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.

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,

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

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 is 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

she regularly visited when an attack was unbearable, "He literally saved my life every time he put 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.

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.

8.4 Symptoms experienced

All the subjects in all three groups regularly experienced somatic symptoms consistent with research findings and established classificatory 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 loss 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

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

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.

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

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

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

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

dynamics, 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 disorder 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

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

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.

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).

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 reassuring 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

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 outliers. 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

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.

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

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

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.

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

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

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.

CHAPTER 9

QUALITATIVE RESULTS AND DISCUSSION

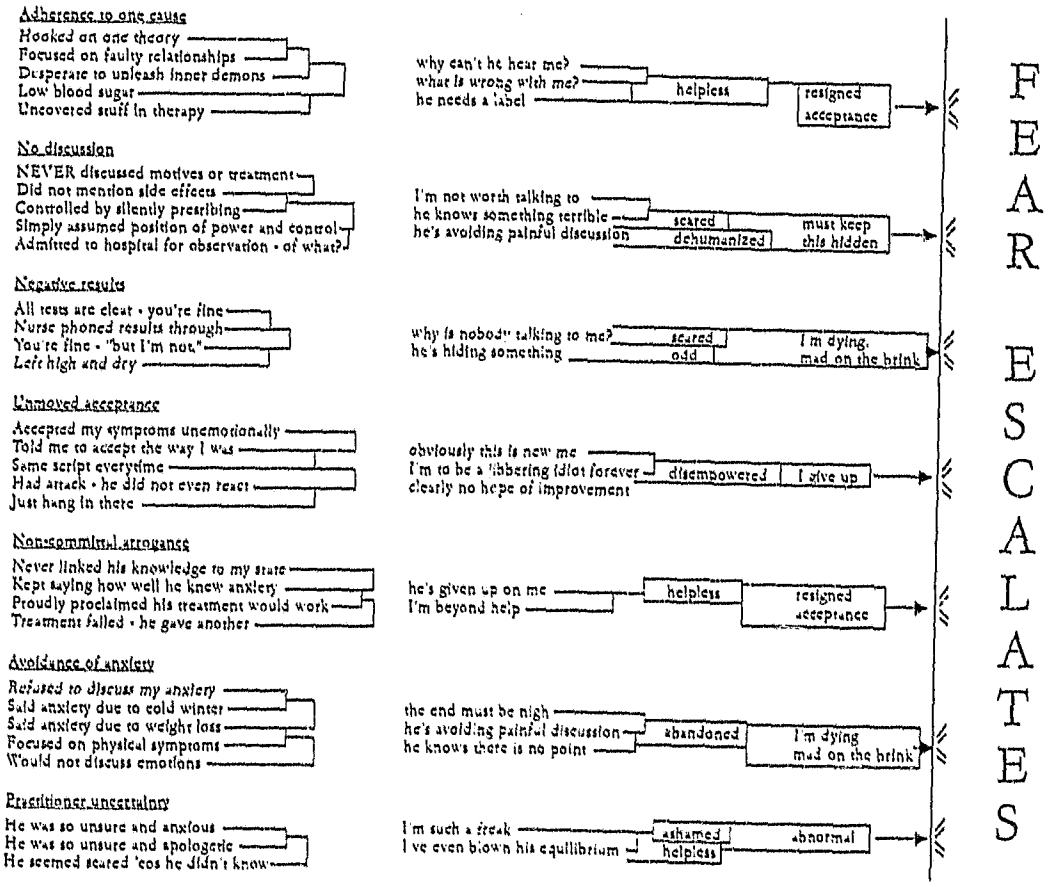
The nature of qualitative research negates a discrete split between results and discussion because the substance of both is narrative. The only difference is in the context, qualitative results form a context of discovery while their discussion forms a context of presentation (Collapinto, 1979). Due 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 direct 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

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



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.

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 that she was going mad and that this practitioner knew it. Her reaction 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.

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,

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.

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

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.

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.

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.

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

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*

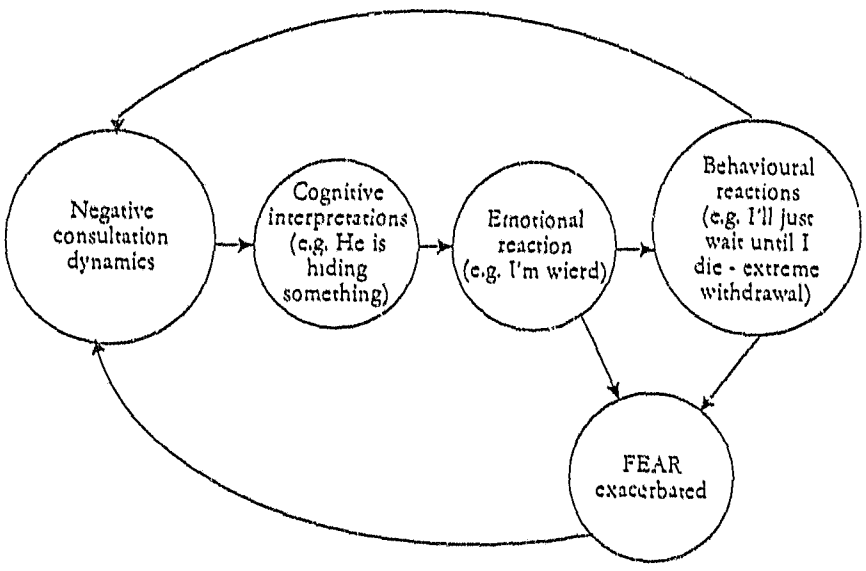
Subject 018, who repeatedly had panic attacks during consultations, even during a reflexology session, to which practitioners showed very little reaction, internalized these experiences as affirmation of her social inadequacy and reinforced her fear that very soon she would behave in an uncontrollably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

enough she would believe it was hopeless because the medication needed time to work, and so the negative vortex became entrenched 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,

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 retrospect, this 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.

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

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

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

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.

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

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 practitioner 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 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.

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

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.

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

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

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.

Subject 009 simply left her position of personal assistant to a senior manager and remained unemployed for 2 years totally controlled by her panic condition.

Subject 008 left the only job he had ever had since leaving school, and an organisation in which he had climbed the corporate ladder and received acknowledgment and recognition, on the spur of a panic-stricken moment. He remained unemployed for 6 months, only 3 of which were remunerated by his employees and, eventually, returned to a position of lower reward in a much smaller organization.
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

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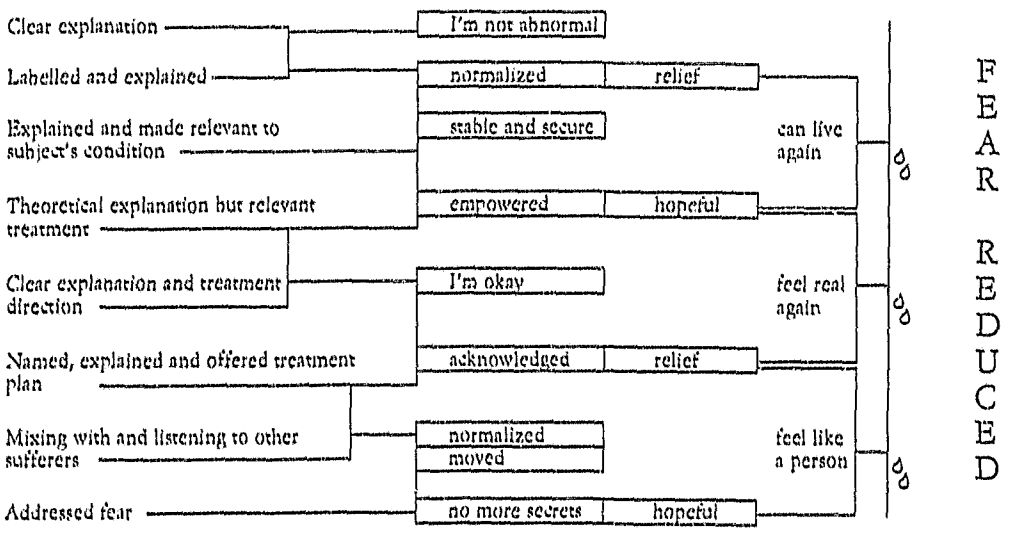
biopsychosocial nature of panic disorder, their widespread infiltration can easily be recognized including their impact on the bigger social and economic picture. They, finally, add weight to the urgent need for active and aggressive multi-disciplinary efforts to improve the availability of appropriate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

9.6 The diagnostic experience

The diagnostic experience centred on subjects' receipt 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.

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.

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.

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 misconstrue 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

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).

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

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 absurdiom*, 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

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.

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

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.

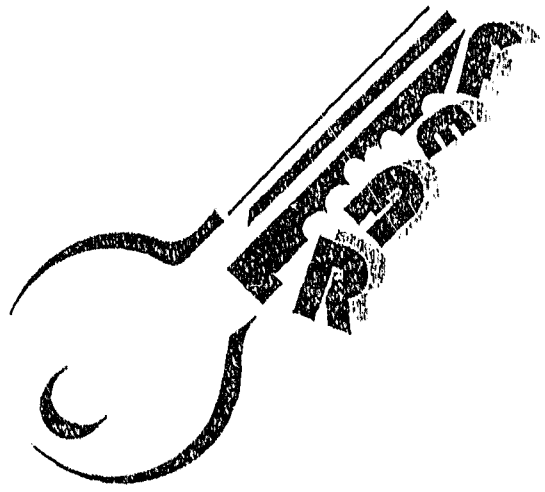
Accessing and exploring fear could become a diagnostic tool for practitioners when faced with a confusing array of vague symptoms for which no organic cause is evident. A short and concise screening questionnaire could help clarify their diagnostic dilemma, followed by an informed and sensitive enquiry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

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



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.

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?

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

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 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.

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 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 diagnosis 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 6

DATA SUMMARY

No.	Sex	Marital Status	Fear	Age	Treatment duration	No. of Treat-ments	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 Neurophaychologist Pharmacist Specialist Physician Physiotherapist Yoga	Homeopath
006	F	S	Mad	39	13 years	9	General Practitioner x 2 Psychologist x 4 Psychiatrist x 2 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 Speccialist Unpaid leave	Psychiatrist
009	F	M	Death	33	8 years	7	General Practitioner x 2 Virologist Self Medication Specialist Physician Aromatherpaist 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	Panic Disorder Support Group
011	F	W	Death	55	1 year & 10 months	5	General Practitioner x 3 Self Medication Physiotherapist	Radio talk & Panic Disorder Support Group
012	F	M	Death	46	5 months	7	Emergency rooms / Neurologist Cardiologist Gastroenterologist Neurologist Gynaecologist Chiropractor Psychologist	Psychiatrist

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 rooms/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 rooms/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 Reika 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 Gynacologist Rheumatologist Psychologist	Panic Disorder Support Group
022	F	M	Social Emb.	44	8 years	8	General Practitioner x 2 Gynacologist Psychologist x 3 Hospitalization Psychiatrist	General Practitioner
023	M	S	Social emb.	21	1 year & 2 months	5	General Practitioner x 2 Emergency rooms/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/hospitalization Hypnotherapist Physiotherapist Emergency rooms/hospitalization Psychologist Orthopedic surgeon Neurologist x 2 Chiropractor	Psychiatrist

026	M	M	Death	43	5 years	8	Emergency rooms/ hospitalization General practitioner x 4 Neurologist Homeopath	Pschologist
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	Panic 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 Neuropheychologist	Psychiatrist
033	F	M	Mad	32	1 year & 2 months	3	General Practitioner x 2 Gastrologist	Psychiatrist via Panic Disorder Support Group

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

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

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