From Adversity to Resilience: The Experience of Living and Working with Panic Attacks

© Jasmin A. Perrone

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To my husband, Peter, for your unconditional love and support;

and to my sons, William and Thomas, you are my inspiration, pride and joy.
Statement of Authentication

The work presented in this thesis is, to the best of my knowledge and belief, original except as acknowledged in the text. I hereby declare that I have not submitted this material, either in full or in part, for a degree at this or any other institution.

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Associated Publications and Presentations


Abstract

Panic attacks are highly prevalent in Australia and the Western world, and the burden of illness associated with this condition is considerable. However, current scholarly research on panic is limited, and does not sufficiently reflect the magnitude of the problem. This study makes a contribution to this largely unexplored area by investigating the research questions: What are the lived experiences of employees who have panic attacks, and how do these experiences impact life, in and beyond the workplace?

The panic experience was explored through a hermeneutic phenomenological lens, and the methodological guidelines outlined by van Manen were used to inform the data collection and analysis. Interviews were conducted with 18 Australians who had experienced panic attacks during a period of paid employment. A thematic analysis of their narratives led to the development of the phenomenological model, consisting of three overarching themes – ‘Facing Adversity: Living with Panic’, ‘Struggling with Organisational Life: Working with Panic’, and ‘Moving Beyond Adversity’.

The study highlighted that despite the perception from others that panic attacks were a trivial and unimportant condition, people with panic experienced real suffering and disadvantage in and around the workplace. Stigma was a genuine concern for participants, and many felt that family members, health professionals, managers and work colleagues trivialised their problems with panic and, in effect, denied their sick role and illness experience. In spite of these challenges, living ‘well’ with panic was possible. Many participants developed resilience and reported that panic attacks were the catalyst that led to positive self-change in their lives.

The study has illuminated the unique challenges and support needs of employees with panic, as well as the implications for these individuals, their families, organisations and the wider community. It is proposed that greater awareness of this lived experience has the potential to increase the visibility, acceptance and treatment of people with panic.
CHAPTER ONE

Introduction

1.1 Preface

My experiences at work initially stimulated my interest in understanding the lived reality for people with panic attacks. In my first years of working in a corporate environment, I encountered several colleagues who were attempting to carry on as best they could at work with this condition. There was the senior work colleague who would take a herbal ‘calming’ supplement before an important meeting in an attempt to stave off a panic attack; another colleague was reluctant to attend a meeting at the top floor of a high rise building because she would often panic when exposed to heights; then there was the women in my department who would walk five flights of stairs to her desk to avoid using the lift; and, still another, who would avoid taking the train at all costs, even if it was the quickest route to work. Some of these colleagues were friends, and they would talk to me in confidence about their struggles. Other experiences were heard via workplace gossip. Often, the storyteller would giggle and roll his or her eyes as they recounted the latest ‘silly’ thing that ‘such-and-such’ had done.

These shared encounters made me reflect on what life might be like for people who experienced panic attacks. I wanted to know more about what it meant to have this condition, how it affected their lives, their intimate relationships, and their work and career aspirations. However, when I turned to the academic literature to learn what had been written about the lived experiences of people with panic attacks, I was
surprised to find just a scattering of qualitative studies on this topic. The lack of research on this subject was even more disconcerting when I learnt how common this mental health condition was in Western society (Kessler et al., 2006), and the significant impact that panic and anxiety can have on the affected individual’s quality of life (Roy-Byrne, Craske & Stein, 2006). I resolved to explore this research topic in my doctoral thesis.

1.2 An Introduction to Panic Attacks

This study invited participants to decide whether their lives had been disrupted by whatever they understood to be ‘panic attacks.’ It was expected that their experiences might encompass some of the signs and symptoms of a panic attack, as defined by the most recent Diagnostic and Statistical Manual of Mental Disorders [DSM-V] (American Psychiatric Association [APA], 2013), and are provided below. However, it is emphasised that reading this list of symptoms will never give a truly accurate representation of what living with panic is like.

1. Palpitations, pounding heart, or accelerated heart rate.
2. Sweating.
3. Trembling or shaking.
4. Sensations of shortness of breath or smothering.
5. Feelings of choking.
6. Chest pain or discomfort.
7. Nausea or abdominal distress.
9. Chills or heat sensations.
10. Paresthesias (numbness or tingling sensations).

11. Derealization (feelings of unreality) or depersonalization (being detached from oneself).

12. Fear of losing control or ‘going crazy.’


During a panic attack, an individual is overwhelmed by at least four of the physical and cognitive sensations described above and experiences an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes (APA, 2013). Panic attacks can last up to half an hour at a time and leave the person feeling tired and exhausted (beyondblue, 2013). Anticipatory fears of having panic attacks in a public place, or where no help or escape seems possible may lead to the individual becoming housebound, and lead to the development of agoraphobia (Anxiety Recovery Centre Victoria [ARCVIC], 2014). Panic attacks vary in the number and intensity of symptoms, the frequency and duration of attacks, the nature of the catastrophic thinking, and whether they occur without warning or are expected (Asmundson et al., 2014). Only some people who have a panic attack will develop an anxiety disorder following an initial panic attack (ARVIC, 2014).

Even though the experience of having recurrent panic attacks was the key focus of this study, it is acknowledged that panic attacks can feature prominently within many different types of anxiety disorders as a particular type of fear response (APA, 2013); in particular, they are very common in panic disorders and agoraphobia (APA, 2013). For this reason, anxiety disorders, as well as panic attacks, are discussed in the next section.
1.3 Study Background

Panic attacks are experienced by many of us. More than one in five people will experience at least one panic attack in their lifetime (Kessler et al., 2006). Panic attacks are a common attribute of many, if not all, anxiety disorders. Research shows that anxiety disorders are the most common mental health problem in Australia, affecting 14.4% of people in the year prior to the survey. More than one in four Australians (26%) experience symptoms in their lifetime (Australian Bureau of Statistics [ABS], 2007). This rate is significantly higher than those with other mental illnesses, such as depression, psychotic disorders, eating disorders or personality disorders (ABS, 2007). While this invisible and often chronic condition is seldom discussed outside clinical journals, it is a fact of working life: an estimated 2.9% of Australian workers will have had an anxiety disorder for at least six months (Waghorn, Chant, White & Whiteford, 2005) and this is likely to manifest in episodes of panic. Furthermore, as anxiety disorders are often underreported in the workplace due to the associated stigma (Dewa, McDaid & Ettner, 2007; La Montagne, Keegel, Louie & Ostry, 2010), the true figure is likely to be considerably higher. Researchers have also confirmed that the majority of those with mental illnesses, such as depression and anxiety, continue to work (Sanderson & Andrews, 2006). Panic is a workplace issue and should be of concern to employers and employees.

It has been increasingly acknowledged that not only are anxiety disorders highly prevalent, but the burden of illness associated with these disorders is also considerable, both in Australia and in the Western world. People with anxiety disorders experience significant impairments in multiple aspects of life, including social, occupational, psychological, family and emotional domains (Mendlowicz &
Anxiety disorders can be chronic, leading to long-term disability (Ansseau et al., 2008; Mancebo et al., 2008). They can also have a substantial impact on health and wellbeing and, when combined with depression, they are the third leading contributor to the burden of disease (both fatal and non-fatal) for men, and the leading contributor for women (ABS, 2009). Studies have shown that both suicide ideation, and attempts on life, are a common outcome for people with anxiety disorders (De Leo, Cerin, Spathonis & Burgis, 2005; Jorm, Christensen & Griffiths, 2006a, 2006b). The 2007 ABS National and Mental Health Survey found that of those who identified as having a mental disorder and had serious thoughts about committing suicide; approximately 77% had an anxiety disorder (ABS, 2009).

Studies that measured quality of life in people with panic disorder indicated that these individuals suffer substantial quality of life impairments (Davidoff et al., 2012). For example, panic disorder can result in: poor physical and emotional health (Sherbourne, Wells & Judd, 1996; Hollifield et al., 1997; Candilis et al., 1999; Simon et al., 2002); an increase in the use of medical services and hospital emergency departments (Markowitz, Weissman, Ouellette, Lish & Klerman, 1989; Chou, 2010; Davidoff et al., 2012); and, family and marital difficulties (Markowitz et al., 1989; Davidoff et al., 2012).

Anxiety disorders also place a substantial strain on the Australian economy. The cost to the Australian government and employers is significant due to increased use of social welfare benefits and medical services, high unemployment rates, lowered
productivity at work and absenteeism (Waghorn et al., 2005; Davidoff et al., 2012). A recent government report (The Department of Health, 2010) highlighted that the outlays by the Australian government and health insurers on mental health services in 2007–2008 totalled $5.32 billion, representing 7.5% of all government health spending. Furthermore, a PricewaterhouseCoopers [PwC] and beyondblue report (2014) estimated that mental health conditions cost Australian workplaces approximately $11 billion per year. This comprises $4.7 billion in absenteeism, $6.1 billion in presenteeism and $146 million in compensation claims.

Anxiety disorders are not just an Australian problem. The WHO World Mental Health Survey Consortium (2004) conducted face-to-face household surveys of 60,643 community adults in 14 countries, including the Americas, Europe, the Middle-East, Africa and Asia, and found that anxiety disorders were the most common disorders in all but one country (Ukraine), with prevalence in the range 2.4% to 18.2%. In the United States (U.S.), anxiety disorders were reported to affect 40 million adults aged 18 and older (18% of the U.S. population) (Anxiety and Depression Association of America [ADAA], 2014). It has been estimated that the annual total societal costs of active anxiety disorders in the U.S. over the decade of the 1990s exceeded $42 billion (Greenberg et al., 1999). This represented almost one-third of the country’s $148 billion total mental health bill; more than $22.84 billion of those costs were associated with the repeated use of health care services (Greenberg et al., 1999). Similar evidence was reported in a study measuring the societal costs of anxiety disorders in the European Union (E.U.) (Andlin-Sobocki & Wittchen, 2005). The researchers found that anxiety disorders accounted for a substantial amount (at least 35%) of all disability and sick leave days that were due to a mental disorder, and that they were rarely treated and even less frequently specifically cared for. They estimated that the
cost of anxiety disorders in the E.U. were in the same range as the figures provided by Greenberg et al. (1999), who estimated that the overall cost per patient for anxiety disorders in the U.S. was $1542.

The employment outcomes for workers with anxiety or panic are less well known, however, research has established that unemployment rates remain high for individuals with mental illness in the Western world (Carr & Waghorn, 2013; Harvey, Modini, Christensen & Glozier, 2013). Studies revealed that people with mental illness face significant internal and external barriers to employment (for example, Cunningham, Wolbert & Brockmeier, 2000; Bassett, Lloyd & Bassett, 2001; Honey, 2002, 2003; Henry & Lucca, 2004; Blitz & Mechanic, 2006). Common external barriers included: the stigma attached to mental illness (Manning & White, 1995; Scheid & Anderson, 1995; Crisp, Gelder, Rix, Meltzer & Rowlands, 2000; Bassett et al., 2001; Scheid, 2005); lack of access to resources and services (Marwaha & Johnson, 2005; Carr & Waghorn, 2013); inadequate social support from work colleagues and managers (Marwaha & Johnson, 2005), and from family members (Honey, 2002); and, potential loss of monetary disability benefits (Rinaldi & Hill, 2000; Marwaha & Johnson, 2005).

The nature of mental illness can obstruct the individual from achieving employment and career related goals. For example, early onset of mental illness, which often occurs in the late teens and early twenties (World Health Organization [WHO], 2000), can disrupt education and early work careers (for example, Turnbull, George, Landerman, Swartz & Blazer, 1990; Kessler, Foster, Saunders & Stang, 1995; Bassett et al., 2001), which may have enduring ramifications on the individual’s career and employment goals. Additionally, people with mental illness can spend considerable
time away from work because of their disability and this can put them at a competitive disadvantage compared to their non-disabled work peers (for example, Frey, 1994; McGurrin, 1994). While, the chronic and cyclical nature of mental illness can also be a significant barrier to employment (Ruffner, 1986; Frey, 1994; Rutman, 1994; Honey, 2002), not only affecting the person’s ability to function within the often rigid structure of the work environment, but also on the person’s feelings of stability and self-esteem (Rutman, 1994). The adverse side effects of some medications can also impact on work performance, and employment outcomes (Scheid & Anderson, 1995; Rebeiro, 1999; Peckham & Muller, 2000; Bassett et al., 2001; Honey, 2003).

Several studies have shown that cognitive deficits linked to mental illness, such as poor attention span, difficulties with concentration, memory, perception and judgement, can also affect work performance (Mancuso, 1990; Cole & McGeary, 1991; McGurrin, 1994; Bassett et al., 2001; Honey, 2002, 2003). Lack of motivation is also a common feature of many mental illnesses, and can also lead to poor employment outcomes (Lagomarcino, 1990; McGurrin, 1994; Braitman et al., 1995; Honey, 2002, 2003).

Anxiety disorders are a serious mental health issue in Australia, and across the world. The impact on individuals and various societal groups is substantial. However, given the severity of the illness burden, it is argued that the current level of research does not sufficiently reflect the magnitude of this problem. The dearth of research in comparison to the body of literature on schizophrenia, and even depression, for example, raises questions about the wider trivialisation of this illness in society.
1.4 Research Objectives

This thesis will use hermeneutic phenomenology to bring this neglected mental health issue to light. Specifically, the research objectives include:

1. To hermeneutically explore, interpret and discuss the lived experiences of employees with panic, including their personal experiences, in and beyond the workplace;

2. To increase the visibility and acceptance of employees who live with panic;

3. To aid allied healthcare professionals, government policy makers, employers, and academic theorists to understand the experience of panic; and,

4. To share the personal stories of employees with panic, so that others can identify with, learn and reflect on their shared experiences.

1.5 Research Questions

This thesis will explore the following research questions:

- What are the lived experiences of employees who have panic attacks?
- How do these experiences impact life, in and beyond the workplace?

In asking these questions, the study seeks to gain a deeper understanding of the participants’ life and work experiences with panic. These questions were influenced by the research objectives above, and align with the principles of hermeneutic phenomenology, which aims to understand and interpret lived phenomenon (Hein & Austin, 2001).
1.6 Significance of the Study

Panic attacks are an important health issue necessitating further investigation. They are experienced by a substantial number of people, they impair functioning and quality of life, they cost governments and organisations large amounts of money, they significantly reduce productivity and employment rates, and they can result in death. Despite this, limited scholarly attention has been paid to the personal experiences of people who have panic attacks, especially those who work.

Research into how people perceive, interpret and describe their panic experiences in and around the workplace is important because enhanced understanding can improve the visibility, acceptance and treatment of people with this condition, both in Australia, and around the world.

The findings have significance for several reasons. Firstly, greater awareness of how employees with panic experience this condition will assist governments and employers to develop policies and practices that improve the working lives of employees with panic. In turn, this knowledge will lead to a more productive and compassionate workplace, and improve employment rates for those affected.

Secondly, information from this study may help GP’s, psychologists, and other healthcare providers better understand the lived experience of those impacted. This has the potential to improve treatment access, treatment adherence and symptom severity, and may lead to an improved quality of life for people who have panic attacks.

Thirdly, it will also provide a reference point for others who have panic attacks, giving them the opportunity to identify and learn from those in similar situations,
reducing feelings of isolation and self-stigma. Those with similar symptoms may also benefit from learning how participants in this study developed resilience and learned to live ‘well’ with panic.

Fourthly, the findings of this study could be used to educate families and significant others about the experiences of those with panic attacks. Allowing participants to voice their experiences has the potential to improve how others perceive the legitimacy of their condition. This may help reduce the stigma and misunderstanding that surrounds those with panic.

Lastly, the concerns raised by participants can provide academics in the disciplines of social sciences, health and organisational behaviour with directions for future research, and improved levels of academic knowledge on this illness experience.

1.7 Terms and Definitions

The definition of a ‘panic attack’ was provided at the beginning of this chapter. For the purpose of clarity, this section provides the meanings of other relevant terms used in this thesis. Although this study was concerned with the non-medical accounts of living and working with panic attacks, it is acknowledged that the current available meanings of terms such as ‘panic attacks’ and ‘anxiety disorders’ are informed by the medical model. This means that the DSM is almost universally referred to in studies investigating panic or anxiety disorders. These professional definitions are provided here, and are used as “descriptive information rather than ‘truths’” (Wilson, 2007: 29). It is stressed that privilege was given to the personal meanings of the participants’ panic experiences and their accounts were treated “as a valid source of
knowledge in their own right” (Scattolon & Stoppard, 1999: 205). Below is a list of terms referred to throughout this thesis:

**Anxiety Disorders:** Anxiety disorders can take many forms. They cover a wide range of diagnoses, including panic disorder, generalised anxiety disorder, social anxiety disorder, and agoraphobia. Common to all of these is excessive fear and anxiety and related behavioural disturbances (APA, 2013). Fear is the emotional response to a real or perceived imminent threat, whereas anxiety is anticipation of a future threat (APA, 2013). As mentioned above, panic attacks feature prominently within most anxiety disorders (APA, 2013). In order to be diagnosed with an anxiety disorder, the condition must have a disabling impact on the person’s life (beyondblue, 2013). This means that there is a pronounced difference between an anxiety disorder and ‘daily life’ stress, worry, and nervousness. All participants in this study reported levels of distress and impairment that well exceeded ‘normal’ levels of anxiety and stress.

Given that anxiety disorders are highly comorbid with each other, and are usually only differentiated by close examination of the types of situations that are feared or avoided, and the content of the associated thoughts or beliefs (APA, 2013), the focus of this thesis was on the participants’ panic experiences, rather than specific anxiety disorders.

**Panic Disorder:** Panic attacks are the hallmark of this disorder (APA, 2013); this term is used to describe when individuals experiences recurrent unexpected panic attacks and are persistently concerned or worried about having more panic attacks (beyondblue, 2013). The individual worries about the implications or consequences of a panic attack, for example, physical concerns that it may reflect the presence of an
undiagnosed medical problem or life-threatening illness; social concerns, such as embarrassment or fear of being judged negatively by others because of visible panic symptoms; and concerns about mental functioning, such as ‘going crazy’ or losing control (APA, 2013). In an attempt to minimise or avoid panic attacks or their consequences, individuals begin to modify their behaviour and activities to try and ensure that they will always feel safe (beyondblue, 2013). Safety behaviours include avoiding physical exertion because it increases the heart rate, reorganising daily life to ensure that help is available in the event of a panic attack, restricting usual everyday activities and routines, and avoiding agoraphobia-type situations, such as leaving home, using public transportation, or shopping (APA, 2013).

The term panic disorder is informed by the medical model. To avoid reinforcing this model, the terms ‘panic’ or ‘panic attacks’ are used to describe the multitude of experiences which can create a feeling of panic and/or fear of having more panic attacks in the future. Where possible, the term ‘disorder’ has been omitted from this thesis in order to remove some of the medical connotations associated with panic. Instead of using the term ‘disorder’, other descriptive terms are used, including ‘condition’, ‘illness’, ‘problem’, and ‘affliction.’ These terms have more neutral connotation, and can act as umbrella terms for the various forms of ill health (Perrin et al., 1993).

Finally, the term ‘panic attacks’ is often abbreviated to ‘panic’ in this thesis to provide a more succinct reading experience.

**Agoraphobia**: The diagnosis of panic disorder can also lead to the associated condition of agoraphobia. People with agoraphobia start to avoid situations which are associated with previous panic attacks, for example, driving on freeways, or a
crowded shopping centre. Often these individuals will remain within a ‘safe’ radius from home; people with severe cases may completely avoid leaving home (Saul, 2001).

**Mental illness:** Mental illness encompasses a broad array of different conditions of psychological distress, and is a term used frequently in this thesis. Mental illnesses can be categorised into psychotic types, such as schizophrenia, and non-psychotic conditions, such as anxiety disorders. The symptoms of non-psychotic mental illnesses remain based in reality (Edward, 2007). For the purpose of this study, the following definition is offered:

> Mental illness “relates to a condition in which a person manifests behaviours, feelings, ideas, and/or thought processes that are seemingly, and at least relatively, unusual, irrational, illogical, incoherent, unacceptable, undesirable, and serious enough to cause personal anxiety, discomfort, and problems in functioning” (Gupta, 1993: 3).

**Chronic illness:** The participants’ panic experiences are referred to as a ‘chronic’ condition. Chronic illnesses an “ongoing physical, emotional, or cognitive conditions, and may or may not be treatable or curable” (Vickers, 2003: 86). All participants had experienced panic attacks for at least 6 months duration, usually for many years. Additionally, all participants believed that they would never fully recover.

**Lived Experience:** The paramount aim of this thesis was to understanding the ‘lived experiences’ of employees with panic attacks. Moi (as cited in Raheim & Haland, 2006) has emphasised that lived experience refers to the way human beings give meaning to their situation. In this thesis, the ‘lived experience’ of participants has been conceptually defined as “everyday life” (Streubert-Speziale & Carpenter, 2003:}
This term provides meaning to how each individual perceives a particular phenomenon (Streubert-Speziale & Carpenter, 2003).

**Work and Employment:** The terms ‘work’ and ‘employment’ are used interchangeably in this thesis. Employment and work are defined here as the situation where a person is paid money for performing specified tasks (Honey, 2002).

1.8 **Thesis Outline**

The first four chapters provide background information and research considerations. Following the introductory chapter, literature relevant to the study is reviewed in Chapters 2 and 3. Chapter 2 focuses on anxiety and panic literature in the social science, health and organisational arenas. Chapter 3 reviews mental health and illness literature that aids in locating the current study within a wider context.

Chapter 4 provides a detailed discussion of the research methodology and methods that guided the study. The related issues of trustworthiness and ethical considerations are also discussed.

The research findings make up the body of this thesis and are divided into Chapters 5, 6 and 7. Chapter 5 focuses on the adversity that participants experienced in their personal lives. It emphasises the difficulties and trauma surrounding the early stages of illness; the isolation that accompanied this condition; the lack of support and understanding from healthcare professionals and family members; the experience of living with a stigmatised illness; and, the feelings of loss that resulted from a changed life.
Chapter 6 examines the work-life experiences of employees with panic attacks. Specifically, it explores the role of work in contributing to the participants’ panic attacks; the negative impact that panic had on the participants’ career and working life; the stigma, lack of practical support, and discrimination encountered in the workplace; strategies to survive working with panic; and, the outcomes of disclosure.

Chapter 7 moves beyond the adversity experienced by participants and highlights the participants’ experience of developing resilience and living ‘well’ with panic attacks. Details of the positive changes that resulted from their panic experiences are given.

The final section of the thesis discusses the findings and provides a conclusion. Chapter 8 provides a discussion of the key findings within the context of the relevant literature. The implications for employees with panic attacks, and various groups in the wider community are explored, and practical recommendations are offered.

Chapter 9 returns to the research question and study objectives and concludes this thesis with a reflection on the employees’ lived experiences with panic attacks. The limitation of the study and directions for future research are also discussed.
CHAPTER TWO

Panic and Anxiety: In and Beyond the Workplace

2.1 Introduction

Outside clinical journals, research investigating panic and anxiety conditions is sparse. This chapter examines the dominance of the medical model for understanding these conditions, and shares the small number of studies that have explored the subjective experiences of people with panic or anxiety, in and beyond the workplace. Research investigating the stigma attached to anxiety and panic is also presented, followed by a review of organisational studies that have measured the cost of these conditions on workplace productivity and organisations’ bottom line. Lastly, this chapter spotlights emerging research that has linked poor working conditions with the onset of panic.

2.2 The Dominance of the Medical Model

Despite the pervasiveness of panic attacks, and the significant burden that panic attacks can have on the individual, organisation and community (Roy-Byrne et al., 2006), the experiences of people who have panic attacks, especially those who work, have received scant scholarly attention. To date, few studies have been located that explore the subjective experiences of those with panic conditions (see, for examples, Davidson, 2005; Haslam, Atkinson, Brown & Haslam, 2005a). Those that exist reflect the dominance of the medical model in Western culture. There is a considerable
volume of medical research on anxiety disorders and panic attacks (see, for examples, Barlow, Brown & Craske, 1994; Baillie & Rapee, 2005; Story & Craske, 2008); that is, research written by clinicians for clinicians. The vast majority of this research is grounded in reductionist, positivist, empirical methods, which can result in the reduction of the experience of mental illness to a mechanical or chemical process. The possible outcome of this kind of investigation means that the lived experience of those experiencing panic has been largely overlooked.

The medical model can provide many people with a powerful explanatory framework that fits their experience and assists them to live with their illness (Cox, 2012). However, the dominance of this framework means that clinicians and lay people rarely examine other ways of understanding, and this can silence particular narratives and ostracise particular individuals. The lack of non-medical discourse on affective disorders, including panic is problematic because:

It makes certain experiences invisible, normalises potentially unrealistic norms of emotional coping and may increase an individual’s sense of isolation. In addition, when an individual’s lived experience of an affective disorder and the expected medical narrative do not align, increased emotional distress may result as the individual attempts to navigate the cultural invisibility of their experience (Cox, 2012: 14).

Inadequate research on the individual’s perspective can result in misunderstanding the issues of significance for the individual and lead to the person feeling invalidated and undermined, and possibly lead to the development of ineffective treatments (Edwards & Titchen, 2003).

There is growing concern among researchers that positivist and empirical methods used in clinical studies do not sufficiently address the real-life complexities of
psychiatric illnesses, such as panic (Fossey, Harvey, McDermott & Davidson, 2002; Williams, 2006). It is argued that a more balanced discourse is needed in the mental health field in order to meet the complex and dynamic needs of people with panic; a discourse that values a variety of theoretical perspectives and different methodological techniques (Williams, 2006).

One of the objectives of this study is to bring to the fore the lived experiences of employees with panic attacks. This research perspective, distinct from the medical model framework, provides a means to improve our understanding of the person with panic.

2.3 Stigma and Anxiety Disorders

Information about the impact of stigma and self-stigma on individuals with anxiety disorders is noticeably absent in the literature. Instead, much of the research is focused on stigma for people with psychoses, such as schizophrenia (for example, Barney, Griffiths, Jorm & Christensen, 2006; Yanos, Roe, Markus & Lysaker, 2008). The lack of stigma research in this area is unfortunate, as studies show that common mental disorders, such as anxiety, are stigmatised (Alonso et al., 2009; Ociskova, Prasko & Sedlackova, 2013). Few studies were located that examined the stigmatising beliefs about depression and anxiety (Alonso et al., 2008; Griffiths, Batterham, Barney & Parsons, 2011; Wood, Birtel, Alsawy, Pyle & Morrison, 2014). Just one study was found that used qualitative research to explore how people with phobias experienced stigma (Davidson, 2005). This study is discussed in more detail at pages 25-26.

Researchers investigating the stigma attached to people with anxiety disorders have mainly used quantitative methods to measure this phenomenon. For example,
Griffiths et al. (2011) measured the public attitudes of 617 people towards people with Generalised Anxiety Disorder (GAD). Their findings indicated that 13% of those surveyed did not believe GAD was a real illness, and 16.7% felt that people with GAD were unstable. Over half of the respondents endorsed the view that most people did not believe anxiety disorder was a ‘real’ medical illness; that those affected could snap out of it if they wanted; and, it was a sign of personal weakness, and associated with instability. Results also indicated that of those surveyed, 14.4% were unwilling to socialise with a person with GAD; 23.7% did not want to work closely with an employee with GAD; and, 36.1% did not want someone with GAD to marry into the family (Griffiths et al., 2011).

A similar study measured public attitudes towards people with schizophrenia, depression and anxiety and found that anxiety and depression incurred more patient blame than schizophrenia (Wood et al., 2014). Results of an international study that surveyed 80,737 household residing adults from 16 countries showed that having depression or an anxiety disorder (versus no mental disorder) was associated with approximately a twofold increase in the likelihood of stigma. Comorbid depression and anxiety was even more strongly associated with stigma (Alonso et al., 2008).

Research confirms that stigma has been a real issue for people with anxiety disorders. However, the almost complete absence of studies describing how individuals with anxiety disorders perceive and experience stigma is concerning, and presents a sizeable gap in the literature. This qualitative study adds insight, and will extend the stigma research in this area.
2.4 Living with Panic

Personal, first-hand accounts of panic and anxiety conditions in the social sciences are scarce. The amount of qualitative literature on panic lags considerably behind studies that focus on the lived experience of depression (for example, Scattolon & Stoppard, 1999; Rogers, May & Oliver, 2001; Schreiber, 2001; Stoppard & McMullen, 2003; Cornford, Hill & Reilly, 2007) and schizophrenia (for example, Johnson, 1998; Kennedy-Jones, Cooper & Fossey, 2005; Lester & Tritter, 2005; Kirkpatrick, 2008; Snyder, Gur & Andrews, 2008). This is concerning given that anxiety disorders are more prevalent in the Australian population than both of the above conditions (ABS, 2007). The lack of international studies investigating panic and anxiety has been recognised by Katon and Roy-Byrne (2007: 390), who describe this area of research as the “neglected stepchild” in the mental health field. This study will go some way towards addressing their concern.

Only a small number of research papers were located that attempted to understand the lived experience of panic. Some of these studies examined specific anxiety disorders, such as panic disorder or agoraphobia, whereas others studied anxiety symptoms or anxiety disorders (often in combination with depression) as a single broad category. Of particular note are two published doctoral theses and one master’s thesis that have explored the personal narratives of individuals with panic disorder. Reid’s (2004) master’s thesis ‘Hiding from the moon: Living with panic disorder’, investigated from a sociological perspective, the lived experience of panic disorder in Canadian women, and their interactions with the larger world. Their experiences were examined within the context of disability and mental health, and the shortcomings of the medical model were revealed.
Olstead (2007) interviewed 13 Canadian women, who self-described as suffering with panic disorder, in her doctoral thesis, ‘Panic Narratives: A sociology of gender, power and space’. She used various postcolonial, post-structural, feminist and institutional ethnographic theories to argue that panic disorder is a psychological problem arising out of a significant conflict between desiring inclusion within, and resisting domination by the patriarchal relations.


These theses are noteworthy as they reject the dominant medical construction of panic, and base their research findings on personal panic narratives gleaned from in-depth interviews with participants. What distinguishes this thesis from those above is that this study examines the Australian panic experience through a hermeneutic phenomenological lens, and considers the impact of panic on an employee’s work and personal life. This viewpoint will offer new insights into the lived experiences of employees with panic.

Social geographers have taken an interest in exploring the personal accounts of people with agoraphobia and other phobias. Many of these studies use first-hand experience of agoraphobic individuals to help elaborate wider theoretical concepts and the connection between gender, agoraphobia, mental health and geography (Garbowsky, 1989; Capps & Ochs, 1995; Carter, 2002; Davidson, 2000, 2001, 2003; Bankey, 2004; Lemon, 2004; Smith & Davidson, 2006). Joyce Davidson’s work has been
particular significant in increasing understanding of the first-hand experiences of agoraphobic individuals. Davidson, a social geographer, has been primarily interested in the embodied and daily spatial experiences of those who are agoraphobic. Her research highlights the importance of place and space within the production of agoraphobia.

Panic has also been reported as a “women’s problem” (Olstead & Bischoping, 2012: 282). Sociologists have largely focused on the experiences of women with this condition (Valentine, 1989; Capps & Ochs, 1995; Davidson, 2001, 2002, 2003; MacKay, 2004; Olstead, 2007; Jacobson, 2011). Only two studies were located that explored the gendered accounts of men and women with panic disorder (Olstead & Bischoping, 2012); and, post-traumatic stress disorder (Krause, DeRosa & Roth, 2002). Another study focused on the everyday emotional spatialities of New Zealand men who experienced anxiety and depression (Keppel, 2012). This study will broaden understanding of the experiences of both women and men with panic attacks.

Other research exploring the personal narratives of people with panic and anxiety include investigations of: the efforts to obtain a ‘normal’ life as experienced by individuals with anxiety (Lloyd & Moreau, 2011); the embodiment of disgust in personal accounts of phobias and nature (Smith & Davidson, 2006); the wives/female partners perspective of living with post-traumatic stress disorder (Lyons, 2001); the experience of panic disorder in mothers during the postpartum period (Beck, 1998); the lived experience of undergraduate nursing students with panic attacks (Scott, 2007); and, the individual’s perspective of panic disorder and how it influenced their quality of life and recovery (Hamer, 2009).
Another way of understanding the subjective experiences of people with panic attacks is through the published writings of non-medical experts who have lived with panic. These viewpoints are found in novels, autobiographies and self-help books, and reflect a range of understandings of ‘panic.’ A recent search for ‘panic attacks’ on Amazon.com, an online bookstore, revealed 11,700 books have been written on this subject. Many of these books offer advice to the lay person on how to overcome panic and anxiety. Book titles reveal how panic attacks are conceptualised, for example, they are described as ‘nerves’: “*Hope and help for your nerves*” (Weekes, 1990) and as an ‘it’, for example, “*Living with it: A survivor’s guide to panic attacks.*” (Aisbett, 2013). Autobiographies written from the viewpoint of the affected individual are also prolific, and often document stories of recovery, for example: ‘*Autobiography of an Agoraphobic: One man's struggle with panic disorder*’ (Patrick, 2003); and, ‘*The road to Fort Worth: Recovery from panic disorder*’ (Smith, 2010).

The small amount of scholarly research exploring the lived experiences of people with panic and anxiety suggests that researchers in Western countries, including Australia, rely on medicalised knowledge to understand this condition, rather than also utilising personal illness narratives and experiences.

### 2.5 The Lived Experiences of People Working with Panic

An estimated 361,326 or 2.9% of working age Australians have an anxiety disorder of at least 6 months duration (Waghorn et al., 2005: 61). Despite this, little is known about the individuals’ lived experience in the workplace. To this researchers knowledge, only three research papers can be found in the English speaking literature that examine the personal perspectives of people with panic or anxiety problems in...
the workplace setting. Haslam et al. (2005a) conducted nine focus groups with United Kingdom employees, who had suffered anxiety or depression, and three focus groups with organisational representatives from human resources, occupational health and health and safety. In total 75 participants, aged 18-60, from a range of occupations, took part. Participants with anxiety and depression reported that the illness symptoms and medication took a toll on their work performance, and also caused a range of workplace accidents, including industrial injuries and falls. These employees were reluctant to disclose their condition to colleagues or managers because they felt stigmatized. Additionally, 75% of participants felt that management methods and unmanageable workloads contributed to the development of their mental health problems. These significant employee concerns are extended in this study. However, in contrast to Haslam’s et al. (2005a) study, this research investigates the experiences of people who self-identify as having panic, rather than general anxiety and depression. This research is also focused on the Australian experience and uncovers additional concerns unique to those with panic living in Australia.

Haslam et al. (2005b) also provided further insight into the problems workers faced in managing their anxiety and depression symptoms when dealing with the side effects of psychotropic medication at work. Using a qualitative, descriptive approach, their findings indicated that both the symptoms of anxiety and depression and the medication prescribed for these disorders caused workplace accidents, and could represent a risk to occupational safety.

Lastly, Davidson’s (2005) study used grounded theory to analyse in-depth interviews with 40 phobic participants. The findings showed that phobias were trivialised, and this had a negative impact on the participants work and home lives. To manage the
negative ramifications of stigma, participants in Davidson’s study (2005) either concealed their condition from others, or spoke out to directly challenge the flawed perceptions of family, friends and employers. Themes relating to stigma and disclosure decisions will be extended upon and explored further in this thesis.

2.6 Research Favouring the Employers’ Perspective

In contrast to the dearth of literature investigating the subjective workplace experiences of employees with panic, there are a growing number of studies that have measured the costs of anxiety and panic on lost productivity, and the organisation’s bottom line (see, for examples: DuPont, Rice, Miller, Shiraki & Rowland, 1996; Greenberg et al., 1999; Marciniak, Lage, Landbloom, Dunayevich & Bowman, 2004; Dewa et al., 2007; Sanderson & Andrews, 2006). Much of this research disregards the concerns of the employee with panic in favour of the employers’ perspective and how to best minimize the economic impact on organisations (Diener & Seligman, 2004).

The findings from one study found that over three quarters of the total workplace cost of employee anxiety were directly related to lost productivity (DuPont et al., 1996). A U.S. study revealed that employees with anxiety disorders were more likely to have unofficial absences from work, or short-term disability or worker compensation claims, than a comparison group (Marciniak et al., 2004). However, when people’s mental health problems are reduced to economic terms, the suffering of the individual is often overlooked in favour of how to best minimize the impact on the employer (Diener & Seligman, 2004). This study allows for the subjective experiences of the individual employee in the workplace with panic related problems to be heard.
Such a research orientation is unsurprising, given the rationalist, capitalist context in which modern, Western organisations operate (Landau & Chisholm, 1995; Rees, 1995; Vickers, 1999, 2001), and where efficiency and output are highly valued (Vickers, 1999, 2001; Allen & Carlson, 2003). The outcome of such a perspective finds employees who are perceived to be unable to operate at ‘optimal capacity’ (Vickers 1999, 2000, 2001) due to ill-health, being viewed as a ‘problem’. Employees with any form of a mental illness have the additional challenge of having to contend with their emotional distress and ‘irrational’ fears (frequent markers of panic attacks), while not conforming to traditional and normative employer ideals as to how staff should be when working in rational, bureaucratic organisations (Gherardi, 1995, cited in Vickers, 2001; Davidson, 2005). Those employees unable to conform are often marginalised (Vickers, 1999, 2001; Peterson, Pere, Sheehan & Surgenor, 2004). Those with unseen chronic conditions (Vickers 2001), may then choose to conceal their stigmatising health status to mitigate the impact it might have on their occupational identity (Dodier, 1985; Fitzgerald & Paterson, 1995; Vickers, 1995, 2001; Dyck & Jongbloed, 2000; Allen & Carlson, 2003; Beatty & Joffe, 2006).

Although not entirely favouring the employers’ perspective, Waghorn et al.’s (2005) Australian study compared at a population level, patterns of disability, labour force participation, employment and work performance among people with anxiety disorders. Researchers surveyed household residents across Australia diagnosed with an ICD-10 classified anxiety disorder. They concluded that anxiety disorders were associated with “reduced labour force participation, degraded employment trajectories and impaired work performance compared to people without disabilities or long-term health conditions” (Waghorn et al., 2005: 55). They found that anxiety disorders had an adverse impact on career development because of education disruptions and the
production of employment restrictions, such as greater non-participation in the workforce, reduced job seeking, and less part time or full time employment. A Canadian study also found that anxiety disorders, specifically social phobia, can significantly interfere with the participants occupational functioning (Stansfeld, Blackmore, Zagorski & Munce, 2008).

2.7 Connecting Work and Anxiety Disorders

Working conditions can be detrimental to mental health, irrespective of the employees’ mental health status (Maslach, Schaufeli & Leiter, 2001; Wilhelm, Kovess, Rios-Seidel & Finch, 2004; Plaisier et al., 2007; Promislo, Giacalone & Jurkiewicz, 2013). These studies are often grouped under headings such as ‘work stress’, ‘burnout’, ‘work-load’ and ‘mobbing’ (for example, Zapf, Knorz & Kulla, 1996; Turnipseed, 1998; Hobson & Beach, 2000; Nagata, 2000; Rahe, Taylor & Tolles, 2002). More recent studies have shown that workplaces may contribute to the development of anxiety disorders. This research is still in its infancy (Linden & Muschalla, 2007). Evidence indicates that these disorders can impair the ability of employees to work productively, and can have a direct impact on job participation or sick leave and early retirement (Linden & Muschalla, 2007).

Notable studies investigating the link between workplace factors and anxiety disorders have found that: high job demands increase the risk of depression and anxiety; work stress appeared to cause psychiatric disorders in previously-healthy young adults (Melchior et al., 2007); high strain and stressful working conditions contributed to the development of anxiety and depression in employees (Plaisier et al., 2007); anxiety and depression levels increased linearly and considerably with
increasing demands, and with decreasing support scores (Sanne, Mykletun, Dahl, Moen & Tell, 2005); high job strain and job insecurity increased the risk of social phobia (Stansfeld et al., 2008); and, lastly, better working conditions (lower psychological demands) were associated with a decrease in the risk of anxiety disorders (Plaisier et al., 2007).

Research has also demonstrated that post-traumatic stress disorder can develop in employees who witness upsetting events in the workplace, such as emergency workers (Laposa, Alden & Fullerton, 2003; MacDonald, Colota, Flamer & Karlinsky, 2003; Price, Monson, Callahan & Rodriguez, 2006). Working conditions can contribute to the onset of anxiety problems; an important finding that requires further attention.

Disabling anxiety has also been shown to be a workplace specific problem only, and may not affect other parts of a person’s life. Disabling workplace anxiety has been termed ‘workplace phobia’ and appears to be a new clinical concept (Haines, Williams & Carson, 2002; Muschalla & Linden, 2009). However, these investigations, in general, show that most employees with work-related anxieties and phobias do also suffer from anxiety disorders that affect others aspects of their lives (Linden & Muschalla, 2007).

2.8 Summary

This chapter has highlighted that there are very few studies that provide a platform for the individual with panic to voice their experiences. This considerable gap is especially notable within workplace studies. Researchers that have explored the personal accounts of people with anxiety disorder were mostly social geographers
who elaborated on the connection between agoraphobia and geography. Many of these studies were conducted in the United States or Canada, including three significant theses that focused on the personal accounts of people with panic disorders. There is little research related to the Australian experience of living and working with panic.

The current discourse on panic attacks is found mostly in medical and psychiatry journals and textbooks. The medical model for understanding panic fails to address the complexities of living day-to-day with panic, and minimises the suffering of the individual.

Within the organisational and management field, only three research papers were found that explored the personal perspectives of workers with anxiety disorders. A small number of quantitative studies highlighted that stigma is a real issue for people with anxiety disorders. Again, none of these studies focused specifically on those with panic.

This chapter revealed emergent research that shows a connection between poor working conditions and the onset of anxiety disorders. By focusing on the subjective employment perspectives of people with panic, a better understanding of the work-life experiences of this group of mental health consumers may be revealed. In order to contextualise the study, the next section will explore studies that have highlighted key issues and concerns for mental health consumers, in and around the workplace.
CHAPTER THREE
Mental Illness: In and Beyond the Workplace

3.1 Introduction

This chapter presents literature relevant to the work and life experiences of employees with mental illness. The vast amount of research in this area meant that this review has been necessarily selective, and topics were chosen to locate the current study within a wider context. This section primarily concentrates on studies that have explored the key issues and problems that exist for mental health consumers, in and beyond the workplace. Topic areas include: stigma, illness and identity, recovery, coping techniques at work, the impact of mental illness on family members, and barriers to employment.

3.2 Subjective Experiences of Mental Illness

Interest in the individuals’ subjective experiences of mental illness gained momentum in the 1980’s as researchers began to challenge the dominant pathological and biomedical perspectives of the day (for example, Lovejoy, 1984; Deegan, 1988; Strauss & Estroff, 1989). Scholars in a range of disciplines including anthropology, cultural studies, organisational management studies, gender studies, psychology, nursing, occupational therapy, and sociology have analysed the subjective experience of mental illness and the way it has impacted the lives of those affected. Such research has used various methodologies including case studies, thematic analysis,
phenomenology, anthropological fieldwork and linguistic analysis to explore these personal perspectives (Cox, 2012).

3.2.1 Socio-demographic Groups and Mental Illness

Many qualitative studies on mental illness have focused on the subjective experiences and understandings of particular social or demographic groups. For example, research has investigated: particular ethnic groups, including, Asian Canadians (Li & Browne, 2000), Latinos (Barrio et al., 2008; Ishikawa, Cardemil & Falmagne, 2010), Aboriginal Australians (Vicary & Westerman, 2004; Vicary & Bishop, 2005); Taiwanese (Lin, Kopelowicz, Chan & Hsiung, 2008), Chinese (Lee, Lee, Chiu & Kleinman, 2005; Hsiao, Klimidis, Minas & Tan, 2006) and Swedish youth (Danielsson, Bengs, Samuelsson & Johansson, 2011); social groups such as lesbians (Barnard, 2004, 2009), black women (Black, White & Hannum, 2004), older women (Tryssenaar, Chui & Finch, 2003; Allan & Dixon, 2009), mothers (Diaz-Caneja & Johnson, 2004; Krumm & Becker, 2006; Montgomery, Tompkins, Forchuk & French, 2006); migrants (Nahas, Hillege & Amasheh, 1999; Blignault, Ponzio & Eisenbruch, 2008; Maier & Straub, 2011), people from rural areas (Nieuwsma, Pepper, Maack & Birgenheir, 2011); and, certain age groups, including the elderly (Campbell, 2002; Switzer, Wittink, Karsch & Barg, 2006; Allan & Dixon, 2009) and adolescents (Woodgate, 2006; McCloughen, Foster, Huws-Thomas & Delgado, 2012; Bluhm, Covin, Chow, Wrath & Osuch, 2014).

There is also a large amount of research that examines the effect of gender on mental illness experiences (Stoppard, 2000; Stoppard & McMullen, 2003; Gattuso, Fullagar & Young, 2005; Emslie, Ridge, Ziebland & Hunt, 2006; Marecek, 2006; Lafrance,
Findings from these studies have shown that culture, ethnicity, and social characteristics alter the experience of having a mental illness. These factors influence the recognition of symptoms, the labelling of illness, access to mental health care resources, responses and level of support from family members and health professionals.

### 3.2.2 Identity and Mental Illness

Researchers have also attempted to understand the subjective reality of people with mental illness by examining specific aspects of their experience. Qualitative researchers have paid particular attention to how mental illness impacts on identity, the experience of recovery from mental illness, and the effect of mental illness on family members.

Identity-related themes are particularly prolific in mental illness research. Researchers have attempted to understand how individuals make sense of their suffering, and come to terms with an altered existence and identity. Research by Hyden (1997: 57) has argued that a diagnosis of mental illness can be all encompassing, a “vantage point from which all other events are viewed and to which all other events are related.” He claims the individual’s entire self-concept and choices become dictated by their illness.

Research on mental illness and identity have focused on several key themes, including: the loss of self and a loss of previous held identities (Carless, 2008; Rhodes & Smith, 2010; Wigney, 2010; Fernandez, Breen & Simpson, 2014); perceptions of normality after diagnosis (Estroff, Lachicotte, Illingworth & Johnston, 1991; Judge,
Estroff, Perkins & Penn, 2008); searching for an authentic self (Karp, 2006; Montgomery et al., 2006); and, redefining the self, which involves “re-conceptualizing mental illness as simply one aspect of a multi-dimensional identity rather than assuming a primary role as ‘mental patient’” (Davidson et al., 2005: 484). Studies have shown that the renegotiation of identity following mental illness allows for increased self-acceptance and recovery (Russell & Browne, 2005; Mauritz & van Meijel, 2009; Proudfoot et al., 2009; Fernandez et al., 2014). Given the important relationship between mental illness, identity, and recovery, it is useful to investigate how people incorporate the experience of panic into their identity.

3.2.3 Recovery Narratives

There is a particularly large corpus of research that examines the subjective accounts of recovery from mental illness. This concept gained prominence in the mental health field in the late 1980s and has been widely discussed ever since (Onken, Craig, Ridgway, Ralph & Cook, 2007). There is a lack of consensus in the mental health field on the definition of ‘recovery’ from the perspective of the mental health consumer. However, researchers concur that it is a non-static, lifelong process (Deegan, 1988; Frese & Davis, 1997; Jacobson & Curtis, 2000) that involves confronting the challenges of mental illness using a unique combination of strengths, vulnerabilities and available resources (Deegan, 1996; Tooth, Kalyanasundaram, & Glover, 1997; Jacobson & Curtis, 2000; Spaniol & Wewiorski, 2002), in order to live a full and productive life (Onken et al., 2007). Recovery is not synonymous with ‘cure’ and is not a return to a previous state of health (Deegan, 1993; Walsh, 1996; Jacobson & Greenley, 2001), rather, it means finding a level of resilience in one’s daily life in order to live with symptoms (Stewart & Geller, 2014).
The literature revealed a multifaceted understanding of how people recover from mental illness, including: having a sense of hope and believing in the possibility of a renewed sense of self and purpose (Davidson et al., 1997, 2001; Young & Ensing, 1999; Jacobson & Curtis, 2000; Mead & Copeland, 2000; Smith, 2000; Jacobson & Greenley, 2001); incorporating the illness into everyday life and accepting the limitations imposed by the condition (Deegan, 1988, 1993; Sullivan, 1994; Young & Ensing, 1999; Sayce & Perkins, 2000; Smith, 2000; Munetz & Frese, 2001; Ridgway, 2001); being involved in meaningful activities and making worthwhile contributions to society (Young & Ensing, 1999; Lunt, 2000; Davidson et al., 2001; Jacobson & Greenley, 2001; Ridgway, 2001); and, developing resilience to stigma and/or actively fighting against it (Perlick, 2001; Ridgway, 2001; Houghton, 2004).

The literature shows that recovery is also possible through assuming control over one’s life and actively participating in the management of symptoms and treatment strategies (Jacobson & Curtis, 2000; Lehman, 2000; Lunt, 2000; Mead & Copeland, 2000; Smith, 2000; Frese, Stanley, Kress, & Vogel-Scibilia, 2001; Jacobson & Greenley, 2001; Munetz & Frese, 2001; Ridgway, 2001). The support of family members, friends, health professionals and community members was also found to be important for recovery (Mead & Copeland, 2000; Smith, 2000; Jacobson & Greenley, 2001; Ridgway, 2001). These various perspectives highlight that recovery is an active process, requiring the person to change or develop one’s engagement in the everyday world.

The growing amount of research on this topic suggests that researchers are recognising the importance of understanding the recovery experiences of people with mental illness. While the theoretical understanding of this phenomenon is developing,
there are still clear gaps in knowledge, particularly, related to recovery within the context of panic.

### 3.2.4 Mental Illness Impacting Family Members

The deinstitutionalisation of the mental health care system and advances in the development of medications in the Western world means that more mentally ill adults have moved into the community, or remain in the household with family members (Zauszniewski, Bekhet & Suresky, 2009). By choice or by necessity, more families have taken on the caregiver role for their relative with mental illness (Lively, Friedrich, & Rubenstein, 2004; Kohn-Wood & Wilson, 2005; Wynaden et al., 2006).

The move away from deinstitutionalisation has generated a considerable amount of social sciences research that has investigated the experiences of families living with mental illness (Foster, 2010; Foster, O'Brien & Korhonen, 2012; Sin, Moone, Harris, Scully & Wellman, 2012). Currently, much of this research focuses on the experiences of family members of persons with schizophrenia (Teschinsky, 2000; Wuerker, 2000; Saunders & Byrne, 2002; Saunders, 2003).

Only a few studies have examined the experiences of family caregivers of persons with anxiety disorders (Stengler-Wenzke, Trosbach, Dietrich, & Angermeyer, 2004), or major depression (Ahlstrom, Skarsater, & Danielson, 2007), and bipolar disorder (Perlick et al., 2007). However, studies highlight that there are significant personal costs for family members that care for a relative with mental illness. The term *caregiver burden* has been used to “reflect the stress experienced by family caregivers of persons with mental illness, including feelings of stigma, strain, family disruption,
and the dependency needs of the person with mental illness” (Zauszniewski et al., 2009: 413).

Literature on families experiencing mental illness has revealed that stigma contributes to much of the burden experienced by family caregivers (Muhlbauer, 2002; Angermeyer, Schulze & Dietrich, 2003; Tsang, Mok, Au Yeung & Chan, 2003; Rose, Mallinson & Gerson, 2006). Other studies have explored how mental illness alters the roles and relationships of families, sometimes permanently, including marital and family relationships, daily routines and activities, finances, employment, physical health and social life (Dore & Romans, 2001; Rose et al., 2006; Ali, Ahlström, Krevers & Skärskä, 2012; Skundberg-Kletthagen, Wangensteen, Hall-Lord & Hedelin, 2014). These studies provide evidence that mental illness creates ongoing caregiver burden and can significantly affect family functioning. Research on the experience of panic within families is needed to help identify their support needs and provide research-based support interventions.

3.3 Stigma and Mental Illness

This section discusses literature on mental illness stigma, which has been the subject of considerable social science research. Many researchers (for example, Falk, 2001; Smith, 2002) have argued that “people with mental illness suffer the greatest impact from stigma” (Corrigan & Kleinlein, 2005: 17), and that stigma and discrimination are the “most significant obstacles ... to ensuring a life of quality to people suffering from mental illness” (Sartorius, 1998: 1058).

Erving Goffman’s (1963: 3) seminal work first brought attention to this “deeply discrediting” attribute, which reduced the recipient of stigma “from a whole and usual
person to a tainted, discounted one.” Since Goffman’s landmark work, stigma research has flourished. Studies have covered a wide variety of topics, and have demonstrated the unfavourable effects of mental illness stigma, including: delaying help-seeking behaviours (Leaf, Bruce, Tischler & Holzer, 1987; Holmes & River, 1998; Corrigan, 2004; Rusch, Angermeyer & Corrigan, 2005); preventing people from disclosing their illness (Dinos, Stevens, Serfaty, Weich & King, 2004; Lee et al., 2005); adversely impacting social interactions and leading to social isolation (Schulze & Angermeyer, 2003); eroding self-esteem (Link, Struening, Neese-Todd, Asmussen & Phelan, 2001; Camp, Finlay & Lyons, 2002; Ritsher, Otilingam & Grajales, 2003; Corrigan, 2004); and, limiting prospects of recovery (Link et al., 2001; Dinos et al., 2004).

The literature confirms why mental illness remains the ‘ultimate stigma.’ Unlike physical illnesses, people with mental illness are viewed as being in control of their afflictions and thus responsible for causing it (Weiner, Perry & Magnuson, 1988; Corrigan, 1998). This leads to the perception that a person with mental illness “must have a character flaw” (Corrigan & Kleinlein, 2005: 25).

Adding to this problem are the negative depictions of people with mental illness found in everyday discourse – within advertising, films, television and insults in jokes (Wahl, 1995; Camp et al., 2002). Estroff (1981) observed that people with chronic mental illness are often viewed as ‘crazy’, and as non-contributing members of society. Living in a culture steeped in stigmatizing language and images means that people with mental illness are often labelled as fundamentally different, irresponsible, and less competent. People with psychiatric disorders, such as schizophrenia, are also viewed as dangerous and violent (Wahl, 1995; Angermeyer & Schulze, 2001, Camp
et al., 2002; Couture & Penn, 2003), leading to the belief that people with serious mental illness should be “feared and isolated from communities” (Couture & Penn, 2003: 292).

Numerous researchers (Angermeyer & Schulze, 2003; Rüsch, Lieb, Bohus & Corrigan, 2006) have highlighted that people with mental illness struggle with a double problem. First, they have to cope with the symptoms of their illness, which can adversely impact their quality of life. Secondly, they must also deal with stigma, which can result in considerable social disadvantage. The suffering caused by stigma can be even more devastating than the original illness (Angermeyer & Schulze, 2003), and can lead to self-stigma, which occurs when the ill person accepts and internalises common misconceptions about mental illness (Rusch et al., 2005).

Organisational studies have revealed that people with mental illness can be robbed of important life opportunities and goal achievements (Link, 1987; Link, Struening, Rahav, Phelan & Nuttbrock, 1997). Unemployment has been associated with stigma (Link, Cullen, Struening, Shrout & Dohrenwend, 1989; Wahl, 1999; Mechanic, Bilder & McAlpine, 2002; Angermeyer, 2003; Corrigan et al., 2003; van Brakel, 2006); stigma can also minimise the opportunity for career advancement and lead to underemployment (Whal, 1999; Simmie & Nunes, 2001; Cook, 2006; Nunes & Simmie, 2002; Stuart, 2004). People with mental illness can have problems getting a job, or being laid off due to stigma and discrimination (Link et al., 1989; Scheid, 1999; Wahl, 1999; van Brakel, 2006). Both the general population and people with mental illness perceive that employers would discriminate against mentally ill individuals (Link et al., 1989, 1997). Higher unemployment rates among people with stigma could be due not only to discrimination from employers, but also because
people with perceived stigma are less likely to apply for job opportunities (Wahl, 1999).

Research has shown that mental illness is related to lower education (Wahl, 1999; Corrigan et al., 2003; van Brakel, 2006). Individuals with mental illness report reduced educational opportunities (van Brakel, 2006) and stigma experiences make people with mental illnesses less likely to apply for educational opportunities (Wahl, 1999).

On a final note, much of the research on stigma in the mental health literature focuses on people with schizophrenia (for example, Wahl, 1995; Angermeyer & Schulze, 2001; Stuart & Arboleda-Flórez, 2001; Schulze & Angermeyer, 2003; Stuart, 2003), and more recently, depression (for example, Karp, 1994; Schreiber, Stern & Wilson, 2000; Schreiber & Hartrick, 2002; Dowrick, Kokanovic, Hegarty, Griffiths & Gunn, 2008; Kokanovic, Dowrick, Butler, Herrman & Gunn, 2008; Hansson, Chotai & Bodlund, 2010). Just as individuals experience stigma in different ways (Dowrick et al., 2008), it is plausible that people with panic also respond to the experience of stigma in unique ways. Insights into the stigma experiences of those with panic problems will offer a fresh perspective on this topic.

### 3.4 People Working with Mental Illness

The following section reviews relevant research studies that have sought to understand the subjective work experiences of employees with mental illness. Two common topic areas have been addressed, including: identity and the meaning of employment; and, coping techniques at work.
3.4.1 Identity and the Meaning of Employment

For people with mental illness, who may already be grappling with a loss of authentic self, self-worth and identity (for example, Karp, 1994; Emslie et al., 2006; Stevenson & Knudsen, 2008; Thompson et al., 2008), the meaning of work takes on an added dimension and can affect a person’s identity and sense of self. Honey’s (2002, 2003, 2004) research provides particular insight into how employment can affect social identity and self-esteem. Using grounded theory, 41 users of mental health services in Sydney, Australia were interviewed to obtain their perspectives about employment. The findings show that the effects of employment on a consumer’s self-image and identity, mental health, and social belonging ranged considerably from negative to very positive, depending on the individual involved. This is similar to a study conducted by Kirsh (2000), who interviewed 36 mental health consumers and found that the positive aspects of employment for people with mental illness, such as improved self-worth, a sense of achievement, normalisation, and improved finances were tempered by the negative effects of work, such as avoidance of stress, difficulty in finding suitable employment, and difficult interactions with co-workers after disclosure.

Research also indicates that mental illness leads to a loss of self-esteem and self-confidence in work abilities and goals, which can make it difficult for these individuals to obtain and retain employment (Bassett et al., 2001; Honey, 2002, 2003; Marwaha & Johnson, 2005; Blitz & Mechanic, 2006). Studies have shown that mental illness causes self-stigma in which “negative social stereotypes are internalized and a mental illness comes to be viewed as a personal failure” (Stuart, 2004: 106). The fear of stigma and rejection in the workplace can demoralize the individual’s confidence.
and self-esteem, in which they view themselves as ineffective and unemployable and as a result may avoid job interviews (Link, 1982; Wahl, 1999; Marwaha & Johnson, 2005; Corrigan et al., 2006). The anxiety and fear that colleagues will discover the person’s mental illness may lead that person to go to “great lengths to ensure that others do not find out, including staying in unsatisfactory situations for fear that moving will result in disclosure, avoiding friendships and avoiding treatment” (Stuart, 2004: 106).

Due to the stigma of mental illness, literature has found that the decision to reveal a mental illness to supervisors and colleagues in the workplace was a common dilemma for people with mental illness (Alverson, Becker & Drake, 1995; Corrigan & Matthews, 2003; Clair, Beatty & Maclean, 2005; Tregoweth, Walton & Reed, 2012). Research has pointed to a number of benefits of disclosure, such as relieving the stress of secrecy, and allowing the employer to make workplace adjustments to assist the employee (Kirsh, 1996; Basset et al., 2001). However, research reports that the risks of disclosure can be far greater, in terms of stigma and potential discrimination (Krupa, Lagarde, Carmichael, Hougham & Stewart, 1998; Kirsh, 2000; Bassett et al., 2001; Corrigan & Matthews, 2003). Problems surrounding disclosure for employees with panic are extended upon within this thesis.

3.4.2 Coping Techniques at Work

Coping with mental illness has gained attention as a significance areas of research in the mental health field (for example, Plum, 1987; Jacobson & Greenley, 2001; Ridgway, 2001; Cornford et al., 2007). However, few qualitative studies have explored the coping experience within the context of the workplace. Thompson et al.
(2008) described the depressed individual’s desire to stay busy and distracted as a way of coping. Cornford et al. (2007: 362) found that depressed employees coped by “blotting out the experience” through sleep, antidepressant medication or by forcing themselves to carry out social, family and work responsibilities.

Employees with mental illness also describe using cognitive techniques, such keeping a positive outlook and focusing not on the illness, but on recovery, as a way of coping with bad days at work (Alverson et al., 1995; Peckham & Muller, 1999; Cunningham et al., 2000). Maintaining mental and physical health by avoiding substance abuse, using medication and through exercise, rest and nutrition were also utilised as coping strategies (Alverson et al., 1995; Krupa, 1998).

Social support also plays an essential role in a person’s ability to cope and recover from mental illness (Corring, 2002; Sells, Stayner & Davidson, 2004); and as a factor related to employment success (Alverson, Alverson, Drake & Becker, 1998; Kirsh, 2000; Honey, 2002). Research highlights that people with mental health conditions place importance on a “friendly, respectful, communicative work environment with a culture of flexibility and inclusion” (Kirsh, 2000: 27). However, the social relationships that people with mental illness have with colleagues and supervisors has been shown to be harmful, and difficult co-workers can have significant adverse effects on employment (Van Dongen, 1996; Graffam & Naccarella, 1997), including lowered self-esteem (Bedell, 1998).

Minimising stress at work is also used as a coping technique by people with mental illness (Alverson et al., 1995; Van Dongen, 1996; Graffam & Naccarella, 1997; Cunningham et al., 2000; Kirsh, 2000; Peckham & Muller, 2000; Honey, 2002). Honey’s (2002) grounded theory study of 41 users (most commonly, schizophrenic)
of mental health services showed perspectives of employment in unstructured in-depth interviews. She found that many participants avoided stress at work in order to cope and to decrease the probability of becoming unwell. However, the tactics participants engaged in to avoid stress were detrimental to their employment situation, such as sticking to menial jobs with little opportunity for career advancement, decreased work performance, and avoiding job interviews. Even those participants who believed that employment was generally good for their mental health engaged in these types of stress reduction tactics. Honey’s (2002) research has particular relevance to the current study, as people with panic were also found to commonly avoid stress and anxiety to cope with their illness. Thus, employees who have panic attacks may be particularly prone to using stress minimisation tactics in the work environment. This is especially relevant to considerations of the modern workplace where competition, high workloads and pressure are widely prevalent (Scheid, 2005).

The majority of the above organisational studies have collected data from individuals with psychosis, such as schizophrenia (for example, Bassett et al., 2001; Marwaha & Johnson, 2005) and, who have received supported employment services (for example, Honey, 2002, 2003; Marwaha & Johnson, 2005). Although such research provides valuable insight into the employment experiences of employees with mental illness, this narrow focus could mean that additional employment concerns have been overlooked, especially those that relate to employees with panic, working in a competitive, open workplace.
3.5 Summary

This chapter has provided an overview of the wider mental illness literature, as it is rich in discussion about the current issues impacting on mental health consumers in and beyond the workplace. The review had confirmed that living and working with a mental illness is complex and multifaceted, and often has a detrimental impact on the individual’s life. Mental health researchers have examined these subjective experiences from a variety of perspectives, and have used an equally diverse range of methodologies to conduct their research. Studies have typically focused on the understandings of particular social or demographic groups, different aspects of the illness experience, including stigma. However, the majority of this research has focused on the experiences of people with psychosis, such as schizophrenia. By focusing on the lives of people with panic attacks, the nature of the stigma experience for these consumers may be disclosed in new ways.

To begin to understand the work and life experiences of employees with panic, it is important to ask these individuals how they have experienced daily life with panic attacks and the key issues of concern to them. The following chapter outlines the research process that was used to uncover the unique and as yet uncharted experiences of people who have panic attacks.
CHAPTER FOUR

Crafting the Research Design: From Methodology to Methods

4.1 Introduction

The goal of this exploratory study was to understand the lived experiences of employees who have panic attacks, in and beyond the workplace. Qualitative research, from a hermeneutic phenomenological perspective was seen as particularly useful in informing this research endeavour. This chapter sets out the philosophical and methodological choices used in the study and then discusses the complementing methods used to gather and explore the in-depth work and life experiences of those with panic. Special attention was paid to using methodology and methods that were sensitive to the needs of participants, a group that belong to a vulnerable population, such as those with mental illness.

4.2 Revisiting the Research Objectives

The research objectives are “at the heart of the research design”, and fit closely with the methodological framework used in this study (Maxwell, 1996: 49). Before discussion turns to the methodology and methods used, I pause here briefly to revisit the research objectives, which were first introduced in Chapter 1.
The research objectives include:

1. To hermeneutically explore, interpret and discuss the lived experiences of employees with panic, including their personal experiences, in and beyond the workplace;

2. To increase the visibility and acceptance of employees who live with panic;

3. To aid allied healthcare professionals, government policy makers, employers, and academic theorists to understand the experience of panic; and,

4. To share the personal stories of employees with panic, so that others can identify with, learn and reflect on their shared experiences.

4.3 Qualitative Research

Qualitative inquiry allows the researcher to see the world from the emic (individual) perspective, a perspective that is not easily accessible using positivist, quantitative research methods. Qualitative research has gained wide acceptance from the scientific community and is increasingly being utilised in mental health research (Holloway, 1997). Qualitative research is also suitable when the research topic is exploratory or under-researched, such as this research study, as it can access previously untapped data and capture authentic insight, rather than test hypotheses (Richard & Morse, 2007; Griffiths, 2009). Qualitative research shifts the focus from understanding the disease, to understanding the nature of illness-related suffering and impact on daily life (Lundman & Jansson, 2007). Choosing qualitative research for this exploratory study allows for a new and deeper insight into the participant’s day-to-day experiences with panic.
Qualitative research is linked to particular philosophies, methodologies and methods. Methodology bridges the divide between philosophical assumptions and practical and applicable research methods (Liehr & Marcus, 1994). This study was guided by the methodological framework of hermeneutic phenomenology.

4.4 Methodology: Hermeneutic Phenomenology

Phenomenological inquiry seeks to explore and examine individual experiences (Cohen, Manion & Morrison, 2007; Gill, 2014), and to question the way we experience the world (van Manen, 1990). Phenomenology aims to gain a deeper understanding of the meaning or nature of everyday experiences (van Manen, 1990). Hermeneutic phenomenology is a methodological framework that seeks to achieve understanding through interpretation (Hein & Austin, 2001) – a search for what it means to be human (van Manen, 1990). This methodological approach “attends to the apparent and the unseen” (Hilton, 2002: 21). It can bring to light, through interpretation, the personal and authentic experiences of everyday human life (Walton & Madjar, 1999). This complements the aim of this study, which was to explore, understand and interpret the lived experiences of employees with panic attacks. It was also selected because hermeneutic phenomenological accounts of lived experiences can illuminate the “ordinary, the unexpected and the ineffable elements of human experience” (Walton & Madjar, 1999: 1), especially applicable to accounts of health and illness.

The term hermeneutics has been used in ancient and modern times to mean interpretation (Vandermause & Fleming, 2011). This approach became a part of the phenomenological movement of the 1800-1900s, when philosophers, such as Edmund
Husserl, Martin Heidegger, Gabriel Marcel, Jean-Paul Sartre and Maurice Merleau-Ponty began writing about the essence of experience. These philosophers introduced a way of translating the meaning of common everyday experience to writing, which has extended to the current day (Vandermause & Fleming, 2011).

The methodological framework for this study was based largely on the writings and ideas of German phenomenologist Martin Heidegger (1927/1962), who is considered the prime instigator of modern hermeneutics (Annells, 1996). He is credited with developing hermeneutics in order to “clarify under what conditions understanding occurs for the purpose of ontology” (Dowling, 2004: 32). Heidegger’s writing concentrated on the nature of human existence and ‘Being-in-the-world’, which refer to the way human beings exist, act, or are involved in the world (van Manen, 1990). Heidegger (1962: 182; emphasis in the original) used the word *Dasein*, which translated into ‘Being-there’, to refer to human existence itself. To Heidegger (1962), *Dasein*, self and the world are interconnected. His views suggest that although each individual makes their own life choices, individuals come up against history and cultural influences. Thus, from this approach, societies’ understanding of mental illness, including panic attacks, shapes the beliefs of sufferers, their families and clinicians.

Heidegger’s (1889-1976) ideas developed from Edmund Husserl’s work (1859-1938); Husserl was regarded as the father of phenomenology. Although Heidegger and Husserl shared a common concern about the “essence of human experience” (Denscombe, 2003: 104; emphasis in the original), they differed on their underlying philosophical positions. Husserl (1939/1954) believed that phenomenology was
related to everyday conscious experience and that the researcher’s preconceived opinions of the world should be bracketed to enable objectivity in the research.

Heidegger (1962) argued that it was impossible to bracket our assumptions as gender, culture, history and related life experiences prevented an objective viewpoint. Heidegger claimed that through earnest reflection, one might become aware of many assumptions as the researcher acknowledges his/her own background and uses it in collecting and interpreting data. He argued that understanding is a reciprocal activity and proposed the concept of ‘hermeneutic circle’ to illustrate this reciprocity (Koch, 1996). Unlike Husserl, Heidegger maintained that the shared meanings and practices under investigation should not just be described, but should also be interpreted (Benner, 1984).

Hans-Georg Gadamer (1900-2002) followed the works of his mentor, Heidegger, and developed his own philosophical hermeneutics (Annells, 1996). A core principle of Gadamer's hermeneutics, is that all research contains a pre-understanding which originates in the researcher’s historical context. These pre-understandings or prejudices, rather than impeding on the research are an advantage and make the research meaningful to its consumers (Koch, 1995). He described the hermeneutic circle as the fusion of horizons, which is a circular process that involves the joining together of the perspectives or world views of the researcher and the participant in order to gain new understanding (Hein & Austin, 2001). In keeping with this philosophical position, my initial pre-understandings of this research topic were detailed in the Preface, Chapter 1, in which I documented how my personal interest in the research topic developed.
More recently, Max van Manen (1984, 1989, 1990) further developed a hermeneutic approach of phenomenology. Van Manen is known primarily for his concept of lived experience and for developing methodological guidelines for doing hermeneutic phenomenology. His approach follows Gadamer as his philosophy emphasises that language is important for revealing being within historical and cultural contexts, and that our assumptions and pre-understandings cannot be bracketed (Langdridge, 2007). Van Manen’s (1990: 180) research approach is both descriptive and interpretive, in that the descriptive “(phenomenological) “facts” of lived experience are always already meaningfully (hermeneutically) experienced.” Van Manen’s (1990) methodological guidelines have also informed the data collection and analysis.

4.5 Trustworthiness of the Research

The establishment of trustworthiness (Holloway, 1997) was paramount, and ensured that the findings were “worth paying attention to, worth taking account of” (Lincoln & Guba, 1985: 290). For Lincoln and Guba (1985), the basis for trustworthiness involves the credibility, transferability and confirmability or dependability of data.

A qualitative study is credible when its “findings ring true to people and let them see things in new ways” (Karp, 1996: 2002). In phenomenological research this is referred to as the ‘phenomenological nod’ and shows the trustworthiness of research (van Manen, 1990).
Personal Reflections:

I encountered the ‘phenomenological nod’ from many different people over the course of my research – from my hairdresser, to an academic listening to a colloquium presentation of my initial findings. After listening to me talk about the emerging findings from my study, they opened up to me about their own experiences with panic attacks, and confirmed that it was not a subject they openly talked about because of the stigma attached to this condition. During these conversations I found that my research findings resembled their own thinking about their panic experiences. My research had resonated with them. This resonation or ‘phenomenological nod’ confirmed that I had been writing and interpreting text in a way that suggested I was approaching understandings that were shared by others.

To ensure credibility, a number of techniques were built into the data collection and analysis of this study. These included prolonged engagement (Erlandson, Harris, Skipper & Allen, 1993), in which participants were interviewed for an extended period of time (interviews sometimes lasted for up to 2 hours). This allowed trust and rapport to build between the interviewer and the participant (Erlandson et al., 1993), and ensured that more than just “a snapshot of the phenomenon” was obtained (Rossman & Rallis, 2003: 69).

Credibility was also built into this study through peer debriefing. This occurs when a person other than the primary researcher analyses and confirms the data (Lincoln & Guba, 1985). Peer debriefing allows for a fresh perspective for analysis and critique. Findings of qualitative research are strengthened if found to be “plausible” and “meaningful to both participants and peers” (Crossley, 2000: 105). My two research supervisors acted as peer debriefers during analysis.
Qualitative inquiry does not seek generalisability, in which the “findings of a study can be applied to other settings and cases or to a whole population” (Holloway, 1997: 78). Transferability is preferred, and is used to determine the degree to which the findings can be applied to other contexts or participants (Erlandson et al., 1993). To achieve transferability, thick description and purposive sampling were used. Thick description transports the reader into the participant’s world and conveys to the reader a sense of the participants’ feelings, thoughts and perceptions (Holloway, 2008). Purposive sampling also provided rich and specific information as the selection of participants was guided by emergent insights and the relevance to the study.

Trustworthiness was also built into the research through the dependability or consistency of the research process. This means that if this study was replicated with the same or similar participants and in the same or similar context, the findings would be repeated (Erlandson et al., 1993). To ensure dependability, an ‘audit trail’ was maintained, allowing the reader to follow the derivation of any evidence from initial research question to the final conclusion of the study (Yin, 1994). Moreover, the external observer should be able to follow this chain of evidence in either direction, “from conclusion back to initial research questions or from questions to conclusions” (Yin, 1994: 98). Additionally, a journal of all research activities was kept, including my thought process during the research journey.

Theoretical assumptions, biases and methodological choices were made clear, adding to the authenticity and trustworthiness of the research. Delamont (1992: 8) argued that “as long as qualitative researchers are reflexive, making all their purposes explicit, then issues of reliability and validity are served.”
The final standard of trustworthiness for qualitative research is that it be conducted in an ethical manner. To ensure this research adhered to ethical standards, this doctoral research was approved as a phenomenological study by Western Sydney University Human Research Ethics Committee (Approval Number: H6701) (See Appendix 1).

4.6 Ethics: Conducting Research with Vulnerable Groups

Careful consideration was given to the numerous ethical issues that could arise from conducting ‘sensitive research’, which involves participants disclosing behaviours or attitudes that would typically be kept private and personal, and could lead to social censure or respondent discomfort (Wellings, Branigan & Mitchell, 2000). Ethical consideration was also given to researching individuals who were vulnerable due to their life or social situations, as in the case of those who have chronic or mental illness (Nyamathi, 1998); and, marginalized and stigmatized individuals who are on the edge of society (James & Platzer, 1999). In order to protect the participants from harm the following ethical considerations have been anticipated and were addressed in the research design.

Informed consent was a prime concern in this study. Care was taken to ensure that participants fully understood what it meant to take part in the research and that consent was voluntary. After verbal discussion with the potential participant about the nature of the research topic, and with the participants’ permission, a covering letter (Appendix 2), an information sheet (Appendix 3) and a consent form (Appendix 4), which included a full disclosure of the nature of the research and a forewarning about potentially sensitive or emotional topics that could arise at the interview were sent to them. It was also made clear during the initial conversations, and in the consent form,
that participants could withdraw from the study at any time, even if they had already signed the consent form, and that they would not be adversely affected if this occurred (Liamputtong, 2007).

Due to the personal and sensitive nature of the research topic, and because people that have panic attacks can be stigmatised (Liamputtong, 2007), confidentiality and privacy of the participants was imperative. This allows the vulnerable participant to feel secure about speaking up about personal issues that they find difficult to tell people outside the research sphere (Liamputtong, 2007). Pseudonyms were used rather than real names, and any organisation or external marker that could potentially identity the participant were given fictitious or generic names (Melrose, 2002). Pseudonyms and fictitious/generic names were used throughout the research process. Participant’s real names and contact details were kept in a secure file cabinet that only the principal researcher had access to. Intermediaries who connected potential participants with the researcher were only told if contact had been made, no further information was given (Perrone, 2001).

Consideration was also given to “ensure the physical, emotional, and social well-being” of participants (Sin, 2005: 279). Because this research was concerned with participants who have panic attacks, there was a chance that participants could become distressed or have a panic attack during the interview. None of the participants reported having a panic attack during the course of the interview, but a number of participants did become emotionally upset. Sometimes it was anger, at other times they wept during the interview.

When this occurred participants were asked if they would like to terminate the interview, or take a break to rest. All declined, and continued on. Indeed, some of
these participants seemed much more at ease and relaxed after expressing their emotions. The interview process also may have acted as an emotional release for participants. Many had never spoken to anyone outside their immediate family about their panic experiences. All participants were provided with contact details and referrals to a counselling service if they needed further assistance.

An often neglected area in ethical research design is deciding on the researcher’s exit strategy. Marshall and Rossman (2006: 91) argued that “one does not grab the data and run.” The participants had opened up their lives to me, and respect needed to be shown to participants when ending the research relationship. Thus, a “gradual exit” from the research arena occurred so that participants did not feel resentment or a “sense of abandonment” (Marshall & Rossman, 2006: 91). The exit strategy involved talking to and debriefing the participants at the completion of the interview, providing a referral to a counselling service if it was required, and checking up on a number of the participant a few days after the interview, who had seemed particularly emotionally vulnerable during the interview process (Marshall & Rossman, 2006: 91).

### 4.7 Methods

Hermeneutic phenomenological research has no step-by-step method or analytic requirements (von Eckartsberg, 1986; van Manen, 1990). Van Manen (1990: 30) maintained that, “discussions of method and methodology are meant not to prescribe a mechanistic set of procedures, but to animate inventiveness and stimulate insight.” With this in mind, method for method’s sake has been resisted (Bergum, 1991). However, phenomenological and hermeneutic principles have been drawn upon to
inform analysis and bring structure to the study, especially those outlined by van Manen (1990).

4.7.1 Sample Size

The number of individuals participating in the research was kept to 18 participants as the emphasis in qualitative research is on obtaining depth and information-rich data, rather than generalizability (Holloway, 2008). The small sample size suited the purpose of this phenomenological study, as the aim was to illuminate the particular, the specific, and the essence of a phenomenon (Pinnegar & Daynes, 2006; cited in Creswell, 2007). In the initial stages of research design, a pragmatic and flexible approach was adopted when deciding on the sample size (Marshall, 1996). Although a range of between 10 to 25 participants was initially chosen, it was recognised that the number of required participants usually becomes apparent as the study progresses, and new categories and themes stop emerging from the interview texts (Marshall, 1996). After 18 interviews, data saturation was reached.

4.7.2 Selecting Participants

In qualitative research, choosing who to sample is critical (Creswell, 2007), as it has a powerful impact on the overall quality of the research (Coyne, 1997). Purposeful sampling was used to select information-rich cases for detailed study (Coyne, 1997: 624). Criterion-based sampling was also utilised as it “works well when all individuals studied represent people who have experienced the phenomenon” (Holloway, 2008: 212). There were several selection criteria for inclusion in this research study: potential participants had to be 18 years or over; located in Sydney, Australia; self-
identified as having experienced panic attacks; and, had to have been in paid employment when experiencing panic attacks. It was not necessary for the person to be employed at the time of interview.

### 4.7.3 Diagnostic Dilemmas

It was decided to look past medical labels, such as ‘panic disorder’, or ‘agoraphobia’, and focus on the lived experiences of people who had panic attacks. As discovered during the recruitment and field work portion of this study, the symptoms and features of a panic attack were more straightforward and easily identifiable to people, making it easier to find and recruit participants. Indeed, many of the people who participated in my study may not have come forward if strict diagnostic criteria had been implemented.

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**Personal Reflections:**

*From my personal encounters with people who had experienced panic attacks, I perceived that this was a very real and disabling experience that needed further investigation. However I was faced with a conundrum – a panic attack is not classified as a disorder, but is a defining feature of a whole host of different anxiety disorders. I spent weeks considering which anxiety disorder to base my research on, and was faced with the problem of how best to ensure potential participants met strict diagnostic criteria in order to participate. After weeks of uncertainty and little progress, I came to the realisation that I had been focusing too intently on the medicalised categories of anxiety disorders, which had absolutely no bearing on the sufferers’ subjective experiences and problems with panic. This was a phenomenological study that valued individual experience. It was important for the potential participants...*
... to decide for themselves whether their experiences might be relevant. The diagnostic labels used by medical professionals to categorise different anxiety disorders were unhelpful and was confirmed during my interviews. Participants could clearly articulate, in rich detail, the feelings and experiences of living and working with panic attacks. However, many were unsure, confused, or did not care about the medical label attached to their condition. Their panic experiences were very real, ongoing and debilitating, and the label was irrelevant.

During these interviews, I also noted that the confusion over diagnostic labels extended to the participants’ encounters with the medical profession as well. Several of the participants recounted stories in which their GP or mental health professional had used conflicting descriptions and definitions to describe their panic condition.

4.7.4 Locating a ‘Hidden Population’

Potential participants belonged to a group that was marginal, hidden or unwilling to speak openly about their experiences (Bhopal, 2010). Accessing this hard-to-reach population presented a challenge (Liamputtong, 2007: 48). Researchers have advocated the use of the snowball sampling techniques to access vulnerable and difficult-to-reach groups (for example, Lichtenstein & Nansel, 2000; Atkinson & Flint, 2001; Sadler, Lee, Lim & Fullerton, 2010). This means that once initial participants are recruited, they will be asked if they know others who would be likely candidates for the research. This technique was used throughout the interview process, but was found to be only mildly effective. Only one participant was recruited through snowball sampling.

The Modified Chain Referral Technique (Watters & Biernacki, 1989) was also used and involved asking ‘intermediaries’, such as friends and family members to
recommend potential participants (Sarantakos, 1998). Intermediaries were given an information sheet about the study to pass on to the potential participant. Contact details were provided so the potential participant could contact me if interested. This technique was only marginally affective and two participants were recruited this way. Reasons for the limited success could relate to the secretive nature of panic attacks, which meant intermediaries may not have been aware of others with this condition. Potential participants may have also feared that the intermediary would make the connection between the research findings and their personal experiences. To ensure confidentiality, it was made clear to the intermediary that they should not reveal the name of the participant until after they had agreed to take part.

Lastly, working in partnership with the Western Sydney University media coordinator (Appendix 5), the study was advertised on the University’s website, and in several newspapers. This proved to be the most effective recruitment technique. From this, 26 potential participants made enquiries about taking part in the study, and 16 consented to participate.

### 4.7.5 Gathering Stories through Interviews

The interview serves a very specific purpose in hermeneutic phenomenological research (Ajjawi & Higgs, 2007). It allows for the exploration and gathering of stories of lived experiences, enables the participant to share their story in their own words, and is a ‘vehicle by which to develop a conversational relationship with the participant about the meaning of an experience (Ajjawi & Higgs, 2007: 619). Conversational interviewing was used, and resembled an engaged conversation between the researcher
and participant about the meaning of their experiences, during which time both parties reflected on the topic at hand (van Manen, 1990).

Participants were interviewed at a location determined by the participant. Most chose to be interviewed at their homes, a few at their offices, and several at the library or in a private meeting room at Western Sydney University. One participant was interviewed by phone as she was interstate at the time. The interviews lasted between one to two hours and the average interview time was approximately 90 minutes. All of the interviews were audio recorded to allow immersion in the interviews with participants and to remain open to what was being said.

Privacy and confidentiality were reemphasised at the beginning of the interview. It was made clear to each participant that the interview process would cease immediately upon their request. Conversational style interviewing meant that developing a rapport with each participant was essential. Rapport occurred by engaging in general conversation prior to the formal interview starting, and answering any questions they had about the interview process with honesty and openness. To ease participants into a more formal conversation, the demographic details (Appendix 6) were collected first.

Hermeneutic phenomenology means staying close to the experience as lived by the participant (van Manen, 1990). To do this, the participant was asked to think of specific examples, situations events or instances that would reflect their experiences to the fullest (van Manen, 1990). Sample prompt questions included (See Appendix 7):

- Have you had a panic attack at work before? Is there a particular situation that stands out for you?
• Can you tell me what happened when you first started experiencing panic attacks? How did you feel?
• Can you think of a situation where your panic attacks have presented a challenge or limited you at work?

At the end of each interview handwritten field notes about my early thoughts and interpretations of the interview data were recorded. Observations about important non-verbal behaviours, such as facial expressions, gestures, and bodily tone were also noted. For example, it was noted how one participant’s hands started to shake during the telling of a particularly traumatic experience, or another, who began to cry while telling her story. Data from these observations allowed for a richer insight into the meaning of the participants’ oral comments and gave for a more accurate interpretation of their experiences.

All interviews were transcribed verbatim and these transcriptions, along with the field notes and participants’ demographic details, comprised the text that was used for data analysis.

4.7.6 Data Analysis

In keeping with the methodological framework guiding this study, data analysis methods drew on phenomenological and hermeneutic principles to structure this research study, especially those outlined by van Manen (1990). He suggests that a phenomenologist should conduct a thematic analysis to determine the themes, which can be viewed as written interpretations of lived experience (Sloan & Bowe, 2014). So in the application of hermeneutic phenomenology it is essential to examine the text, to reflect on the content and isolate themes that reveal something “telling”,
something “meaningful”, something “thematic” (van Manen, 1990: 86). Van Manen (1990) maintained that there are three ways to isolate thematic aspects of a phenomenon. The holistic approach which asks what phrase captures the fundamental meaning or main significance of the text as a whole; the selective approach which asks what phrases or statement seems particularly revealing about the phenomenon or experience; and finally the detailed or line by line approach in which every sentence is examined to see what it reveals about the phenomenon.

Interview transcripts were read and reread in order to hermeneutically interpret the text for the meaning of everyday experience with panic attacks. The immersion process involved questioning the meaning of the text and what it revealed about the experience of living and working with panic attacks. Initial emerging themes were isolated using van Manen’s (1990) holistic and selective reading approach. In this way, key phrases and sentences were identified that captured the fundamental meaning of the text as a whole, as well as the phrases that were essential in revealing the experience being described. These key phrases were underlined and clustered into emerging themes and sub-themes. Also extracted were meanings and assumptions in the participants’ stories that participants themselves may have had difficulty in articulating (Ajjawi & Higgs, 2007). As van Manen (1990: 130) eloquently states, “phenomenological text succeeds when it lets us see that which shines through, that which tends to hide itself.”

Having identified the initial themes, the stories were again re-read with a view to discover the stories that might best illustrate each of these themes. During this reading, aspects of the stories that did not seem to be captured by the initial themes were noted. Consideration was then given to the extent to which the initial themes
embraced these recently revealed phrases or statements. This led to a revision in the way the themes were being described.

The isolation and interpretation of themes were considered along with the text as a whole, which constituted the ‘hermeneutic circle’ (van Manen, 1990; Smith, Flowers & Larkin, 2009). This meant frequently stepping back from the specific details of the key parts, and looking at how each of the parts contributed towards the overall design of the study. Cycling between the parts and the whole also prevents getting “buried in writing” and enables the research to move forward (van Manen, 1990: 33). The ongoing thematic analysis detailed here led to the development of the phenomenological model described in the next chapter.

4.8 Summary

This chapter described research design decisions that guided this study. Firstly, the study’s research objectives were revisited and the reasons for conducting research from a qualitative, hermeneutic phenomenological perspective were detailed. Trustworthiness and the ethical considerations of conducting research with vulnerable groups were discussed. The final section of this chapter focused on the research methods used to recruit participants, and collect and analyse the data. These methods were partly informed by the hermeneutic phenomenological principles outlined by van Manen (1990). Conversational interviewing was shown to be a rich source of phenomenological material, and thematic analysis revealed something of the meaning of living and working with panic attacks. The following chapters describe the findings that emerged.
CHAPTER FIVE
Facing Adversity: Living with Panic

5.1 Introduction

This is the first of three findings chapters. It commences with an overview of the phenomenological model that illuminates the phenomenon of living and working with panic. The participants are then introduced, and details of their personal and working lives are provided. Finally, the chapter explores the first overarching theme of the phenomenological model – Facing Adversity: Living with Panic – which identifies the hardships experienced by those living with this condition. These hardships have been reported as four distinct but interrelated themes, including: A Changed Life, Being Alone, Living with Stigma, and Living with Loss.

5.2 The Phenomenological Model

The phenomenological model arose from the thematic analysis discussed in the previous chapter. The model is presented here, and in the following two chapters, and features three overarching or core themes, which are outlined in Table 1 (p. 67). The first overarching theme, discussed in this chapter – Facing Adversity: Living with Panic – develops an understanding of the hardship and implications of living with panic. Participants shared their efforts to make sense of the difficulties that panic has brought to their lives. The second overarching theme, discussed in Chapter 6 – Struggling with Organisational Life: Working with Panic – widens the interpretive
lens to consider the experiences and implications for people working with panic. Again, adversity, but this time, workplace adversity, is central to the participants’ narratives. The final overarching theme, presented in Chapter 7 – Moving Beyond Adversity – highlights the participants’ experiences of developing a resilient self through the adversity experienced. The themes and sub-themes discussed in this study are not separate entities and should not be viewed in isolation; rather, they reflect aspects of the whole experience of living and working with panic. For this reason, similar interconnected elements appear in a number of themes and sub-themes. For example, the concept of stigmatisation is reflected in the themes Living with Stigma, Being Alone, and, “A Real Battle”: Surviving the Workplace.

5.3 An Introduction to the Participants

Before turning to the findings, it is useful to pause here and reflect on the very different life and work experiences of the fifteen women and three men who took part in this study. At the time they told their stories, the oldest participant, Hattie, was 71 years old, and the youngest, Hannah, was in her early twenties. There were married participants, divorced participants, mothers, fathers, grandparents, and those without children (see Table 2: 68). The education and employment details of participants were also wide-ranging and spanned a diverse range of occupations, industries, education levels and employment positions (see Table 3: 69). Interestingly, although participants qualified to take part in this study if they had experienced at least two panic attacks in their lifetime, it became apparent from their stories that panic was not an isolated experience, but a chronic condition that shaped their lives.
### Table 1: The Phenomenological Model

<table>
<thead>
<tr>
<th>Overarching Theme</th>
<th>Theme</th>
<th>Sub-theme</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A Changed Life</td>
<td>A Seismic Shift</td>
</tr>
<tr>
<td></td>
<td></td>
<td>A Creeping Change</td>
</tr>
<tr>
<td></td>
<td>Being Alone</td>
<td>Withdrawing From the World</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Thrown into the Wilderness”: Professional Non-Support</td>
</tr>
<tr>
<td></td>
<td>Living with Stigma</td>
<td>Seeking Legitimacy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Get Over It!”: Shame, Blame and Personal Failings</td>
</tr>
<tr>
<td>CHAPTER 5:</td>
<td></td>
<td>Stigmatisation and Family Relationships</td>
</tr>
<tr>
<td>Facing Adversity:</td>
<td>Living with Loss</td>
<td>A Restricted Life</td>
</tr>
<tr>
<td>Living with Panic</td>
<td></td>
<td>Loss of Control</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“If this is Living I’d Rather be Dead”: Profound Suffering</td>
</tr>
<tr>
<td>CHAPTER 6:</td>
<td>“Pushed Over the Edge”: Work Triggers</td>
<td>Bullying and Mobbing</td>
</tr>
<tr>
<td>Struggling with</td>
<td>Career Concerns</td>
<td>Pressures of Work</td>
</tr>
<tr>
<td>Organisational Life:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working with Panic</td>
<td>“A Real Battle”: Surviving the Workplace</td>
<td></td>
</tr>
<tr>
<td>Disclosure at Work</td>
<td>Disclosure at Work</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Negative Responses</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Positive Workplace Support</td>
</tr>
<tr>
<td>CHAPTER 7:</td>
<td>Developing Resilience</td>
<td>“Learning to Live with It”: Acceptance</td>
</tr>
<tr>
<td>Moving Beyond Adversity</td>
<td></td>
<td>Enhanced Knowledge and Understanding</td>
</tr>
<tr>
<td></td>
<td>Positive Self-Changes</td>
<td>Social and Professional Support</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Finding Comfort</td>
</tr>
<tr>
<td></td>
<td></td>
<td>A Healthier Lifestyle</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Personal Growth</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“A Wake-up Call”: Re-evaluating Life Priorities</td>
</tr>
</tbody>
</table>
Table 2: Participants’ Personal Details

<table>
<thead>
<tr>
<th>Name</th>
<th>Gender</th>
<th>Age</th>
<th>Marital Status</th>
<th>Length of time with panic attacks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audrey</td>
<td>Female</td>
<td>57</td>
<td>Separated or Divorced</td>
<td>6 years</td>
</tr>
<tr>
<td>Charlotte</td>
<td>Female</td>
<td>24</td>
<td>Single</td>
<td>“As long as I can remember.”¹</td>
</tr>
<tr>
<td>Chloe</td>
<td>Female</td>
<td>26</td>
<td>Single</td>
<td>10 years</td>
</tr>
<tr>
<td>Faye</td>
<td>Female</td>
<td>59</td>
<td>Married</td>
<td>7 years</td>
</tr>
<tr>
<td>Grace</td>
<td>Female</td>
<td>56</td>
<td>Married</td>
<td>1 year</td>
</tr>
<tr>
<td>Hannah</td>
<td>Female</td>
<td>25</td>
<td>Single</td>
<td>6 years</td>
</tr>
<tr>
<td>Hattie</td>
<td>Female</td>
<td>71</td>
<td>Married</td>
<td>56 years</td>
</tr>
<tr>
<td>Helen</td>
<td>Female</td>
<td>56</td>
<td>Separated or Divorced</td>
<td>9 years</td>
</tr>
<tr>
<td>Jacqueline</td>
<td>Female</td>
<td>51</td>
<td>Married</td>
<td>6 years</td>
</tr>
<tr>
<td>John</td>
<td>Male</td>
<td>47</td>
<td>Married</td>
<td>33 years</td>
</tr>
<tr>
<td>Lauren</td>
<td>Female</td>
<td>36</td>
<td>De facto</td>
<td>7 years</td>
</tr>
<tr>
<td>Lily</td>
<td>Female</td>
<td>47</td>
<td>Single</td>
<td>4 years</td>
</tr>
<tr>
<td>Lucy</td>
<td>Female</td>
<td>23</td>
<td>De facto</td>
<td>7 years</td>
</tr>
<tr>
<td>Mack</td>
<td>Male</td>
<td>57</td>
<td>Married</td>
<td>7 years</td>
</tr>
<tr>
<td>Maya</td>
<td>Female</td>
<td>42</td>
<td>Separated or Divorced</td>
<td>“A very long time.”</td>
</tr>
<tr>
<td>Ruth</td>
<td>Female</td>
<td>57</td>
<td>Single</td>
<td>1 year</td>
</tr>
<tr>
<td>Steven</td>
<td>Male</td>
<td>45</td>
<td>Married</td>
<td>15 years</td>
</tr>
<tr>
<td>Wendy</td>
<td>Female</td>
<td>53</td>
<td>Married</td>
<td>41 years</td>
</tr>
</tbody>
</table>

¹ Charlotte and Maya were unable to recall the length of time they had been living with panic attacks. However, they both confirmed their affliction with panic had been with them for many years.
<table>
<thead>
<tr>
<th>Name</th>
<th>Education Level</th>
<th>Employment Industry</th>
<th>Employment Status (Employed/Unemployed, Retired etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audrey</td>
<td>Trade or Vocational Degree</td>
<td>Health Care</td>
<td>Temporary employment, Part-time</td>
</tr>
<tr>
<td>Charlotte</td>
<td>Trade or Vocational Degree</td>
<td>Education</td>
<td>Employed, Full-time</td>
</tr>
<tr>
<td>Chloe</td>
<td>Completed High School</td>
<td>Arts</td>
<td>Temporary employment, Full-time</td>
</tr>
<tr>
<td>Faye</td>
<td>Post Graduate</td>
<td>Education</td>
<td>Employed, Full-time with reduced hours</td>
</tr>
<tr>
<td>Grace</td>
<td>Trade or Vocational Degree</td>
<td>Education</td>
<td>Employed, Full-time</td>
</tr>
<tr>
<td>Hannah</td>
<td>Trade or Vocational Degree</td>
<td>Service Industry</td>
<td>Employed, Full-time</td>
</tr>
<tr>
<td>Hattie</td>
<td>Completed High School</td>
<td>Service Industry</td>
<td>Retired (Previously self-employed)</td>
</tr>
<tr>
<td>Helen</td>
<td>Post Graduate</td>
<td>Education</td>
<td>Employed, Full-time</td>
</tr>
<tr>
<td>Jacqueline</td>
<td>Trade or Vocational Degree</td>
<td>Health Care</td>
<td>Early Retirement (Previously temporary employment)</td>
</tr>
<tr>
<td>John</td>
<td>Trade or Vocational Degree</td>
<td>Computing/Technology</td>
<td>Employed, Full-time</td>
</tr>
<tr>
<td>Lauren</td>
<td>University Degree</td>
<td>Education</td>
<td>Employed, Full-time</td>
</tr>
<tr>
<td>Lily</td>
<td>Post Graduate</td>
<td>Education</td>
<td>Temporary employment, Part-time</td>
</tr>
<tr>
<td>Lucy</td>
<td>University Degree</td>
<td>Arts</td>
<td>Employed, Full-time</td>
</tr>
<tr>
<td>Mack</td>
<td>Completed High School</td>
<td>Police Services</td>
<td>Early Retirement, with Police Pension</td>
</tr>
<tr>
<td>Maya</td>
<td>University Degree</td>
<td>Public Administration</td>
<td>Employed, Full-time</td>
</tr>
<tr>
<td>Ruth</td>
<td>Commenced High School</td>
<td>Manufacturing</td>
<td>Unemployed (Previously temporary employment)</td>
</tr>
<tr>
<td>Steven</td>
<td>Trade or Vocational Degree</td>
<td>Education</td>
<td>Employed, Full-time</td>
</tr>
<tr>
<td>Wendy</td>
<td>Completed High School</td>
<td>Service Industry</td>
<td>Employed, Full-time</td>
</tr>
</tbody>
</table>
The participants’ life and work experiences may have varied widely, but it became apparent that when living with panic, all participants shared the experience of ‘facing adversity.’ This chapter depicts the adversity experienced by participants, and will be discussed below.

5.4 An Introduction to Adversity

The first overarching theme – Facing Adversity: Living with Panic – was an experience shared by all participants. Facing adversity meant confronting the difficulties and hardships of living with panic. Participants revealed their subjective experiences as they attempted to convey and make sense of these difficulties. Through their stories, a picture emerged of how adversity was experienced by the women and men of this study.

Adversity, which is “the state of hardship or suffering associated with misfortune, trauma, distress, difficulty, or a tragic event” (Tugade & Fredrickson, 2004; cited in Jackson, Firtko & Edenborough, 2007), was experienced by the participants in several unique ways and has been reported as four distinct but related themes.

The first theme, A Changed Life, acknowledges that the participants’ initial panic experiences were extremely disruptive and traumatic. These early experiences shattered participants’ previous understandings and ways of being in the world. The confusion and uncertainty attached to the initial stages of illness also added to the adversity experienced. This theme also serves to introduce the panic experience to the reader. The second theme, Being Alone, considers the suffering that participants experienced as they simultaneously withdrew from the world and reached out without success to the medical profession for support. The third theme, Living with Stigma,
recognises that participants faced adversity in their lives as a result of the stigma associated with panic. Participants struggled to have their illness recognised as authentic; confronted the stigmatising attitudes of family and friends, and also had to cope with the shame and embarrassment that resulted from self-stigma. Finally, the last theme, *Living with Loss*, was identified by participants as an integral part of the adversity they experienced. Loss was multi-faceted and affected participants on several levels. Previous taken-for-granted aspects of life, such as the control of bodily functions, and the normal experience of everyday living now eluded participants; this led to feelings of sorrow and despair, and even suicidal ideations. The table below provides an overview of the themes in this chapter.

<table>
<thead>
<tr>
<th>Table 4: Themes presented in Chapter 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHAPTER 5: Facing Adversity: <em>Living with Panic</em></td>
</tr>
<tr>
<td>A Changed Life</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Being Alone</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Living with Stigma</td>
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<td></td>
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<tr>
<td></td>
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<tr>
<td>Living with Loss</td>
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<td></td>
</tr>
</tbody>
</table>

5.5 **A Changed Life**

As participants shared their stories, it became evident that, for many, the peak of suffering occurred during the early stages of illness. One possible reason why participants might have identified this period of time as being particularly traumatic
was because it marked the moment when their lives were irrevocably changed and all
their previous assumptions and understandings of their being in the world were
shattered. Audrey confirmed: “the initial period was so devastating.” Chloe
concurred: “the first couple of years were pretty bad.”

For some, this changed life occurred at the same time as other negative life events.
For example, several participants stated that workplace bullying and/or excessive
work and life demands had contributed to their first panic attack. These experiences
are expanded upon in Chapter 6. The following sub-themes explore the shift to a
changed life as experienced by participants during the early stages of illness. The
participants’ stories indicated that the transition from wellness to illness could occur
as A Seismic Shift, or A Creeping Change.

5.5.1 A Seismic Shift

Many of the participants were able to give poignant and detailed descriptions of their
first experience with panic, even years after it had occurred. They shared their
experience as one of great trauma, and as being unlike anything participants had
experienced before. It also signified the significant, even seismic, shift in their lives,
from wellness to chronic illness, and marked a sharp, unwelcome and unheralded
shift to a life fractured by uncertainty, fear, and stigma. The significance of this life-
changing event was shared by Helen who, almost a decade later, easily recalled
minute details of her first panic attack:

And I thought I was going to die that night. That was on the 16th of
June 2000 ... Five o’clock in the night – Friday night. I was standing
in the rumpus room.
These memories were so painful to Helen that she “used to dread coming up to the anniversary.” Although the pain of this memory seemed to have dulled for Helen, over time, she had come to the uncomfortable realisation that she was still emotionally connected to this event and confessed that “nine years later you shouldn’t be able to [remember] that.” Wendy’s narrative also confirmed the magnitude of her initial panic experience in changing her life: after forty-one years she was able to vividly recall the particulars of her first panic attack:

My first panic attack, I was in sixth class. So, I would have been twelve … And this class was really noisy … and everybody was screaming and yelling and shouting. And all of a sudden I felt like I was having an out-of-body experience … It was like I was on the outside looking into something. And, ah, [clears throat] the more I sort of thought about it the worse it got. And I turned around to my girlfriend who was sitting next to me … and I said to her, “I think I’m going mental.”

During her sharing of this memory, Wendy’s emotions showed clearly on her face and through her voice: her voice shook, she coughed to clear her throat, and her eyes appeared glassy, as though she were on the verge of weeping. Such was her experience of illness onset as a seismic shift, and her past experience was so vivid and pressing, that even after all those years, she appeared to relive it while describing it.

I would also draw attention, here, to the capacity for a phenomenological model to allow for alternative experiences within an identified theme. Within the sub-theme of a Seismic Shift, while still experiencing swift recognition of what was happening to her, Lily depicted a slightly different experience. She confidently asserted that when her panic attacks first occurred, she “knew immediately what they were.” When asked how she knew, she replied:
I think I’d just always known about what panic attacks were because I’ve had … this backdrop of generalised anxiety disorder, and also a friend of mine has panic attacks, so I knew about them from him as well. Yes.

What is significant about Lily’s slightly different experience is that, although Lily knew immediately what was happening to her, it took her three months to seek help. She did not confirm why she was reluctant to seek help from a health professional. However, one possible explanation might be that Lily felt ashamed of her condition, having previously been stung by the discrediting comments and delegitimising actions of those around her.

The above stories illustrate that the initial panic experience can manifest as a sudden and abrupt event, immediately thrusting participants into a changed life. However, not all participants experienced this transition as a swift and sudden shift, as the next sub-theme reveals.

5.5.2 A Creeping Change

For several participants – Steven, Audrey and Grace – the shift into illness occurred more gradually, but no less profoundly. It was a Creeping Change in their lives, and was characterised by being insidious, sneaking up on participants, being unnoticed initially, and then thrusting them into a life with panic without them feeling they had a chance to gather themselves and respond. Audrey explained her experience of this creeping life change: that she went through a period of “gradual realisation” before understanding that she had a problem with panic, and that it had “snuck up on [her], more or less.”
Grace also remarked that her problems with panic “started out slowly and [she] didn’t recognise it at first.” She continued her story of creeping change, stating that it “sort of gradually built up from [physical tension] ... but it just got worse and worse and worse.” Similarly, Steven also recalled that panic started to creep in to all aspects of his life: “[panic] started to creep into my driving and then catching a train and stuff like that.” Steven’s comment, in particular, illustrates how sufferers can begin to fear having panic attacks in situations or places that had previously been perceived by them as non-threatening. This creeping change meant that for them, panic, and all the associated, fear, uncertainty and challenge it brought could creep into any aspect of their lives, sometimes without them even noticing. However, regardless of how their initial path into illness commenced – as a seismic shift or a creeping change – these early experiences marked the beginning of what they described, over and over, as a traumatic life, a life facing adversity.

The creeping change to a life of panic was also filled with a high degree of confusion and uncertainty; many participants struggled, at first, to understand what was happening to them. They also spoke of the confusion they experienced when first trying to interpret their ambiguous and misleading symptoms. This uncertainty and confusion intensified the trauma participants felt during the early stages of illness; many participants also reported travelling a long and circuitous journey before receiving appropriate medical support. Mack confirmed that, for him: “The not knowing was the biggest problem.” The lack of clarity about the illness and its prognosis then created further confusion for them, as well as feelings of self-blame, preoccupation with their panic, and was characterised by reported feelings of frustration, even despair. Indeed, the “deluge of ambiguity often becomes as debilitating as the illness itself” (Boss & Couden, 2002: 1352).
Almost every participant described an initial stage in their lives with panic during which they had no vocabulary for naming their problem. It was not unusual for participants to go for long periods of time – months, or even years – without realising that the distressing mental and physical symptoms they were experiencing were panic attacks. Twelve of the eighteen participants expressed these particular concerns. The associated confusion and uncertainty was exemplified by John, and Mack:

My first experience [with panic], I didn’t know what was happening. I can remember that. I couldn’t understand the feeling that I was getting … the feelings were really hard to explain, and terrible. (John)

My main concern was trying to find out what was wrong with me, because I didn’t know … I’d never ever seen anybody have a panic attack … I’d never heard of it ... So I didn’t know what was happening to me. So, in that initial [period], probably for three months, I thought, “I don’t really care what happens to me, at the moment, I just -, I need to know.” (Mack).

Many panic symptoms, including chest pain, palpitations, shortness of breath and paraesthesia (numbness or tingling) can mimic a wide variety of different physical medical conditions (Taylor, 2000). As a result, many participants misinterpreted the symptoms that they were experiencing. For example, Hannah initially believed that the “shortness of breath” she experienced during a panic attack was a sign that she was having an asthma attack, an illness she had been diagnosed with in previous years:

Like I said, when I first got [a panic attack] I just chalked it up to asthma, because I had no idea what a bloody panic attack was. I just put it into a really bad case of asthma.

During her initial stage with panic Chloe also came to the conclusion that the tremors and shakes that afflicted her as a result of her panic attacks had another cause, perhaps related to ageing:
Because I have a nerve tremor as well, and I just thought it must have been a physical thing that I’ve got as I’ve got older.

Several participants misinterpreted the physical symptoms they experienced during their initial panic attack as signs of heart failure. Mack, Faye and Steven were all admitted to a Hospital Emergency Department with suspected cardiac failure. For four months Mack and his doctors “were quite convinced it was [his] heart” that was causing his dizziness, chest and arm pains. Faye commented that, during her panic attacks, “my heart just feels like it wants to leap out of my chest.” When asked if she knew she was having a panic attack she replied:

No, I didn’t know it was a panic attack. I had no idea it was a panic attack. I come from a family that’s just riddled with heart disease and I thought that I was having a heart attack … So [the Emergency Department staff] had me in a [hospital] bed with all sorts of things attached to me. And I was there for about … five hours, and they said, “Well, we can’t find anything.”

The panic experiences of the participants who thought they were suffering from heart problems must have been particularly terrifying, as they perceived their symptoms to be life threatening. For Mack especially, the not-knowing about his panic attacks pushed him to the edge of despair, including the contemplation of suicide:

Prior to [finding out] what was wrong with me … I was out there. If I needed to go out and jump in front of a bus, I probably would have.

Mack’s comment is especially useful in vivifying the depth of suffering that panic sufferers can experience, especially when their panic condition remains undiagnosed. However, it is Audrey’s story that really highlights just how difficult it is for people with panic attacks to recognise the physical symptoms of panic when they first occur. The reason her case is of particular interest is that Audrey is an enrolled mental health nurse who manages the care of in-patients with panic disorders and other mental
health conditions. Even with her expert professional knowledge of the condition, and its symptoms and presentation, Audrey initially failed to recognise the signs of her own first panic attack; instead, interpreting her sensations as a “physical thing” resulting from her being overweight. With hindsight she realised: “Looking back, they were classic panic attack signs.” Following, is an extract from the interview with Audrey, showing this mental health care professional – with over four years’ experience – being unable to make sense of her own panic symptoms:

**Interviewer:** When you started having the panic attacks did it dawn on you that they were [panic attacks]? …

**Audrey:** [Slight pause] No, not immediately, I wouldn’t say. No. Because … when you’re shaking, and when you’re sweating, and when you’re hyperventilating, you immediately look for a medical physical illness. And you go through the whole process of what you could have and couldn’t have, and I think it’s a gradual realisation … So no, initially it didn’t [dawn on me] as soon as I had one. I didn’t think, “That’s what it is!” No. It snuck up on me, more or less.

Audrey’s response was particularly troubling because it showed a mental health nurse, who regularly has to “talk [patients] through a panic attack” having difficulty identifying accurately her own panic symptoms, such is their propensity to baffle and confuse even experts in the field. Her comments emphasised that, even experts in the field of mental health can have difficulty recognising the phenomenon of panic attacks.

### 5.6 Being Alone

The theme *Being Alone* considers the suffering participants reportedly experienced as a result of being alone with their illness. During analysis, it became apparent that one significant aspect of this experience of aloneness is the deliberateness of choices made
by many participants that resulted in ensuring their isolation. Many participants withdrew from the world and those around them, deliberately, creating a physical, emotional, and/or psychological space that isolated them (and their panic) from other people. Paradoxically, and also explored in this section, is that participants did not like being alone and frequently reached out – without success – to medical professionals for support. The lack of support they reported subsequently receiving when they did reach out then amplified their sense of isolation and, many reported that they felt they were struggling through their illness very much on their own.

Participants commonly used vivid metaphors to convey their sense of isolation, alienation and disconnection from other as a result of living a life with panic. Many of these metaphors shared a striking similarity:

It was like I landed on Mars, and had no idea who I was, where I was, or why I was here. (Hattie)

I felt strange – alien; like I was on a new planet. (Faye)

I was walking home, I felt quite strange and quite alien to everybody. (Wendy)

The sense of isolation and disconnection that was reportedly felt by participants was not only conveyed by the use of such metaphors, but was evident in the narratives of all participants. Feeling that they were alone with their panic was one of the most common reported struggles faced by those living with panic. Evidence of these experiences is presented below within two sub-themes Withdrawing from the World, and “Thrown into the Wilderness”: Professional Non-Support.
5.6.1 Withdrawing from the World

This sub-theme highlights that during the worst episodes of panic, it was common for participants to deliberately isolate themselves from others, and from the world around them. It was not that these participants lacked having people in their lives, or were not wanted by others – indeed, many participants confirmed the love and support of family and friends. Rather, participants felt incapacitated by the crippling effects and overwhelming feelings of panic and anxiety, and consciously organised their lives in order to separate themselves from spaces and/or people that they perceived as threatening to their fragile mental state.

Many participants isolated themselves by withdrawing to the perceived safety of home. Hattie’s narrative exemplified one of the most extreme cases of this. During her darkest days with panic, Hattie’s panic kept her imprisoned in her home for over four years. She described this isolated period in her life:

I spent three years where I didn’t go out my front door or my back door. I spent four years where I couldn’t get to the letter box, and I couldn’t get to the clothes line. Nobody could do anything about it.

While not as debilitating or as protracted as Hattie’s experience, retreating to the perceived safety of home was frequently reported by other participants. To deal with the overwhelming nature of the panic experience Grace reported that she “sort of went to bed and pulled the covers up for a while” and that, “I was really almost confined to the house, because I just didn’t want to go anywhere.” During Audrey’s darkest time, she took leave from work, and also isolated herself in her home:

I’d isolate. Take to my bed and stay there when I had that period off work. Take to my bed; watch TV; try and distract myself.
During periods of extreme anxiety, both Chloe and Lily reported staying at home and avoiding contact with others. Both reported not answering the telephone when they felt really anxious, not wanting to communicate with anyone. Chloe conceded that, “I’ll actually not answer my phone for entire days.” Chloe also admitted:

The more they ring me, the more I don’t want to answer the phone, and I start getting anxious about not having answered their phone call.

The paradox here is that Chloe’s isolation rendered her at once relieved, and also distressed; the more she tried to “shut out” the world, the more anxious she became. The telephone calls were a constant reminder to Chloe of the challenges provoking her anxiety that waited for her on the outside world. The paradox of the isolation experience was also felt, and confirmed, by other participants. Steven tried to explain his apparently contradictory experience: “It’s a feeling of [being] isolated and not wanting to be isolated.”

As well as staying confined to the home, considerable effort was reportedly directed by participants towards avoiding people, places and situations that might aggravate, or trigger, their panic. However, living a restricted life then intensified subsequent feelings of isolation. This isolation held particular significance for the young adults in this study, who placed great importance on meaningful social interactions. Lucy and Chloe, both in their early twenties, described having to restrict their social activities because of panic. Chloe’s frustration with the limits panic placed on her social life was clear; when Chloe was asked if panic had restricted her life outside the workplace, she exclaimed:
Yes, yes, yes! Definitely, in terms of social activities – especially those involving food\textsuperscript{2}, which would tend to freak me out. I'd just avoid going because I didn't want to put myself in the situation of panicking.

Lucy shared similar frustrations, and was unhappy about having to restrict her social activities. She also felt that such a disabling condition set her apart from her young friends because they were able to continue with activities that she felt she no longer could:

Because it’s a hard thing, you know, when you’ve been a really social person, to really change your lifestyle to a point where you actually have to stop at x-amount of drinks; and you can’t have caffeine; and you can’t go out partying all night, and that sort of thing. And it’s hard when all your friends still do that as well.

Lucy reported feeling a sense of being ‘other’ which resulted in her feelings of alienation from her friends who she described as still taking part in “normal” activities that she couldn’t. Charlotte’s narrative also exemplified this sense of social isolation and feelings of ‘otherness’ that a young adult in her twenties might feel as a result of the limitations arising from this illness. When asked what impact panic had had on her social life, she joked:

Oh, I know what that means! [Laughs] I’ve never really had one. I do know what that means, yes. I’d never been to a club – as in a nightclub. I get invited: My friends say, “Oh, we’re having a birthday party,” and I’m like, “No, no. I couldn’t handle the crowds” … I couldn’t handle the trip in and all that kind of stuff. I mean back when I was in school even going to the movies was almost off limits.

While Charlotte might have used humour to try and make light of her situation, her sense of despair and aloneness were palpable during interview. Later in the same interview, Charlotte confirmed just how devastating these social restrictions had been.

\textsuperscript{2} Chloe’s anxiety and feelings of panic were particularly intense when eating in public.
on her life. She revealed that she felt: “Depressed; incredibly depressed. Incredibly disappointed.” Of interest, such comments were in stark contrast to her behaviour during our interview, where she appeared deliberately upbeat: laughing and joking, and often downplaying the seriousness of her illness. Charlotte appeared to be trying to keep her ‘otherness’ invisible, perhaps due to being adept (and well rehearsed?) at wearing a ‘mask’ of normality for others, where she acted well and unaffected by any anguish she may have been experiencing. However, remarks such as the one above, revealed glimpses of a different reality, one including real distress and alienation. Proffering a ‘mask’ of normality and concealing their ‘otherness’ was a common response from participants, particularly when discussing experiences in and around their work setting. This workplace phenomenon is detailed in Chapter 6, in the sub-theme Working Behind a Mask.

Almost all participants perceived themselves as being very much alone; that they were the only ones experiencing such frightening and strange symptoms. Grace voiced this feeling by stating: “I was just in it and inside myself.” Lucy described a similar reality: “It would just feel like it’s me and my head, and all the thoughts that are going through it, and I can’t stop them.” Feeling alone in their reality was very distressing for participants, as it increased their sense of ‘otherness’ and isolation. Some, like Helen, wondered if they were losing their minds:

I thought I was the only one in the world that felt like this … so you were very on your own, and that made it very scary too. Because I thought I was losing my mind. I really thought I was going crazy … I didn’t know if I was going to die, scream, or just lose my mind.
5.6.2 “Thrown into the Wilderness”: Professional Non-Support

Compounding the participants’ sense of isolation was the paucity of information and resources available to them about panic attacks, as well as a lack of felt support from the medical profession. Many participants felt abandoned by those in the medical profession; that they needed to respond to any consequences of their illness on their own. Concurrently, they felt compelled to defend the legitimacy of their illness, even to medical professionals – who participants believed should have better understood the condition and its implications.

The lack of information, resources and professional support available to participants was also evident in the frequency of stories describing a protracted journey to diagnosis. For example, Hattie recalled that “They didn’t really know what to do about it back then, in ’57, ’58.” She explained that it took “four or five years” to get answers about her illness, and she likened her experience to being “thrown into the wilderness.” The latter comment from Hattie was a particularly illuminating metaphor, conveying the sense of isolation many participants experienced as a result of not having adequate information and support. Being in “the wilderness” vividly portrays an experience of being lost, and separate from others, and her use of the verb “thrown” suggests Hattie felt, not just ignored or disbelieved, but rejected by those in the medical profession. Disconcertingly, the challenges faced by Hattie over five decades ago were still being reported by participants with more recent panic experiences. Many participant stories focused strongly on the experience of having their illness symptoms dismissed by health professionals and living, for months or even years, with the debilitating outcomes of panic attacks before finally receiving appropriate care. Chloe, a twenty-six year old, admitted to struggling alone with her
panic for ten years, reluctant to seek help due to feeling “silly” and embarrassed about her condition. Finally, when she found the courage to bring her condition to the attention of her General Practitioner (GP)\(^3\), they then “sort of brushed it off.” This insensitive action (or inaction) by her physician confirmed in Chloe’s mind the illegitimacy of her illness; she admitted that, after this occurred: “I never brought it up [with my GP] again.” Similarly, it took Lucy five years to get a confirmation of a panic disorder diagnosis from her GP. During this time, she was treated for depression, but “the anxiety part of it wasn’t recognised.” Lucy’s comment illustrated how a health professional gave more legitimacy to her depression rather than her anxiety symptoms.

Chloe’s experience, in particular, highlighted how a dismissal by a clinician can reinforce a person’s decision to subsequently keep their condition hidden, thus hindering their recovery, and contributing to that person’s ongoing sense of isolation as a result of not having the opportunity to share their experiences with other people. This is especially true for those that already struggle with the shame and stigma that can be associated with panic.

Steven also recalled having his panic attacks dismissed by those in the medical profession, and felt that he was left to make sense of his illness on his own. He recounted his experience of going to the Emergency Department, after suffering (and unknown to him at the time) a panic attack, and the hospital staff saying to him, “There’s nothing wrong” and sending him home in a taxi. It was months after this event, when flicking through a self-help book on panic attacks at a bookstore, that

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\(^3\) In Australia, a General Practitioner (GP) provides person centered and continuing whole-person health care to individuals and families in their communities (The Royal Australian College of General Practitioners, 2011).
Steven came to the realisation that he was experiencing panic attacks. He recognised his symptoms in the pages of the text:

No one told me anything until -, I think I was at a bookshop and I saw an American book or something like that and I thought, “Well that's what I get.”

Disconcertingly, the participants’ sense of isolation was magnified by a sense of being judged and delegitimised by those in the medical profession. Judgements were observed in various forms, and led to feelings of shame and humiliation, and a reluctance to seek further help. For example, Wendy, who first started experiencing panic as a child, felt that her integrity was under attack from her medical practitioner, as he questioned her motives for being ill. She recalled:

He had no idea ... And he said to me, “You’re only doing it for attention” … And I said, “No I’m not. I don’t care what you say; I’m not doing it for attention.”

Helen also encountered negative judgements from her GP, a man she had relied on and trusted for her health care for over twenty years. Helen’s faith in him was shattered as a result of his response; she felt he had abandoned her as he began to treat her differently because he believed her illness was psychological rather than physical:

He was just a nightmare, he made me feel worse ... He wasn’t comfortable in anything psychological or emotional. He was good at cutting up, and diagnosing, all sorts of other things. He didn’t know how to care. He couldn’t empathise; he couldn’t make me feel safe. I had no confidence in him … At my lowest ebb … all he wanted to do was send me to a psychiatric hospital. And that was one of my biggest fears.

Although she eventually found a “kind” doctor who made her “feel normal”, the actions of her former GP had a lasting impact. Two years after this event and still
feeling very strongly about her perceived injustice, in a chance encounter, she confronted her former GP about the way he had treated her. She elaborated:

I said, “Do you realise what damage you did to me? … Now I think you’re a fabulous diagnostic physician, but you’re hopeless at psychological injuries. Don’t do this to somebody else, because you’re not good at it.”

Helen’s narrative illuminated the difference in care she received from a previously trusted GP, and exemplified her experience of how a trusted and “fabulous” medical practitioner could turn her life into a “nightmare”. Similarly, Wendy was scathing of the mental health care system in Australia, and summed up many participants’ experiences:

I really feel mental health is not addressed properly in this country, in particular. And we don’t support people with mental health enough, and I just don’t believe that people have the capacity to have that total understanding, and look at you the same way without saying, “Oh she’s mad.”

It must be noted again, that the phenomenological model requires us to report the subjective experiences of those who have lived the phenomenon (Vickers, 2001). This allows, and sometimes even demands, the highlighting of differing experiences – sometimes diametrically opposed, within the same reported theme in order to bring a richer understanding of the life-world of those involved. Not all participants had a negative experience with the medical profession during their diagnostic journey; several commented on the fantastic medical healthcare they received.

The reported experience of isolation also stemmed from participants feeling as though they were in an information vacuum regarding their condition. They reported having difficulty locating information and resources about panic attacks. All participants expressed almost identical concerns about the struggles they encountered when
attempting to obtain answers to their questions about panic. The lack of information, they felt, hindered their ability to understand and manage their illness, and also intensified their sense of being alone. Mack confirmed: “Unless you go and see a psychiatrist, I don’t think there’s much help out there at all.” Similarly, Hannah acknowledges that panic and anxiety disorders are “in the media a bit more – but, no, there is no information on how to deal with it.”

Three participants commented that there was more information available to those who suffered with depression, compared to panic or other anxiety disorders. Helen confirmed:

I was looking for help. I was looking for support structures. I was looking for something. I mean beyondblue wasn’t even around then. There were things for depression, but I didn’t have depression, I had anxiety, and that was very different. I mean I had friends who couldn’t get out of bed; I couldn’t get out of bed quick enough. [Laughs] They wanted to be left alone; I didn’t want to be left alone. It was almost opposite poles. And I couldn’t find anybody; I couldn’t find anything or anyone who understood this.

Helen’s narrative confirmed her confusion, and need for useful informational support and how the lack in this area made things worse for her and reinforced her ambivalence with regard to wanting, on one hand, to reach out to others, while concurrently withdrawing from the world.

Some participants also claimed that the lack of access to appropriate healthcare, information and resources, contributed to the severity of their illness. For example, Steven believed that his recovery was hampered because he was not able to find appropriate professional support:

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4 beyondblue is an Australian not for profit organisation that aims to provide awareness, prevention and early intervention of depression, anxiety and other related disorders.
But I think if there would have been better facilities available I probably would have been able to get out of it a lot quicker. Maybe I just wasn’t looking in the right places, I don't know.

However, in the same breath, Steven then went on to blame himself for not finding the appropriate support. This narrative illustrated how a lack of information, resources and support can perpetuate a participant’s feeling of self-blame, possibly leading to self-stigma and a loss of self-worth. Maya also felt that if she had known earlier that what she was experiencing were panic attacks, she would not have struggled as much, especially in her role as a mother:

But I think it did affect me a lot; and I feel that I could have been, maybe a better mother, if I had known what these things were. Because it’s not really publicised a lot.

Again, Maya’s comment highlighted how the panic experience can negatively impact on a participant’s sense of self. Without access to appropriate healthcare and information, many participants had to do battle with their illness alone; and as illustrated, endured a long and unnecessarily difficult journey. The following theme *Living with Stigma*, explored participants’ struggle to defend themselves against the stigmatising responses of partners, family and friends.

5.7 Living with Stigma

This theme explores the participants’ experience of stigma. It became evident from their narratives that panic was a heavily stigmatised condition. Their shared stories demonstrated that either subtle or overt stigmatisation had occurred. Frequently, the participants’ condition was delegitimised, which is an “experience of having one’s perceptions of an illness systematically disconfirmed” (Ware, 1992: 347). These negative responses often evoked feelings of shame, self-stigma, inadequacy, self-
blame and low self-esteem. Participants encountered stigmatisation from health professionals (as discussed previously in Being Alone); from their social networks, or their significant other (to be explored in the theme Stigmatisation and Family Relationships); and, from work colleagues and employers (examples of workplace stigma and discrimination are detailed throughout Chapter 6: Struggling with Organisational Life: Working with Panic.

5.7.1 Seeking Legitimacy

More than half of all participants reported that the people in their lives did not recognise panic attacks as a legitimate illness, and that their experiences were routinely questioned, trivialised or disconfirmed. For example, John was told that that his panic attacks were “just like a cold” and that “everyone gets anxiety. That’s just when you’re having a bad day.” While it was suggested to Hannah that her panic attacks were “like a headache.” Comments like these were dismissive and suggested that their panic attacks were not indicative of a legitimate illness, but rather, participants were imagining symptoms or needlessly exaggerating normal, everyday complaints (Japp & Japp, 2005). The inference that participants were fabricating or embellishing the authenticity of their experiences, in itself, becomes a challenge to the participants’ moral integrity. This was echoed by Chloe who remarked:

Because they don’t understand that it’s actually a genuine thing that I’m going through … they don’t take what I’m going through seriously. And in essence, they don’t take me seriously.

Consequently, many of the participants reported a continual struggle to convince or remind others that their illness was real and debilitating. As Lauren said, people “...don’t know how horrible panic attacks really are.” Steven confirmed that “others
consider panic to be such a minor thing ... but people like us have to fight to get back to being normal.”

Not surprisingly, the perceived uphill battle to convince others of the authenticity of their illness, left many participants feeling frustrated, and sometimes angry. For example, Steven resented that he had to “keep telling people” that he had panic attacks, as “they just normally forget that I’ve told them.” The exasperation was evident in his voice as he explained:

I would think that when you tell them something like that that they wouldn't forget … Even now, I still have a friend that I cycle with, and he'll sometimes have a go at me for not driving out to his place. He always comes to my place if we go for a long ride. And I go, “Damn dude! Don’t you remember? I can't.”

Not only do participants like Steven have to deal with the debilitating consequences of a life-altering illness, but they do so without the comfort of validation – the validation that they’re suffering is real and deserves to be recognised by family and friends. For Steven, and indeed, many of the participants, having their illness delegitimised and their moral credibility questioned, led to frustration, shame, self-doubt and alienation (Japp & Japp, 2005). This concept is explored in the next sub-theme.

Mack also felt the burden of proving that his suffering was real. He faced suspicion from his friends and ex-work colleagues in the police force, who said “Oh, he’s putting it on.” To defend himself against the charge that he was embellishing his suffering, Mack distributed educational pamphlets on panic attacks, which he found at a chemist, to those that doubted him:
I’d give them a pamphlet about panic attacks, and I said, “Just have a read of that and that’s what I’m going through. And then see if you can understand a bit.”

As Mack continued his narration, it was revealed that his friends did become more understanding of his suffering. However, the measures Mack took to ‘prove’ his illness were real, confirmed the difficulties people with panic encounter when trying to convince others that their experiences are authentic – that they are not merely moaning, imagining symptoms, or maladaptive.

5.7.2 “Get Over It!”: Shame, Blame and Personal Failings

Many participants faced ridicule, blame and charges of moral weakness. This led to feelings of shame, which results from attacks on, and loss of, social status (Gilbert, 1997). These shaming experiences led many participants to become acutely self-conscious of their panic attacks, and inwardly focused on personal deficits and perceived inadequacies, leading to self-stigma. For participants, shaming often involved being ridiculed when disclosing their panic attacks to others: Charlotte recalled that during the last year of high school her two close friends laughed at her after she disclosed her condition to them; Jacqueline reported that she was affectionately known as “loony Jack” by a group of her friends who knew of her condition. This did not seem to concern her (she laughed while recalling the details), and she insisted her friends were well-intentioned. However, of concern here is that Jacqueline unwittingly accepted her friends’ derogatory and stigmatising label without question. Chloe was also met with ridicule and remarked that her adult “brother thinks it’s hilarious.”
The narrative accounts of those interviewed also exposed the perception that participants were in control of their illness, and responsible for causing panic attacks. For example, participants had to frequently shield comments that implied they should and could *decide* not to have panic attacks. Faye was told by her sister “*to get over it!*” Hattie was informed to “*snap out of it*”; Charlotte was told: “*Oh, get over it – suck it up*”; Mack was asked “*Why don’t you get over it?*”; while, Lily was told to “*get a grip.*” The perception of many that panic was something that could be controlled and stopped at will was a source of frustration for the participants. As Faye remarked, “*It’s not a thing you just get over. It’s not very helpful at all.*” These stigmatising reactions by others, again, served to discredit the participants. These responses inferred that participants were flawed – they were weak, incompetent, or lazy. This was confirmed by Lily:

I actually think a lot of people just don’t *get* it. I just don’t think they *get* panic attacks. They don’t *get* anxiety … I think in some ways, it’s seen as something that you can control, and that if you don’t, you’re either lazy or you’re weak. You’re defective in some way.

These discrediting responses were also confirmed by a further six of the eighteen participants, who all discussed how others regarded them as having a character flaw. Mack, John, and Lauren all reported being ridiculed, and were called “*stupid*” or “*silly*” because of their panic attacks. Chloe felt others perceived her to be “*more highly strung and, I guess, prone to being a bit weaker.*” Faye agreed, and stated:

There’s a perception out there that you *can* control them. So if you’re having panic attacks and you’re losing control – you’re a bit dopey.

For Lauren, her panic attacks were used overtly by another person to discredit her. This person attempted to convince Lauren’s (now) husband that as Lauren had a
mental illness, she was defective and unstable, and that he should reconsider his decision to be with her. She explained:

Well his ex-wife actually rang [my now husband] and said, “Do you realise that she suffers from depression and anxiety, and she has to take medication? Do you realise what you’re doing?” And I just thought, “There is a stigma.” … It’s this stigma that you are mental, or that you’re going to fly off the handle at any time or something.

Faye, John, Steven and Mack also experienced the hurtful assumption that they were fictionalising their struggle with panic attacks to garner sympathy or attention. For Faye, there was the perception from some of her colleagues that she was making up her condition to attract sympathy:

And other people were thinking “This is just Faye telling another story so we’ll all feel sympathetic towards her.” So, I don’t tell people.

Again, because panic was seen as a discrediting attribute, Faye made the decision to conceal her illness. This tactic was not unique to Faye. Indeed, concealment was frequently used by many of the participants in the workplace to protect themselves from being disadvantaged due to the stigma associated with panic attacks. This is discussed further in Chapter 6, in the sub-theme *Working Behind a Mask*.

In sum, participants frequently reported having their credibility questioned, and were often dismissed, denigrated, ridiculed, or laughed at. These painful experiences confirmed that panic is a heavily stigmatised condition that often left participants feeling shameful and alone. The next sub-theme strengthens these findings, and discusses how even the participants own family members delegitimised their illness.
5.7.3 **Stigmatisation and Family Relationships**

Family networks remain the primary source of social support in times of illness (Ell, 1996). However, of concern here, is that many of the participants reported receiving inadequate or misguided support from family members or significant others due to the stigmatisation of panic attacks. These unsupportive family interactions were particularly devastating for participants, and deprived them of an important coping resource. For some, disclosure had even led to rejection, estrangement, or the disintegration of intimate relationships. Indeed, five participants had since divorced or separated from their partners. This sub-theme considers these negative family and spousal responses, and the impact on sufferers.

Traditional support networks often involve the family network. However, for some participants, the stigmatising nature of their panic attacks meant that their family or significant other denied them the recognition that their suffering was real and, as a result, withheld support or sympathy. These unsympathetic encounters served to compound the participants’ sense of alienation and feelings of shame and low self-esteem, as they felt that they could not even rely on their families for affirmational support. This was true for Grace, who was living in a home where family members refused to talk about her panic attacks. Grace surmised that the reasoning behind her husband and children’s silence was due to boredom:

> No, I just think they’d be bored [laughs]. They’d just be bored with it. Because they wouldn’t really understand, and it’s like, “Yes we know about it. Why are you telling me?” But I don’t think they know how I

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5 I don’t wish to suggest that panic was the sole reason for these relationships ending. It is possible that these relationships were under stress before the onset of illness. Further research would be useful to specifically address the potential role of panic attacks on relationship breakdowns.
feel; what happens. They just know that I get upset and I run away [laughs]. That's all they really know.

Although Grace laughed at her family’s disinterest, possibly in an attempt to normalise the lack of support she received, it still failed to deflect the disappointment and hurt in her voice. The lack of empathy and the unwillingness of Grace’s family to take her illness seriously highlighted how much her panic condition was devalued by those closest to her. In effect, her family denied her the recognition that her suffering was real and therefore she was not entitled to sympathy or support. These actions further undermined Grace’s moral legitimacy.

Helen also spoke in-depth about the lack of affirmational support and understanding she received from her (now) ex-husband. Helen’s narrative indicated that her then husband had little patience for the suffering she experienced and, instead, was frustrated with her and her condition. This exacerbated Helen’s already fragile sense of self, as she had to defend the legitimacy of her illness:

Well my ex-husband used to say to me, “I’m tired of walking around you on egg shells.” [Pause] Egg shells? Get in this body and see what it feels like! You’ll know what egg shells are. I sometimes used to feel like I was pieces of paper all stuck together, and that’s how I felt – so fragile, that they could easily just break. It was just like I was just glued together – very fragile.

Audrey’s then husband, not only failed to provide her with support or sympathy but also “disregarded” the credibility of her illness. Instead of support, Audrey encountered cynicism and derision from her then husband. For example, even when Audrey pleaded with him to help her during the middle of a panic attack, he did nothing, except to question the validity of her experience, which in essence, meant that he questioned Audrey’s integrity and honesty:
I said “Look, I need to go to a doctor and get a Valium injection or something, because I’m having a panic attack.” And my ex-husband said, “What have you got to panic about?” And he just disregarded it like he does with everything else.

Lily’s panic attacks were also discredited by her then partner. After disclosing her ongoing health issues with panic and anxiety, he was unable to accept the validity of her condition and so ended the relationship. Lily reported:

I have disclosed it to a partner and um, ah, that went against me … He ended up ending the relationship and using [my panic attacks] as one of the reasons … He didn’t understand it because he hadn’t experienced it. And he didn’t seem to be able to make that mental leap that it is a real condition or an illness that affects me sometimes – he didn’t seem to be able to make that mental leap.

The rejection by her partner had a significant impact on Lily’s self-identity and her ability to trust others, and led to self-stigma. During her interview, she mentioned on several occasions that she felt “defective”; she was also careful to conceal her illness from others:

…and basically since this situation with my partner, I think it’s very unlikely that I’m going to disclose it very much to anyone.

The delegitimation of the participants’ illness experience by close family members revealed an overwhelming sense of disappointment and rejection. These feelings were apparent in Lily’s narrative, as she spoke of having to cope with the hurtful assessments and lack of support from her immediate family:

… they don’t have any understanding or compassion with that sort of an illness. They just think it’s a weakness … They certainly don’t see it as any sort of legitimate illness … It’s sad, that these people – who you’re related to by blood – that they don’t accept or have any concern or compassion or acceptance of it as an illness.
Lauren also had trouble convincing her mother of the validity of her panic experiences. Like Mack, Lauren gave her mother “lots of literature to read” because if she tried to talk to her mother about her panic attacks, her mother would respond with “you’re just being silly. How ridiculous.” Again, the difficulty and frustration of convincing a family member of the legitimacy of panic was illustrated in Lauren’s account. Although she pleaded with her mother to learn more about her illness: “Just read it. Just read this. Just so you can understand it all”, her efforts were to no avail. Lauren admitted that her mother “hasn’t even read it. I think she just chucks it.” These unsympathetic encounters with her mother damaged their relationship, and Lauren admitted that they don’t talk as much anymore. To have her own mother delegitimise and ignore her suffering must have been particularly upsetting for Lauren, as parental support, even in adulthood, provides comfort and confirmation of worth.

Living with panic meant that many participants were no longer able to carry out activities they once enjoyed. By association, this restricted life often extended to the partner of the participant. Participants felt guilt that their partners were also burdened with their illness. They also reported feeling anxious that this would damage their intimate relationships. For example, Lauren feared that her husband would leave her because they no longer could have “fun” and share their favourite pastime – kayaking – due to her recent fear of being on the water: “I think if I can’t do all these things, is [my partner] actually going to stay with me because of the fact that we can’t do anything together? I don’t know.”

Wendy also reported that the restrictions that panic attacks imposed on her life made it difficult to maintain intimate relationships. Wendy reported that she “broke up [her]
relationship because [she] didn’t want to make excuses all the time about not going out.” She also “didn’t have relationships” for a long time because she “didn’t want to burden anyone with it.”

These narratives have highlighted the damage that panic attacks can have on a person’s relationship with family, friends and partners. Additionally, not being able to rely on family members for affirmation and practical support may have possibly exacerbated the participants’ feelings of aloneness, low self-worth, self-stigma, hopelessness and grief.

5.8 Living with Loss

Participants identified loss as a significant part of the panic experience. This theme explores the losses that the participants felt most keenly in their lives. These included the losses associated with a restricted life, and the loss of perceived control. Participants indicated that these multiple losses were accompanied by feelings of hopelessness and grief, and in extreme cases, thoughts of suicide.

5.8.1 A Restricted Life

Participants admitted that their lives were irrevocably altered by panic attacks. As Mack confirmed, “life will never be the same ... it has affected my whole life.” Their altered reality meant restrictions on the things they could do and experience. Wendy commented that her “radius of going out became smaller and smaller” and Faye noted that her life “had become really sectioned off.” The loss of previous taken for granted routines and activities was a significant concern for participants. Before they were ill, many led active lifestyles: playing sport, pursuing hobbies, travelling,
participating in family activities and socialising with friends in and out of the workplace. All that changed. This loss engendered feelings of frustration, anger and grief, as everyday activities such as driving, and grocery shopping were actively avoided. For example, Steven expressed frustration that driving and windsurfing had become activities that he no longer felt comfortable doing. He added:

I was frustrated, because I'd been a person - , I was bit of a free spirit. Once I got my licence when I was young, I used to love driving and just getting away. I liked that freedom. So, yes, I kind of miss that. And I miss the freedom of being able to just jump on a surf board and surf all day, or go windsurfing or something like that.

Steven’s comments also indicated that these restrictions had become a reminder of the loss of freedom and independence in his life. Driving, in particular, represented choice, freedom, and independence. Since his panic attacks, Steven was only able to drive certain distances and familiar routes. This loss of freedom had a major impact on his life. His narrative also indicated that the panic experience can lead to a loss of carefreeness and exuberance for life.

Panic had stopped Lauren from kayaking, which had been a large part of her and her partner’s lives:

I kayak, and I love kayaking and now I can’t even get on the water, on a boat. I actually had one panic attack on the water, so now I can’t even get back on a boat.

Participants, such as Lauren found it particularly difficult to accept that feelings of panic had become associated with previously enjoyable and carefree activities. Lauren admitted that she would “like to go back to the way [she] was” before panic attacks, as life “was more fun and fulfilling before ... now I basically don’t do anything because I don’t know what’s going to happen.” In addition, not being able to share her
pastime with her partner was a significant loss for Lauren. And she admitted that it “upsets her ... and that was something we did together all the time.” By association, Lauren’s partner also felt the loss of their shared hobby. Lauren, as well as other participants felt guilty that their illness impacted on the lives of their loved ones. For example, Grace expressed remorse that she was unable to fully participate in her children’s lives as they were growing up because of panic attacks:

I still avoided crowds, and avoid a lot of noise and things like that. So, even when the kids started school and they had their school discos and things like that, I would take them to the door, but I wouldn’t go in, whereas, a lot of other mothers would go in and stay. But I just couldn’t because of the noise and lots of people … perhaps if I hadn’t got sick, I would have been more involved in my kid’s school and things like that.

As a result of living a restricted life, participants frequently spoke of the loss of opportunities, dreams and experiences. One of the most poignant examples of this loss is embodied in Hattie’s narrative, who mourned for all the things she missed out on during her many years with panic:

They really took control of my life by the time I was 21 – and here I am 71. I still haven’t seen the Opera House and I know I’m not going to see the Opera House. Darling Harbour – when Johnny Cash came out here – I wished. I was in love with Johnny Cash. But then you've just got to be thankful that you can see and hear and walk and talk.

Hattie’s narrative illustrated how much of her life had been governed by panic. Her comments also showed how restricted her life had been and she had not ventured very far from her local area because of panic attacks. As shown by her comments, this had huge ramifications on her life experiences, dreams and goals. Many other participants lamented the loss of dreams and opportunities because of panic. For example, Wendy mourned that she was not as “adventurous as [she] would have liked to have been.

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[She] would have loved to travel and [she] hasn’t.” While Lauren felt that she had lost her chance to have a second baby because of her panic attacks.

Like one thing I did want to do was have another baby, but looking at the way I am, whether that would be a good idea or not. And my partner said, “How would you cope?” Like that’s his sort of big thing, he just worries, because he’s seen me have a panic attack and whatnot, and he doesn’t know how I’d cope. And then I sort of think back to what I was like with [my first born] and think, “Oh, how would I?”

5.8.2 Loss of Control

Another central concern for participants was the perceived loss of control that came with having panic attacks. The panic attack symptoms made many feel that they were losing control of their minds and bodies, while the restrictions that panic attacks imposed on the participants made them feel controlled by their illness. Paradoxically, the more participants felt controlled by their panic attacks, the more they attempted to control every aspect of their lives in order to avoid having a panic attack. This resulted in a loss of spontaneity, a loss of a carefree life, and constant monitoring of symptoms and thoughts.

Participants felt that they were losing control of their minds and bodies. Many no longer felt comfortable in their own skins, and did not trust how their thoughts and their bodies would react in certain situations. This was often very frightening for the participants, and most described a time when they thought they were going to die, go crazy, or insane. Their stories reverberated with evidence of this mental anguish. Some exemplars of the symptoms consuming and overwhelming the participants are shared below. Chloe felt unable to control her breathing, and thought she was going to die:
I couldn’t breathe and felt the outer-body thing, and really, really thought -, the heart palpitations and all that sort of thing. I thought I was going to die.

Wendy didn’t know whether she was going to die or lose control of her mind:

It’s because you get into that very frightening mind set, that you just think, ‘This is it. This is going to be -, I’m going to die this time.’ [Laughs] Or I’m going to be totally -, I’ll go so psychotic I’m going to end up being mental. And I think that’s what the most frightening thing is – that fear that you’re never going to come out of it sane again. I don’t know why I have this thing that I’m going to end up being insane.

Helen shared her distress of not being able to control her body, or get away from those feelings and sensations:

You’re not going crazy. But that’s what it felt like … It’s hard to describe. But it’s like you just aren’t in control of anything – you can’t control your mind, your body. You just can’t do anything … it’s a horrible feeling. Everybody looks for safety somewhere and the trouble is the fear is in you and you can’t run away from yourself. You just can’t get away from it.

Participants also felt a sense of powerlessness that panic attacks had taken control of their lives and dictated the places they could go and the things that they could do. For example, Hattie believed that panic attacks had taken away most of her choices in life:

If I had my choice I would have loved to have done a whole lot of different things but that’s not the way my life has gone. I really had no choice in anything. I chose the man I married and that’s as far as I got.

Normal activities that were once carried out with relative ease and little thought, now required considerable planning, and were approached with dread and apprehension. The participants needed to run through various scenarios in their heads before leaving home to ensure they did not encounter a scenario that would trigger a panic attack. Some planned exit strategies in case they became anxious and felt the urge to escape.
And previously enjoyable activities became a test of endurance. For example, Faye’s “day to day life has become very structured, so [she] knows what [she’s] doing when and why.” John’s comments illustrated the oppressive and insidious way panic attacks had taken control of his life. His every movement was governed by fear:

Well, I constantly have to consider the positions I’ll put myself in, and avoid those positions. I mean it’s something that’s on my mind from the time I wake up in the morning, until the time I go to sleep at night. Like, if you said to me, “Oh, let’s go somewhere pleasant, somewhere nice.” I’d say: “How are we going to get there?” “We’re going on a bus.” “Is there going to be a lot of people on the bus?” [Grimaces and then laughs].

John and Faye’s comments illustrated how being controlled by panic attacks led to a loss of spontaneity and feeling carefree. Jacqueline also confirmed how her panic attacks resulted in a loss of spontaneity:

[Long pause] Yes, I have to stop and think about things that I’m doing a lot more. I can’t be spontaneous or anything, so that’s a major impact.

Participants who felt that they were losing control of their lives, mind and bodies were hyper vigilant in monitoring any bodily sensations and thoughts that could signal the start of a panic attack. As Helen described:

But I’m very good at monitoring myself now. I do a scan [laughs loudly]. This sounds crazy doesn’t it? I do a body scan. I do! [laughs] It’s funny talking about it. But I do. I physically will sit there and think, “Mm, like my shoulders feel tight”, or I’ll feel sick in the stomach, “Oh okay what’s going on.” I’m very cautious of monitoring myself.

Lucy also discussed how she would monitor and assess how she was feeling when the anxious thoughts began:

So I guess it has made me a lot more aware. I'll feel anxious and I'll be like, “Okay, why am I feeling anxious? What's led to me this feeling?”
And then I'd go “Okay, that's why I'm anxious. Well, that's an okay reason to be anxious. So, I shouldn't let this feeling take over.”

These narratives show how participants based many of their life choices and decisions on avoiding scenarios that could lead to panic. Unfortunately, this meant that they lived restricted lives, in which their choices were controlled by their illness. This loss of control, both real and perceived would have been a major adjustment for participants, and combined with the often devastating symptoms of panic attacks, led many to mourn for their previous lives, and express feelings of hopelessness, despair and even thoughts of suicide. These darkest moments in the participants’ journey with panic are discussed in the sub-theme below.

5.8.3 “If this is Living, I’d Rather be Dead”: Profound Suffering

The participants’ narratives revealed the depth of their suffering as a result of the mental torment and debilitating impact of panic attacks. Sorrow, grief, and hopelessness were emotions that participants reported feeling during their lowest moments with panic attacks. At this point in their lives, participants felt that they had nothing positive to look forward too, and that their lives were not going to improve.

Chronic sorrow was frequently experienced by participants. For example, Wendy remarked that from the moment of her first panic she “never viewed life the same. It’s almost like there was a gloss taken off my life.” Similarly, Faye’s joy of living was also altered as a result of having panic attacks. She remarked that she “didn’t laugh as much as [she] used to” and admitted that she was a “harder” person since having panic attacks. Audrey’s comment emphasised the extent of her pain by describing
living with panic attacks as “so encompassing, so black, and so debilitating ... it just absolutely crippled you.”

In the midst of illness, some participants expressed feelings of hopelessness. They felt that their life was always going to involve pain and suffering and would never improve. John’s narrative illustrated this sense of hopelessness and emphasised how bleak he perceived his future to be:

It makes you pretty miserable. But when you’re pretty miserable anyway [slight laugh], you’re not expecting it to get any better … I’d say it’s a fine balancing act between just keeping yourself sane and ah, comfortably numb [slight laugh].

So immense was the depth of their suffering that four participants thought about suicide as a way to end the pain. At her lowest point, Helen felt that suicide was the only way to end her suffering:

And I remember thinking I cannot live like this forever. If this is living, I’d rather be dead … I couldn’t live in a constant turmoil of fear. I couldn’t live like that. With those fears being there constantly, day and night, never turning off, and being afraid inside your own skin, afraid of everything. I mean it was ridiculous. How could you live like that forever? It would have been too painful. It was a painful experience.

Several other participants remarked that they had thought of suicide during their most painful moments with panic attacks. Mack commented that if he “needed to go out and jump in front of a bus, [he] probably would have.” While, during Wendy’s “absolute breakdown”, she “had no will to live.” The participants’ descriptions of suicide ideation serve to establish the severity of their condition and immense suffering. As Cox (2012: 152; emphasis in the original) confirmed, suicide is an “indicator of extreme distress because the lived experience of suicide is profoundly
distressing: suicide tends to occur during periods of acute emotional torment and is also a distressing symptom in and of itself.”

Although these participants gave descriptions of suicide ideations, none indicated that they had planned or attempted to take their own lives. For these participants, their descriptions of suicide ideation were often framed as an effort not to commit suicide, as evidenced in Helen’s comment:

I was having the most horrible, black thoughts. I thought I was going to kill myself. And I was terrified. I didn’t want to kill myself.

This section has highlighted the seriousness of panic, and the suffering it can bring about. Participants experienced sorrow, despair and hopelessness because of the major life changes, losses and restrictions that resulted from this condition. For some participants, the distress was so great that they thought of suicide. This concerning finding has spotlighted the possible life threatening consequences of panic attacks.

5.9 Summary

The findings in this chapter have highlighted the adversity that people with panic attacks confront in their day-to-day lives. The stories revealed that panic attacks were a profoundly distressing experience. This was particularly apparent during the early stages of illness, especially before a diagnosis became known. The findings affirmed that a significant aspect of the panic experience is that of isolation and struggling through their illness on their own. A paradox emerged within this theme: it was discovered that participants deliberately withdrew from the world, and at the same time reached out – without success – to the medical profession and others for support. Participants also revealed that they were subject to stigmatising attitudes and
prejudices from those in the medical profession, and from family and friends. Frequently, their condition was delegitimised, and they were subject to ridicule, and accusations of moral and personal failings. This led to feelings of shame, low-self-esteem, self-stigma, and isolation. Lastly, it was discovered that loss was a significant aspect of the panic attack experience. Loss was felt due to the restrictions on previous taken-for-granted activities. Participants also reported a loss of control over their lives, their minds and their bodies. These multiple losses led many to feel hopelessness and chronic sorrow. Significantly, four participants reported suicide ideation as a way to end the pain. These findings have indicated the severity of the suffering that panic attacks can inflict on the individual. The next chapter continues discussion on the struggles that people with panic attacks face in their lives, however, it does so within the context of the workplace.
CHAPTER SIX

Struggling with Organisational Life: Working with Panic

6.1 Introduction

This chapter explores the participants’ experiences of working with panic. The women and men in this study reported significant employment challenges, and struggled to survive organisational life with panic attacks. This first theme “Pushed Over the Edge”: Work Triggers reveals that many participants linked the onset of panic with poor working conditions. The second theme Career Concerns explores the impact of panic on the participants’ career progression and job security. Difficulties commuting to work proved to be a major employment obstacle. The third theme “A Real Battle”: Surviving Work highlights the strategies participants used to enable them to continue working with panic. These strategies often had a detrimental impact on their well-being. The final theme Disclosure at Work reveals incidents of participants’ lives being made more difficult at work because of panic. Participants reported being disparaged, discriminated against, and bullied as a result of the disclosure of their condition. Only a few participants reported receiving workplace support after disclosure. Table 5 on the following page provides a summary of the chapter themes and sub-themes.
Table 5: Themes presented in Chapter 6

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6.2 “Pushed Over the Edge”: Work Triggers

The narratives revealed that a large number of participants believed that toxic workplaces and poor working conditions had contributed to the onset or exacerbation of their panic condition. Contributing factors reported by participants included: workplace bullying and mobbing; the stress of working in a high pressure and demanding work environment; and, failing to manage the competing demands of work and home. Theses contributing factors are discussed below.

6.2.1 Bullying and Mobbing

This sub-theme explores the participants reported experiences of being bullied or mobbed at work, which they felt led to the onset or worsening of their panic symptoms. Workplace bullying involves “situations in which employees are subjected to repeated, persistent negative acts that are intimidating, malicious, and stigmatizing” (Lewis & Orford, 2005: 30). Mobbing describes the nonsexual harassment of a coworker by other workers that is designed to force the target out of the workforce.
(Duffy & Sperry, 2007). Workplace bullying has increasingly being acknowledged as a major workplaces stressor in Western society, and can negatively impact on a target’s mental and physical health (Ishmael & Alemoru, 1999; Matthiesen & Einarsen, 2001; Zapf & Einarsen, 2001; Lewis & Orford, 2005).

The relationship between workplace bullying and panic emerged when participants were first asked about their workplace experiences with panic attacks. Unprompted, seven participants reported that they were bullied by a coworker or manager and this had triggered their initial panic attack. For example, Jacqueline confirmed she had been bullied by a senior staff member:

Definitely. Definitely! I felt like she was always riding me – always. Nothing I ever did was ever good enough – even when I helped her out … She used to take my ideas and tell everyone they were hers and run to the boss and get the credit for it … and then she’d pick on me for the stupidest thing … So definitely, I think she was the trigger.

Ruth, a factory worker, was also bullied by her Line Manager:

I mean her mannerism was enough to scare anybody. And I mean she was half the reason why I ended up with the panic attacks. Because, it was her attitude – her attitude was so lousy, and so was the way she treated people.

Workplace bullying became so traumatic for some participants that they reported having panic attacks when physically approaching their workplace. Grace began having panic attacks when driving to work:

And that’s when I found that I’d get to work and couldn’t get out of the car park; or I’d get out of the car park, walk down the [path], and I’d find it hard to actually walk in; or I’d walk in and have to walk out again, and all that sort of business. Oh, it was terrible! And it got so that as soon as I got in the car and started to drive to work, I’d have to pull over because I’d start to panic.
Grace’s narrative illuminated that her workplace had become a source of fear. She struggled to work because of her panic attacks. While she wanted to “run away from work”, her economic necessity to work gave her no other option but to stay. After a time, her distress became so overwhelming that she took six weeks of unpaid leave. Grace then requested to be transferred to a temporary position in another department to escape being bullied and to avoid further panic attacks. This decision meant Grace took a pay cut, and worked in a role below her skill set. She found herself in employment “limbo” because she was in a temporary role with an indeterminate end date and did not want to return to her original position. Grace’s experiences have illustrated how bullying and panic attacks can lead to underemployment and employment insecurity. This has potential negative ramifications for Grace’s livelihood and financial security. Working in a role below her capabilities may also adversely impact her long-term career plans, and sense of self-worth.

Charlotte reported being mobbed at work, and felt this exacerbated her panic condition. She described her workplace as “toxic” and said there was “no trust of management ... and people were scared of managers.” The fear that Charlotte’s management team instilled in her was so powerful that she would panic if one of these people walked past her desk. She reported:

I’ll be sitting at my desk, and, the management will walk past and I’ll just be like [takes sharp breath in] -, freeze, crap! [Slight laugh] ... I’d have a panic attack, sitting at my desk, just out of the middle of almost nowhere, because [my Manager] walks into the room.

This statement confirmed the impact that workplace mobbing had on Charlotte. Such intense distress at the sight of her manager would have made it difficult for her to concentrate and focus, thereby impacting her work performance, and taking an emotional toll on Charlotte.
Other participants blamed their workplaces for their panic condition. Faye asserted that she “didn’t have panic attacks when it was nothing to do with work”, and Grace reported that panic attacks had “not affected [her] until one of [her] own started to attack [her].”

This section has highlighted that the experience of being bullied or mobbed at work led to the onset of some participants’ panic attacks. The fear was so intense for some that they panicked while approaching their workplace or in the physical presence of a bully. The following sub-theme shares participants’ claims that unrealistic work demands and the competing pressures of work and home, contributed to the onset of panic.

### 6.2.2 Pressures of Work

Participants also attributed their panic attacks to the pressures of modern work life, including the competing demands of work and home domains, increased workloads, and organisational demands for ever increasing employee performance (Schor, 1991; Burke, 2001). Many of these individuals felt that their long working hours, taxing work environments and unrealistic workloads contributed to their panic attacks. Faye reported that she was not coping with her workload just prior to her first “severe” panic attack, and that she was working “seven days a week”, and very long hours. However, the pressure became too much. Faye started to get a “panicky feeling”, knowing the “insurmountable mountain of work ahead of [her] ... that there would never be an end to it.” She reported her “panicky feeling” escalated until her “whole system just broke down.”
Lily shared a similar experience. She explained taking on the additional responsibilities of a work-colleague when he resigned. She became overloaded with work and this triggered her panic. She commented:

> Basically, my workload was just far too much. And the panic attacks would start to come on when I’d be trying to work on one thing, and then realising that as soon as I finished with that particular task, that I had all of these other things that I had to get through. And then that would just escalate my panic until I’d have a full blown panic attack.

Lily’s comment depicted her response to an organisation demanding greater performance and efficiency from her, while downsizing to cut costs and improve their bottom line.

The women participants, in particular, reported that they had difficulty balancing large workloads with their considerable family responsibilities. This led to the onset of panic for a number of women participants. For instance, Helen’s narrative suggested that the pressure of a demanding job, combined with carrying the weight of domestic responsibility at home “just pushed [her] over the edge.” She reported:

> I think it was a long period of built up pressure. I had to be the perfect mother, so I used to always make sure I took the kids to school and picked them up. I thought I was being the perfect wife as well. I did everything around the home; I paid all the bills, did everything there. And then I came to work as well, and I ran all the programs at work.

Faye also reported that the competing demands between work and home contributed to the onset of panic. Her high workload caused conflict between her and her family and she was “fighting with them all the time.” These stressors led to Faye having her first panic attack while at work.

Participants frequently reported working in organisations that prioritised productivity and efficiency gains over the welfare of their employees. Faye commented that her
organisation “treated their academics like slaves”; Lily reported that her workplace was “being run on the smell of an oily rag”, and yet they “wanted more and more performance from their employees, all the time.” Disconcertingly, participants felt that the disregard their employer held for their wellbeing was not unique to their situation, but rather, a reality of life in contemporary organisations. Wendy felt that modern work environments would only increase the stress experienced by employees, and lead to more people having panic attacks:

The workplace needs to be more aware of the pressures, because I think it’s only going to get worse. People will continue to get panic attacks now, because of the environment we live in and the stressful work environments, you know? There are more demands on us; more demands to be perfect and everything. So I think people just need to know and be more aware about it.

Helen confirmed Wendy’s sentiments and likened the modern worker to a “manufactured commodity” that could lead to more stress problems, and panic attacks:

I think because the way we live today, the stress, it’s going to get worse. Because we are fragile human beings, and we’re not meant to necessarily be the way we are now. The pressures of society and the workplace is on us; everybody has such high expectations of what we can do. We have to be perfect wives, perfect partners, perfect children, perfect parents, and perfect employees. Hey, we’re not a perfectly manufactured commodity here! We have flaws, and I think we put so much pressure on ourselves, there’s going to be more of this unless it comes out in the open – that [panic attacks] are what happens to people if you put these sorts of pressures on them … employees should be aware that you can’t do this to people; that there’s value in people.

Helen and Wendy’s comments articulated the bleak outlook many participants held about contemporary organisational life. Few participants had anything positive to say about their workplaces.
This theme has highlighted participants’ negative experiences at work, such as bullying, mobbing, unreasonable work demands, and work-home conflicts, contributed in some way to their panic attacks. This is a concerning finding given the amount of time that adults spend in the workplace, and that paid employment for most people is necessary for their livelihood. The next theme explores the key ways in which panic disrupted participants’ career progression, employment choices and job security.

6.3 Career Concerns

This theme suggests that panic attacks can significantly disrupt a person’s career progression, employment choices, and lead to insecure employment. Participants revealed having to give up full-time employment, retire early, sacrifice career dreams, relocate to be closer to work, stay in unsatisfactory and, at times, hostile working conditions, and stay in roles below their capabilities. The sub-themes discussed below are clustered around the most significant career concerns and problems identified by participants.

6.3.1 Sacrificing Career

This sub-theme explores how panic had a detrimental impact on participants’ career pathways and employment security. Participants reported that they: were working below their level of education, intellect or training; engaged in a cycle of temporary employment; had downgraded their career goals; and, felt trapped in toxic organisations. Understandably, many participants felt insecure and dissatisfied with
their current employment arrangements. Discussed below are the major impediments that prevented participants securing meaningful and secure employment.

Participants reported that they worked below their capabilities because they wanted to minimise stress in their lives. Participants felt that stressful events often exacerbated or contributed to their panic. Hence, some avoided applying for jobs perceived as too stressful. For example, Lauren, a teacher, avoided promotional opportunities that could result in more stress in her life, and possibly more panic attacks:

I probably wouldn’t go for a promotion because of the stress. I think when I am stressed I am more likely to have a panic attack. So I would probably avoid it. A lot of people say to me, “You should be trying to go for a higher role.” But I just think with my kids and all of that, I have enough stress with them. I don’t want more stress, because that will set me off … I don’t know about later on, but I know at the moment I wouldn’t even consider it.

Lucy also had concerns that she would not be able to cope with the added stress if she decided to advance in her career:

I think about moving up, in terms of job levels. But there is a part of me that is like, “How much am I going to be able to cope with?” I guess the other thing is, the higher you get, the more stressful your job is … and then the harder it is to cope with that job, and the more your work might suffer.

Avoiding stressful situations by lowering long-term career expectations limited the participants’ ability to develop new skills and knowledge, thereby hampering their future employability. Participants perceived inability to grow and advance in their careers resulted in unmet career goals and unfulfilling work. Charlotte, a 24 year old officer in the Education sector, reported that she “won’t take opportunities that [she] should take” in her career because panic made it difficult for her to travel or be in
situations that she perceived as difficult to escape from. The realisation that she may
not be able to achieve her career goals was a huge loss for Charlotte:

I would love to get into a nice niche in management. But I couldn’t go
and travel to attend conferences. I couldn’t sit through long meetings.
Um, maybe in ten years’ time I’ll have dealt with this enough that I
can do that and that I will have the confidence to be able to assume
that position. But at this point it’s a pipedream [slight laugh]. I mean I
would love to travel ... I’d love to achieve those things. But not now;
not in the foreseeable future anyway.

Charlotte was in the early stages of her career, meaning the limitations of her panic
condition may have already foreclosed career paths before they could be potentially
explored. This has potential ramifications on her future income earnings,
employability, life experiences, such as travel, career satisfaction and self-worth.
Other participants also reported that their self-worth and self-esteem were diminished
by the knowledge that they were working below their capabilities, skills and
knowledge. Pamela reported that she “felt like a failure”; Lauren commented that she
felt “a bit useless” because she knew that she was “capable of better or more”; Lily
felt “defective” and expressed her disappointment and frustration that her panic and
anxiety problems were “holding [her] back”:

Interviewer: Are there any positives to having panic attacks?

Lily: There are no positives for me at all. It just stops me from being
able to function. And it’s really irritating because I’m a high achiever and
I’m well educated and I’ve got degrees – good results, good academic
transcripts. And yet I am sort of stymied in my ability to function
professionally in a full-time capacity. So, yes I find that quite difficult.
Yes. It’s very irritating.

The participants’ sense of self-worth was not only diminished from their perceived
failure to live up to their potential in the workplace, but also from the weight of
having a stigmatised condition, and subsequent feelings of self-stigma. Pamela
commented that “[her] self-esteem was very low anyway, and these panic attacks just confirmed it”; Wendy blamed herself for her panic attacks, and wondered if “[she] was doing it to [herself] deliberately ... and that just makes [her] not like [herself] even more”; Lily surmised that anxiety and panic “would eat away at [her] confidence.” This added self-stigma and blame adds an extra dimension of suffering to these individuals’ work lives.

Another way participants attempted to minimise the stress in their working lives was to reduce the hours that they worked, often by moving from full-time to part-time work. However, participants found it difficult to find suitable permanent part-time work, with temporary positions offering little in the way of career progression or security. Lily, an academic researcher, reported that she would like to work full-time, but she could only cope with part-time work because of her panic attacks. This created significant impediments to obtaining permanent and secure employment:

> Even though the panic attacks are under control now, I think that if I tried to work full time they’d probably start again and I’d probably end up getting quite sick. So yes, it has limited my career because I haven’t been able to get a permanent job. I’ve only worked temporarily for well over a decade. And that’s mainly because a lot of the part-time jobs are temporary. And it also limits the jobs I can apply for, because I don’t apply for the full time ones.

At the time of interviews, five participants had a history of temporary employment. One of these participants had since become unemployed and the other retired at 51 years of age because of a lack of job prospects. These findings have highlighted that participants in temporary roles were vulnerable to underemployment and unemployment. This had serious ramifications for the participants’ financial security and livelihood, such as their ability to pay their mortgage, provide extra-curricular activities and education for themselves and their children, make ends meet, and retire
with enough passive income to live comfortably. Financial insecurity also had the potential to put pressure on marital relationships, and lower self-esteem and confidence.

The inability to gain permanent employment left many participants vulnerable and exposed to employment insecurity. They perceived that they did not have the same employment rights and protections as permanent employees, and that any disclosure of their panic could make them vulnerable to dismissal. Lily was reluctant to disclose her panic and anxiety problems to her employer because she feared it would jeopardise her employment:

I suppose the other issue was that I was a temporary employee in the public service which means [after] three years ... they make you permanent or get rid of you. Well, I thought being a temporary employee - I didn’t think it was in my interest to disclose any sort of stress problem because that could limit my ability to make it to a permanent position.

Participants in temporary roles perceived themselves as disposable; that they had no rights to request employee support at work. Unsurprisingly, they rarely requested support and did not feel protected against unfair dismissal. So participants either managed their illness alone in the workplace or, if unable to cope, resigned without asking for additional flexibility that could have helped them stay in their jobs. This predicament leaves employees extremely vulnerable to workplace exploitation. Also, temporary employees are often not entitled to sick leave and paid holiday leave. This meant that the participants in temporary roles either had to work while sick with panic or take unpaid sick leave. Both scenarios would be detrimental.

While some participants remained trapped in a cycle of insecure and temporary employment, others found themselves trapped in permanent roles with little
opportunity for career advancement. These participants were reluctant to leave their current employment situation because they feared that starting over in a new job would be too stressful and would exacerbate their panic. For example, Audrey, a mental health nurse, with “debilitating” panic attacks, had been with her current employer “for twenty-one years”, and planned to stay there until her retirement:

Oh, for me it was never an option [to leave] because I’ve been at that particular place for twenty-one years ... Whereas if I was to go out cold and go into another job, that would be so stressful. That it would be detrimental to my mental health than to stay where I am until I retire. So no, it wasn’t an option to move out and go somewhere else.

Participants were also reluctant to leave their current positions because of the perceived difficulty in finding alternative employment. Their panic placed many restrictions on the type of work that they could do. For example, John had remained with his current employer for eleven years because many of the positions he was interested in had the potential to trigger his panic attacks:

One of the positions I could have got I believe ... I was going to go for [it], and the money was better; the responsibility was less, not that that worries me. But I would have had to work in an office environment, commute by crowded passenger train, which I can’t do - [pause]. That was about two years ago.

It is also proposed that many of the participants, such as John, had such low self-worth that they felt powerless to move on from their current roles. Indeed, both John and Charlotte continued to work in organisations where they were mobbed and bullied. Charlotte described her workplace as “toxic”, while John spoke of the “constant turmoil” at work and admitted it’s “not a very pleasant place to work.” They felt disempowered and disenfranchised, making it difficult for them to leave their abusive work environments. This was illustrated in Charlotte’s narrative. She attended an interview for a higher level position with a higher pay rate. Even though she knew that
she “could do the job blindfolded ... [her] confidence and self-esteem were so low that [she] defeated [herself] before [she] walked in.” To be trapped in a hostile work environment day-after-day, year-after-year, with little hope of leaving, would have been extremely distressing for both John and Charlotte, and would likely have had many spillover effects into other areas of their lives, including relationships with family and friends, psychological health and well-being, financial security, and quality of life.

These stories have highlighted the career sacrifices that participants made and the disillusionment and dismay as their career goals and dreams fell by the wayside. The difficulties and obstacles to finding suitable employment have left many participants stuck, trapped in positions and workplaces that offer neither opportunities for development or personal wellbeing.

6.3.2 Commuting to Work

This section explores how travelling to and from work was a significant impediment to participants finding and maintaining meaningful employment. Almost all participants reported that travelling triggered their panic attacks. Some, like John, found travelling on public transport difficult. Audrey could not endure driving long distances or on freeways. As commuting to work was a necessity for all participants (none worked from home), the majority of participants reporting making (often drastic) career choices in order to avoid the anxiety and panic that occurred when commuting. Participants then had limited employment options and, as a result, became underemployed or were forced out of the workforce. For example, Jacqueline’s
employment choices were restricted to her local suburb in the outer suburbs of Sydney because of her inability to drive long distances:

**Interviewer:** Do you think panic attacks have limited you or disadvantaged you in any way?

**Jacqueline:** Only in the bit where I don’t want to drive. You know, because I do temp work, I limit myself to my area. I mean I could get a job in the city; I could get a job anywhere with my qualifications, but I just -, [pause] I don’t even look. Yes, so it does limit me that way, because I know I would end up getting myself worked up and you know, so yes. Mm.

Jacqueline’s nonchalant comment that she is “only” limited by her inability to drive long distances suggests that she could be employing psychological defence strategies, such as denial or repression, as a way of coping (Carver & Connor-Smith, 2010). As there were limited employment options in her area, she found it difficult to obtain casual work and so felt that she had no other choice but to become “semi-retired.”

**Interviewer:** You’re not working at the moment?

**Jacqueline:** Well if someone rings me with a job in [my local area], I’ll take it. But no, I’m not actively seeking work. I’m still registered with temp agencies.

**Interviewer:** Are you getting any -,

**Jacqueline:** I’m still getting calls, yes. But they’re not local. They’re like in [areas further from home], which you’ve got to sit on the motorway, and I’m not prepared. I just think, for the money I earn, which is a pittance, you know, I’m not sitting in traffic for an hour.

Jacqueline was fifty-one years old when she chose, because of her panic, to retire early. This significant life change occurred well before the traditional Australian retirement age of sixty-five years (Shacklock & Brunetto, 2005). As people in the Western world live longer (Speirs & Wilson, 2002), the question arises whether
Jacqueline will have adequate income to finance her retirement as a result of finishing work prematurely.

Charlotte’s panic also necessitated her having a short commute to work. One of her major fears was “being stuck in traffic and not being able to get out. Not having a backup route.” However, her specialised role meant that there were limited work opportunities near her home and, as a result she decided to relocate a considerable distance in order to be within a five minute drive of her new workplace:

[Work is] nice and close. I think it’s 4.7 kilometres or something. And I’m like, “Yes! Five minute drive, compared with a forty minute drive.”

When asked if she would move again if she found another job in another location, she confirmed that she would:

Um, yes ... when I first got the job here I was like, “I’m going to move out here.”... That’s what I’ve done, so, if I was to get another job somewhere else I’d have to up and move again.

Charlotte’s comments exemplified the severe limitations that panic attacks can have on a person’s employment options and the drastic flow-on effects this had on other areas of their lives. Due to her travelling restrictions, Charlotte’s life would have involved considerable instability and uncertainty, as any decision to find alternative employment could necessitate the disruption of another house move. This predicament could also mean working indefinitely at her current organisation in order to avoid having to relocate. As discussed above, Charlotte’s narrative suggested a woman who felt trapped in a “toxic” workplace because of the difficulties of finding alternative employment.

This section has demonstrated that commuting, a frustrating necessity for most employees, is a source of constant distress, even terror, for many workers with panic.
These travelling restrictions created major employment obstacles for participants and forced some, like Jacqueline, into semi-retirement. Others, like Charlotte, remained trapped in harmful and “toxic” workplaces. The next theme explores how participants attempted to survive in the workplace with panic attacks.

6.4 “A Real Battle”: Surviving the Workplace

This theme explores the ways participants attempted to carry on effectively in the workplace despite their panic symptoms. For most, this involved continuing to work, even while unwell, and concealing their illness to avoid the negative effects of stigma. Two significant survival strategies emerged from the participants’ narratives and constitute the next two sub-themes: Presenteeism, which involved participants continuing to work, despite at times being very unwell; and, Working Behind a Mask, which involved participants concealing their panic attacks in the workplace to minimise the potential negative ramifications of stigma. Both of these strategies involved keeping up appearances in the workplace in order to appear normal and capable to their coworkers and managers. The negative ramifications of these strategies are also discussed.

6.4.1 Presenteeism

This sub-theme reveals that most participants continued to work despite the ill effects of their panic attacks. This phenomenon of working with impaired functioning has been labelled presenteeism (Dewa et al., 2007). Almost all participants reported at one time or another working during their worst times with panic attacks. Wendy “continued to work every day” during her “breakdown”; Maya “thought [she] couldn’t
go to work but still went”; and Charlotte would “force [herself] … to go to work at least once a week” by telling herself “you have to do this, you haven’t got a choice.”

The participants found it difficult to cope when they went to work during periods of illness. The battle metaphor was used by two participants to portray the tremendous struggle that occurred when needing to remain at work and appear well and able to function normally. Grace described this experience as ‘a real battle to stay at work.” Similarly, Chloe articulated that she would wake up in the morning and experience a panic attack, and even though she felt “not quite right. [She’d] still go and try and battle through.”

Other participants pushed themselves to their physical and mental limits. The lengths participants would go to stay at work while unwell illustrated the strength of their desire to contain their panic attacks and continue on as normal. For example, Hattie would push herself “all the time” when she was experiencing panic attacks. To keep working she would “constantly throw cold water over [her] face or had [her] head in the fridge and was putting ice on [herself].” However, the effort to work with panic attacks took a toll on the participants’ health and home lives. Grace described feeling exhausted at the end of a work day because she had pushed herself to go to work while she was experiencing panic attacks:

Exhausted; absolutely exhausted. Quite a few times when I got home I’d just go lie on the bed, and sometimes go straight to sleep. It could be six-o-clock at night and my husband wouldn’t even be home and I’d be in bed asleep. Other times, I’d cook tea but didn’t feel like eating. But yes, quite often I’d just collapse into bed. But then I wasn’t sleeping either. I’d wake up at three-o-clock in the morning, my heart racing and all that. So I started not being able to sleep, which made going to work harder.
Grace’s comment illustrated how she felt that she had no other option but to sacrifice her health and her home life in order to continue working with panic attacks. Some participants reported risking their safety in order to continue working with panic attacks. These narratives suggested that presenteeism has the potential to increase the risk of workplace accidents, including during the commute to and from work. For example even though Faye “had a panic attack in the car ... and felt really unsafe driving”, she forced herself to continue driving to work:

I remember having pains, and having my heart thumping away, and sweating. I’d sweat really badly. And, pulling over, stopping the car and then driving on, and feeling really unsafe and really uncertain. I don’t remember anything else of that day. Don’t remember how many classes I had, or what I taught. I don’t even remember what day of the week it was.

Looking back on this incident, Faye realised that she had put herself in a precarious and potentially risky situation:

What a stupid idea ... And I let the adrenalin take over, which is a bad thing to do. Why didn’t I ring up work and say I was sick and turn around and go home? I should have rung up work and said I was sick.

Why did these participants feel so much pressure to continue to work when seriously unwell? The narratives reveal that many of these participants did not feel like they had a choice and, importantly, the participants internalised the stigma that their panic attacks were not a “legitimate” reason to take sick leave. Internalising stigma is often known as felt or internal stigma, and can negative impact on subjective well-being (Whitley & Campbell, 2014). Faye commented that she “absolutely” felt that her panic attacks were not serious enough to justify a day off work. Similarly, Chloe commented:
It will be to the point where I’m having severe dissociation and numbness and tingling … but I still feel in the back of my mind that it is not a legitimate reason to be having time off.

Participants also felt compelled to keep working during periods of impaired functioning because of their desire to distance themselves from the stigma that people with mental illness are lazy, unreliable and incompetent. For example, Lily emphasised that “ninety-five per cent of the time [panic] doesn’t affect my ability to work.” She was also quick to point out that she had “never taken my full quota of sick leave for anything to do with panic attacks.” Faye wanted to prevent her colleagues from thinking she was “really lazy and was just putting it on.”

Other participants felt that they had no choice but to continue working because of the immense pressure they were under at work. Faye cited her overwhelming workload as the reason she kept working during her “breakdown.” Paradoxically, this was one of the reasons why she began to have panic attacks in the first place. On reflection, Faye realised that the demands of work should not interfere with taking sick leave:

That means in six years I’ve only taken a handful of days of sick leave. And that’s ridiculous ... We shouldn’t have to think that we have so much work to do that we can’t take a break to be sick.

The participants’ narratives revealed that their presenteeism negatively impacted their work performance. Participants like Charlotte felt unable to do much in the way of work in the mornings because she spent that time trying to control her anxiety and panic attacks:

The first bit of the day I was really jittery and not particularly coping, and if I managed to get something done that was good. And then I would sort of calm down and it would be okay towards the end of the day. If I can get over that first hurdle I’m usually -, as long as nothing difficult is happening during the day, then I’m usually okay.
As one can imagine, the ability to concentrate on work would have been difficult for Charlotte if much of her mental effort was directed towards trying to “calm down.” This is reiterated by Helen who felt that “you can’t perform like you normally would, because you’ve got all this turmoil going on inside you.”

Lily also admitted that “having panic attacks at work was starting to interfere with [her] ability to do my work.” Her narrative below illustrated just how much energy and effort it took her to survive the feelings, thoughts and physical sensations that accompanied a panic attack:

Well, my mind would speed up and then I’d start thinking of all the things that I had to do and the amount of time I had to do it in. And then my hands would start getting really, really sweaty. And I’d reach this crescendo in my brain and everything would just fragment. And I was just basically incapable of doing anything. And sometimes I’d get this choking feeling, where I felt like I wasn’t getting enough air. And then at that stage [pause], I knew that I wasn’t going to be of any use to anyone, because my mind was fragmented and I couldn’t concentrate or think. I just had to go away and calm down.

Participants were often left physically and mentally exhausted after having a panic attack. When these episodes occurred in the workplace, participants found it difficult to concentrate, or carry out work activities that required strenuous and focused thinking. For example, when Lily experienced panic attacks at work she reported that she “wasn’t capable of doing any sort of activities that required higher cognitive functioning.” Instead, she would do what she coined “sheltered workshop work”, such as photocopying or filing:

I’d do my sheltered workshop work – if I had panic attacks at work. I don’t think I actually left work for the rest of the day. I usually stayed at work and either did my sheltered workshop work or just worked very inefficiently.
The findings have shown that most participants continued to work despite being, at times, seriously unwell. This had negative ramifications for the participants’ health, safety and home life. Much of the pressure to continue working had to do with the participants’ beliefs that they did not have a choice. Either they felt that panic attacks were not a “legitimate” reason to take sick leave; they wanted to prove they did not fit the stereotype of a person with mental illness; or, because they felt pressure to keep working in order to keep on top of a seemingly insurmountable workload. The findings also illustrated that panic attacks lead to impaired functioning and the participants’ work performance suffered as a result. This has implications for the participants’ future employability, their health and wellbeing, relationships, work-life balance and career progression.

6.4.2 Working Behind a Mask

This section explores the phenomenon of concealment, and how most participants were careful to keep their panic attacks a secret in the workplace in order to survive. The mask metaphor has been used here to illustrate how participants hid the physical symptoms of panic, and the accompanying feelings and thoughts. The mask worn by participants at work portrayed wellness and was an attempt to pass as ‘normal’. The participants feared that the flawed beliefs and stereotypes associated with panic attacks would disadvantage them in the workplace. Lily reported:

I just didn’t think it would be in my interest to tell anyone … I think you would get labelled as a bit wounded or something. Particularly in my organisation, that just wasn’t a clever thing to do. And if certain people knew it, it could influence my ability to get a higher position …
Lily was concerned that if her panic attacks were discovered by her employer, they would use covert manifestations of prejudice against her. She explained: “I just think [my condition] would be used against me behind closed doors. That’s just a little bit of how the organisation operates.” This would make it difficult for her to prove that any unfair treatment she received was a result of discrimination (Dovidio et al., 2002). Also, Lily’s comment that she would be “labelled” as “a bit wounded” showed that she perceived other people would view her panic attacks as a weakness, which would make her vulnerable to discrimination and job insecurity. Other participants shared her concern. Hannah and Wendy felt that their panic attacks would be perceived as a “weakness” that potentially opened them up to workplace discrimination, bullying and other unfair treatments. For example, Hannah explained that “once they’ve seen the weak side of you, you’re vulnerable.” While Wendy felt it would “give [her employer] more ammunition” to use against her. She commented:

They would probably treat me differently. I suppose they would see it as a weakness ... I think they’d say, “Oh no. We can’t give that role to her because it might be too stressful for her.” So, I think you would be disadvantaged in the workplace. You would be discriminated against.

Wendy’s statement also revealed her belief that disclosure would tarnish her status as a capable and competent worker. This fear was shared by almost half of the participants, and was one of the key reasons for keeping silent about their panic in the workplace. Lily confirmed: “I didn’t want them to think I couldn’t do my work.” She also wanted to “give the appearance that [her] work was under control.”

Working as a mental health nurse made it even more important for Audrey to conceal her mental illness. Audrey felt that to be “competent” in the mental health field meant not having any mental issues herself. For this reason, she felt that disclosure would be disastrous for her career:
It was less harmful to my career and my standing, and to keep the respect of the people at my work, to not disclose … In my line of work you’ve got to be seen to be most competent in the area of mental health. That’s my job.

Audrey’s comment illustrated her belief that disclosing her condition would mean a loss of status, reputation and authority with her patients and coworkers, as she believed she would no longer have the competency to meet the considerable demands of her position. It was concerning that Audrey felt she would be exposed to discrimination, given the fact that she works in the mental health field intended to support those with similar conditions. Many other participants believed that the risks involved with disclosure were just too great. By keeping their panic attacks hidden, these individuals felt that they were able to retain some control over their professional image and reputation in the workplace.

To maintain secrecy participants used the passing tactics identified by Herek (1996), and included concealment, fabrication and discretion (Clair et al., 2005). Concealment involves hiding personal information from others in order to pass as normal (DeJordy, 2008). The narratives revealed several examples of this psychological defence mechanism, including feigning an outward appearance of calm whilst in an anxious or fearful state, or concealing the visible signs of a panic attack, for example, by covering excessive sweating with a heavy jacket, or concealing signs of hyperventilation behind a cough, or a hand over a mouth. For example, Chloe reported how she concealed a panic attack that she had during a work function:

6 Unfortunately, their fears were not unfounded and as discussed in the next section, many of the participants who did disclose their condition were treated unfairly and discriminated against.
So I just had to stand there and just hope no one was watching me, and just try and be awkwardly discreet [slight laugh] about trying not to hyperventilate.

During a panic attack some participants reported withdrawing into themselves, so it appeared that they were just being quieter than usual or were intensely focused on their work. Lucy confirmed that she “would just appear a bit quieter.” Lily said that “the only impression someone might get is that you’re really focused on what you’re doing.”

In an effort to pass as normal, several participants reported disguising their real feeling behind “a mask” or a different “persona.” Hattie confirmed that she would wear a “mask of normality – that I’m no different to anyone else.” Wendy was also careful to ensure that her real feelings remained hidden from those in her workplace:

I went through a bad spell four years ago … nobody [at work] had any idea I went through it. They knew I was a bit stressed, but really they didn’t have any idea what was happening in my life … So I learnt to put on this persona that I was great. I’d get up, I’d do my makeup … but inside you’re feeling like crap, but you just put this mask on, this persona, that everything was fantastic [laughs].

Participants that worked in the service industry felt pressured to present a happy and positive image to their customers. This meant that any negative emotions resulting from a panic attack were concealed. For example, after having a panic attack in the workplace, Hannah hid away from her customers, until she “had calmed down … [and then] it was on with the game face.” Hannah explained what her “game face” entailed:

When you’re dealing with the customers you’ve got a game face on. You’re always smiling. If you’re pissed off, you don’t show them. If you’re upset, you don’t show them. It’s always a pleasant, smiling, happy face.
For participants working in the service industry it is suggested that it would be particularly difficult for them to continue with the pretence that all was well, because in the event of a panic attack they would have limited opportunities to remove themselves from customers in order to regain composure. Lucy, an office worker, confirmed this sentiment, and commented that she would find it more difficult to conceal her panic attacks if she worked in a service role because of the difficulty of remaining “in the spotlight” all the time. She then went on to report that: “with an office job, if I’m having a bad day, I can still probably get on with my work. You don’t necessarily have to talk to a lot of people or have a happy face on all the time.”

Fabrication was also used by participants to maintain secrecy in the workplace. This entailed providing managers and colleagues with false information or half-truths. Hattie confirmed that “you have to learn to lie very well.” The narratives reveal that some participants attributed any visible signs of a panic attack to a physical and less stigmatising condition. For example, Lily would “tell them I was near fainting”; Faye would say “there’s something wrong with my heart”; and, Maya blamed her excessive sweating on “rushing” to get to a meeting. Unexplained extended leave also drew the attention of colleagues, and participants like Wendy would use “family reasons” to justify her time away from work. These participants may have felt guilty about fabricating stories to keep their condition hidden, or may have worried that they would be caught out in a lie, and the potential ramifications of being viewed as dishonest.

Lastly, discretion involved participants avoiding or escaping situations where they would have to conceal or reveal information (Clair et al., 2005). Escape-avoidance strategies (Paxton & Diggens, 1997) were used frequently by participants to keep away from panic-inducing situations. So, it was no surprise to learn these strategies
were also used by participants to manage their stigmatised identities in the workplace. Numerous stories were shared of participants fleeing from work colleagues, supervisors and customers during or prior to a panic attack so as to avoid discovery. For example, Hannah reported that “when they start to come on, I’ll go somewhere where no one is going to see.” Chloe reported that she had two hiding places at work that she could retreat to during a panic attack:

I'll just excuse myself and just go and sit in the loo and try and get over it [slight laugh]. Or, I'll go and sit in the meeting room in the dark and just try and calm myself down.

Other participants reported leaving the workplace premises in order to avoid discovery. Lily reported that when she “had a full blown panic attack” at work she would go “across the road and sit in the Church or ... sit in the park.” This gave her time to work through the effects of a panic attack without worrying about the prying eyes of others. It took Lily about “half an hour” before she was composed enough to return to work. Wendy was also “able to hide it at work” by leaving the workplace premises during her lunch break.

These behaviours can also have the potential to cause problems for the participants. For example, the individual’s managers and work colleagues may be critical of such unexplained absences, perceiving the employee to be lazy, dishonest or inept; their attempt to conceal their emotional distress may be unsuccessful leading to questioning from others and suspicion; and, the participants’ efforts to conceal their stigmatised condition sometimes contributed to the very symptoms – anxiety, stress related illness, emotional strain, depression – from which they were struggling to recover. Lucy explained:
I didn’t want to have to think about how I was going to hide it anymore. I mean, part of the anxiety comes from trying to figure out how to make sure other people don’t notice.

Lucy’s comment revealed the mental effort and stress involved in maintaining secrecy. It is possible that the anxiety associated with being discovered may have worsened her panic condition. The preoccupation with concealment may have also affected her ability to function effectively at work.

Lastly, as the phenomenological model allows for alternative experiences within the same theme, not all participants felt compelled to conceal their panic attacks in the workplace. One notable exception was Helen, who made it her “crusade to get the word out there” about her panic attacks:

For me it was far easier for everybody to know, than it was for me to hide it and pretend they weren’t happening … It was part of my therapy, part of my coping.

Helen was self-assured and was not worried about the reactions of her co-workers: “Now if other people can’t deal with it, that’s not my problem. That’s their problem.” She held a senior position at her workplace and was well respected by her peers. It is argued that it was her seniority and the accompanying power and authority that gave her the confidence to disclose her panic attacks to her coworkers and managers. This finding is echoed in the disability literature, which shows that positive workplace support relates to an employee’s seniority level (Dyck & Jongbloed, 2000; Werth, 2011). Although Helen reported a mostly positive workplace response, there were still times that she had to assert her authority to prevent being disadvantaged from the prejudicial attitudes of others:

There is one person here at work who always says, “Now we have to be sure that … we know you can do the job, but … we don’t want to make
you sick again.” So I took him aside some time ago and said, “Listen here. I know my capabilities, I know my own limitations. I don’t need you to do it for me” … I sorted him out quick smart. And then I rang my new boss, and I said, “Now by the way, just in case you’re thinking along similar lines…” [Laughs]. So, they don’t see me as wilting violet.

Helen’s comments demonstrated how even a confident, successful, and well regarded senior manager was still required to fight against the doubts that surrounded her competence and abilities in the workplace. It is conjectured that vulnerable employees with little power in the workforce would have a much more difficult time defending themselves against the prejudicial responses of others. Disability literature supports the notion that employees with low seniority or low status are more likely to experience adverse workplace outcomes (Young et al., 2002; Lerner et al., 2004). Evidence of this occurring is provided in the next theme, Disclosure at Work.

For most participants, surviving the workplace meant censoring their panic attacks symptoms and related difficulties in order to appear ‘normal’ and competent. To preserve their appearance of capability, participants worked extraordinarily hard to push their panic attacks aside in order to continue working. This put enormous pressure on participants, and many were left exhausted, stressed and even worse off than before. Disconcertingly, the alternative option – disclosure, was also found to be harmful for participants. The following theme discusses the negative ramifications of disclosure in the workplace.

6.5 Disclosure at Work

This theme highlights how some participants had their lives made more difficult by work colleagues and/or managers after disclosing their panic condition. Participants’ experiences included discrimination, bullying, mobbing and being left to manage their
illness alone. A positive workplace response was reported by a few participants and is offered as an alternative experience at the end of this chapter.

### 6.5.1 Negative Responses

Participants reported a range of negative responses from their managers and/or their work colleagues after disclosing their panic attacks. It was common for participants to have their condition trivialised. For example, Lauren, a teacher, said that her school Principal “couldn’t care less” that she had panic attacks. Similarly, Chloe described her manager’s insensitive response when she explained her lateness to work was due to panic:

So, at this point I said, “This is why I was late. I suffered from this very severe panic attack, and I have been suffering from them a lot over the past three years, and I’ve never really had them checked out.” And I went into great detail about it. And he kind of looked at me blankly and just said, “Okay, well I guess shit happens. But you need to tell me where you are.” And I said, “Well, I just did.” So he kind of still didn’t really take it on board.

The response from Chloe’s manager demonstrated that he lacked understanding of her condition, and did not perceive her panic attacks as a legitimate reason for being late to work. His response trivialised her experience and implied she was not deserving of any considerations. After disclosure, Lauren and Chloe both reported that their managers did not have any follow up conversations with them or suggest any practical workplace support or assistance. And far from letting Chloe have any flexibility in her starting time, her manager began to set “these ridiculous” one-on-one, progress meetings with her every Monday morning, fifteen minutes earlier than her usual starting time. This suggested he believed that Chloe was a malingerer, using her panic attacks as an excuse to arrive late to work. Lauren vocalised a similar suspicion, and
commented that she thought her school Principle perceived her disclosure “as just an excuse” to dodge workplace responsibilities.

A number of participants reported that their managers’ behaviour towards them worsened once they became aware of their panic attacks. Charlotte reported that “the way [her manager] speaks to [her] now is different to the way she used to … a lot of it has come down to the panic attacks.” She described an incident which demonstrated how her manager’s perception of her had changed since her disclosure. Previously, her manager had “never, ever [had] an issue” with her driving the company car. However, after her disclosure, her manager put a stop to her driving:

And [my manager] said, “Oh, well [X] is driving isn’t she?” And [X] said to my manager, “No, no, Charlotte’s driving.” And she was like, “Oh no, no. Charlotte you can’t do that. Charlotte can’t. No, no, no, no. [X’s] got to drive. [X] has to drive.” And there was no argument, no discussion. She did not discuss it with me … And the only thing I can put it down to is because I told her I had panic attacks and it was related to travel.

Her narrative suggested that her manager’s perception of her driving capabilities had been tainted, and she now viewed Charlotte as an incompetent driver, unable to be trusted to drive at all. Had Charlotte’s manager attempted to understand her condition, she would have discovered that she was far more likely to have a panic attack as the passenger in the car, rather than as the driver. But, as Charlotte reported, “she doesn’t understand it in the slightest, couldn’t care less to come and ask and have a conversation or anything.”

In an effort to manage their panic attacks in the workplace, several participants reported utilising the confidential counselling service attached to their workplace, usually referred to as the Employee Assistance Program (EAP). Disconcertingly, not
one of these participants had a positive experience with this service; they all reported coming away from this experience feeling worse than they had before. For example, when Steven revealed to the workplace counsellor that he had panic attacks, she said “I don’t think you should tell too many people about that.” The implication behind her message was that there was something inherently wrong with having panic attacks and it needed to be hidden from others. This message, from a person in a position of trust, only serves to fuel the shame and stigma surrounding panic attacks. Lily also described the workplace counsellor that she went to for support as “useless, she was awful.” Lily reported that the counsellor was “ dismissive” of her panic attacks and her concerns that her high workload had contributed to her condition. Lily reported how she felt after this counselling session:

I actually came away from that feeling like I was stupid, and that I was handling the situation really badly. I didn’t feel that I got any support. I felt completely alone with the problem after going to utilise that service anonymously [pause]. So, I only did it once and I never did it again. And, as I said, I went off and found someone privately.

After her session with the workplace counsellor, who “ certainly didn’t encourage [Lily] to go and see her again”, Lily felt “isolated”, let down and “angry” that she was left to manage her panic attacks on her own in the workplace, especially as she believed that it was her organisation that had contributed to her condition in the first place. She commented:

I mean, because one part of me was really angered that I had to go and pay all this money to get help and to learn strategies to manage this illness in the workplace. I mean, I was going because I was having problems in the workplace, and yet I had to fork out [money] personally to figure out ways to manage it from impacting on my work. When I was actually really overloaded; I mean, there’s no doubt about that.
Lily and Steve’s narratives demonstrated that their workplace support programs, such as EAP’s, were not equipped to help and support employees with panic attacks. Similarly, several participants felt that their organisation’s anti-discrimination policies and procedures were a token, as they were not followed in practice. For example, Steven remarked that his organisation “has all these nice lovey-dovey policies about equity and all that kind of stuff.” However, when he submitted a form to his Equity and Diversity unit informing them that panic attacks restricted him from driving, “they never got back to [him].” Steven became angered when his employer subsequently requested him to drive as part of his work role. This led to an argument with his manager and he found another role elsewhere in the organisation. Steven’s experience demonstrated the ways in which organisations ignore mental illness in the workplace.

John and Ruth were two notable participants who experienced extreme bullying after disclosing their panic attacks to their managers. Ruth, a process worker, reported that her supervisor “seemed to thrive on it” and described how her manager delighted in her suffering:

She would see me having panic attacks and she’d stand back and watch … and you could see it on her face, the enjoyment of watching somebody [panic] was just hilarious [to her].

Ruth reported that the more she was bullied at work, the more anxious she became, which led to further panic attacks. She exclaimed that this manager would also “pick on” one other employee who had panic attacks in the workplace. Ruth asked her Personnel Manager for support, but no action was taken to stop the bullying. Additionally, during her employment, her hands began to “swell up” from doing repetitive work tasks. After several more months of bullying, Ruth, who was on a temporary contract, was dismissed. Her employer implied that her dismissal was in her
best interest, so as to prevent further damage to her hands: “Knowing you, you would have stayed here and you would have buggered your hands up. That’s why I put you off.” She accepted her dismissal without question, and when asked during the interview if she thought her dismissal related to her panic attacks and subsequent bullying, she said, “No. It was because I couldn’t use my hands.” Ruth’s unquestioning of this decision suggested that she was not knowledgeable of her employment rights with regards to discrimination and compensation entitlements for workplace injuries and illnesses. Ruth’s experiences highlighted the consequences of being a vulnerable, unskilled employee with panic attacks, who was unaware of her employment rights. Her panic attacks, combined with the negative impact of bullying on her self-esteem, and minimal education and skill level, suggest that Ruth would find it difficult to gain further employment. At the time of interview, Ruth was still unemployed.

John reported a similar experience. John felt that he had no other option but to disclose his condition to his manager after he was told that he would be required to start flying interstate for work. John was terrified of “being enclosed” in confined spaces, including aeroplanes and lifts, and argued against this request. He hoped for understanding by disclosing panic attacks to his managers. Instead, he was mocked:

The first time I told them all I’m not going on aeroplanes, they said, “Johnny’s frightened of aeroplanes!” And it proliferated: “You can’t go on an aeroplane? Ah, you’ll be right mate.”

At the time of the interview, his management team had “been on his back”, repeatedly telling him, “You’ve got to go on an aeroplane.” The fact that he told them he had “been getting treatment for years and years and years … Doctors, Psychiatrists – they can’t help me”, made no difference to his managers. As he voiced: “But they just
won’t stop. They just keep on and on and on and on, because they don’t understand.”

John shared the frustration of having an invisible illness that his managers did not understand, or have any compassion for:

Like I said, it’s not something they can conceive, it’s not tangible. They can’t grasp it. They can’t say, “Oh, there’s Johnny. He’s lying on the floor vomiting. Oh, he must be sick.” I mean, sometimes, I thought, “I wish you could experience what having a panic attack was like and then you’d bloody know!”

The ramifications of John’s disclosure were disastrous. His managers used this knowledge to threaten and control him. John was threatened with being relocated to the office in the city, which was a considerable distance from his home. This move would have required him to travel by train, something he couldn’t do, because he feared “crowded environments.” John detailed the conversation his managers had with him about his possible relocation:

They say, “You know we might close that office down. You might have to come and work in the city every day.” And that causes me a lot of anxiety, because they’ll say, “Oh, Johnny’s not a team player.” That’s one thing they use all the time: “Oh, if you don’t go on an aeroplane, you’re not being a team player.”

Not only had John been threatened with relocation, which would make it extremely difficult, if not impossible, for John to get to work, but his managers implied that John was no longer capable of doing his job because of his panic attacks. For example, one of his managers used implausible hypothetical scenarios to argue why John could no longer carry out his role. When John recalled this incident, his voice became increasingly louder:

My manager said [mimics the sarcastic tone of his manager], “Oh, we can’t send you on any jobs anymore. What happens if you go into a shed
“and the door blows shut?” I said, “I’d kick the fucking door down!” Excuse the language.

John’s comment and associated expressions of anger would suggest that he was upset that he had to keep defending himself and his illness at work. With his job security threatened, John was anxious about his future. He was aware that finding another position might be difficult:

I haven’t had a stable working life in any case. So, up until recently, I really haven’t cared much about my job. Now that I’m older and the years are slipping away, I haven’t got the opportunities that used to be there for me.

If John was to lose his job, he may find it difficult to find employment because of the severe restrictions panic attacks had placed on the type of work he could do, as was discussed previously in the sub-theme Career Concerns. The outcome of losing his job would also be devastating for his financial security and emotional health. Yet, staying trapped in such a toxic workplace environment was going to be disastrous for John’s mental health.

### 6.5.2 Positive Workplace Support

This sub-theme explores an alternative experience to the one above. Three participants reported that disclosure was a mostly positive experience and led to their managers offering support. Interestingly, two of these supportive managers revealed that their significant other or family member was also living with panic. Their personal experiences gave them an understanding of the significance of this illness and the impact it could have on a person’s life.
Flexibility in the workplace was one of the key ways in which support was shown to participants. For example, Steven reported that he was able to “do a lot of [his] work from home and [his] boss is like, ‘If you need to work from home because you can’t come in, you work from home.’ He’s just so cool about it.” Similarly, Lucy’s manager also discussed ways to accommodate her panic attacks in the workplace:

Yes, she was very supportive. We talked through a lot of options for me as well, just in case I couldn’t be at work all the time. If I needed to work from home or if I wanted to go part time or needed to take time off … we went through a lot of different options that I could do.

Showing empathy and understanding was another way participants received support in the workplace. Lucy commented that her manager “could empathise with how [she] was feeling. She’ll always ask me if everything is okay.” Maya reported that if she “got all flustered,” her manager would say to her “‘It’s okay, calm down. It’s okay.’ She’d make [her] a cup of tea. And so she knew. She was very understanding.” Having support and understanding in the workplace had a positive effect on Maya’s confidence and mental health. She explained:

I think in the last two years, since I’ve been working in this workplace, it’s improved so much in my life, and they’ve been so supportive in every way possible – with my kids, the problems I’ve had with panic – everything. So I don’t think it’s affecting me anymore … because they’re so supportive. I don’t have them as severe or as often.

Because of the flexibility and compassion shown to Steven, he admitted he was “in a really good place with these [work] guys.” These stories demonstrated that small gestures of support and understanding were enough to improve the working lives of these employees. Indeed, when asked what type of support they were looking for in the workplace, most participants wanted minimal workplace concessions. Chloe commented:
I don’t necessarily expect time off for going through them. I expected to be cut a bit of slack for having to walk out of the office for ten minutes, or half an hour, just to try and get through it. And that it’s seen as a genuine problem … and that it is recognised as an illness, because it does hinder your work quite a lot.

Positive experiences mostly involved small, ad-hoc gestures of emotional support rather than more formal and ongoing workplace accommodation and assistance. Although this was a positive step in the right direction, there still seemed to be a lack of acceptance and understanding that panic attacks were a legitimate illness and should be treated accordingly. These positive stories also suggested that participants did not expect much in the way of support and were happy with even the smallest gestures of understanding. It is clear that the workplace has a long way to go before panic attacks become accepted as a legitimate health condition that requires accommodation and practical assistance.

### 6.6 Summary

This chapter has illuminated an important aspect of life for panic sufferers, which has so far received insufficient scholarly attention – their work life. The initial findings highlighted the role that work plays in contributing to an employee’s panic attacks, and the negative impact that panic can have on a persons’ career and working life. Employees with panic were forced to sacrifice career goals and plans; remain trapped in positions and workplaces that were detrimental to their health and wellbeing; struggled to find employment that did not involve a long commute; had to forego career development and promotional opportunities; and, were often overqualified and underemployed. Not surprisingly, these difficulties had a detrimental impact on these individuals’ wellbeing and self-worth, and many participants expressed that they felt
like a failure because of their inability to thrive in the workplace. These career
difficulties and disruptions have negative consequences for the persons’ relationships,
finances, and life and career goals. In sum, this chapter has demonstrated the high
level of disadvantage that people with panic attacks experienced in the workplace. The
next chapter considers the experiences of participants as they moved beyond adversity.
CHAPTER SEVEN
Moving Beyond Adversity

7.1 Introduction

This chapter presents the final two themes of the phenomenological model. Both themes explore the experiences of participants as they moved beyond adversity. The first theme, Developing Resilience highlights the participants’ development of resilience through acceptance and learning to live well with their condition, enhanced knowledge and information, leaning on others for support, and by finding comfort and distraction in positive thinking and enjoyable activities. The second theme, Positive Self-Changes explores the positive changes that resulted from the participants’ panic experiences. These positive changes included a healthier lifestyle, personal growth, reordering their life priorities so as to enrich their relationships, and developing new meanings and importance in life. Table 6 below provides a summary of the themes in this chapter.

Table 6: Themes presented in Chapter 7

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7.2 Developing Resilience

This theme considers the ways in which some participants developed resilience through their experiences with panic. The findings suggest that participants were all at very different stages in their journey with panic. Some participants, such as John and Ruth, were still very much in the midst of their illness, and were clearly suffering and could not see any positives in their future. Other participants had emerged from the darkness, and had developed resilience as a result of their panic experiences, including Helen:

I feel like I’m much more on the other side … I’ve had to come through terrible storms to get to where I am.

Most of the other participants were somewhere in between these two stages, and it became clear that developing resilience, defined for the purpose of this research as the ability to positively adapt to adverse circumstances (de Terte, Becker & Stephens, 2009), was often a lengthy, enduring and non-linear process, in which participants often took two steps forward, and one step back. The first step towards a resilient self, involved accepting that they could live a full and satisfying life with their enduring symptoms and vulnerabilities. This sub-theme will now be discussed.

7.2.1 “Learning to Live with It”: Acceptance

The findings highlighted that all participants believed that they would never fully recover from their panic experiences, and that the lingering symptoms would be with them for the rest of their lives. Thus, being resilient meant accepting their condition and learning to live well in the presence of their ongoing panic symptoms and
limitations. A number of the participants, including Wendy and Steven, described this process as “learning to live with it”. Wendy commented:

I learnt to live with it. And that’s the thing, I learnt to control it better and I learnt to live with it.

Steven also developed resilience by “learning to live with it”, and admitted that by doing so, he had ultimately reconstituted a new sense of self, which he felt “grateful” for:

And it’s like, well, I just live with it and I’m doing alright. I know how to pick myself up, and I get help to do stuff. And so there’s no use crying about what you used to be like. Like I was saying, this is the new person and you’ve got to live with it. And I think it’s made me a better person anyway.

These comments demonstrated that for participants, a large part of their resilience was about accepting their limitations, adapting to their situation, and growing through their experiences. Resilience was also built when participants accepted that they would need to take prescription medication indefinitely to help control their symptoms. All participants, except Hannah, Ruth and Lily, reported that they had used medication. Participants reported that medication had helped stabilise their symptoms, which enabled them to regain control of their lives and facilitate new beginnings. Jacqueline, Lauren, Wendy and to a certain extent, Mack, felt comfortable with the knowledge that they would need to take medication indefinitely. They likened their situation to those people with physical illnesses, who also required medication to keep well. For example, Lauren compared her situation to those with diabetes:
Interviewer: How do you feel about being on medication on a continual basis?

Lauren: It doesn’t really worry me. I look at it like diabetes. You know, if you need it for that, you need it. That’s the way I look at it.

Wendy also had reconciled with the fact that she would need to continue taking medication in order to treat her chemical imbalance:

I just feel that I’m better off if I’m on something. Because I do believe in my heart of hearts that it’s a chemical imbalance. I don’t care what anybody says … And I feel quite normal when I’m on just one Effexor7 a day. I still may feel a bit anxious and get stressed about different things, but I cope relatively well now.

Mack held conflicting feelings about taking medication. On one hand, he didn’t enjoy having to take medication every day, however, he was also grateful for the positive changes it had had on his life. He explained what being on medication meant to him:

I don’t enjoy it. But, I feel that if I was to stop taking it I’d get back to square one. And I don’t want to get back to square one … so at this stage I’m quite happy to take it. Although I still have bad days, I don’t have anywhere near like what I was having before. So I just live with the medication, I suppose, and look, I think I’m only one of probably millions of people that live with medication daily. Whether it be for psychological reasons or anything else.

Acknowledging that medication was a necessary tool in “living with it” helped participants develop resilience. Additionally, participants were able to adjust to a life with panic when they accepted that they had a chronic illness that needed to be treated with medication, just like those with other chronic physical illnesses, such as diabetes.

7 Effexor is an antidepressant medication that is often used to treat people with panic conditions.
7.2.2 Enhanced Knowledge and Understanding

Life with panic attacks involved confusion and uncertainty. As discussed in Chapter 5, in *A Changed Life*, many of the participants misinterpreted their panic symptoms as a sign that they were suffering from a life-threatening physical illness, or that they were “going crazy”, or about to die. To positively adjust to life with panic attacks, many of the participants found it beneficial to increase their knowledge and understanding. This alleviated some of their uncertainty and fear. It also opened up different avenues of treatment. Seven participants agreed that they became more resilient when they increased their understanding of panic. For example, Hattie reported that the “turning point” in her journey occurred when she read a self-help book on panic attacks. Even though she would have an attack when reading about panic, she persevered, and learnt how to control her symptoms more effectively.

Helen also had “a thirst for knowledge”, and she acknowledged that she spent a considerable length of time seeking information about her affliction in order to try and “solve” her problem with panic, as well as to connect with other sufferers as a way to alleviate her isolation:

Because I was trying to solve the problem; I wanted to fix this … I ended up using lots of tapes from psychologists: relaxation tapes and meditation tapes, visualisation tapes. I read everything I could get my hands on. And I’m not a reader, I don’t like reading, but I couldn’t get enough. I spent a lot of time on the Internet, reading what other people were saying … and that made me feel better – that there were other people out there who felt like I felt. I thought I was the only one in the world who felt like this.

Audrey also sought to increase her understanding of panic attacks so that she could gain greater control over her symptoms:
But I guess, learning to ride with the panic attacks, like through personal research and through looking up my own books and things like that. Getting an awareness of what it’s all about, that was very helpful.

With enhanced knowledge and understanding, these participants came to the realisation that they were not alone in their experiences. In fact, many realised how common it was for people to get panic attacks. This lessened their feelings of isolation, and gave them a sense of relief as they realised there was nothing inherently wrong with them. For example, Helen commented:

The thing I didn’t know, and I’ve only learnt this as years have gone on, by talking to lots of practitioners, and lots of different doctors, is that the thought process is identical for everybody [having panic attacks]. They get exactly the same thoughts that I was getting, and I thought I was the only one getting these crazy thoughts.

Chloe also found it “a huge help and a huge relief” to know that “other people have been through it.” Steven, in his search for answers on his illness, became aware that he was not alone in his experiences. He found this knowledge comforting:

It’s realising that there are so many people that have the same problems or similar problems, then I just feel better being able to cope.

These comments highlighted that resilience developed through knowing about, then naming and understanding their condition. Identifying and learning about panic attacks was empowering for participants. Greater knowledge of their illness allowed participants to cope and adjust to their situation as they were able to initiate illness management strategies that helped them overcome the negative effects of their experience. Lastly, through enhanced knowledge, participants came to the realisation that they were not the only ones experiencing these distressing symptoms. This was comforting for participants, and helped them accept that they were not “crazy.”
7.2.3 Social and Professional Support

In contrast to the findings detailed in Chapter 5, a number of participants credited their resilience to the support they received from their social circles and from health professionals. Support from family and friends facilitated positive illness self-management behaviours. For example, Steven reported that his wife played a central role in encouraging and motivating him to persist with illness management strategies during his worst moments with panic. When Steven found himself in a “rut”, his wife encouraged him to begin cycling again, a recreation activity that had always helped him keep “sane”, and made his symptoms more tolerable. Steven explained:

So I was in this little rut for about three days, and then eventually [my wife] says, “Right, get your bike.” And she drove me out to the Northern road, just to the start of it. “You ride, and I’ll pick you up on the way in the afternoon.” I just need a little help sometimes, just to do things. And, I mean, we work good like that. I feel it’s a no biggie, it’s cool.

Mack’s wife also played an active role in supporting him with his illness self-management activities. When Mack felt his anxiety levels increasing, his wife would remind him of the cognitive coping strategies he had learnt. He elaborated:

Just the family life; my family is so good. My wife has been very, very strong and supportive … I mean if I have a bit of a cry or a bit of a -, you know, I start to say to her, “Look I’m getting some headaches and I think I might be getting a bit anxious.” She’d say, “Well, just try and, think what the doctor said to you.” She’s always been supportive.

The support Mack received from his family not only enabled him to continue with his illness self-management techniques, but was also essential for his survival:
I think without [my psychiatrist] and my family – I don’t think I’d be here. I really don’t. I think I’d be over The Gap somewhere, because I was at my end.

Just being able to talk to family and friends about their worries and concerns with panic attacks helped participants develop resilience and cope with the demands of living with panic. Hannah commented that she relied on her family and friends as resources to talk her through a panic attack:

Like I have a very, very good support system, and I've got family that's dealt with it. I've got friends that know how to deal with it. Worst case scenario, I hit one of the buttons on my phone and I'm bound to get someone who will be able to help me, to talk me through it, even just on the phone.

The benefits of talking to family and friends about panic attacks were also boosted when the participant had someone to talk to who had similar illness experiences. This provided the participants with both understanding and a feeling of security and comfort. Chloe commented that she relied on her mother, also a panic sufferer, as a resource whenever she felt her panic returning. She reported:

I’m actually really close to my mum, which helps a lot. I think, because she has it too. So, I will call her when I’m going through a bad run, like that time, that big one that I had, I spoke to her on the phone for about an hour. She was trying to take my mind off it … she’ll sit on the other end of the phone while I’m talking through it. So, she’s there as a tool [slight laugh] – poor thing, but she’s had them as well, and it sort of goes both ways as well, which is good.

These findings highlighted that having access to support was important for building resilience. The participants who had a key support person in their lives, often their spouses, who showed love and unconditional regard, were often better placed to

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8 The Gap is an ocean cliff in Sydney, Australia, infamous for suicide attempts.
develop resilience. Also, participants who shared their experience with others also developed their resilience, as they realised they were not alone.

Accessing the right form of professional support also allowed participants to develop resilience. Nine of the participants used health professionals, usually psychologists or psychiatrists, in order to regain control of their symptoms and adjust to life with panic. Many of the participants had an ongoing relationship with their health care provider and would access them either on a regular or ad hoc basis, when they felt themselves slipping back into illness. As Lily commented:

So it’s just sort of something that I just have to manage, and I seek professional assistance when I need to. And it can be quite useful.

Unsurprisingly, participants that formed beneficial and ongoing relationships with their healthcare providers were more likely to report that they trusted and had confidence in the abilities of their practitioner. For example, Audrey’s trust in her GP was the motivating force that spurred her to return to work. Audrey discussed the relationship she had with this practitioner:

She’d been my GP for thirty-five years, still is. And she was just able to be very candid with me, not a professional Doctor, down to, you know, a stupid panic attack patient. It was like, “Audrey, you know the longer you stay off work, the harder it’s going to be to get back there?” She said, “You really do need to get back to work.” … And yes, because I believe her and trust her, I’d go home and think, “Yes, you’ve got to set yourself some planning here. You’ve got to get back to work. You’ve got to make a date – work towards it, get back there.”

Wendy also credited her rebirth to the “nurturing” relationship she had with the nurses at a mental health facility, where she stayed as a private patient:

And I was in a private hospital … and it had fantastic nurses, like, the best nurses. And they all loved me in there, and they were just so supportive … and it was just the most beautiful, nurturing thing I’ve
ever had in my life, because it was three months of rebuilding my esteem, because I was flat. It was like I had a new lease of life. I felt like I was reborn again.

The participants often reported that their healthcare providers would provide them with suitable cognitive tools, skills and strategies that enabled them to manage their symptoms and improve the quality of their lives. Relaxation techniques and Cognitive Behaviour Therapy (CBT) were often mentioned by participants as tools they learnt from their practitioners. Jacqueline commented:

The psychologist had given me a few things to try and calm me down, like counting backwards from nine hundred and ninety nine million thousand, you know, one of those [techniques] - , and my breath and all that, so I normally calmed myself down.

These comments highlighted that resilience occurred when participants found a trusted health professional that they could rely on for support. These professionals were able to enhance the participants understanding of their illness, and were given tools so as to manage their symptoms more effectively.

As discovered, social and professional support were important to adapting positively to a life with panic. Unfortunately, the findings in Chapter 5 suggested that finding the right support was more difficult than not. This meant that many participants were left to deal with their illness alone, hampering their ability to develop a resilient self.

### 7.2.4 Finding Comfort

Participants built resilience through positive self-talk, and it was used as a way to comfort and encourage themselves during times of distress. For example, Helen engaged in “a lot of self-talk” to get herself through situations, such as air travel, which had the potential to trigger her panic attacks. Self-talk also enabled Hannah to
control her breathing and prevent hyperventilation, which would “get [her] into a panicked state because [she] couldn't breathe”:

I just had to reassure myself, in my head, that, “You're breathing is fine. Nothing is wrong” … Now I would breathe through it, and sort of talk myself out of it.

As discussed in the previous sub-theme, Social and Professional Support, participants often learnt the techniques to be able to talk themselves out of a panic attack from their mental health practitioner. Participants who were “a lot more aware” (Lucy) of their thought processes and feelings were able to comfort and calm themselves during times of distress.

Lastly, participants developed resilience by finding comfort in enjoyable activities and hobbies. It was often small, relaxing, everyday activities, like reading or watching television, which enabled participants to see the positives in life. Lily called this her “downtime.” Steven commented:

If I’m home and I’m really feeling like crap, I’ll go and put on a nice movie that will make me feel good … So I’d say a really important and key to a panic disorder is to build up in areas you feel comfortable in, little positive experiences, so that you don’t automatically flip back to the darkest times.

Faye, Audrey and Lucy also reported that watching television, listening to music and reading were activities that helped them build resilience. Often, these activities were used as a way to distract them from their anxious feelings. Lucy commented that “watching movies and listening to music ... takes [her] out of [her] head.” Similarly, Audrey would “try and distract [herself], by watching TV.”

Other participants commented that they participated in more physically active hobbies to distract themselves from their anxiety and as a way to build confidence. For
example, Mack played “lawn bowls once a week” to “fill the void that was left when [he] originally left [his] job.” Similarly, Lucy “made [herself] go” to “theatre classes every week ... even when [she] was feeling really, really anxious.” Once she was there she “enjoyed [herself]” and it “gave [her] a big confidence boost.” By pushing herself outside of her comfort zone, even during times of anxiety, Lucy became more aware of her inner strength:

I think well, I might be going through all this anxiety, but, look, I'm still doing theatre classes with a bunch of strangers. Most people with our anxiety levels probably wouldn’t want to do that.

The hobbies that Mack and Lucy enjoyed were shared with other people. One positive of these group activities was that it allowed participants to connect with people, and helped prevent isolation. These groups also acted as informal support networks. For example, Faye reported that when she was “sick” she would go to her “knitting group” every week and would talk to them about her “breakdown.” She found acceptance amongst this group: “They're wonderful; they've been terrific.”

This sub-theme has illustrated that developing resilience required thinking positively, being active, and distracting themselves from their anxious thoughts and feelings. Their panic experiences often initiated a desire to take better care of themselves. These and other positive changes are discussed below.

7.3 Positive Self Changes

Panic attacks were the catalyst that led to many positive self-changes in the participants’ lives. Participants reported improved health, personal growth, reordering life priorities and improved empathy to others.
7.3.1 A Healthier Lifestyle

One such positive change involved a move to a healthier lifestyle. Participants reported taking better care of themselves through increased physical fitness, healthy eating habits and getting enough rest. Positive changes to health were often credited as one of the reasons why participants were able to recover from their illness. For example, Wendy made healthy changes to her lifestyle in order to “turn things around”:

I had to start exercising. I had to watch what I ate; I made sure I ate regularly. I had to exercise on a regular basis.

Steven also credited improved physical fitness as one of the reason he was able to “get back on [his] feet”:

So I started running and getting fit … and that probably helped as well. After that I started doing triathlons and stuff. It was good because it set me on this positive track … I do believe that exercise really helps you start to feel more positive about yourself and have self-confidence.

Participants also improved their health by getting more sleep. Being well rested helped them manage their days better and improved their ability to cope with stress. For example, Helen had to “make sure [she] got enough sleep because [she] knows if [she’s] tired it’s going to be bad.” To be “kinder to her body”, Chloe also tried to “get more sleep”, and “changed [her] diet and eats healthier.”

These findings have highlighted that their panic attacks motivated a number of participants to improve their health and fitness. This then had a positive flow on effect on their wellbeing and sense of self. Improved health also enabled participants to rise above their illness.
7.3.2 Personal Growth

Another positive self-change involved the way in which participants viewed themselves. Participants reported that they had a greater appreciation of their strengths and personal resilience. For example, Lucy felt that she had become stronger as a result of the adversity she experienced:

I think it's made me a stronger person because I have challenged myself a lot and pushed myself to do things that I haven’t necessarily wanted to do. They have been for the better, in general.

Maya also felt that her experiences had made her stronger and more determined to achieve her personal goals:

Since I had my breakdown, I’ve achieved every goal I’ve set myself in the five years. And I feel really proud that I’ve got this far, going through everything that I went through, because for me it’s a plus.

These comments have shown that a positive change in self is borne through “hard fought experience” (Linley, 2003: 607). Their experiences had forced participants to face and overcome some of the biggest challenges of their lives. This has given participants a sense of achievement and boosted their self-belief. Helen confirmed:

So I found my voice in lots of ways. So it’s made a difference to that. I suppose I’ve been through this storm now, I feel far more confident, more empowered. I know I’ve come through a bad time, and I can do it. I’m not the weak little thing I thought I was.

A number of participants felt that they had become “better” people since having panic attacks. Helen was “glad” that she was no longer her old self, as she did not like the person she was before:

She was too bloody hard. No. I’m glad she’s gone. She made my life difficult. She expected far too much. No. She was cranky all the time.
She used to yell at the kids all the time, because she was pushing so hard. She was too demanding. No, I don’t like her. No, I’m glad she’s gone [laughs].

Steven also felt that he was “a better person than what he was” before becoming ill. He felt appreciative that the panic attacks had allowed him to see life from a new perspective, and this had enabled him to change as a person:

I’m actually kind of grateful for it. I know it probably sounds silly, but I am. Because I was not a really nice person, I don’t think, before it happened … when this happened it kind of brought me back to ground. It’s like a reality check. I feel more in touch with life and people than I ever did. I know myself a lot better than I ever did before.

Steven and Helen’s comments illustrated how their experiences with panic had led to personal growth and enhanced self-esteem and self-efficiency. Both Steven and Helen had undergone profound transformations and were happier with who they had become since their panic experiences. Hannah also had a similar viewpoint and confirmed: “I’m a much happier person now and that’s just through learning to deal with it.” Having panic attacks allowed participants to have enhanced empathy and compassion for others. After her experiences, Maya took a “life coaching course” so she could “help other people.” Wendy felt that the adversity she had experienced had “absolutely made [her] a better person … it made [her] absolutely, totally compassionate.” Her experiences “opened up her eyes” to the suffering people experienced, and as a result she would spend time visiting the mentally ill at a specialist hospital.

Indeed, a number of the participants, including Helen, Mack, Maya and Charlotte, had participated in this study as a way to reach out and “help others” (Charlotte) in similar situations. These comments demonstrated that the participants’ panic
experiences had made them stronger, more caring and empathetic, and allowed positive personal growth.

### 7.3.3 “A Wake-up Call”: Re-evaluating Life Priorities

A number of participants re-evaluated their life priorities as a result of their experiences. They were grateful that this momentous experience had set the stage for reflection on the meaning and value they placed on life. Helen called it her “wake-up call.” Maya felt grateful that her condition gave her the “courage” to re-evaluate and make positive changes to her life:

> Well, I think my panic attacks and my breakdown were the best things that happened to me. Because it gave me time to think and assess and evaluate my life and what I needed to do to sort it out … and I’ve had to remove things and people from my life to stop the [panic] attacks …

Maya’s comments highlighted that changing her outlook on life assisted in her recovery. Hannah also “changed [her] outlook”, and learnt to “not let things get to [her] that much.” As a result, Hannah is a “much happier person now.” As participants emerged from their lowest point, they realised how precious the small moments in life were. Helen explained:

> To just be content was something that I’d never thought I’d have again. I never thought I’d be comfortable in my own body again. I never thought I’d be able to drive or walk into a supermarket again. To be able to do all those things was just wonderful. So yes, I don’t need the big things, or the high achievements.

This realisation propelled participants to re-evaluate their life priorities, and actively choose their relationships with their families over other life domains, especially, work. For example, before she was sick Faye was “driven by work” and was “worried
about work 24 hours a day”, and she admitted that she was a “pretty tense person” as a result. Her focus on work affected her health and her relationship with her spouse and son. Her journey through illness became “a lesson for [her]” and forced her to “rethink how [she] goes about her [her] day-to-day life.” Now, Faye’s priorities have changed:

I’m doing things for myself now and my family. I do the minimum I have to do for this [work] place. I’m not going to jump hurdles for them anymore … It’s just freed me. So I don’t feel any sorrow for the life I lived before the 2nd of April. I now can see that I have my work slot, and all these other times are for me and my son, and the things I like to do.

Reordering her life priorities had a positive impact on Faye’s relationship with her family: “And my relationship with both my husband and my son has improved beyond belief.” Other participants placed less importance on their work domains in order to take better care of their health and wellbeing. For example, Wendy placed her health needs above her career:

So, I don’t want to put any more pressure on myself. I know when to back off now, where before I never used to. I’d just keep going until I’d collapse. I don’t do that anymore. I realise that I’ve got my boundaries, and I need to take stock. I need to look after myself. So career is secondary. You know? It’s not the be all and end all.

Helen also felt that she needed to reprioritise her personal life over her work domain in order to “be a bit more caring of [herself].” She “cut [herself] some slack” by becoming more assertive at work and saying no to extra work demands:

It made me have a voice, whereas before I would have always said, “Yes, yes, yes, yes.” Now I don’t … I never take work home now,

9 The commencement of Faye’s panic attacks occurred on this date.
whereas before I used to. I make a very definite decision, work is work and home is home.

This section has spotlighted how panic attacks triggered participants to re-evaluate their life priorities. Often participants realised that they had placed too much importance and value on their work lives, and this was at the expense of their health, wellbeing and relationships. These individuals made positive changes to their lives in order to remedy this. Faye’s comment encapsulated what it meant to re-evaluate life priorities after panic:

So I’m having to learn to relive my life and be much kinder to myself.

7.4 Summary

This chapter has presented the final two themes of the phenomenological model. These themes have centred on the experiences of participants as they journeyed beyond adversity. The first theme, Developing Resilience shared how participants developed resilience in response to their illness experiences. Specifically, this involved accepting that they could live well with their enduring symptoms and vulnerabilities, and accepting that medication was a necessary tool to manage their symptoms. Resilience also involved increasing their knowledge and understanding of their condition in order to alleviate some of their uncertainty and fear, while this also opened up different avenues of treatment. The findings revealed that participants who had access to supportive family members and a trusted health professional were also in a better position to develop resilience. Finding comfort and distraction through positive-self talk and enjoyable activities and hobbies also led to a resilient self. The second theme, Positive Self-Changes highlighted the positive changes that occurred in the participants lives as a result of their experiences. Participants reported that their
panic attacks were the catalyst that led to a healthier lifestyle, which included increased exercise, healthy eating and getting enough rest. Another positive change included the way in which participants viewed themselves. Participants reported a greater appreciation of their personal strengths, and experienced personal growth and transformation and had enhanced empathy and compassion for others. Lastly, the findings affirmed that the participants’ experiences led to a re-evaluation of their life priorities. As a result, their relationships with their families, and their health and well-being became a priority over their work domain. The next chapter discusses the implications of the findings from the last three chapters.
CHAPTER EIGHT
Ending the Silence: A Discussion

8.1 Introduction

This study has illuminated the experiences of employees who live and work with panic attacks. The discussion in this chapter is framed around the key findings already shared, within the context of the relevant literature. The implications of these findings for the individual and their families, employers and organisations, health professionals and the federal and state governments will also be considered. There are five major topics of discussion, including: ‘A Secret Life’; ‘A Shrinking World’; ‘Relationship Conflict’; ‘Working in Quiet War Zones’; and, ‘Living ‘Well’ with Panic Attacks’.

8.2 A Secret Life

The findings suggested that almost all participants kept their panic experiences hidden from those around them – especially in the workplace. Suffering in silence, fearful and alone much of the time, the participants led A Secret Life with panic attacks. This study confirmed that secrecy was rooted in the ingrained social stigma and shame attached to having a mental health condition (Quinn, Kahng and Crocker, 2004; Bos et al., 2009). Other researchers have made similar discoveries. For example, Luoma et al. (2007: 1342) confirmed that internalised shame associated with perceived stigma leads to higher levels of concealment and “secrecy coping”. Markowitz (2001) suggested that individuals who have a stigmatising condition anticipate being demoralised and discriminated against and so conceal their invisible stigma.
It was no surprise that stigma was a significant feature of the participants’ illness experience. As Campbell and Kaufmann (1997: 224) suggested, people with mental illness have remained “among the most stigmatized of those with disabilities.” Since Goffman’s (1963) seminal work on stigma, in which he presented evidence of the challenges involved in being discreditable, research on mental illness stigma has been well documented, especially in more recent years (Corrigan & Watson, 2002; Link et al., 2004; Corrigan & Kleinlein, 2005; Rusch et al., 2005; Hinshaw, 2007). However, much of this literature is focused on individuals with ‘serious mental illness’, such as schizophrenia (Teschinsky, 2000; Corrigan, 2005; Mak & Wu, 2006; Grubaugh et al., 2011; Sibitz et al., 2011). This study contributes to new knowledge by highlighting the stigma experiences of a currently neglected group of mental health consumers. The distinction within the academic literature between those with ‘serious’ mental illness and those with so-called ‘milder’ and more common mental health complaints, can trivialise the suffering experienced by people with ‘milder’ conditions, such as panic. Far from being trivial, there are very serious implications for those affected by panic in and around the workplace. Individuals with panic regularly attempted to conceal their condition, in order to protect themselves from flawed assumptions, negative attitudes and judgements from their community, family and employment circles.

The findings have highlighted that secrecy reportedly amplified the participants’ isolation. Participants spoke of withdrawing from work, their community, and those around them, deliberately creating a physical, emotional, and/or psychological space that isolated them (and their panic) from other people. This isolation, combined with the initial confusion, stigma, and shame meant that many participants avoided or delayed seeking treatment – sometimes for years. This discovery has implications for
the person with panic’s recovery and well-being. Clinical studies have proven that delays in diagnosing panic disorder can lead to a deteriorating quality of life (Candilis et al., 1999; Carrera et al., 2006; Husser et al., 2006). Further, living with a worsening undiagnosed mental health condition, sometimes for years, without the necessary support networks, would have been a distressing experience for participants and their families. This may have contributed to the reported relationship strains and breakdowns, discussed in the sub-theme, *Stigmatisation and Family Relationships*.

It is common for mental health problems to be underreported by individuals in the community, and an estimated two-thirds of people with a diagnosable mental illness do not seek treatment (Byrne, 2000). One notable study, surveyed 3,099 participants with an anxiety disorder and found that over 90% of these individuals did not approach a professional to get help. For those individuals who eventually sought professional help, the average delay exceeded 15 years (Johnson & Coles, 2013). Delays in treatment could mean additional years of distress, an increase in the severity of the condition, as well as cumulative effects (Johnson & Coles, 2013). This study confirmed the importance of removing the barriers that prevent people with panic from seeking treatment, including a lack of mental health literacy and the stigmatising attitudes of others. The fact that many participants encountered judgement and insufficient support from their GP underscores the importance of educating primary care practitioners about the legitimacy of the panic condition, appropriate treatment options, and the symptoms of panic. At a federal and state government level, public mental health campaigns that increase the legitimacy of panic attacks as a real condition with potentially devastating effects on the individual and his or her family should be explored. Stigma should be directly addressed in these campaigns.
Additionally, these campaigns should bring awareness to how common this condition is in order to reduce feelings of social isolation for those affected.

8.2.1 Workplace Secrecy

Secrecy was common in the workplace; almost half of participants believed that disclosure would tarnish their status as a capable and competent worker. This was one of the key reasons for concealment at work. To preserve their appearance of capability, employees used a number of tactics to keep their stigmatised illness a secret. These tactics broadly corresponded with the theoretical construct of ‘passing’ (Leary, 1999; Joachim & Acorn, 2000; Clair et al., 2005; Lonardi, 2007; DeJordy, 2008), which involves the deliberate decision to manage identity-related information in order to pass as ‘normal’ and thus avoid negative reactions from others (DeJordy, 2008). Passing tactics included concealment, fabrication and discretion (Herek, 1996; as cited in Clair et al., 2005). Strategies were also similar to Goffman’s (1963) concept of covering, whereby individuals made significant efforts to prevent the stigma attached to their condition from being known (Exley & Letherby, 2001).

Participants, particularly in the service industry, also reported using emotional labour to cover their feelings associated with panic (Hochschild, 1983). Emotional labour occurs when the employee is paid to modify “their feelings to the needs of the customer and the requirements of the work situation” (Lupton, 1998: 20). This may involve suppressing, faking or enhancing emotions (Grandey, 2000). Participants reported putting on a mask and trying to uphold a ‘happy’ appearance during times that they felt extreme distress due to panic.
Although these strategies could potentially protect people from the damaging consequences of stigma, studies have shown that the efforts to conceal a stigmatised condition can contribute to the very symptoms – anxiety, stress related illness, emotional strain, depression – from which they are struggling to recover (Cole et al., 1996; Frable, Platt, & Hoey, 1998; Major & Gramzow, 1999; Miller & Major, 2000; Smart & Wegner, 1999, 2000; Pachankis, 2007). Goffman (1963: 108-9) found that individuals who employed ‘passing’ or ‘covering’ tactics were likely to suffer psychological harm due to the excessive levels of anxiety associated with potentially being caught out in a deception. There are also many studies that have documented the negative effects of emotional labour on the employee. For example, emotional labour has been found to impede with cognitive task performance (Baumeister et al., 1998); increase levels of psychological distress (Gross & Levenson, 1997); contribute to emotive dissonance (Kruml & Geddes, 2000); and, burnout (Miller et al., 1995; Morris & Feldman, 1996). This corresponds with this study’s findings, in that participants worked extraordinarily hard to push their panic attacks aside in order to continue working, and were anxious about their condition being discovered. This put enormous pressure on them, and the effort to conceal their condition left many exhausted, stressed and even worse off than before.

Disclosure literature has confirmed that being caught lying can mean being further stigmatised and discredited (Joachim & Acorn, 2000). Being caught out in a lie could also potentially ‘mark’ an employee with panic as untrustworthy. The combination of having a stigmatised condition combined with being viewed with suspicion meant that employees could be the subject of workplace gossip, bullying and isolation from work colleagues. An employee’s career and financial security is also put at risk, as they
may be denied career opportunities, including promotions and training. Ultimately, the evidence presented confirmed that disclosure of panic can result in job loss.

Secrecy also caused a host of other problems for employees with panic. Attempting to pass as normal in the workplace meant participants needed to be vigilant in keeping their condition hidden. This would be mentally taxing for the employee, and could lead to an inability to concentrate or perform at work (DeJordy, 2008). In an effort to keep panic hidden some participants felt compelled to work above their capacity. This led to additional stress, panic and anxiety, and for those who were unable to keep up with the demands of their role, they either resigned or were dismissed. This has highlighted that participants would rather deny themselves the possible opportunities to request reasonable workplace adjustments from their employer, such as flexible work hours, reduced workload or working hours (Munir, Leka & Griffiths, 2005) than risk disclosing their condition.

Most participants expressed a desire to maintain secrecy at work, which suggest that panic attacks and other anxiety disorders are underreported in organisations and may be going largely unrecognised. Organisational researchers (for example, Dewa et al., 2007; la Montagne et al., 2010) have confirmed that the size of mental stress disorders is substantially underestimated in the workplace. This is also reflected in the Australian Bureau of Statistics (ABS) Work-related Injuries Survey 2009–2010 (ABS, 2010), which showed that workers who reported mental stress were less likely to claim workers’ compensation than workers with other injuries, such as fractures. Indeed, 70% of workers who reported experiencing work-related stress did not apply for workers’ compensation (la Montagne et al., 2010; Safe Work Australia, 2013a).
The majority of participants reported that they were more likely to reveal their condition to their family as opposed to those at work. These findings are consistent with emerging research that indicates employees with invisible stigmas do not disclose to the same degree across work and family domains, and are more likely to maintain secrecy within the workplace (Button, 2001; Chrobot-Mason, Button, & DiClementi, 2001; Ragins & Cornwell, 2001; Griffith & Hebl, 2002; Clair et al., 2005; Ragins & Wiethoff, 2005; Ragins, 2008). This differing level of disclosure across life settings can lead to “disclosure disconnect” (Ragins, 2008: 195), in which the individual experiences psychological incongruence, anxiety, and uncertainty as a result of presenting different identities across work and non-work domains (Ragins, 2008). Research also suggests that the pressure to closely self-monitor behaviours and actions across different life settings can lead to an unhealthy preoccupation with the stigma, and intrusive thoughts (Smart & Wegner, 2000). Currently, much of the organisational literature views employees primarily in terms of their work roles, and so there is a lack of recognition that inconsistent or non-disclosure across life domains may negatively impact the health and well-being of employees (Vickers, 2001; Ragins 2008). This study provided valuable insight into the disclosure decisions of employees with panic across work and non-work domains.

Disclosure in the workplace could result in increased support from sympathetic work colleagues (Joachim & Acorn, 2000; Vickers, 2001), as was experienced by a minority of participants. Research suggests that disclosure can be used by employees a way to gain support (Creed, 2003); increase awareness of stigmatising conditions, influence organisational culture (Bowen & Blackmon, 2003); and, create social change (Meyerson & Scully, 1995; Creed & Scully, 2000). Unfortunately, disclosure proved disastrous for many of the participants who worked in negative or abusive
work environments (Powell, 1998; Perrone & Vickers, 2004). The findings from this study confirmed disclosure was complex and although a minority of participants reported tangible benefits, a much greater number of participants found disclosure (either voluntary or involuntary) in the workplace resulted in considerable disadvantage. This is discussed in more detail in the upcoming section, *Working in Quiet War Zones*.

Lastly, secrecy meant that employees with panic in the workforce were less likely to come to know other people with the same mental health problem. Thus, they could miss out on support and mutual understanding, leading to further feelings of isolation. Additionally, contact theory states that contact is among the most effective ways to reduce stigma towards people with mental illness (Pettigrew, 1998; Corrigan & Matthews, 2003; Couture & Penn, 2003). The study’s findings support this theory. It was generally found that the participants with the most supportive and understanding managers, were ones that had personal experience with panic attacks. However, until people with panic can discuss their condition openly without facing the stigmatising attitudes and disbelief from others, finding an ally in the workplace will remain a problematic undertaking.

Secrecy in the workplace means that it is essential that employers create a safe workplace environment for employees to disclose their panic attacks and request support. Developing and implementing organisation-specific mental health policies that provide practical guidelines and tools that encourage employees to discuss their situation is recommended. Practical solutions could include: supporting employees return to work; linking to internal and external mental health support services; making reasonable adjustments to work; and, respecting the individual’s need for
confidentiality. Organisations need to be aware that even if supportive policies are established, if employers are seen as unapproachable and do not demonstrate compassion and sensitivity, employees will still be hesitant to disclose their condition.

8.3 A Shrinking World

The findings reveal that the participants with panic became socially isolated and cut themselves off from people and situations that they feared. They reported avoiding normal life events, including those that revolved around work-related activities, or travel to and from work. The essence of this experience has been termed *A Shrinking World*. Living in a shrinking world could have a direct and negative impact on these people’s quality of life, their capacity to socialise, to do the work they were employed to do, to get to work, and to otherwise provide for themselves, financially and socially, in an adult world. The implications of these restrictions could include: a loss of opportunities, dreams and experiences; considerable strain on spousal, family and social relationships; and, additional financial pressure for families, as financial and lifestyle goals were pared back or abandoned. Work loss and the inability to provide for their families could further diminish the persons’ sense of self.

A number of participants reported suicidal ideations because of their severe life restrictions and suffering that they experienced. Suicidal ideation was not confined to this study: research shows that there are high rates of suicide in anxious individuals, with just over one in four (27%) people who attempted suicide experiencing anxiety and panic attacks at the time of their attempt (De Leo et al., 2005). Individuals with anxiety are also at higher risk of suicide ideation and behaviours than those with depression (Jorm et al., 2006a, 2006b). Far from being trivial, this study underscored
the serious and even life threatening consequences of panic attacks. It also goes some way to disproving the assumption that those who are depressed are the dominant group at risk of suicide.

The impact of suicide is devastating, not only for the individual, whose life is cut short, but for the person’s family and wider community. These findings have highlighted the importance of early recognition and treatment of people with panic and provide further evidence that panic attacks and other anxiety disorders are highly under-recognised and undertreated in the community and by primary health services. Educating health professionals about the potential life threatening outcome of this condition may serve to increase the legitimacy and seriousness in which this condition is taken. Being viewed as a potentially fatal illness may increase the empathy and medical assistance that panic attack consumers receive from health professionals. Untreated panic attacks and other anxiety disorders are a missed opportunity for preventing suicidal behaviour. In Australia in 2011, there were 2,273 deaths from suicide (Reavley & Jorm, 2013). It is concerning to think of how many of these people may have had untreated anxiety disorders.

Participants spoke of feeling “useless” as their previous taken-for-granted day-to-day activities became unattainable or were endured under sufferance. Their self-worth was diminished, not only from having a stigmatising condition, but as a result of the disruptions the illness has wrought upon their lives. These experiences are similar to Bury’s (1982) concept of a biographical disruption, which emphasised that the impact of injury or illness on a persons’ ability to perform valued and predictable everyday activities may lead to lowered self-worth (Hammell, 2004). When “people lose their ability to do those occupations that are important to them this erases their perceptions
of themselves as capable and competent, such that they describe feeling useless and valueless” (Hammell, 2004: 300).

Paradoxically, as participants withdrew from the world they also reached out for support from health professionals and family members. However, most reported receiving judgement and inadequate support from others and were left to cope with their illness alone. Of particular concern is that participants reported encountering stigmatising attitudes from health professionals. This study showed that support from a trusted health professional was important to adapting positively to a life with panic and building resilience. Thus, it is vital that health professionals have the necessary skills to identify patients experiencing panic attack and that they acknowledge the legitimacy of their patient’s experiences. This is particularly important for GP’s and staff in emergency departments as they are often the panic attack consumers first line of contact. Educational campaigns that target these health professionals would be valuable.

Participants also reported having difficulty locating information and resources about panic attacks. They commented that there was more community awareness and information about depression than panic and anxiety. The lack of information, they felt, hindered their ability to understand and manage their illness. This intensified their sense of being alone. These findings have shown that the severity of panic and anxiety disorders are being minimised in the community and that there is a clear lack of health literacy and community awareness about anxiety disorders, including from health professionals. This is despite the fact that anxiety disorders are the most common psychiatric diagnosis in Australia (ABS, 2007). This has implications for the level of self-stigma felt, help seeking behaviour and recovery, the level of support and
empathy received from family, friends and employers, and does nothing to clear the misconception that panic attacks are not a legitimate and serious condition. These findings are supported by research which shows that panic and anxiety disorders are less frequently represented in mental health awareness campaigns, such as those by high profile Australian non-government organisations (NGO) beyondblue and SANE (Jorm et al., 2006a; Cox, 2012). Rather, depression has been the main focus of these campaigns and has been positioned as the most debilitating and most common mental illness in Australia (Cox, 2012).

To combat the lack of awareness and poor mental health literacy surrounding panic attacks, federal and state governments should develop campaigns to increase community awareness about the signs and symptoms of panic attacks. Campaigns should also target hospital emergency staff and GP’s, as the findings show that these are the health professionals that consumers first reach out to when experiencing a panic attack. This may serve as an effective early intervention strategy, allowing this problem to be identified and treated before it becomes more serious and entrenched. Increasing the mental health literacy of panic is important as the findings have highlighted that greater knowledge and understanding of panic helped build participants’ resilience.

Finally, the majority of participants in this study were young adults when they first experienced panic attacks. This corresponds with research that places the median age of onset for panic disorder at 24 years (Burke, Burke, Regier & Rae, 1990). Avoidance behaviour and self-imposed isolation during this critical stage of life, when a young adult is trying to establish independence in the adult world, cannot be underestimated. Opportunities to participate in recreational and social activities, and
form significant adult relationships may become limited, hampering emotional independence and the development of secure identities.

This is also the time that young adults usually embark on higher education and transition to the workplace. For young adults, gaining employment “symbolically represents an entry point into the world of adulthood with responsibilities, freedom and respect” (House of Representatives Standing Committee on Education and Employment, 2012: 155). If panic attacks restrict their education, employment opportunities and ability to participate in the workplace, this can have lasting negative effects on one’s sense of self-worth, and ability to build a positive future. Without support, people with panic may disengage from education, training and employment, and risk long-term social and financial disadvantage. Additionally, the transition to work generally occurs when young people are most vulnerable to mental health difficulties. Their limited life experiences, self-confidence, and lack of knowledge about appropriate working conditions and entitlements can make young workers vulnerable to exploitative workplace practices and workplace bullying (House of Representatives Standing Committee on Education and Employment, 2012). This makes it even more difficult for young workers to speak up about their panic attacks and request workplace support. Young adults are also less likely to ask for help and will drop out of work if they experience problems (House of Representatives Standing Committee on Education and Employment, 2012).

Young adults with panic are likely to be particularly vulnerable to the negative effects of panic attacks. Governments, health professionals and employers need to provide targeted support to assist these young workers achieve a positive future. For example, an awareness campaign targeted to this group of people would be useful. High schools
and higher education institutes should be the focus of such campaigns. Additionally, young people are particularly vulnerable as they transition from school to work institutes, therefore educating young people of their workplace rights, and the avenues available to seek assistance would be useful. Targeting young people would allow for early intervention before panic attacks became too entrenched.

8.4 Relationship Conflict

The delegitimation of panic attacks within the family context emerged as a particularly strong theme within the narratives. Nearly all participants were concerned about the lack of acceptance and understanding of panic attacks from family and friends. This situation often created relationship conflict, stress and tension, as many felt that their loved ones trivialised their problems with panic and, in effect, denied their sick role and illness experience. This often led to collapsing relationships. These findings are concerning, given that supportive social relationships can have a positive influence on health outcomes (Barrera, 2000; Berkman & Glass, 2000; Uchino, 2004). For example, research indicate that family support is important for managing and coping with chronic illness (Lazarus & Folkman, 1984; Zipple & Spaniol, 1987; Manne & Zautra, 1989; Gallant, 2003; DiMatteo, 2004; Lett et al., 2005; Patel et al., 2005; Rosland et al., 2012); buffering against depression in the face of negative life events, including illness (Rich and Bonner, 1987; Marino et al., 2008); and, contributing to higher marital quality and better family functioning (Primomo et al., 1990).

The participants’ dissatisfaction with the support provided by family and friends confirmed that panic is a heavily stigmatised and misunderstood condition. It also
highlighted that participants were having difficulty conveying to other people the meaning and implications of having panic attacks. Frustrating for the individual, this again spotlit the lack of awareness and understanding in the community about panic, and that it is a legitimate illness. Negative interactions with others combined to isolate the affected person from others – in effect, these individuals were deprived of recognition of their lived experience and were often left to cope by themselves, leading to *A Shrinking World* (as discussed previously). Participants may also have interpreted these difficult encounters with family members to be a sign of rejection (Rook, 1992). People who have panic attacks may also be particularly vulnerable to the negative responses from family and spouses, as they are already depleted of the psychological resources to cope with stressful life events (Ingersoll-Dayton, Morgan & Antonucci, 1997; Druley & Townsend, 1998).

This research revealed many parallels with other contested chronic illnesses, including multiple sclerosis (MS) (Vickers, 2009, 2012); chronic fatigue syndrome (CFS) (Dickson et al., 2007); primary biliary cirrhosis (Montali et al., 2011); fibromyalgia (Sim & Madden, 2008); and, cancer-related fatigue (Pertl et al., 2014). Participants in these studies also reported a perceived lack of concern and misunderstanding from their family and friends. These parallel findings could be because these illnesses all share similar characteristics: they are invisible, ambiguous, subjective, difficult to quantify, and lack a precise bodily location (Montali, 2013), which may cause the sick person’s credibility to be questioned and make it difficult to have their sick-role accepted by others, including family and friends (Montali, 2013). However, where this study differs is that people with panic also needed to contend with the additional burden of having a mental illness. Those affected were also confronted with the negative attitudes of others, who implied that they were in control of their panic.
attacks, and so were either weak-willed, lazy or a malingerer (Lafrance, 2007). People with panic struggled to accept the legitimacy of their illness, with evidence pointing to feelings of shame, self-stigma and low self-esteem. A demoralised person may lack the confidence to pursue work and vocational goals, isolate themselves from others, and experience strained relationships with family and friends.

Participants were also concerned about the lack of empathy they received from a spouse or significant other. This is concerning, as partners have a critical role in a sick persons’ adjustment to chronic illness (Cutrona, 1996), and for their well-being in general (Burman & Margolin, 1992). Several participants reported that the lack of support from their partner or spouse led to a relationship breakdown. Interestingly, it was mostly the women participants who felt that their partners were not responsive to their needs. One possible explanation for this might be because women typically provide more emotional support than men do (Cutrona, 1996; Helgeson, 2003; MacGeorge et al., 2003), and, perhaps because, traditionally, women were expected to fulfil the carer role within the family (Fahey, 1999). Moreover, studies have shown that women might be in danger of having their symptoms undervalued because of stereotypes that describe women as neurotic and prone to worrying over trivial issues (Milliken & Northcott, 1996; Werner & Malterud, 2003). This is a relevant issue as anxiety related disorders are at least twice as prevalent amongst women, compared to men (Somers et al., 2006). This gender disparity was also reflected in this study, with fifteen women, compared to only three male participants taking part in the study.

The delegitimation of their panic attacks by family members could also explain part of the reluctance of many to seek health support. Family shame as a response to a psychiatric diagnosis has been shown to be a predictor of treatment avoidance (Leaf,
Bruce, & Tischler, 1986; Greenley, Mechanic, & Cleary, 1987). Not surprisingly, and as discussed earlier, it is common for people with a mental illness, including anxiety, to delay help seeking (Byrne, 2000). This has implications for a person’s recovery, as studies show that early intervention is important for recovery (Bertolote & Mcgorry, 2005).

Lastly, participants, particularly those with families, were aware that the disruption to their social lives, work lives and general activities had a significant impact on others, particularly their spouses and children. Participants reported feeling anxious and guilty that their restricted lives also meant possible restrictions for those closest to them. Family recreational activities, such as travelling, hobbies, and social gatherings became increasingly difficult, or stopped completely. This put further pressure and strain on families, especially spouses, who were already struggling to understand and, in many cases, accept the legitimacy of their partner’s condition. Relationship breakdowns were often the outcome when the strain of living a restricted life proved too great for spouses. These findings confirmed what is well documented in the literature: that families can also be burdened by their relatives’ mental illness (Ohaeri, 2003; Saunders, 2003; Skundberg-Kletthagen et al., 2014). One relevant study surveyed 74 people with an anxiety disorder and 74 family members and found that family members of people with anxiety disorders experienced significant burden, negatively impacting their physical and mental health and family functioning (Senaratne et al., 2010). This study extends these findings by highlighting that caregiver burden and disbelief about the legitimacy of the panic condition can lead to relationship conflicts and breakdowns. It has highlighted that the impact of panic and anxiety disorders on family dynamics has not been sufficiently studied. The evidence also indicates that healthcare professionals should acknowledge the impact of panic on...
family members and provide support to alleviate caregiver burden. These factors should be considered when developing an individual’s care plan. For example, mental health practitioners should reach out to family members; listen to their issues and concerns; and, offer information and skills to cope with the condition and its consequences.

People with panic face unique challenges in the family environment, as they are often not given the support they need to cope with the challenges of panic. Perhaps this is because panic attacks are contested and are not deemed serious enough to warrant support by family and friends. This can have potentially damaging consequences on the individual’s sense of self, their social and intimate relationships, working life, treatment, and ability to develop resilience. To alleviate family conflict, federal and state government should develop training programs to educate families about panic attacks and provide support skills to help them cope. Creating self-help groups for family members is another option, and may alleviate families’ feelings of isolation. Awareness campaigns that increase the legitimacy of panic attacks as a real condition could help increase understanding and reduce tensions within families.

8.5 Working in Quiet War Zones

Participants with panic were seen to be on the organisational margins and were quietly fighting to survive in workplaces that did not recognise panic attacks as a legitimate illness. Discrimination and stigma within the workplace was also a pervasive issue for employees with panic. These findings are significant, and employers need to recognise that a considerable percentage of their workers will eventually live with limitations due to anxiety disorders, including panic attacks (Waghorn et al., 2005). Neglecting
this group of workers is costly for organisations, as well as for employees. As highlighted in Chapter 1, it has been estimated that mental health conditions, including anxiety disorders, cost Australian workplaces approximately $11 billion per year: $4.7 billion in absenteeism; $6.1 billion in presenteeism; and, $146 million in compensation claims (PwC & beyondblue, 2014). This does not take into account hidden costs such as staff turnover and reduced productivity due to poor staff morale, and the costs to the broader economy, as once capable and productive workers transition away from the workplace. The social costs of unrecognised mental illness in the workplace are immense; the ability to participate fully in paid employment and benefit from the economic opportunities that follow are important components for a happy and healthy society (Sheppard, 2002).

Participants reported that poor working conditions contributed to their panic attacks. Reasons cited included: bullying and mobbing, high job demands, and work pressures that impinged on family life. Research has confirmed that psychosocial hazards at work can lead to employees experiencing psychological harm (Promislo et al., 2013). For example, workplace bullying can lead to lowered self-esteem (Randle, 2003); depression, anxiety (Quine, 2001; Schieman, McBrier & Van Gundy, 2003); social phobias (Stansfeld et al., 2008); and, post-traumatic stress disorder (Mikkelsen & Einarsen, 2002; Laposa, Alden & Fullerton, 2003; MacDonald, Colota, Flamer & Karlinsky, 2003; Price, Monson, Callahan & Rodriguez, 2006). Job stress has also been linked to depression (La Montagne et al., 2010); similarly, a New Zealand birth cohort study found that 45 per cent of incident cases of depression and anxiety were attributable to job stress (Kivimaki, Virtanen et. al., 2003; Melchior et al., 2007). Research has also shown that workers who reported high job demands, low job control
or insufficient social support were also at increased risk of major depression and generalized anxiety disorder (Melchior et al., 2007).

These results indicate that at a societal level their needs to be an ongoing discussion about workplace culture and the detrimental effects that can result from working in negative environments. It is crucial that federal and state governments implement systems, policies and procedures to ensure that workplaces provide an environment that is conducive to mental health as a minimum standard (Turney, 2003). As Turney (2003: 7) stated, “an individual should not be subjected to ongoing threats to their health and safety in the closed environment of work, in the course of earning their living.” It is important to recognise that a person has a right to dignity and safety at work; and, that “work should not hurt” (Namie, as cited in Turney, 2003: 7). As well as the human costs of toxic workplaces, organisations that contribute to mental health problems also cost society in the long-term, as these ill individuals become a drain on medical and social support systems, thereby increasing healthcare and societal costs (Giga, Hoel & Lewis, 2008). Practical initiatives to improve workplace environments could include: national conferences and workshops on psychosocial hazards in the workplace and its impact on mental health; supporting research and strategies that promote healthy organisations; and, developing a more comprehensive national database of workers compensation statistics that identifies claims related to panic and anxiety disorders.

Initiatives to improve the mental health of organisations have already begun in Australia, and the federal government, business members and non-profit organisations have formed a coalition called The Mentally Healthy Workplace Alliance (MHWA), to create initiatives that promote mentally healthy workplaces. In 2014, the Alliance
partnered with *beyondblue*, and rolled out a national campaign – titled Heads Up – to encourage employers to take action on mental health problems such as depression and anxiety. However, the success of this initiative rests on treating the causes of negative workplace conditions, and not just treating the symptoms. Another concern with this campaign is that the human toll of working with a mental health issue is largely ignored. Organisations need to be made aware that they have a role to play in causing mental illness, such as panic attacks. Taking responsibility for this is the first step to developing a compassionate workplace that fosters an equitable and inclusive culture.

Additionally, a new national Code of practice: *Guide for Preventing and Responding to Workplace Bullying* (Safe Work Australia, 2013b) was developed to provide guidance to employers on how to achieve compliance with this duty. The code of practice sets a minimum standard on how to prevent workplace bullying and how to respond effectively if it occurs. However, initiatives to improve mental health outcomes can be challenging, owing to the stigma and secrecy associated with these conditions, and the employees’ legitimate concerns about privacy (Dewa et al., 2007).

The findings have highlighted that the implications for employees experiencing panic attacks, especially for their work and career, were potentially catastrophic. Participants reported being: underemployed; engaged in cycles of temporary and insecure employment; and, felt trapped in unhealthy working environments. Participants felt very much alone in managing their symptoms in the workplace, and perceived that they were not entitled to accommodation or support, and that any disclosure of their panic attacks could make them vulnerable to dismissal. Indeed, a number of participants reported being dismissed, or forced into early retirement because of their condition. The Australian-wide *Disability Discrimination Act 1992* (Commonwealth of Australia) makes it illegal to discriminate against a person based on a mental illness
and employers are legally obligated to provide “working conditions that do not cause a mental health condition or aggravate any existing mental health condition” (beyondblue, 2014: 7). However, the results showed that when participants disclosed their panic, discrimination often occurred and employees felt powerless to stop it. This may indicate workers with panic were confused about their employment rights, did not know about this legislation, or did not trust it. This would indicate a need for tailored information and advice to help employees with panic better understand their rights at work and the legal obligations and responsibilities of their employer. This is particularly apt for young adults just entering the workforce.

For the participants in this study, work was mandatory and essential for assuring their livelihood. A loss of employment can be an endangerment to existence (Strazdins, D'Souza, Lim, Broom & Rodgers, 2004). Further, many people’s social status and identity is tied to their job and the threat of job loss is an additional mental load to carry. These threats to employment have the potential to cause the employee even greater anxiety and could aggravate the employees’ existing panic condition. Employees exposed to job insecurity are at higher health risk (Strazdins et al., 2004), but because work was essential to the participants’ survival, they endured traumatic events at work, including bullying, and found it difficult to defend themselves or escape the workplace.

One of the biggest obstacles for employees with panic attacks involved travelling to and from work. Organisations, where possible, should offer flexible work arrangements, such as working from home; variable start and finish times (for example, to avoid stressful peak hour traffic); or reduced working hours to support these employees during times of high anxiety. Panic attacks do not follow a
predictable path, and the severity of symptoms can change daily, weekly or monthly. Employers need to understand the high variability and long term nature of this condition, and where possible, adjust flexible work arrangements to accommodate the variability of the employee’s condition.

Due to the participants’ limited job opportunities, many found themselves in casual or temporary positions. This is consistent with a beyondblue submission (2011: 2) on Insecure Work in Australia, which confirms that “people with depression and anxiety and their carers are more at risk of insecure work than the general population.” The findings highlighted that causal employees with panic were further disadvantaged in the workplace, as they perceived that they did not have the same employment rights as the permanent staff. This meant they were even less likely to ask for support, accommodation or compensation in the workplace. Work that feels insecure “encourages presenteeism, excessive and often unpaid hours at work, failure to take annual leave (with a consequent risk of burnout), and discourages employees from joining health promotion initiatives, reporting OHS problems or taking part in OHS committees” (beyondblue, 2011: 4)

The ABS Work-related Injuries Survey 2009–2010 (ABS, 2010), found that casual employees were less likely than employees with leave entitlements to apply for workers’ compensation even though they reported higher injury rates. Reasons cited for not claiming included their lack of knowledge surrounding eligibility, and fears that their current or future employment opportunities would be put at risk (ABS, 2010). For casual workers with panic attack, employment insecurity would have been constant, and would have worsened their anxieties and fears. It also meant that they were denied many of the positive benefits of secure employment, such as a defined
social role, identity and purpose, routine and structure and access to a social network and support (beyondblue, 2011).

The loss of a paid job also meant financial insecurity, and as discussed above, would have impacted the person and their family’s livelihood, including the ability to pay the mortgage, pay for their children’s education, participate in travel and recreational activities and save for retirement. beyondblue (2011) confirmed that the economic consequences of insecure work included: a lack of income and financial security; an increased risk of being in debt; retirement not being provided for; and, the possibility of losing one’s home due to serious rent arrears. The financial strains experienced would have put considerable stress on families and intimate relationships. Work loss and the inability to provide for their families could further diminish an employee’s sense of value. While living under the threat of job loss could have further affected the self-esteem, and mental health of employees with panic and their families.

These results indicate that federal and state governments should develop policies and procedures that improve the employment security and workforce participation of people with panic. This is a timely issue considering that Australia (and so many other nations) are grappling with the heavy burden of an ageing population. Improving the workforce participation of people with panic could help alleviate the weight of an already over-burdened health care and welfare-provision system, as people with panic may not be as reliant on the government for health care and retirement support.

The results show that employees with panic felt that there was nowhere to go in the workplace to get advice and support, as panic attacks were not viewed as a legitimate illness. This was exacerbated by their reluctance to disclose their condition because of the perceived risks associated with having a stigmatised illness. As a result,
participants were at a considerable disadvantage in the workplace, and felt that their only choice was to manage their illness alone, which often involved continuing to work when unwell, taking unpaid sick leave, or resigning. Thus, stigma plays a large part in creating employment barriers for individuals with mental illness. A number of participants felt that the only support available to them at work was support through their workplaces Employee Assistance Program (EAP). Significantly, this service was deemed ineffective and even detrimental to their mental health. In addition, the participants reported that their organisation’s anti-discrimination policies and procedures were tokenistic and were not followed in practice. All these examples point to a severe lack of support services in organisations for workers with panic attacks. Implications for these workers could perhaps include being: disempowered; vulnerable to bullying and discrimination; and, ill-equipped to manage their illness on their own at work. Poor support services could also threaten their wellbeing and future employment prospects. These experiences show how pervasive mental illness stigma is in organisations and indicates that improving workplace support for employees with panic could be challenging.

This study confirmed that the risks of disclosing panic attacks in the workplace were high. The disbelief and stigma resulting in flawed assumptions and judgements from employers and co-workers led to bullying and harassment, rejection or isolation by work colleagues, lack of career advancement, increased supervision, not being provided with reasonable accommodations, and even loss of employment. Additionally, bullying can lead to lowered self-esteem (Randle, 2003); depression, anxiety (Quine, 2001); and, post-traumatic stress disorder (Leymann, 1990; Mikkelsen & Einarsen, 2002). The individual’s family can be affected as they watch the person they love and care about suffering (Duffy & Sperry, 2007). Loss of income
from being expelled from their job can lead to financial stress and insecurity, further impacting the individual and his or her family life (Duffy & Sperry, 2007). The fear of stigma and rejection in the workplace can demoralize the individual’s confidence and self-esteem, in which they view themselves as ineffective and unemployable and as a result may avoid job interviews (Link, 1982; Wahl, 1999, Stuart, 2006). The redefinition of self and identity because of mental illness also impacts on work considerations (Scheid & Anderson, 1995).

The lack of support, discrimination and stigma within the workplace was a pervasive issue for participants with panic and indicates a need for federal and state governments to partner with employers to develop anti-stigma initiatives and policies that reduce stigma and employment barriers for people with panic. For example, participants were concerned about the false assumption that people who experienced panic attack lacked the competence to continue working. A targeted anti-stigma campaign to reduce this belief in the workplace would be useful. However, as stated previously, initiatives to improve mental health outcomes can be difficult, due to the stigma and secrecy associated with these conditions, and the workers’ valid concerns about privacy (Dewa et al., 2007).

Few participants reported experiencing positive support from their employer at work and such incidents involved small tokens of emotional support rather than any practical and long lasting assistance. Despite this, their overwhelming experience was a lack of acceptance and understanding – that panic was not a legitimate illness. These positive stories also suggest that participants did not expect much in the way of support and were happy with even the smallest gestures of understanding.
To improve the capacity of managers to support employees with panic, education and training programs that provide guidance on how to respond to the mental health concerns of employees would be useful. These training programs could also be used to reduce psychosocial hazards in the workplace, for instance, through cultural diversity training, recognising signs that can lead to mental illness, and interventions to reduce work stress and improve employees’ work-home balance. This and other research demonstrates that psychosocial work hazards, including bullying, are risk factors for causing panic attacks. The workplace strategies discussed above not only benefits people experiencing panic attacks, but could also reduce the likelihood of other staff developing mental health problems due to a poor work environment.

Employers should consider partnering with mental health practitioners, who specialise in anxiety disorders, to improve employment and health outcomes for workers with panic attacks. For example, mental health specialists could provide support and training to EAP counsellors to improve the level of support given to employees with panic. As discussed above, they could also help employer’s modify their workplaces to accommodate people who have panic attacks.

It is clear that the workplace has a long way to go before panic attacks become accepted as a legitimate health condition that requires accommodation and practical assistance. Although the initiatives suggested above could improve the work-life of employees with panic attacks, it is critical to acknowledge the challenges involved in bringing about such changes. These challenges are exacerbated by the issues employers need to deal with in modern organisations, such as cost cutting, technological changes, reduced resources, and the need for greater productivity. Many employees also find themselves working in abusive workplaces characterised by
bullying and managerialism. The stigma attached to having panic attacks is also an impediment to achieving these initiatives. Nonetheless, awareness of the needs of this group of employees is the first step towards making positive changes in the workplace.

8.6 Living ‘Well’ with Panic Attacks

In spite of the challenges, living ‘well’ with panic attacks was also possible. Many participants developed resilience and, not only survived, but grew and thrived from the adversity they experienced (Kralik, Visentin & Van Loon, 2007). The literature supports that resilience factors can be learned (McDonald & Hayes, 2001; Margalit, 2003; Edward & Warelow, 2005). Thus, health professionals should be made aware of the factors that build resilience in people experiencing panic attacks. This can allow for successful adaptation to living with this condition. For example, resilience occurred when people were able to name, and then learn more about panic attacks. This enabled them to initiate illness management strategies that allowed them to adjust to the changes in their lives. With this in mind, health professionals should provide consumers with ample information about their condition, management strategies and support services that are available to them. Additionally, resilience strategies could be widened from an individual focus to apply to families of those affected and whole communities (Patterson, 1995; Hawley & DeHaan, 1996; Foster et al., 2012). Using resilience factors to successfully adapt to the difficulties of panic attacks could reduce the burden on individuals, families, employers and the community.
Participants all reported that there was no returning to their previous way of life. Although recovery was achievable, there was always the possibility of a relapse. Participants were better able to build resilience when they could accept this fact and learn to live well in the presence of their enduring symptoms. This finding has important implications for help seeking and treatment options. Health practitioners should develop a long term treatment plan for people with panic, and consumers should be encouraged to continue treatment over the longer term.

The findings indicated that social and professional support was important to adapting positively to a life with panic. However, participants reported that support was difficult to obtain, leaving them isolated and dealing with their illness alone; hampering their ability to develop a resilient self. Social support and belonging is paramount to the development of resiliency (Deveson, 2003). These findings highlight an urgent need for better social and professional support for people with panic. The false assumption that panic attacks are not a legitimate illness needs to be challenged in the community; and, federal and state governments have a role to play in providing more information to consumers so that they do not feel so isolated and implement initiatives that build better support systems for people with panic.

Lastly, panic attacks were often the catalyst that led to many positive self-changes in the participants’ lives. Participants reported improved health, personal growth, a reordering of life priorities, and improved empathy for others. This study highlights that living with panic attacks does not have to be devoid of all hope and meaning (Roe & Chopra, 2003). This information can offer a sense of hope to those who are experiencing the adversity associated with panic attacks. Knowledge that living with panic attacks can lead to positive outcomes provides hope for persons with panic and
their loved ones. Health professionals should also incorporate this information into their treatment plans. Hope for the future may enable these individuals to more adequately cope with and accept their chronic condition.

8.7 Summary

This chapter has discussed the key findings in relation to the relevant literature. These findings were grouped into five principal discussion areas that elucidated the experience of living and working with panic. These emerging themes highlighted: the stigma and secrecy attached to the panic condition; the participants experiences of isolation and living a restricted life, the impact of panic attacks on family life and relationships; the challenges and consequences of working with panic attacks; and, the ability of participants to develop resilience and adjust positively to a life with panic. The implications for individuals, families, health professionals, employers, communities and state and federal governments were presented throughout this discussion, and practical recommendations that could improve the lives of employees with panic were offered. The concluding chapter will provide some final remarks about this study and consider areas that would benefit from future research.
CHAPTER NINE

Reflections on the Lived Experiences of Employees with Panic

9.1 Introduction

This final chapter offers reflections on the research questions: What are the lived experiences of employees who have panic attacks, and how have these experiences personally impacted them, in and beyond the workplace? What is clear from the stories shared is that this chronic condition has very serious implications for the life and work of those affected. This chapter returns to the research objectives, discusses the conclusions from the research, as well as the limitations and potential opportunities for further research. The chapter concludes by documenting some final thoughts on this lived experience.

9.2 A Return to the Research Objectives

The research objectives have proved useful in guiding the direction of this study. They are revisited here briefly, in an effort to discern how well the objectives were met:

1: To hermeneutically explore, interpret and discuss the lived experiences of employees with panic, including their personal experiences, in and beyond the workplace.

The first objective was fulfilled through the exploration and (hermeneutic) interpretation of the participants’ stories of living and working with panic attacks. By
uncovering the meaning that participants placed on their experiences, a new and deeper insight into the participant’s day-to-day experiences with panic was gained. The study highlighted the nature of panic-related suffering, and the challenges experienced by employees with panic; as well as the impact this condition had on their work and home lives. It was discovered that participants could experience both adversity and feelings of resilience as a result of their experiences. The results of the analysis were represented in a phenomenological model, and the implications of the most significant findings were then discussed.

2: To increase the visibility and acceptance of employees who live with panic.

By allowing the participants’ stories to be heard, the second objective was achieved, and awareness was shed on the personal experiences of people who have panic attacks, especially those who work. Enhanced understanding of this illness experience can improve the visibility, acceptance and treatment of people with panic. The findings and subsequent discussion provided a greater awareness of how employees with panic experienced this condition. The implications of living and working with panic were discussed, and practical strategies were offered to assist governments, employers and health care professionals to develop initiatives that could improve the lives of employees with panic.

3: To aid allied healthcare professionals, government policy makers, employers, and academic theorists to understand the experience of panic.

Information from this study may also assist primary healthcare providers, such as GP’s, to better understand the personal experiences of people living with this
condition. This has the potential to improve treatment outcomes for people with panic, and ultimately, may give these individuals a greater quality of life.

The lack of family member support and related strain on relationships was an unanticipated finding. The participant narratives could also be useful in educating families and significant others about the detrimental impact that panic can have on a person’s life. This has the potential to improve how family members perceive the legitimacy of their relative’s condition, and may help reduce the stigma, misunderstanding and conflict that seemed to be occurring in families.

Finally, scholarly research to date has had little focus on the lived experiences of people with panic. By providing new understandings of this chronic illness experience, the study provides academics in the organisational, health and social science fields with potential new research pathways to explore.

4: To share the personal stories of employees with panic, so that others can identify with, learn and reflect on their shared experiences.

Research objective four was achieved by allowing participants to voice their experiences, feelings, and concerns on living and working with panic. It is possible that people with a similar condition may identify with the personal stories of participants. Feelings of self-stigma and isolation may be reduced when they realise they what they were experiencing was shared by many other people, and that they are not alone in their suffering. Those with similar symptoms may also benefit from learning that some participants developed resilience and learned to live ‘well’ with panic – even viewing it as a positive experience. This can potentially provide others with a sense of hope, and foster their ability to build resilience.
9.3 Reflections

Despite the widely held perception that panic attacks are a trivial and unimportant condition, this study has illuminated the very real suffering experienced by people with panic, in and around the workplace. Clear evidence has been presented as to some of the difficulties employees with panic might experience, especially early in the course of their illness; just getting a diagnosis proved frustrating and challenging. And without the support and understanding of medical and allied health professionals, the potential flow-on impacts for employees with panic were numerous and significant: no legitimate illness diagnosis to help their understanding of the experience; a lack of access to informational and clinical support to assist managing their condition; delays in treatment; isolation and severe restrictions on their lifestyles and career choices; and, disbelief, discrimination and stigma resulting in flawed assumptions and judgements from employers, co-workers and even family members.

The above outcomes also presented ongoing threats to panic sufferers’ ongoing wellbeing, their self-esteem, self-worth, and recovery, their relationships with family and friends, and to their future employment. That there was so much evidence of a lack of recognition of panic disorder – not just from employers, and family and friends, but by trained health professionals – was disconcerting. This lack of understanding certainly made things worse for individuals experiencing panic disorder whilst trying to maintain employment.

Participants themselves recognised early on the stigma, and disbelief, surrounding their panic disorder, including the lack of understanding as to how seriously they were impacted. They had a legitimate medical condition, and they needed support in living
with this condition, not exclusion or punishment. Unfortunately, what many of them reported was a strong sense of shame, being stigmatised, and as a result, feeling left alone to cope with their illness as best they could (often without medical or other information support to assist them), and becoming increasingly alienated and isolated as their life and work journey with panic continued. The deligitimsation of their panic attacks by family members and intimate partners was particularly difficult for participants to accept, and led to strained relationships, self-stigma, and diminished feelings of self-worth. It was this shame and stigma that constrained participants to a life of secrecy, and participants worked extraordinarily hard to conceal their condition, especially in the workplace. This pressure left many exhausted, stressed, and contributed to their anxiety problems.

Far from being trivial, this study has highlighted the high level of debility and suffering that may be experienced by some individuals with panic, to the point where some of those suffering had suicidal thoughts. The potential life threatening consequences of panic provides further evident that this condition is highly under-recognised and is being minimised in the community and by primary health services. Failing to assist individuals who are experiencing panic attacks is a serious issue and could be a missed opportunity for preventing suicidal behaviour.

For the participants, work was mandatory and essential for assuring their livelihood. However, it became evident during the study that employers did not view panic as a legitimate illness. This meant that many participants were left underemployed; engaged in cycles of temporary and insecure employment; had to manage their illness alone; and, were subject to bullying and discrimination, in which they felt powerless to defend themselves or escape their toxic workplaces. These all had direct and negative
impacts on their career dreams and opportunities, financial, retirement and lifestyle goals. Participants also reported that poor working conditions contributed to their panic attacks. These results suggest that at a societal level their needs to be an ongoing discussion about workplace culture, the detrimental impact of toxic workplaces on an employee’s mental health, and the need for employers to recognise that panic is a legitimate illness, and employees are deserving of support.

Scattered through these stories of adversity were narratives of hope, resilience and transformation. Participants shared profound reflections on how panic attacks had transformed them. They spoke of being more compassionate and tolerant of others, especially those with a mental illness or disability. Indeed, the motivation for participants to take part in this study was so that they could reach out to others in similar situations; to help bring awareness to this invisible chronic illness. Having this condition also altered their approach to life, and many realised that work was no longer the main priority and time was better spent with family and friends. Despite the challenges that these people confronted in their work and home lives, their ability to build resilience and live well with panic attacks was inspiring.

9.4 Limitations of the Study

In common with most qualitative studies, the findings reflect the opinions and experiences of a small number of employees from the Sydney metropolitan area, in Australia, hence, generalisations cannot be made. A larger sample size, with participants from across the nation would provide a better representation of the panic experience, in and out of the workplace.
This study was also limited by the extent of the participants’ ability to identify their symptoms as being panic-related. Some participants may not have experienced panic attacks, though this is highly unlikely, given their depth of understanding. Furthermore, because panic attacks feature prominently within most anxiety disorders (APA, 2013), it was possible that participants had panic attacks comorbid with other anxiety disorders. Comorbidity may have altered the meanings that participants placed on their experiences.

9.5 Directions for Future Research: Where to from Here?

These exploratory findings call attention to numerous gaps in the research and a need to consider how these issues can be further investigated to increase our awareness and understanding of this lived phenomenon.

A possible avenue for future research is to better understand the adverse spill over effects of panic on families and intimate partners. Participants reported receiving little support and understanding from those closest to them, and often spousal relationships broke down during this stressful time. Discussion in Chapter 8 pointed to the important role of family involvement in treatment and in helping building ongoing resilience. Hence, further research to better understand the reasons for the lack of family support would be a worthwhile investigation. Research should also be extended to understand why some families are more supportive than others. The outcomes of this research have the potential to impact on the individual’s treatment and recovery, and improve support outcomes for the individual and his or her family.

This study recruited participants from suburban Sydney, a large cosmopolitan city in Australia, a developed country, and a location where sufferers of panic attacks could
reasonably assume they may be able to access the medical and allied health service support they might need (but, that even they had considerable difficulty accessing). What was not investigated at all in this study, and should be in the future, is the lived experience of panic sufferers in regional and country areas, both in Australia and elsewhere, where medical, social and allied health support provision can be more difficult to access, even for those with routine and widely understood conditions. One can only guess that the experience for panic sufferers in regional and country areas of Australia, and elsewhere around the world, may well prove even more alienating, frightening and challenging for those so located. Hence, this would be an area of further research that is overdue for investigation.

The findings of this study call for a broader investigation of the intersection of panic attacks and work. This study has shown that the pressures and psychosocial hazards in contemporary organisational life are causing or exacerbating the panic attack condition. Qualitative and quantitative studies that explore the role modern work-life plays in the development of panic attacks would be worthwhile, and could encourage workplaces to create organisational practices and policies that improve their employees’ mental health.

This study also revealed that employees did not view this condition as a legitimate illness and workplace support for employees with panic was almost non-existent. Employees with panic were vulnerable and were left to manage their illness alone. The outcome of this included underemployment, and insecure and temporary employment. Additional research should increase our understanding of the impact of workplace support on the employment patterns of people with panic, including which support practices are most effective in helping these employees maintain secure
employment. Research that explores employers’ attitudes and perceptions of workers with panic attacks may also provide a better understanding of the reasons behind the lack of workplace support reported by employees with panic. Future research could assist in developing measures that improve the working lives of people with panic.

Similarly, this study did not explore directly the financial impacts for those experiencing panic, such as the long term impacts on their employment, and associated income, and the specific losses they bore as a result of panic. Serious questions remain around the long term financial security of those with panic, especially for those with early onset of the illness, perhaps resulting in crucial interruptions to schooling, adult professional training, and career development that could flow throughout the term of that person’s working life.

Lastly, this research has not made a distinction between the lived experiences of men and women. This study raised concerns unique to both men and women. Further exploration and comparison of gender-based experiences and concerns would provide valuable insights into the gendered nature and understandings of this illness experience.

9.6 Final Thoughts

There needs to be much greater concern for the individual that has experienced panic attacks. Given how prevalent panic attacks are, and the considerable burden that they can have on individuals, families, organisations and communities, an explorative, qualitative analysis of this ‘lived experience’ was timely and relevant. The findings have highlighted that panic is a highly stigmatised condition and negatively impacts on many areas of an employee’s life – both in and beyond the workplace. Concern has
been given to the unique challenges and support needs of employees with panic, and practical strategies to improve the lives of those impacted have been suggested.

By bringing this mental health condition to the forefront of organisational and social health studies, it is hoped that a new level of awareness about panic will occur, facilitating new responses and directions. It is imperative to understand, from a purely phenomenological perspective, what life is like for people living and working with this condition. It is also important to understand the implications of panic on the individual, family members, organisations and society. In this way, we can remove the misunderstanding that surrounds employees with panic, and develop initiatives that can improve the lives of those living with this condition.

Living and working with panic was shown to be a confusing, isolating and frightening experience, with serious consequences for the person’s lifestyle, finances, relationships and career. Additionally, the participants’ overwhelming experience was a lack of acceptance and understanding; that panic was not a legitimate illness. It is only through awareness that a shift in thinking can occur, which will allow others to see the legitimate nature of this chronic condition; to realise that these individuals need empathy, understanding and compassion, not, for example, belittling and stigmatising responses, in which they are told to “get over it.” It is hoped this research provides avenues for future inquiries that will allow for a more compassionate understanding of the needs of these silenced individuals.
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Appendices

Appendix 1 – Ethics Approval Letter

Appendix 2 – Covering Letter

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Appendix 5 – Media Release

Appendix 6 – Participant Demographic Details

Appendix 7 – Focus Areas for Interviews
Appendix 1 – Ethics Approval Letter

25 June 2015

Professor Margaret Heather Vickers
School of Business

Dear Margaret Heather,

I wish to formally advise you that the Human Research Ethics Committee has approved your research proposal H6701 “Life and work with panic attacks: A phenomenological study”, until 31 December 2013 with the provision of a progress report annually if over 12 months and a final report on completion.

Conditions of Approval

1. A progress report will be due annually on the anniversary of the approval date.

2. A final report will be due at the expiration of the approval period.

3. Any amendments to the project must be approved by the Human Research Ethics Committee prior to being implemented. Amendments must be requested using the HREC Amendment Request Form: http://www.uws.edu.au/__data/assets/pdf_file/0018/491350/HREC_Amendment_Request_Form.pdf

4. Any serious or unexpected adverse events on participants must be reported to the Human Ethics Committee via the Human Ethics Officer as a matter of priority.

5. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the Committee as a matter of priority

6. Consent forms are to be retained within the archives of the School or Research Institute and made available to the Committee upon request.

Please quote the registration number and title as indicated above in the subject line on all future correspondence related to this project. All correspondence should be sent to the email address humanethics@uws.edu.au.

This protocol covers the following researchers:
Margaret Heather Vickers, Lesley Wilkes, Jasmin Perrone

Yours sincerely

Professor Elizabeth Deane
Presiding Member,
Human Researcher Ethics Committee
Appendix 2 – Covering Letter

College of Business,
School of Management

[Date]

[Respondent Name]
[Respondent Address 1]
[Respondent Address 2]

Dear [Respondent Name]

Thank you for your expression of interest in my research project entitled ‘Life and Work with Panic Attacks’.

As we have discussed, please find attached an Information Sheet that will explain further what this research is about, and perhaps answer any further questions you may have.

Also enclosed is the Consent Form, and if you agree to participate in this study, I would ask that you print two copies of this form, complete and sign both forms and bring one copy with you to our meeting. If you do not have access to a printer, I will have spare copies with me when we meet.

I will be conducting interviews with participants from now until the 1st October 2009. Due to the large number of participants that have expressed an interest in taking part in this study, I plan to stagger my meetings with respondents over several months. This means that I may not be able to meet with you until July or August 2009. Please let me know if you have a date and/or time preference.

Interviews can be scheduled to take place in my office at the University of Western Sydney, Parramatta Campus or at a location in the Sydney Metropolitan area that is convenient for you, for example, you home or office. Please contact me with your preference.

Should you like to schedule an interview time with me, or have any further questions with respect to any part of this research, please do not hesitate to contact me by phone on [phone number] or email [email address].

I look forward to corresponding with you.

Yours sincerely,

Jasmin Perrone
Chief Researcher
Appendix 3 – Information Sheet

Participant Information Sheet
Life and Work with Panic Attacks

Who is carrying out the study?
You are invited to participate in a study entitled “Life and Work with Panic Attacks”, conducted by the following researchers from the Family and Community Health Research Group (FaCH) at the University of Western Sydney:

- Professor Margaret H. Vickers, School of Management, College of Business;
- Professor Lesley Wilkes, School of Nursing and Midwifery, College of Health and Science; and,
- Jasmin Perrone, PhD student, School of Management, College of Business.

The research will form the basis of the degree of a Doctor of Philosophy at the University of Western Sydney for Ms. Perrone, and will be supervised by Professor Vickers and Professor Wilkes.

What is the study about?
The purpose of this study is to explore the experiences, thoughts and feelings of persons who have suffered from panic attacks in and around their working lives and to identify the problems that exist for people who have panic attacks and who work.

Am I eligible to participate in the study?
The researchers seek involvement from people in the Sydney Metropolitan area who have experienced panic attacks during their working lives. Participants may be currently or no longer employed.
What does the study involve?

If you participate you will be asked to take part in one or two confidential in-depth interviews lasting approximately one to one-and-a-half hours at a venue agreed between the Chief Researcher and the participant.

During the interview(s) you will be asked open-ended questions about your work and your panic attacks, and your experiences with the two combined. You may also be asked about the impact panic attacks have on your life outside of work.

How much time will the study take?

Each interview will last for approximately one to one-and-a-half hours.

Will the study benefit me?

The responses collected in the study will be used to raise awareness and to increase the understanding of the issues and concerns that confront employees who have panic attacks in and around their working lives.

The information will also assist organisational practitioners to develop workplace practices and policies that support employees who have panic attacks. The insights will help to further build the knowledge needed for anxiety support networks and enhance the level of care offered by health care services.

Will the study involve any discomfort for me?

You may find that recalling events about your experiences with panic attacks could cause you emotional or psychological discomfort. If this occurs, you may wish to obtain some counselling to help you work through these feelings. The Chief Researcher is not a counsellor or a psychologist; however, she can provide a referral to Lifeline Australia, a telephone counselling service. For information call Lifeline on 13 11 14.

How is this study being paid for?

The study is being sponsored by the Australian Postgraduate Award (APA) in conjunction with the University of Western Sydney.

Will anyone else know the results? How will the results be disseminated?

The results will be disseminated in Ms. Perrone’s doctoral thesis and in publications, including but not limited to journal articles and conference papers.

All aspects of the study, including results, will be confidential and only the researchers will have access to information on participants.
Can I withdraw from the study?

Participation is entirely voluntary: you are not obliged to be involved and - if you do participate - you can withdraw at any time without giving any reason and without any consequences.

Can I tell other people about the study?

Yes, you can tell other people about the study by providing them with the Chief Researcher’s contact details. They can contact the Chief Researcher to discuss their participation in the research project and obtain an information sheet.

What if I require further information?

When you have read this information, Ms. Jasmin Perrone will discuss it with you further and answer any questions you may have. If you would like to know more at any stage, please feel free to contact Ms. Perrone, College of Business, on Tel [phone number] or email [email address]. Alternatively, you can contact Professor Margaret Vickers on Tel [phone number].

What if I have a complaint?

This study has been approved by the University of Western Sydney Human Research Ethics Committee. The Approval number is H6701.

If you have any complaints or reservations about the ethical conduct of this research, you may contact the Ethics Committee through the Office of Research Services on Tel 02-4736 0083 Fax 02-4736 0013 or email humanethics@uws.edu.au. Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.

If you agree to participate in this study, you will be asked to sign the Participant Consent Form.
Appendix 4 – Consent Form

College of Business,
School of Management

Participant Consent Form
Life and Work with Panic Attacks

I,………………………………………………….., consent to participate in the research project entitled "Life and Work with Panic Attacks"

I acknowledge that:

I have read the participant information sheet and have been given the opportunity to discuss the information and my involvement in the project with the Chief Researchers, Professor Margaret H. Vickers, Professor Lesley Wilkes and Ms. Jasmin Perrone, a PhD student at the University of Western Sydney.

The procedures required for the project and the time involved have been explained to me, and any questions I have about the study have been answered to my satisfaction.

I consent to participate in one or two in-depth interviews lasting approximately one to one-and-a-half hours at a venue agreed upon between myself and the Chief Researcher. I give permission for the researcher to use a digital tape recorder to tape the interview and make brief additional notes during the interview to clarify understanding and to assist with the later analysis and interpretation.

I understand that my involvement is confidential and that the information gained during the study may be published but no information about me will be used in any way that reveals my identity.

I understand that participation in this research may result in emotional or psychological discomfort before, during or after the interview takes place. I understand that the Chief Researcher, Jasmin Perrone is not a counsellor or psychologist, and if I feel the need to discuss my emotional responses to the interview process further, I will seek support on my own initiative, either with someone of my own choosing, or via a referral made by the Chief Researcher, Jasmin Perrone.

I understand that I can withdraw from the study at any time, without affecting my relationship with the researcher/s now or in the future.

Signed: _______________________________
Name: ________________________________
Date: ________________________________
University of Western Sydney Media Release

Release Date 9 June 2009

Study: Work-Life Experiences with Panic Attacks

Call for participants who have experienced panic attacks in their working lives

A new University of Western Sydney study will reveal new insights into the experiences, thoughts and feelings of employees who have suffered from panic attacks in their working lives.

Jasmin Perrone, PhD candidate from the School of Management and the Family and Community Health Research Group (FACH), seeks involvement from people who have experienced panic attacks during their working lives for confidential, face-to-face interviews. Participants may be currently employed or no longer working.

“Panic attacks are one of the most common mental health problems in Australia, and more than one in five people will experience one or more panic attacks in their lifetime,” says Ms Perrone.

“Panic attacks often involve a sudden feeling of intense terror which may occur in certain situations or for no apparent reason at all. They are not only uncomfortable and distressing for the sufferer, but can also have a detrimental impact on communities, families and the individual’s quality of life.”

The uncontrollable nature of panic attacks, and the fact they can occur at any time, has led Ms Perrone to address the potential impact that panic attacks have on employees and their work experiences.
The responses collected in the study will be used to increase the understanding of the issues and concerns that confront employees who have panic attacks in and around their working lives.

The information will also assist organisational practitioners to develop workplace practices and policies that support employees who have panic attacks. The insights will help to further build the knowledge needed for anxiety support networks and enhance the level of care offered by health care services.

For more information, or to take part in the study, contact Jasmin Perrone, on [phone number] or [email address].
Appendix 6 – Participant Demographic Details

Demographic Survey – Life and Work with Panic Attacks

If there is any question you do not wish to answer please feel free not to answer it. Participation in this research is entirely your choice.

PERSONAL

1. What is your age? ______________ (years)

2. What is your gender? (please tick one)
   □ Female       □ Male

3. What is your current marital status? (please tick one)
   □ Single       □ Married
   □ Cohabitating □ Separated or Divorced
   □ Widowed

4. Please describe your ethnic background?
   _______________________________________________________________________
   _______________________________________________________________________

5. What is your highest achieved level of education? (please tick one)
   □ Commenced High School   □ University Degree
   □ Completed High School   □ University Postgraduate Degree
   □ Trade or Vocational Degree □ Other ________________________
EMPLOYMENT

6. What is your employment status?

☐ Employed, Full-time ☐ Not employed, but looking for work

☐ Employed, Part-time ☐ Not employed and not looking for work

☐ Student ☐ Retired

☐ Other ____________________________

7. What is your income range? (please tick one)

☐ $0-24,999 ☐ $75,000-99,999

☐ $25,000-49,999 ☐ $100,000-124,999

☐ $50,000-74,999 ☐ $125,000 or higher

Please answer questions 8 to 12 based on your most recent employment position (even if you are not currently working).

8. In what employment sector do you work?

☐ Private Industry ☐ Self employed

☐ Government/Public Sector ☐ Non-profit organisation

☐ Other? (Please describe) __________________________

9. In what industry do you work? (please tick one)

☐ Banking/Finance ☐ Health Care

☐ Education ☐ Public Administration

☐ Computing/Technology ☐ Service Industry

☐ Retail ☐ Other? __________________________

10. What is the title of your most current position?

________________________________________________________________
11. How long have you been in your current position?
_______________________________________________

12. Briefly describe what you do at work: activities you may perform or tasks required of you on a regular basis?
_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________

HEALTH

13. When did you first start having panic attacks? How long since they began?
_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________

14. Have you sought treatment for your panic attacks?
□ Yes □ No

15. If you answered “Yes” to the above question, briefly describe the treatment that you have sought?
_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________

Thank you for filling out this survey. The information on this form will be stored securely and will remain confidential.
Appendix 7 – Focus Areas for Interviews

INITIAL ILLNESS NARRATIVE
1. Can you tell me what happened when you first started experiencing panic attacks? How did you feel?
2. What were things like after that time?
2. When did you realise what they were?
3. Can you tell me what happens when you have a panic attack?
4. How would you describe it to someone who has never had one before?
5. Did you seek treatment? Did you seek early treatment? Why/Why not?
6. If you went to see a doctor, tell me about your visit to the Doctor?
7. Has a doctor officially diagnosed you? What was the diagnosis?
8. Are they still are part of your life now?
9. Are you on medication? How do you feel about being on medication?

EXPLANATORY MODEL NARRATIVE
10. Why do you think your panic attacks started when they did?
11. Was there something happening in your family, at work or in your social life that could explain the panic attacks?
12. Do you think panic attacks are somehow linked to your work life?
13. Can you tell me more about those events and how they are linked to your panic attacks?

WORK AND ILLNESS NARRATIVE
14. Can you tell me what it’s like to work where you are?
15. Can you tell me a bit about your role?
16. Can you tell me about what work was like after you first started experiencing panic attacks?
17. Can you tell me about any situations that stand out where this health problem has created problems for you at work? Or interfered with your work role?

18. Can you tell me about an experience where you’ve had a panic attack at work before? Or felt like you were going to have a panic attack? Is there a particular situation that stands out?

19. Can you think of a situation where your panic attacks have presented a challenge or limited you at work?

20. Have panic attacks ever stopped you doing anything work related? I.e. training courses, career development, relocation, travelling, etc.?

21. What do you think the biggest problem is for people who work and have panic attacks?

22. Do you think this health problem has impacted on your future career or financial goals?

23. Can you tell me about a time when you have gone to work and shouldn’t have because of your panic attacks? Why did you go? What happened during the day? How did that make you feel?

24. Can you tell me about a time that you have rang up sick because of your panic attacks? What did you tell work? Why? How did this make you feel?

25. Do you think your panic attacks cause you to try and avoid stressful situations?

CONCEALMENT OF ILLNESS

26. Do you feel that you need to keep your panic attacks hidden? Or pretend that you don’t have this problem? Why/why not? How does this affect you?

26a. How do you try and keep this health problem hidden?

27. Have you told anyone at work about this health problem?

27a. YES: Why did you tell them and how did they react?

27b. YES: If you could do it over again, would you tell?

27c. NO: Why did you keep it hidden?

27d. NO: How do you think people at work would react if they knew? Why?

27e. NO: Would there be any circumstances that would make you change your mind?

28. How do other people react to someone who has panic attacks? Has anyone reacted negatively towards you?
29. When you have had a panic attack at work, has anyone noticed what was happening? What did they do? What did you do? How did you feel?

**COPING AND RECOVERY FROM ILLNESS**

30. Are there adjustments that you make at work to help you cope or manage with panic attacks? Can you tell me about them?

31. Are there adjustments that you make in your everyday life that help you cope or manage with panic attacks?

32. Where do you think you are currently in terms of living with panic attacks? How do you see your future?

33. How did you get from where you were then to where you are now?

34. What has helped you through this period in your life?

35. How have your family or friends helped you through this difficult period of your life?

**SYMPTOM OR ILLNESS LABEL**

36. What does having this health problem mean to you?

37. Do you think of panic attacks as an illness? Why/why not?

38. Do you identify yourself as a person with a mental illness? Why/why not?

**IMPACT ON LIFE**

39. How have panic attacks changed the way you live?

40. How have panic attacks changed the way you feel or think about yourself?

41. How have panic attacks changed the way you look at life in general?

42. How have panic attacks impacted on your relationships with family and friends?

43. How have panic attacks changed the way that others look at you?

44. How have panic attacks impacted on your personal life goals?

45. Are there any good things that have come out of having this health problem?

46. Why did you want to take part in this study?