 20s
  - First presentation after 40 years a red flag

Lisa Lampe

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Comorbidity

- Other anxiety
- Major depression: comes first in about 33%
- Medical conditions (especially respiratory), also medical conditions associated with dizziness, arrythmia, and irritable bowel syndrome, migraine and hyperthyroidism (cause/effect not clear)
- Side effects of medication

Lisa Lampe

Precipitants

First onset of panic attack more often preceded by:

Current:

- Being away from home
- Intoxication or withdrawal from substances

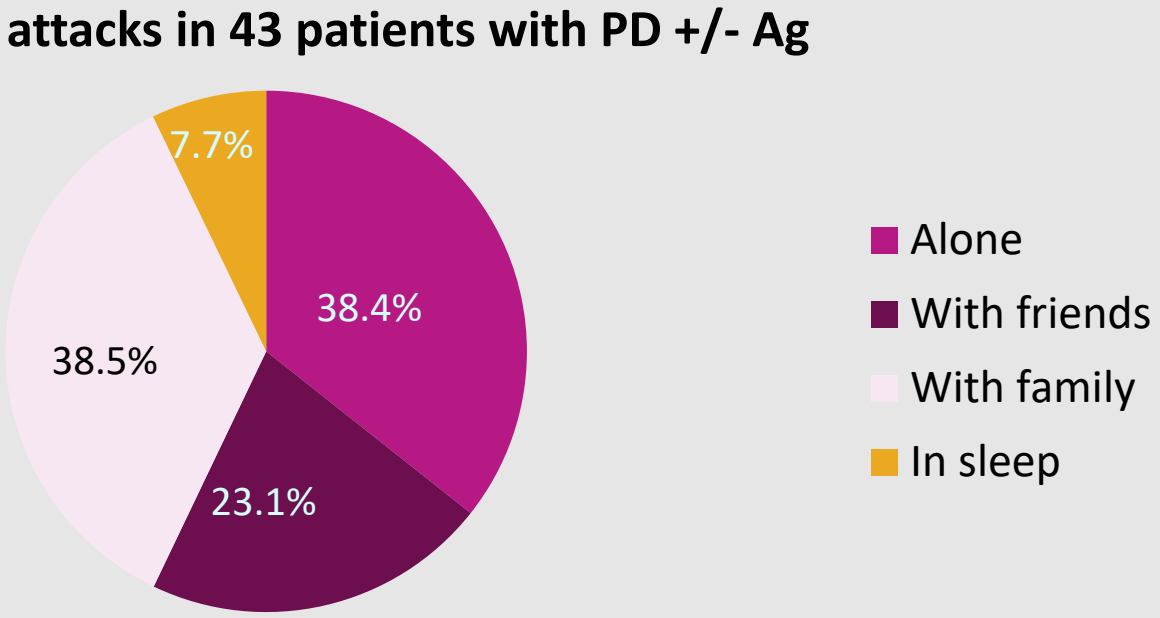
Recent:

- Illness
- Increased stress

Lisa Lampe

When do panic attacks occur?

- Meuret and colleagues (2011) performed 24-hour ambulatory monitoring on volunteers with PD +/- Agoraphobia



Lisa Lampe

Meuret A, *Biol Psychiatry* 2011;70:985–991

A Psychiatrist's perspective

Treatment Algorithm: RANZGP Clinical Practice Guidelines

Assessment & Initial management
Assess comorbidity, substance use, suicidal ideation, stressors, supports
Provide psychoeducation & lifestyle advice

↓

Watchful waiting and review

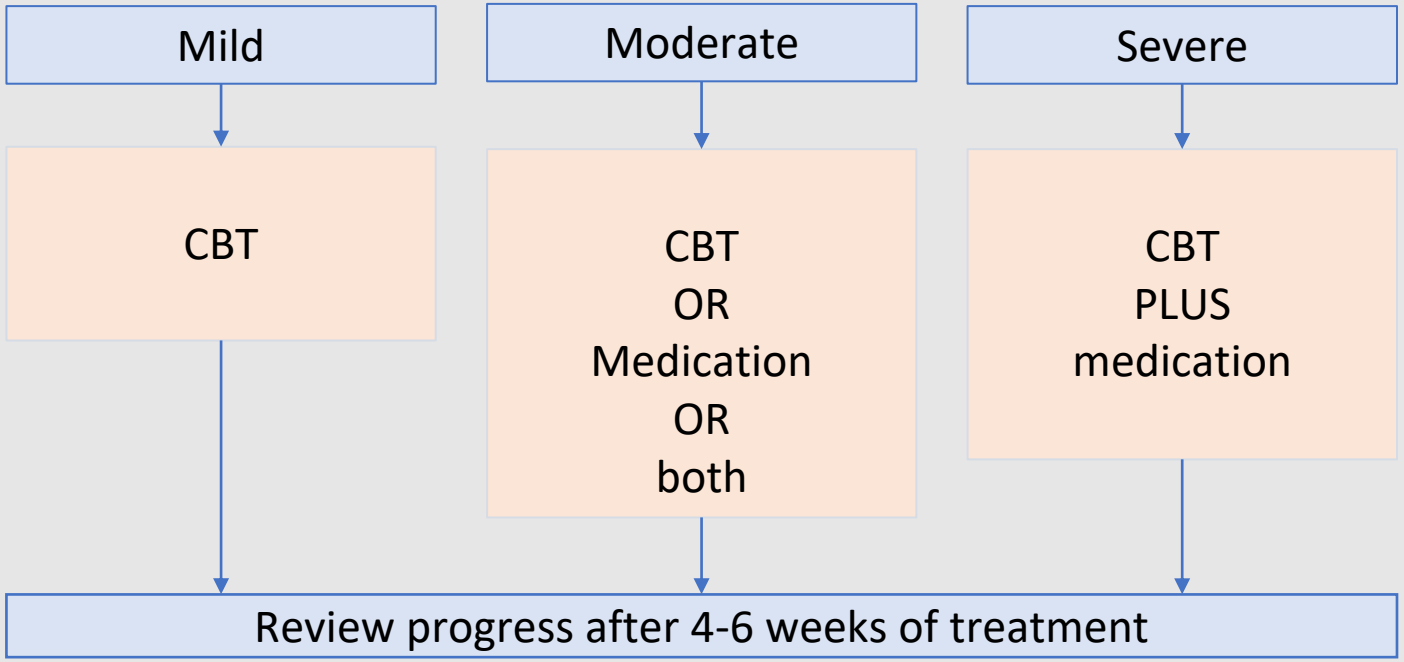
↓

Initial treatment
based on severity

Lisa Lampe

Andrews et al, ANZJP 2018, Vol. 52(12) 1109-1172.

Treatment Algorithm: RANZGP Clinical Practice Guidelines (cont'd)



First line medication is an antidepressant – not a benzodiazepine or beta blocker. It will take 4-6 weeks to see much response.

Lisa Lampe

Andrews et al, ANZJP 2018, Vol. 52(12) 1109-1172.

Thank you for your participation

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Emerging Minds Navigating Cultural differences: Culturally responsive practice supporting families – Wednesday 20th of March (Tomorrow) at 7:15pm AEST

No I can't: Overcoming school refusal – Wednesday 10th April at 7:15pm AEST

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Thank you for your participation.

Good evening.

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