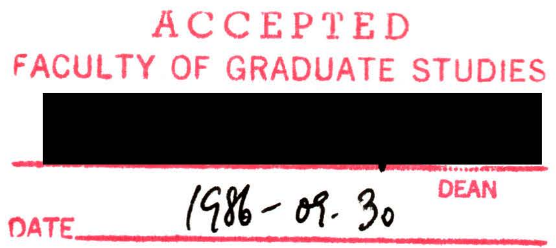

A PHENOMENOLOGICAL STUDY OF PANIC DISORDER

by

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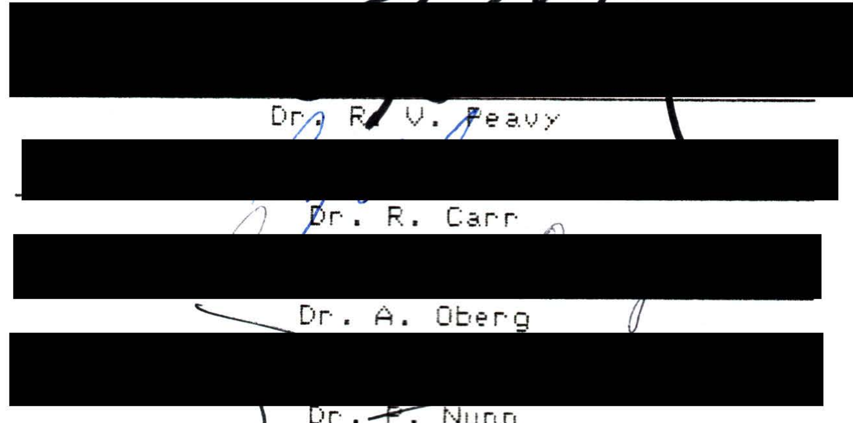

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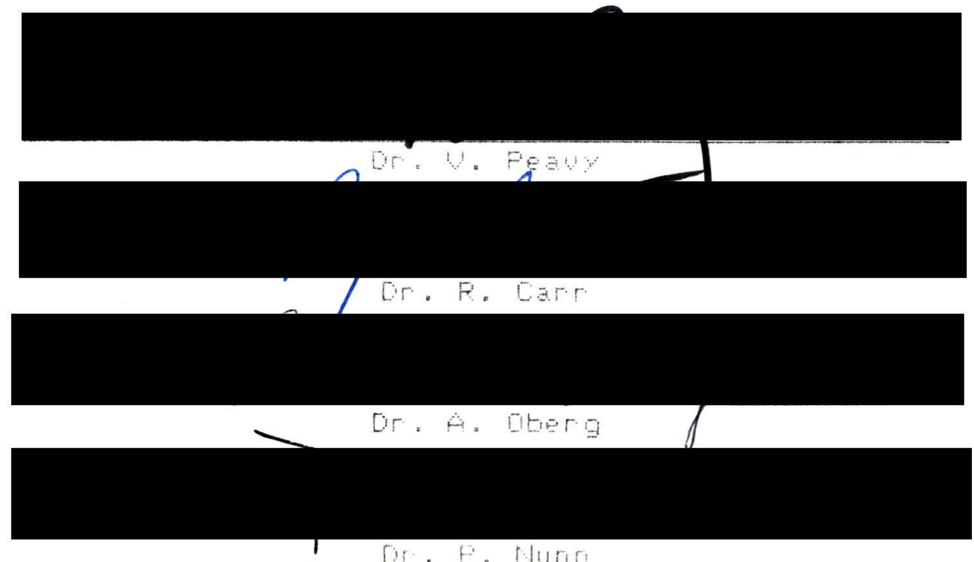
ABSTRACT

This study explores and describes the state of acute panic from the phenomenological perspective. Panic disorder is characterized by the repeated occurrence of spontaneous, acute panic attacks. It has been known historically by a variety of labels; tachycardia, mitral valve prolapse, anxiety neurosis, hysteria and hypoglycemia. Not until the 1980 edition of the Diagnostic and Statistical Manual of Mental Disorders(DSM-111) was there a clear definition outlining the specific symptomatology of this disorder. Few studies, however have isolated their focus to subjects who suffer from panic attacks in accordance with the panic disorder criteria.

In this study, each of the five panic sufferers was interviewed in-depth to determine their self-reported description of the attack experience; its diagnosis and treatment; and the meaning and effect the attacks had on their lives. As well, implications for counsellors were suggested based on their attack experiences. Transcripts of the interviews were analysed and a descriptive account of the findings was presented.

The research findings indicated that diagnosing, assessing and treating panic disorder still presents a major problem for most medical and mental health professionals. The panic attack victims in this study often did not attempt to seek help until they were experiencing some of the secondary manifestations of either anticipatory anxiety, agoraphobia or depression. These side effects tended to confuse and often obscure the original symptoms of panic. As a result, they were often treated for their secondary symptoms rather than for the primary problem of panic disorder. Tranquilizers, which were frequently the treatment of choice by clinicians, were seen in this study, to have a limited effect on anticipatory anxiety and no effect on suppressing the attacks themselves. None of the participants were given any of the attack suppressant drugs mentioned in the pharmaceutical literature. The results further demonstrated that for these participants, understanding and creating meaning for their attacks was the most effective way of diminishing them. Taking charge of their lives, dealing with and changing what they perceived as threats to their personhood, and learning new coping skills, all appeared to contribute to the ongoing recovery of these participants.

In the concluding chapter of this study, a pragmatic guideline of the essential characteristics of panic disorder is given and implications for counselling are suggested. A review of the relationship between the findings of the study and the research and theoretical approaches is discussed and recommendations for future research are made.



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Lastly, I would like to dedicate this thesis to the participants, whose willingness to share their experiences made this study possible.

CHAPTER ONE

INTRODUCTION

Anxiety has always attracted a large amount of attention from mental health professionals as a common basis for emotional distress. One of the greatest difficulties in understanding this abstract emotion is that the term encompasses a diverse array of clinical manifestations. Although all of these anxiety states exhibit certain shared characteristics, there are also a number of distinguishing characteristics that separate them and permit a differential diagnosis of anxiety subtypes. One of the more interesting and less understood subtypes is panic disorder.

Impetus for Study

The impetus for this study came from my own personal experience of having suffered from panic attacks and from the conflicting, often confusing information that I received about the diagnosis, assessment and treatment of them.

When I was experiencing an attack, I would suddenly, without warning and for no apparent reason, become absolutely paralysed with terror, my body drenched in perspiration, my pulse racing, and a feeling as if I was suffocating. At the peak of the attack, I was convinced that I was about to die. The

symptoms were always the same, varying only in their intensity. They seemed to have no predictable pattern - I would get them at home, in cars, on the street, in public buildings and in bed at night. At the time, it seemed to me that there was no safe place where they would not occur. During the first year I only had two or three sporadic attacks but they were the most severe. Over the next two years, the number of attacks increased until I was having one almost every night. When I tentatively tried to explain my symptoms to a general practitioner, I was told that I was just having some kind of an hysterical or neurotic reaction and that the best way to treat them was to get my mind off myself and get on with my life. This explanation did not fit with either the severity of my symptoms or the way in which I saw myself or my life at that time - I believed that I was an easy-going, down to earth, pragmatic, fairly competent, healthy human being who was experiencing no real problems in her life, certainly none that would cause the type of symptoms I was having. In no way did I see myself as either acting hysterically or having a neurotic personality. At the time, I was given no medication or treatment of any kind nor was it suggested that I seek help from a therapist. So I began to talk to other people because I needed to know if anyone else had ever experienced

the same terrifying sort of symptoms that I was having and if so, how were they being assessed and treated. What I found was more confusion - people who were experiencing similiar types of symptoms were being diagnosed as suffering from such diverse conditions as mild forms of epilepsy, tachycardia, mitral valve prolapse(excess of connective tissue at the mitral valve), anxiety neurosis, hysteria and hypoglycemia. All of these people were given medication appropriate to their supposed condition and all of them reported to their doctors that the drugs did not relieve their attacks. If the drug perscribed was a tranquilizer, they reported that it helped to relieve some of the anticipatory anxiety around getting the attack but not the attack itself. This often led to their dosages being increased but it still did nothing to suppress the attack. Some of these people became victims, either to the attacks themselves or to the drugs they were on - giving up not only their jobs but as well driving a car, going outside, and seeing anyone other than family. Others fought back, taking themselves off their medication, changing their doctor, and adopting whatever coping stategies they felt were necessary in order to stop the attacks.

My attacks disappeared over eight years ago as mysteriously as they had appeared; however, this

experience has left me with some unanswered questions which I intend to address in this study:

1. Prior to having these attacks, why had I never heard or read of them before, even though I had been a nurse for ten years and had worked with both physically and mentally ill people?

2. Why was the general practitioner that I approached for help unable to acknowledge or validate my experience of having panic attacks?

3. How do the other purported diagnoses of hypoglycemia, tachycardia, epilepsy, mitral valve prolapse, and anxiety neurosis etc. relate to panic disorder?

4. Are panic attacks related to other forms of anxiety or are they a separate entity all on their own?

Statement of Problem

The concept of anxiety has always assumed a central position in most theories of behaviour and personality. However, in spite of the prevailing consensus as to its significance, there appears to be little agreement among theoreticians regarding the specific nature of this phenomenon. In the research literature, prior to the 1980 revision of the _Diagnostic and Statistical Manual of Mental Disorders_(DSM-III), anxiety had been viewed more or less as a unitary entity which manifested itself as a common thread in all the

so-called psychoneurotic disorders (Stampler,1982). There was an implication of a quantitative rather than a qualitative distinction being made between the various types of anxiety. However,in the revised 1980 edition, the section on anxiety articulated, clear qualitative differences. The old DSM-II label of 'Psychoneurotic Disorders' was replaced with 'Anxiety Disorders' and within that category, two new subcategories were created 'Generalized Anxiety Disorder' and 'Panic Disorder'. Thus, for the first time, the new DSM-III distinction between panic and generalized anxiety disorder, gave some credence to the idea that there might be differing types of anxiety, with panic disorder being considered as a distinct clinical entity.

This refinement of categories was brought about in part because of the enormous amount of psycho-pharmacological research that had been done over the past 20 years demonstrating " That the panic attack is qualitatively distinct from, and not just an intensification of the anticipatory anxiety, is supported by a differential response to pharmacological agents"(Leibowitz & Klein,1979,p487-88). In other words, drugs that had been successful in alleviating anticipatory anxiety were unable to prevent the symptoms prevailing during a panic attack and

conversely, drugs that supressed the panic attack did nothing to relieve either the anticipatory anxiety preceding the attack or the phobic avoidance behaviour that followed it.

Clinically, the panic state is an acute stress reaction characterized by sudden and inexplicable jarring physiological symptoms caused by the arousal of the autonomic nervous system. These symptoms can include palpitations, chest pains, tachycardia, shortness of breath, dizziness and profuse perspiration. This clinical picture is further complicated by intense subjective feelings of apprehension, terror, impending doom and fears of losing control, dying and/or of going insane. Prior to their first attack, individuals who suffer from this disorder will report that their general health has been excellent.

In contrast, people who suffer from generalized anxiety disorders tend to experience frequent and prolonged episodes of sustained anxiety along with a lengthy personal history of poor emotional and physical health which is often characterized by fatigability, nervousness, muscle tension, poor attention span and insomnia(Davison & Neale, 1982; Levitt, 1967; Schweitzer & Adams, 1979).

Purpose of this Study

Because the Panic Disorder syndrome is only a recently defined phenomenon(DSM-III,1980), few studies have restricted their focus to only subjects who suffer from these attacks (Stampler,1982). As well, other difficulties have arisen when attempting to apply traditional scientific experimental methods to the study of Panic Disorder because: a) the highly subjective nature of a panic attack does not lend itself to the objective empirical approach b) the extreme level of intensity experienced by someone who is having an attack is rarely encountered in an experimental situation where anxiety is being studied (Levitt, 1967) and c) individuals who experience a panic attack are more likely to believe that their symptoms are physiologically based and so bring them either to the attention of their family doctor or an Emergency Room Physician and it is only after the acute phase is over and no pathology has been found that they are likely to be referred to a mental health professional (Schweitzer & Adams, 1979).

Methodological Consideration

Phenomenological psychologist Fischer(1970), upon reflection of some of the prior research and speculation on the relationship between anxiety and behavior, concluded that the term 'anxiety' was really

only an abstraction. He believed that it simultaneously referred to and subsumed two distinctly different experiential phenomena: one from the internal perspective - subjective experiencing of anxiety and the other from the external perspective - objective observer who views another being anxious. These two perspectives appear to resemble closely the two current approaches toward the scientific study of anxiety: modern experimental psychology (objective observer of another being anxious) and existential phenomenology (subjective experiencing of anxiety). Although there has been much experimental research done from the objective observer perspective on generalized anxiety disorders, there appears, at least in the psychological journals, to be a scarcity of material on the acute panic state other than to account for its symptoms (Davison & Neale,1982). The main source of research material on panic attacks seems to have come from the medical journals and then only from a pharmacological perspective. Additional non-pharmacological research is needed in order to clarify the differences between the symptoms of generalized anxiety and panic disorder. The significance of this distinction for the selection of appropriate treatment strategies has yet to be adequately explored (Stampler,1982).

It is for this reason that I have chosen to explore and describe the acute panic state from the subjective perspective of the individual who experiences it. My secondary aim was to examine the implications this knowledge could have for counsellors in the mental health field in their treatment and regulation of clients who suffer from these attacks.

Contributions of the Study

I intend that the knowledge developed by this study will assist other researchers in their investigation of panic attacks, through its contribution of personal, subjective accounts as given by attack sufferers who have offered to share their insight and understanding of their own experience.

There has been much experimental, medical research done regarding the effectiveness of certain drugs on the various stages experienced by an individual during the attack process. However a paucity of psychological literature exists on the description, assessment and treatment of these attack victims. This study is intended to help fill this gap as well as offering some useful implications for counselling.

I would also like to make the extreme and often frightening variety of both physiological and psychological symptoms experienced by an attack sufferer more familiar to clinicians. In this way

medical practitioners, who are often the first contact for these people, will be able to recognise, diagnose and assess more accurately their condition in the acute stage. This should increase the chances of eliminating the often chronic, long term secondary symptoms of phobic avoidance behaviour, anticipatory anxiety, and depression that can occur when this disorder is not diagnosed accurately in the beginning stages.

CHAPTER TWO

REVIEW OF RELATED SCIENTIFIC RESEARCH AND THEORIES

For the first part of my literature review, I will present a brief overview of some of the scientific research that has been reported by the medical journals on the effects of various drugs in the treatment and management of panic attacks. In the second part, I will review the three most prominent theoretical approaches to the phenomenon of anxiety that have helped to guide our present thinking and understanding of this complex emotion.

SCIENTIFIC RESEARCH

During the 1940's several researchers had observed that strenuous exercise intensified the symptoms of people with chronic anxiety. These patients also had higher levels of lactic acid in their blood when they exercised than did control groups of normal(defined here as people who do not suffer from chronic anxiety) individuals who did the same amount of exercise. The anxiety of the former group increased as the levels of lactic acid rose in their blood, while people in the control group experienced no such anxiety (Cohen, Consolazio, and Johnson, 1947). Pitts and McClure(1967) used these findings as the basis for their research. Under double-blind conditions, they injected two groups

of people - one with a history of spontaneous panic attacks, and the other, a control group of normal volunteers - with sodium lactate. The injections produced panic similar to their usual attacks in the first group, while the control group had no such responses to the lactate. When they gave lactate to panic attack sufferers in the form of an infusion(a constant flow of sodium lactate), they found they could stop their panic simply by turning off the flow.

Their discovery has triggered extensive pharmacological research. Employing this method, researchers have been able to test the effectiveness of certain drugs in alleviating the symptoms that occur during a panic attack(Pitts & McClure,1967; Gorman, et al.,1984). Based on their investigations, three distinct classes of drugs have been found to be useful in the psychopharmacological treatment of panic attacks for people who suffer from this disorder: benzodiazepines which include tranquilizers such as valium, atavin, librium etc.; beta-blockers, specifically a drug known as propanalol; and lastly anti-depressants, namely a drug called imipramine. However several problems have emerged with the use of these drugs in treating panic disorder. First, benzodiazepines do not prevent panic attacks from occuring, rather they seem only to alleviate some the

generalized or anticipatory anxiety around getting an attack. These drugs are often over-perscribed by clinicians or abused by the sufferer in an attempt to prevent these attacks from recurring (Mathews,Gelder,and Johnston, 1981). Second, the high dosage of beta-blocker and anti-depressant drugs often needed to suppress the attack can cause harmful side effects such as extreme drowsiness, high blood pressure, dizziness, blurred vision and nausea (Gorman, Fyer and Klien, 1981; Garakani, Zitrin and Klein, 1984; Shehi and Patterson, 1984). Thirdly, people who are chronic sufferers find that although these attack suppressant drugs block the attack, they do not relieve either the anticipatory anxiety that precedes it or the phobic reactions that follow and prevent them from functioning normally (Mathews, Gelder, & Johnston, 1981).

At this stage then, it appears that the existing research into pharmacological intervention presents more questions than answers. Additional research is needed in order to help provide a more precise picture of some of the biochemical and physiological events that occur during a panic attack (Sheehan and Fishman 1985).

THEORIES

Theories of anxiety have primarily originated from three sources: psychoanalytic, learning and existential theorists.
This part of the review will summarize each of these theories, keeping in mind my methodological consideration of Fischer's two experiential perspectives: the internal(subjective experiencing of anxiety) and the external(objective observer of another being anxious) in order to note into which category the following theories fit. In this way, I plan to clarify and support my decision for using the phenomenological method to study panic attacks.

PSYCHOANALYTIC THEORY

Freud

Freud was the pre-eminent explorer of the psychology of anxiety, supplying many of the most effective techniques for its understanding, although it is widely believed now that many of his conclusions must be requalified and re-interpreted (May,1950). He directed attention to anxiety as the basic question for the understanding of emotional and psychological disorders because he saw anxiety as the fundamental phenomenon and central problem of neurosis. Freud made a distinction between normal anxiety which he defined as a proportionate response to danger, and neurotic

anxiety which he believed was a disproportionate response to danger. His theory arose out of his increased emphasis on the division of personality into Id, Ego and Superego, with anxiety being the function of the way an individual, via their Ego, perceived and interpreted their reality. According to Freud, neurotic anxiety was caused by the perception of danger from the Id instincts(libidinous impulses) when the defences of the Ego failed to prevent these instinctual demands from discharging themselves in impulsive actions(Fischer,1970). He divided anxiety into three forms, free-floating anxiety which was characterized by a general apprehensiveness that displayed a readiness to attach itself to any new possibility that might arise, phobic reaction which he believed was an intense fear of some object or event that seemed all out of proportion to the danger inherent in the situation as viewed by an outside observer, and lastly an acute anxiety or panic attack, where there appeared to be no evidence of an apparent connection between the reaction itself and the danger dreaded(Fischer,1970). Freud also made an important distinction between fear and anxiety when he stated that in fear, the attention was directed at the object whereas anxiety referred to the condition of the individual and ignored the object.

If one examines Freud's theory of anxiety in the light of Fischer's two experiential perspectives, it can best be understood as a structure that has been built upon various observer experiences of another being anxious. Essentially, his psychoanalytic theory seeks within the limits of certain theoretical aprioris, to grasp and understand that which the 'other' must be experiencing and as well striving to explain its own experience of another being anxious by postulating events or processes within the 'other'. Freud's defense mechanisms - repression, projection, denial,etc. might simply be seen as convenient theoretical labels for various psychoanalytically oriented experiences of the 'other' being anxious(Fischer, 1970).

Neo-Freudians

The leaders in the Neo-Freudian movement were psychiatrist, Harry Sttack Sullivan; psychoanalyst, Karen Horney; and psychologist, Eric Fromm. They set about changing the orientation of psychoanalysis from the biological and instinctual to the cultural and environmental(Levitt,1967). For them, Freudian theory tended towards positivism, mechanism and biologism, whereas they believed that human personality development was largely a product of social influence in which biological drives played a relatively minor

role. They saw anxiety as occuring in two stages. First there was primary anxiety, which came about early in life when a young child realized that he or she was relatively helpless and very dependent upon 'significant others' for fulfillment of their basic needs. The second stage occurred in adult life when the defense mechanisms employed to protect them from primary anxiety were threatened, thus requiring an increased intensification of the existing defense or the adoption of a new one (Fischer, 1970).

It would seem then as well, that Neo-Freudians are fundamentally committed to the perspective of an objective observer of another being anxious. Instead of accepting these external aspects as constitutive components of anxious experiencing, they choose to characterize them as necessary conditions antecedent to the experience of anxiety.

LEARNING THEORY

According to Fischer (1970) and May (1950), Dollard and Miller, Eysenck and Mowrer were all leaders in the field of Learning theory. Their position arose out of the need to bring psychoanalytic theory, which up until then had been based largely on observational clinical data, into line with scientific experimental research. Thus the form they adopted in their theory of the origin and development of anxiety was typically that of

the experimental psychologist who works in the area of learning but whose content parallels psychoanalytic theory. They defined anxiety as a subtype of fear, the latter being understood as a learned drive. They concerned themselves with conceptualizing and explaining the behaviour of the 'other', which was understood as an object of nature, passively receiving and responding to stimuli of both internal and external origin. The derivation of anxiety from fear was a perfectly reasonable assumption if one only concerned oneself with the subject's overt behaviour and not with his/her experience.

This theory is primarily concerned with the objective observer perspective, which in this case is the scientist's experience of another being anxious. The subject's experience is not acknowledged or validated and because of this, their approach is unable to distinquish between fear and anxiety(Fischer,1970).

EXISTENTIAL THEORY

The existentialists, in striking contrast to the psychoanalytical and learning theorists, have been exclusively concerned with the subjective experiencing of being anxious. Furthermore, they have generally understood this experience as being valid in its own right and as not requiring any confirmation from the observer scientist perspective. Their approach to the

phenomenon of anxiety has tended to avoid reference to hypothetical internal body states, to allegedly objective, outsider observations and to the explanatory power of some life event of the past. Instead, they have attempted to describe the phenomenon of being anxious from the perspective of the individual who experiences it, in order to elucidate what meaning being anxious has for them.

The basic tenet of the existential belief system rests on the assumption that truth is in man and not in nature. "Man is that through which there is a universe" (Fischer,1970,p.83). The Danish philosopher, Soren Kierkegaard was one of the first thinkers in the 19th century to emerge with this point of view. Prior to his time, philosophers had for the most part been searching for immutable and eternal truths, their assumption being that everything in the universe, including man, could be understood through reason. This type of rational explanation naturally called for objectivity and above all the avoidance of subjective thoughts and feelings. Kierkegaard, as an existentially oriented thinker, was more concerned with the problems of freedom, choice, and personal responsibility. He was not interested in the causes of behaviour or the assumptions concerning the alleged functioning of an assortment of hypothetical drives, instincts or needs.

Man was not seen merely as a passive recipient of stimuli, nor as a mere respondent to his environment but rather as an active participant who confronts his own freedom and takes personal responsibility for his decisions and actions. For Kierkegaard, anxiety was both inherent in and necessary for growth. He saw it as an experiential state, constituted by a person's awareness of his own possibilities, by his realization that he has no objective justification for choosing among them, and by his limited capacity to foresee all the consequences of a possible choice. The process of becoming a self, which Kierkegaard believed was every person's essential task as a human being, proceeds through the confrontation with anxiety (Fischer, 1970).

Rollo May

As a practicing psychotherapist, lecturer and writer, Rollo May has devoted most of his working life in a continuing effort to understand and deal with the human experience of anxiety. Based on his clinical psychotherapeutic experience, his understanding of the mechanisms explored by Freud, and his affinity with and experiential grasp of Kierkegaard's insights, May has developed a philosophical inquiry into the nature of anxiety as an ontological structure of human existence (Reeves,1977). He defines anxiety as "the apprehension cued off by a threat to some value which the individual

holds essential to his existence as a personality" (May, 1950; p.191). The value threatened is the 'cue' to apprehension which May defines as the 'subjective, objectless experience' and it is not to be confused with the danger situation which called it forth(May,1950). Thus May incorporates both Freud's and Kierkegaard's interpretation by confirming Freud's assertion that anxiety relates to the condition and ignores the object and as well supporting Kierkegaard's view of anxiety as a psychological state where anxiety is seen as a threat or dread inherent in existence. In threatening the core or essence of one's personality, May believes that anxiety strikes at the very basis of the psychological structure on which one's clear perception of one's self and one's world is built. He uses the word 'value' in his definition because he believes that an individual's anxiety is conditioned by the fact that s/he lives in a given culture at a particular point in the historical development of that culture. Therefore the understanding of anxiety can never be separated from an individual's values, which are an integral part of his normal milieu. Rather than postulating on the causes of anxiety, May has based his understanding on the clinical, subjective experience of being anxious as described by his clients, thus

allowing their own personal experience of anxiety to speak for itself.

In examining the above theories, it was my intent to include and set forth a representative sampling of these three theoretical approaches to the phenomenon of anxiety. Keeping in mind, Fischer's two experiential perspectives, one can see that they all began with agreement as to the significance of anxiety, each sharing some common ground and realm of experience, yet subsequent differences began to emerge as they attempted to formalize their original common experiences in terms of their differing assumptions as to the ultimate nature of reality. It appears that the psychoanalytic approach is based on a set of theoretical assumptions which have been formulated from an objective observer perspective; as well as the learning theorists whose approach acknowledges only the subject's overt behaviour. The existential theory, on the other hand, grounds its understanding of the phenomenon of anxiety on the subjective experiencing of the individual who is anxious. As May (1950) states, " to comprehend an individual's anxiety, we need to know how he subjectively interprets his crisis situation; anxiety has an inner locus as Kierkegaard and Freud insisted, and to the extent that we cannot get at that,

the essential meaning of anxiety in human beings will elude us"(1950;p.240).

Thus it is for this reason that I have chosen the phenomenological method which validates subjective experience to study panic attacks. This descriptive method neither denies the experience, nor does it transform it into operationally defined behaviour; rather it remains with human experience as it is given (Colaizzi,1978).

CHAPTER THREE

METHOD

Rationale

In the psychological literature, attempts to research anxiety have not fared too well. A persistent problem that has plagued behavioural science is the absence of a consensual operational definition. The multiplicity of definitions has made for confusion and difficulty in understanding the many conflicting, experimental findings(Levitt,1967). If it is to be explained at all by modern, experimental psychology, anxiety as a phenomenon, must be conceived and defined in overt, physicalistic, quantitative terms. This means that it must ultimately be isolated and reduced to measureable, physiological processes and equally measureable overt behaviours; its whole scientific existence depending upon the empirical inter-related network of observable events. But what does this really tell us about anxiety. Although this method may help us to understand some of the antecedents and consequences of anxiety, it does nothing to enlighten us as to what it is as a human experience(Fischer, 1970).

Part of the problem rests in the researcher's dedication to experimental 'objectivity' which seeks to eliminate human experience from scientific

investigations. As Colazzi (1978) states; "It should be clear that the experimental psychologist's operational definitions and his conception of objectivity both rest upon the belief that whatever is given to human experience is somehow not quite acceptable to scientific psychology"(p.51). In other words, the perceptions of their subjects are seen as being a mixture of fact and fancy, as well as being chronically vulnerable to the distortions of supposedly operative drives, previously acquired habits and biasing attitudes. If their research is to be truly 'objective', experimental psychologists must remove the contaminating influence of human experience. Thus, anxiety as an expression of the total human being, signifying the condition of both the individual and his or her world can never be disclosed.

Phenomenology, on the other hand, is the study of phenomena as experienced by humankind, with its primary emphasis being on the phenomenon itself, exactly as it reveals itself to the experiencing individual with all its concretness and particularity. Its approach is characterized by the attitude of openness for whatever is significant for the proper understanding of a phenomenon. Its content is comprised of the data of experience, its meaning for the participant and most particularly, the essence of the phenomenon.

Objectivity, from a phenomenological perspective, is defined as 'fidelity to the phenomenon'(Colazzi,1978) as it is lived. This means acknowledging first the perception of the person, which in this case is the one who experiences a panic attack, and secondly how the researcher receives and understands that information. As a phenomenological researcher, it is important to remember that it is the participant's experience and not the participant him or herself that is the 'object' of study (Colazzi,1978).Thus it is my responsibility as an investigator to listen openly and respectfully to the phenomenon, allowing it to speak for itself rather than imposing my own assumptions upon it. Knowing that I will have my own presuppositions about panic attacks and that they will influence how I approach my investigation, it is essential that I make them explicit so as not to implicitly impose them on the phenomena under study(see page 27). The phenomenological approach also emphasizes lived phenomena exactly as they are revealed to us because it affirms the everyday world as it is lived by all of us prior to explanations and theoretical interpretations of any kind (Giorgi,1975). It is to the extent that I can elicit each person's lived experience of these attacks that I will have been successful in elucidating the phenomenon.

Overview of Method

The phenomenological approach uses as its method a comprehensive and systematic, descriptive analysis of the experiences of participants, in order to reveal what meaning these experiences have for them.

The descriptive data in this study were derived from individual, audio-taped interviews with participants who had experienced panic attacks. In these dialogal interviews, participants were asked a series of open-ended questions which were specifically related to their attack experience. These data were transcribed and then analysed into discrete units of meaning, with special attention being taken wherever possible to stay with the intended meaning of the original expressions. The resulting written accounts were checked for accuracy by means of a second taped interview with each of the participants. At that time supplementary questions were asked based on my analysis of the initial material. These transcribed interviews were then treated in the same manner as the initial data.

Personal Assumptions of the Researcher

In keeping with the principle of phenomenological research as stated in my rationale(see page 26),I will now present my own assumptions about anxiety attacks,

making explicit my beliefs, hunches and attitudes that I may hold implicitly about the phenomenon under study.

The following presuppositions about panic states are based entirely on my own experience of these attacks as well as on information that I received from talking to others who had shared similiar experiences prior to doing this study.

* There is not a clear diagnostic picture of a panic attack sufferer.
* Most doctors mis-diagnose panic states.
* Drugs don't help other than to relieve the anticipatory anxiety that is associated with longterm sufferers.
* The symptoms experienced during a panic state are not the same as those suffered by individuals who are chronically anxious.
* These attacks cause people to change their lifestyles in drastic ways.
* Because attack sufferers usually believe that their attacks are physiologically rather than psychologically based, counsellors or therapists with non-medical backgrounds don't get to see these people until the secondary phobic avoidance behaviour sets in.
* Many mental health professionals are not sure how to treat or work with clients who suffer from panic attacks.

Interview Questions

In order to help generate ideas for what type of questions I wanted to ask, I decided to interview a friend and fellow student who had in the past suffered from anxiety attacks and who offered to share her experience with me. Out of that dialogal relationship and my own presuppositons about panic attacks came the preliminary formulation of my research questions. There appeared to be four specific areas that needed to be investigated;

1. description of personal experience of a panic attack
2. diagnosis and type of treatment received, if any
3. what meaning they attached to these attacks
4. suggestions for counsellors - what worked and what didn't

These four areas, each with their own set of questions, were further broken down in the following ways;

Description

- preceding and surrounding incidents or events that led up to the attack
- perceptual symptoms - auditory, visual, tactile, kinesthetic, taste and smell
- thoughts - what were they thinking during the attack
- physical symptoms

Diagnosis and Treatment

- how did they discover that what they were experiencing was a panic attack
- who treated them
- how were they treated

Meaning

- what effect have these attacks had on their lives

Suggestions for counsellors

- do they still experience these attacks and if so, what sorts of coping mechanisms do they use, and if not, what do they believe are the reasons
- what suggestions they had to offer counsellors who might be assessing and treating this disorder in the future

I realized, that in asking these questions, it was important to be aware of the relationship between the attack as it actually happened and as it was recalled. Although I asked the participants to let me know if they were actually conscious at the time of what they were recalling or if it was something that they had come to know based upon reflection, I choose not to separate these two entities but rather to see them as a whole. The full meaning of each participant's experience would not so much be contaminated by time but rather enhanced and completed as it came to be understood through reflection.

As one of the main principles of phenomenological research is an open dialogal relationship between the participant and the researcher, these questions were accompanied by sensitive and respectful listening, empathic reflecting, and some probing for clarification in order to help stimulate the recollection of each participant's experience.

Selection of Participants

Two criteria were used to select the five participants for this study. The first one was that they had all actually suffered from acute panic attacks, based on the criteria set out in the DSM-III. I chose at that time, not to make a distinction between panic attacks with agoraphobia and panic disorder without agoraphobia and so I made an arbitrary decision not to include the last measure which states that " the disorder is not associated with Agoraphobia"(see appendix A), and the second criteria was that they were not in therapy for those attacks at the time of the study.I wanted to be sure that they had dealt with any sensitive issues around their attacks prior to participating in this study.

I found all but one of my participants through word of mouth. When I began to talk about my thesis subject and mentioned that I was looking for people who experienced anxiety attacks, various students and

friends approached me, saying that they knew of someone who had these attacks and might be interested in participating in my study. I asked each of these people to contact the person they knew and ask them personally so as to allow them the privilege of refusing without feeling pressured if they were not interested. As soon as I received an affirmative response, I contacted every participant myself and set up an interview time. The one participant with whom I did not follow this method was approached directly by me because she had expressed an interest in participating in my study.

At the beginning of the interview, I carefully explained my thesis topic and openly encouraged questions. They were assured that their involvement in my study would be entirely voluntary and that they could decide to withdraw at any time. They were each asked to sign a consent form(see appendix B) which carefully explained that their participation would be kept in the strictest confidence, their name and all identifying information such as place of employment, names of family, and friends would be changed in order to protect their identity.

Research Procedure

The first interview was scheduled by telephone and at that time, a place to meet was decided upon based on their time schedules and preferences. Each of the

initial interviews took approximately two hours because I wanted to help the participant to get to know me and to allow her/him the opportunity to ask any questions that were concerning them about me or the study itself. After the consent form was read, understood and signed, I turned the tape machine on and began the questioning. A second interview was set up as soon as my initial analysis of their first tape was completed and had been mailed to the participant in order to allow him/her the opportunity to read it over, change anything that they felt didn't fit with their understanding of their experience and/or add anything that they forgot to mention at the interview. During the second interview, we went over any corrections or elaborations that the participant wanted included as part of their protocol and I asked a few new questions that had come up for me based on their initial transcript material around the issues of control and death.

Analysis of the Data

The phenomenon under study is a 'panic attack' which is elucidated through the subjective accounts of the individual who experiences it. The researcher and the participant are only co-constituents of the research process who work together in a dialogal relationship in order to uncover and reveal the phenomenon as it is lived and experienced by the

sufferer. The research data is the descriptive experience of each of the participants. After all of the taped interviews had been transcibed, corrected and elaborated upon by each of the participants, I read each one of them over very carefully, immersing myself as much as possible in their understanding of the attack experience. I began to extract any significant statements that pertained to the investigated phenomenon and as well I eliminated any repetitions. I stayed wherever possible with the participant's own words in order to ensure that none of the intended meaning was lost through misinterpretation. The resulting 'meaning units' were then transposed onto individual index cards which had been colour coded to signify the four areas that I had chosen to investigate with my research questions. As well, each card was marked at the top right-hand corner with the participant's pseudonym. Every attempt was made to allow the data to speak for itself in accordance with the basic principles of phenomenological analysis. This meant allowing theme categories for each of the four main areas(description, diagnosis and treatment, meaning, and suggestions for counsellors) to emerge as much as possible from the data.

Keeping in mind that the phenomenon under study was the panic attack itself and not the participant, I

sorted and resorted the cards many times trying to discover the best way to elucidate the phenomenon. In my first sorting, I divided up the cards so that each set represented the participant's own experience. After I had carefully read each of these sets, I realized that although I now had an excellent understanding of each participant's personal history of their attacks, I still did not have a clear picture of the attack experience itself. It seemed that with the cards being sorted on an individual basis, the essence of the attack experience was being obscured by the often overwhelming personal history of the participants. I then sorted the index cards according to the four areas posed by the research questions (description, diagnosis and treatment, meaning, and suggestions for counsellors) and read them again carefully. This time the phenomenon emerged clearly because when all the personal accounts came together under the four areas to be investigated, they presented a strong and vivid description of the attack experience.

After the sorting was completed, a descriptive account was written for each of the four areas, using the collected, subjective experiences of each of my participants.

CHAPTER FOUR

RESEARCH FINDINGS

A Brief Profile of Participants

The following names have all been changed to protect the identity of the participants.

JOHN is a 34 year old man who is married and has two children. He completed high school and is at present a contractor who has his own business. He was diagnosed as having his first attack two years ago but he believes that he also had these attacks when he was about 14.

CAPRICE is a 39 year old woman who is married and has two children. She has both her Bachelor and her Master's degree and is presently fully employed as a counsellor. She believes that she had her first attack over six years ago.

RENI is a 35 year old woman who has been married twice. She has two children both by her first husband. When they divorced, her son stayed with his father and her daughter came to live with her in her present marriage. Prior to becoming agoraphobic as a result of her panic attacks, she was employed as a waitress. She has a Grade 12 education. She had her first attack three years ago.

SALLY is a 45 year old woman who is married and has two children. She has been trained as a secretary and as well has completed an Independent Studies Degree - BA in Health Education and Counselling. Sally is presently a counsellor and Educational Director of a Clinic. She believes that she had her first attack eleven years ago.
KEVIN is a 31 year old single man who is a plumber by trade. He did not complete his high school degree. He states that he had his first attack when he was 19 years old.

I have divided up my data into the four areas that I based my questions on: description of attack experience, diagnosis and treatment, meaning, and implications for counselling. I have also wherever possible, allowed the data to speak through the participants themselves rather than imposing my own interpretations on it.

DESCRIPTION OF ATTACK EXPERIENCE

In this section, the holistic experience of a panic attack will be considered under the following categories: preceding and surrounding incidents, physical experience, and experience of intellectual and perceptual functioning.

Preceding and Surrounding Incidents

I asked all the participants to describe the events leading up to the onset of their first attack because I wanted to know what their general emotional and physical health was like prior to the attack. Later on in a second interview, I asked them what they believed, in retrospect, was the trigger for their attacks. The following excerpts are taken from their five transcripts:

> JOHN My first anxiety attack came when I was on a plane to Hawaii for two weeks of sun and take it easy - we had just boarded a 747 jumbo jet and I guess we were about an hour out of Victoria and then I started to feel claustraphobic - the attack came out of the blue - business was good - I had business waiting for me when I got back - did a fair amount before I left - there was nothing particular going on in my life at the time.
> I believe that the first one was a random attack - however there's no doubt that the subsequent ones were triggered by stressful situations - feelings of insecurity - feeling 'out of control'.

> CAPRICE Well, I remember it was New Year's morning - we had had a dinner party the night before and I'd drunk a fair bit as I think back on it - got up the next morning - not with a particular hangover or anything - my husband and my two children were helping me take down the Christmas tree - I made lunch - and then I started to feel really peculiar - but there was no specific incident - more a tremendous amount of stress over a long period of time - stress that I wasn't really aware of - I mean, I was aware of it but I had no idea of how intense it was - until even now, I am only now getting a grasp on how intense it was.
> I think that the trigger for me is a feeling of being alienated, isolated - a sense of not being liked.

<u>RENI</u> I was lying in bed thinking about my son who dosen't live with me - I was worried about him - just a mother's normal worry - nothing too intense - I felt guilty that he wasn't with me - I was trying to go to sleep - I felt really uncomfortable - started to feel hot - could feel my heart beating - it was pounding in my ears - so I got up and made a cup of tea - it got worse. There was no major crisis going on in my life at the time - my physical health was excellent. I believe that the trigger was my family situation - especially my relationship with my present husband and his son - an ongoing continuing battle with my step-son - it was like he would do something on purpose to create trouble - I would discipline him and my husband would immediately step in and take his side and so we would always end up fighting - this would happen over and over again - I couldn't win - I was stuck - punished for something I hadn't done, like a child - I just let him bully me around - a'no win' situation.

<u>SALLY</u> It all had to do with my husband and another woman. The first attack was when I knew that this woman and my husband were going to be spending some time at our house one evening and I was going to be out. It was with my permission - I was out and getting more and more anxious and having to drive back home - it was difficult to get out of the car and very difficult to come into the living room and when I saw them sitting there - I don't remember whether he had his arm around her or was holding her hand, I forget the actual thing - I just flipped out. The underlying feeling was sheer terror - a sense of helplessness - a feeling of being in the present and its too much for me to cope with.
I believe that anything that triggered helplessness in me caused my attacks - whatever was happening with my husband - my attacks all centered around him.

<u>KEVIN</u> I remember going into a bank and suddenly feeling the place just close around on me - people who probably weren't looking at me or even worried about me were starting to become more obvious -I felt myself begin to tighten in the neck and under the eyes, and around the nose as I was waiting in the lineup to cash a check. I can't remember any specific thing that caused the attack - my job and my relationships weren't particularly stressful at

> that time - I had been in banks before and nothing had ever happened. The only thing that I can think of is that I didn't feel too good about myself - I didn't like what I saw in the mirror.
> Its funny, I could have answered that question before when I first started gettiing them but now I don't know - I just expect them to come. I believe my first attack was triggered by my low self esteem - a general lack of confidence. The other attacks - when you go back to a place where you've had one - you're expecting it to happen - so you're defeating yourself before you even get in there.

It seems that with the exception of Sally's attack, the participants perceived that there was no specific incident responsible for their first attacks and as well that their general emotional and physical health were normal. However, upon reflection, they all stated that their attacks had been triggered by ongoing feelings of stress relating to a perceived sense of self at that time. To quote each of them :

- John - "feelings of insecurity, feeling out of control"

- Caprice - "a feeling of being alienated, isolated, a sense of not being liked"

- Reni - "I couldn't win, I was stuck, punished for something I hadn't done, like a child - I just let him bully me around - a 'no win' situation"

- Sally - " anything that triggered helplessness in me caused my attacks"

- Kevin - "low self esteem, a general lack of confidence"

Physical Experience

The following data is no longer specifically related to the first attack but rather to any attack experience the participants wished to talk about.

The most common physical symptom experienced by all participants was one of a driving sense of having to move:

- John - "at the restaurant, I had to move, to get out of there, pace up and down the street"

- Caprice - "I just lept out of bed and I remember walking through the house - just trying to hang on to reality"

- Reni - "I can't stay in one spot, I have to move - I feel as if I'm suffocating"

- Sally - "a feeling of having to move, I kept wanting to bash things off tables or just clear the room, get everything out of my way - the wringing of my hands. The drivenness of these movements was very unpleasant because I am a very controlled person"

- Kevin - "I just wanted to be out of that place, a feeling of wanting to run - I don't know if I'd go as far as terror - yea I guess I would"

Other physical symptoms that most of them shared in common were either hot or cold sweaty, clammy hands, and breathing difficulties although each participant's symptoms varied - "a sense of suffocating, I couldn't

get my breath"; "shortness of breath - hyperventilating"; "very shallow breathing - lump in my throat, felt constricted"; "I could hardly breathe and when I did it was in a sobbing fashion, almost like diaphramatic spasms".

It is interesting to note that the three female participants experienced some intense cardiovascular symptoms, which ranged from a moderate feeling of "my heart was pounding"; "I had a pain in my chest, my heart was racing"; to more severe "heart palpitations - chest pains which were stabbing"; while neither of the male participants experienced any of the above sensations. Other physical symptoms that were not common to all were abdominal cramps, nausea, bowel spasms, frequent voiding, a feeling of loss of muscle control in lower extremities, tingling and feeling of tightness around face and neck.

Experience of Intellectual and Perceptual Functioning

The following quotations from their transcripts are cited to give a sense of the variation and extent of the disorganization of thought patterns which is common in panicking.

> John Fear, I was fighting the fear, uncontrollable fear - I felt that I was coming unglued, my brain was breaking down - there was something drastic going on here and it needs tending to right away - when I got back in the

car, the panic rose and I thought something was going to snap - I thought I was having a stroke - I tried to put logic to it - something's happening - you don't go crazy in one night - obviously there is something physically wrong with me - I could actually feel it starting to surface, feel it coming and getting stronger - I'm losing control - I have to get out.

Caprice I started to feel really peculiar, really weird, scared - my fear came from the thought that I must be dying. I had a pain in my chest, I felt like I was suffocating - I really had to get to the hospital and find out what was wrong and get it fixed. I felt like I was sort of removed, like I really had to hang onto reality. I felt a bit like floating - like I was walking on egg shells - I had to be careful or I was going to fly apart - I felt like I was disintegrating and that I was going to go out of control in a physical way.

Reni I was not in control at all - my body was taking over - I was terrorized and I didn't know why - I couldn't stop it - like the worst thing in the world was going to happen to me at that moment. Although I didn't really know what a nervous breakdown was, I thought I was working up to it and I thought when I was having one of these attacks that one day my mind would just click off, just snap and I wouldn't know who I was and who the kids were and I was afraid of that happening. I felt really overwhelmed - I thought that I was going to die everytime - even after I knew what it was - I really wasn't certain that it was true - it just couldn't be my nerves - it was something physical inside and they weren't seeing it - my body was breaking down and noone would listen.

Sally I felt completely out of control - this crazy,ridiculous, I'm going nuts - I don't understand what's going on - let me out of here. Some of it I blanked out - my husband said that I was rushing up and down and yelling, screaming and shouting - I just hated everything - I hated myself - I wanted everything and everybody out of the way. I wanted to bash everything that I possibly could - I wanted to tear the room to shreds -I just wanted everything to stop, to eliminate everything - for it never to have happened.

> Kevin I thought that there was something wrong but I wasn't sure what - I think I put it down to something I ate or didn't eat because at that point I was always on a diet. I just wanted to be out of that place - a feeling of wanting to run - terror - a fear of showing yourself, of showing imperfection - of falling apart - of losing control - I felt really nervous and as I finally got up to the counter to cash my check, I was in complete dissarray - my legs felt weak - I felt like I had lost control of the muscle in my legs, they were shaking - that is the worse part of my attack - I don't want anyone to see that side of me.

In all of the above transcripts, the fear of losing control was a major aspect of their attacks. So I asked them later in a second interview, how control was connected with their experience of panic and without exception they all admitted to a strong need for being in control; "I had more than a normal need for control in every aspect and in every area of my life - panic was almost a physical manifestation of that lack of control"; "unrealistic expectations of myself - like I had this perception of what I should be acting like and how other people saw me versus what was actually happening"; "a feeling of things happening to me which I had no control over - helplessness"; "control to me is a neurotic sort of defense - making very strong rigid limits for everyone and myself to live within - there's a kind of paradoxical intention - being in control is admired and yet too much is self-defeating"; "It's pretty much the key for me, I've got to be in

control of everything and yet staying in control really caused me to panic".

Another commonly reported fear was that of either going crazy or dying. In two accounts there was also almost a welcoming of death which would have relieved them from their seemingly endless suffering of these attacks; "death would be a release - I get depressed by these attacks - I just feel like I'm a drain"; "when I really think about this death issue I wonder about myself - I know that is what I want to do at that time but I know in other times when I have been faced with possible death, I was absolutely terrified so I suspect that death is not a welcome friend although in the panic stage I just want to die".

The degree of disorganization of perceptual functioning varied with each person.
For John, his vision, hearing, taste, and smell all became extremely sensitized.

> Through the restaurant window, the sun was setting and the glare off the water was suddenly painfully bright, overpowering for my eyes, I couldn't bear it...... there was some singer entertaining in the background which normally I wouldn't mind but again I found the noise overpowering.......the smell of food also became overpowering - there was a real fear of vomiting - I couldn't touch the food.

For Caprice it was as if she needed to use her visual and tactile senses to help keep her in touch with reality

> It was almost like I was looking hard to make sure that everything was the way it was supposed to be - to keep me in contact with reality - it was my visual capacity that I used to try to keep myself conscious - to reassure myself that I was really here ....my hearing was distorted - a sense of muffle...........things didn't feel any different - I remember wanting to touch things - I couldn't be close to anybody - I didn't want to be touched - I just have to be alone - I've got to hold on.

Reni experienced alot of auditory and visual distortion during her panic attacks which made it really difficult for her to cope with the world in this state.

> I could hear people but I can't relate to what they are saying - I can't think straight enough to answer - sound was amplified, it went right through me and it hurt - I could hear my heart - I could count the beats without taking my pulse.........my vision was blurred - kind of wavy like a heat wave that you see across the road on a real hot day - it's hard to focus on anything - I feel unable to concentrate - my eyes don't want to focus.

When she wasn't experiencing a panic attack, Sally saw herself as someone who was particularly sensitive to both visual and auditory stimuli. However during an attack she believed that she blocked out both of those senses.

> I was trying very hard to cut off from anything visual - I don't remember seeing them(her husband and another woman) after the first moment - so I must have cut them off.........auditorally, I also cut them off - I don't remember sound and normally I am a very auditory person - usually I have difficulty in cutting anditory and visual out in a normal sort of state.

After the attack is over, Sally goes through a hypersensitive period where all her senses are more

acute. It is as if by cutting off these senses during the attack, they became more intensely experienced after.

> Everything was different in a startling way - the leaves, the sun, my sheep - everything was sharper - sounds, sights etc. - like the effects people have when they are stoned - I noticed more - it wasn't a pleasant feeling because it was new.

For Kevin, it was his vision that became distorted. He broke it down into two parts - how he felt other people visualized him during the attack and how he saw the world around him at the time.

> I interpreted everybody as looking at me the wrong way - like I visualized them as seeing me breakiing down - almost like pre-judging me or knowing what I was feeling - which I knew wasn't true but it's how I felt - I also saw everything as being painfully bright - it wasn't a pleasant sensation - I found myself looking mainly at the floor because it didn't look back at me ....hearing, I don't know - maybe I blocked that part of it out - I think I was so pre-occupied with the visual part that even if somebody had shouted something across the room, I probably wouldn't have heard it even if it had been in reference to me.

As can be seen by the above excerpts, some disorganization ranging from mild to severe, of both intellectual and perceptual functioning appears to be a shared characteristic of panic disorder experienced by all the participants in this study.

DIAGNOSIS AND TREATMENT

The first and most difficult step for all of the participants in this study in getting help for their

attacks was figuring out what was wrong with them. If their physical symptoms were more severe, they went either to Emergency or to their family doctor, if their psychological symptoms were more acute, they asked to see a psychiatrist.

> JOHN After I continued on and had attacks on a daily basis, I phoned my family doctor and told him something was wrong and to line me up with a psychiatrist but I couldn't get an appointment for 6 months. I had been out to the Pain and Stress Clinic a couple of years ago for a stress workshop, so I called the doctor there and went to see him - he was the one who diagnosed them as panic attacks and I immediately felt a lot better - now I've got something to fight because by that time I had become agoraphobic. By that I mean, I had become withdrawn, depressed - my life centred around my home and my boat - I needed some answers - maybe I was a schizophrenic - I just didn't know

> CAPRICE I don't think I really knew what it was for a long time - even years - at the hospital (where she was treated for her first attack), they didn't say that it was anxiety or anything - I thought I had drunk too much - I was just glad it was over and they said I was O.K. - I wanted to believe them - it's funny when I think back on it - I don't know how I could have done that - how could I have been so blase'- I think I connected it with heart disease - tachycardia and high blood pressure although no tests were ever done at that time. Several years later after many attacks, I volunteered to take part in a project for a psychologist who was doing research on anxiety - I think at that point, I really understood for the first time what I had been experiencing.

> RENI It was during my second attack and I had been taken to a clinic and the doctor there told me that what I was experiencing was a panic attack - thats when they told me what it was - well not exactly because I still didn't really know what a panic attack was - he just said that I had had one and he didn't think I would have it again - so I felt really good - I had been given a clean bill of health. It was not until much later when I was

having the attacks on a daily basis that I started reading about them and talking to my own doctor - it was then that I really understood what they were. By that time, I could only be with my girlfriend or my immediate family but other than that I couldn't see anybody else - I couldn't go outside anymore - I stopped my job - stopped driving the car - I couldn't function outside of my house - even to go into the backyard where the car was parked - I couldn't do it. I never did go for any therapy because I always thought that they would commit me and I knew I wasn't crazy.

SALLY I don't think I thought aboout it in terms of attacks or panic until I started to work at the clinic - until I started counselling people - these people kept coming in with these symptoms and yes, I'd say, the same thing happened to me and I would start to talk about it - I understood them and nobody else had ever understood them. Interestingly, I had gone through all the Cold Mountain programs - years of that type of work and I never knew. It took me ten years of trying to understand before I solved the problem of my husband being the trigger for my attacks.

KEVIN For the longest while, I didn't really know - my first G.P. never told me it was a panic attack - he just said that he'd send me to a counsellor and let them look after me - I figured at the time that I was a little bit nuts or going off the deep end - even the counsellor didn't tell me - she just wanted me to go into group therapy and there was no way that I could handle that situation at that point - I felt it would make me worse. I eventually changed doctors and it was my new G.P. who eventually told me and sent me to the Pain and Stress Clinic. He couldn't explain why it was happening - I don't think anyone really knows but he was the first one to say we've got to do something about it - you can't live the rest of your life like this.

It appeared that after the first attack was over and the symptoms had completely disappeared, the participants usually experienced a sense of relief that their problem wasn't serious and forgot about the

incident. Their anxiety returned to a normal level, without any further evidence of the anxiety symptoms that occurred during the attack itself. A few days, weeks or months later, however, a second spontaneous panic attack would usually occur, and then a third, fourth and so on. It was at this time that they began to search for help in earnest because their lives were becoming seriously disrupted by these attacks.

The type of treatment varied for each participant. Caprice and Sally never received any medication for their attacks. Understanding the attacks and learning good coping skills over time gave both of them the necessary relief that they needed from their attacks.

> CAPRICE When I had my first attack and was taken to Emergency, I was given no treatment or medication - they were very reassuring - they didn't treat me as if I were a 'whacko' or anything - one time after another attack I went to a Clinic here in town and that doctor did a rectal examination on me and told me that I was coming down with the flu - it wasn't till several years later when I volunteered for Morita therapy that I really understood what all of this was - before that I don't know what I thought they were.

> SALLY I was different from most people because I had a husband who was a doctor and as well understood a certain amount of my process - so I felt cared for by him - I didn't take tranquilizers or anything like that and I was never rushed off to hospital. However it took years before I really understood what was wrong with me.

John, Reni, and Kevin were all given medication for their attacks. Reni has managed to wean herself off but

both John and Kevin periodically still feel the need for theirs.

JOHN I had to wait six months and then I went to see a psychiatrist - I only saw him twice and I liked him - he sat me down and said - look here, what you've got is easy to cure - we'll fix you up right now - in a couple of days you're going to be fine - take a couple of these pills a day and read this book - and sure enough I was well on my way - however I didn't like the idea of the pills although they worked great - maybe too great - I immediately started cutting back and tried to learn on my own. I also went to the Pain and Stress Clinic and did some biofeedback and relaxation exercises as well as seeing the doctor out there - I began to explore the past and the causes and to know myself - I think that was a very important thing. If I feel like I'm going to have one, I take half an Atavin - I feel self-conscious about taking it and I know I shouldn't but I do and it just kills it - I've got it in my head that half of one of these pills just kills it.

RENI When the ambulance came, the woman para-medic seemed mean - just seemed rough - she gave me some oxygen and then she hooked me up to all these wires - she kept asking me questions and I couldn't say anything and she was getting mad at me - it was just too much effort to talk and I was shaking all over - I remember her saying that my heartbeat was 160 and irregular and I thought - this is it, I'm going to die right here in the ambulance - finally they took me to the hospital. It kept coming in waves and it wouldn't stop - in the hospital they rewired me onto something else and my heart beat was just pounding and pounding. They didn't give me anything - they told me I was hyperventilating and to calm down - they wern't very nice at all. After about an hour and a half, I felt fine again and so they unhooked me and I walked out. They never told me what it was except that I was hyperventilating. The next attack was about 4 months later when I was driving my car - the police took me to a nearby clinic and when I saw the doctor - I told him about my symptoms - I was very frightened but I was not hysterical - he seemed so calm - he listened to my heart and said it was O.K. - it was then that he told me that he

thought I was having a panic attack - he said that what he would do was give me an injection of Valium and then he would know for sure - so he did and it worked almost immediately - my symptoms started to go away and I began to feel normal. He told me that I wouldn't have another one so I got back in my car and went on my way. After I began to have the attacks all the time, my family doctor gave me Moxepan (tranquilizers) and I would take a half a pill every night whether I needed it or not because I didn't want to have an attack - however I was worried that I was becoming addicted so I took myself off them - I found that most of the time I didn't need them and on the nights when I started getting anxious about not taking them, I thought - you have to feel some pain - you have to be able to get through something as simple as this and that really helped and I didn't take the pill.

KEVIN I was given Valium for awhile but it didn't help much but it was better than getting up in the morning and drinking a beer or a shot of Rye - it was the lesser of two evils. I also took Atavin but it wasn't any better than Valium. I'm on a medication now called Serax which to me is the most effective of all the drugs I've ever taken and I can probably take half of one a day or if I'm feeling tense I'll take the other half - however I think now I want to go back to the Pain and Stress Clinic and go into therapy again - I don't want to keep depending on this.

Based on the above quotes, it seemed that some of the confusion around diagnosing and treating panic disorder lay in the multiplicity of symptoms that were present during their attack experience. With the exception of Reni, who was told that she was experiencing a panic attack, none of the others were given a clear explanation of their condition. As can be seen, it took months and for some even years before they had a clear understanding of what they were suffering from. Another serious concern was around the

issue of dependency for the three participants who were given medication for their attacks. Although they believed that the medication helped to relieve their anxiousness around having another attack, they all expressed some doubts about continuing with this method of treatment.

MEANING

I was interested in finding out what effect having these attacks had on the lives of these individuals and what significance, if any, they attached to them.

> JOHN I am more withdrawn - I'm not the outgoing person that I was before - most of my activities centre around the home, family and my boat - just drawing inward was probably the most distructive thing - but I still get on well and enjoy talking to people - it's not such a drastic change - just more than I would be normally. As far as meaning is concerned - its done quite a bit for me - the learning process that I've gone through in the last couple of years has been nothing short of phenomenal - its made me curious - it has just opened up so much possibility - the lid has just blown right off - I've learned alot about communication.

> CAPRICE Initially there was no effect - now, I feel a little on edge a lot - I feel often a pervasive anxiety, even when I am relaxing - sometimes I am more anxious then than at work - there's a kind of edge - kind of waiting - anticipating. I think it has added to my life - it was a trigger for me to take a good look at my life - I went back to school, I quit my job, I left my husband - I did a lot of things that I really felt I needed to do before I died. I asked myself questions - what do I want out of life - what can I contribute - it is time to do something with whatever potential I have. It has made me more introspective and more aware of my own process - understanding them helps - knowing

really does help. However, there's still a part of me thats afraid I'm going to disintegrate or that I'll have a heart attack or something.

<u>RENI</u> Yes, there is a definite change - I think before I thought I was a very strong person and I didn't think that anyone or anythihg could ever really bother me or push me over the edge - I know now that that's not true - I am now more understanding of other people who have had phobias - it now makes me really angry when I hear people talk about other people being 'mental' - its O.K. to have heart trouble and yet as soon as its your mind, its not O.K. - I'm more aware of just doing things - before I used to take everything for granted, now, I think its something just to be able to do it. I know now that I'm not crazy - before, after you've been told a few times, you begin to believe that you really are - especially when I became agoraphobic due to the attacks - I'm more sure of myself now - I have come through it - I have survived - I haven't really done it all on my own - like I've talked to my doctor and read a lot of books, asked a lot of questions and became really interested in my attacks and what caused them - I knew that if I didn't they would get worse and worse. It made me deal with the problems that I was having with my marriage and not just let it go on and on.

<u>SALLY</u> It's had a tremendous effect - I think its been the thing that I have learned the most about myself through - I feel very excited about it - I'm glad in a lot of ways that I've had that experience. I guess in a way I've made it my life's work - I do a lot of teaching and seminars - so from my panic attacks, I've gained an enormous amount of meaning for my work.

<u>KEVIN</u> It's had a terrible effect on my life - I can see more or less the last ten years of my life has been wasted - I mean its just like a ball and chain - its as bad as alcoholism or drug dependency - I've never really lived up to my potential - I've never lived life, I've always kind of dreamed of whats happening in the future and dwelled on the past - I've never lived in the present - its made my life very shallow and empty - having the attacks and not understanding them and then when you know about them and you knew they were coming - you begin to back off from

> everything - you are always living in the past because you are always thinking about your panic attacks - you never live in the 'here and now'. I could say that it was fate - that they were meant to happen - I think in the beginning I thought - why me - but now especially in the last six months with just the counsellors and the people I've had around me - just understanding it a bit more and understanding its not something you're alone with - it can be cured or at least controlled - I don't think I ever understood that before.

It seems that for all the participants, having panic attacks had a significant effect on their lives. The one common thread seen in each of the above comments was that the attacks stimulated a process of self-exploration and change triggered by the need to know what was happening to them. Understanding and creating meaning for their attacks appeared to help remove some of the more limiting, negative side effects of this disorder on their lives.

SUGGESTIONS FOR COUNSELLORS

I asked the participants if they still suffered from these attacks in order to find out what coping mechanisms they used to help relieve them or, if they no longer had attacks then how they accounted for their disappearance. Without exception all of them stated that they are still vulnerable to having an attack but only rarely and with less intensity.

> JOHN Yes I still have them but rarely - if I have a terrible one, I take half an Atavin and it just kills it - I've got it in my mind that half of one

just kills it. If I feel really anxious, I relax - let my stomach breathe - sit calmly - tell myself it will pass - in 10 minutes you'll be fine - and that simple technique seems to work - just having an understanding of what's happening in the body helps. I had a real bad one just awhile ago and I thought I was having a heart attack because I had such stabbbing pains in my chest and my heart was beating so fast - once I realized that it was my nerves - the symptoms calmed down - I just accepted what was happening and talked myself down.

One of the negative side effects of these attacks for John was depression and so I asked him if that was still a problem for him.

No, I haven't been depressed for a long time because now I understand what's happening to me and I have some resources to fight it with - I can function now - I can do anything I want.

CAPRICE I still have anxiety and occasionally I have a panic attack. What helps for me is going outside alone - deep breathing - internal talking - trying to get a little distance from it - talking myself down - I have never taken any medication for my attacks.

RENI Yes, I still have them but not like I used to - when I do get them they're really much less severe - I only get them now for a minute or so and when I get them I know what it is and I just sit down, as long as its not too full blown, I'll just sit and be quiet and breathe slowly and try and relax and just think about what's happening.

SALLY Yes, I still have panic attacks or attack might be the wrong word - I have an experience of building up of anxiety and it seems to come when I am overloaded - when I have too much to do - I can now feel the buildup happening - I can feel the agitation - I notice my breath changing and then I have to find time and a way to give myself more space. When I feel that way, I pay more attention to relaxation training - do visualization with symbols and then calm the symbols down - spend time by myself - picture this little girl who is feeling the agitation and the terror and the panic

and the confusion and I spend a lot of time with her - talking with her and generally sort of having her with me.

KEVIN I still get them but not to the same degree - I do breathing exercises - more physical activity - I'm in better shape now than I've been in 10 years - I like more what I see in the mirror - relaxation exercises - I'm slowly expanding my life - I'm giving myself a chance - I'm still taking Serax - not every day but only when I get uptight.

Understanding what happens to them when they are experiencing an attack seems to be an important key for all the participants in relieving their symptoms. As well, they also mention the value of internal dialogue -"talking myself down",deep breathing, and relaxation exercises. For John and Kevin, medication was also seen as an option if they were feeling very tense or 'uptight'.

Based on their own experiencing of these attacks, I asked the participants if they had any suggestions to offer professionals who will be assessing and treating this disorder in the future.

JOHN It is very important that counsellors know how to diagnose panic attacks - I think there is a lot of mis-information out there - people who have them and don't know what they are - a client isn't going to be able to come up and say that they are having panic attacks and so it is important to be able to weed through all their symptoms and say - yes, that is what you've got - to move quickly especially if someone is in a real emergency situation - maybe even give them some medication so they can rest for a day or two - read Dr. Week's book(Hope and Help For Your Nerves) - learn biofeedback techniques for body control -

relaxation techniques to control the symptoms - work on the cause -counselling is very important.

CAPRICE I think counsellors should be educated about these type of attacks - I've felt reasonably adequate to deal with clients that came to see me because I've been through it - it is important to be clear on the difference between panic attacks, phobias and chronic anxiety - the kind of treatment I got from Dr. X was probably, for me, the most valuable treatment - reassurance - he disclosed a bit of his own anxiety and was able to describe to me what was happening based on his own experience - so I felt that I wasn't alone - his instructions were - get some distance from it - use the attack as a signal to look at what's going on in your life. His suggestions were really valuable and I think would be useful for counsellors - it is also important to look at what sorts of expectations people who suffer from panic attacks have about themselves.

RENI I think it is important to be believed and to be understood - I felt that some of the doctors at the clinic didn't understand what was wrong with me. Another thing - if your client is married, it is important to work with their spouses too. I never went for therapy because I always thought that they would commit me and I knew I wasn't crazy.

SALLY Counsellors who work with these clients should have experienced a panic attack themselves - absolutely no tranquilizers unless there is such physical crisis that they need to have something to alter it - there is a tendency on the part of both medical and mental health professionals to want to do that - to stop it for the person. To help them through it, it is better to hold them, help them breathe, stroke their head, massage them - but let them go through it - help them to talk it through so they know they can do it on their own - help them to understand some of the theories about panic attacks - enough information so they know they are not going to die or go crazy and that this is actually quite common and in a sense very healthy - its our body telling us that something is wrong and we then have a choice whether to look at it or not and if we don't do that - its going to keep happening. I think every counsellor who works with clients who have panic

attacks should understand and have participated in body work - they will need a lot of confidence in their own process.

KEVIN I think it is important just to be able to recognize it - I think a lot of doctors diagnose it wrong - I really don't think that drugs are the answer.

One of the implications that they all shared in common was the importance of careful assessment and diagnosis when treating someone who is experiencing panic attacks. Another was that every professional have a good theoretical understanding and working knowledge of this disorder so they could explain what was happening to their clients and thus help alleviate some of their often intense fears of dying or going crazy. There was also a real sense from the participants of this study that drugs were not the answer except for emergency situations when the individual felt overwhelmed and exhausted by continuous attacks.

CHAPTER FIVE

DISCUSSION AND IMPLICATIONS

In this chapter, the significance of the study will be considered first, followed by a summary of the major findings which will be presented in the form of a pragmatic guideline of the essential characteristics of panic disorder as experienced by the participants in this study. Implications for counselling will be suggested based on that guideline.

The rest of the chapter will deal with the relationship of findings in this study to the reviewed pharmacological research and theoretical approaches to anxiety that were considered in Chapter Two. Lastly, recommendations for future research will be discussed.

SIGNIFICANCE

In light of my research findings, I will now address the four questions that came up for me in my Impetus of Study (see page 3), based on my understanding of panic disorder at that time. These questions were related to some of the confusion that existed during the sixties and seventies with the quantitative rather than qualitative distinctions that were being made with regard to various types of

anxiety. There were no specific qualitative categories for the many and often complex symptoms of this abstract emotion. Because of this, panic attack victims were treated, depending on their symptoms, either as if they had some sort of physiological disorder like hypoglycemia, mitral valve prolapse, tachycardia etc.(their symptomatology is similiar) or, as if they were suffering from anxiety neurosis, which was a general catch-all label for non-pathological symptoms that didn't fit into any of the existing psychiatric categories. It was not until the DSM-111 was published in 1980, that doctors officially recognized panic disorder as a separate clinical entity. However, even with this official recognition, there still seems to be some confusion about how to diagnose and treat panic attacks effectively.

The purpose of this phenomenological study was to elucidate the tangible, particular elements of the experience of an acute panic attack through the subjective accounts of its five participants. It was not my intention to generalize the particular themes that were revealed by these individuals to all people who have panic attacks but rather to sensitize both medical and mental health professionals to some of the problems regarding assessment, diagnosis and treatment that still exist.

As well, I hoped that by reflecting on the major findings of this thesis and some of the scientific and theoretical literature on anxiety reviewed in Chapter two, both researchers and clinicians in the mental health field might gain an increased awareness and understanding of some of the differences between the symptoms of generalized anxiety and panic disorder. Two significant discrepancies became apparent when I compared the findings of this study to some of the assumptions that I made prior to my investigation. One of my assumptions was that drugs don't help other than to relieve the secondary symptoms of anticipatory anxiety. What I discovered however, even though none of the participants in this study were given any, was that for over two decades, researchers have known that there are specific drugs that block spontaneous panic attacks in individuals who suffer from panic disorder (Gorman, Liebowitz, & Klein, 1984). This raises the question as to whether the doctors were diagnosing the disorder correctly, or were they just basing their assessment and treatment of this problem on the secondary symptoms that were present at the time of the consultation. My second assumption was that counsellors were not sure how to treat clients with panic disorder, however this premise was not supported by the actual experiences of the three participants who received psychotherapeutic

treatment. They all reported feelings of being understood and really helped by their therapists.

The rest of my presuppositions(page 26) were confirmed by my research findings.

SUMMARY OF MAJOR FINDINGS

A Pragmatic Guideline

DESCRIPTION

Panic disorder is characterized by attacks of acute panic whose onset is, by definition, not related to any specific life-threatening incident. These attacks occur spontaneously and will generally follow an unpredictable pattern until the secondary symptoms of anticipatory anxiety and/or phobic avoidance behaviour set in. The first attack can occur anywhere; at work, while driving a car, going into a restaurant, or at home. Although the first and subsequent attacks appear to be unprovoked, sufferers in retrospect, will admit to feelings of ongoing stress due to a perceived sense of feeling overwhelmed by their life situation at that time. Once the cycle of panic begins, it develops a self-perpetuating course which appears to be independent of its original antecedents.

The most common physical symptom experienced by all the participants in this study was an overpowering, driven need for movement which appeared to be triggered by the feeling of panic. Some of the ways it manifested

itself were - having to leave the place where the attack was occurring, pacing up and down, handwringing, a feeling of wanting to run, or flee. Other physical symptoms shared but not common to all of them were

- clammy or sweaty hands
- chest pains
- tachycardia
- breathing difficulties - a sense of suffocating, hyperventilating, shortness of breath
- abdominal cramps
- bowel spasms
- frequent voiding
- tingling and a feeling of tightness around face and neck
- a feeling of loss of muscle control in lower extremities

Along with experiencing the above physical symptoms, these sufferers felt an overwhelming sense of dread, terror or apprehension. They reported fears of having a heart attack, a stroke, going crazy or at the very least calling embarrassing attention to themselves in a public place. During the acute phase, there was a mild to severe degree of disorganization in their thinking, remembering, speaking, hearing, seeing and touching. The issue of control appeared also to play a major part in their attacks and was characterized on

one hand by an abnormal need for being in control of every aspect and area of their life and paradoxically on the other by an intense fear of losing control. Common to all the participants was the feeling of being 'out of control' during an attack. If their attacks remained undiagnosed, they began to harbour deep-seated beliefs that they were experiencing serious medical problems or were having a complete mental breakdown. It was at this point, that the secondary symptoms of anticipatory anxiety, depression and phobic avoidance behaviour could occur. Anticipatory anxiety develops when the sufferer's anxiety level spirals due to the fear of possibly having another attack. This type of anxiety possesses many of the features of generalized anxiety, including constant motor tension, autonomic hyperactivity and apprehension. The amount of anxiety can increase until the level of fearfulness between attacks approximates that experienced during an actual panic attack. Under these conditions, a mistaken diagnosis of generalized anxiety disorder can be made unless the clinician carefully elicits the history of previous panic attacks. Panic attack victims are also prone to depression due to a feeling of helplessness caused by the unpredictable and repetitive nature of their attacks. Agoraphobia(fear of large open spaces) is the most common form of phobic avoidance behaviour

experienced by panic attack victims. It usually develops for two reasons. First the sufferer associates the situation prevailing at the time of the initial attack with the development of the attack itself, perhaps believing that the situation caused it to happen. Secondly and perhaps of greater significance, the sufferer wants to avoid any situation where help or an easy exit is not immediately at hand. Subways, buses, airplanes, crowds in public theatres and elevators are typically avoided. These symptoms of avoidance behaviour tend to further complicate and confuse the clinical picture of panic disorder.

DIAGNOSIS AND TREATMENT

In treating individuals who suffer from panic attacks, it is very important that primary care physicians be able to diagnose panic disorder so that the appropriate referral to a therapy situation can be made. It is apparent that one of the major problems for clinicians is obtaining an early and correct diagnosis of this disorder before the above debilitating secondary symptoms set in. These side effects tend to obscure the original symptoms of panic disorder and thus often mislead clinicians in their diagnosis and choice of treatment. Tranquilizers appear to have some initial value in relieving some of the anticipatory anxiety that is so often associated with panic

disorder. However without any other form of treatment or counselling offered for coping with the attacks themselves, these tranquilizers have a poor long term effect as well as creating additional problems around dependency and addiction.

MEANING

Understanding and creating meaning for their attacks seemed to be one of the most effective treatments for all the participants in this study. Each participant believed that the trigger for their attacks came from ongoing feelings of stress relating to a perceived sense of self-worth that was present at the time of their attacks. In the beginning when they felt victimized by these incidents, their progress was minimal due to a lack of awareness and understanding of their present situation. When their symptoms became severe enough, they sought help but often the treatment they received only relieved the anxiety around the attacks but did nothing to prevent them. So they again felt helpless and unable to cope. The turning point appeared to come about when they began to reach out on their own for answers by looking for alternate sources of help, asking questions and reading any relevant material available. Taking charge and becoming involved in their own process of recovery appeared to create a purpose and meaning for their attacks.

IMPLICATIONS FOR COUNSELLING

Based on the above findings, I would like to offer the following suggestions for counsellors who are going to be working with clients who suffer from panic attacks.

* Be able to recognise panic disorder through eliciting a thorough and careful history. Understand clearly the similiarities and the differences between the symptoms of panic, generalized anxiety and phobias.

* Be empathic and reassuring - the first step to recovery is having the symptoms acknowledged and validated as being real and very frightening to the sufferer. Through reassurance, you begin the process of breaking up the self-generated nature of the panic spiral by reducing the sufferer's 'fear of the fear'.

* Give panic attack sufferers as much information about the disorder as they can understand. Let them know that they are not going crazy and that they are not going to die from their attacks.

* Help them to recognize that their attacks come from within rather than being externally caused. Explain to them that these attacks are a signal from their body telling them that something is wrong. Let them know that they have a choice of whether they want to deal with it or not, but that if they choose not to, their attacks will continue to occur. Let them know

that there are alternatives to medication if they are interested. Explain that there are skills they can learn that will help to alleviate some of their panic symptoms.

* As soon as possible, begin to teach them the following coping skills so that they can have some tools to work with when they get their next attack

- relaxation and deep breathing exercises which will help to inhibit many of the psychophysiological responses associated with panic arousal

- cognitive coping skills in the form of an internal dialogue, where they will be retrained to respond to the interoceptive cues of their disquieting, physical sensations, with more positive coping self-statements instead of using the maladaptive cognitions that reflect feelings of helplessness.

- autogenics and/or biofeedback techniques for body control

The purpose of these interventions is to encourage and enhance the belief that the sufferer possesses a repertoire of skills that can be executed to cope successfully with panic attacks should they arise. A self appraisal of having adequate coping skills at the onset of panic symptoms will help to reduce

anticipatory anxiety and will similarily work to curtail the panic spiral effect.

RELATIONSHIP OF FINDINGS TO PHARMACOLOGICAL RESEARCH AND THEORIES OF ANXIETY

RESEARCH

None of the participants in this study were given any of the drugs that specifically block panic attacks. The drugs perscribed were all tranquilizers from the benzodiazapine family. The effect of this medication on the three participants who were given it was to reduce the secondary symptoms of anticipatory anxiety that accompanies panic disorder. However, it did not prevent the actual attack from occuring or relieve any of the phobic avoidance behaviour that followed.

THEORIES

Psychoanalytic Theory

According to Freud, the sudden, apparently noncontingent onset of panic is readily explained by his psychoanalytic theory of anxiety in two ways. First, the precipitating events are not recognized by the subject because they are related to impulses outside the subject's awareness, and secondly, the panic attack keeps the impulses repressed by directing the subject's conscious attention toward his or her

symptoms of panic and away from the unconscious impulses.

The view of the participants in this study differed in that they believed that the precipitating event or trigger for their attacks was based on their own perceived sense of self-worth in relation to their life situation at that time. When they understood and were able to attach some meaning for having their attacks they were then able to take some action to improve their perceived status which in turn helped to diminish their attacks both in number and intensity. It would seem that their subjective experiences do not fit with Freud's hypothetical concept of unconscious libidinous impulses being repressed by symptoms of acute anxiety. Unfortunately, his hypothesis is not amenable to empirical evaluation because of the problems inherent in the study of the unconscious. Freud's definitions of anxiety, panic, and phobias however, relate very closely to the subjective accounts of the participants when they talked about their symptoms of anticipatory anxiety, panic attacks and agoraphobia.

The effect of social and environmental influences on the lives of the participants in this study appeared to be directly related to their panic attacks. Each, in the context of their life situation at the time saw

themselves as feeling either 'helpless', 'alienated', 'isolated', or in a 'no win' situation. These findings share some similarities with the Neo-Freudian approach to anxiety which is oriented more towards cultural and environmental influences on human personality development and less on biological and instinctual drives.

Learning Theory

Learning theory postulates that anxiety is conditioned by the fear of specific environmental stimuli and does not require unconscious mental processes. Because of this belief, many behaviourists deny that spontaneous panic attacks actually precede phobic avoidance, insisting instead that either the onset of phobia and panic attacks are concomitant or that avoidance behaviour precedes panic attacks(Gorman, Liebowitz and Klien 1984).

In the light of the findings of this study, it would be difficult to concur with their viewpoint. In all the descriptive accounts given by the participants who became agoraphobic, specifically Reni, John, and Kevin, their attacks preceded their avoidance behaviour, and in fact, were seen as the reason for becoming phobic. However, the learning theorist's viewpoint that fear is a learned drive has some relationship to the findings. In each case where phobic avoidance behaviour was

experienced in this study, the sufferer chose to remain at home because of their fear of having another panic attack. Their attacks became the unconditional stimulus and reinforcement for their avoidance behaviour.

Existential Theory

Existential theorists view human beings as active participants in their own lives who are willing to confront their freedom and take personal responsibility for their own decisions and actions. Anxiety is seen as a reaction that occurs when an individual's perceicved sense of autonomy is threatened. May, an existential psychotherapist who based his theory of anxiety on the clinical subjective experiences of his clients, believed that anxiety was triggered by feelings of apprehension which struck at the very basis of the psychological structure of which one's own clear perception of self and world was built. If one accepts that premise it would seem that panic attacks occur because sufferers perceive some threat to their personhood based on their present life situation which they believe prevents them from taking responsible action for their own life. In relating the above views to the findings of this study, there is a definite parallel in that all the participants believed their attacks were triggered by ongoing feelings of stress associated with a perceived threat to their sense of

self at the time. When they made a personal decision to take some action, whether it was changing their doctor, taking themselves off their medication, or leaving their husband etc., their self-esteem improved and their panic attacks decreased.

In keeping with the existential tradition, it may be significant that the participants who became agoraphobic were the only ones that were given tranquilizers. It is as if by accepting the belief that the medication will help to lessen their anxiety, they give up the belief that they have the capability to do it for themselves.

IMPLICATIONS FOR FUTURE RESEARCH

As far as I am aware, this is the first phenomenological investigation that has been done on the study of panic disorder. Goodman's phenomenological investigation of the experiental referent of the word 'anxiety' as distinquished from the words 'panic', 'apprehension', 'fear', and 'terror' was the only other peice of research I found that was somewhat similiar in both method and subject matter(1975). Her work became a valuable guide for me as I struggled to elucidate the phenomenon of an acute panic attack.

Based on my findings, there are a number of areas relating specifically to panic disorder that warrant investigation in the future.

* Two of the participants in the present study believed that they had experienced panic states as children. The other three remember vague sensations of not "feeling right", or of feeling anxious. Expanding this present study to include a more extensive personal history would provide a more complete picture of the holistic experience of panic disorder.

* The issue of control was a prominent theme for each of the attack victims in this study. A clinically oriented phenomenological study of the word "Control" might provide more insight into how it is experientially defined by those who suffer from panic disorder and those who do not.

* In the DSM-111(1980), one of the criteria that must be met before a diagnosis of Panic Disorder can be made is that at least three panic attacks occur within a three week period. For the attack victims in this present study, their initial attacks were widely spaced, occurring only once or twice in the first year. By the time they were having enough attacks to fulfill the above DSM guideline, their diagnostic picture was often distorted by some the secondary symptoms of agoraphobia, depression and anticipatory anxiety that

occur when this disorder has not been diagnosed and treated immediately. More empirical research is needed, based on a much larger scale than this present study could provide, in order to help clarify and redefine this particular axiom so that the measures clinicians depend on to diagnose these symptoms will more accurately relfect the disorder they are attempting to assess and treat.

* In this study, all of the participants suffered from at least one or more of the secondary symptoms of panic disorder; three of them became agoraphobic, all of them complained of anticipatory anxiety, and two of them suffered from depression. A phenomenological investigation into the similiarities and differences between these three side effects and how they relate to panic disorder would be a valuable addition to this present study.

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APPENDIX A

DSM-111 CRITERIEA FOR PANIC DISORDER

A. At least three panic attacks within a three week period in circumstances other than during marked physical exertion or in a life threatening situation. The attacks are not precipitated only by exposure to a circumscribed phobic stimulus.

B. Panic attacks are manifested by discrete periods of apprehension or fear, and at least four of the following symptoms appear during each attack:

1. Dyspnea
2. Palpitations
3. Chest pain and discomfort
4. Choking and smothering sensations
5. Dizziness, vertigo, or unsteady feelings
6. Feelings of unreality
7. Paresthesias
8. Hot and cold flashes
9. Sweating
10. Faintness
11. Trembling and shaking
12. Fear of dying, going crazy, or doing something uncontrolled during an attack

C. Not due to a physical disorder or another mental disorder, such as Major Depression, Somatization, or Schizophrenia.

D. The disorder is not associated with Agoraphobia

APPENDIX B

CONSENT FORM

I, ______________________________ consent to being part of this study, which explores the phenomenon of Panic Disorder.

I am aware that I will be asked certain questions about my attacks during an in-depth audio-taped interview with the researcher.

I understand that my involvement in this study will be kept in the strictest confidence. In order to ensure this, resulting transcripts will not include any information that will reveal my identity such as my name, that of my employer, my address, description of my physical characteristics, etc.

I am aware that my participation in this study is strictly voluntary and that I may withdraw from the study at any time without any unfavourable consequence.

I understand that I will be given a description of the full purpose of the study as well as an opportunity to debrief my personal reactions to the project.

Signed ______________________________

Date ______________

APPENDIX C

RESEARCH QUESTIONS

The following questions will serve as a guide for the interviews with participants.

Please indicate with each response whether you were conscious of what you are reporting at the time you experienced the attack or only became aware of it afterwards, upon reflection.

1. Describe in your own words, the sequence of events leading up to and surrounding your first panic attack?

2. Do you believe that there was a particular incident that preceded your panic attack?

3. Please describe the experience of having a panic attack?

4. What physical sensations did you have while experiencing the attack?

5. Describe the nature of your perception while experiencing the attack - Visual - Auditory - Tactile - Kinesthetic - Taste and Smell?

6. Describe your thoughts while experiencing the attack?

7. How did you experience the world around you while you were feeling this emotion - other people - yourself?

8. How did you come to discover that what you were experiencing was a panic attack?

9. How did you feel about the way you were treated during and after your attack? What sorts of words come up for you when you think about how you were treated?

10. What effect has experiencing panic attacks had on your life and/or on you personally?

11. What meaning, if any, do you attach to having experienced panic attacks?

12. Do you still have panic attacks? If so, what coping mechanisms do you use, and if not, what do you believe are the reasons that you don't?

13. Based on your own experience, what suggestions would you like to offer to counsellors who are going to be working with clients who suffer from this disorder?

VITA

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Author:

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