

## Research Article

# Searching for self: The layers and labels of panic disorder: A New Zealand study

Helen P. Hamer, RN, MN(Hons),<sup>1</sup> Antoinette M. McCallin, RN, BA, MA(Hons), PhD,<sup>2</sup> and Nick Garrett, msc<sup>2</sup>  
<sup>1</sup>School of Nursing, University of Auckland and <sup>2</sup>Faculty of Health and Environmental Sciences, AUT University, Auckland, New Zealand

### Abstract

The diagnosis and management of panic symptoms are relatively neglected. If not treated, people can develop a panic disorder, a condition that has an adverse effect on the client's quality of life and psychological well-being. The aim of this New Zealand research is to understand the clients' perspective of panic disorder and how it impacts on their quality of life. Ten participants were interviewed and the data were analyzed using thematic analysis. The research findings indicate that recovery from panic disorder occurs in a process of the search for self that is made up of self-understanding and the reclaiming the self. The findings provide a psychosocial perspective of panic disorder that will assist nurses who work with these clients. Nurses are pivotal in teaching clients about their body's response to stress and health anxiety, the giving of supplementary health information, and timely referral for specialist treatment. The recommendations for nurse specialist input and biopsychosocial assessments are discussed.

### Key words

cardiac pain, panic disorder, quality of life, search for self.

## INTRODUCTION

Panic disorder (PD) occurs when an individual experiences persistent panic attacks that are diagnosed with the symptoms of palpitations, chest pain, dizziness, shortness of breath, and tingling in the arms (Beck, 1996; American Psychiatric Association, 2000). As these physical symptoms also are associated with more serious cardiac events, the prompt diagnosis of PD is important to reduce anxiety about a condition that is psychologically based and to ensure that the appropriate treatment is provided. Individuals need to be aware of the origins of the physical symptoms so they can understand the psychosocial aspects of the problem and its implications for emotional health (Price *et al.*, 2005). It is surprising that, although there are several quantitative investigations into PD (Fang, 2002; 2003; Fleet *et al.*, 2003), the client's perspective has not been researched to date (Bass & Mayou, 2002; Price *et al.*, 2005). This gap in knowledge makes it difficult for nurses who must assess and manage individuals with PD (Hamer & McCallin, 2006). Understanding both the medical and underlying psychological causes of PD is important, as nurses are vital in facilitating referral to appropriate therapy and support.

The purpose of this paper is to present the findings from research into the client's perspective of PD, to extend the nursing knowledge base about how individuals manage their condition, and to assist service-providers to recognize the

impact that this debilitating psychological disorder has on the health and well-being of clients and their family (Hamer & McCallin, 2006; Oakley-Browne *et al.*, 2006).

## Literature review

The lifetime prevalence rates for PD range from 1–3 per 100 in the population internationally. The rates for New Zealand average 1.7% (Oakley-Browne *et al.*, 2006), higher in females than in males. Panic disorder is associated with an increased risk of agoraphobia and major depression (Kessler *et al.*, 2006). When individuals do seek help, accessing effective treatment is difficult (Leon *et al.*, 1997) as acute symptoms must be differentiated from cardiac pain or other physical complaints. Significantly, research indicates that, of the 50% of people diagnosed with non-cardiac chest pain, 30% suffer from PD (Fleet *et al.*, 1997; 2003; Husser *et al.*, 2006).

Delays in diagnosing PD can mean that the quality of life deteriorates (Candilis *et al.*, 1999; Carrera *et al.*, 2006; Husser *et al.*, 2006). Individuals have difficulty returning to work and an increased risk of suicide and depression. As individuals with PD have a heightened affective vulnerability (Gregor *et al.*, 2005), they use emergency services more frequently (Zane *et al.*, 2003) and visit medical and mental health-providers more often (Roy-Byrne *et al.*, 1999; Batelaan *et al.*, 2006). However, PD often is treated ineffectively (Rollman *et al.*, 2005). Physicians might be either unaware of the differential diagnosis of the condition or underestimate its severity (Fang, 2002; Huffman & Pollack, 2003; Lynch & Galbraith, 2003). Brief psychological interventions, such as cognitive

Correspondence address: Helen P. Hamer, School of Nursing, University of Auckland, Private Bag 92019, Auckland, New Zealand. Email: h.hamer@auckland.ac.nz  
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behavior therapy, reduce the immediate and sustained costs of hospital admission, as well as the symptoms, and increase the quality of life for those individuals with PD and other conditions (Salmon *et al.*, 2004; Parkin *et al.*, 2006; Ferguson *et al.*, 2007; Macht *et al.*, 2007; Marchand *et al.*, 2007; Moore *et al.*, 2007).

### Aim

The aim of this research was to understand the client's perspective of PD and how it influences the quality of life and support in the recovery from this enduring psychological disorder. Researchers, planners, and clinicians need information about the client's perspective to prevent a recurrence of the condition, improve treatment outcomes, and prevent ongoing disability.

### METHOD

The AUT University Ethics Committee in Auckland, New Zealand, approved the research. The informed consent process covered issues about prospective involvement, risks and benefits, confidentiality, privacy, and voluntary participation, thus enabling the participants to make an informed choice about joining the study.

The recruitment response rates were lower than expected, with only 10 women consenting to be interviewed. This might be related to the vulnerability (Flaskerud & Winslow, 1998; Moore & Miller, 1999) of those with PD. Although this limits the generalizability of the findings, the research team believes that the interviewer's skills yielded rich data for analysis.

The participants' age ranged from 18–60 years; eight of them identified as New Zealand European and one identified as both New Zealand European and Māori, and one as Māori. All the participants had received a course of therapy for their condition, with or without drug treatment. Most had a history of seeking help from general practitioners (GPs); few attended emergency clinics. The participants were recruited through psychology and physiotherapy clinics in the private sector and they were interviewed once.

### Data collection and analysis

The data generated from the research question, "What is your main concern about PD and how do you manage that?", was gathered by open-ended questions encouraging the participants to talk about the experience of panic attacks. The discussion was transcribed and checked with the participants. The data were coded and recoded and the patterns were organized thematically (Miles & Huberman, 1994; Minichiello *et al.*, 1999).

### FINDINGS

The findings suggest that the participants were concerned because they had limited knowledge about their condition. The individuals managed this concern using a sociopsychological process, known as searching for self. Searching for the

self, the main theme in this research, had two components: self-understanding and reclaiming the self.

### Self-understanding

Self-understanding explained how knowledge about the condition impacted on the physical and psychological self. The participants reported being locked in a vicious cycle of symptoms and anxiety that sometimes had begun as early as 5 years of age. Self-understanding was possible in adulthood when the client understood the causal conditions and triggers and was taught to breathe properly. The diagnosis was fundamental. If the diagnosis was vague, the client was unable to lead a normal life:

I couldn't function . . . wasn't able to breathe properly. I didn't know back then, if [hyperventilating] was part of having a panic attack because nothing was diagnosed for me. I didn't understand anything. What was going on? (New Zealand European, 45 years old).

Initially, when help was sought, the focus was on the physical symptoms. Mind-body connections were not discussed at all. Although the GP offered emotional support, the symptoms persisted because the client had no knowledge about basic physiological functioning:

It was really hard for the [GP] at first because you don't want to say to someone "I think there's something wrong with your mind." He was very supportive and I was intent it must be something physical . . . do the tests and support me all the way . . . give me asthma medication . . . all those things were covered but, in actual fact, I was [panicking] at home for 24 h or 48 h (Māori, 49 years old).

Not surprisingly, it was difficult for the participants to believe there was "nothing wrong with them", especially when they received medication for a recognized condition that might or might not have been present. Clearly, the client was dependent on the willingness of the doctor to provide medical and/or emotional support and, when that ceased, any chance of recovery was compromised. Some participants responded, accepting medication such as benzodiazepines, and risked the concomitant addiction-withdrawal cycle, which increased the panic symptoms. Others isolated themselves from their friends and family, retreating into a world of constant fear and autonomic arousal:

I thought I was going to be paralyzed and it kept on happening. I went to a doctor and I told him I had numb sensations – I got a full check and the doctor said there was nothing wrong (New Zealand European-Māori, 25 years old).

According to the participants in this study, explanations about what was happening in the physical body were not forthcoming and the PD cycle continued:

Nobody ever sat down [and explained]. Years and years and years later, I discovered that [my family] had been quite concerned. Nobody ever said anything. There was a

real search for a physical thing that might explain what-  
ever was happening (New Zealand European, 55 years  
old).

It was not until a client was referred to a therapist and  
initially taught breathing techniques that they finally under-  
stood how certain triggers stimulated the physiological symp-  
toms that were similar to a heart attack:

You're doing breathing techniques because that's what  
brings [the panic symptoms] back down . . . I now under-  
stand what the brown paper bag was about . . . informa-  
tion is really important, you know (Māori, 49 years old).

However, it was also clear that managing a client with PD  
is not straightforward. Passing on accurate information was  
problematic because the clients with PD have difficulties pro-  
cessing information when they are in a state of heightened  
anxiety and fear:

I was all shaky and I didn't know why . . . I went to the  
doctor and he explained a lot but the next day I still  
didn't feel very well. So, I went back again and the doctor  
explained a bit more. It was good to find out some things  
that caused [me] to react that way. It helps (New  
Zealand European, 20 years old).

Even if a cognitive behavior therapist spent time explain-  
ing how the symptoms occurred, it often took several visits  
for the client to absorb the information:

I didn't really get into it. The therapist sent me home  
with thought records to fill out. I couldn't do it. They  
were really hard. With the short amount of time we had  
together, I don't think it was explained. She didn't really  
explain – well, she did, but I didn't really get it (New  
Zealand European-Māori, 25 years old).

In one instance, a participant was so keen to learn about  
her self that she went on a course that helped her to accept  
what had been a debilitating condition. In this situation,  
health education was significant in legitimizing the symptoms  
of panic. Finally understanding how the physical body  
worked was exhilarating and physiological knowledge  
assisted her recovery:

I went on an anxiety and depression course. We started  
to talk about how my brain worked. What it did to my  
body – how medication worked, my breathing – all sorts  
of things. It was such an awareness! It freaked me out! It  
just blew me away! And learning about it was exciting!  
(New Zealand European, 35 years old).

Education supported self-understanding in that it helped  
the participants to acknowledge recurring patterns of behav-  
ior that represented the mind-body connection:

Doing my nursing training [helped]. I was curious about  
why things were happening – even though I'd been  
unwell for 12 years, locked in my own head. It was safe in  
there . . . when I had a panic attack, I knew that was a  
safe place to be . . . my thoughts weren't that great and it  
was the thoughts that I was having that were causing me  
panic attacks (Māori, 49 years old).

Acceptance led to self-validation and a gradual resolution  
of the symptoms and set people on a course towards recovery.

### Reclaiming the self

It was evident in this research that the fears and isolation  
associated with PD were intangible and subsequently caused  
vulnerability within the individual that required action to  
“reclaim the self”. Reclaiming the self was about recognizing  
that the “fault” was not within the self and that the manage-  
ment of the problem was individual. Reclaiming the self was  
located within the client:

And people used to say: “Oh, it's hormones” or “It's this  
or that!” That's not why I had [panic attacks]. I now have  
an understanding. It's really nice to quietly say “Sorry,  
but this is the way I am and I've learnt about it.” . . . it's  
nice to just know who I am. That's helped (New Zealand  
European, 35 years old).

Reclaiming the self was about freeing the self from the  
thoughts and feelings that triggered panic attacks. The think-  
ing was refocused, so some semblance of a normal life was  
possible. Active strategies began with self-monitoring and  
thinking through how a situation might be managed:

I ask “Am I going to die – again?” It happens nearly  
everyday. It's horrible! People can't see the pain and the  
panic and think that everything is okay. I got a cell  
phone. Now I can ring my [partner] and say “. . . talk  
to me, just talk me through it . . . I know I'll be all  
right!” . . . just needed him to talk to me (New Zealand  
European, 49 years old).

Self-help was clearly important to recovery, as was self-  
control. Once the clients realized that they had some control,  
the condition could be held in check. However, reclaiming  
self-control raised uncomfortable questions about previous  
medical management:

Why didn't the [GP] say “Is there any personal develop-  
ment work that would be helpful?” Why don't they send  
people to a breathing clinic? The doctor was really  
annoyed when I said to him “I work in mental health”  
and we know [PD] is about depression and anxiety. I  
couldn't understand why he was so upset that I came  
along with a plan [of action] (New Zealand European,  
49 years old).

Despite a lack of understanding in that particular situation,  
others found knowledge about the self empowering. This  
self-knowledge led to a variety of strategies to reduce the  
frequency and intensity of the panic attacks. Managing  
the self was paramount in taking responsibility to manage the  
world day to day:

To see yourself in relation to a larger group also has an  
effect – recognizing that we are part of something bigger  
than [the self]. I imagine that panic attacks are very  
much to do with the self and want in relation to the

world. You have to have some knowledge to take responsibility for the self (New Zealand European, 63 years old).

For others, an initial sense of self-relief that followed knowledge about the condition tested long-held beliefs about who was in charge of the self. One participant spoke of how internal and external controls challenged the self on very different levels:

It was too tough. I'd have to change everything. I've always had issues with who I am. I know that I've got low self-image and self-esteem. With every day, I know I've lived better than this. I know I have to do the work and I haven't done that work (New Zealand European-Māori, 25 years old).

Reclaiming the self was evidently a process in which individual ownership was central. According to the data, understanding how self-responsibility affected physical and mental health depended on one's age, life experience, and psychological health status. Clearly, the process involved choice recognition. Acknowledging those choices improved self-confidence and helped the clients to understand the role they had in changing their behavior. Reclaiming, in this sense, required that the client engage in self-teaching in order to behave differently:

I give myself permission to leave when a panic attack comes on . . . talk to myself about how I will leave. I just stop and stand and orientate myself. I know where the exits are. Keep breathing. Keep instructing myself to go slowly and waiting until I've made my choice of how I wish to handle this (New Zealand European, 63 years old).

Commitment to self-talk was important. Even though an individual understood how the body worked, it took energy and courage to pre-empt a panic attack. Some participants in the study welcomed active involvement in their recovery, while others were not ready to reclaim the self. Apparently, reclaiming the self was linked with developmental life stages. Younger people with less life experience required more time to recognize how individual active input affects the recovery process. Reclaiming the self was an ongoing process that necessitated extensive self-exploration, which depended on individuals' willingness to learn more about the self:

I can't figure it out. I have a really good family life . . . no bad childhood. It's been random! I was a nervous person. I was in an abusive relationship with my ex-boyfriend. Our relationship ended when I got the anxiety disorder. The psychologist thinks that maybe it had something to do with that. But, I'm so over him! Why would my mind still be back there? I've moved on completely. But I don't know if it's got anything to do with it. There's no way to prove it, really (New Zealand European, 18 years old).

Although the therapists encouraged the clients to begin self-examination, the timing of that process was individual. It

was sometimes difficult to judge where a client was in the process, as appearances were deceptive. The long-term nature of PD meant that the clients were likely to be adept at covering up layers within the self that remained hidden:

Nobody is as confident as we all think they are. [Diagnosis] has given me permission to deal with the reality. If you're allowed to do that . . . you can start to move on, but as long as you're struggling to have your reality acknowledged, then how on earth can you ever move on? (New Zealand European, 49 years old).

It is interesting to note that, though a physical diagnosis initially blocked recovery, once an accurate label was given and accepted, the client was finally free to reclaim the self gracefully:

I was relieved when I discovered what was wrong with me. I am supposed to be different! After going through that journey and [accepting] that's part of who I am, I [understand] that I'm not necessarily at that end of the continuum. I'm probably something more in the middle. Isn't everybody just all those different layers and labels and everything? (New Zealand European, 48 years old).

In this study, most of the participants spoke about the physical symptoms associated with hyperventilation, a problem that is well recognized by health professionals, however poorly understood in the lay community. Thus, knowledge limitation was problematic. The symptoms of hyperventilation were considered to be medically unthreatening; whereas, for the clients, the symptoms of not being able to breathe, dizziness, numbness, and pains in the chest and arms were frightening. The fear that something serious was wrong in the physical body was perpetuated when the client received a diagnosis of non-cardiac chest pain. Though useful for medical staff to indicate that there was no evidence of a cardiac event, it was less than helpful for the client, left feeling frightened and anxious. Not understanding the basis of the very real physical symptoms was distressing for someone unfamiliar with the mind-body connections known to most health professionals.

Once a participant accessed the appropriate help and understanding, a turning point was reached. Explanations about the connections between the mind and body led to self-understanding and the beginning of learning how to manage PD, whereby the participants were free to reclaim their lives. As the participants regained self-control, confidence, and increased independence, their quality of life improved. For several, the successful search for self culminated in them moving into the helping professions, meaningful careers, and having a family of their own. However, some continued to suffer the consequences of early experiences and residual symptoms of panic.

## DISCUSSION

Panic disorder is a disabling condition and, because by and large it is "dismissed" by health professionals, it is hard for the individual experiencing panic to step outside the

mainstream medical approach and deal with it successfully. As the client does not understand the mind-body connection, there is no frame of reference to recognize what is a serious mental health problem, which, in turn, is perpetuated by the professional's response to this hidden population (Weissman, 1990; Fleet *et al.*, 1996; Leon *et al.*, 1997).

Many of the participants sought help from a GP and a small number of the participants did receive an explanation beyond the medical understanding. Concern still remains, however, in recognizing the psychological basis of medically unexplained symptoms, such as non-cardiac chest pain (Ring *et al.*, 2005). Many clients will readily acknowledge their psychological needs if assessed appropriately (Salmon *et al.*, 2004).

Salmon *et al.* (2004; 2005) suggested that clients will have a greater number of physical investigations, resulting in the client being told "there is nothing physically wrong" (Esler & Bock, 2004). This type of response will shape subsequent consulting behavior, creating the cycle of repeated help-seeking that is more the product of consultation, rather than the client's psychopathology.

This study demonstrates that clients have the power to heal themselves once they receive an appropriate explanation and health education about PD. If, however, a client is labeled psychosomatic, there is a risk that the sense of self will be impaired and any chance of self-discovery and the development of a stronger self-concept will be compromised (Charmaz, 1994; Wisdom *et al.*, 2008). This current study serves to remind both nurses and doctors to consider what they mean when espousing client-centered models of care and to balance the role of friend and healer with the role of technician and detective (Robinson *et al.*, 2001).

Similarly, nurses have a professional obligation to clients' education that potentially increases the opportunities for transformational understanding about their health status (Newman, 1994). Simple explanations about symptoms and supplementary information sheets are crucial (Price *et al.*, 2005). The lack of skill and confidence that nurses have in regard to the completion of psychological assessments in the emergency setting is still of concern and, almost a decade later, it is surely time that this issue is addressed.

It is critical that clinicians consider both the impact of the physiological and psychological aspects of symptoms on the quality of life of this vulnerable population. An inclusive model of assessment, such as the biopsychosocial approach to client education, particularly unexplained physical symptoms, has the potential to improve the health and social outcomes of clients and allows the clinician to manage the uncertainty inherent in chest pain presentations. It is not a Cartesian "either/or" approach. However, it does provide for balance in diagnostic reasoning and importantly does not overemphasize the "It's all in your mind" view. This response can lead to the client disengaging from the clinician during a teachable moment (Esler & Bock, 2004), when they are most receptive to understanding their symptoms.

In summary, adopting a thorough biopsychosocial model by nurses will enhance clients' self-understanding, leading to a reclaiming of the self and a readiness by the clients to pursue psychological therapy. This, in turn, reduces their

return to a medical environment for what is essentially a psychological disorder.

## CONCLUSION

People presenting with chest pain with or without symptoms of panic want the clinician to discuss both the physical and psychological origins of their symptoms (Price *et al.*, 2005). In this study, often these needs were not met and left some participants feeling ill-equipped to help themselves. Receiving extra verbal and written advice and information about the symptoms of panic is valuable (Price *et al.*, 2005). This highlights the importance of helping people with PD understand their physical and emotional pain, developing new explanations to increase hope, and helping them to reclaim their sense of self and identity to support productive, happier lives (Charmaz, 1994; Wisdom *et al.*, 2008).

Nurses also should have prompt access to client case reviews by a cardiac nurse specialist or cardiologist for clients presenting with non-cardiac chest pain and PD (Price *et al.*, 2005; Hamer & McCallin, 2006). This will not only support the clients' search for self-understanding, it also will provide the nurse with a different frame of reference for care planning. Nurses also should receive basic training in the management of medically unexplained physical symptoms and health education (Stuifbergen *et al.*, 2000; Whitehead, 2001). It is clear from this study that, once the participants had mastered a controlled breathing technique, this was the first step in reclaiming their lives. This simple and cost-effective intervention can be easily taught to clients in any setting (Telch *et al.*, 1995; Barlow, 2002).

In conclusion, due to the small number of participants, the findings must be interpreted with caution; however, this study does make a contribution to the scant literature on the qualitative experiences of PD. Findings, such as the importance of psychosocial assessment and health education in nursing practice, are worthy of further research to promote a more active role for nurses in the care of people with this disabling problem.

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