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DEDICATION

To my family
with sincere thanks
for their patience, love and encouragement
during the writing of this thesis.

DECLARATION

I declare that this thesis is my own unaided work. It is submitted for the degree of Master of Science in the University of the Witwatersrand, Johannesburg. It has not been submitted before for any other degree or examination in any other university.

Signed: Lesley Clarence

Date: 14-6-98

ABSTRACT

Physiological anxiety symptoms are experienced as an overwhelming panic attack when the person cognitively interprets them as such. Fear is the emotion initiating the cognitive perception of personal doom which becomes largely influential on the future process of a sufferer's panic disorder. This study used a multimethod research design to investigate the role of fear in panic disorder sufferers' pre-diagnostic help-seeking. Thirty three already diagnosed panic disorder sufferers participated voluntarily. Their help-seeking experiences were quantified in terms of the number and type of treatments sought and their individual financial costs. The directive influence of individual fears' clearly emerged. The narrative data, accessed via semi-structured individual interviews, consistently clustered into positive and negative consultation dynamics. Negative treatment experiences unilaterally reinforced subjects' fears, reciprocally entrenching their panic disorder. Positive treatment experiences consistently disconfirmed subjects' fears which left them energized with a reduced sense of helplessness. These epitomized the beginning of healing. Recommendations are made for future researchers to operationalize this data into clinically accessible diagnostic instrumentation.

THE ROLE OF FEAR IN THE LENGTH, PROCESS AND COST OF PRE-DIAGNOSTIC ILLNESS BEHAVIOUR IN PANIC DISORDER PATIENTS

FEAR - THE COGNITIVE LINK AND CONVERTING FACTOR BETWEEN THE EFFECTIVE AND INEFFECTIVE MANAGEMENT OF PANIC DISORDER

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A dissertation submitted to the Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, in fulfilment of the requirements for the degree of Master of Science (Med).

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Diagnosis is further complicated by the many patients who have recurrent panic attacks but do not meet the full criteria for panic disorder. Research reveals that these simple panic attacks have a relatively high lifetime prevalence, reportedly 3,6% in the general adult population (Klerman, Weissman, Quellette, Johnson & Greenwald, 1991). It also seems that simple panic attack sufferers fall, intermediately, between those with full-blown panic disorder and those with other psychiatric disorders, on measures of impaired quality of life and medical service utilization (Klerman et al., 1991). It seems appropriate that panic attacks which do not meet the criteria for full blown panic disorder should be considered as part of a differential diagnosis.

Despite these difficulties, a comprehensive study of diagnostic procedures showed properly trained and equipped primary care physicians able to correctly diagnose the disorder in 100% of cases (Von Korff et al., 1987).

1.2 Diagnostic questionnaires

Researchers have suggested the use of relatively direct interviews, aimed at the specific symptoms of specific disorders, as useful in promoting effective and efficient psychiatric diagnosis (Paykel & Priest, 1992). The classificatory advances, and associated symptom checklists, of the DSM 111 facilitated the creation of such a bridging instrument, in the form of the National Institute for Mental Health's (NIMH) Diagnostic Interview Schedule (DIS) (appendix 1). This questionnaire offers a structured interview format aimed at simplifying the many tasks involved in making a diagnosis. It can, equally, be used by lay

these classifications, especially to a primary care setting where the majority of psychiatric patients are first seen (Eisenberg, 1992).

Primary care practitioners are faced with a multitude of different types and intensities of illnesses and are regularly forced to make critical decisions (Katon, 1993). Practitioners appear to adequately identify psychiatric patients. The shortcoming is in the **differential diagnosis** of the condition and ensuring the proper and most effective treatment plan (von Korff, Shapiro, Burke, Teitlebaum, Skinner, German, Turner, Klein & Burns, 1987).

1.1.1 Irregular presentation

Panic disorder both presents irregularly and mimics many other conditions. The somatic symptoms of panic disorder could equally indicate an organic condition such as mitral valve prolapse, hypoglycemia, hypothyroidism, temporal lobe epilepsy, as well as the abuse of or withdrawal from alcohol, caffeine or other recreational drugs (Katon, 1993). It is important that a practitioner, while investigating these possible causal conditions, is receptive to the possibility of a panic disorder diagnosis.

It is, likewise, important to be sensitive to other fairly common somatic symptoms of panic disorder not included in traditional diagnostic criteria, such as headaches, diarrhoea, insomnia, chronic fatigue, coldness of hands, thoughts of suicide, intrusive thoughts and ruminations (Forrest & Ricketts, 1995), hence, avoiding the untimely dismissal of a panic condition.

Table 1 - Diagnostic criteria for Panic disorder

a. At some time during the disturbance, one or more panic attacks (discrete periods of intense fear or discomfort) have occurred that were (1) unexpected, i.e., did not occur immediately before or on exposure to a situation that almost always causes anxiety, and (2) not triggered by situations in which the person was the focus of others' attention.
b. Either four attacks (as defined above) have occurred within a four-week period, or one or more attacks have been followed by a period of at least one month of persistent fear of having another attack.
c. At least four of the symptoms listed in Table 1.1 occurred during at least one of the attacks.
d. During at least some of the attacks, at least four of the symptoms developed suddenly and increased in intensity within ten minutes of the beginning of the first symptom noticed in the attack.
e. It cannot be established that an organic factor initiated and maintained the disturbance (e.g. amphetamine or caffeine intoxication, hyperthyroidism).
f. The absence of agoraphobia

Table 1.1 - Symptoms associated with Panic attacks

- shortness of breath (dyspnea) or smothering sensations
- dizziness, unsteady feelings or faintness
- palpitations or accelerated heart rate (tachycardia)
- trembling or shaking
- sweating
- choking
- nausea or abdominal distress
- depersonalization or derealization
- numbness or tingling sensations (paresthesias)
- flushes (hot flushes) or chills
- chest pain or discomfort
- fear of dying
- fear of going crazy or of losing control

Adapted from Diagnostic and statistical manual of mental disorders, 4th ed. Washington, D.C.: American Psychiatric Association, 1994: 397-403.

1.1 Delayed Diagnosis

Despite these precise diagnostic criteria many patients remain undiagnosed, or are incorrectly diagnosed, although they frequently visit medical and mental health practitioners (Forrest & Ricketts, 1995). This raises questions regarding both the application and suitability of

so that a sound understanding of the condition requires the contributions of information from all associated subsystems (Waring & Foreman, 1988).

Under the rubric of a biopsychosocial, or systems, approach, which recognizes the complex reciprocal interaction of hereditary, biological, cognitive, psychological, behavioural and social factors, a set of specific diagnostic criteria, as provided by DSM III, and revised in DSM IV (table 1), is invaluable. It lends order to a potentially overwhelming and diffuse array of symptoms and facilitates communication amongst professionals and lay people alike. Diagnosis on the basis of discrete criteria from a biopsychosocial perspective epitomizes carving a distinction or creating an immediate reality with which to work (Keeney, 1983). This effect infiltrates the individual's entire systemic arrangement through the cybernetic interaction of all associated subsystems, thus initiating change. Although specific, discrete and sometimes considered inadequate (Paykel & Priest, 1992), clear diagnostic criteria offer a useful starting point to healing.

CHAPTER 1

CLASSIFICATION AND DIAGNOSIS OF PANIC DISORDER

Prior to 1980 panic disorder and general anxiety were combined under the heading of anxiety neurosis in recognized classificatory systems. Panic disorder was given official status as a separate psychiatric syndrome in the diagnostic nomenclature of the widely recognized Diagnostic and Statistical Manual of Mental Disorders III (DSM III) in 1980.

Perhaps most influential on the creation of a separate diagnostic syndrome for panic disorder was its idiosyncratic presentation. Specifically, panic disorder presents as sudden, discrete and episodic bursts of anxiety, accompanied by a relatively consistent array of somatic symptoms and a strong sense of impending doom. This condition does share many predisposing, precipitating and reinforcing characteristics with other anxiety disorders and often occurs simultaneously with generalized anxiety disorder, major depression and substance abuse conditions (Weinstein, 1995).

The advent of the DSM III category of panic disorder in 1980 provided researchers, clinicians and sufferers with a whole new ethos and initiated an energetic wave of research. A large and interesting bank of knowledge quickly amassed, reflecting the many different theoretical stances of the researchers. This has culminated in panic disorder being recognized as a complex biopsychosocial phenomenon

The secondary aim of the study is to suggest the use of this understanding, to more sensitively recognize and diagnose panic disorder.

A multimethod research design, consisting of both quantitative and qualitative techniques, will be used to investigate the complex pre-diagnostic help-seeking behaviour of panic disorder sufferers. Both methods have been chosen to best represent the biopsychosocial focus of this study which recognizes the uniqueness of each individual's experience as well as the existence of social regularities. The duration and cost of the pre-diagnostic help-seeking period, the number and type of practitioners consulted, the type of symptoms experienced, the presentation of symptoms to practitioners and the subjects' expetiences of each treatment received will be quantified on self-rating scales. Each subject's unique experience of his panic condition will also be qualitatively accessed during a semi-structured interview. The quantitative and qualitative data will overlap, each substantiating and adding to the results of the other. The planned methodology is discussed in detail in chapter 6.

Chapters 7 details the quantitative results mentioned above. These results are discussed in chapter 8 and related to the proposed hypotheses. Chapter 9 relates the qualitative story of this research study.

Chapter 10 concludes the investigation with an overview of the study, outlining its observations and suggesting possible directions for future research.

Chapter 5 is devoted to panic disorder sufferers' help-seeking behaviour. Panic disorder sufferers consult many and different medical practitioners and other health related services regularly (Katerndahl & Realini, 1995). Despite this, they typically endure a lengthy period of ineffective treatment searching before they are correctly diagnosed (von Korff & Eaton, 1989). During this time, sufferers often undergo many unnecessary and unpleasant medical investigations, at huge psychological, social and financial costs (Markowitz, Weissman, Ouellette, Lish & Klerman, 1989). It has been suggested that these ineffective treatment experiences can easily become part of, and reinforce, the negative and defensive behavioural cycles typical of panic disorder (Katon & Vitaliano, 1987). A correct and efficient diagnosis empowers subjects to begin regaining control of their lives and their functional efficacy (Weekes, 1983). It is suggested that a primary construct underlying the lengthy and costly process of pre-diagnostic help-seeking behaviour in panic disorder sufferers is their irrational but overwhelmingly threatening **fear**. It is anticipated that subjects' fear cognitions will directly influence their illness behaviour.

The prevalence and negative infiltration of panic disorder into sufferers' lives is sufficient to reinforce the critical need to investigate and better understand this condition. This need is further exacerbated when considering the extended and often psychologically, physically, and financially crippling process of help-seeking these sufferers endure before they acquire an accurate diagnosis and effective treatment plan. The aim of this study is firstly to glean a better understanding of the phenomenology of panic disorder sufferers' help-seeking behaviour, specifically the relationship between sufferers' particular fear and the biological, psychological, financial and social areas of his condition.

support group provided most of the subjects used in this study as it offered an accessible network of diagnosed sufferers.

The nature of panic disorder, and its irregular progression and infiltration into sufferers' lives, is discussed in chapter 3. Panic attacks, their associated anxiety and the accompanying sense of doom, or fear (Kaplan & Sadock, 1988) rapidly infiltrate and control a sufferer's entire life (Weinstein, 1995). Irregular behavioural manifestations develop quickly as the sufferer tries to avoid any situation that might trigger another attack (Sheehan, 1982a) and, simultaneously, to get some help, professional or other, in coping with this bizarre condition (Walker & Ashcroft, 1989). Fear is both a precipitating and reinforcing variable in this condition. Trying to alleviate their fear through avoiding trigger situations paradoxically reinforces it. Sufferers become petrified of their ever-present fear. This fear of fear ensnares them in ineffective avoidance behaviours which superficially create an illusion of dealing with their problem.

Chapter 4 provides background information on the aetiology of panic disorder from the cognitive behavioural aetiological model as it is the most relevant to the method and hypotheses of this study. The central tenet of this model is that panic disorder develops in accordance with a subject's cognitive interpretation of his panic attacks (Waring & Foreman, 1988). This study follows this tenet and proposes specifically that sufferers' fear cognitions direct their subjective interpretation of their panic attacks and hence the development of their panic disorder. Panic disorder sufferers' fear cognitions tend to cluster around the fear of dying, going mad or losing control to the point of total embarrassment in public (Hibbert, 1984).

Chapter 2 provides a brief review of research on the prevalence of panic disorder while simultaneously outlining the difficulties in establishing prevalence parameters for a condition like panic disorder, which are largely due to its episodic and irregular presentation and idiosyncratic infiltration and impact on each sufferer's life. These considerations probably account for the discrepancy amongst recorded measures of its incidence which seem to vary from 2% (Lloyd & Jenkins, 1995) to 8% (Gournay, 1995). Even cautiously interpreted, prevalence data emphasizes the urgent need to better understand this debilitating condition.

Although there are no formal prevalence parameters for South Africa, some associated information is startling. Pilot prevalence investigations in Lesotho, Africa reported an alarmingly high occurrence of panic disorder. This is contradictory to traditional beliefs that psychiatric conditions are seldom evidenced in developing countries (Hollifield, Katon, Spain & Pule, 1990). Sociodemographic surveys regularly observe positive correlations between emotional disturbances and acculturation processes, or the realignment of societal norms (McGolderick, Pearce & Giordano, 1982). On this basis twentieth century South Africa represents a high risk population for panic disorder, a fact harshly reinforced by the development of a national panic disorder support group which was initiated in Johannesburg, South Africa, in September 1995 with an immediate voluntary caucus of 45 members. By January 1997, only fifteen months after its inception, this figure had increased to 3 000 members and the group had 35 branches nationwide. Public statements in popular magazines and local media broadcasts empowered many silent sufferers to recognize their condition and seek help openly. This

INTRODUCTION

Panic disorder is defined by a constellation of psychophysiological, cognitive, emotional and behavioural responses in a human organism that are classified as a mental disorder only when they occur together, repeatedly, over time (Baker, 1992). Although sharing high levels of pervasive and frequently uncontrollable anxiety typical of generalized anxiety disorder, panic disorder is unique, both in its presentation and its subjective experience. Panic disorder presents as the repeated occurrence of panic attacks, leaving the sufferer in a state of extreme and enduring fear. He is afraid of having another debilitating attack, afraid of what the attacks are and afraid of the dreadful effect they could have. In fact, the predominant mood of panic disorder sufferers is **fear** (Leaman, 1992). Although the fear concomitant of panic disorder is widely recognized and forms part of the diagnostic requirements, the subjective impact of sufferers' fears on the process of their disorder has, to date, not been investigated. It is this that forms the main focus of the present study, specifically the role of fear in panic disorder.

These anxiety episodes or panic attacks occur out of the blue, have no obvious stimulus and comprise severe physiological anxiety symptoms accompanied by an overwhelming sense of imminent physical, emotional or social disaster (Rachman, Levitt & Loptka, 1987). The psychiatric classification and diagnosis of panic disorder requires that these symptoms occur simultaneously within a specific time frame. This is discussed in chapter 1 of this study.

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unusual and unpredictable physiological and cognitive fear symptoms of panic attacks. Their usual sickness frameworks and behavioural repertoires are inadequate (Clark, Beck & Beck, 1994). Often, the only cue to the intense experience of a panic attack is the internal arousal the sufferer starts to feel (Beck et al., 1992). Panic disorder patients develop an acute sensitivity and a vigilance around these interoceptive stimuli (Barsky, Cleary, Sarnie & Ruskin, 1994) and also tend to misinterpret them as dangerous and overestimate their subjective personal risk (Schmidt, Jacquin & Telch, 1994). The experience is one of imminent doom. The human reaction is to fight or flee but he does not know to where or from what to flee. The terror of these minutes quickly manifests in altered behavioural patterns. These behaviour patterns are reactive on the unexpected and unfathomable physiological fear response, and often initiated during a period of cognitive disorientation (McFayden, 1989) so that the ensuing behaviour typically appears irrational.

The physiological symptoms of arousal, the perceptual processes which hyperfocus on these symptoms and the cognitive appraisal of them as dangerous, interact reciprocally to maintain an anxiety state. This anxiety quickly develops into pervasive anticipatory fear which seems to be functionally related to the development of a panic disorder (Leaman, 1992). Anxiety further restricts cognitive flexibility and exhausts the human person (Levitt, 1971). Panic attack sufferers quickly find that their daily routines require sustained conscious effort. This is doubly difficult because their mental energies have become internally focused and preoccupied with attending to their attacks. Overtly, this manifests in lethargy and disinterest in previously enjoyed activities, while the sufferer's focus is absorbed in coping with his pervasive fear.

The four stages of this sequenced stages model depict the complex psychophysiological, cognitive, emotional and behavioural components integral to panic disorder (von Korff & Eaton, 1989). These criteria must be recognized as broad generalizations. The course of a panic disorder is irregular within the boundaries of these identified stages, mainly because it depends on the interaction of a number of different factors (Durham, 1989). These influencing factors would include the degree to which the sufferer avoids situations believed to be responsible for triggering off attacks, the reaction of significant others, the level of general tension experienced from day to day, and his ability to develop adaptive coping strategies for reducing levels of arousal which would assist him appraise internal sensations in a more realistic manner (Beck et al., 1992). Central to all these interacting subsystems is the sufferer's initial cognitive interpretation of the attack and the degree of his ensuing **fear**. Fear is the emotion that gives rise to the cognition, that gives rise to the behaviour, all of which interactively monitor the severity of the panic condition.

3.2.2 *Insidious infiltration of panic disorder into sufferers' lives*

The impact that panic disorder has on a sufferer's life goes far beyond the number of panic attacks he experiences. The sense of helplessness and uncontrollability he feels during an attack induces acute and intense fear. It is very difficult for sufferers to make sense of the

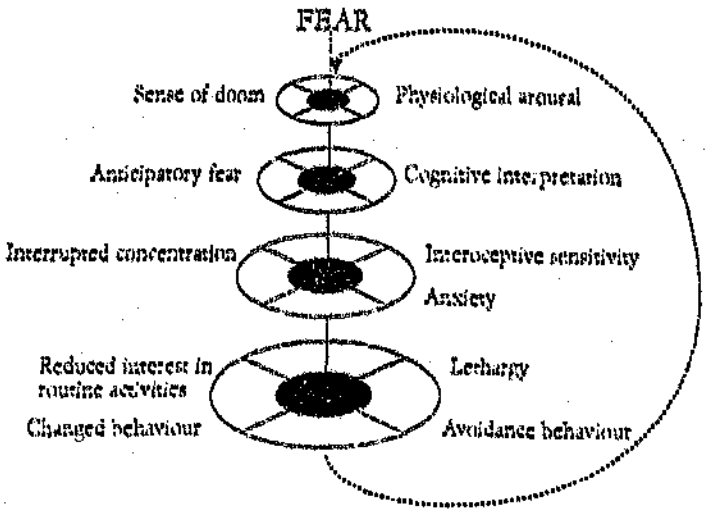
3.2 The development of panic disorder

3.2.1 A sequenced stages of illness model

There are widespread individual differences in the way simple panic attacks develop into a fully-blown panic disorder. However, considerable similarities have been noted, making the use of descriptive models possible. A sequenced stages of illness model has been postulated, and is widely accepted, as an appropriate explanation of the process of a panic disorder (McFayden, 1989). This model typically identifies four stages:

1. The disorder begins with one or more sudden, unexpected full-blown panic attack(s).
2. These events are **construed** as highly dangerous.
3. Following the early spontaneous attacks the person becomes **afraid** of and, therefore, oversensitive to, internal physiological sensations.
4. The sufferer develops strategies to avoid, escape or minimize the feared effects of panic attacks.

Figure 1 - Fear - the cognitive link, central to and influential on the process of panic disorder



emotion was experienced as realistic, appropriate and manageable. The event is quickly dismissed. Likewise, panic disorder sufferers who have learnt to control their condition, interpret the physiological cues as tiresome, but not dangerous, which devoids an attack of its panic or fear element. It is experienced simply as a brief period of unpleasant somatic sensations (Barlow & Cerny, 1985).

Other people, however, cannot make such rational interpretations of this unpredicted anxiety state. Those minutes of high emotional arousal and intense fear induce, instead, a sense of loss of control and helplessness (Rachman, Levitt, Lopatka, 1987). This results in a period of cognitive disorientation. During those few debilitating seconds of extreme arousal, higher level reflective processes become dissociated from lower level automatic processes (McFayden, 1989). A non-pathological explanation of this autonomic arousal and intense fear is unavailable and the event is experienced as catastrophic. This primary alarm reaction, or fear response, is then believed to indicate the imminent danger of a physical or emotional collapse and is experienced as a complete panic attack. Panic attacks can thus be described as the clinical manifestation of the primary fear emotion, comprising unexpected physiological arousal, and its catastrophic interpretation. Panic has been described as unadulterated **fear** (Barlow & Cerny, 1985).

The rationally inappropriate **fear emotions** experienced during the panic attack develop into **fear perceptions** which focus on the most severe and threatening human physical and emotional phenomena - phenomena which are all associated with human helplessness. These perceptions seem to consistently cluster into three groups: a fear of dying, going mad or losing control in public (Hibbert, 1984).

Anxiety restricts cognitive flexibility or functioning and typically interrupts the person's immediate thought processes, forcing their attention away from the task at hand to an internal self-evaluative focus (Barlow & Cerny, 1985). At this early stage of the condition, the person enduring a panic attack's focus becomes interoceptive. Unable to explain, understand or cope with the experience renders the person helpless, with a sense of uncontrollability (Zuercher-White, 1995). A panic attack seldom continues longer than ten minutes and subsides as unexpectedly as it started. The person is left exhausted, scared and confused (Zane, 1989).

3.1.1 The cognitive component

Not every experience of an unexpected arousal reaction develops into a full-blown panic attack. The key, from a cognitive behavioural perspective, lies in the interpretation of the emotion or of the physiological arousal cues. This interpretive process determines the person's emotional and behavioural reactions (Beck, Laude & Bohnert, 1974). A more detailed discussion of the cognitive interpretation of a panic attack is given in chapter 4, with only a qualitative description here.

Some people can quickly associate physical cues with an external event. They can identify the smoky atmosphere in a restaurant as causal to their sensation of a tightening chest and suffocating feeling. This person will initiate an appropriate flight or fight response such as requesting a different table or opening a window. This reaction will not significantly interrupt his immediate attention focus or shift his concentration towards his internal physiological activities. His fear

> if something really terrible was about to happen, or that I was dying but wasn't ready ...I had a strong urge to run, but didn't know where or from what (Leaman, 1992, p.128)."

A panic attack is a sudden and discrete period of intense arousal frequently accompanied by a sense of imminent danger and an urge to escape. It mimics the primary human alarm reaction to a threat, manifesting in high physiological arousal and negative affect, originally designed to enhance our capacity to initiate a flight or fight response. In the grip of the all consuming arousal of a panic attack, the individual can seldom identify a realistic danger cue or threat, so that dispelling this seething cauldron of arousal through appropriate flight or fight is impossible.

Human feelings are a two-phase phenomena requiring the initial physical symptoms of a primary emotion, followed by the person's definition of these physiological cues (Beck, Laude & Bohnert, 1974). A panic attack begins as an unexpected fear emotion, characterized by an adrenalin surge and most commonly manifesting in physiological arousal symptoms such as shaking, heart palpitations, sweating and shortness of breath. Defining this untimely fear emotion is difficult. The conditioned cognitive interpretation of a fear emotion in human beings is danger or doom (Beck, Sokol, Clark, Berchick & Wright, 1992). The physiological symptom of this primary fear emotion designating a cognitive interpretation of danger sum to an intense feeling, which the person cannot easily rationalize or justify, and experiences as overwhelming anxiety (Rachman, Levitt & Lopatka, 1987).

CHAPTER 3

THE NATURE AND COURSE OF PANIC DISORDER

3.1 The nature of a panic attack

The single most recognized identifying characteristic of panic attacks is their unexpectedness and unpredictability. A person often experiences an attack, especially a first attack, in what he would have described as benign, even relaxed, conditions, such as holidaying with loved ones or pottering in the garden.

The terrifying subjective experience of a panic attack is poignantly captured in the following letter from a sufferer:

> "Suddenly, unexpectedly, for no immediate apparent reason, my body was overwhelmed by a surge of elemental panic. Everything seemed to race out of control before I could collect my mind to cope with the onslaught...my mind was so overcome, I could feel my vision go off. Everything faded out and became detached, and my heart felt like it wanted to jump out of my chest. I felt very dizzy and lightheaded. My balance got unsteady. My legs turned to jelly. The fluorescent lights seemed intensely bright and I seemed acutely sensitive to noise. As I felt beads of sweat breaking out on my skin, I noticed I was trembling and having difficulty controlling the shaking. I was also acutely short of breath and the tightness in my chest worsened the urge to gasp for air. I felt that if I couldn't get out quickly, I would surely suffocate. The sheer terror and mental panic were beyond anything I could relate to. It was as

2.3 *In sum*

Although these results and statistics must be recognized as a still snapshot from the unfolding progression of the disorder, they are, nonetheless, startling. Panic disorder is clearly a prevalent condition. Recognition of the limitations of prevalence research clearly highlights the need for broad based biopsychosocial investigations of the disorder.

- the prevalence of limited-symptom attacks was 2,2%.

A consistent finding across most prevalence studies is the predominance of panic disorder amongst females, younger persons and separated or divorced people (Weinstein, 1995) and that panic disorder tends to peak in the 25 - 44 year age group (Baker, 1992).

Hollifield et al. (1990) conducted the first investigation of the occurrence of panic disorder in a developing country. Their results indicate that 11% of 356 subjects investigated met the diagnostic criteria for panic disorder. This is a significantly higher prevalence than recorded in the United States of America and contrary to the common perception that developing countries are almost without psychiatric conditions encountered in Westernized nations.

Most mental illness is treated in primary care settings, suggesting the population of general practitioners' patients as one worth investigating to indicate the prevalence of panic disorder. It has been estimated that a general practitioner with a list size of 2 500 patients identifies approximately 300 cases with a non-psychotic mental illness per year (Lloyd & Jenkins, 1995). Panic disorder patients are said to comprise as many as 27% of those who consult general practitioners with psychiatric symptoms (Kaplan & Sadock, 1988). It may then be estimated that approximately 81 persons suffering from panic disorder consult a general practitioner with a list size of 2 500 annually.

variable pattern of the condition within established descriptive frameworks.

Prevalence surveys to date have largely been cross-sectional, fixed time measurements (Baker, 1992). Bearing the above contingency variables in mind, it is clear that a nominal head count alone will provide only a limited perspective on this disorder. Differences in prevalence rates could equally be measures of differences in the incidence of the disorder, in the duration of severe episodes and in their probability of recurrence (van Korff & Eaton, 1989).

2.2 *Brief review of prevalence research*

Despite the above limitations, prevalence research does indicate the significant frequency of panic disorder in the general population. Estimates of the life time prevalence of the disorder range from 2% (Lloyd & Jenkins, 1995) to as high as 9% (Forrest & Ricketts, 1995).

A detailed and informative prevalence survey was conducted by the National Institute for Mental Health in five independent sites (Baker, 1992). Panic disorder sufferers were identified by their responses to an adaptation of the DIS questionnaire, which was discussed in chapter 1. These researchers identified three levels of panic disorder and reported prevalence data accordingly. Their results can be summarized as follows:

- the lifetime prevalence of panic disorder in the general population was 3,8%;
- the prevalence of panic attacks in patients not meeting the full criteria for panic disorder was 5,6%;

CHAPTER 2

PREVALENCE OF PANIC DISORDER

Prevalence surveys form part of epidemiological research, specifically investigating the distribution of a disorder within the population (von Korff & Eaton, 1989). The official recognition of panic disorder in DSM III gave impetus to the need to estimate the actual incidence and distribution of this disorder. As a result, during the last two decades, epidemiological researchers have been preoccupied with the difficult problem of counting the number of panic disorder cases in the community or with prevalence surveys.

2.1 Difficulties in prevalence research

The prevalence of panic disorder is difficult to measure because of the many "closet" or undiagnosed, as well as misdiagnosed, cases and because of the inconsistent presentation of this chronic episodic condition (Dilsaver, 1989). Sufferers often have intensely severe periods with attacks more than daily and then go into sudden remission experiencing fewer attacks (Katerndahl & Realini, 1993). This is further complicated by the irregular staged development of the psychological and behavioural symptoms which follow the initial panic attacks (McFayden, 1989). Panic disorder typically begins with the occurrence of panic attacks, followed by each sufferer's idiosyncratic cognitive appraisal of his symptoms and sensitization to them. This usually initiates reactive avoidance strategies which become self-maintaining. The process of panic disorder is discussed in detail in chapter 3. For present purposes, it is simply noted to indicate the

interviewers and professionals and seems to be a reliable detector of panic disorder (Robins, Helzer, Croughan & Ratcliff, 1981).

Simpler and shorter diagnostic questionnaires (appendix 2) have subsequently been developed and are widely utilized, especially in community projects, aimed at the early detection of undiagnosed panic disorder sufferers.

These and other instruments, sensitively employed, could help organize primary practitioners' diagnostic dilemmas and reduce the large number of incorrectly diagnosed, or non-diagnosed, cases of panic disorder (Lloyd & Jenkins, 1995).

1.3 In sum

The delineation of discrete classificatory criteria, used with wisdom and empathy, could be an important step towards alerting professionals and the general public to the occurrence of panic disorder, thus improving the early detection of sufferers, the provision of effective treatment and destigmatizing the condition.

and helps explain why panic ends or anxiety decreases over time. Cognitive behavioural therapy for panic disorder aims to stimulate the mechanisms of this negative feedback loop.

4.1.2 First and second stage fear model

Weekes (1983) describes the process in terms of first and second stage fear. The initial part of a stress reaction consisting of mainly somatic sensations, such as a thumping heart, chest pain, giddiness, sweating, agitation and shortness of breath, are described as the "first fear" reaction. These symptoms are seen as self-curative given time and rest. Weekes places great emphasis on the "second fear" stage which she characterizes as a sense of bewilderment, alarm and flashes of almost incapacitating terror. This stage is a reaction to the "first fear" stage and produces more physiological sensations, causing more alarm, and an ever-increasing spiral of anxiety symptomatology. The escalation of panic episodes into a severely disabling condition depends on interoceptive cueing of panic, perception of threat and fear of fear.

4.1.3 Contingency variables

The variables influencing the probability of firing of the positive feedback loop, or second stage fear, to a point of panic, include internal cues, catastrophic ideations, individual predispositions and situational factors.

CHAPTER 4

THE COGNITIVE BEHAVIOURAL MODEL OF THE AETIOLOGY OF PANIC DISORDER

Aetiological research is most valued for the direction it offers both preventative and healing treatments. Translated into clinically accessible methodology, aetiological research could enhance the lives of many panic disorder sufferers by directing effective treatment (Regier, Hirschfeld, Goodwin, Gurke, Lazar & Lewis, 1988). Eaton, Badawi & Melton (1995) clearly illustrate this in their investigation of the precursors to panic disorder. Their results include the predictive power of the simple question, "Are you a nervous person?" This question correlated to the development of panic disorder during the following year in 60% of their research subjects. It is these kind of simple specifics, made accessible to primary health worker , that could significantly reduce the misdiagnosis of panic disorder.

Specific aetiological models representing the paradigm of their researcher are individually unable to address the problem of panic disorder in all its complexity but have great heuristic and clinical value if seen as part of the broader contextual picture (Margraf & Ehlers, 1989). The following discussion focuses on the cognitive behavioural aetiological model because its central assumption is that cognitive processes translate external events into meaningful internal events which then become the pathogenic agents (Teasdale & Barnard, 1993)and the central assumption of this study is that subjects' **fear cognitions** influence their interpretation of their panic attacks which then directs the course of their condition.

inconsistent reinforcing stimuli, but as integral to the qualitative experience of the disorder (Markowitz et al., 1989).

Panic disorder sufferers report more impairment in perceived physical and emotional health and reductions in occupational and financial functioning than those suffering other psychiatric disorders (Klerman,1991). They are often far too afraid to take holidays or travel outside of their safety network which usually comprises medical practitioners, pharmacies and emergency rooms (Gournay, 1995). Self medication is a common and secret coping mechanism and companion to panic disorder (Baker, 1992). Sufferers are afraid and unsure of their symptoms but equally afraid of facing another day or night without some help. Over-the-counter medications are often the most easily accessible in the frenzy of the fear of an attack and the overwhelming fear of collapse (Ashcroft & Walker, 1989).

Recognizing the psychosocial concomitants to panic disorder and their impact on the sufferer's qualitative experience of life, helps clarify the frequent reports of continued functional impairment after effective, short term treatments have reduced the actual number of panic attacks experienced (Klerman, 1991). It also lends validity to sufferers' self reports of improvement only when these aspects have been dealt with, even despite a much earlier psychiatric diagnosis and biologically effective treatment. Patients need to develop a personal understanding of their problem and address its impact on their lifestyles, to alleviate their sense of helplessness (Weekes, 1983). A sense of helplessness is directly related to the level of fear experienced (Forrest & Ricketts, 1995). The negative behavioural manifestations are resultant on the intensity of fear and helplessness experienced (Cloitre, Heimberg, Liebowitz & Gitow, 1992). Futhermore, as much as the severity of

CHAPTER 5

HELP-SEEKING BEHAVIOUR IN PANIC DISORDER PATIENTS

Panic disorder very quickly becomes the sole focus of sufferers' existence. Their lives become a series of avoiding anything that might precipitate or worsen an attack, their cognitions become internally focused, always alert for a cue signaling another attack. Pertinent amongst the concomitants of panic disorder is the time, energy, emotionally and financially consuming process of help-seeking. Panic attacks are too frightening to overlook, deny or ignore but finding the correct, or most effective help, is difficult. Panic disorder patients are amongst the most frequent users of mental health and medical services (Salvador-Carulla, Sequi, Fernandez, Cano & Canet, 1995) yet the mean latency period between the onset of panic attacks and entering an effective treatment programme is 12,7 years (von Korff & Eaton, 1989). The benefits of early detection and management of mental illness are clearly documented as including health gain for the patient, better prognosis if detected early and still better prognosis if the problem is also managed appropriately (Lloyd & Jenkins, 1995). This position is especially true of panic disorder because, with the rapid entrenchment and reinforcement of dysfunctional cognitions and behaviours, the duration of the disorder is inversely related to the prognosis (von Korff et al., 1987).

overpowering preoccupation with, and response to, increasing numbers of imagined and experienced dangers (Forrest & Ricketts, 1995).

and experienced as fear (Barsky et al., 1994) or as incapacitating terror (Weekes, 1983).

4.1.3.4 Situational factors

Situational factors impact on how internal or physiological cues link into the positive feedback loop. This seems directly linked to the availability of both explanations for the sensations and of coping resources (Rachman, Levitt & Lopatka, 1987). Panic patients report fewer catastrophic cognitions and less general distress during the experience of physiological anxiety cues in the presence of a safe person (Carter, Hollon, Carson & Shelton, 1994). Likewise, expected panic attacks seldom carry the same fear intensity as unexpected attacks (Barlow & Cerny, 1985). Typical situational factors associated with the exaggeration of panic include driving on a busy highway, shopping malls and standing in queues (Margraf & Ehlers, 1989). Medical treatments experienced as negative and leaving a sufferer confused and helpless can become a situational variable reinforcing a panic condition (Andrasik, 1990). These external situations quickly become conditioned fear cues and the sufferer adjusts his behaviour in an effort to avoid these learnt cues.

4.3 In sum

The central focus of the cognitive model of panic disorder is fear related to coping during unusual or unfamiliar events. Panic attacks involve the interpretation of terror around an unusual somatic event, resulting in an exaggerated emotional experience of fear. Clinically, fear and panic, though qualitatively different, seem linked quantitatively, passing from one phase to the other as a result of an

4.1.3.1 Internal cues

Panic patients are more likely to **experience** physical symptoms and are more **sensitive** to their occurrence. These physical symptoms are exaggerations of normal bodily processes and panic disorder patients experience them more frequently and at a higher level (Barlow & Cerny, 1985).

4.1.3.2 Catastrophic interpretation

The heightened occurrence and awareness of somatic symptoms does not directly trigger panic but operates via their interpretation or association with danger (Margraf & Ehlers, 1989). Thoughts influence feelings, behaviours and moods. Panic patients report catastrophic ideations or interpretations of physiological arousal and these distortions typically centre around physical (e.g. death, heart attack) or mental (e.g. losing control, going crazy) catastrophes (Rapee, 1985). Research studies very consistently show that fear cognitions, particularly fear of physical or mental collapse, are more regularly reported by panic disorder sufferers compared to other clinical and normal control groups.

4.1.3.3 Individual predispositions

Attempts to identify individual predispositions to panic disorder have shown some common trends but these are not evident in all panic patients. It seems that different diatheses precipitate the experience of panic by a common pathway. Cognitive behavioural theorists propose that this pathway, or the link between the physiological cues and a panic attack, are cognitive and emotional reactions centring on danger

challenging events, as opposed to the rapid escalation of fear and catastrophic interpretations represented by the positive feedback loop.

4.1.1.1 Components of the positive feedback loop

- Physiological or emotional cues Physiological changes occur for which the individual cannot identify a precipitating stimulus (Margraf & Ehlers, 1989).
- Cognitive cues The person notices the physiological changes.
- Cognitive interpretations The physiological changes are associated with immediate danger (Barlow & Cerny, 1985).
- Fear The person experiences intense and inexplicable fear which increases both the physiological and cognitive components and completes the positive feedback loop. The fear response escalates to a panic attack. The positive feedback loop is a fast process.

The four interactive components of the positive feedback loop mirror the four stages of the development of panic disorder identified in the sequenced stages of illness model discussed in chapter 3, section 3.2.1.

4.1.1.2 Components of the negative feedback loop

Components of negative feedback processes include self limiting activities such as habituation, fatigue and homeostatic mechanisms (Margraf & Ehlers, 1989); repeated reality testing invalidating catastrophic anticipations and coping mechanisms, including breathing techniques (Rapee & Barlow, 1992); distraction strategies (Forrest & Ricketts, 1995); cognitive strategies (Clark, Beck & Beck, 1994); and help-seeking behaviour (Katerndahl & Realini, 1995). The negative feedback loop operates more slowly than the positive feedback loop

4.1 The cognitive behavioural model

Two of the central tenets of a cognitive behavioural aetiological model of panic disorder include the nature of the triggering events (internal vs. external) and the content of feared consequences (immediate bodily/mental catastrophes vs. other more long-term negative events). From this perspective , panic attacks are not spontaneous events but rather the consequence of a feedback loop between bodily sensations and the person's reaction to them. Cognitive behavioural theorists use various heuristic descriptive models explaining these assumptions. A brief discussion of the Positive and Negative Feedback Loop Model (Margraf & Ehlers, 1989) and the First and Second Stage Fear Model (Weekes, 1983) will be used to illustrate this perspective.

4.1.1 The positive and negative feedback loop model

This model describes the link between physiological or interoceptive cues and the experience of panic in terms of positive and negative feedback loops (Margraf & Ehlers, 1989). The positive feedback loop is fed by physiological, cognitive and emotional responses and is a quick process culminating in a panic attack. Clark (1987) explains individual's perceptions of the spontaneity of a panic attack as due to the failure to recognize the factors feeding this positive loop.

The positive feedback loop operates simultaneously with a negative feedback loop which influences all the components of the positive feedback loop and serves to reduce anxiety (Margraf & Ehlers, 1989). The negative feedback loop is represented by effective coping mechanisms and assists with the appropriate and rational appraisal of

panic attacks is relative to the intensity of accompanying fear, dispelling that fear is likewise positively related to improved social and occupational functioning (Zane, 1989) and reduced anxiety (Barlow & Cerny, 1985), thus alleviating the severity of the disorder.

The frequency of panic attacks is clearly only part of the syndrome. The consecutive qualitative symptoms must be recognized as integral to the condition and, therefore, as a necessary part of treatment and research. The qualitative experience of panic can be quantified in anxiety ratings, quality of life ratings and observations or ratings of the degree of avoidance behaviours (Weinstein, 1995).

3.3 *In sum*

Panic attacks represent the pathological manifestation of the primary fear emotion which quickly becomes associated with intense anxiety feelings. This unpredictable and inexplicable experience flusters the individual's rational thought processes, so that he can only interpret the event as signalling imminent doom. This intensifies his fear, initiating repeated panic experiences and ineffective behavioural changes, typically characterized by the avoidance of events believed to trigger these attacks. Panic attacks are not situation specific so that resultant avoidance behaviour, following their path, is irregular and confuses both the sufferer and significant others in his life. These social and psychological accompaniments to panic insidiously creep into the individual's life and soon dominate his existence.

integrally part of panic disorder is irregular, not situation specific and epitomizes a desperate and frenetic attempt to escape the horror of another panic attack (Sheehan, 1982a). These irregular behavioural manifestations make panic disorder even more perplexing for both the sufferer, significant others in his life, and the medical practitioners he consults (Peykel & Priest, 1992). The driving force behind this behaviour is the absolutely unbearable fear of another panic attack. The mean latency period between the initial panic attacks and the development of avoidance behaviour has been estimated at three months with a range from one day to two years (von Korff & Eaton, 1989). These desperate and dysfunctional behaviours increase the sufferers' anxiety and facilitate the repetition of panic attacks. Once experienced, whether the triggers are identified or not, it seems that panic can be reproduced "spontaneously" merely by association or memory (Zane, 1989). The progress of panic disorder is individually variable but, generally, without treatment it insidiously and rapidly invades the person's being and life style (Leaman, 1992).

3.2.4 *Quality of life in panic disorder*

The sequenced stages of illness model describes the process of panic disorder as evolving from physiological symptoms, to cognitive, psychological and behavioural manifestations (McFayden, 1989). The course of this evolution depends on the complex interaction of hereditary, biological, cognitive, psychological, behavioural and social influences (Weissman et al., 1989) and directly and reciprocally influences all these systems. It is becoming increasingly evident that an understanding of panic disorder requires the scrutiny of its psychological and social concomitants, not as mere by-products or

Panic disorder sufferers' typical coping behaviours attempt to avoid anything or any place that seems associated with or likely to bring on another attack, or make it worse. These behavioural changes appear irrational, the patients are afraid and feel foolish, making them reticent to discuss their changed behaviours or changed needs (Ingham, 1993), but the immediate relief offered by the avoidance behaviour quickly reinforces it for the sufferer (Forrest & Ricketts, 1995). This impacts almost immediately on their interpersonal relationships, their social functioning and their work efficacy (Weinstein, 1995). These are the condition's first infiltrations into the sufferer's broader life systems, or into his quality of life and epitomize what has been referred to as panic disorder's biopsychosocial nature.

A lack of understanding of the condition in both the sufferer and significant others in his life is one of the greatest reasons for its negative impact on his quality of life. The inability to rationally explain his condition increases his sense of loss of control (Rachman, Levitt & Lopatka, 1987) exacerbated by the disruption of his concentration due to his intensely anxious state (Leaman, 1992). The resultant defensive behaviours, typically manifesting in a series of running away, hiding and avoiding (Ingham, 1993), further add to his sense of uncontrollability and a vicious negative behavioural vortex develops.

3.2.3 *The irregular pattern of panic disorder*

Avoidance behaviour must be distinguished from phobic behaviour which constitutes a different psychological syndrome, although often occuring co-morbidly with panic disorder. Avoidance behaviour that is

(Cloitre et al., 1992). The typical doctor-patient consultation style renders the patient helplessly under the control of the practitioner. The experience of repeated ineffective treatments adds to a perception of the enormity of their panic condition (Katon, 1993) as well as their own helplessness. This interaction quickly becomes self-fueling as the patient feels more weak and vulnerable, and relies more and more on the practitioner.

The only way a patient can manage and eventually overcome the negative impact of panic disorder is by taking control of his condition, by taking full responsibility for his body, including his panic attacks, and to willfully decide on the help and guidance he will utilize (Weekes, 1983). The dependence developed in the doctor-active, patient-passive interactions and the contradictory acceptance of his illness symptoms simultaneous with a diagnosis of health, creates the exact antithesis of a sense of coping, clarity and competency.

5.2 The direct monetary costs of pre-diagnostic help-seeking

It is evident that panic disorder patients make far more frequent use of traditional health care facilities (Klerman et al, 1991) and other forms of healing therapies (Katerndahl & Realini, 1995) than patients with other psychiatric conditions or normal control groups. As well as potentially reinforcing negative behavioural patterns these treatments all carry a financial cost. Krupnick & Pincus (1992) investigated the cost-effectiveness of psychological treatments and concluded that the economic costs of panic disorder are in fact enormous, with subjects making at least twice as many health care visits as comparison subjects, and experiencing longer hospitalization.

and cubital tunnel syndrome. He suggested I see a psychiatrist for the neuropathy because he felt it was an emotional problem. At that point I felt that I'd seen enough doctors and would take care of the emotional problem myself. I didn't want to take the chance of being labelled a hypochondriac or worse.

Finally, a friend prodded me into seeing her family doctor. He asked me a lot of questions about my past medical history and my present symptoms, and did a complete physical. He then told me I had panic disorder, and had had it since I was twenty-one. I was surprised and relieved. At last it all made sense, (Leaman, 1992, p.156)."

The dramatic advances in the diagnosis and treatment of panic disorder have seemingly not relieved the fruitless and individually and nationally costly phenomenon of a long and ineffective treatment search. Both panic attack and panic disorder patients have elevated rates of general and specialized medical care utilization (Weinstein, 1995) yet they often remain undiagnosed for a long time, often do not receive effective treatment and very often receive little or no psychoeducation or information on the nature and consequences of their disorder (Regier et al., 1988). Hollifield et al.'s (1990) pioneer survey of the incidence of panic disorder and associated help seeking behaviour in Lesotho, Africa, discussed in chapter 3, reported that 77% of sufferers had in fact sought help for their condition. Yet, 72% of these, who had attended Western doctors, did still not know how to treat themselves and 68% did not know what caused their attacks.

The high incidence of patients with panic disorder who are not receiving any, or at least not appropriate, treatment is posing a significant problem for psychiatry. As the available treatment methods

with sound medical judgement, can be a useful diagnostic aid (Dilsaver, 1989).

5.3.2.1 *Influences on their symptom presentation*

Individuals differ worldwide in their experience of pain, their labelling of a symptom, their communication about their pain o. symptom, their belief about the cause of their illness, their attitude to doctors or medical practitioners and their expectations of treatments (McGolderick, 1982). These individual differences would logically effect how they both perceive and communicate their perception of their symptoms (von Korff & Eaton, 1989). The symptom profile of panic attacks might be interpreted by the patient as the manifestation of psychological distress or physical illness. Their personal interpretation is functionally related to their fear perceptions (Beck et al., 1992) and how they communicate this is influenced by social and cultural scripts, as well as individual personality factors (McGolderick, 1982).

Ordinarily, patients explain physical symptoms in terms of conventional illness frameworks, but when they experience somatic symptoms unexpectedly, and concomitantly with emotional arou.al, they do not easily fit into these parameters. Furthermore, panic disorder sufferers feel different and perplexed and will often present their symptoms in ways to alleviate these feelings, trying to make them appear as "normal" as possible (Ingham, 1993) often forcing them into conventional sickness conceptual frameworks, even emphasizing lesser symptoms to accommodate this fit (Perry & Cooper, 1989).

- males who attributed the cause of their condition to others used psychologists most.

Factors associated with seeking care at specific sites appear to include attitudes, perceptions and treatment experiences, in addition to symptom characteristics, sex and socioeconomic status. Panic disorder sufferers' pre-diagnosis treatment search is, therefore, a dynamic process as each attempt reciprocally influences most of these variables and in turn directs the next treatment sought. This study aims to explore the directive influence of sufferers' fear on their pre-diagnostic help-seeking behaviour.

5.3.2 How do panic disorder patients present their symptoms ?

Specific symptoms reported seem to be similar for benign panic attacks and for attacks associated with panic disorder. Panic disorder patients typically present with multiple somatic complaints often including a fear of dying, going mad or losing control (Dilsaver, 1989). These somatic complaints include chronic headaches, myalgias, lack of energy, poor concentration, irritability, difficulty breathing, dizziness and chest pain (von Korff & Eaton, 1989).

This conglomeration of vague physical symptoms is often difficult to understand and can leave a practitioner irritable, perplexed, anxious and helpless. It is difficult to find a clear-cut explanation but he can, equally, not be sure that the patient does not suffer from some physical disorder that he has failed to diagnose (Mechanic, 1972). It has been suggested that the practitioner's emotional responses, when tempered

physical or mental collapse, death or social humiliation (Kaplan & Sadock, 1988).

Hibbert (1984) investigated the relationship between somatic symptoms, ideational content and resulting behaviour. He noticed that patients experiencing palpitations, breathlessness and weakness, feared heart attacks and death, and tended to consult medical health practitioners. Those experiencing sweating, butterflies in the tummy and depersonalization, feared loss of control and social embarrassment, and tended to consult mental health officers or counsellors. He concluded that the nature of somatic symptoms experienced is possibly influential on the sufferer's fear and in turn on the choice of help seeking behaviour.

Katerndahl & Realini (1995) scrutinized correlations between somatic symptoms, personality factors and sociodemographic variables with help-seeking behaviour in panic disorder patients. They identified the following trends:

- alcohol dependent males, unable to drive themselves, visited emergency rooms;
- persons with severe chest pain and dyspnea and functionally impaired persons consulted general practitioners;
- patients who believed their condition was self-caused related inversely to the use of general practitioners;
- higher social class correlated to cardiologist usage;
- higher concern about pain correlated to cardiologist usage;
- perceived severity of panic attack correlated to ambulance usage;
- patients with greater treatment experience used psychiatrists more;

- 32% used emergency rooms
- 35% used general practitioners
- 9% used cardiologists
- 19% used ambulance services
- 24% used psychiatrists
- 10% used psychologists
- 13% used alternative settings

It seems unanimous that most panic conditions are, at some stage, treated in general medical practice (Paykel & Priest, 1992) but there is, equally clearly, some inadequacy evident in the many misdiagnosed or undiagnosed cases. This results in the lengthy, individually and socially, costly, experience of pre-treatment help-seeking.

5.3.1.1 Influences on their choice of help sites

A lot of the research into panic disorder has focused on identifying why particular patients seek help from particular help sites. Illness behaviour is a coping skill influenced by social and cultural variables, personality factors and life experiences (Sue & Zane, 1987). People tend to appraise new bodily perceptions against their own prior experiences, and their anticipations, based on the observed experiences of others, and on general knowledge socially and culturally gleaned (Mechanic, 1972).

At some point a physiological cue alerts an illness perception. The **converting factor** in the case of panic disorder seems to be the sufferer's fear perception. Remember, the dreadful universal accompaniment to panic attacks is the overwhelming fear, typically, of

Enlightened positive investment in timeous and effective diagnosis and treatment of panic disorder must become the active commitment of relevant health workers (Forrest & Ricketts, 1995). This would relieve the tragic human costs and also the substantial economic burden on society (Lloyd & Jenkins, 1995).

5.3 Characteristics of help-seeking behaviour

5.3.1 Where do panic disorder patients seek help?

It has been generally observed that most non-psychotic psychiatric conditions are treated in general practice (Paykel & Priest, 1992). It has, in fact, been estimated that as many as half of all persons affected by a mental disorder, who are under treatment, receive care only from a general health provider (von Korff, Shapiro, Burke et al., 1987). Panic disorder sufferers seem to follow this trend as they, especially initially, experience the problem as physical (Forrest & Ricketts, 1995).

Research studies have consistently confirmed panic disorder patients' regular and elevated usage of medical services. Klerman et al. (1991) compared the help seeking behaviour of panic attack, panic disorder and other psychiatric patients. They reported that 24% of the panic attack sufferers visited general practitioners, psychiatric professionals and emergency departments as opposed to 42,9% of the panic disorder patients and only 7,5% of other psychiatric disorder patients. These findings were again confirmed in an extensive review of studies on panic disorder patients' help-seeking behaviour by Katerndahl & Realini (1995). There conclusions are summarized as follows:

- 49% used medical settings

Still, the direct costs of panic disorder can outstrip those of other chronic conditions. The crux is, however, not only this financial difference but that most of these medical procedures are unnecessary and make little impact on sufferers' condition, or worse still, can reinforce the negative process of their condition.

The financial outlay can be crippling for the individual and this effect can reciprocate socially. The social costs of panic disorder are twofold. They include, firstly, the loss of social and economic productivity in sufferers because of their panic condition (Rupp, 1995); and, secondly, the unnecessary channelling of medical insurance and, hence, government resources to the payment of ineffective medical procedures (Wolff & Rickstens, 1994). Regier et al. (1988) go as far as heralding the possibility of shifting even a small portion of these indirect costs into direct treatment costs, as having a potentially profound improvement on the lives of currently untreated or undertreated sufferers. The social costs of panic disorder on the broader social network is not included in the aim of this study but an alertness to it, while reading the alarming individual impact, is valuable and adds emphasis to these hard facts.

The post-diagnosis costs of panic disorder are also beyond the scope of this study and there is, generally, a paucity of research in this area. It is noted, however, that the positive effects of an efficient diagnosis clearly include the improvement of both the psychological and social concomitants of the disorder (Salvador-Carulla et al., 1995) amongst which ineffective and costly treatment searching is pertinent.

precipitating further panic attacks and the development of his condition (Zane, 1989).

The patient role can be maintained through positive reinforcement, such as attention from others, including empathetic medical practitioners, while "well" behaviour is insufficiently acknowledged (Andrasik, 1990). This is especially easy when the patient has a long standing, somewhat vague, disorder and is well known to the practitioner (Paykel & Priest, 1992) or can be due to fear, or uncertainty, on the part of practitioners, or significant others, in the patient's life who, out of kindness, instruct sufferers to do only what they can (Stiles, Shapiro, Harper & Morrison, 1995). The patient receives an ambiguous double-bind. He has been proclaimed physically fit but his pain is recognized and his illness behaviour accepted. The sufferer quickly assumes an illness orientation living from one diagnostic evaluation to the next (Gournay, 1995).

5.1.2.1 The practitioner-patient experience

Westernized patients have been socially schooled to respect a doctor or other medical practitioner's wisdom and tend to assume a docile role, immediately giving the practitioner the power during a consultation (Ingham, 1993).

This typical doctor-active, patient-passive interplay easily feeds the negative behaviour patterns seen in panic disorder. Feelings of helplessness and uncontrollability are positively related to the deterioration of panic disorder (Barlow & Cerny, 1985). The degree of fear experienced in panic is directly related to feelings of uncontrollability and to the perception of the severity of the disorder

become increasingly effective and economical, the difference between the potential for ameliorating the condition and the actual performance of health and mental health services in providing this care is likely to become of tantamount concern (von Korff et al., 1987).

5.1.2 *Medical consultations as part of the negative behavioural chain*

During this pre-diagnostic help-seeking period sufferers often undergo unnecessary, unpleasant and costly medical procedures. These are not only time and financially costly, unpleasant and anxiety provoking, but can also, unwittingly, become part of the negative vortex of catastrophic cognitions and avoidance behaviours central to the deterioration of panic disorder (Andrasik, 1990).

A person, experiencing the terror of a panic attack, often rushes to medical rooms, where he undergoes a thorough medical examination, after which he is proclaimed healthy, with no sign of pending heart failure or death. This diagnosis is technically correct, and offers some immediate relief, but the patient remains confused and afraid. He endured powerful, real and debilitating symptoms for which he has been offered no explanation or consolation. This diagnostic evaluation may paradoxically reinforce his cognitive appraisal of panic attacks as potentially harmful and may, thus, provide social sanction for his avoidance behaviours (von Korff & Eaton, 1989). Already caught in acute interoception and cognitive catastrophizing (Rapee, 1985) the person may now engage fears that he has not been told the truth, or that there is some very severe underlying condition. This increases the confusion that typically accompanies panic disorder, increases the patient's typical feelings of helplessness, all increasing his anxiety, thus

5.1.1 Extended pre-diagnostic help-seeking period

The extended latency period between the onset of panic symptoms and the procurement of appropriate treatment contributes significantly to both the sufferer's reduced quality of life and to the steadily deteriorating progress of the disorder. The following letter from a panic disorder patient after enduring twenty years of the disorder, as well as many stressful and unnecessary medical procedures, illustrates the frustration and futility of this ineffective treatment search:

> "Although I had panic disorder for a long time. I only recently discovered what it was. I had my first attack twenty years ago when I was 21. I went to my family doctor who told me I was suffering from anxiety and prescribed Librium. I took the medication for about a year, then stopped because it wasn't doing me much good. I was still having the attacks.
>
> My symptoms (dizziness, unsteadiness, skipped heartbeats, shortness of breath, tight chest) recurred off and on over the next seventeen years, although less frequently.
>
> Then I developed new symptoms which I didn't realize were part of the same disorder and which worried me. These included numbness in my hands and feet.
>
> A specialist internist did a complete physical with lab tests. He suspected arthritis, myasthenai gravis or multiple sclerosis, eventually ruling out the first two. The lab tests were inconclusive, so he referred me to a radiologist for x-rays, a neurologist for further testing, and a physical therapist for the numbness. The x-rays showed nothing abnormal. The neurologist performed another battery of tests. He concluded I had nonspecific idiopathic neuropathy, carpal tunnel syndrome

5.1 Help-seeking as a social concomitant of panic disorder

The far reaching social and psychological effects of panic disorder are accepted as integral to the condition, not merely irregular side effects (Weissman et al., 1989). Panic disorder sufferers' help-seeking behaviour is, undoubtedly, one of these social and psychological concomitants which impacts on their condition and general life style, and can readily become a symptom maintaining environmental consequence when treatments are experienced as negative (Katon & Vitaliano, 1987). A large part of a panic patient's life, until he has his condition efficiently managed, revolves around searching for an answer or for treatment and help. Not only do panic disorder subjects visit more medical practitioners than other psychiatric patients (von Korff & Eaton, 1989), they often create a network of health practitioners around them (Gournay, 1995). This generally includes three or four health workers, comprising, for example, two or three general practitioners, a well known and friendly pharmacist and a hospital crisis centre. Many patients report living from consultation to consultation (Ingham, 1993). Panic disorder patients are always alert for the latest treatment on the market, including anything from vitamin preparations to the latest beta-blocker (Baker, 1989). This obsessive individual quest often has to be hidden from others, because panic disorder patients feel abnormal and ashamed (Ingham, 1993), exacerbating the time and energy it consumes from an organism already depleted through the process of his panic condition. Help seeking, in some form, is a part of every panic disorder and directly interactive with, and influential on, sufferers' behaviour and the severity of their condition (Waring & Foreman, 1988).

6.3 Method

6.3.1 Study design

A multimethod research design was utilized to investigate the complex pre-diagnostic help-seeking behaviour of panic disorder sufferers. This study is embedded in an ecumenical conceptual framework, recognizing both the subjectivity of panic disorder as well as the common trends. In keeping with this, the method chosen must include enough formalization to keep the research relevant to the problem under investigation, spiced with enough flexibility to prevent premature closure and the loss of valuable phenomenological data. Pre-designed techniques provided the structure and quantitative information, after which open-ended techniques were used to explore the individual experiential component of help-seeking behaviour.

This multimethod design epitomizes the dialectic between deductive and inductive research (figure 2). The theory-driven deductive data both relates to the research hypotheses and simultaneously informs new ideas. These create the intuitions that the open-ended techniques of qualitative data then creatively explore. These results reflect back, further validating and/or enriching results obtained.

The methodology of this study also meets the criteria for triangulation which is characterized by the utilization of more than one research method, so that the shortcomings of one are compensated for by the strengths of the other (Rosnow & Rosenthal, 1996). Specifically, the quantitative approach provides empirical, objectively measurable data while the qualitative approach ensures the inclusion of valuable subjective and phenomenlogical data (Miles & Huber, 1984).

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H3: Group A subjects will use more traditional medical practitioners; group B subjects will use more mental health practitioners; group C subjects will use more alternative practitioners.

H4: Group A subjects will experience more physiological symptoms; group B subjects more psychological symptoms; group C subjects, symptoms suggesting loss of physical and/or mental control.

H5: Group A subjects will present their physiological symptoms to traditional practitioners; group B subjects will present their psychological symptoms to mental health practitioners; group C subjects will present their threateningly embarrassing symptoms to alternative practitioners.

H6: Group A subjects will present their symptoms clearly and directly to practitioners; group B subjects will selectively present their symptoms to chosen practitioners; group C subjects will show selectivity in both symptom presentation and practitioner choice.

H7: There will be no difference in the number of practitioners consulted by each group despite the differences expected in the duration of the pre-diagnostic help-seeking periods

H8: There will be no difference in the experience of the beginning of healing between the groups. This will coincide with the first normalization of subjects' fears.

H9: There will be no difference between the groups in the type of practitioner from whom they receive an effective diagnosis. This will most frequently be a traditional medical practitioner.

Fear is the most consistent symptom accompanying panic disorder. It is, to date, an under recognized component of the disorder urgently requiring attention. The primary aim of this study is to investigate the complex impact of this overriding symptom on the prognosis of the condition. Research has repeatedly reported that panic disorder sufferers' fears fall into three clusters: fear of death, fear of going mad, and fear of social embarrassment. The present study aims to investigate the influence of these fear categories on subjects' illness behaviour and the process of their disorder. These recognized fear categories will form the research groups: group A will comprise subjects fearing death, group B subjects afraid of going mad and group C subjects afraid of social embarrassment.

6.2 *Hypotheses*

Against the above background the research hypotheses of this study are:

H1: Group A subjects will reflect the shortest pre-diagnostic help-seeking period followed by group B. Group C subjects will reflect the longest pre-diagnostic help-seeking period.

H2: Medical costs during the pre-diagnostic help-seeking period will be highest for group A subjects, followed in descending order by group B and group C. The medical costs of all research subjects will be higher than those of the control groups.

It is imperative that practitioners recognize the existence of a panic condition and explain both the nature and process of panic disorder to the patient, as well as outlining available treatment programmes. It is, finally, critical that this explanation is sensitively couched in terms of the patient's idiosyncratic illness framework.

CHAPTER 6

METHOD

6.1 Aims of the present study

From the preceding chapters it is clear that panic disorder is an insidious and debilitating condition that rapidly assumes control over a sufferer's life. The symptoms of panic disorder have been adequately categorized and organized into diagnostic instruments. Prevalence research is difficult because of the irregular and episodic course of this condition but existing data emphasizes the urgent need to further understand and recognize panic disorder. Extensive research has been carried out and has clearly shown the complex and idiosyncratic nature and course of the condition but has also identified recurring trends. An extended and ineffective pre-diagnostic help-seeking period with an adverse financial, social and psychological impact on a sufferer's life is an almost universal phenomenon within this syndrome. This has been enthusiastically researched from various psychological paradigms but probably most convincingly from a cognitive behavioural perspective. This model is the most relevant to this study as they both focus on the link between cognitive processes and individual reactions to external and internal stressors. The specific cognitive process of interest to the present study is the experience of **fear.**

practitioner and patient (Mechanic, 1972). Conversely, an explanation of panic disorder as a psychophysiological condition involving the reciprocal interaction of both psychological and physiological variables could relieve the stigma and fear of a purely mental condition (Baker, 1992). Explanations that do not take into account the **patient's assessment** of the threat that he faces might serve only to mystify him and to undermine his confidence in his physician and his prognosis (Andrasik, 1990).

The practitioner must be able to educate the patient further in the nature and treatment of the disorder and must take the time to do so. He should discuss treatment options clearly (Durham 1992). Discussions should include both the role of pharmacologic agents **and** behavioural treatments **and** the role of the patient's self management (Walker & Ashcroft, 1989).

Public education is a meaningful aspect of psychoeducation. It aims at addressing sufferers, medical professionals and the general public to reduce the stigma and increase the understanding of panic disorder. This would encourage patients to acknowledge their symptoms, both physiological and psychological, to the doctor and to significant others in their lives (Paykel & Priest, 1992).

5.5 In sum

Help-seeking behaviour constitutes a significant part of panic disorder patients' lives, especially until they embark on a programme of effectively managing their condition. Ineffective or negative treatment experiences during this period can have a negative influence on its progression while simultaneously imposing a severe economic burden.

Whether doctors offer any explanations or not, the patient will anticipate and acquire expectations of the course of his condition, how he expects to feel and what is likely to happen. To the extent that the patient is not informed, his expectations may be highly contrary to what is likely to occur and this discrepancy may alarm him and disrupt the management of his condition (Mechanic, 1972). Furthermore, a panicking person, in the absence of knowledge, can create a host of unmanageable, although unreal, possibilities to which he then reacts with alarm (Zane, 1989). A lack of understanding is one of the most common reasons for the negative process of a panic condition, while sharper knowledge improves realistic judgment and allows symptoms to be reconceptualized within the context of this new knowledge (Rachman, Levitt & Lopatka, 1987).

Education about the patient's condition is vital, but the adequacy of a practitioner's management of a patient depends, not only on the provision of expectations and instructions, but also on the relevance of this information to the patient (McGolderick et al., 1982).

A physician can generally relieve a patient's symptoms to the extent that he can provide interpretations that are credible and which can bolster the patient's esteem and sense of mastery (Paykel & Priest, 1992). These explanations must relieve anxiety and be culturally and psychologically acceptable to the patient (Sue & Zane, 1987). To offer explanations meeting these criteria, the practitioner must be aware of the patient's sickness framework and, therefore, of what kind of explanations would be appropriate. For example, if a patient is socially schooled to minimize and criticize psychological complaints, a purely psychological explanation of his condition may exacerbate his anxiety and his condition, as well as disrupting relations between the

■ ask questions from patients' statements not only from theory (Paykel & Priest, 1992).

Once a trusting and caring rapport has been established, it is important that the practitioner sensitively probe the specific patient's panic experiences, treatment expectations and psychological needs (Stiles et al., 1995). The patient must experience the practitioner as caring but also as knowledgeable, communicated through the nature and direction of his questions (Paykel & Priest, 1992). It can be useful to enquire under what conditions concern about illness, in contrast to alternative definitions of a symptom, became manifest. The appraisal of the internal cues of a panic attack as dangerous and illness related is largely reactive on the patient's fear (Schmidt et al., 1994) and understanding and normalizing this fear correlates positively with the beginning of improvement (McFayden, 1992).

5.4.2 *Psychoeducation*

As already discussed, the diagnosis of physical health to a patient experiencing unfathomable panic attacks, is more likely to influence his condition negatively than to offer him relief. Likewise, simply naming his symptoms as constituting a panic disorder can breed severe uncertainty and add to the patient's fear and anxiety. Credible instructions, provided in a sympathetic and supportive way, would reduce attributional errors and not offer patients **new reasons for anxiety**. These might be more helpful to the patient than blanket reassurances that provide no alternative framework for understanding his symptoms (Mumford, Schlesinger, Glass, Patrick & Cuerdon, 1984).

5.4.1 Some guidelines to effective consultations

The essence of an effective consultation is the fit of the treatment to the individual's expectations, experiences, life-style and culture (Sue & Zane, 1987). Primary health practitioners are faced with an enormous number and diversity of cases daily and cannot be expected to be experts in all disciplines. It is, however, important to realize sensitively that a patient's experience of his symptoms is idiosyncratic. This experience rests as much within the patient's cognitive interpretive framework as it does within the stimulus event (Andrasik, 1990). This was clearly demonstrated in an investigation of patient and practitioner treatment expectations (Packard, 1983). Of chief concern to the patient was an explanation of what was causing the problem, while physicians rated such an explanation much lower in importance, with pain relief being their top need. This study clearly emphasizes the necessity for open discussion with the patient, to understand both his needs and to empower him to help himself, rather than merely offering him a prescription, which ultimately has more control over his condition than he has, obviously exacerbating his sense of helplessness and uncontrollability (McGolderick, 1982). Panic disorder patients must be allowed and free to discuss their somatic symptoms, without feeling stigmatized (Katon, 1993).

Paykel & Priest (1992) offer the following guidelines for establishing and communicating trusting, empathetic and effective consultation dynamics:

- good eye contact;
- listen to patient with few interruptions;
- appear not to be in a hurry;
- ask direct questions with a psychological and social content;

established in the consultation is often dictated by socialized habits and only inadequately meets individual needs (Ingham, 1983).

Panic attack symptoms can equally represent an organic or a primary psychiatric condition (Dilsaver, 1989). Sadly, although a comprehensive physical diagnostic evaluation is carried out this all too often, and despite the wealth of research and knowledge, does not include the evaluation of a possible psychiatric diagnosis (von Korff & Eaton, 1989). Even when stress is identified as a cause, intervention is often limited to brief counselling, or non specific, anti-anxiety medications, rather than clear explanations and the introduction of appropriate biological and/or psychological treatments.

The picture is not all gloom. It seems that, notwithstanding the unspecific presentation of symptoms, primary care practitioners are able to identify patients with psychiatric problems relatively accurately (72%). The diagnostic problem seemingly lies not in the identification but in the differentiation of a specific psychiatric disorder (Robins et al., 1981). This diagnostic specificity is absolutely necessary as a precursor to the patient's understanding of his condition and to appropriate and effective treatment.

There is, clearly, an urgent need to establish precise clinical methods of case identification and to understand how to make best use of available methods of assessing patients.

Social learning, if not prescriptive, is certainly significantly influential on the vocabulary patients use to present symptoms and their willingness to use different medical assistance and divulge different symptoms. In social circumstances where psychological vulnerability is not recognized, patients often somatize emotional disturbances and the "patient role" becomes their coping mechanism (Sue & Zane, 1987). Somatic symptoms are also more easily explained via traditional symptom terminology than are the intangible emotional symptoms of panic, such as an overwhelming and seemingly irrational sense of imminent doom.

The dynamic nature of treatment searching in panic disorder must again be recognized. Each treatment experience becomes part of the sufferers' social circumstances and, thus, directly influential on ensuing symptom presentation.

5.4 Diagnostic difficulties

The immediate diagnosis of panic disorder is difficult due to the irregular and confusing nature of the disorder, complicated by the array of somatic symptoms typically presented to the practitioner and the frequent comorbidity with other emotional disturbances, most often major depression and substance abuse (Paykel & Priest, 1992). An inadequate diagnosis or treatment experience is a function of the patient, the practitioner and their interaction (Sue & Zane, 1987). Patients often present their symptoms in ambiguous and confusing ways, practitioners can be too rigidly attached to theoretical approaches or inclined to avoid certain, especially emotional, diagnoses because of feelings of inadequacy or lack of expertise. The communication

with sound medical judgement, can be a useful diagnostic aid (Dilsaver, 1989).

5.3.2.1 *Influences on their symptom presentation*

Individuals differ worldwide in their experience of pain, their labelling of a symptom, their communication about their pain or symptom, their belief about the cause of their illness, their attitude to doctors or medical practitioners and their expectations of treatments (McGolderick, 1982). These individual differences would logically effect how they both perceive and communicate their perception of their symptoms (von Korff & Eaton, 1989). The symptom profile of panic attacks might be interpreted by the patient as the manifestation of psychological distress or physical illness. Their personal interpretation is functionally related to their fear perceptions (Beck et al., 1992) and how they communicate this is influenced by social and cultural scripts, as well as individual personality factors (McGolderick, 1982).

Ordinarily, patients explain physical symptoms in terms of conventional illness frameworks, but when they experience somatic symptoms unexpectedly, and concomitantly with emotional arousal, they do not easily fit into these parameters. Furthermore, panic disorder sufferers feel different and perplexed and will often present their symptoms in ways to alleviate these feelings, trying to make them appear as "normal" as possible (Ingham, 1993) often forcing them into conventional sickness conceptual frameworks, even emphasizing lesser symptoms to accommodate this fit (Perry & Cooper, 1989).

pro-rata basis from their total medical expenses relative to the length of their pre-diagnostic treatment search.

Part of the social costs of panic disorder, specifically the individual loss of occupational and financial productivity, was qualitatively discussed where it formed part of the subjects' experiences during their pre-diagnostic help-seeking and, therefore, of the narrative data of this study.

The **types** of symptoms subjects reported were recorded and separated into those consistent with DSM IV diagnostic requirements and those outside of this group. The **differential presentation** of symptoms to particular practitioners was also recorded and compared.

The **subjective experience** of treatments received was categorized into treatment expectations, experience and satisfaction. Subjects rated these dimensions on 5 point Likert scales. A rating of 5 was the most favourable rating across all measures. A biopsychosocial rating of each treatment experience was also obtained from each subject. These ratings were correlated to different practitioners consulted and descriptively arranged relative to the experimental groups of this study.

The subjective experience of the **beginning of healing** was narratively accessed and qualitatively recorded. This experience was substantiated by any concurrent improvements noted on subjects' biopsychosocial rating of their panic condition.

An **effective diagnosis** required not only that the subject's condition was named "panic disorder" but also that the subject was directed onto an appropriate treatment plan allowing him to thereafter, curtail his

utilization of one psychologist. In the analysis of medical expenses, however, each consultation was costed.

The **cost** of pre-diagnostic help seeking behaviour was calculated in South African rands and cents according to 1996 South African Medical Association's recommended fees. Each consultation and treatment, or medical procedure such as X-Rays, scans or electrograms, a subject underwent was costed. The overall total was calculated and then separated into the costs of practitioner consultations and of medical procedures. The cost of over-the-counter medication was calculated according to 1996 recommended retail prices obtained from the South African Drug Information Services. The use of 1996 standardized rates, regardless of the actual year of subjects' treatments, ensures uniformity and realistic inter subject comparison.

Panic disorder subjects' medical expenses were then compared with those of 3 groups of twelve control subjects, matched on age, sex, marital status and socioeconomic status. These control groups represented the general population of subjects with no chronic condition (NC) and with two chronic physiological conditions, namely asthma (AST) and hypertension (HYP). The twelve subjects were randomly chosen, using a table of random numbers, from medical scheme administrators' client profile records.

Control subjects' medical expenses were obtained from medical scheme administrators, for the twelve month period January 1996 to December 1996. As these expenses did not include money spent on over-the-counter medicines, these amounts were excluded from panic disorder subjects' expenses, to ensure realistic comparisons. The mean annual medical expenses for the research groups were calculated on a

- the procurement of an effective diagnosis

6.3.4.1 Operationalization of dependent variables

The **duration** of pre-diagnostic help-seeking behaviour was calculated from subjects' retrospective recall of their very first attempt to procure some formal assistance for their panic attacks until the time that they received an accurate and effective diagnosis of their condition. Formal assistance was defined as the consultation of a health or helping practitioner primarily for the alleviation of the subject's panic symptoms. The time lapse between the first consultation recalled and receiving an effective diagnosis was calculated in calendar years and months. This provided the raw data representing the duration of pre-diagnostic help-seeking behaviour.

The **specific practitioners** sought were listed according to subjects' recall and categorized into 3 groups:

- **traditional medical practitioners** which included psychiatrists, general practitioners, medical specialists, physiotherapists, and dieticians.
- **mental health practitioners** which included psychologists, counselors, hypnotherapists and re-birthers.
- **alternative practitioners** which included homeopaths, aromatherapists, chiropractors, acupuncture, yoga, reflexologists and run-for-life.

The number and types of practitioners consulted were tabulated in terms of each treatment procedure, not each consultation. For example, a twelve month psychotherapy session was tabulated as one

The direct questions and self-rating scale were, therefore, considered to have adequate content validity and to offer meaningful measures of subjects' help-seeking behaviour and treatment experiences.

6.3.4 *Independent and dependent variables*

Fear cognitions created the three levels of the independent variable in this study on the basis of which subjects were divided into research groups consistent with DSM IV classificatory requirements:

Group A - fear of dying

Group B - fear of going mad

Group C - fear of social embarrassment

These levels of the independent variable could not be experimentally manipulated creating an ex post facto research design which limited obtained results to the description of observed correlations and differences.

The dependent variables to which the 3 levels of fear cognitions were related are:

- the duration of pre-diagnostic help-seeking behaviour
- the cost of pre-diagnostic help-seeking
- the specific type of practitioners consulted
- the type of symptoms experienced
- the presentation of symptoms to practitioners
- the manner of symptom presentation
- the number of pre-diagnostic practitioners or treatments utilized
- the subjective experience of the beginning of healing

Subjects completed these three pre-designed techniques for each treatment they had procured since first actively seeking help for their panic condition until, and including, their correct diagnosis as a panic disorder sufferer, in other words, each treatment used during their pre-diagnostic help-seeking period.

6.3.3.5 *Justification of instruments used*

The direct questions and one self-rating scale were constructed specifically for the present study and every effort was made to ensure their content validity Content validity cannot be expressed in terms of a quantitative index, it is instead evaluated on logical grounds and informed by theory (Huysamen, 1996). This is best achieved by clearly defining the universe of interest, systematically sub-dividing it and ensuring that items adequately represent each one of these sub-divisions (Bless & Kathivia, 1993). The universe of interest to this study is the pre-diagnostic help-seeking behaviour of panic disorder sufferers which was sub-divided in terms of the hypotheses of this study. Distinct items were created to investigate each one of these sub-divisions or hypotheses.

The self-rating scale measured subjects' experiences of each treatment used in terms of three variables: how well they thought the practitioner understood their condition, how confident they were in the proposed treatment, and how satisfied they were with the results of the treatment. The choice of these variables was based on repeatedly emerging themes during the scrutiny of case histories (Baker, 1989; Thamm, 1995) and research studies (McGolderick, Pierce & Giordano, 1982; Markowitz et al, 1989; Schmidt, Jacquin & Telch, 1994).

Each subject was also asked to rate the severity of his condition at the time of consulting each practitioner using the shortened version of the SCID diagnostic assessment instrument of panic disorder for DSM-IV (Paykel & Priest, 1992). These ratings epitomize a biopsychosocial perspective. The biological component of his condition was estimated by rating the frequency of his panic attacks on a scale from 1 - 7; the psychological component by rating the severity of his associated anxiety on a scale from 0 - 5; and the social component by his condition's impact on his quality of life on a scale from 0 - 8 (table 5). Where appropriate, improvements indicated on these scales also substantiated narrative descriptions of the experience of the beginning of healing.

Table 5 Likert self rating scales measuring the severity of subjects' panic disorder

1. How frequent were your panic attacks at this stage?

More than once a day	(7)
everyday	(6)
more than once every week	(5)
every week	(4)
more than once a month	(3)
monthly	(2)
less frequently	(1)

2. How much time did you spend worrying about your panic attacks?

Almost all the time	(5)
significant majority of time	(4)
about half the time	(3)
significant minority of the time	(2)
rarely	(1)
none at all	(0)

3. Did your panic attacks cause any of the following problems with your work or other regular daily activities?

	(2)	(0)
cut down on the amount of time you spent on them	Yes	No
accomplished less than you would like to	Yes	No
were limited in the kind of activities you did	Yes	No
had difficulty performing your usual activities	Yes	No

Table 3 Direct questions investigating each treatment subjects underwent

1. What was the first/next attempt you made to get help for your panic condition?
2. When was this?
3. How did you present your symptoms to this practitioner?
4. What treatment did you receive from this practitioner?
5. How many times did you consult this practitioner?
6. Were you being treated by other practitioner(s) at the same time?
7. Which practitioner diagnosed your panic condition?
8. What treatment did he prescribe?

6.3.3.4.2 Self-rating scales

Subjects were also asked to rate their subjective feeling of being understood by each practitioner, their confidence in the practitioner's proposed treatment and their satisfaction in the outcome of this treatment on Likert scales ranging from 1 - 5 (table 4).

Table 4 Likert self rating scales measuring subjects' treatment experiences

Please rate your experience of this consultation and treatment on the following scales:

I felt understood

5	4	3	2	1
(extremely)				(not at all)

I felt confident in the proposed treatment

5	4	3	2	1

I was satisfied by the results of this treatment

5	4	3	2	1

allowing for spontaneous discussion and preventing the unnecessary loss of valuable information through restricting subjects' narratives.

These 8 questions simply opened the door through which the researcher followed the subject's lead. The researcher's role then became twofold: having both to travel the path of the subject's experience, while sensitively leading back to a research orientation when appropriate. It is essential that, within a conceptual orientation, the researcher maintains a commitment to completion allowing the subject to fully expand on and describe associated memories.

After discussing each particular type of treatment the subject was asked to complete a questionnaire and 2 self-rating scales with reference to that treatment. These are discussed below. The entire testing procedure took between ninety and one hundred and twenty minutes.

6.3.3.4 *Pre-designed techniques*

The pre-designed techniques utilized were 8 direct questions forming a short questionnaire (table 3) and 2 self rating scales (tables 4 & 5).

6.3.3.4.1 *Direct questions*

The first question asked subjects to name the type of treatment under discussion. The subsequent questions each directly asked for information necessary to investigate the hypotheses of this study (table 3).

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6.3.3.1 Screening

Respondents completed a panic disorder screening questionnaire used in community clinics, a fear identification questionnaire and a basic demographic details form (appendix 4). Suitability required, primarily, that the subjects had already been diagnosed as suffering from panic disorder and that they had no co-morbid psychiatric or chronic physiological diagnosis.

6.3.3.2 Informed consent

Screened subjects who were suitable for this study were asked to read and complete a consent form confirming their informed voluntary participation (appendix 5).

6.3.3.3 Open-ended technique

A recorded semi-structured interview was conducted by the researcher with each subject. The structure of the interview was formed by eight open-ended questions (table 2) aimed at maintaining the researcher's conceptual orientation and ensuring that all subjects were asked the same questions. The order in which the questions were asked varied

Table 2 Open-ended questions

- what was the first/next attempt you made to get help for your panic condition?
- why did you chose this particular line of treatment?
- what did you expect from this treatment?
- to what extent did this treatment meet your expectations?
- what impact did this treatment have on your panic disorder?
- what impact did this treatment have on your quality of life?
- did your panic disorder affect your occupational and financial functioning?
- why did you stop this line of treatment?

more detail and offer a sense of the process or continuity of a condition (Baker, 1992). The manner in which a subject structures and recalls his life is valuable information in itself. Clark's (1988) review of cognitive assessment indicates that no single approach, in vivo versus delayed, is consistently superior to another, and that there is constant discordance between methods. The greatest benefit is derived from the reciprocal usage of prospective, objective, retrospective and subjective dimensions recognizing both the discrete and combined contribution of each.

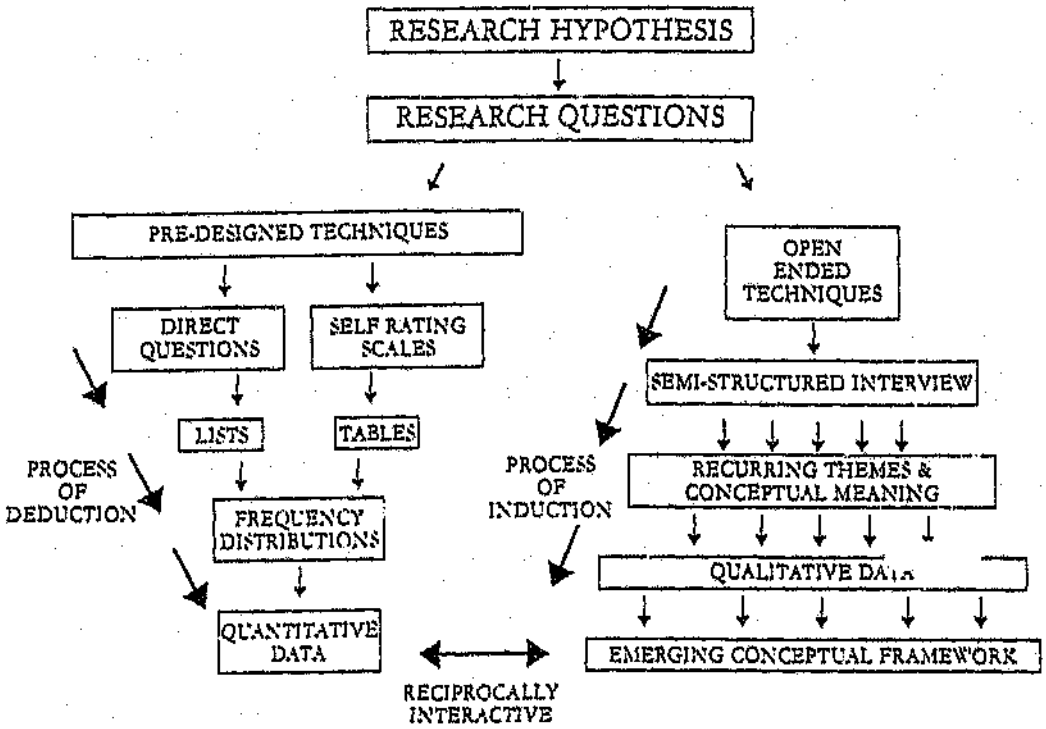
6.3.2 Subjects

Volunteer subjects were selected from responses to an explanatory request form (appendix 3) which was distributed at a panic disorder support group meeting. The National Panic Disorder Support Group was discussed in the introduction to this study. The marketing of this group has ardently attempted to reach every population group through appropriate media, and a census of membership demographics suggests that this has been largely successful. The group from which this study drew its volunteers was, however, a splinter group representing the larger Gauteng area. This restricts the generalizability of results.

6.3.3 Procedure and instruments

Volunteers' response forms were collected by the researcher who then contacted the respondents to arrange an appointment for the testing and interview procedures. This took place at subjects' homes except for one subject who was interviewed at the Medical School of the University of the Witwatersrand and one who preferred to travel to the researcher's home.

Fig.2 - Schematic representation of research method



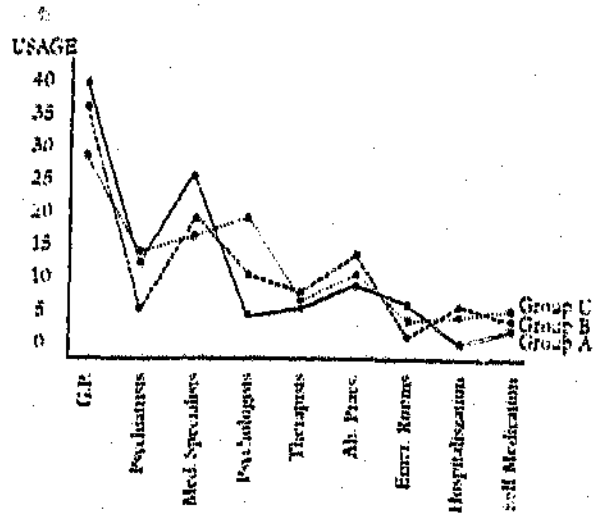
6.3.1.1 A word on retrospective and subjective research

Retrospective and subjective research is often criticized for its openness to memory distortions, post hoc rationalizations or the impositions of present viewpoints on earlier events. Panic attacks are emotional, ego-charged, personality-forming experiences which individuals are unlikely to forget (Allport, 1951). Further, anxiety, and specifically panic, are subjective experiences and it is necessary to re-search and re-examine these subjective processes, interpretations and behavioural manifestations to truly understand the phenomena (Atkinson & Heath, 1987). Subjective or personal accounts can open the door to new phenomena, expose the degree of human suffering involved, provide

Group C subjects' results showed a tendency towards the utilization of alternative practitioners (8,7; 9,0; 13,4) and of other, less traditional, mental health therapists (4,3; 5,4; 6,1) relative to the other groups.

It is also noted that while Group C subjects score on usage of medical specialists is high, this usage was divided among the infrequent consultation of many and different specialists including neurologists, cardiologists, specialist physicians, ear nose and throat specialists, gynaecologists, dermatologists, orthopaedic specialists and rheumatologists while the medical specialists attended by group A centred around specialist physicians, cardiologists, neurologists and gastroenterologists.

Fig. 6 Graphic representation of practitioners consulted



7.6 Symptom presentation

Table 12 shows subjects' differential presentation of symptoms to the different practitioners they consulted. The single most consistently

7.5 Types of practitioners consulted

Table 11 shows the percentage utilization of different practitioners. Scores are presented in percentages.

Table 11
Percentage utilization of different practitioners

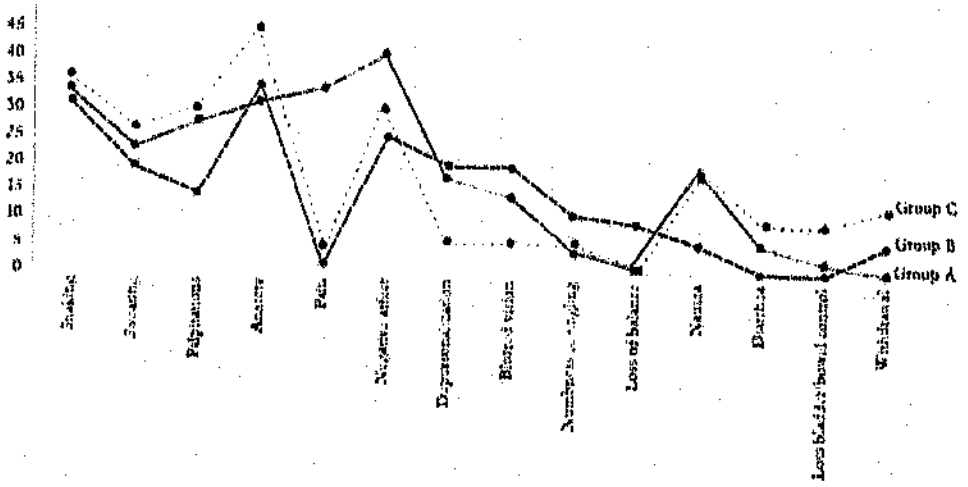
Type of treatment	Group A	Group B	Group C
	%	%	%
General Practitioner	39	28,6	38,3
Psychiatrist	11,7	12,5	5,0
Psychologist	3,2	19,6	10,0
Mental health therapists	4,3	5,4	6,1
Medical specialists	25,7	15,9	18,5
Alternative practitioners	8,7	9,0	13,4
Emergency rooms	5,3	1,8	1,2
Hospitalization	-	3,6	5,0
Self medication/help	2,1	3,6	2,5

General practitioners were the most frequently and consistently consulted practitioners across all the groups, (39; 28,6; 38,3), with the mean number of consults lowest for Group B.

Group A subjects visited the most general practitioners (**39**; 28,6; 38,3) and medical specialists (**25,7**; 15,9; 18,5), a high percentage of psychiatrists (**11,7**; 12,5; 5,0) and the least psychologists of the three groups (**3,2**; 19,6; 10,0).

Group B subjects consulted fewest medical specialists (25,7; **15,9**; 18,5) and, as noted, fewest general practitioners (39; **28,6**; 38,3). These subjects were the most frequent users of psychologists (3,2; **19,6**; 10,0) and psychiatrists (11,7; **12,5**; 5,0) and readily consulted other mental health therapists (4,3; **5,4**; 6,1).

Figure 5 Graphic representation of symptoms subjects experienced



Group A subjects reported significantly more experiences of negative emotions than either groups B or C (41, 24, 30).

Group B subjects reported the least negative affect symptoms (41, 24, 30), the most experiences of blurred vision (15, 19, 5) and they were the only group to report impaired balance (0, 8, 0).

Group C subjects' reported symptoms, additional to those consistent with the DSM checklist, reinforced their experiences of digestive discomfort, particularly diarrhoea (6, 0, 9) and loss of bladder and/or bowel control (2, 0, 9). These subjects also reported significantly more social withdrawal than their counterparts (0, 5, 11).

7.4.2 Symptoms additional to DSM diagnostic checklist

In addition to recognized diagnostic symptoms, significant clusters of other symptoms were repeatedly reported, as indicated in table 10,1. The most frequently and repeatedly presented symptom across all the subjects was anxiety and stress (31, 34, 46). All subjects also reported high experiences of not coping or dysfunctionality (15, 15, 18) and negative affect (41, 24, 30). Negative affect was calculated by the sum of reported excessive emotionality, depression, desperation and exhaustion symptoms.

Table 10,1
Symptoms additional to DSM checklist.

	Group A	Group B	Group C
Anxious/stressed	31	34	46
Excessively emotional	19	7	13
Going to explode	5	-	-
Depressed	9	5	7
Desperate	7	7	5
Exhausted	6	5	5
Dysfunctional/not coping	15	15	18
Attacks controlling my life	16	5	6
Social withdrawal	-	5	11
Impaired concentration	-	5	-
Blurred vision	15	19	5
Slurred speech	6	1	1
Dragging legs	5	-	9
Loss of balance	-	8	
Difficulty breathing	10	-	1
Difficulty swallowing	6	1	9
Pain in arms/limbs	10	-	3
Diarrhoea	6	-	9
Loss bladder/bowel control	2	-	9
Acute unexpected attacks	6	10	6
Explained past treatments	3	6	7
Had attack there	12	3	3
Insomnia	4	1	2
Headaches	1	-	3
Sinus	-	-	2
Rash	1	-	-
Weight loss	-		1

7.4.1 Symptoms consistent with DSM diagnostic checklist

Table 10
Symptoms consistent with DSM diagnostic checklist.

	Group A	Group B	Group C
Shortness of breath	8	3	7
Dizziness, lightheadedness	16	13	17
Palpitations	26	14	30
Trembling or shaking	33	31	36
Sweating	23	19	26
Choking	1	-	1
Nausea or abdominal distress	18	5	18
Depersonalization	17	19	5
Numbness or tingling	3	10	5
Chest pain	23	1	1
Fear of dying, going crazy or social embarrassment	4	4	-

All the subjects from all the groups frequently and consistently reported shaking (33, 31, 36), sweating (23, 19, 26) and palpitations (26,14,30).

Group A subjects' reports of pain symptoms, including chest pai and body pains, were very high relative to the other groups (33, 1, 4) and they reported frequent nausea and digestive discomfort (18, 5, 18).

Group B subjects reported less somatic symptoms than the other subjects. Their idiosyncratic symptom reports centered on depersonalization (17, 19, 5) and numbness or tingling (3, 10, 5).

Group C subjects' symptoms clustered around shaking (33, 31, 36), sweating (23, 19, 26), palpitations (26, 14, 30) and nausea and abdominal distress (18, 5, 18).

7.2 Duration of pre-diagnostic help seeking behaviour

Table 8 indicates the mean lengths of subjects' fruitless pre-diagnostic treatment searches, as well as the relevant ranges and standard deviations.

Table 8
Mean duration, range and standard deviation of pre-diagnostic help seeking behaviour.

Group	Mean	Range	SD
A	3 yrs. 3 mths.	5 mths. - 8 yrs.	28,3
B	7 yrs. 2,4 mths.	2 mths. - 16 yrs.	73,2
C	7 yrs. 6 mths.	1 yr. 2 mths. - 20yrs.	81,6

7.3 Number of pre-diagnostic treatments experienced

Table 9 indicates the mean number of treatments procured by each group and the relevant ranges and standard deviations.

Table 9
Means, ranges and standard deviations of pre-diagnostic treatments

Group	Mean	Range	SD
A	7	3 - 13	2,5
B	7	3 - 12	3,2
C	7,4	3 - 11	2,25

7.4 Symptoms experienced

Figure 5 graphically illustrates the symptoms subjects experienced associated with their panic disorder. Table 10 shows the symptoms subjects reported, during their treatment search, that are consistent with DSM diagnostic checklists. While, all subjects experienced diagnostic symptoms regularly, there are distinct differences between the 3 groups. The bold numbers indicate results that are particularly interesting or are referred to in subsequent discussions.

and creating an post facto research design. The distribution of subjects amongst these 3 groups is indicated in table 6.

Table 6
Number of males and females in each experimental group

Group	Fear	Females	Males	Total
A	Death	10	3	13
B	Madness	7	2	9
C	Social Embarrassment	10	1	11
	Total	27	6	33

7.1.2 Demographics

A detailed summary table of subjects' demographic details, including the duration of their pre-diagnostic treatment searching, the number and type of practitioners consulted and a list of their diagnostic practitioners is presented in Appendix 6.

AGE

The means, ranges and standard deviations of subjects' ages are shown in table 7.

Table 7
Means, ranges and standard deviations of subjects' ages

Subjects	Mean	Range	SD
Females	42	22-67	9,87
Males	39	21-56	11,67
Both	41,5	21-67	10,30

GENDER AND MARITAL STATUS

The thirty-three subjects comprised 27 females and 6 males. Of the twenty-seven female subjects 19 were married women, 4 single women, 3 divorced women and 1 widowed woman. The 6 male subjects comprised 4 married men and 2 single men.

CHAPTER 7

QUANTITATIVE RESULTS

All the subjects in this study readily remembered the many years of unsatisfactory treatment searching comprising the frequent, and often unnecessary, unpleasant and costly, medical procedures before they were diagnosed as suffering from panic disorder.

7.1 Subjects

Thirty-three volu tary subjects, selected from those who responded to the request form distributed at a panic disorder support group meeting, were deemed suitable for this study. All subjects were white South African residents from the northern and eastern residential suburbs of Johannesburg.

7.1.1 Screening and sampling

The completion of a panic disorder screening questionnaire confirmed subjects' suitability to this study (appendix 4). Subjects were then divided into three experimental groups according to their fear identification questionnaire responses (appendix 4). All subjects spontaneously verbalized an overriding fear falling into one of the three DSM-IV diagnostic fear categories, specifically: fear of death, fear of going mad and fear of extreme social embarrassment. These fear experiences provided the independent variables of this study. These variables are classification factors so the experimenter could not manipulate their occurrence resulting in research groups of unequal size

conclusions. This allows the reader to truly understand the study and to, therefore, personally evaluate conclusions drawn, as well as to draw his own conclusions (Atkinson & Heath, 1987).

6.5 Conclusions

The methodology of this study comprised a dual quantitative and qualitative approach. Quantitative data obtained from self-rating scales and direct question responses investigated the process, cost and biopsychosocial impact of subjects' help-seeking behaviour. Qualitative data obtained during a semi-structured interview substantiated the pre-designed techniques and added rich subjective information on treatment dynamics. This approach was chosen to create as complete an understanding as possible of the role of **fear** on panic disorder sufferers' help-seeking behaviour. Being an ex-post facto design limits the inferential capacity of this study but it does provide a rich descriptive and correlational indication of the link between **fear cognitions** and the process of panic disorder.

This analytical process mirrors both the sequenced stages of illness model (McFayden, 1989), discussed in chapter 3, and the positive loop

Figure 4 - Example of a conceptually clustered matrix

Treatment No: 1

Subj. No.	Severity of Disorder			Type of Prac.	Treatment	Symptom Presentation	Consultation Dynamics	Treat. exp.		
	Sev.	Anx.	Q-O-L					Underst.	Control.	Satis.
007	5	5	6	G.P.	ECG. Full blood profile. Tranquillizers (situation-ally).	Still in panic. Burst into tears. Said she was shaking, having palpitations & feeling terrible.	Expected answer. It relaxed her. Said it wasn't a heart attack. He didn't know what it was except that her B.P. was raised. Guessed it was anxiety. S thought - "now what"?	4	3	1
002	7	5	8	Psychiatrist	Anafranil	Acute & unexpected intense arousal periods - making me dysfunctional.	S had complete faith in this clever man. S was distant, intellectualized her problem, explained brain anatomy & told her to take her pills. S felt confused & seated.	4	4	1
012	7	5	6	Ear, Nose/ throat.	Admitted to ICU - ECG, Valium drip. EEG blood tests, nuclear X-ray, sleeping pills.	Uncontrollable shaking. Terrible pain in arm & chest. Petrified.	Hoped they could save me. Guess they did but they were so cold. Attached tubes, prodded & poked at me but NEVER said a word except that I would have to be admitted.	1	3	1

of Margraf & Ehler's (1989) cognitive behavioural model of panic disorder, discussed in chapter 4. The process moves from the actual physical experience, or the raw data, via the subjects' cognitive and emotional interpretations and reactions, to their behavioural manifestations and the impact on their complete lifestyle.

In keeping with the recommendations of qualitative research the methodology of this study has been explained at length exposing the process of data assimilation and interpretation, rather than merely the

Figure 3 Example of a simple checklist matrix

Subject No: 007

Severity of Disorder			Type of Prac.	Treatment	Symptom Presentation	Consultation Dynamics	Treat. exp.		
Sev.	Anx.	Q-O-L					Underst.	Confid.	Satis.
5	5	6	G.P.	ECG. Full blood profile. Tranquillizers (situationally).	Still in panic. Burst into tears. Said she was shaking, having palpitations & feeling terrible.	Expected answer. E relaxed her. Said it wasn't a heart attack. He didn't know what it was except that her B.P. was raised. Guessed it was anxiety. S thought - "now what"?	4	3	1
5	5	8	G.P.	Just talked.	Attacks recurring often & controlling her life.	E said nothing physiological. She must go to a psychologist. S found this very hard.	4	1	1
7	5	6	Psychologist	Therapy.	Sure she was dying but doctor would not admit it.	E said that as most attacks happened at night the problem was her home life. As she was newly married, it must be her marriage. Perhaps she should consider divorce. S was furious.	1	1	1
7	5	8	Emer. Rms.	Valium injection.	Arrived sweating, shaking, crying, wrapped in a blanket & stuttering.	S wanted to be saved from dying. Prac. did not say much but were efficient & took control. They reassured S & anxiety she relaxed & felt momentarily safe.	4	1	1

made up the third level of abstraction. This highest le[illegible]ituted the conceptual meaning and effect of treatments received and created the conclusions presented in this study. To clarify this process it will be graphically presented in the form of dendograms for some of the recurring trends analysed (fig. 7, section 9.1). Through the procedure of trend analysis the rich narrative data collected from subjects' interviews was organized into manageable bites allowing comparison and interpretation.

relentless help-seeking. The type of practitioner providing an effective diagnosis was tabulated relative to each research group.

6.4 Analysis of data

6.4.1 Quantitative data

The responses to both the direct questions and self-rating scales provided the quantitative data of this study. These were ordered and presented in frequency distributions and graphs. Trends and between group differences were noted and discussed.

6.4.2 Qualitative data

The qualitative analysis procedure used in this study was **trend analysis** (Strauss & Corbin, 1990). Tape recorded interviews were largely transcribed. The analytical process then began with identifying the gist of the responses and noting patterns and recurring trends. These themes were then coded and recorded on a simple checklist matrix for individual subjects (figure 3). Themes were then combined onto a conceptually clustered matrix allowing inter-subject comparisons and analyses (figure 4). This process involves shifting from f to their conceptual meanings, or of moving up to higher levels of abstraction. The experience of each treatment, as described by the subject, created the first level of abstraction. His emotional reaction to these consultations constituted the next level, illuminating the subjective effect of this treatment. His cognitive interpretations, guided by the treatment experience and his emotional reactions, and the behavioural manifestations of these interpretations,

frequency of their consultations with each of these practitioner groups; they reported most negative affect to psychologists and shared their pertinent symptoms of numbness and tingling (4, 4) and loss of balance (2, 5) between general practitioners and medical specialists and blurred vision (6, 5,4) among general practitioners, psychologists and alternative practitioners.

Group C subjects spread their identifying symptoms of nausea (5, 2, 5) and diarrhoea (5, 2, 2) among general practitioners, psychologists and medical specialists and loss of bowel and/or bladder control (4, 2, 2) between general practitioners, medical specialists and alternative practitioners. They reported their social withdrawal behaviour primarily to general practitioners and also to psychologists, psychiatrists and alternative practitioners (6, 2, 2, 1).

7.7 Treatments received

Table 13 lists the medications prescribed for subjects during their pre-diagnostic treatment search. All subjects received frequent prescriptions for anxiolytics and anti-depressants while group A were given significantly more *other* medication.

Table 13
Number of medications prescribed during pre-diagnostic treatment search

Medication	Group A	Group B	Group C
Anti-depressants	18	11	18
Anxiolytics	24	20	26
Other	29	10	11
Total	71	41	55

Table 13,1 shows the number of psychotherapy sessions each group underwent. This was a consistently utilized treatment across all 3 groups.

1989). The individual's primary emotion and cognition at this moment is **fear.** Embedded in this theory, this study suggests that the specific personal danger, or fear, the sufferer experiences is the primary cognitive component of his panic disorder. Fear is the central core of panic and the converting factor between a benign attack and a full-blown panic disorder. Fear, therefore, significantly influences sufferers' behaviour, including the way they chose to seek help for their condition.

Help-seeking behaviour quickly becomes the sole focus of panic disorder sufferers' existence, confirmed in statements by subjects in this study such as: "my life consisted of warding off a panic attack in whatever way possible, be it self medication, finding a new doctor or cleaning the brass all night," (subject 011); "life centred around finding a solution to my problem," (subject 015); "my whole life was ruled by panic and how to deal with it," (subject 018). Help-seeking behaviour is, therefore, a pertinent biopsychosocial concomitant of panic disorder and inextricably linked to the process and impact of the disorder. Sufferers' particular fear experience seems central to, and directly influential on, their help seeking behaviour.

8.3 Duration of pre-diagnostic treatment search and number of treatments

Group A, on average, procured a diagnosis of panic disorder far earlier than either groups B or C (3 years 3 months versus 7 years 2,4 months and 7 years 6 months) but during this shorter time span they underwent almost as many different treatments (7; 7; and 7,4). These

Chapter 8

DISCUSSION

8.1 Subjects and samples

The subjects readily and spontaneously fell into 3 groups according to their individual fear cognitions verifying the relevance of this variable to panic disorder.

The quantitative analysis of subjects' responses revealed clear differences amongst the three groups in this study with respect to the frequency with which they sought treatments, the practitioners they consulted, the symptoms they experienced and presented to various practitioners, their unique experiences of the different treatments received and the medical costs of their pre-diagnostic help-seeking years.

8.2 Fear - the cognitive link

It was proposed that panic disorder sufferers' fear cognitions are significantly influential on their help-seeking behaviour. The cognitive component of panic disorder is directly influential on sufferers' behaviour and has repeatedly been linked to the severity and process of their disorder (Barlow & Cerny, 1985). This cognitive component seems most accessed at a pre-rational level, when higher order rational processes are momentarily detached from lower order autonomic processes, creating a period of cognitive disorientation (McFayden,

Table 19
Diagnostic practitioners

Practitioner	Group A	Group B	Group C
Psychiatrist	4	4	3
General Practitioner	3	2	4
Radio talk precipitating contact with support group	1	2	4
Psychologist	4	1	
Homeopath	1		
Counselor	1		

Psychiatrists and general practitioners were the most frequent diagnosticians across all three groups. Group A also often received their diagnosis from psychologists, while group C equally often received their's after radio talks initiating contact with a local support group and appropriate practitioners.

specifically January 1996 to December 1996 inclusive, excluding dentistry and optometry.

Table 18,1
Means, ranges and standard deviations of control groups' annual medical expenses

Groups	Means	Ranges	SD
NC	R1 288,02	R51,10 - R5 930,61	1,6
AST	R2 173,22	R614,30 - R5 611,06	1,5
HYP	R2 225,13	R48,00 - R6 620,36	1,7

Table 18,2 lists the mean, ranges and standard deviations of medical expenses, over a 1 year period, for both the control and the experimental groups. As no control subjects had been hospitalized duri..g the twelve month period investigated, hospitalization costs were excluded from the experimental groups' means. The cost of over-the-counter medication utilized by panic disorder subjects was also excluded as this would not be included in the control subjects' medical aid claims from which their expenses were calculated.

Table 18,2 -
Means, ranges and standard deviations of annual medical expenses for both experimental and control groups

Group	Mean	Ranges	SD
A	R6 269,73	1009,81 - 14 851,86	3,9
B	R6 958,18	1285,90 - 18 618,09	6,1
C	R3 222,94	245,54 - 9 951,12	3,1
NC	R1 288,02	51,10 - 5 930 61	1,6
AST	R2 173,22	614,30 - 5 611,06	1,5
HYP	R2 225,13	48 0 - 6 620,36	1,7

7.11 Diagnosis

Table 19 indicates the practitioners who finally diagnosed the subjects of this study as suffering from panic disorder.

The total medical expenses were divided between the cost of consultations with medical practitioners and the cost of treatments received, including x-rays, blood tests and prescribed medicines for each subject. These are presented in appendix 7 with their means presented in table 17 below.

Table 17
Means, ranges, and standard deviations of the costs of practitioners and medical procedures (including medicines) for each group.

Groups	A	B	C
Mean practitioner costs	R6 568,54	R18 871,53	R12 486,28
Range of practitioner cost	R1 608,60 - R14 697,60	R897,60 - R55 885,20	R621,00 - R69 300,30
SD of practitioner costs	3,9	21,4	19,9
Mean treatment costs	R15 700,71	R8 284,60	R12 496,14
Range of treatment cost	R384,37 - R68 606,79	R1 006,26 - R26 816,47	R800,60 - R38 907,84
SD of treatment costs	18,5	7,6	14,0

Table 18 presents the mean ages, ranges and standard deviations for the control subjects utilized. The groups consisted of subjects with no chronic illness diagnosis (NC), subjects diagnosed as suffering from a chronic asthma condition (AST) and subjects diagnosed as suffering from a chronic hypertension condition (HYP). Each group had 12 subjects made up of 9 females and 3 males.

Table 18
Mean, ranges and standard deviations of control subjects' ages

Group	Age	Range	SD
NC	38,3	26-46	4,9
AST	40,7	28-56	8,1
HYP	42,0	30-68	10,6

Table 18,1 show the means, ranges and standard deviations of medical expenses incurred by control groups over a 12 month period,

period showed very little alteration. Most subjects rated their disorder at the most severe rating in terms of frequency of attacks (7), anxiety around their disorder (5) and the impact of their disorder on their quality of life (8). Six subjects did report changed ratings during the pre-diagnostic search. These are shown in table 15 above.

7.10 Direct medical costs of pre-diagnostic treatments

Table 16 indicates total pre-diagnostic medical expenses for all subjects in this study. Table 16,1 splits these among the 3 groups, while table 16,2 gives the individual subject's pre-diagnostic medical costs.

Table 16
Mean, range and standard deviation of total pre-diagnostic medical expenses for all subjects

Mean	R24 506,43
Range	R1511,60 - R99 559,02
SD	24,1

Table 16,1
Means, ranges and standard deviations of pre-diagnostic medical expenses for each group

Group	Mean	Range	SD
A	R22 269,25	R3 362,67 - R75 721,09	19,7
B	R27 156,13	R2 428,11 - R63 581,75	22,6
C	R24 982,43	R1 511,60 - R99 559 02	31,1

Table 16,2
Costs of pre-diagnostic treatment

Group A		Group B		Group C	
Subject no.	Costs (R)	Subject no.	Costs (R)	Subject no.	Costs (R)
002	18510,32	001	58871,76	003	4314,28
005	10342,61	004	2428,11	010	4419,80
007	3362,07	006	63581,75	013	1511,60
008	4334,31	014	14582,90	01[illegible]	5825,85
009	40801,59	017	33130,48	01[illegible]	11466,02
011	15904,14	024	6429,50	019	13875,13
012	12427,66	028	14787,05	02[illegible]	56145,54
016	36912,24	032	38931,37	022	99559,02
020	26277,75	033	11654,28	023	3872,67
026	22945,89			025	52267,71
027	14851,86			030	11549,11
029	75721,09				
031	7108,21				

7.9 Severity of panic disorder

Table 15
6 Subjects' self ratings of the severity of their pre-diagnostic panic condition

Group A			Group B			Group C		
Freq.	Anx	QOL	Freq.	Anx.	QOL	Freq.	Anx.	QOL
Subject No. 005			Subject no. 001			Subject no. 018		
7	5	6	7	5	4	4	4	4
7	5	8	7	5	8	5	5	6
7	5	8	5	5	6	5	5	6
6	5	8	6	5	8	7	5	8
5	5	8	7	5	8	7	5	8
5	5	8	7	5	8	7	5	8
5	4	8	7	5	8	7	5	8
6	5	8	6	4	8	7	3	8
7	5	8				5	3	6
7	5	8				5	5	6
Subject no. 012			Subject no. 006					
7	5	6	6	4	6			
7	5	8	6	4	6			
7	5	8	6	5	6			
7	5	8	3	4	4			
6	5	8	7	5	8			
6	5	8	7	5	8			
5	4	6	7	5	8			
			4	4	6			
			5	4	6			
			Subject no. 032					
			6	5	8			
			7	5	8			
			7	5	8			
			7	4	8			
			7	4	8			
			7	5	8			
			7	3	6			
			7	3	6			
			7	3	6			
			7	3	6			

Subjects rated the process of their condition on Likert self rating scales. The frequency of their attacks was rated from 0 - 7, their associated anxiety from 0 - 5 and the impact of their condition on their quality of life from 0 - 8, as outlined in chapter 6. Generally, subjects' ratings of the severity and impact of their disorder during the treatment search

Group A and group B subjects rated medical specialists highest on all three aspects while Group C subjects were most satisfied with psychologists' and mental therapists' treatment.

Group C's ratings of mental therapists' treatments is especially interesting as it is the only occasion where subjects rated their experience of the satisfaction of the treatment higher than either feeling understood by the practitioner or confident in his proposed treatment (3,0; 2,5; **3,5**).

Conversely, subjects seemed particularly disappointed in the effects of some treatments received. Specifically, group A's experience of satisfaction from mental health therapists (5,0; 3,0; **1,5**), group B's from psychologists (2,9; 2,1; **1,6**) and group C's from medical specialists (3,8; 3,1; **2,5**) were particularly low relative to their experience of being understood and their confidence in the proposed treatments.

Table 14
Mean ratings of treatment experiences

Practitioner	Group A			Group B			Group C		
	U/stood	Conf.	Satis.	U/stood	Conf.	Satis.	U/stood	Conf.	Satis.
General Practitioner	2,1	2,0	1,6	2,8	2,6	1,8	2,4	2,3	2,0
Psychiatrist	2,2	2,1	1,2	2,0	2,3	1,7	2,8	2,0	1,3
Psychologist	2,0	2,0	1,7	2,9	2,1	1,6	3,3	2,9	2,9
Medical Specialist	4,6	4,6	3,4	4,4	4,2	3,6	3,8	3,1	2,5
Mental therapist.	5,0	3,0	1,5	1,3	1,0	1,0	3,0	2,5	3,5
Alternative prac.	3,2	2,5	2,0	2,5	1,5	1,3	3,1	2,7	3,1

subjects were exposed to 44% more medical procedures that either groups B or C subjects although the mean number of practitioners consulted by each group was almost the same (7, 7, 7,4).

7.8 Treatment experience

Table 14 lists subjects' mean self-ratings on Likert scales ranging from 0 - 5 for each practitioner group. Treatments were rated by subjects on 3 components:

- subjects' experiences of practitioners' understanding of their problem
- subjects' confidence in practitioners' proposed treatments
- subjects' satisfaction in the treatment provided

Practitioners consulted were divided into 6 groups:

- general practitioners
- psychiatrists
- medical specialists (excluding psychiatrists and including physiotherapists and dieticians)

These 3 categories comprised the traditional medical practitioners referred to in section 6.3.4.1 and in the hypotheses of this study.

- mental therapists (including counsellors and re-birthers)
- psychologists

These 2 categories comprised the mental health practitioner group referred to in section 6.3.4.1 and in the hypotheses of this study.

- alternative practitioners (including homeopaths, aromatherapists, reflexologists, chiropractors, acupuncture, yoga and run-for-life)

Table 13,1
Number of pre-diagnostic psychotherapy treatments

Group A	Group B	Group C
10	13	12

Table 13,2
Number of pre-diagnostic medical procedures

Treatment	Group A	Group B	Group C
ECG	13	6	4
Stress ECG	2	2	1
Holter ECG	2	-	-
EEG	5	5	3
Brain CAT scan	3	-	2
Brain MRI scan	2	2	1
Lumber puncture	1	1	5
Myelogram	-	-	2
Full blood count	12	9	11
Liver functions	2	2	-
Hormone functions	4	2	5
Thyroid functions	3	1	4
Kidney functions	1	1	-
Glucose test	6	3	2
AIDS test	1	1	-
Malaria test	-	1	-
Allergy tests	-	1	-
Urine test	-	2	-
Cholesterol test	-	1	-
Tilt test	-	1	-
Pap smear	1	-	1
D & C	-	-	1
Carpel tunnel test	1	-	-
Pregnancy test	1	-	-
Lung capacity test	1	-	-
Spine X-ray	-	2	-
Chest X-ray	-	1	-
Abdominal ultrasound	2	2	1
Gall bladder X-ray	-	-	1
Nuclear X-ray	1	2	-
Barium Meal X-ray	1	-	3
Gastroscope	5	1	2
Colonoscope	2	1	1
Total	72	50	50

Table 13,2 (above) lists the various medical procedures subjects endured during their frequent consultations with medical practitioners before they were diagnosed as panic disorder sufferers. Group A

reported symptom by all subjects to all practitioner groups was anxiety and stress.

Table 12
Differential presentation of symptoms

Symptoms	G.P			Psychiatrist			Psychologist			Medical specialists			Mental health therapists			Alt. praes.		
Groups:	A	B	C	A	B	C	A	B	C	A	B	C	A	B	C	A	B	C
Fear	2	-	-	-	1	-	2	2	-	-	-	-	-	-	-	-	1	-
Sweating	13	7	13	4	2	-	-	4	4	4	3	3	-	-	-	-	3	5
Shaking	18	10	16	5	4	2	-	8	4	9	5	6	-	1	2	-	3	5
Palpitations	14	8	14	5	-	1	-	4	2	7	2	6	-	-	2	-	-	3
Dizziness	6	7	3	3	-	2	-	-	2	6	4	1	1	-	-	-	-	1
Anxious	12	12	15	5	3	1	2	10	5	5	3	9	1	1	3	5	4	8
Depersonalization	5	11	4	4	2	1	1	4	-	6	1	-	1	-	-	3	3	1
Negative Affect*	18	9	13	6	2	-	2	11	10	6	1	6	-	-	-	-	1	-
Nausea	10	1	5	-	-	1	-	1	2	4	1	5	-	-	-	-	-	-
Pain	12	-	5	-		-	-	-	-	12	2	1	-	-	-	1	-	-
Not coping	-	2	8	-	1	1	-	4	6	-	-	1	-	-	1	-	-	1
Attacks in control	7	-	1	2	3		4	1	1	3	-	-	-	1	1	-	-	2
Had attack there	4	2	1	1	-	1	-	-	-	4	-	-	-	-	-	-	-	-
Blurred vision	5	6	3	2	1	-	-	6	-	7	3	1	-	-	-	-	4	1
Numbness	2	4	3	-	1	-	-	-	-	1	4	2	-	1	-	-	-	-
Loss of balance	-	2	-	-	-	-	-	1	-	-	5	-	-	-	-	-	-	-
Diarrhoea	5	-	5	-	-	-	-	-	2	1	-	2	-	-	-	-	-	-
Loss of bladder/ bowel control	2	-	4	-	-	1	-	-	-	-	-	2	-	-	-	-	-	2
Social withdrawal	-	2	6	-	1	2	-	2	2	-	-	-	-	-	-	-	-	1

* including excessive emotionality, depression, desperation and exhaustion

All subjects clearly took their somatic symptoms to medical professionals, primarily to general practitioners and secondly to medical specialists.

Group A subjects also described somatic symptoms to psychiatrists but not to psychologists at all. The only symptoms these subjects reported to psychologists were anxiety and negative affect.

Group B subjects reported their somatic and anxiety symptoms fairly evenly between general practitioners and psychologists, relative to the

dynamic., would experience none, or only brief, satisfaction at the relief of this symptom as it is not directly relevant to his condition.

Subjects' specific fear ideations are closely associated with the symptoms they experience and significantly directive on the type of practitioner they choose to consult, how they present their symptoms to these practitioners and their individual phenomenological experience of these consultations.

Subjects' ratings of treatments experienced must, however, be cautiously interpreted with due considerations to their expectations of each treatment and their reasons for the consultations. For example, a person visiting a gastroenterologist might present only his digestive problems and feel satisfied if these are successfully alleviated but his panic attacks and anxiety may continue unchanged. This point is reinforced by the analysis of subjects' self ratings of the progressive severity of their disorde during the treatment search period. There are very few indications of significant improvement although subjects have rated various treatments during the search period as fairly satisfactory. It seems that, although the treatment met some immediate need, it often made little impact on the panic condition in either its biological, psychological or social arena.

8.6 Self ratings of pre-diagnostic panic conditions

Most subjects consistently rated their panic condition at the most severe levels on all three dimensions: specifically the frequency of their attacks (7), their associated anxiety (5) and their impact on the subject's

frequented mental health practitioners, they presented only a vague array of somatic symptoms and little negative affect, giving practitioners very little tangible data with which to work. The result is an unclear consultation making decisive treatment difficult. These consultation dynamics are qualitatively discussed in chapter 9.

Group A subjects were extremely disappointed in their treatment from mental therapists despite their feeling that these practitioners certainly understood their condition, **(5,0, 3,0, 1,5)**. As discussed, these subjects only presented their psychological or negative affect symptoms to these practitioners. It seems that understanding of these symptoms without some positive approach to alleviating their physiological symptoms, and hence their fear of imminent death, was inadequate for these subjects.

Conversely, group C subjects reported significant disappointment in the treatment received from medical specialists. This could be influenced by the array of different specialists they consulted but it is suggested that it is also resultant on these subjects' needs and communication style. Characterized by inaccurate symptom presentation (e.g. sinus, headache) camouflaging their real requirements, and the spasmodic and irregular usage of a network of practitioners, it is not surprising that the intermittent alleviation of these often pseudo symptoms did not render an enduring experience of treatment satisfaction. Consider a group A subject consulting an ear, nose and throat specialist with severe sinus which the specialist alleviates. This subject will now have one less reason to believe he is dying. Whereas, a group C subject, involved in the same consultation

panic disorder patients who are inclined to cognitively catastrophize (Rachman, Levitt & Lopatka, 1987) and over focus on issues of personal danger (Schmidt et al, 1994). The subjective interpretation of treatment experiences and its influence on the course of subjects' panic disorder and life style is discussed in more detail in chapter 9 of this study.

8.5.3.1 Psychotherapy received

Psychotherapy was regularly and abundantly utilized across all subject groups but did not precipitate a diagnosis.

8.5.4 Treatment experiences

Group A subjects rated medical specialists most favourably which is not surprising because, as discussed above, they utilized a small sector of specific specialists and presented discrete somatic symptoms. This would facilitate effective communication and focused treatment. A similar conclusion holds for group C who reported the highest satisfaction in psychologists and mental therapists visited. These subjects primarily reported their social withdrawal symptoms to these practitioners and this symptom is probably most appropriate to psychotherapy.

Group B subjects' disappointment in the effect of treatment received from psychologists is hypothetically interesting as it is these practitioners they probably found the most threatening in their presumed professional ability to identify subjects' imminent mental collapse. Paradoxically, these practitioners hold the key to alleviating this same fear by declaring it unfounded. Although this group

practitioners and, finally, the sixth hypothesis' prediction concerning group C subjects' selectivity in both the symptoms they present and the practitioners to whom they present them.

8.5.3 Treatments received

All subjects received frequent anti-depressant and tranquilizing medication. Group A subjects received more prescribed medication falling into the *other* category, which includes pain preparations, anti-inflammatories, muscular relaxants and digestive remedies (29, 10, 11). This is consistent with their regular reports of pain and digestive symptoms and their consistent use of medical rather than psychological or alternative practitioners in comparison to the other two groups.

All subjects underwent frequent and extensive medical procedures including blood tests, x-rays, electrocardiographs, electroencephalographs and, less frequently, but worrying and unpleasant, gastroscopes, colonoscopes and lumbar punctures.

The subjects in all groups, clearly, received comprehensive physical diagnostic evaluations with little consideration to the possibility of a psychiatric condition. Where mention was made of stress or anxiety it was limited to the prescription of anxiolytic and/or anti-depressant medication, seldom including an explanation. Mechanic (1972) conducted a brief literature survey of doctor-patient interactions and concluded that patients will make their own assumptions of treatments and, in the absence of correct explanations, these will be subjective and often incorrect. The unexplained prescription of central nervous system medication can easily be incorrectly interpreted especially in

Group C's symptoms mimic those of group A with the inclusion of more dramatic and potentially embarrassing digestive conditions. The symptoms experienced do, however, form a relatively concise and communicable cluster, far less vague than group B's. These subjects presented their symptoms fairly equally among the practitioners consulted. A major difference lies in group C's tendency to frequent more alternative practitioners, therapists and psychologists as well as a more diffuse array of medical specialists.

Subjects from group C were the only ones to present headaches and sinus as pseudo symptoms during a medical consultation they hoped would alleviate their panic condition. These subjects also frequently doctor shopped or saw 2 or more practitioners simultaneously and became adept at copying scripts and filling them at different pharmacies. This typifies the running and hiding behaviour of panic disorder sufferers (Leaman, 1992) simultaneously trying to find help but also trying to hide their problem (Ashcroft & Walker, 1989). It is also consistent with the universal tendency for panic disorder patients to avoid threat and, therefore, approach their condition defensively (Parker, Taylor & Bagby, 1993). These events will be discussed again in the qualitative analysis of data but, at this point, it is noted that, despite experiencing fairly clear and concise symptoms, these were ineffectively communicated and subjects' help-seeking behaviour oscillated amongst a diffuse array of practitioners. These observations further support the third hypothesis' prediction that these subjects would use more alternative practitioners, and the fifth hypothesis' prediction that they would present specific symptoms to these

and the practitioners they chose, this is discussed again in the qualitative analysis of data (chapter 9).

8.5.2 *Symptom presentation*

Group A subjects split the reporting of their symptoms between practitioners. They only reported their psychological symptoms to the psychologists they consulted. In addition group A subjects repeatedly reported severe pain and abdominal distress to both general and specialist medical practitioners. These subjects, therefore, presented a very different profile both to different practitioners and, on comparison, from the subjects in the other groups. This observation supports hypothesis 6 of this study which predicted that group A subjects would present their symptoms clearly and directly to appropriate practitioners.

Group B subjects, desperately afraid of going insane, admitted to only differentially disclosing their symptoms to practitioners. One subject in this group said she was only totally honest about her condition to her yoga instructress whom she felt sure would not certify her as insane and intern her. The thought of offering a symptom profile easily indicative of a mental collapse seems, to these subjects, likely to precipitate the confirmation of this fear, as opposed to group A subjects where active and direct communication and treatment could contain and delay, if not negate, their dreadful fear of dying. Group B's manner of symptom presentation is also consistent with hypothesis 6 which proposed that they would selectively present their symptoms to chosen practitioners.

symptoms and group C subjects symptoms suggesting loss of physical and/or mental control.

Interestingly, group B's reports of negative affect were the lowest. Negative affect, including depressed mood, exhaustion and ineffective functioning, is traditionally associated with emotional disturbances. These subjects openly reported hiding, and only discriminately reporting, their symptoms which is consistent with hypothesis 6 of this study and research reports of panic disorder sufferers often uncharacteristically lying and misconstruing of symptoms (Baker, 1992). This suggests that their infrequent identified experience of negative affect symptoms could be due to their defensive denial of those symptoms and efforts to focus instead on their physiological symptoms, resulting in only a diffuse and confusing array, including depersonalization, blurred vision and occasional balance impairment. This observation further supports research findings that have identified panic disorder patients' coping styles as centring around dependency, cognitive avoidance and rumination (Vollrath & Angst, 1993).

Panic disorder patients' fears have been reported as reactive on their somatic symptoms (Schmidt et al, 1994) and subjects' interpretation of their symptoms has been reported as dependent on the fear they experience (Beck, Sokol & Clark, 1992). The fear and somatic symptom relationship quickly becomes reciprocal and develops into an escalating spiral of anxiety (Weekes, 1989). This study's data shows a consistent correlation between the symptoms subjects' experienced and

their individual fears and suggests this is largely directive on the type of practitioner consulted and the way they present their symptoms.

8.5 Consultation dynamics

8.5.1 Practitioners consulted

Group A subjects gravitated largely toward general practitioners and medical specialists, logically consistent with their fear of physical collapse and the type of symptoms they experienced.

Equally logically, group B subjects were the highest users of psychologists (3,2; **19,6;** 10,0) and psychiatrists (11,7; **12,5;** 5,0) and regular users of other mental health therapists (4,3; **5,4;** 6,1).

Group C subjects' less definable fear seems to have directed them towards alternative practitioners and healers more than their counterparts (8,7; 9,0; **13,4**). The third hypothesis of this study predicted this differential utilization of practitioners by the three groups.

Group C subjects explained their practitioner choice in terms of hiding away and protecting themselves from the insight and directness of traditional learned practitioners while still fulfilling their need to seek some help. This phenomena further substantiates the third hypothesis and is also consistent with hypothesis 6, which predicted that group C subjects would show selectivity in both their symptom presentation

8.4 Symptoms experienced

All the subjects in all three groups regularly experienced somatic symptoms consistent with research findings and established classificatoty systems, especially sweating, shaking and palpitations.

In addition to these recognized panic disorder symptoms, all subjects repeatedly experienced severe anxiety, stress and negative affect (including depression, exhaustion and desperation) and reported frequent experiences of not coping.

Subjects also experienced unique symptoms distinctly relative to their fears:

- group A subjects, afraid of death, experienced more intense and specific physical symptoms easily associated to physical collapse;
- group B subjects, fearing mental collapse, experienced vague, imprecise and intangible symptoms rendering them unsure and helpless, reinforcing and/or reactive on their fear of truly going mad;
- group C subjects, fearing social embarrassment, experienced symptoms very likely to catalyse just this fear, specifically diarrhoea and lo[illegible] of bladder or bowel control, and were also prone to social withdrawal behaviour.

The different symptoms experienced by subjects relative to their group, and, hence, to their idiosyncratic fear, confirms the fourth hypothesis of this study which expected group A subjects to experience more physiological symptoms, group B subjects more psychological

Secondly, of the three fear categories (death, madness, social embarrassment) death is the most discretely definable and communicable in traditional Western medical settings. The fear of either going mad or of embarrassing oneself socially, while equally threatening, is vague. How either madness or social embarrassment ultimately manifest is idiosyncratic and identifiable catalysts are not clear, making the experience difficult to communicate in terms of the subjects' usual illness conceptual frameworks. Communicating a series of physiological symptoms as indicative of a heart attack, or organic collapse signifying death, is easier. It is simpler to say, "I have frequent spells of shaking, sweating and palpitations with severe chest pain and limpness in my left arm and feel terribly anxious all the time. In fact, I am sure I am having a heart attack," than to verbalize the same symptoms, believed to be indicative of a pending mental collapse or social disaster, which is difficult to clearly describe and which the sufferer is petrified the practitioner will confirm.

These phenomenological differences in subjects' fear experiences seem to direct their help-seeking behaviour and symptom presentation consistent with three proposed hypotheses. Specifically hypothesis 3 which proposed that group A subjects would use more traditional medical practitioners, group B more mental health practitioners and group C more alternative practitioners; hypothesis 5 which predicted the differential presentation of symptoms to these practitioners by the three groups and hypothesis 6 which outlined expected differences in the actual mode of symptom presentation.

she regularly visited when an attack was unbearable, "He literally saved my life every time he p ut me on a Valium drip."

Afraid that one is going mad or about to embarrass oneself in public, probably including the possibility of uncontrollable, inappropriate and bizarre behaviour at any moment, exerts different pressures and manifests in different behavioural patterns. Subject 018 in this study reported this fear as so powerful that she could not stay in a practitioner's waiting room, afraid that her awaited uncontrollable behaviour episode would occur there, and often left before it was her turn. Subject 021 described how impossible it was for her to return anywhere she had had an attack, even a doctor's rooms, resulting in her often suddenly curtailing a specific course of treatment. Subject 013 said she was so embarrassed by her fears that her life task became to hide them from everyone, so that any help she sought had to be outside of her usual social or medical support networks.

Group B & C subjects desperately wanted help but equally desperately feared that the full recital of their symptoms could precipitate the diagnosis they most fear, i.e. that they are insane and will not be able to cope with their behaviour. These subjects adopted a reticent defense oriented approach confirming hypothesis 6 of this study which predicted that the three groups would present their symptoms to practitioners in different ways. They also took basically twice as long to receive the same number of treatments, consistent with hypotheses 1 and 7, which respectively predicted differences in the duration of the three groups' pre-diagnostic help-seeking periods but no difference in the number of practitioners consulted.

results substantiate this study's first hypothesis which expected group A to reflect the shortest help-seeking period followed in ascending order by group B and group C; and also hypothesis 7 which predicted that there would be no difference in the number of practitioners consulted by each group.

It seems that these subjects adopted a task-oriented, proactive approach to their condition, ardently and actively visiting many health practitioners. A twofold explanation of this influence ir offered. Firstly, fear that one is **about to** die is a powerfully urgent and immediate emotion needing active attention, as opposed to being afraid that one is **going to go** mad or embarrass oneself in public. This urgency results in these subjects' ardently proactive help-seeking behaviour, clearly illustrated in their elevated usage of emergency room services (5, 1, 1). Subject 016 in this study emotively described the immediacy of his fear explaining, "You say to yourself, I escaped yesterday but this is definitely the end, today I will die." Driven by this forceful and unquestionable interpretation of one's physiological symptoms as signifying death, these subjects almost frenetically seek help, or salvation. The same subject described his desperate need to be close to medical care manifesting in his spending his evenings sitting in his car parked outside a hospital until sleep practically overcame him and, also, having his daily lunch in a hospital cafeteria. Similarly, subject 008 created a network of general practitioners near both his work and his home and in between the two. These behaviours support Gournay's (1995) observations of panic disorder patients' tendency to create a medical support structure. Medical practitioners are literally lifesavers and, thus, able to allay these subjects' worst fear, their fear of losing their lives. As subject 012 said of her general practitioner whom

reciprocally influences the duration of their pre-diagnostic help-seeking and their experience of consultations during this period. There are also suggestions that, even the minimal, reduction of this fear seems to offer subjects a glimmer of hope and energize them to gradually take control of their condition and their lives.

are most common when a practitioner and patient have a familiar and long standing relationship.

Group C's diagnoses were frequently initiated by radio talk shows resulting in introductions to support groups and specific practitioners, which is doubly interesting. It is, firstly, consistent with hypothesis 6's predictions that these subjects' would approach help-seeking in a reticent and selective manner, and, secondly, it illustrates the vital need for public education on, and understanding of, panic disorder. Practitioners, health workers and lay people all crucially need to be well schooled in the manifestation of this unpredictable condition and alert to its early recognition (Forrest & Ricketts, 1995).

Although the post diagnostic process of their panic condition was outside the scope of this study, many subjects spontaneously recounted the changes. These descriptions centred around the relief that a clear explanation of their condition, accompanied by focused treatment suggestions, offered. Primarily, they no longer felt poised on the brink of a physical, psychological or social disaster but saw themselves as normal people, suffering from a manageable and comprehensible complaint. The phenomenological experience of a correct diagnosis is discussed in chapter 9, section 9.6.

8.10 In sum

The analysis of the quantitative data, assimilated from subjects' responses to the pre-designed direct questions and self-rating scales in this study, shows that the specific fear component of subjects' panic conditions exert a strong directive influence on the symptoms they experience and the way they seek help for these symptoms. This

8.9 Diagnosis

Subjects in this study all rated their experience of the diagnostic consultation at the most favourable levels (5,5,5) clearly indicating the impact it had on their condition and life style.

Psychiatrists and general practitioners were the most consistent diagnosticians across all the groups confirming the expectations stated in hypothesis 9, that there would be no difference between the groups in the type of practitioner from whom they received an effective diagnosis, and that this would largely be a traditional medical practitioner.

As well as regular diagnosticians, general practitioners were also the most frequently consulted practitioners across all the groups, and 16 of the 33 subjects visited general practitioners at their first consultation. Although only 2 subjects visited psychiatrists on a first consultation and none psychologists, both practitioners were abundantly utilized by subjects during their treatment searching. Despite this, there remained the tedious time lapse before a diagnosis was procured. There is unquestionably a serious need to fine tune both practitioners' receptiveness to and differentiation of this condition. This is not an unrealistic goal as research findings have shown that primary care physicians can 100% correctly diagnose panic disorder **when they are properly prepared and trained** (von Korff et al, 1987).

All practitioners diagnosed subjects on a first consultation, confirming Paykel & Priest's (1992) observation that missed and/or misdiagnoses

symptoms formed a definable cluster, similar to that of group A's subjects but their desperate need to avoid social embarrassment, which they believed would be precipitated by clear and complete symptom presentations, led them to, both, present irrelevant symptoms and consult a diffuse array of practitioners as anticipated in hypothesis 6. This unfocused help seeking approach resulted in the equal division of their expenses between consultations and procedures and delayed their diagnosis. These observations support hypothesis 1 of this study which suggested that group C subjects would take longer to be diagnosed and hypothesis 3 which expected them to utilize more alternative practitioners than groups A and B.

8.8.2 Comparison with costs of chronic physiological conditions

The medical expenses of the panic disorder subjects were compared to 3 matched control groups representing the general populations of subjects with no chronic condition (NC), with chronic asthma (AST) and chronic hypertension (HYP). As planned, the costs of over the counter medicines were excluded from these calculations and, further, as no randomly chosen control subjects had been hospitalized during 1996, the costs of hospitalization were also excluded from the experimental groups' means. This comparison unequivocally shows the significantly high cost of panic disorder sufferers' help-seeking despite both asthma and hypertension patients requiring regular monitoring and consistent medication. These results confirm the second hypothesis' prediction that the medical costs of all research subjects will be higher than those of the control groups. Caution must, however, be exercised as these costs for both groups AST and HYP are post-diagnostic.

These revised means are significantly lower but remain above quoted research data of a costs of approximately R12 000,00 (von Korff & Eaton, 1989). Group A still reflect the most elevated medical expenses, followed in descending order by group B and group C, which exactly reflects the predictions of the second hypothesis in this study.

8.8.1 *Practitioner versus treatment costs*

Their different help-seeking behaviour is clearly illustrated by a comparison of the 3 group's medical expenses divided between the costs of consulting practitioners and the costs of medical procedures received, including x-rays, blood tests and medicines. These are presented on table 17 in chapter 7 of this study.

Group A spent more than twice as much on medical procedures as on practitioner consultations while exactly the reverse holds true for group B, who spent more than twice as much on practitioner consultations. This verifies the impact of extended hospitalization on group A subjects and psychotherapy on group B subjects, which was discussed above. This comparison also poignantly captures the different help-seeking behaviour of these two groups of subjects, each driven by their idiosyncratic fears. These results support hypothesis 3 of this study which proposed that group A subjects would use more traditional medical practitioners, group B more mental health practitioners and group C more alternative practitioners.

Group C's consultation and medical procedure costs are almost identical. This reinforces the influence of their unique fear, which was associated with the symptoms they experienced. Their reported

Subject 013 presents an interesting case. Her treatment searching only lasted twenty months but during this time she was totally overwhelmed by a need to hide her abnormal and humiliating condition from anyone familiar, including her usual medical practitioners. As a result, she did little active help-seeking and resorted instead to extreme and unpredictable withdrawal and avoidance behaviours with negative effects on her interpersonal relationships. Her first husband left her during this time and her young son developed serious learning and behavioural problems, for which she still holds herself, and the way she mishandled her panic condition, responsible.

These outlier scores are considered representative of the general population of panic disorder sufferers and relevant to this study. Their extreme costs were legitimate and burdensome adding emphasis to the potentially crippling years of aimless treatment searching and reaffirming observations and research findings. In the light of this it is suggested that the calculated costs are representative data.

However, in the interests of cautious reliability and content validity, the following table was composed indicating the mean medical expenses for each experimental group excluding hospitalization and psychotherapy costs.

Table 20
Mean pre-diagnostic medical expenses excluding hospitalization and psychotherapy

Group	Means
A	R 15 903,87
B	R 14 761,69
C	R 14 682,43

ineffective searching for an answer to her problems, and during this time experienced severe digestive symptoms concurrent with her anxiety attacks. These were often medically investigated and regularly medicated at a considerable financial outlay.

Conversely, there were 4 subjects (007,008, 004, 013) in the inclusive sample who spent substantially less on their panic disorder treatment attempts than the others.

Subject 007 suffered for 3 years 4 months before being diagnosed but did enjoy a period of spontaneous remission of about 15 months during this period, when she did not have any medical treatment. She also had an extremely negative treatment experience with a psychologist who unilaterally blamed her marriage for her problems, this is discussed again in the next chapter. This encounter made her hesitant in her further treatment searching and she suffered silently for many months. These 2 events together explain her lower costs.

Subject 008 initially experienced very little satisfaction from the treatments he attempted and, within this frustration, sunk to a very low ebb but did not immediately know where to seek further help. He resigned from his job and stayed aimlessly at home for over 8 months. It seems the direct medical costs indicate only a small portion of this man's panic disorder debt.

Subject 004 was one of the "lucky ones" as she describes it. Her regular general practitioner diagnosed her condition within 2 months and put her on the road to effectively managing it. This is the fortune that should be available to all panic disorder sufferers.

their approach to their disorder. This phenomena is consistent with hypothesis 8 of this study and is discussed again in section 9.2.6.

8.8 Direct individual medical costs of pre-diagnostic treatments

The mean medical costs calculated for subjects' pre-diagnostic treatment search are alarming and substantially higher than the approximate figure of R12 000,00 reported in research (von Korff & Eaton, 1989).

There is a wide range amongst individual costs, suggesting that calculated means could have been influenced by extreme scores or ouliers. The scrutiny of these extreme scores is, therefore, necessary.

Substantially elevated costs were calculated for 5 group A subjects (009, 016, 020, 026, 029). All those subjects, except 020, were hospitalized for lengthy periods at an enormous cost. Subject 020's costs were inflated by a consistent 6 year period of expensive anti-depressant medication.

No significantly large hospitalization costs were recorded for group B subjects, but 3 subjects (001, 006, 007) did endure particularly higher medical expenses. The scrutiny of these totals reveals this to be due to many, many years of regular psychotherapy.

Subjects 021, 022 and 025 from group C had exceptionally high medical expenses. Subjects 022's and 025's costs were inflated by extended hospitalization. Subject 021 endured twenty years of

In this study, these inklings seemed to arise as subjects' primary fears were differentially addressed as anticipated in hypothesis 8. Subject 012, fearing and focusing on death, reports improvement when she becomes health-oriented. Subject 006, afraid of going mad, reports improvement when a specialist acknowledged and encouraged his effective coping ability by implication respecting him as a functional versus an insane man. Subject 018, fearing social embarrassment, felt energized on being treated like a person, allaying some of her experience of herself as abnormal and a social misfit. Subject 032, fearing that he was going mad, was revitalized by a psychologist simply normalizing his reactions and assuring him that he was not insane.

8.7 *Fear - the cognitive link*

Subjects' idiosyncratic fear ideations influence their behaviour and life style, specifically their help-seeking behaviour and treatment experiences. This study now suggests that panic disorder may be maintained through the reinforcement of subjects' fears, which infiltrate their biological, psychological and social systems. The infiltration of panic disorder into subjects' biological (frequency of attacks), psychological (associated anxiety) and social (quality of life restrictions) systems has been illustrated. The alleviation of only one aspect, such as the frequency of physiological panic attacks, addresses only part of the problem. Despite the different manifestations of panic disorder, a common thread through consultation dynamics seems to be that the reassurance of subjects' fears, even a subtle minuscule reassurance, initiates a glimmer of hope, empowering the sufferers and reinstating a sense of control or efficacy, and can be a turning point in

Although these identified treatments did make a positive impact on subject's conditions, their ratings, especially of their satisfaction in the treatment received, were low (1,2,2,3,2,3). The highest ratings were for those practitioners who did address or at least acknowledge, either through formal medication or through their consultation interactions, the biological, psychological and social aspects of panic: i.e subject 006's psychiatrist; subject 032's psychologist; subject 018's alternative practitioner.

These small indications of the experience of the beginning of healing were consistent with subjects' narrative reports of this experience, discussed in section 9.2.6, and support hypothesis 8 or this study.

These subjects' ratings and explanations clearly show that the psychological and social concomitants of the condition are in fact intrinsic to it, not vague by-products (Markowitz et al., 1989). The mere reduction in the frequency of attacks was not tantamount to curing the condition. The beginning of healing seems to occur when subjects feel a little less helpless and experience the first inklings of regaining control of their lives. This is consistent with Weekes' (1989) conclusion that panic disorder sufferers need to understand their condition and address its impact on their lives which gradually alleviates their sense of helplessness; and with frequent research reports that correlate the deterioration of a panic condition to the individual's experience of uncontrollability and helplessness (Cloitre et al., 1992; Leaman, 1992; Barlow & Cerny, 1985).

treatment experience at 4,2,2. She learnt practical coping skills, such as breathing and relaxation, which helped these aspects but she said her quality of life was still abominable and dominated by her panic condition.

Subject 006 reported a generalized and significant improvement after consulting a psychiatrist (rated 4,3,2) whom she describes as "more than a medicine man." He prescribed an anti-depressant for her but also clearly understood the depth and impact of anxiety and encouraged her to face her fears and gradually regain control of her life.

Like subject 006, subject 032 expressed distinct relief which impacted on his anxiety and quality of life when a psychologist told him he was not going mad and explained his reactions as anxiety driven. He remarks that, although work colleagues still thought he was "incapable and out of it," he started to believe he could be functional again. He rated this treatment at 3,3,3.

Group C subject 018 felt her anxiety levels reduce when she was prescribed a beta blocker and muscular relaxant by a general practitioner (rated 3,3,2) Initially, this improvement did not infiltrate the other areas of her life but the improvement was catalysed on visiting an alternative practitioner (rated 4,4,3). She felt he acknowledged her suffering and "treated her like a person" helping her to channel some of the energy, gained from her reduced anxiety, effectively and begin to live again.

quality of life (8). Clearly, subjects remember those months and years as debilitating, ineffective, anxiety ridden and panic driven.

The six subjects who did alter their ratings could give clear reasons why this had occurred.

Two group A subjects reported a reduction in the frequency of their panic attacks during this period. Subject 005 experienced a spontaneous abatement in the number of attacks she was having as is so common during the unpredictable course of this condition (Leaman, 1992). This reduction had no impact on her anxiety, which she described as debilitating, or on her quality of life. She remarked that one attack per week easily controlled her entire existence which she said was ruled solely by her panic condition at this stage.

Subject 012's attacks reduced in number when she was prescribed a beta blocker and sleeping tablet by a cardiologist. She rated this treatment experience at 1,2,1. This subject, likewise, reported no difference in her anxiety levels or quality of life ratings. Her entire life was simply waiting for that final attack that would kill her and which she was unquestionably convinced was imminent. She only reported a wider spread improvement in her final pre-diagnostic treatment which altered her focus from illness oriented to health oriented.

Three subjects in group B reported changes in their condition during this period. Subject 001 noted a reduction in both the frequency of her attacks and her anxiety levels after private yoga tuition. She rated this

her condition after which the practitioner gave her a prescription and ended the consultation. The subject said she was confused and wondered what he could possibly have prescribed having no idea of how she felt. She interpreted the interaction as clear evidence that she was dysfunctional and weird, unable to even conduct an effective discussion.

Subject 025 reported a practitioner being totally unsure of her problem and apologizing profusely and anxiously for his own incompetence. The subject said this accentuated her own anxiety and her perception of herself as an abnormal social misfit who had now scared even this medical person.

The subjects longed for discussions with their practitioners, but both these forms of discussion reflected the practitioners' agendas and did not in any way confirm the patients' existence or person.

9.1.8 Some specific experiences

Subject 018, who repeatedly had panic attacks during consultations, even during a reflexology session, to which practitioners showed very little reaction, internalized these experiences as affirmation of her social inadequacy and reinforced her fear that very soon she would behave in an uncontrollably and overwhelmingly inappropriate manner.

Lastly, subject 028, instructed to take medication when necessary, found it very difficult, and reported becoming totally, one hundred percent, introspective and illness oriented, constantly waiting and wondering whether she now felt bad enough. Thinking she was bad

Subjects experienced this reticence as frightening and interpreted it as the practitioners' hesitance to embark on a conversation that would force them to discuss death. The subjects now believed death was very close and, therefore, there was no time to, and no point in, trying to deal with it. Again, it is clear how subjects reflect these dehumanizing and unclear interactions in a sense of futility and helplessness, which is directly related to their fear, their ensuing help-seeking and to the severity of their disorder.

9.1.7 Dealing with practitioner uncertainty

From the above discussions it is evident that subjects do not assume practitioner uncertainty from their hesitancy to discuss treatments, or lack of explanations, but, instead, interpret this practitioner behaviour as a premeditated and conscious decision to withhold insight from them. The patient feels underrated, disregarded and helpless, reinforcing his fear and its imminence.

Two group C subjects reported treatment experiences where the practitioners were clearly unsure and handled it in two different ways. The first practitioner would not openly admit it. The subject detected his confusion by his questions and responses which were repeatedly inappropriate and which the subject (012) tried to clarify. For example, the practitioner suggested to the subject that it seemed she got diarrhoea after she ate in a restaurant. The subject explained that she had constant diarrhoea, which she was petrified would become uncontrollable, she also often found it almost impossible to swallow, and was consequently unable to even enter a restaurant. She said that these unsynchronized interchanges continued on different aspects of

9.1.5 Arrogant non-committal practitioners

Subjects described practitioners as arrogant when they lyrically told subjects how well they understood anxiety and its related conditions but failed to accommodate this knowledge to the subjects' specific and immediate needs. When subjects dared to voice any doubts about a treatment's efficacy (subject 016) or concern about its side effects (subject 001), these practitioners offered bland reassurances, summarized by subject 016 in the statement, "just hang in there." These subjects felt frustrated and unacknowledged but caught in a bind between wanting to abandon treatment and simultaneously desperately needing it. Their interpretations again centred on interpreting practitioners' arrogance as indicative of their superior knowledge and that they saw no point in sharing this because the subject was both too dysfunctional to understand and too ill for it to make a difference.

9.1.6 Avoidance of anxiety symptoms

Five subjects from group A found a reticence among practitioners to discuss the anxiety component of their condition in any detail, despite the subjects' regular references to it. Or similarly, to quickly label a reason for the anxiety component and dismiss it without further ado. As subject 016 put it, "it is all very well doing scans and scopes but some conditions cannot be measured like that, which does not mean they do not exist." This experience was obviously not in the consultations with psychologists as these subjects only presented emotional symptoms to psychologists (chapter 7), forcing their response to them.

Common in this type of treatment experience were the practitioners who enquired as to the present status of the condition but glibbly accepted it as a *sine qua non* with no possibility of ever being cured or even improved. Patients' emotional responses to these interactions were largely humiliation and worthlessness. They did not long for judgment or evaluation but just for some human reaction confirming the practitioner's authenticity and reciprocally confirming their own human presence or existence.

Their subjective interpretations, again, attributed this practitioner behaviour to their secret knowledge and presumed that these people were merely keeping them contained until the dreaded event happened. Responses such as, "he's just helping me through the waiting period" (subject 012) illustrated this. These cognitive reactions exacerbated subjects' primary fears which directly influenced their behaviour and precipitated future negative consultation experiences (figure 8).

Subjects' behavioural manifestations of these interpretations again varied amongst the three groups. Group A subjects responded with despondent resignation that death was closely imminent. Group B subjects interpreted practitioners' unquestioning acceptance as confirmation of their ineffective and disturbed psychological state putting them already beyond help, and lived in constant anticipation of a complete emotional breakdown. Group C subjects internalized an image of themselves as dependent on this practitioner's treatment to keep a lurking and overpowering force inside themselves. Subject 023 described this secret force as, "life threatening should it escape," similar to knowing that your father is a murderer. Logically, they tended largely towards avoidance type behaviours.

their need to harness this monster within through exaggerated withdrawal, and dishonest or camouflaged symptom presentation. Group A and B subjects' behavioural manifestations of these experiences were most tragic centring on extreme resignation. Subject 033 said she thought she was obviously mad and was too weak and helpless to resist; subject 029 believed there was obviously no hope so why even try, everyone has to die sometime.

9.1.4 *Unmoved acceptance of condition*

Subjects seemed to find the unmoved or almost indifferent acceptance of their condition extremely negative and alarming. This interaction style was communicated in descriptions of practitioners who simply interjected subjects' explanations with the occasional "Hmm, mmm," seldom even raised their eyes and offered repeated unexplained prescriptions.

Subject 017 said, about her general practitioner of many years standing, that she was sure if she suddenly arrived with a complaint of tonsillitis she would have got the same medication. This example is, of course, tainted by the typically stereotyped interaction between a practitioner and subject who know each other very well which correlates positively to missed or misdiagnoses (Paykel & Priest, 1992) but also illustrates the phenomena under discussion.

Subject 005 reports having a fully fledged panic attack in two different practitioners' rooms during a consultation, to which neither gave a glimmer of a reaction and rapidly dismissed her.

Again, their interpretations of these consultation dynamics reinforced their accompanying fears. These subjects believed practitioners were aware of the extreme gravity of their conditions and, hence, thought any discussion would be totally fruitless.

9.1.3 Negative test results

Another variable repeatedly identified as catalysing negative treatment experiences was the procurement of negative test results followed by the quick dismissal of the patient as healthy. The plea by subjects was that they accepted the results as valid but then **what is wrong**; why did they still feel so terrible?

All subjects believed practitioners had stumbled upon some other dreadful thing lurking inside them that could neither be controlled nor cured and were, therefore, washing their hands of them. The feeling of being left "high and dry" was often mentioned and always interpreted as a conscious practitioner choice precipitated by some life threatening observation.

Individual interpretations of this experience varied consistently with their fears. Group A subjects generally assumed that the practitioner had uncovered an irreversible physiological condition. Group B subjects assumed the practitioner now knew they were going mad. Group C subjects' interpretations centred on their individual sense of being abnormal and reinforced their needs to control this seething monster inside themselves that was imminently liable to erupt.

Subjects' behavioural manifestations of these interpretations also varied according to their individual fears. Group C subjects operationalized

epitomizing their worst fear come true. One of these subjects (001) went so far as to believe the medication was actually precipitating the onset of her dreaded insanity. As a result she refused to take any medication for many years into the future.

Equally dehumanizing were subjects' (012, 025, 016, 001, 002) reports of practitioners discussing their condition with other practitioners in front of them, often while they were prodding and examining them, but totally ignoring their presence. These subjects felt humiliated, degraded and unacknowledged for even their presence, let alone their person.

Similarly, practitioners were accused of frequently referring subjects to other practitioners with no reasons offered. One subject (012) described her repeated experience of opening her mouth to ask why, but before any sound had emanated, the practitioner had smiled and shown her the door. Subject 025 reported being admitted to hospital for five days for observation and tests with no explanation of what they planned observing or testing. While there, she was examined by many and various practitioners, who were equally non-commital, and then discharged. On telephonically contacting the original referring practitioner he told her she was actually fine. As subject 016 described, "these practitioners are focused on stopping your cough, and often succeed in stopping one of your coughs, or your cough for a short time, but simply **refuse** to consider or discuss **why** you are coughing in the first place, or **how** they plan to stop your cough."

All subjects experienced these interactions as poignantly humiliating and dehumanizing sorely reinforcing their individual feelings of helplessness, uselessness and their inability to function efficiently.

Consistent across all the groups in reaction to practitioners who obstinately stuck to their personal conclusions were subjective feelings of helplessness and of being totally disregarded as real people. It must be stressed that these subjects repeatedly questioned the practitioners' conclusions but they would not re-consider. Equally consistent were their interpretations of this tendency as indicating practitioners' awareness of their imminent and unavoidable fate or doom and, therefore, the uselessness of any preventative measure or even explanation.

9.1.2 *Lack of discussion*

Subjects frequently reported practitioners' complete lack of any discussion or explanation of their proposed treatments or medical investigations. They often described practitioners as kindly and empathetic but never discussing what they were prescribing, just sending the subject off with a script. Subjects were often grateful to practitioners who controlled their condition by regular medication and frequent hospitalization but felt like pawns totally at these practitioners' mercy. The condition was exacerbated when specific treatments, that practitioners had confidently announced would alleviate subjects' conditions, failed and practitioners did not discuss why this had happened but simply progressed to some other treatment, equally confidently.

In the absence of any pre-warning or discussions many subjects found the side effects of certain medication very frightening. This was especially so for two group B subjects (001 & 006) who experienced these side effects as indications of an immediate emotional breakdown,

Another therapist emphasized the need to release inner demons which he maintained were causing the subject's condition (subject 017). This subject's response was that she was bad enough with these demons caged inside her, imagine should they be released …in her mind, this would undoubtedly induce immediate and undeniable insanity. This deeply entrenched her belief ti at she was going mad and that this practitioner knew it. Her reac don was a conscious plan to keep this secret hidden, especially from mental health practitioners.

Also in this category were practitioners who focused on **one**, or **one set** of, symptoms and **one way** of treating these. For example, subject 008 had an almost consistently weakened right arm for which a particular practitioner repeatedly prescribed muscular relaxants. The subject recounts that these made his whole body limp. He begged to try and find out "why" his arm was limp, rather than only trying to treat the symptom. This subject interpreted the practitioner's reticence to meet his requests as indicative of his intention to hide the brutal truth, that is that he had only weeks left to live.

Therapists who helped subjects gain improved self insight but did not carry this through to any practical application or conclusion also had a negative effect on subjects. They were typically left with a sense of everything being wrong in their lives and being totally unable to rectify this, reinforcing their feelings of fear and helplessness. Their interpretations emerged from practitioners' decisions to end treatment at the point of improved insight with no suggestions of translating this insight into a different way of being. Subjects attributed these decisions to the therapists' awareness of the short time they had left before their worst fear came true, that is, they died, went totally mad or did something overwhelmingly inappropriate and embarrassing.

9.1.1 Practitioners' obstinate adherence to one illness cause

The tendency of practitioners to offer one explanation to subjects for their panic symptoms and rigidly adhere to this despite subjects' pleas to consider other causes, or to re-consider this cause in the light of other symptoms, was repeatedly identified as a negative treatment experience.

Common in this study was practitioners' identification of marital stress as causal to subjects' problems. This conclusion seemed to arise from reasons as arbitrary as, "because I get panic attacks at night," (subject 033); "because my husband travels a lot," (subject 010); "because I'm fairly newly wed"" (subject 007); and "because I have problems sleeping," (subject 004). Subjects professed to ardently disagree with these conclusions which practitioners doggedly reinforced.

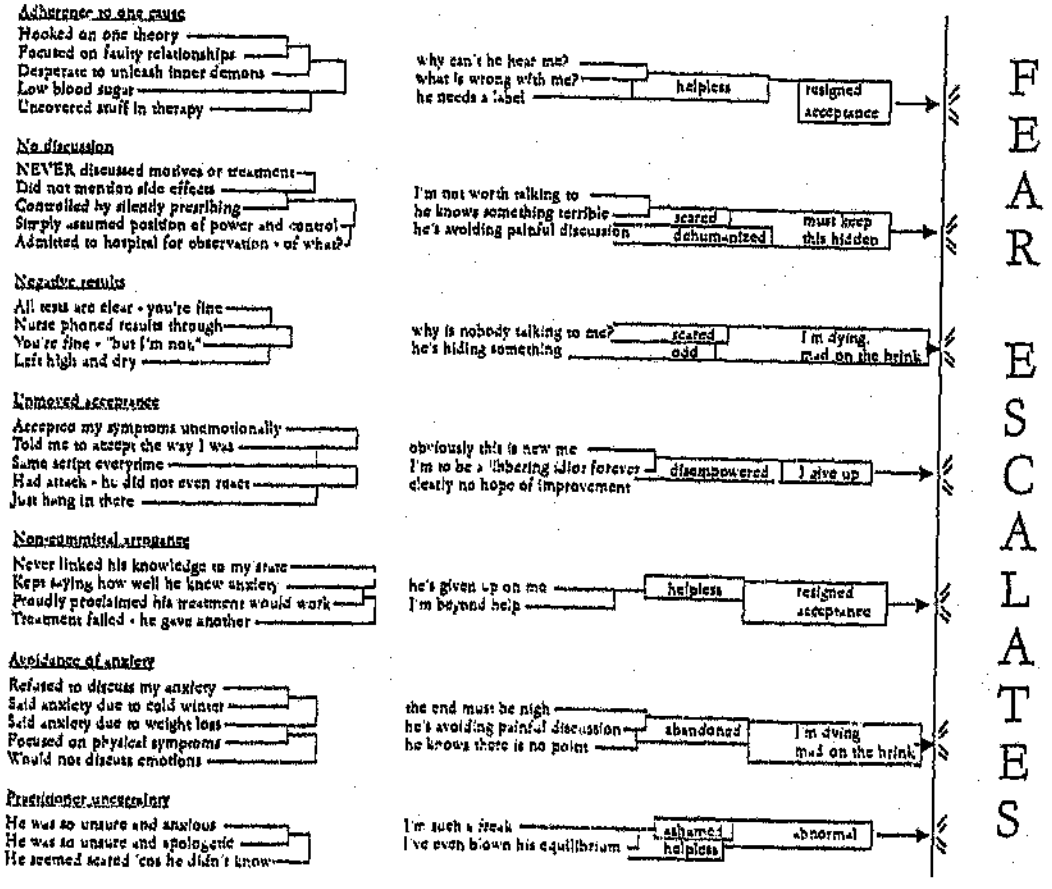
Other practitioners focused on causes such as low blood sugar (subject 005) or a possible stroke (subject 025) as primarily influential on subjects' conditions.

Subjects' responses to these treatments centred on feeling unheard, dehumanized and helpless. They interpreted this interaction as the practitioner's need to find a tangible label to prevent him from needing to tell them the real truth of their condition. Practitioners were seen as "copping out" (subject 011) because there was no hope of a cure and, therefore, it was pointless telling subjects the truth.

alleviation of sufferers' fears. This freed the energy, that had been consumed in containing these fears, to focus, instead, on active living. Distinct trends in consultation dynamics were easily identified facilitating the division of this section into negative treatment experiences, positive treatment experiences, general treatment experiences and the beginning of healing.

9.1 Negative treatment experiences

Figure 7 - Dendogram illustrating the extraction of the conceptual meaning from raw data of negative treatment experiences



CHAPTER 9

QUALITATIVE RESULTS AND DISCUSSION

The nature of qualitative research negates a discrete split between results and discussion because the substance of both is narrative. The only difference is in the context, qualitative results form a context of discovery while their discussion forms a context of presentation (Collapinto, 1979). Due to the inductive nature of the qualitative research in this study these two contexts reciprocally feed back into one another prohibiting their separate scrutiny (Bogdan & Taylor, 1975). The qualitative results in this study will largely comprise excerpts from the raw data or from subjects' descriptions, which will be discussed relative to both the individual's experience, the inter-subject context and the inter-group context.

Chapter 8 discussed the different practitioners consulted by the three experimental groups and their quantitatively weighted experiences of these consultations. In this section treatments are categorized according to this experience and the phenomenology, the individual why's and how's, of this experience are considered. Each treatment experience comprising one, or a set of, consultations was discussed in depth. Subjects were questioned specifically on their *a priori* expectations versus their *post hoc* experiences of each treatment. Striking in this analysis was the similarity between specific treatment interactions and their effect on subjects across all the groups. Certain practitioner attitudes or behaviours are clearly experienced as positive or negative by panic disorder sufferers and impact on their condition accordingly. A positive impact was consistently associated with the

Subject 028 received support from work colleagues when driving over or on highways was very difficult for her. Her colleagues rearranged their work terrains so that her own client base was within close proximity. For some weeks colleagues also drove her to and from work daily. Despite this practical help, these people never gave this subject the impression that she was losing it, or in any way incapable. They included her in all discussion and decisions and did not even try to reduce her work pressure in any other ways.

Subject 027 fondly remembers her family's commitment. Her married sister and her parents visited her daily. They regularly brought prepared meals and helped with household chores **but** they still encouraged and, in fact, expected her participation in family occasions. She says she sometimes wished they wouldn't but was, simultaneously, grateful to be treated as if she were still normal.

Subject 006 received wonderful and unconditional support from her mother. She says her mother helped her in a practical way when she really needed it, but left her free when she felt she could manage. She never, even remotely, suggested that the subject might not be strong or capable enough to do the things she wanted. The subject says, "she never labelled me as weird or odd but just recognized and loved the real me."

Similar relationships were mentioned by 18 of the 33 subjects (55 %) suggesting this to be a fairly consistent need in panic disorder sufferers. The recurring experiences they valued in these relationships were an unconditional acceptance that was communicated in a respectful and caring way, never taking control, pressurizing or rendering them helpless. This was communicated by these caregivers' readiness to

with her husband on week-ends. Her life line was a local general practitioner. She visited him frequently and, when she felt her anxiety attack symptoms had been over presented, she would dream up some other complaint. She dreaded her husband getting ill, not because, as she guiltily admits, she did not want him to suffer, but because he would use up the medical aid allowance thus restricting her visits. This general practitioner did very little for her anxiety attacks but showed her respect, honest concern and interest.

Subject 005 relied on her pharmacist to keep her "sane" for many months. At this stage the height of her activity was taking her children to and from school. She would visit her pharmacist almost every morning on her way back home. Together, they would explore any new product on the market for anxiety and decide whether she should try it.

Subject 011 had great difficult sleeping due to almost consistent panic and hyperventilation. When she was totally exhausted she would just visit her doctor's rooms and sleep in the chair. She says she felt safe, cared for and unpressurized there.

Subject 029 was forced to continue working and says this would have been impossible without the company doctors who were always there for her. They regularly helped her with medication and always had a ready empathetic ear but never suggested she was not functioning efficiently, or that she should not be at work. She interpreted this silent acceptance as a subtle acknowledgement of her still adequate coping ability.

Likewise, subject 008 said a practitioner, at the start of his help seeking, talked about panic disorder. The subject actually enquired what this was but the practitioner only offered a glib, uninformative and closing response.

These subjects respectively endured 5 years and 5 treatments at a cost of R22 945,89, and 2 years and 5 treatments at a cost of R 4 334, 31, after these initial labels and before receiving an effective diagnosis of panic disorder. Subject 008 also resigned from his work due to his panic condition during this period and subject 026 reports the sad, negative effect his condition had on his inter-personal relationships, especially his marriage. It is tragic to think that these two men's suffering could have been significantly reduced had these early diagnoses been effectively and coherently communicated and followed through. This is reinforced by both their reported improvements when this did finally happen.

9.4 A life line

A recurring phenomenon noted in subjects' discussions of their help-seeking behaviour was the reliance on a non-judgmental, accepting, reassuring person. These persons included family members, work colleagues and medical practitioners who literally became subjects' life lines, sometimes their only regular contact with the outside world.

Subject 015 had only recently arrived in South Africa and was entrenched in avoidance behaviour, did not work and only shopped

subject was fired at the height of his panic disorder because of his panic condition. After being unemployed for approximately 3 months he started combing the job market but, as he describes, "stupidly set my sights much lower because medical practitioners had now dulled my senses, and my perceptiveness, to believing that this new, only partially functional, person was me." He said, "you become like a little bird being fed by its mother, accepting every morsel (of wisdom) coming your way." Retrospectively, he believes his behaviour was detrimental to his life style, his self esteem and his career, and that this could have been prevented through frank and open discussions with practitioners regarding the probable prognosis of his condition and what life style changes might become necessary and unnecessary.

This interactional format is particularly detrimental to panic disorder sufferers who are, generally, ready and willing to hand over control (Vitaliano et al., 1987) but who desperately need to take control of the management of their condition (Weekes, 1983).

9.3.4 A label alone

Before discussing the diagnostic experience in detail, it seems pertinent to mention two subjects who were both labelled "panic disorder sufferers" early in their help seeking behaviour but for whom this label was meaningless.

Subject 026 remembers an early practitioner using the label panic disorder with no clarifying explanation whatsoever and certainly with no suggestion of appropriate treatment. He said it made no impact on him or his condition.

these treatments, which are amongst the most frequently prescribed for panic disorder, she had an irrepressible need to address her increasingly debilitating condition. This resulted in her regular attendance of different practitioners but, equally regular, streamlining of every presentation of her symptoms to suit the particular practitioner and lead him towards any diagnosis other than insanity. This subject said, "you are actually conning yourself into believing that you are doing your utmost to get help and it is the practitioners that are ineffective." This process continued for 9 - 10 years for this subject. It is suggested that her fruitless and exhausting search could have been mitigated at that first sleep therapy session by the clear discussion and explanation of its benefits and possible side effects, as well as the closer monitoring of the subject.

9.3.3 Doctor-active patient-passive role

Traditional Western illness-behaviour expects a patient to assume a subservient role during medical consultations (Katon, 1993). This is deeply ingrained and, typically, Western patients seat themselves on the opposite side of a practitioner's desk, explain their problem and accept his interpretation and proposed treatment with little or no enquiry. These interactional dynamics pave the way for practitioners to take unilateral control without any discussions or explanations, resulting in negative treatment experiences, as discussed above in section 9.1.2 above.

Subject 016, who is a dynamic, confident and extroverted man, described how, "crazily you have faith in these learnèd, well dressed men in their ivory towers, you mould your life to suit the you that they present and create through their medication and treatment." This

Subject 006 underwent efficient cognitive behavioural therapy a few years into her panic condition when it was particularly severe and when she had, as yet, not received any effective treatment for it. This practitioner tried to desensitize her to her fears and feared situations but, the subject recounts, she was in a constant state of panic and anxiety, and simply not accessible for this kind of therapy, or definitely not without some other help such as medication.

Subject 019 received a series of what she described as excellent hypnotherapy sessions but, again, this was at a time when she was one hundred percent under the control of, and overwhelmed by, her panic condition. She was unable to focus on, or work through, her repressed needs that were surfacing.

Both these experiences reinforced subjects' self perceptions of uselessness, stupidity and ineffectiveness, and hence their fears of losing their grasp on reality to an emotional or social crisis.

9.3.2 The paradox of seeking and avoiding treatment

Subject 001 vividly described this contradictory help-seeking behaviour of panic disorder patients. Her first treatment was supposed to have been a ten day sleep therapy session. On the first night this subject experienced severe reactions to the treatment, to the point of hallucinating, struggling to speak, losing her balance and her fine motor co-ordination. This reinforced for her that psychiatric treatment, or in fact any medication, would simply precipitate her total emotional collapse and her primary aim became, therefore, to avoid these treatments. She says the irony was that while focused on avoiding

criteria outlined in chapter 5 as instrumental in fostering effective medical consultations.

9.2.6 The beginning of healing

As discussed in the quantitative analysis of this study's data, a few subjects did pinpoint particular treatment experiences as having a positive and enduring impact on their panic disorder. These will only be discussed in summary here. Subjects identified similar practitioner styles to those discussed under positive treatment experiences. These practitioners all explained, discussed, listened, encouraged and supported subjects. In these processes they regularly asked subjects' opinions and explored their wishes. The focus shifted from an illness to a health orientation. Subjects all reported feeling recognized as real people which encouraged them to live like real people. They interpreted these practitioner reactions as evidence that their fears were unfounded or at least premature. These consultations initiated some of the components of the negative feedback loop discussed in chapter 4, which slowly dissipates anxiety and restores individuals to at least a functional equilibrium (Margraf & Ehlers, 1989), and illustrated the reversal of the doctor-active patient-passive role so typical of traditional Western illness culture, as discussed in chapter 5.

9.3 General consultation dynamics

9.3.1 Patient-condition-practitioner fit

Patients often acknowledged the value of a practitioner's line of treatment but felt it was offered at an inappropriate time in their panic disorder.

knowledgeable and explained the neurology of anxiety to her in great depth. He then related all this theory to her immediate condition and discussed possible ways of dealing with it. He also reinforced that his treatment was part, albeit a large part, of the whole picture, and they discussed other areas of her life she would gradually have to address. This subject remembers feeling understood and accepted, despite the fact that she felt and had behaved so abnormally. She found this experience both normalizing and encouraging.

9.2.5 *Practitioner uncertainty*

Two subjects reported the positive experience of consultations with practitioners who openly admitted and discussed their own uncertainties regarding the subjects' condition. Both practitioners were bewildered and said so. They explained what they had investigated, what they had hoped to find, and that no clear causative results had emerged. They then acknowledged the patients' suffering and the urgent need to alleviate this. Together, these practitioners and the subjects discussed plausible alternatives and planned a line of action.

Through their frank and open discussions, these practitioners appeared authentic and, reciprocally, the subjects felt heard, recognized and empowered. They, again, interpreted this interaction as indicative that there was still hope and every reason to try and deal with their panic condition. This reaction is the antithesis of the despondently resigned approach subjects adopted after negative treatment experiences.

These practitioners did little ostensibly or tangibly different from those experienced as negative by subjects, except that they were honestly and sincerely communicative. Their interactional style meets many of the

revealing her secret abuse of medication diffused the need and initiated its cure. She says she walked out of the consultation feeling "20 kilograms lighter." She interpreted this practitioner's open interest and honest discussion as evidence that she was a worthwhile person and must still have some time ahead of her.

Subject 027 explained the empowering experience of a practitioner who, after hearing her recount her condition profile, actually said: "This is not fatal but you cannot go on in such torment." Her response was, "Wow, I'm not dying and someone is going to help me!" She said he then discussed how he planned to support and guide her through managing her condition. She said she not only believed she was not dying but also that she could actually live again.

9.2.3 *Negative test results*

Subject 027, whose many and different medical investigations all rendered negative results, reports the different experience of a practitioner who did not merely dismiss her as fit, but reinforced for her that she was physically sound and healthy but needed to find help in dealing with the way she was feeling. Together they discussed and planned possible alternatives. This subject reports having felt accepted, supported, and understood, which she interpreted as indicative that there was still every reason to seek and expect recovery and life.

9.2.4 *Knowledgeable and communicative*

As opposed to the experience of a highly professional practitioner who expounded the depth of his knowledge but never met the patient's situation, subject 002 reports one practitioner who was extremely

9.2.2 *Willingness to discuss openly*

Subjects appreciated and respected practitioners' openness to discussion of both their investigations and reasons for them.

Group B subject 006 remembered a medical practitioner, to whom she presented her physiological symptoms, offering to investigate these but explaining to her that, in the light of both past medical procedures and results, and listening to the subject's explanation of her condition, he felt sure it was an emotional problem and suggested an alternative treatment route.

Group A subject 012 fondly remembers consultations with a practitioner who did intensive medical investigations, many of which she had previously undergone, but this man explained what he was doing, why he had chosen to do them, and what the results could indicate. She said suddenly anticipating even the worst became less anxiety provoking. She felt accepted as a reasoning and reasonable person and empowered to deal with whatever results arose. She interpreted this as evidence that there was still time and she could enjoy some quality of life.

Subject 011, who unashamedly abused over-the-counter medication for many years, explained her positive treatment experience with a practitioner who, although only addressing the pain aspect of her condition, talked her through the whole spectrum. He not only allowed, but encouraged and led the discussion, until she found herself, "telling all." She reports this as such a different experience from "receiving a quick script and a pat on the back." She said the relief of

interacting on their future treatment experiences and the severity of their disorder (figure 8).

9.2 Positive treatment experiences

Subjects' discussions of their positive treatment experiences spontaneously fell into the same categories as their negative treatment experiences except that practitioners now exhibited the cybernetically complimentary, or traditionally opposite, type of behavioural interaction, experienced as affirmative by patients.

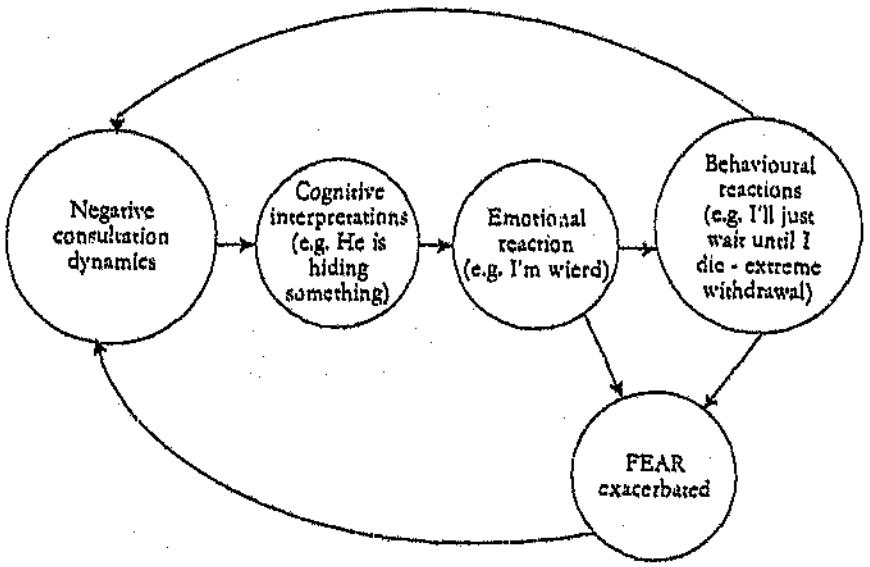
9.2.1 Willingness to accept subjects' treatment needs

As opposed to obstinately adhering to his favoured treatment, a group C subject (010) reported a practitioner as discussing her treatment preferences at length. This subject felt very dubious about taking psychiatric medication. She said the practitioner did try to encourage her but kindly explained that with her unwillingess it would probably be more harmful than beneficial. The practitioner suggested she, initially at least, try the therapy route, always remembering medication might be necessary as part of the whole picture. In retrospe practitioner did nothing tangible to help the subject's condition but she felt recognized and acknowledged as a person worthy of an opinion and, therefore, obviously not "too far gone yet," perhaps there was hope.

enough she would believe it was hopeless because the medication needed time to work, and so the negative vortex became enttrenched until she felt sure insanity had set in. This is consistent with Andrasik's (1990) subjects' negative reports of medication prescribed when necessary.

Consistent across all treatments experienced as negative is a lack of clear and effective practitioner-patient communication. This allowed patients' subjective assumptions to run amok. They regularly credited practitioners' with superior insight into and knowledge of their imminent physical, psychological or social doom. Firmly believing this, they rapidly and resignedly accepted it. 'Treatments experienced as

Figure 8 Schematic representation of the effects of negative consultation dynamics



negative were interpreted consistently with individuals' fears and simultaneously reinforced the fear component of their panic disorder,

able to continue. She subsequently started selling real estate because it was more individually flexible and she could arrange it around her panic condition. Subject 006 also had to end her chosen career of dancing for similar reasons and embarked on a marketing career, which she controls from her home and can, likewise, organize her own timetable. Subjects 014 and 015 similarly relinquished careers that required fitting into established routines, financial adviser and private secretary respectively, to pursue less financially rewarding endeavours operated by themselves and allowing for the irregular influence of their panic condition.

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Finally, subject 016 was fired from a senior managerial position because of his changed and irregular behaviour as a result of his panic condition. After 3 months, he began job hunting but settled for a mediocre position inappropriate to his ability and experience because of the self-esteem his panic disorder had drained from him.

These events add impact, or horror, to the already startling direct costs of pre-diagnostic panic disorder discussed in chapter 8. They offer only a brief account, but after the preceding discussions on the

They conclusively attributed their feelings of disempowerement and helplessness to their imminent physical, psychological or social collapse, or as reinforcing their personal fears.

Treatments experienced as positive engendered the exact opposite emotions. Sufferers felt empowered and capable. The success of a specific medical procedure was not the most important variable. The way it was communicated was the crux. Open, honest and authentic consultation interactions engender a positive treatment experience. It is important to reduce a panic disorder patient's sense of uselessness. This can be achieved through clear and gently explanations and treatment suggestions without autocratically taking control of his condition away from him. The conversion factor in these equations is the subjects' fear experience. Once fears were normalized and disconfirmed, even partially, subjects experienced renewed hope and vigour which they operationalized in a health orientation and gradually regained zest for life. It is only through these feelings of hopefulness as opposed to hopelessness and effectiveness as opposed to ineffectiveness that sufferers can learn to manage a panic condition. It is, therefore, highly pertinent to scrutinize the types of treatment interactions that engendered these feelings.

The preceding literature review and research study unequivocally show that panic disorder is an overwhelming, frightening and unpredictable condition that rapidly depletes sufferers' coping resources rendering them exhausted and confused, feeling helpless and worthless.

This depleted person presents only a diffuse and unclear symptom profile to the many medical practitioners he consults, making a quick and clear diagnosis very difficult. A practitioner, entrenched in specific

practitioners consulted but was also directly related to individual sufferer's subjective experience of their condition and their well being, especially the beginning of their healing.

In fact, the fear component clearly emerged as the primary cognitive link between a state of emotional arousal and an ensueing panic disorder. Fear peaks during the cognitive disorientation caused by the inexplicable and overwhelming physiological symptoms. Fear traditionally indicates danger and, in the absence of any tangible danger cue, the person creates a personal danger cue centring on death, insanity or social embarrassment. Fear then becomes the driving force of his panic condition.

The abstraction of conceptual meanings from the raw data collected in this study clearly indicates recurring consultation dynamics, patient reactions, their typical interpretations and their behavioural manifestations. The directive force behind all these processes is sufferers' immediate experience of their particular fear.

Each treatment experienced as negative, reinforced subjects' fear which is intimately connected to the severity of their condition. Variables in consultations experienced as negative centred largely on a lack of direct, authentic and empathetic communication and interaction between the practitioner and patient. Acutely introspective, subjects absorbed all negative consultation interactions into and adding to their own inadequate selves, never seeing these as shortcomings in the practitioners or significant others. These experiences were unilateral across all subjects and left them feeling dehumanized, disempowered and helpless. Subjects' interpretations of these emotions confirmed panic disorder patients' universal tendency to cognitively catastrophize.

often unnecessary. The sufferers emerge biologically, psychologically and socially depleted. Those years are a waste.

The phenomenological investigation of panic disorder patients' help-seeking behaviour in this study expressively captured its enormity. There is no doubt that during those pre-diagnostic months and years the primary focus of sufferers' lives is their panic disorder and how to deal with it. As subject 024 eloquently explained, "if all the energy that I used trying to hide and contain my panic, while at the same time trying to expose and explain it; and trying to ignore and forget it, and at the same time trying to concentrate on it and understand it, could be captured it would be sufficient to launch the space shuttle all the way to Mars." The descending spiral of negative affect after experiencing repeated ineffective treatments was also poignantly shown. In a nutshell subjects assume and live out a "patient role," almost *ad absurdum*, as many resignedly report simply waiting to die.

Current psychological and psychiatric expertise can capably and effectively treat this condition. The extended time lapse between people's needing and obtaining appropriate help cannot be allowed to continue.

The second direction in this study, the influence of fear cognitions in the above process, had not been researched in this context to date. Fear has been accepted as a regular companion to panic disorder from almost all exploratory perspectives. In fact, it has been so well documented and accepted it has almost become overlooked. This study, through directly exploring the role of fear in the panic process found it not only influenced the overt manifestations such as the duration, cost, types of symptoms experienced, and types of

CHAPTER 10

CONCLUSION

The primary aim of this study as stated in the introductory chapter was to glean a better understanding of the phenomenology of panic disorder sufferers' help-seeking behaviour, specifically the role of their particular fear experiences in this process. The research hypotheses directed this aim by identifying constructs within this process to be explored. These hypotheses have been substantiated as was discussed in chapter 8 of this study. Two directions emerged within the investigation. The first focused on the overt indications of the extended and debilitating period of pre-diagnostic help-seeking behaviour panic disorder sufferers typically endure relative to their individual fears. The second focused on the influence of these fear cognitions on their help-seeking behaviour. The burdensome pre-diagnostic help-seeking period is well documented in existing literature and further expounded in the present study.

The quantitative data in this study shows the extreme debilitating, in fact agonizing, symptoms sufferers endure, their multiple attempts at getting help for them and the enormous direct financial cost of these attempts. All research subjects had been through this tedious period identifying it as almost integral to panic disorder conditions. There were difference between the three experimental groups on all these variables recognizing the influence of different fear cognitions. The futility of those years becomes more tragic realizing that the expenditure of their energy and resources on their panic condition was

insight, not that he did not know. This deeply ingrained respect for practitioners is intrinsic to traditional Western medicine (Katon, 1993) as is patients' tendency to assume an accepting submissive role (Ingham, 1992).

An effective diagnosis is undisputedly the answer to panic disorder sufferers' problems. An effective diagnosis has three central and necessary components: a name or label, an explanation and a clear treatment plan. It is, further, necessary that these are communicated in a respectful way.

9.7 *In sum*

All these reactions to and interpretations of consultation dynamics are clearly consistent with relevant literature's repeated reference to the severity and progression of panic disorder being relative to subjects' feelings of helplessness and hopelessness (Barlow & Cerny, 1985) and the ease with which practitioners can unwittingly reinforce (Andrasik, 1990) sufferers' catastrophic cognitions and their vortex of negative self statements, so typical of panic disorder (Beck, Sokol & Clark, 1992). Likewise, all subjects interpreted and made assumptions from their experience of medical consultations and, in the absence of clear explanations, these attributions were often incorrect (Mechanic, 1972) and consistent with subjects' individual fears (Schmidt et al, 1994). Also indicated in these observations was, not only the close link between subjects' individual fear and their cognitive interpretation of a medical consultation, but also the influence of this on their associated behaviour, resulting in both a frequent tendency to not consume or misrepresent symptoms (Waring & Foreman, 1988), and to assume avoidance strategies (Vitaliano et al., 1987) exercising only an ineffective facade of help-seeking (Sheehan, 1982a). Furthermore, it is interesting how subjects constantly, silently acknowledged practitioners' superior knowledge. When a practitioner offered no explanation or alternative, subjects believed he was hiding this superior wisdom or

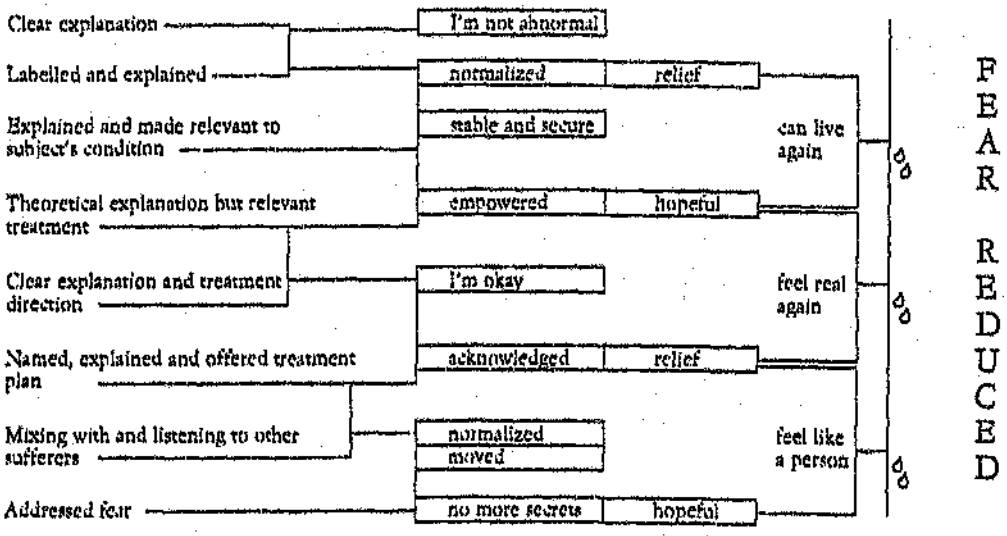
Subject 033 was so weakened by her panic condition and unable to concentrate or comprehend the practitioner's diagnosis that he requested she return with her husband, which she did. She says, however, that although she could not repeat or discuss what the practitioner had said, she knew she was different from the person who had walked into that consultation, and that she would never go back to being that person again.

Subjects 030 and 013 descriptively expanded their relief by verbalizing their understanding that it was not they, but their panic disorder, that was abnormal.

Subjects 013 and 023 both noted the incredible unburdening of honestly and openly disclosing their symptoms and fears and no longer carrying this dark and weighty secret inside themselves.

Two subjects experienced initial anger after their diagnosis. Subject 024 was angry that all the previous practitioners had missed the core problem and put her through so many and unnecessary medical procedures. Subject 015 felt angry that she could have such a condition and initially denied it. Only through interactions with other sufferers in a support group did she gradually come to accept it, which, she says, was necessary before she could begin the path to recovery. Subject 027 experienced intense guilt at being so feeble as to succumb to such a condition. He, also, gradually worked this through by joining a support group and mixing with other panic disorder sufferers who were still highly functional and effective people.

Figure 9 - Dendogram illustrating process from diagnostic consultation dynamics to their behavioural manifestation



That the emotions of relief and hope were explained as offering merely the possibility of being a person, and being able to live again, implies just how despondently low these subjects had sunk and how dehumanizing their lengthy and aimless help-seeking years had been. This was often poignantly conveyed in their descriptions of their own resigned acceptance of a harshly imminent physical, emotional or social collapse. It is only from these levels that hope and relief simply signify life, as opposed to excitement, exuberance or excellence.

biopsychosocial nature of panic disorder, their widespread infiltration can easily be recognized including their impact on the bigger social and economic picture. They, finally, add weight to the urgent need for active and aggressive multi-disciplinary efforts to improve the availability of appropriate and efficient care for panic disorder patients (Regier et al., 1988).

9.6 *The diagnostic experience*

The diagnostic experience centred on subjects' receip of a name or label and explanation of their condition and, in most cases, this was followed by a clear treatment plan. These dynamics were inherent in all diagnostic consultations, even those procured through exposure to a support group. Where explanations were cold and theoretical, it seems this could be compensated for if the subject was offered a clear and practical treatment plan (subject 006). Explanations that were not only theoretically sound but also streamlined to suit a subject's immediate condition and life style were particularly successful (subject 028). Subjects agreed that the name and explanation were important but second to a clear treatment path, which seemed to catalyse their renewed sense of taking control and living.

Subjects' experiences of these consultations clustered cohesively around feelings of relief, acknowledgement, empowerment, hope, security and normalization, with almost all subjects experiencing relief and renewed hope (figure 9). These manifested in the alleviation of their fears and instilled instead a sense of being a real person again and being able to start living again.

able to continue. She subsequently started selling real estate because it was more individually flexible and she could arrange it around her panic condition. Subject 006 also had to end her chosen career of dancing for similar reasons and embarked on a marketing career, which she controls from her home and can, likewise, organize her own timetable. Subjects 014 and 015 similarly relinquished careers that required fitting into established routines, financial adviser and private secretary respectively, to pursue less financially rewarding endeavours operated by themselves and allowing for the irregular influence of their panic condition.

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Finally, subject 016 was fired from a senior managerial position because of his changed and irregular behaviour as a result of his panic condition. After 3 months, he began job hunting but settled for a mediocre position inappropriate to his ability and experience because of the self-esteem his panic disorder had drained from him.

These events add impact, or horror, to the already startling direct costs of pre-diagnostic panic disorder discussed in chapter 8. They offer only a brief account, but after the preceding discussions on the

offer practical assistance while, at the same time, recognizing and accepting, in fact expecting, subjects retained ability to function effectively. While these relationships did not cure their problems, they did contain subjects' fears and help them maintain some semblance of a normal lifestyle.

9.5 *The indirect cost of panic disorder*

As mentioned in chapter 6 this topic is largely outside the scope and aim of this study. Brief mention is, therefore, only made of the financial and occupational impact on ten individual subjects by whom it was spontaneously related. An awareness of this impact emphasizes the crippling cost of this chronic condition before it is effectively managed.

Subject 001 resigned, or literally walked out of, a position she had held for over 6 years which she valued and for which she was respected. This subject was divorced at that time and supporting herself financially.

Subject 002 was fired from 2 vacation jobs. Firstly, because she avoided people contact due to her panic condition, and the second time, because she had repeated panic attacks in the morning traffic, forcing her to stop her car and wait, making her late for work. She tried to explain her reasons but they fell on deaf ears. This subject was trying to finance her own tertiary education and was in desperate need of this money.

Subject 004 ended her hairdressing career because she was desperately afraid of having a panic attack during a hair appointment and not being

FEAR IDENTIFICATION QUESTIONNAIRE

I would like you to try and remember your first panic attack and specifically the thoughts that went through your mind.

.....
.....

I would like you to try and remember specifically what you feared was going to happen to you.

.....

Which of the following best describes what you feared was going to happen?

- I am going to die
- I am going crazy
- I am going to do something uncontrollable or socially embarrassing

DEMOGRAPHIC DETAILS

Subject no: .....
Age: .....
Sex: .....
Marital Status: .....

When did you experience your first significant panic attack?
.....

When and how did you learn that you suffer from panic disorder:
.....

APPENDIX 3

EXPLANATORY REQUEST FORM

An investigation of the treatments people try in order to alleviate their panic attacks

My name is Lesley Clarence. I am a masters student at the University of the Witwatersrand and would like to conduct a research project investigating why it typically takes many years before panic disorder sufferers obtain a correct diagnosis. During this period they often consult many and varied practitioners, spend large amounts of money and endure both unnecessary medical procedures and a reduced quality of life. It is my aim to clarify and understand this process paving the way for earlier diagnosis and appropriate treatment, thereby alleviating some suffering.

In order to carry out this project I need your help. Ideally I would like to spend 1-1,5 hours with you discussing the treatment(s) you tried, and your experience of them, until you were diagnosed, or realized in some way, that you suffer from panic disorder.

The results of this study will be strictly confidential and your name will not be used.

If you are willing to help me in this project please fill in your particulars in the space provided below and I shall contact you.

Name: .....

Address: .....

.....

.....

Tel. No(s).: .....

.....

When is the most convenient time to contact you?

.....

Thank you very much for agreeing to be part of this project.

.....

APPENDIX 2

Diagnostic questionnaire

During the past month (check all that apply)

1. Did you experience a sudden, unexpected attack of intense fear, anxiety or panic for no apparent reason?	Yes	No
(If YES checked, please answer 1a, 1b and 1c. If NO checked go on to no.2).		
1a. Were you afraid that you might have more of these attacks?	Yes	No
1b. Were you worried that these attacks could mean you were losing control, having a heart attack or "going crazy"?	Yes	No
1c. Did you have unexplained heart palpitations, a racing heart or shortness of breath for no apparent reason?	Yes	No
2. Have you been afraid of not being able to get help or not being able to escape in certain situations, like being on a bridge, in a crowded store or in similar situations?	Yes	No
3. Have you been afraid or unable to travel alone without a companion or friend?	Yes	No

026	M	M	Death	43	5 years	8	Emergency rooms/ hospitalization General practitioner x 4 Neurologist Homeopath	Psychologist
027	F	M	Death	35	8 months	7	General Practitioner x 5 Specialist Physician Gastrologist	Psychiatrist
028	F	D	Mad	40	8 months	6	General Practitioner x 2 Emergency Rooms Psychologist Psychiatrist Hospitalization	Cognitive Behavioural Therapist
029	F	M	Death	40	3 years & 10 months	8	General Practitioner x 3 Emergency rooms Neurologist Ear Nose & Throat Specialist Psychiatrist Psychologist	General Practitioner
030	F	M	Social Emb.	59	4 years & 9 months	6	General Practitioner x 3 Self Medication x 2 Emergency rooms	Pain Disorder Support Group
031	F	M	Death	38	1 year & 1 month	3	General Practitioner x 2 Psychiatrist	Psychologist
032	M	M	Mad	56	13 years	12	Neurologist x 3 E.N.T. Orthopaedic Surgeon General Practitioner x 4 Psychologist Cardiologist Neuropsychologist	Psychiatrist
033	F	M	Mad	32	1 year & 2 months	3	General Practitioner x 2 Gastrologist	Psychiatrist via Pain Disorder Support Group

013	F	M	Social Emb.	32	1 year & 8 months	3	Counsellor General Practitioner x 2	General Practitioner
014	F	D	Mad	34	3 years & 8 months	6	Emergency room/Hospitalization Aromatherapist Neurologist x 2 Cardiologist Psychologist	General Practitioner
015	F	M	Social Emb.	30	6 years & 7 months	9	General Practitioner x 7 Geneticist Psychologist	General Practitioner
016	M	S	Death	40	2 years & 11 months	13	Emergency room/Psychiatric ward Psychiatrist x 4 General Practitioner x 3 Dietician Hypnotherpist Acupuncture Yoga Specialist Physician	General Practitioner found through Panic Disorder Support Group
017	F	D	Mad	54	16 years	9	Self Medication Psychologist x 2 General Practitioner x 3 Hypnotherapist Psychiatrist x 2	Panic Disorder Support Group
018	F	S	Social Emb.	43	14 years	11	General Practitioner x 6 Psychologist Re birther Run for life Reflexology Reiki Therapy	Psychiatrist
019	F	M	Social emb.	46	2 years	7	Neurologist Specialist Physician Hypnotherapist Aromatherapist Reflexologist Psychiatrist General Practitioner	Psychiatrist
020	F	M	Death	51	7 years	5	General Practitioner x 4 Specialist Physician	Counselor
021	F	M	Social Emb.	42	20 years	9	General Practitioner x 2 Gastrologist Dietician Homeopath Specialist Physician Gynaecologist Rheumatologist Psychologist	Panic Disorder Support Group
022	F	M	Social Emb.	44	8 years	8	General Practitioner x 2 Gynaecologist Psychologist x 3 Hospitalization Psychiatrist	General Practitioner
023	M	S	Social emb.	21	1 year & 2 months	5	General Practitioner x 2 Emergency room/hospitalization Psychiatrist Yoga	General Practitioner via Panic Disorder Support Group
024	M	M	Mad	43	5 years	3	General Practitioner x 3	Psychiatrist
025	F	S	Social Emb.	44	3 years & 9 months	9	General Practitioner/hospitalizatio n Hypnotherapist Physiotherapist Emergency room/hospitalization Psychologist Orthopedic surgeon Neurologist x 2 Chiropractor	Psychiatrist

APPENDIX 6

DATA SUMMARY

No.	Sex	Marital Status	Fear	Age	Treatment duration	No. of Treatments	Type of Practitioners	Diag.
001	F	M	Mad	48	10 years	8	Psychiatrist x 2 Homeopath Yoga Psychologists x 2 Acupuncture Self Help	Psychiatrist
002	F	S	Death	22	4 years	6	Psychiatrists x 4 Hypnotherapist Specialist Physician	Cognitive Behavioural Therapist
003	F	M	Social Emb.	44	2 years & 4 months	8	General Practitioner X 4 Homeopath Gynaecologist x 2 Dermatologist	General Practitioner
004	F	M	Mad	47	2 months	3	General Practitioner X 3	General Practitioner
005	F	M	Death	35	1 year & 4 months	10	General Practitioner x 2 Neurologist Cardiologist Pathologist Neuropsychologist Pharmacist Specialist Physician Physiotherapist Yoga	Homeopath
006	F	S	Mad	39	13 years	9	General Practitioner x 2 Psychologist x 4 Psychiatrist x 3 Cognitive Behavioural Therapist	Psychiatrist
007	F	M	Death	32	3 years & 4 months	5	General Practitioner x 2 Psychologist Emergency Rooms Psychiatrist	General Practitioner
008	M	M	Death	33	2 years & 4 months	7	General Practitioner X 4 Counsellor Gastro Specialist Unpaid leave	Psychiatrist
009	F	M	Death	33	8 years	7	General Practitioner x 3 Virologist Self Medication Specialist Physician Aromatherapist Run for life	Psychiatrist
010	F	M	Social Emb.	67	18 years	6	General Practitioner x 2 Specialist Physician Ear Nose & Throat Specialist Psychologist Psychiatrist	Pain Disorder Support Group
011	F	W	Death	55	1 year & 10 months	5	General Practitioner x 3 Self Medication Physiotherapist	Radio talk & Pain Disorder Support Group
012	F	M	Death	46	5 months	7	Emergency rooms/Neurologist Cardiologist Gastroenterologist Neurologist Gynaecologist Chiropractor Psychologist	Psychiatrist

APPENDIX 5

INFORMED CONSENT FORM

My name is Lesley Clarence. I am a masters student in Psychology and am conducting a research project to determine the role that specific fearful thoughts play in panic disorder and to determine the health costs involved in the search for a correct diagnosis. Specifically, I would like to see if there is any relationship between peoples' different fears and the kind of treatment they choose, the cost of these treatments, the length of time it takes to get a correct dia,gnosis and the development of their disorder.

The study involves a short screening questionnaire focusing on your panic symptoms, followed by an interview discussing the different treatments you tried before you were correctly informed of your panic disorder. I also need to quantify the costs of treatments you pursued from any records you may have. If you no longer have specific records I am able to get reliable estimates of the cost of a particular practitioner, medication or therapy in a specific year. This should take no longer than 1-1,5 hours of your time.

Although there is no direct benefit to you as a subject I hope that this study will both alert the medical and general population to the reality of panic disorder and pave the way for earlier diagnosis and appropriate treatment, thereby alleviating some suffering.

Your participation in this study is entirely voluntary and there will, of course, be no cost to you as a participant and you are free to withdraw at any stage.

The results of this study will be strictly confidential and your name will not be used.

If you consent to take part, please complete the rest of this form. Thank you very much for your help in this project.

I, ..., have read and understand the information above and consent to participate in this study under the terms stated.

Signed: ..... Date: .....

Witnesses: 1..... .....

2..... .....

APPENDIX 4

SCREENING QUESTIONNAIRE

Have you ever had a panic attack when you felt frightened, anxious or extremely uncomfortable for no particular reason? Yes No

Have you ever had a panic attack that seemed to come out of the blue? Yes No

Have you ever had 4 attacks like that in a 4 week period? Yes No

If "no," then ask, "did you worry a lot about having another attack? Yes No

How much time did you spend worrying about having another attack?

None at all	1
Very little	2
About half the time	3
More than half the time	4
All the time	5

How long did you continue worrying about having another attack?

Less than a month
One month
More than a month

- Subjects must have had at least 4 attacks in a 4 week period or have spent at least half the time worrying about having another attack for a month or longer to be eligible for this study.

APPENDICES

APPENDIX 1

Diagnostic interview schedule (DIS) version 3
(Questions relating to panic disorder - adapted from Robins et al, 1981)

Have you ever considered yourself a nervous person?

Have you ever had a spell or attack when all of a sudden you felt frightened, anxious, or very uneasy in situations when most people would not be afraid?

During one of your worst spells of suddenly feeling frightened or anxious or uneasy, did you ever notice that you had any of the following problems?

During this spell:
- were you short of breath, having trouble catching your breath?
- did your heart pound?
- were you dizzy or light-headed?
- did your fingers or face tingle?
- did you have tightness or pain in your chest?
- did you feel like you were choking or smothering?
- did you feel faint?
- did you sweat?
- did you tremble or shake?
- did you feel hot or cold flashes?
- did things around you seem unreal?
- were you afraid either that you might die or that you might act in a crazy way?

How old were you the first time you had one of these sudden spells of feeling frightened or anxious?

If don't know and age under 40, code as such.

If don't know and age over 40, ask "would you say it was before of after you were 40?"

Have you ever had 3 spells like this close together, say within a 3-week period?

Have spells like this occurred during at least 6 different weeks of your life?

Have you had a spell like this within the last 2 weeks?

If no, ask "when did you last have a spell like this?"
- within last 2 weeks
- within last month
- within last 6 months?
- within last year?
- more than 1 year ago?

The subtleties of consultation dynamics are another area suggested as worthy of further investigation. Patients and practitioners alike could benefit by understanding the effects of their behaviour and perhaps be helped in developing more effective interactional styles.

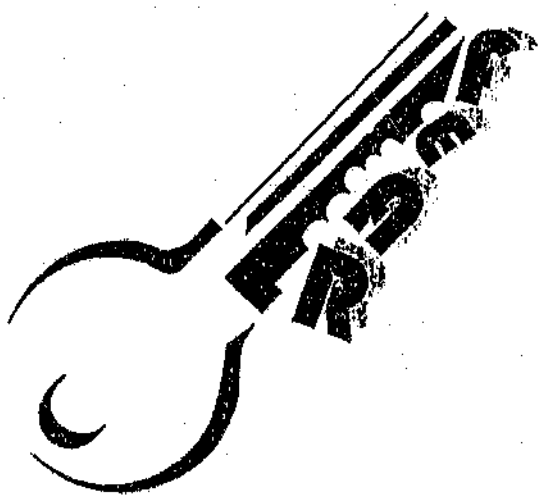
A final word of caution, although some of the data obtained in this study offers a shocking description of the reality of panic disorder while sufferers are still unsure and groping aimlessly for help, the limited generalizability of these results must be recognized. The study would need at least to be cross culturally replicated to extend its external validity in a Southern African context.

early in its existence and reduce, or preferably prevent, endless years of depleting and fruitless treatment searching.

Such interventions would need to be clearly monitored in practice and the effects carefully noted. As the majority of panic disorder sufferers visit primary health care practitioners in the early stages of their help-seeking, they would provide a logical research site. In this way primary practitioners could act as local scientists (Miller & Magruder, 1997) contributing substantially to the reciprocal link between research data and clinical methodology.

It is further recommended that a treatment intervention focusing specifically on the fear component of panic disorder be created. Studies comparing its efficacy with that of current treatments could expand the results of this study.

Figure 10 - Fear is the key



theoretical treatment approaches, can readily miss the crux of the treatment requirements and, with the best intentions, focus only on superficial aspects. The patient, unaware of his ineffective symptom presentation, feels snubbed, dehumanized and afraid.

To the patient his fear and his condition have assumed mammoth, all consuming proportions which he believes he wears like a banner clearly visible to the world. From this perspective it is difficult for him to understand that others cannot see and identify his condition just by looking at him. Vague and defensive as these subjects' symptom presentations may be, they require clear and direct consultation interactions. A label, or specific treatment alone, are clearly inadequate unless grounded in authentic discussions and explanations. These three components comprise an effective diagnosis which leaves the patient feeling understood and less afraid. The level of his fear is directly related to the severity of his disorder.

Having successfully substantiated the hypotheses and primary aim of this study by indicating the critically influential role of fear in panic disorder it is suggested that the fear component of panic disorder could simultaneously be the key to its alleviation (figure 10). It could be valuable for future researchers to focus on operationalizing this insight into clinically accessible methods.

Accessing and exploring fear could become a diagnostic tool for practitioners when faced with a confusing array of vague symptoms for which no organic cause is evident. A short and concise screening questionnaire could help clarify their diagnostic dilemma, followed by an informed and sensitive enquiry into subjects' fears. These procedures could unlock and unleash the dark secret of panic disorder

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Group C			
Subject no.	**Consultation costs**	**Treatment costs**	**Total**
003	2011.00	2303.28	4314.28
010	3619.20	800.60	4419.80
013	621.00	890.60	1511.60
015	9410.10	6415.75	15825.85
018	6011.70	5454.32	11466.02
019	3278.80	10596.33	13875.13
021	17237.70	38907.84	56145.54
022	69300.30	30258.72	99559.02
023	1933.30	1939.37	3872.67
025	20689.50	31578.21	52267.71
030	3236.50	8312.61	11549.11

APPENDIX 7

Individual subjects' practitioner and medical procedure (including medication) expenses

Group A			
Subject no.	Consultation costs	Treatment costs	Total
002	10400.80	8109.52	18510.32
005	3315.30	7027.31	10342.61
007	2978.30	384.37	3362.67
008	2087.20	2247.11	4334.31
009	5753.00	35048.59	40801.59
011	11634.80	4269.34	15904.14
012	5966.60	6461.06	12427.66
016	14697.60	22214.64	36912.24
020	8194.50	18083.25	26277.75
026	6386.10	16559.79	22945.89
027	5253.90	9597.96	14851.86
029	7114.30	68606.79	75721.09
031	1608.60	5499.61	7108.21

Group B			
Subject no.	Consultation costs	Treatment costs	Total
001	57865.50	1006.26	58871.76
004	897.60	1530.51	2428.11
006	55885.20	7696.55	63581.75
014	5953.30	8629.60	14582.90
017	26962.50	6175.98	33138.48
024	2636.70	3792.80	6429.50
028	5116.50	9670.56	14787.06
032	12114.90	26816.47	38931.37
033	2411.60	9242.68	11654.28

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