

Agoraphobia

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WHAT IS AGORAPHOBIA?

Agoraphobia literally means “fear of the marketplace,” based on *agora*, the word for the Greek marketplace (Durand & Barlow, 2003). The term “agoraphobia” was first introduced by Westphal in 1871 to describe the fear and avoidance of public places, although this condition was not widely recognized until the late 1970s (Barlow, 2002). Diagnosis of Agoraphobia first appeared in the *Diagnostic and Statistical Manual of Mental Disorders* in its third edition (DSM-III; American Psychiatric Association [APA], 1980). Agoraphobia was then considered a primary diagnosis, which may or may not be accompanied by recurrent panic attacks (Mennin, Heimberg, & Holt, 2000). However, since publication of the DSM-III-R (APA, 1987), a diagnosis of Panic Disorder is considered primary and is diagnosed either with or without Agoraphobia. Under the current DSM-IV (APA, 1994) diagnostic system, individuals exhibiting symptoms of Agoraphobia but never meeting full diagnostic criteria for Panic Disorder are given a diagnosis of Agoraphobia Without History of Panic Disorder (AWHPD).

The DSM-IV (APA, 1994) describes Agoraphobia as anxiety about several different places or situations from which escape would be either difficult or embarrassing if some sort of unexpected or unwanted bodily symptoms occurred (Criterion A). As a result, such situations are either avoided, require the presence of a trusted person, or are endured with great distress (Criterion B). This anxiety and situational avoidance is not better explained by another anxiety disorder, such as Social Phobia or Specific Phobia (Criterion C). Although panic attacks or “panic-like” bodily sensations are often feared, other feared symptoms include loss of bladder or bowel control, vomiting, or severe headache. Agoraphobia is not recognized by DSM-IV as a diagnosis on its own. An individual meeting criteria for Agoraphobia is then diagnosed with either Panic Disorder With Agoraphobia (PDA) (if diagnostic criteria for Panic Disorder are also met) or AWHPD. Both diagnoses require that the symptoms cannot be fully explained by a general medical condition and do not reflect the direct physiological effects of a substance.

Common agoraphobic situations include shopping malls, public transportation, supermarkets, restaurants, theaters, additional situations involving crowds or waiting in line, travel far from home, and being alone (Barlow & Craske, 2000). Such agoraphobic situations are avoided because of feared bodily sensations or physical symptoms; therefore it is not surprising that other daily activities causing such interoceptive sensations are also avoided. Activities involving physical exertion, such as aerobic exercise, running up flights of stairs, heavy lifting, and dancing, may be avoided because they induce sensations of physiological arousal. Similar interoceptive activities include hot and stuffy spaces, sexual relations, watching suspenseful movies or sporting events, expressing anger or engaging in emotionally arousing discussions, and ingesting caffeine or chocolate (Barlow & Craske, 2000). Individuals with AWHPD who fear sensations other than “panic-like” symptoms might avoid

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additional activities causing other feared sensations. For example, an individual with AWHPD stemming from gastrointestinal distress and fear of losing control of his bowels might avoid eating spicy foods or heavy meals to prevent unwanted gastrointestinal sensations. Nevertheless, the actual agoraphobic situations avoided by individuals with AWHPD do not seem to differ from those avoided by individuals with Panic Disorder With Agoraphobia (Pollard, Tait, Meldrum, Dubinsky, & Gall, 1996).

DSM-IV conceptualizes Agoraphobia as a condition most often secondary to Panic Disorder or sub-clinical panic symptoms. This view rests on the assumption that avoidance of public places and other agoraphobic situations develops as a behavioral reaction to the unexpected physiological arousal of panic (Barlow, 2002). Indeed, re-assessment of 26 AWHPD patients revealed that 57% appeared to suffer from panic attacks containing too few symptoms to meet criteria for Panic Disorder (Goisman et al., 1995). In a longitudinal naturalistic study of 562 participants suffering from panic and agoraphobia symptoms, only 6% were assigned diagnoses of AWHPD (Goisman et al., 1994). These researchers proposed that AWHPD might be best conceptualized as part of a panic syndrome, in which AWHPD lies on a single continuum with PDA and Panic Disorder Without Agoraphobia (PD). Similarly, Andrews and Slade (2002) concluded that these three diagnoses represent three variations of a single disorder after finding strong similarities among AWHPD, PDA, and PD clinical groups.

Although AWHPD is not often seen in mental health treatment settings (Pollard, Bronson, & Kenney, 1989), Agoraphobia can develop in response to somatic conditions other than panic. For example, AWHPD has been associated with Generalized Anxiety Disorder (Hoffart, Thornes, & Hedley, 1995), Irritable Bowel Syndrome (IBS; Mennin et al., 2000), headache (Spierings, Reinders, & Hoogduin, 1989), and fear of vomiting (Pollard et al., 1996). Wittchen, Reed, and Kessler (1998) found that most agoraphobic individuals in their community sample reported no history of uncued panic-related symptoms, challenging the predominant view that panic-like experiences are usually responsible for the development of Agoraphobia. They argued that AWHPD is not often seen in mental health settings because such individuals seldom seek treatment, not because it is a rare condition. Regardless of whether or not panic-related sensations are responsible for the development of an individual's Agoraphobia, the behavioral avoidance is driven by a fear of some sort of internal bodily sensation or event.

BASIC FACTS ABOUT AGORAPHOBIA

The American Psychiatric Association estimates the 1-year prevalence of Panic Disorder between 1% and 2%, with up to one-half of these individuals also suffering from Agoraphobia (APA, 1994). The US National Comorbidity Survey (NCS) lifetime prevalence estimate for PD with or without Agoraphobia is 3.5% (Kessler et al., 1994). Determining the prevalence of AWHPD has proven much more complicated. Initial epidemiological results suggested that AWHPD was more common than PDA. The NCS found the lifetime prevalence for AWHPD to be 5.3% (Kessler et al., 1994). Similarly, the Epidemiological Catchment Area (ECA) survey based on DSM-III criteria reported a 4.2% lifetime prevalence of AWHPD compared to only 0.9% for Panic Disorder (Robins et al., 1984). However, the high rates of AWHPD found in large-scale epidemiological research might reflect overestimates due to methodological difficulties. Both the ECA and NCS relied on structured diagnostic interviews conducted by lay interviewers rather than trained clinicians: the ECA determined DSM-III diagnoses with the Diagnostic Interview Schedule (DIS;

Robins, Helzer, Croughan, & Ratcliff, 1981) and the NCS assigned DSM-III-R diagnoses after administering the Composite International Diagnostic Interview (CIDI; World Health Organization, 1990).

Researchers have since taken a closer look at AWHPD cases from epidemiological studies. Horwath, Lish, Johnson, Hornig, and Weissman (1993) blindly re-interviewed 22 AWHPD participants from the original ECA study. Only two received a diagnosis of AWHPD, one of which had sub-clinical panic attacks. The remaining participants were reclassified with simple (specific) phobias or PDA. In a more recent study using DSM-IV criteria, Andrews and Slade (2002) reported a 1-year prevalence rate of 1.3% for PD, 1.6% for AWHPD, and 0.6% for PDA in their Australian community sample. Although AWHPD and PD groups were mutually exclusive, 18% of those with AWHPD reported recurrent and unexpected panic attacks that did not meet criteria for PD. Thus, the prevalence of AWHPD and its relationship to panic attacks and Panic Disorder remains the subject of much debate.

The prevalence of PDA does not seem to differ among ethnic groups (Eaton, Dryman, & Weissman, 1991; Horwath, Johnson, & Hornig, 1993). However, African Americans are rarely found in treatment outcome research studies (Paradis, Hatch, & Friedman, 1994). Early epidemiological research based on DSM-III criteria consistently revealed that Agoraphobia was more common for women than men (see Pollard & Henderson, 1987). In the later NCS study, women were more than twice as likely as men to meet diagnostic criteria for Agoraphobia (ratio of 2.2:1.0; Magee, Eaton, Wittchen, McGonagle, & Kessler, 1996). According to the DSM-IV-TR (APA, 2000), approximately 75% of those suffering from PDA are women. One explanation for this gender difference is that avoidance behavior is more culturally acceptable for women than for men. Agoraphobic individuals' tendency to avoid situations correlated with "masculinity" scores, such that the lower the score, the greater the avoidance behavior (Chambless & Mason, 1986). Consistent with this view, men are more likely than women to cope with unwanted anxiety and panic symptoms by using alcohol and other psychoactive substances (Kushner, Abrams, & Borchardt, 2000). For a thorough review of gender difference research see Craske (1999, 2003).

Although little is known about the course of AWHPD, the course of PDA is often quite chronic. One longitudinal investigation reported a 1-year remission rate of only 17%, and relapse among these individuals was common (Keller et al., 1994). The onset of Agoraphobia usually occurs in the late-twenties, with a median age of onset of 29 years (Magee et al., 1996). Panic Disorder begins as early as the mid-teens (Burke, Burke, Regier, & Rae, 1990), but PDA is rarely found in younger children (Albano, Chorpita, & Barlow, 1996). More than half the time, individuals with PDA are diagnosed with additional comorbid conditions. This most often involves another anxiety disorder such as Generalized Anxiety Disorder, Specific Phobia, or Social Phobia, or a mood disorder such as Major Depressive Disorder or Dysthymia. Substance use disorders and Axis II personality disorders are also common (see Barlow, 2002; Craske, 1999 for reviews).

Agoraphobia can become quite disabling. Although the NCS study found that only 26.5% of those with Agoraphobia reported that their avoidance interfered "a lot" with their life (Magee et al., 1996), severe functional impairment across many life domains is common among clinical samples (Mennin et al., 2000). Interpersonal problems and marital difficulties have been documented with PDA (Hoffart, 1997; Marcaurelle, Bélanger, & Marchand, 2003), although it is unclear whether these problems were present before the onset of PDA. Other important costs include medical utilization and work disability. PDA often leads to increased use of nonpsychiatric general medical services and emergency room visits (Markowitz, Weissman,

Ouellette, Lish, & Klerman, 1989). Unemployment and other forms of work impairment are also common. Studies of treatment-seeking clinical populations have documented unemployment rates of 50%, and 33% of individuals suffering from PDA may be financially dependent on public assistance programs (Edlund & Swann, 1987; Massion, Warshaw, & Keller, 1993). Although little information about the social costs of AWHPD is available, severe agoraphobic avoidance associated with sub-clinical panic or conditions other than panic can also lead to significant impairment.

WHAT CAUSES AGORAPHOBIA?

Early theories of agoraphobia viewed avoidance behavior as a conditioned fear response. One influential model was the two-factor theory of Mowrer (1960). He proposed that fear is first acquired from a classical conditioning experience, then escape from or avoidance of the conditioned stimulus situation maintains the fear by preventing extinction of this fear response. According to this view, the fear of certain public places would originate when some sort of noxious or aversive event happened to occur in that context and the person became motivated to avoid that particular situation due to their conditioned fear response. In support of this model, Öst and Hugdahl (1983) found that 81% of their agoraphobia sample could identify a specific conditioning experience to account for their fear. Later behavioral theories focused on fears of what might happen in the feared situation rather than fears of the situation itself. For example, Goldstein and Chambless (1978) proposed that agoraphobic avoidance resulted from a fear of impending panic or other feared bodily sensations, a model labeled “fear of fear.” From this perspective, innocuous bodily sensations become classically conditioned to the aversive physiological arousal associated with panic attacks. Because these classically conditioned sensations could trigger an unwanted panic attack across situations, individuals avoid various agoraphobic situations out of fear that they would be unable to cope with their panic if it were to occur in that situation.

Modern approaches view the development of Agoraphobia and PDA as a complex interaction between both biological and psychological influences. Agoraphobia is believed to begin with a general predisposition or vulnerability common to all the anxiety disorders (Craske, 1999). This temperament risk factor is often referred to as “negative affectivity” (Watson & Clark, 1984), and is quite similar to constructs such as neuroticism (Eysenck, 1967) and behavioral inhibition (Kagan, 1997). Genetic influences for negative affectivity are well established, but genes only explain half the picture (Craske, 2003). Environmental influences can also make a person vulnerable to experience negative emotional states across situations. Early experiences with stressful situations, particularly those in which the individual perceived the event(s) to be unpredictable and difficult to control, also contribute to the negative affectivity temperament (Craske, 1999). Other developmental experiences that can predispose a person to anxiety disorders include parental modeling of anxious behavior, overprotective treatment, and parental encouragement of anxious behavior and avoidance (Vasey & Dadds, 2001).

More specific physiological and psychological factors could make an individual prone to experience Panic Disorder and Agoraphobia symptoms in particular. Evidence for an overactive hypothalamic–pituitary–adrenal (HPA) axis and autonomic hyperactivity in Panic Disorder exists, although research results are mixed (Craske, 1999). Psychological factors center on a specific fear of unwanted bodily sensations. Cognitive components include attributions and beliefs that certain

innocuous sensations are dangerous. For example, accelerated heart rate might be interpreted as a sign of heart attack or stroke, shortness of breath could be taken as a sign of suffocation, and dizziness could be perceived as evidence that the person will faint (Barlow, 2002). Other feared consequences of unwanted bodily sensations include losing control over one's body and going crazy. Clark (1988) described these cognitions as "catastrophic misinterpretations," in which normal anxiety sensations and sometimes other harmless physical sensations are interpreted in a catastrophic way to signal immediate and impending physical and/or mental disaster.

Along similar lines, Reiss et al. (1986) defined "anxiety sensitivity" as the tendency to interpret anxiety sensations as harmful. They suggested that anxiety sensitivity represents a specific vulnerability to Panic Disorder and agoraphobic avoidance, and longitudinal research supports this idea (Ehlers, 1995). Anxiety sensitivity among treatment-seeking agoraphobic clients reflected fears of heart and breathing symptoms, loss of mental control, gastrointestinal difficulties, and other people detecting anxiety symptoms (Wardle, Ahmad, & Hayward, 1990). Individuals with PDA appear more likely to fear physical catastrophes than AWHPD individuals (Hoffart, Friis, Strand, & Olsen, 1994).

Barlow (2002) proposed a comprehensive etiological model of PDA that integrates these various components. He suggested that an individual may be predisposed to experience anxiety through both biological and psychological generalized vulnerability factors. When a stressful event triggers an exaggerated physiological fear response, the individual becomes fearful of the associated interoceptive cues due to a specific tendency to interpret unexplained physical sensations as dangerous. This fear leads to anticipation of future unwanted somatic sensations, or "anxious apprehension." Agoraphobia develops when the individual responds to feared somatic sensations and anticipation of future interoceptive cues with behavioral avoidance of certain situations. This avoidance maintains the fear of unwanted sensations, reinforcing beliefs that such sensations are indeed harmful and need to be avoided in certain situations. This model might also be applied to cases of AWHPD. For individuals fearing panic-like sensations, the same physiological fear response might lead to interoceptive conditioning and the development of avoidance behavior even though full-blown panic attacks are not experienced. Individuals with AWHPD in the absence of subclinical panic may also possess a specific psychological vulnerability to interpret unexplained physical sensations as dangerous. In this case, unwanted bodily sensations other than panic could lead to the same cycle of anxious apprehension and behavioral avoidance seen in PDA.

ASSESSMENT

What Should be Ruled Out?

Before PDA or AWHPD is diagnosed, the clinician should rule out any medical conditions that might account for the client's feared bodily sensations. For example, certain thyroid and vestibular problems can cause panic-like sensations (see Panic Disorder chapter, this volume). Similarly, the clinician should determine that the somatic sensations associated with the client's Agoraphobia are not merely due to the effects of a substance. If the client uses psychoactive substances, careful assessment of when the physiological effects of these substances were experienced is necessary. This allows the clinician to determine whether the direct effects of the substance can account for the avoidance behavior.

Clinicians must also determine that a client's avoidance behavior is not better accounted for by another DSM-IV diagnosis. As reviewed above, epidemiological survey results may have been confounded by misdiagnosed cases of Agoraphobia. Specific Phobia and Social Phobia are easily confused with PDA and AWHPD because all involve behavioral avoidance of *in vivo* situations. However, the defining feature of Agoraphobia is that fear and avoidance of certain situations stems from a fear that escape would be difficult or embarrassing or that help would be unavailable in the event of a panic attack or other unwanted bodily sensations. If an individual's avoidance is driven by a fear of negative evaluation or fear that he or she might behave in a way that other people would scrutinize, an alternative diagnosis of Social Phobia (Social Anxiety Disorder) should be considered. If the situational avoidance is confined to specific types of situations or objects, a diagnosis of Specific Phobia (formerly Simple Phobia) may be more appropriate. An individual might avoid various public places due to contamination fears or other intrusive obsessive thoughts, but this avoidance behavior would be best conceptualized as a symptom of Obsessive-Compulsive Disorder. Sometimes individuals suffering from Posttraumatic or Acute Stress Disorder will avoid certain places, people, or activities because these stimuli remind them of the traumatic event or because they fear additional harm from the environment. From a diagnostic perspective, this form of behavioral avoidance is usually subsumed under the "avoidance of stimuli" criterion required for both stress disorder diagnoses and does not warrant a separate AWHPD diagnosis.

What is Involved in Effective Assessment?

In clinical settings, Agoraphobia is often detected at the initial diagnostic interview. Structured diagnostic interviews such as the DIS (Robins et al., 1981) and the CIDI (World Health Organization, 1990) have been developed for administration by lay interviewers, but this practice may not always yield a valid diagnosis. Ideally, diagnosis is obtained with a semi-structured clinician administered diagnostic interview so that differential diagnosis issues can be explored fully. Empirically supported semi-structured interviews such as the Anxiety Disorders Interview Schedule for DSM-IV (ADIS-IV; Brown, Di Nardo, & Barlow, 1994) allow the clinician to systematically assess the function of reported anxiety symptoms and avoidance behavior. This information prepares the clinician to conduct a functional analysis of the individual's ideographic cognitions, interoceptive avoidance, situational avoidance, and subtle avoidance and safety behaviors that maintain the disorder (see Barlow, 2002).

Additional information regarding specific cognitive and behavioral features of Agoraphobia can be obtained with self-report questionnaires. Widely used self-report measures include the Anxiety Sensitivity Index (ASI; Reiss et al., 1986), the Anxiety Control Questionnaire (AnxCQ; Rapee, Craske, Brown, & Barlow, 1996), the Body Sensations Questionnaire and the Agoraphobic Cognitions Questionnaire (BSQ and ACQ; Chambless, Caputo, Bright, & Gallagher, 1984), and the Mobility Inventory for Agoraphobia (MI; Chambless, Caputo, Jasin, Gracely, & Williams, 1985). Complete descriptions of these and many other measures, along with reviews of available psychometric data, are available from Antony (2001).

What Assessments are Not Helpful?

Personality inventories such as the Minnesota Multiphasic Personality Inventory (MMPI) and its revision, the MMPI-2, are not particularly useful in the assessment of Agoraphobia. Neither projective psychological tests, including the Rorschach

inkblot test and the Thematic Apperception Test (TAT), nor neuropsychological tests such as those found in the Luria-Nebraska and Halstead-Reitan batteries are useful in the diagnosis of Agoraphobia. Medical markers or tests for this condition are not available.

TREATMENT

What Treatments are Effective?

Situational exposure has been central to the psychological treatment of agoraphobic individuals for decades. Although variations in procedures exist, effective exposure involves repeated contact with the avoided situation while the client experiences moderate levels of anxiety (Gelder, 1991). See Hazlett-Stevens and Craske (2003) for a description of in vivo exposure procedures. Teaching clients how to apply progressive relaxation in agoraphobic situations may also prove beneficial, and this Applied Relaxation approach was about as effective as in vivo exposure alone (Öst, Westling, & Hellström, 1993).

When Agoraphobia is present in the context of PDA, treatment typically begins with educational information about the physiology of panic and the harmless nature of the fight or flight response. Cognitive restructuring addresses misappraisals of feared bodily sensations, and the client is encouraged to engage in activities within and between sessions that induce their feared interoceptive cues. Finally, a hierarchy of agoraphobic situations is constructed, and treatment continues with systematic live exposure to each of these feared situations for the remainder of treatment.

What are Effective Self-Help Treatments?

A number of self-help books containing these cognitive-behavioral elements are available to the public. Many of these resources are designed for people suffering from PDA (see Panic Disorder chapter in this volume). However, a few books target Agoraphobia symptoms exclusively:

- Pollard, C.A., & Zuercher-White, E. (2003). *The agoraphobia workbook: A comprehensive program to end your fear of symptom attacks*. Oakland, CA: New Harbinger Publications, Inc.
- Eisenstadt, M. (2003). *Freedom from agoraphobia*. Anchorage, AK: Mark Eisenstadt, M.D.
- Weekes, C. (1990). *Agoraphobia: Simple effective treatment*. New York, NY: HarperCollins Publishers.

One additional self-help resource might be beneficial to friends and family members of people suffering from Agoraphobia:

- Chope, R.C. (2001). *Healing options for you and the agoraphobic in your life*. Oakland, CA: New Harbinger Publications, Inc.

While much empirical research supports the practice of therapist-administered cognitive-behavioral treatment for Agoraphobia, bibliotherapy approaches have been studied much less. Ghosh and Marks (1987) administered a self-help book instruction coupled with only three therapist contacts to treat mild agoraphobic avoidance. Results suggested that this treatment approach was as effective as therapist-guided treatment in less severe cases of Agoraphobia. However, these results do not seem to generalize to more severe agoraphobic individuals, possibly due to difficulties engaging in self-guided exposure exercises (Holden, O'Brien,

Barlow, Stetson, & Infantino, 1983). Self-administered bibliotherapy appears to be an effective treatment approach in some cases of PDA as well (Gould, Clum, & Shaprio, 1993).

Further information about Agoraphobia can be found on the following websites:

- <http://www.adaa.org/AnxietyDisorderInfor/PanicDisAgor.cfm>
- <http://www.nimh.nih.gov/HealthInformation/panicmenu.cfm>
- <http://www.anxietynetwork.com/pdhome.html>
- <http://pages.infinet.net/drnayman/agorapho.htm>

What are Effective Therapist-Based Treatments?

Barlow and colleagues (Craske & Barlow, 2001; Craske, Barlow, & Meadows, 2000) have developed a widely used cognitive-behavioral therapy for PDA known as Panic Control Treatment (PCT). This therapist-based treatment has received much empirical support (see Craske, 1999 and Barlow, 2002 for reviews). However, recent research suggests that situational exposure targeting agoraphobic avoidance might not be necessary for effective treatment of PDA (Craske, DeCola, Sachs, & Pontillo, 2003). See Panic Disorder chapter (this volume) for more information about cognitive-behavioral treatment approaches for PDA. Therapist-guided exposure was moderately effective for severe Agoraphobia when administered over 4–8 weeks (Holden et al., 1983). Öst and colleagues found that their Applied Relaxation (AR) approach coupled with self-exposure instructions was also an effective treatment for PDA agoraphobic avoidance (Öst et al., 1993).

What is Effective Medical Treatment?

Pharmacotherapy for Agoraphobia has been widely studied in the context of PDA. Tricyclic antidepressants such as imipramine have effectively treated agoraphobic avoidance symptoms (Lydiard, Brawman-Mintzer, & Ballenger, 1996). More recently, several selective serotonin reuptake inhibitors (SSRIs) have received empirical support in the treatment of PDA (see White & Barlow, 2002 for a review). Benzodiazepines were the first approved for PDA treatment, but these medications have the potential to undermine effective situational exposure when combined with cognitive-behavioral therapy.

Other Issues in Management

Many theoretical and practical issues remain unresolved. The role of panic attacks and feared anxiety sensations, while clear in cases of PDA, might not always explain the development of AWHPD. Some researchers have suggested that the pathway leading to Panic Disorder differs from the pathway leading to Agoraphobia (Wittchen et al., 1998). Alternatively, comprehensive PDA models (e.g., Barlow, 2002) might be extended to explain how fears of unexplained bodily sensations lead to AWHPD clinical presentations involving sensations other than panic. Nevertheless, careful assessment of any feared sensations associated with agoraphobic avoidance is crucial. The clinical nature and treatment of AWHPD needs to be further explored, particularly in medical settings where individuals experiencing IBS, headaches, and other physical conditions that might lead to Agoraphobia would likely present for treatment.

How Does One Select Among Treatments?

Exposure-based cognitive-behavioral therapy treatments are a good choice for individuals willing to confront their feared situations. This treatment can be quite

difficult for severely agoraphobic individuals. Therefore, clinicians must assess whether the individual can endure the distress involved in exposure. Individuals at a heightened risk for suicide may need additional intervention before exposure is attempted. In cases involving domestic violence, avoidance behavior that appears to be Agoraphobia might be serving an adaptive self-protective purpose. Exposure treatment may also be inappropriate for individuals suffering from comorbid psychosis, mania, or dementia. As with all psychological disorders, the potential for side-effects and medical contraindications should be addressed with individuals considering medication treatment.

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