A Case of Panic Disorder Treated With Cognitive Behavioral Therapy Techniques

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A case of panic disorder in a woman with mild intellectual disability is presented. Psychotherapy using cognitive behavioral techniques was successful in treating her panic disorder and eliminating her avoidance of participation in a work training program. Recommendations for recognizing this disorder in the intellectual disability population are made, in addition to suggestions for cognitive behavioral therapy treatment.

Keywords: anxiety, cognitive behavior psychotherapy, developmental, intellectual disability, mental retardation, panic disorder

Panic disorder (PD) is a common condition for which many people seek treatment. It can occur with or without agoraphobia and with other anxiety disorders as well. The panic attack is an event in which there is a sudden onset of intense apprehension, fearfulness, terror, and feelings of impending doom. The patient may experience a multitude of symptoms including shortness of breath, heart palpitations, choking, smothering sensations, and feeling as if he or she is “losing control.”\(^1\) Frequently, the onset of panic attacks leads the patient to their primary care physician or emergency room believing that a heart attack is occurring. After this is thoroughly evaluated and ruled out, a diagnosis of panic attack is made.

The panic attack is a physical response to a perceived fear, the “fight or flight” reaction, which is adaptive when faced with a severe and urgent threat. Research evidence suggests that some individuals are very sensitive, with a dysfunctional “brain alarm system” so that ordinary events cause overarousal.\(^2\) Panic attacks often occur within the context of a number of anxiety disorders, but many individuals may experience panic attacks alone. Many people experience a panic attack once or on occasion throughout life and do not have any other psychiatric conditions nor do they go on to develop PD. Sometimes panic attacks occur with regard to a specific situation or they appear to come randomly without any identifiable precipitant. In PD the panic attacks become recurrent, are unexpected, and are accompanied by a persistent concern or worry about having more attacks.

Table 1 presents the criteria for PD.\(^2\) Note that each criterion relies on self reflectice assessment and requires self-report to the clinician. Because it is necessary for the patient to report internal complex perceptions, it is difficult to diagnose PD, as well as other anxiety disorders, in people with intellectual disability.\(^3\) Indeed, the diagnosis of anxiety disorders requires that the patient be able to verbalize, for example, his or her feelings and perceptions of worry, apprehension, or impending doom. These perceptions require a moderate level of awareness wherein one can “reflect upon his or her reflections,” a higher cognitive capacity that typically arises in puberty with increasing development of the frontal lobe and executive control systems. It is unclear to what extent most people with intellectual disability achieve this level of cognitive capacity. Thus, it is possible that individuals with intellectual disability and great anxiety cannot communicate their symptoms or understand them sufficiently so that the anxiety is recognized by others and/or interpreted correctly by diagnosticians. It is for these reasons that much of the field of psychiatric illness and intellectual disability uses “behavioral equivalents” of diagnostic criteria. Some disorders, however, have more observable features than anxiety disorders. For example, depression is often accompanied by sleep or appetite disturbance, and a facial expression signaling the change in mood, or by crying. For PD, there may be no clear observable behavioral criteria.

Because of difficulties in assessing patients with intellectual disability, the Royal College of Psychiatrists published The Diagnostic Criteria for Psychiatric Disorders for Use with Adults with
Learning Disabilities/ Mental Retardation (DC-LD) in 2001. This guide offers substitutions for some key features requiring self-report such as “depersonalization/derealization” (a complex self-reflective phenomenon requiring substantial self-reporting skills) and recommends substituting increased irritability and increased restlessness.

Studies of the incidence and prevalence of anxiety disorders in people with intellectual disability are limited due to the above discussed problem of self-report. Nonetheless, anxiety disorders, including PD, have been reported.

Stavarakaki and Mintsoulias described a case series treated in a specialty clinic of 257 individuals with intellectual disability. In this sample, 27% were diagnosed with an anxiety disorder. PD alone was found in 14 patients and six had PD with agoraphobia. The symptom presentation for these patients included aggression, agitation, self-mutilation, overactivity, panic, and agoraphobia. No patients reported depersonalization or derealization.

Malloy and her colleagues reported a case of a patient with mild intellectual disability and possible PD. At age 58 her caregiver passed away and she developed paranoid delusions and auditory hallucinations. She was diagnosed with depression with psychotic features and had three inpatient hospitalizations. After her depression remitted, she developed anxiety and panic symptoms, but could verbalize mainly “I feel bad.” Finally, an adapted Structured Clinic Interview (SCID) aimed at panic symptoms was administered and although she gave inconsistent responses, readministration of the 4th and 5th questionnaires found she had experienced 8 of the 13 symptoms associated with PD. Clonazepam had been prescribed previously and nortriptyline was added resulting in a marked decrease in symptoms of anxiety and panic.

Linden and colleagues described a case of a 15-year-old female with compound heterozygous fragile-X. She attended regular classes and received special assistance for her learning disabilities. She had behavioral characteristic of females with fragile-X including shyness, anxiety, panic, mood swings and attentional deficiencies. She responded to therapy and medication.

Khreim and Mikkelsen reported the case of a 19-year-old male with mild intellectual disability and PD. This patient responded to combined pharmacotherapy of sertraline, clonazepam and cognitive behavioral therapy. He was referred from the emergency services of a hospital with the complaint, “I feel I am dying,” (he had had six previous visits to the emergency room). He verbalized sudden episodes of intense fear of death associated with chest pain, tachycardia and presumed palpitations, which he characterized as feeling his heart would stop beating. He also reported dizziness, feelings of fainting, shortness of breath, dryness of mouth, pressure in his head, and tingling in his hands and face. His family history was positive for a sister with mild intellectual disability and anxiety with possible panic. The patient was treated with 100mg sertraline and 0.25mg clonazepam b.i.d. Brief cognitive therapy was used that involved simple cognitive exploration and discontinuing his beliefs about the PD. At five month follow-up he had no panic attacks.

In this paper, a case of a woman with mild intellectual disability and reasonable verbal skills is presented. Treatment with drug therapy had failed to address her core symptoms of anxiety and panic attacks. She responded to long term cognitive behavioral psychotherapy, the psychotherapeutic approach with the most evidence-based research for effectiveness. The technique was modified to suit the patient’s concrete level of intellectual functioning.

CASE REPORT

HISTORY AND DIAGNOSIS

Ms. A was a 40-year-old woman who presented with PD in relation to a work situation and subsequent quitting of her workshop job and avoidance of further work. She was the product of a normal birth and delivery. She developed slowly and in first grade was unable to function well in her Catholic School. She was enrolled in special education at the local public school system, and continued within this educational setting until she was 18 years old. At age 16, a psychological assessment found IQ scores on the Wechsler Adult Intelligence scale of Verbal 65 and Performance 68. Her adaptive living skills were quite good. Ms. A did a wide variety of chores at home quite well, attended church, and was well known in her local community. Her cognitive assessments and adaptive skills placed her in the mild level of intellectual disability.

Ms. A lived with her mother. Her father died when she was 10 years old. Two siblings lived close to the home and were very involved with the patient and her mother. Ms. A was in a good
Ms. A articulated her chief complaint as "I'm nervous." Through a lengthy questioning, it became clear that Ms. A had panic attacks at least weekly but she had not conceptualized these events as panic attacks. With much help, treatment began to work. She was taught relaxation techniques and learned to practice relaxation every night to the point of falling asleep. Ms. A also learned to use coping cards, e.g., a large pink index card with the word "RELAX", written in large letters. A variety of techniques helped her to remember her coping skills at home and helped her use them. She learned to practice relaxation every night to the point of falling asleep.

**TREATMENT**

The psychotherapeutic treatment of choice for PD is cognitive-behavioral psychotherapy, and this was modified for the patient's intellectual disability. Each session was structured to address a current concern and the last session and assignment were reviewed. Ms. A enthusiastically embraced the problem-solving and skill-building approach. She was very good about trying assignments and following through. She could always articulate what she was working on at the beginning of the session.

Ms. A was first taught coping skills for the panic attacks. She was given specific education about panic attacks and was taught relaxation and breathing exercises to ride out the panic attacks. This therapy occurred over a six-month period, due to Ms. A's cognitive deficiencies that entailed her needing simple teaching, repetition, simple homework assignments, and much practice in sessions. Because her academic skills were basic, she was able to use some simple coping cards, e.g., a large pink index card with the word "RELAX" written in large letters. A variety of techniques helped her to remember her coping skills at home and helped her use them. She learned to practice relaxation every night to the point of falling asleep.
### Table 1. Criteria for Panic Attack (from the DSM)

- Note that all require self-report.
- Those reported by Ms. A are tagged with an asterisk (*).

A discrete period of intense fear or discomfort, in which four (4) or more of the following symptoms developed abruptly and reached a peak within 10 minutes.

<table>
<thead>
<tr>
<th>Symptom</th>
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<tbody>
<tr>
<td>Palpitations</td>
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<tr>
<td>Sweating *</td>
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<tr>
<td>Trembling</td>
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<tr>
<td>Shortness of breath *</td>
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<tr>
<td>Feeling of choking</td>
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<td>Chest discomfort *</td>
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<td>Abdominal stress</td>
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<td>Dizziness *</td>
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<tr>
<td>Derealization</td>
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<td>Fear of losing control</td>
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<tr>
<td>Fear of dying</td>
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<tr>
<td>Numbness or tingling</td>
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<td>Chills or hot flashes</td>
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### Table 2. Criteria for Panic Disorder Without Agoraphobia

- Those reported by Ms. A are tagged with an asterisk (*).

1. Recurrent unexpected panic attacks *
2. At least one of the panic attacks has been followed by one month of the following:
   - persistent concern about having more attacks *
   - worry about implications of the attack, such as “going crazy”
   - a significant change in behavior related to the attacks *

Radio. She posted her coping cards on the dresser in her bedroom. For example, additional coping statements were, “It is no big deal—it will be OK,” and so forth. Fears at the pharmacy were addressed; others might not judge her or they could judge her but that did not matter. She was “OK—a good person—I try my best.” This approach was always repeated and written out on cards, and sometimes pictures or other multisensory materials were used as well.

At the end of our first year, she gained considerable ability to cope with her worries and anxiety, and she markedly reduced her panic attacks. Ms. A complained that she had little to do and wanted again to try to work. Work was encouraged and a referral was made to the local developmental disability agency, and a trial work placement was found by the end of our second year in therapy. This placement was in a large sheltered workshop that had a variety of off-site placements. During her 8-week evaluation period, her anxiety increased considerably. She had multiple panic attacks daily and found work assignments again to be overwhelming. Staff at the workshop felt she needed too much individual attention and were not able to calm her and encourage her sufficiently. She quit the work experience in the fourth week of her evaluation.

Psychotherapy continued monthly for the next two years. We again brought her panic attacks under control and talked about work coping skills. Techniques were aimed at teaching her about the world of work, that no one has to be “perfect” on the job, and helping her to see that her skills were very good, that she was just a slow learner, and that she would be a good worker.

Ms. A was again referred for another 8-week evaluation to a different sheltered workshop program. This time the staff enthusiastically wanted to help her adjust and worked
collaboratively with me to augment Ms. A's coping skills. Staff became very sensitive to her anxiety and when she was feeling incompetent, staff were able to adjust tasks to her learning pace so that she succeeded.

Over the next two years, Ms. A continued to work very well. She used the coping techniques and only on occasion was additional collaboration needed. This typically occurred when a new and more complex work job was obtained by the workshop. She was looking forward to the day she would try an off-site supervised job.

Ms. A was a model employee. She was polite and kind to other workers, responsible, and was always on time. She went to work independently and always called herself if she was to be late or miss a day for a medical appointment. Throughout this treatment, she remained on fluoxetine 20mg/day.

Case Discussion

People with intellectual disability suffer from psychiatric illness at a rate that is thought to be much higher than the general population. Yet, anxiety disorders, and PD specifically, have only rarely been reported. This may be due to inability to sufficiently verbalize the cognitive nature of worry and anxiety; it may also be due to lack of awareness and understanding about psychiatric illness and its diagnosis in people with intellectual disability. The present case reports a woman with mild intellectual disability who had PD and who was successfully treated with cognitive behavior therapy. Ms. A was able to sufficiently verbalize so that basic symptoms of PD were able to be documented. She learned to identify them as a psychological event, and also learned techniques to control her panic attacks and to sharply reduce her worry that helped precipitate attacks. As a result, she was finally able to work full-time in a sheltered employment training program.

It is difficult to diagnose PD in people with mild intellectual disability and it may be impossible to diagnose it in people with more moderate disability level unless signs of physiological arousal are observed by others. In this case, previous clinicians had diagnosed Ms. A as having bipolar disorder, and it is unclear how that diagnosis was made. Indeed, unlike intellectually typical patients, she could communicate only concrete statements regarding her internal mental life and symptoms. With extensive specific questioning during the interview, basic symptoms were able to be identified. Thus, clinicians must be very assertive when interviewing a patient with intellectual disability and provide a strong framework while probing for symptoms. In addition, clinicians must postulate and use behavioral equivalents for required symptoms. One study found aggression well-represented in PD, and this global response to distress has been researched in depression as well.¹⁹

Anxiety disorders may also be underdiagnosed in people with intellectual disability because they are internalizing disorders. People do not generally “act out” when anxious, as they do when afflicted with another condition such as a mood disorder. Thus, staff and family may not be sensitive to internal states, nor as concerned as they would be when faced with externalizing behaviors such as a aggression or oppositionalism. Thus, clinicians, family, and direct support professionals must be educated in the presentation of anxiety disorders and panic so that people with intellectual disability can receive proper treatment.

It may be helpful for clinicians to use one of the anxiety scales developed or adapted for people with intellectual disability. For example the Glasgow Anxiety Scale for People with an Intellectual Disability (GAS-ID) showed very good test-retest reliability and internal consistency.¹⁸ In addition, there was a good correlation between the physiological subscale and changes in pulse rate. The scale is easy to complete due to a three-option response of “always,” “sometimes” or “never.” And it takes only 5 to 10 minutes to administer.

Several genetic causes of intellectual disability have been associated with anxiety disorders, including Williams syndrome and fragile-X.⁵,⁶,¹⁴,¹⁵ Thus, for individuals presenting with psychiatric or behavioral issues, in certain genetic conditions, a diagnosis of anxiety disorder and/or PD should be considered.

Cognitive behavioral treatment is the psychotherapeutic method of choice to treat PD. Ms. A required much more verbal and written direction and repetitive rehearsal to learn relaxation and deep breathing techniques compared to the intellectually typical patient. Throughout treatment, she continued to need this extra support. In addition, when using psychotherapy for patients with intellectual disability, the therapist must be vigilant in...
screening level of language, vocabulary, and concepts so that they are understandable to the patient. Although there has been some recent controversy regarding the efficacy of psychotherapy for people with intellectual disability, it appears that the consensus of the field is that these techniques must certainly be tried, and that they may have some success for people with mild intellectual disability.

References


