Case Study on Millie: Agoraphobia and/or Avoidant Personality Disorder

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The purpose of this paper is to clinically assess a patient by the name of "Millie" and provide a DSM-5 diagnosis—specifying the signs and symptoms that she presents with; detailing both negative and positive criteria for this diagnosis—which indicate *severe agoraphobia (with potential comorbid panic disorder).* We then provide a differential diagnosis of *avoidant personality disorder*, and propose a series of questions to test this hypothesis. This paper concludes by recommending treatment using the author's INSIDE/OUTSIDE model—a Biblical counseling approach leveraging cognitive-behavioral and exposure techniques.

Assessment & Provisional Diagnosis

The Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM–5; American Psychiatric Association [APA]) acknowledges that "anxiety disorders tend to be highly comorbid with each other, [although] they can be differentiated by close examination of the types of situations that are feared or avoided and the content of the associated thoughts or beliefs" (2013, Anxiety Disorders). For instance, the issue for those with social phobia or social anxiety disorder (SAD) is more about being scrutinized by the many judging eyes in public versus the fear or anxiety of being too far away from the care that those with agoraphobia would be enmeshed with at home, per se. Both have to do with not leaving their prison-sanctuaries, and yet one has to do with external factors, and the other with internal considerations.

Positive Criterion

My provisional diagnosis in Millie's case is agoraphobia, as she clearly presents with both *marked fear* ("afraid to leave her home") and *intense anxiety* ("anxiety, inability to leave the house") (Criterion A). These are general in nature while SAD would have been more likely if her concerns were restricted to going to the doctor's office and having her health judged. Indeed,

even in her twenties, she was so intently-focused on the potential for being "unable to get help should she become anxious" (Criterion B) that she became *consistently anxious* (Criterion C) and *actively avoided* going out by "living like a recluse and supported by her husband," to the extent of relying on her husband to run "most of the errands" (Criterion D). This is clearly "out of proportion to the actual danger… and to the sociocultural context" (APA, 2013)—particularly given the fact that in her earlier years, Millie not only dismissed her own anxiety treatment needs, but had a child that should have taken precedence when needing to be shuttled around for various activities. Her psychological aversions continue to outweigh her biological needs in the current context, as she deprioritizes regular medical attention for the diabetes (not to mention the ensuing "open sores on her legs" that would qualify as basic needs).

Risk and Prognostic Factors. There are also indications that point to Millie having been at risk of developing agoraphobia since her childhood.

Temperamental. Millie reports having been "always shy and preferred to stay home rather than play with friends" as a child, which reflects the behavioral inhibition that is a known temperamental risk factor. Her "many absences [from school] for stomach complaints" hinted at a tendency towards "[diminished] role functioning [and] work productivity (APA, 2013, Agoraphobia" and foreshadowed her seeking a husband who would enable her being a less hands-on mother.

Environmental. Millie does not report any specific negative events from her own childhood, but the "family climate and child-rearing behavior [she grew up with is clearly] characterized by reduced warmth" (APA, 2013, Agoraphobia). Her father was largely absent while working out-of-state (and presumably drunk a lot when he was home given her memory of him as having "drank a lot of beer" and left her mother to "fend for their four children."

Negative Criterion

It is also important to note that contrary to those diagnosed with SAD, Millie *never felt better when left alone* at home (APA, 2013), *but was increasingly distressed* to the point of clinical impairment ("[complaining] of increasing nervousness… shakiness and intense fear, which began in the past year") (Criterion E and G). The timing and *persistence* of this escalation in symptoms aligned with the recent passing of Millie's husband two years ago and has lasted more than half a year. This has likely been a period of her *stalling the anticipated exposure* that then led to the worsening condition from her diabetes (Criterion F). All of these symptoms were *beyond what might be expected* from other medical conditions (e.g., diabetes, medical complications, or motor disturbances that come from old age) (Criterion H) or mental disorders. In terms of the latter, again Millie's symptoms are not limited to a specific phobia or certain situational type, which precludes SAD. Moreover, despite a "family history of alcohol use" she denies any substance use disorders as well as "any history of abuse or trauma" which would have indicated any trauma-related disorders—even the mention of a "spotless kitchen in the perfectly ordered home" does not appear to be related to any obsessions (Criterion I). It is interesting to note that she does not exhibit any signs of demoralization or depression from being homebound.

However, most diagnoses of agoraphobia come with comorbidities, and beyond SAD, comorbid panic disorder (PD) is probable, given the *presence of physiological symptoms* (e.g., "excessive sweating… palpitations, flushing") accompanying the "maladaptive changes in behavior… to minimize or avoid panic attacks or their consequences" (APA, 2013, Panic Disorder). Of course, one can also be diagnosed without the other, as "agoraphobia should not be diagnosed if the avoidance behaviors associated with the panic attacks do not extend to avoidance of two or more agoraphobic situations" (APA, 2013, Agoraphobia).

Differential Diagnosis for Comorbidities

The DSM-5 adopts a *categorical approach*, but "when diagnostic criteria for agoraphobia and another disorder are fully met, both … should be assigned, unless the fear, anxiety, or avoidance of agoraphobia is attributable to the other" (APA, 2013, Agoraphobia).

As previously discussed, SAD and PD come to mind first and foremost when we consider a differential diagnosis. If Millie's fears were concentrated in "one or more social situations in which [she] is exposed to possible scrutiny by others" (APA, 2013, Social Anxiety Disorder), then this would be *plausible*—as in the case of going to the doctor's office. What complicates things further is how disorders can also be view from a *dimensional perspective*—SAD can be seen on a spectrum with avoidance personality disorder (Barlow, 2008)—bearing in mind significant overlaps can combine into "maladaptive variants of personality traits that merge imperceptibly into normality and into one another" (APA, 2013, Personality Disorders).

This can be a slippery slope as a personality disorder is an "enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, [and] is pervasive and inflexible" (APA, 2013, Personality Disorders), and it is not entirely far-fetched to suggest that Millie exhibits Cluster C patterns—e.g., the social inhibition of *avoidant personality disorder* and the tendency to be dependent as with the aptly named *dependent personality disorder*. Diagnosing Millie's condition must account for the fact that, in addition to extreme severity, *early onset chronicity* is a defining characteristic: Age of onset can be a key differentiator supporting a diagnosis of avoidant personality disorder or social anxiety disorder. It is noteworthy that while Millie is now elderly, she reports that she "was always an anxious person," "went through a period of anxiety in her twenties," and as "a middle child, was always shy." Indeed, a childhood preference to stay home was a type of her current reclusive lifestyle.

Diagnostic Questions (For the Diagnosing Clinician to Be Able to Ask/Answer)

Social Anxiety Disorder. What exactly is she afraid of happening if she went outside? Which situations did/does this come into play? She mentioned worrying of being "unable to get help." Is she afraid of something happening? Or afraid of *being judged* for what happens? Is she afraid of not being able to handle it well? Or being *humiliated* in front of others? Was she afraid of being *rejected by peers* or only judged by adults? Was she "calm when left entirely alone (APA, 2013, Social Anxiety Disorder), as a child or in her twenties, or anxious as she is now?

Panic Disorder. What cues/triggers? *Unexpected (full symptom)?* Or no, only expected (limited)? Panic attacks thinking of panic attacks? Onset (rare in childhood)? Suicidal ideation?

Avoidant Personality Disorder. Have those events happened before? If so, at *what age*? Agoraphobia onset during childhood is rare, typically at 17 years, but common in avoidant personality disorders (APA, 2013). Why did she avoid school? Types of functional impairment?

Dependent Personality Disorder. If so, what did she do in that prior situation? Was there anyone with her at the time? How were her symptoms lessened with her husband around? Was she able to better confront her fears then? During what errands or situations? How did her family act if/when they were with her, or how did her family react when they heard about it?

Treatment Plan

Millie's daughter signed her up for concurrent medical and psychological care, and we need to be wise about any combined treatment of the agoraphobia. Research has shown that "combined treatment [is] no better than individual treatments…. [and in fact] patients on medication, whether combined with CBT or not, had deteriorated somewhat, and those receiving CBT without the drug had retained most of their gains…. [Furthermore,] drugs, particularly benzodiazepines, may interfere with the effects of psychological treatments…. [and] taken over a

long period are associated with cognitive impairment" (Barlow & Durand, 2015, p 146-147).

As a Biblical counselor, I leverage the evidence-based methods that have been given to us through God's common grace (as opposed to nouthetic counselors who eschew approaches used in secular counseling or pastoral counselors who are not trained in behavioral, biological, cognitive, existential, humanistic, psychodynamic, and/or socio-cultural models). Assuming that Millie is a Christian who agrees that we all live *Coram Deo*—in God's presence—treatment would begin with cognitive-behavioral therapy that rests on God's active working in her life, exposure to interoceptive sensations and their place in the experience that He is sustaining her through, and acceptance of His sovereign and good will through intentional reality testing (Barlow & Durand, 2015). See Appendix A for further detail.

Psychological treatments for agoraphobia such as "gradual exposure exercises, sometimes combined with anxiety-reducing coping mechanisms such as relaxation or breathing retraining, have proved effective in helping patients" and have been leveraged for use with panic disorders as well (Barlow & Durand, 2015, p. 145). Intentionally working on cognitive restructuring through virtual sessions and coached homework could be useful getting Millie out the door and on her way in a manner of speaking. Then when she is ready, she can also be given panic control treatment (PCT)—concentrating on acclimating to physical sensations that mimic the panic attacks that she has been experiencing at home—by exercising in a lab to get her palpitations and perspiration going. It is important to manage expectations, however, because even while "as many as 70% of patients undergoing these treatments substantially improve as their anxiety and panic are reduced and their agoraphobic avoidance is greatly diminished…. Few… are cured, because many still experience some anxiety and panic attacks, although at a less severe level" (Barlow & Durand, 2015, p. 145).

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Appendix A

Approach for Treating Symptoms from Comorbid Social Anxiety Disorder

Integrating the discovery of cognitive errors requires a high level of counselor skill, and is imperative—given that research shows that "psychological treatments seemed to perform better in the long run (6 months after treatment stopped)..." rather than the combination of drugs and CBT—suggesting that psychological treatment should be the priority step.

Further gains can be gained through: "social skills training, cognitive therapy, relaxation training, exposure, interpersonal psychotherapy, dynamically oriented supportive psychotherapy, and various pharmacotherapies…. where the efficacy of exposure is improved by the addition of cognitive restructuring" (Barlow, 2008, p. 116). Given Millie's overlap in symptoms, she can give this three-headed monster a final one-two-three punch by reducing physiological symptoms by comparing them with lesser/non-existent ramifications of actually going outside, testing and debunking them by systematically practicing any errands that she is anxious about performing (does the experience get better with experience?), and considering alternatives to her other dysfunctional beliefs about the outside world (what are the null-hypotheses to her hypotheses?).

Cognitive-behavioral therapy in a group (CBGT) can show the greatest improvements in mood, functioning, and quality of life—on par with mindfulness and acceptance-based treatments, but superior results in social anxiety and higher rates of response and remission (Barlow, 2008, p. 117). Such a program allows her to interact with others in a safe environment and nurture her out of her shell, so to speak. Identification/elimination of social anxiety drivers (e.g., idiosyncratic thoughts/images, safety behaviors, and attentional strategies) is particularly efficacious when "negatively distorted self-representations are modified using video feedback" (Barlow, 2008, p. 117). This is helpful for those with inaccurate self-views from living alone.

Appendix B

Biblical Counseling through Cognitive Restructuring and Behavioral Modification

Stage 1: Distorting Realities in Comorbid Agoraphobia/ Panic Disorder	**Stage 2: Denying Self-Estimated Risk & Valence with Evidence-Based Intervention**	**Stage 3: Delivering All Anxieties to God through His Wise Biblical Counsel and Clinical Common Grace**
		Orientation: You are neither alone nor left on your own. It is important to know yourself, but that is secondary to knowing the One who is of primary importance. Center on the Omnipresent God who is with you everywhere all the time. You are not the sole determinant of what will happen—you are a distant second. You are in the Omnipotent God's system. (cf. Ps 121:1-2; Col 3:1-4)
Isolation: You look around and see no one who will help you.	**I**dentification: Know yourself, and come to know all the things/places that trigger you (Barlow, 2014, p. 31). Nothing that you can possibly do will force a catastrophe.	**U**nderneath: The Omniscient God knows you and your needs and places you under His wing. The Alpha and the Omega will save you and redeem from all. Nothing will ever separate you from His presence, protection, and provision. (cf. Ps 91:1-16; Rom 8:33-39; Rev 22:13)
Nothing: You see people, but they will not or cannot help.	**N**egation: Consider none of those cognitions to be harmful (Barlow, 2014, p. 31). "Everyone has errors in thinking when anxious…. Treat [your] thoughts as hypotheses [to be proved wrong] or guesses rather than facts" (Barlow, 2014, p. 35). Bring both (a) risk, and (b) valence, back to reasonable limits (Barlow, 2014, p. 35-36, 38).	**T**otality: (a) Even if the impossible happened against all odds, you can still rely on God for everything you can possibly need before you even realize it. (b) Even if what shouldn't matter ends up mattering, He is always attentive and never dismissive. The moment you voluntarily let go of things or have them ripped from you, you can choose to receive everything that is of any value at all, simply by accepting from Him. (cf. Jer 32:17, 27; Matt 19:26; Luke 9:24-26)

Stage 1: Distorting Realities in Comorbid Agoraphobia/ Panic Disorder	**Stage 2: Denying Self-Estimated Risk & Valence with Evidence-Based Intervention**	**Stage 3: Delivering All Anxieties to God through His Wise Biblical Counsel and Clinical Common Grace**
Sensations: Your body feels like it's going haywire.	**S**elf-Awareness: Rationalize with the three-response model (viz., cognitive/think, physiological/feel, and behavioral/do) of a personal scientist: to contrast between anxiety and panic. It's not harmful. It's just a panic attack. Sometimes feeling anxious is a good thing. Practice diaphragmic breathing as a coping mechanism—even hyperventilate and recognize it's ok and slow back down—but do not fall into trap of placing that performance on a pedestal (Barlow, 2014, p. 31, 32, 39).	**S**ignals: God created us as embodied souls (not just souls contained in husks), so everything that you feel is part of the way He designed you. Interoceptive awareness can place somatic sensations in God's context of your body, so whether or not they are false alarms, they are reminders of how He is sustaining you, animating you, and empowering you. If you can discern not only the gradations in feeling, but also what He is telling you through His biological processes in you (or telling you by allowing them), then you are one step closer to submitting to His design and His purpose for you. (cf. Prov 29:11; Isa 30:15; Rom 8:15; Col 1:11, 17, 29)
Independence: You start thinking that you must figure it all out or do everything yourself, so you stay at home doing only what you can on your own.	**I**ndex: Recognizing your own role and clarity of what you do to cause your situation is the first move in trying to stop repeatedly going down the wrong path and then moving interoceptive responses from avoidance to adherence (Barlow, 2015, p. 145). Detail the incremental steps that spur the vicious downward spiral (e.g., I was worried, so I felt bad, so I began to… which made me more afraid…) (Barlow, 2014, p. 32). Be aware that none of these techniques are critical—which would be antithetical to the premise of downplaying one's role (Barlow, 2014, p. 32).	**I**nvitation: How many times do veer to the left and right instead of going straight? How many times do we do what we know we shouldn't or fail to do what we know we should? Let God light your path to Him so that you can walk with Jesus. You can draw near to Him, because He is the One who chose you and "took [you] from the far ends of the earth, and called [you] from its farthest corners" (Isa 41:8-10) and is now right next to you—simply turn to face Him. What can you do when you are in union with Christ? Will you accept and commit to the Holy Spirit's invitation to order your steps? (cf. Amos 3:1-10; Micah 6:8; John 15:5; 1 John 1:7)

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Danger-Sign: You see bad things everywhere you look and cannot move past them whenever you open your physical/imaginary front door.	**D**ownward-Arrow: Get specific so that you can stop assuming risks are facts; then you can deny the reframed hypothesis. Certain things would make anyone feel/think catastrophically for the purpose of avoiding danger, as "distortions have an adaptive function…. However, [they] are unnecessary because here is no real threat in the case of panic disorder" (Barlow, 2014, p. 33, 35). Don't worry. It's not real. (Caveat: learned helplessness may contribute to a triple vulnerability.)	**D**eliverance-Exit: You don't have to fear, worry, or avoid anything. Those things are unlikely to happen, but God would provide a way out even if any/everything happened—specifically and generally. He has predestined your part in His story and can/will redeem whatever you are concerned about or even the fact that you are concerned. When smoke clouds your view, do you have time/energy to think about where to go or not, or will you focus on the lit Deliverance Door / Emergency Exit? Do you seek out the headlamps of the FDNY who have saved you before? (cf. Judg 6:7-10; 2 Kings 17:39; Ps 46:1-3)
Exposure: You feel vulnerable to what is happening and what can happen (e.g., impending calamitous eventualities) (Barlow, 2014, p. 36).	**E**xpectation: Prepare a hierarchy of anxiety triggers for cognitive restructuring—the places/situations that you already know will give you anxiety— and categorically acclimate to each in vivo exposure by expecting only what is likely to happen given historical evidence (Barlow, 2014, p. 34, 39).	**E**nvelopment: Let God protect you from the N+1st possibility. Black swans are by definition insidious threats: seemingly rare and insignificant to stay off radar. But when you realize that God not only gives you armor, but that He is your armor, you will be already ready for anything and everything, now and forever. All you have to do is to have the faith to stand firm in the strength of His might and withstand in the day that will inevitably come (cf. Ps 34:17-22; Isa 11:1-5; 59:16-21; Gal 3:25-27; Eph 6:10-20)