PERCEPTIONS OF COLLEGE STUDENTS DIAGNOSED WITH PANIC DISORDER WITH AGORAPHOBIA: ACADEMIC, PSYCHOSOCIAL, AND ENVIRONMENTAL VIEWS OF THEIR COLLEGE EXPERIENCE

by

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THE EFFECTS OF COLLEGE ON STUDENTS DIAGNOSED WITH PANIC

DISORDER WITH AGORAPHOBIA: AN ACADEMIC, PSYCHOSOCIAL, AND

ENVIRONMENTAL PERSPECTIVE

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ABSTRACT

The number of reported students with psychiatric disabilities who are seeking

services and/or accommodations is steadily increasing on college campuses. Much of the

research and documentation that surround the study of college students with psychiatric

disorders is extremely broad in focus and tends to group all psychiatric diagnoses together

when reporting outcome studies.

The research literature that is devoted to the study of the college student diagnoses

with Panic Disorder with Agoraphobia is limited in scope and nature. The majority of the

literature is devoted to the physiological and behavioral ramifications of the disorder or

treatment modalities. a review of the extant literature reveals that there is no substantive

research available that provides insight into the college experiences of the student

diagnoses with Panic Disorder with Agoraphobia.

In summary, it is safe to say that there is not enough pertinent information readily

available to enlighten college and university faculty and staff about the experiences of

college students diagnosed with Panic Disorder with Agoraphobia. specifically, little is

known about: (1) the academic, psychosocial, and environmental needs of these students

(2) what disability related barriers these student may have experienced (3) what coping mechanisms are typically employed, and (4) what services and accommodations these students have found to be the most effective while they were enrolled in college.

The purpose of this study was to examine the nature and the scope of the college experiences of students who were diagnosed with Panic Disorder with Agoraphobia. The subjects for this study consisted of a select group of upperclassmen at Virginia Tech. Gender or age was not a factor in the selection process. For purposes of this study, the qualitative in-depth interview method was considered the most appropriate form of data collection.

Analysis of the data revealed the following common experiences among the subjects in the study: (1) All subjects experienced difficulties in the classroom due to their Panic Disorder. (2) All of the subjects had concerns with the physical setting of the campus (i.e. preferential seating, avoidance of large classrooms and auditoriums, and anxiety-like symptoms as the result of bright or fluorescent lighting). (3) A lack of social contacts both in and out of the classroom was a common experience. (4) While all subjects had tried medication to control their Panic Disorder, two of the subjects stopped their medication even though they reported an improvement I their symptoms. The majority of the subjects stated that they did not want to remain on the medication for fear of addiction or using the medication as a "crutch." (5) All of the subjects sought out counseling while attending Virginia Tech. All of the subjects, with the exception of one, did not seek any treatment for their anxiety of Panic Attacks until after they arrived at Virginia Tech. (6) All of the subjects, with the exception of one suffered with either chronic anxiety, or Panic Attacks for over one year before seeking any medical relief or

counseling. (7) All of the subjects reported that counseling was helpful and for the most part, they all tried to use relaxation techniques when experiencing a Panic Attack. (8) All of the subjects are still having difficulty with chronic anticipatory anxiety and occasional Panic Attacks. (9) While the majority of the subjects interviewed were optimistic about their career options, it was evident that all of the subjects have encountered significant anxiety-related barriers that have impacted their choice of major and possible future jobs. the majority of the subjects reported that it was important to have a job where the workload was not too stressful and the workplace was viewed as a "safe" environment.

DEDICATION

To my children in hopes that they will

understand in time that boundaries and limitations

are either the keys to success or the road

to failure...may you choose your paths wisely!

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CHAPTER 1

INTRODUCTION

"She apprehensively climbed the three flights of stairs to reach the small classroom located on the top floor in one of the older buildings on campus. Pausing briefly outside the door, she took a deep breath and maneuvered her way past desks and talkative graduate students, hoping to find a seat near an open window since the weather outside was still balmy and humid. Before she was able to pick the perfect window seat, a familiar voice in the classroom called out her name and motioned for her to come and sit near him. She felt a flood of relief when she recognized the friendly face of one of her co-workers and felt confident that she would not have to struggle through the dreaded statistics class alone. Putting off the research and statistics classes until the end of her graduate program had been a cat and mouse game she had managed to wrangle with her advisor. There were always excuses or what seemed like plausible explanations as to why she needed to take the other classes in her graduate program first. Math had never been her forte and she was guilty of taking to heart all of the 'horror stories' she had heard from fellow classmates, regarding the research and statistics classes, to be the gospel. Surely, it was a clear case of math anxiety.

After taking the empty seat beside her friend from work and enthusiastically commenting to him that she was thankful to have someone she personally knew who could "suffer" through the course with her, she began to scan the room. She immediately noticed that she was seated smack dab in the middle of a classroom of about fifty other graduate students. She was nowhere near that perfect window seat where a nice cool

breeze would be a big plus at this point since the room was hot and stuffy and seating capacity was at its maximum.

The professor entered the room. After a brief introduction, he immediately began lecturing and writing equations on the blackboard. At first, she was attentive and listened intently while taking notes and trying to comprehend the professor's lecture on the difference between *variance* and *covariance*. Soon, she found herself lost in his words and once again began scanning the room. The students around her, including her friend, seemed immersed in the lecture and they were nodding their heads from time to time as if in agreement or total understanding of the professor's explanations. Was she the only person who did not understand the content of his lecture? Suddenly, she felt a surge of heat starting at the top of her forehead and slowly moving its way down to her cheeks, throat, and chest. She glanced at the small opened window and wished she had gone with her original choice of seating instead of being stuck in the middle of a classroom where there was no air or breeze to bring her relief. Within a matter of minutes, she noticed that her chest began to ache and she found it difficult to get her breath. The professor and his formulas seemed to be irrelevant as she nervously searched for a *Hall's* coughdrop thinking that this would help her to breathe easier. She told herself that she was just experiencing a bout of allergies even though she was usually only affected by allergies in early April and May. This was August.

Five minutes or so passed and she found that the coughdrop had not made a difference in her ability to breathe easier. Instead, she noticed that the aching and tightness in her chest had stepped up a notch and she was struggling to take a deep breath. She looked around the room for the doorway and wondered if she should just stand up

and walk out of the classroom to get some fresh air but she fought the impulse to do anything that would draw attention to herself from either her classmates or the professor. At this point, she could feel her temples throbbing and her heart felt as if it were racing at twice its normal rate. She massaged her throat as she found it more and more difficult to swallow. She continuously scanned the room to see if any of her classmates had noticed her struggling to take a normal breath. Her eyes darted to the professor as he was beginning to ask questions from different students in the room. Her eyes quickly shifted to the floor in hopes that he would not make eye contact with her and possibly ask for her opinion on a topic she had no knowledge of. Besides, the last fifteen minutes of class were just a blur to her as she was too caught up in her own private battle of just trying to survive this horrible physical attack on her body. She felt lightheaded and at one point thought that she was going to fall off of her seat from the vertigo she was experiencing. Her breathing became more shallow and rapid as each eternal minute crept by. She clinched her desktop to steady herself from the reeling sensation she equated with being on merry-go-round stuck in warp speed. After several minutes had passed, she noticed that her knuckles were white from the intense vice-grip she had on her desk in an effort to combat the sensation of the room spinning. A wave of nausea overcame her and she once again scanned the room to see if anyone had noticed her writhing in agony. The doorway to the classroom seemed a million miles away as she planned over and over in her head her escape out of this inferno of a room. Fear, perhaps, of being laughed or starred at, kept her from moving from the seat and bolting out of the classroom. How much more of this torture could she endure?

As if by some miracle, the professor decided to let the class be released early since it was the first night they had met. As she started her decline down the three flights of stairs, she felt a sense of relief and calmness. By the time she reached her car, the chest pains were gone and she could breathe normally. Once again, she chalked the episode up to a bad case of allergies.

Unfortunately, she experienced the same episode the next two times she attended class with similar 'attacks' at work and one at home. Some episodes were more acute than others. On the days that she had to take a test in her research and statistics class, her anxiety level was so high she either went completely blank on the questions or made frequent careless errors. Her main thoughts and immediate goal was to finish the test as fast as possible so that she could escape from the room and all of the anxiety she was experiencing there. She felt as if she were loosing control of her life.

What followed were several visits to her family and allergy doctor and two trips to the emergency room. She was convinced that she was either having a heart attack or that she was dying from some deadly disease or abnormality. The fear of having another attack plagued her daily - all day - every minute. The only place that seemed to bring her comfort and relief was being at home lying in her bed. It was the only place where she had not experienced an attack.

The diagnosis was always the same. 'We really can't find anything wrong with you other than the fact that your heart is beating a little irregular...but it's nothing serious.' These visits resulted in a pharmaceutical nightmare - inhalers for asthma, inhalers to prevent asthma, medicine to alleviate allergy symptoms, decongestants (since she could not breathe), medicine for vertigo, medicine to help regulate her heartbeat, and medicine

for her gastrointestinal complaints. Nothing seemed to work. If anything, she felt worse and her symptoms became exacerbated.

The episodes became more and more frequent and she felt herself loosing a grip on reality - spiraling in a tidal pool of fear. Sometimes she felt as if she was existing outside of her body as she watched this person who was once strong, fun loving, and adventuresome, crumble like the petals of dead rose once it had been sucked dry of all nutrients. She feared going to class, to work, to the supermarket, and to the shopping mall because she might have another attack. Eventually, she feared driving on the interstate, fearing that she would become dizzy and wreck or run off of the road. She knew it was way past time to seek professional help. She made an appointment with a counselor who diagnosed her with panic disorder. 'Thank God' this monster of slavery had a name!

The early treatment plan prescribed for her consisted of several counseling sessions to pinpoint the major stressors in her life and to learn about relaxation techniques. Because of the frequency and the acute physical symptoms that accompanied her panic attacks, she was referred to a psychiatrist for medication to help alleviate her symptoms. At this point, she was introduced to an antianxiety medication, a benzodiazepine, which helped to take the edge off of the physical symptoms she manifested and which significantly reduced the number of panic attacks she was having. Unfortunately, the medication and relaxation techniques were not enough to help her return to normal - to her 'old self.' She still lived in fear that she was going to have a really bad panic attack which might render her incapacitated. Also, she was plagued by a host of physical symptoms (headaches, stiff neck, sudden onsets of heart palpitations, gastrointestinal

problems, fatigue, and frequent colds) that never seemed to end and subsequently resulted in frequent absenteeism from her place of work. Having to travel to job related meetings or other functions that were more than an hour away from her home, sent her searching for excuses as to why she could not go. Or, if she did travel, she worried daily if she would have another panic attack while she was gone. All of her vacations were conveniently planned around activities at home or within a short traveling distance from her home.

Her psychiatrist recommended increasing her dosage of benzodiazepine to help control some the physical symptoms, particularly the heart palpitations, but she was hesitant to follow his advice since she had taken it upon herself to read some literature about the addictive nature of those type of drugs. Her mistrust in her psychiatrist's treatment solution lead her to seek out another psychiatrist who suggested a regimen of benzodiazepines in conjunction with an antidepressant. The antidepressants either made her too sleepy or too hyper to function at work, not to mention the problems with the nausea she experienced. She became more and more leery of taking any medications that would make her feel 'funny' or perhaps send her into another state of panic. Her psychiatrist relocated to another job after only six months after starting treatment and she was left in the lurch again, trying to find a professional to treat her who would not load her down with more benzodiazepines or antidepressants.

Fortunately, she happened upon a psychiatrist who referred her to a group counseling setting that dealt exclusively with panic disorder. The group was led by a trained psychologist who focused on the following aspects in his sessions: education about the nature and causes of panic disorder; education on medications used to treat

panic disorder; progressive relaxation techniques; breathing and breathing retraining;

learning to use positive affirmations and how to dispel negative thinking; analyzing one's

thoughts, feelings, and actions; and desensitization.

She was on her way to recovery (Anonymous, 1997)!"

The Problem

Panic Disorder with Agoraphobia

Approximately 1.6 percent of adult Americans, or 3 million people, will have Panic

Disorder at some time in their lives (National Institute of Mental Health, 1993).

Agoraphobia is the most prevalent of all the anxiety disorders and it is estimated that one

in twenty or about five percent of the general population suffers from varying degrees of

agoraphobia. Frampton (as cited in Myers, 1990) states that the word *agoraphobia* is

derived from two Greek words - *phobos*, meaning "fear" and *agora*, meaning "a place of

assembly, or market place." Hence, the fear of public places. While the word

agoraphobia means fear of open spaces, the essence of agoraphobia is actually a fear of

panic attacks. Individuals who suffer from this disorder are afraid of being in situations

from which escape might be difficult or in which help might be unavailable. The fear of

embarrassment plays a key role as most agoraphobics fear not only having panic attacks

but what other people will think should they be seen having a panic attack. Hence,

avoidance behavior of a variety of situations is common: crowded public places such as

grocery stores, department stores, restaurants; enclosed or confined places such as

tunnels, bridges, or the hairdresser's chair; public transportation such as trains, buses, subways, planes; and being at home alone (Bourne, 1990).

Imagine the impact these avoidance behaviors could have on the college student's everyday life. The ramifications of being afflicted with this disorder could affect the college student at every conceivable level from their dining and meal ticket choices, their presence in a largely populated and confined classroom, to giving classroom presentations, transportation to and from classes, study time in a crowded library, living arrangements, and their daily social interactions. In a study of college students who reported agoraphobic-like anxiety, panic experiences, and childhood separation anxiety, a link was found to exist between separation anxiety, difficulties experienced when away from home, family patterns such as enmeshment (which interferes with individuation and intimacy), and self reports of panic and agoraphobic anxiety. This study suggests that these factors may predispose the individual to agoraphobic anxiety (Shean & Lease, 1990).

Panic Disorder with Agoraphobia is so complex that it must be viewed as different from all the other phobias. According to Wilson (1996), it is not the moment of panic that distinguishes agoraphobia, nor is it simply that a broader group of fears is involved. The primary difference between agoraphobia and all other phobias lies in the beliefs that sustain the fear within the individual. These beliefs are established by their past life experiences and are supported by current relationships and by memories of the past. Research, compiled by the Diagnostic and Statistical Manual – IV (DSM-IV) research teams, indicates that in clinical settings, almost all individuals (over 95%) who present

with Agoraphobia also have a current diagnosis (or history) of Panic Disorder (American Psychiatric Association, 1994).

Background

The number of reported students with psychiatric disabilities who are seeking services and/or accommodations is steadily increasing on college campuses. Weiner & Wiener (1996) conclude that with the deinstitutionalization movement and the introduction of more effective medications, many individuals are able either to become university students for the first time or to return to campus following recovery from an acute mental illness. Students with psychiatric disabilities, however, remain a relatively unknown and unstudied population in terms of their experiences on college campuses. College campuses are being forced to take a more proactive look at services and programs as nationwide, the enrollment trends indicate a steady increase in the number of students with psychiatric disabilities.   This study seeks to examine the unique college experiences of students diagnosed with Panic Disorder with Agoraphobia and to determine what their particular academic, environmental and psychosocial needs are, and what disability related barriers, if any, they have encountered during their college careers.

By law, under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act, students with psychiatric disabilities are allowed certain services or accommodations provided their documentation of a disability is current and supports such needs. These students will be granted services and accommodations only if they choose to self-identify to the office on campus that is responsible for certifying that the student does indeed qualify as being an individual with a disability.   The unfortunate dilemma,

however, is that university programs and services are being provided for these students based on a global set of accommodations which are housed under the umbrella of services for students with any psychiatric disability rather than considering the uniqueness of the different subpopulations. For instance, is it safe to assume that the services or accommodations that are needed by a student diagnosed with Bipolar Disorder or Schizophrenia will be the same for a student diagnosed with an Anxiety Disorder?

The literature, as it relates to college students who have been diagnosed with a psychiatric disability, is particularly sparse in the area of Panic Disorder with Agoraphobia. An extensive search of all Educational Resources Information Center (ERIC) journals submitted since the year 1990 revealed only one article that addressed the topic of college students with psychiatric disabilities. No mention was given to any one specific subgroup (i.e. Bipolar, Panic Disorder, etc.) of disability area. All psychiatric disabilities were classified and treated as one group with treatment and strategies applicable to everyone.

Panic Disorder with Agoraphobia is such a pervasive disorder in that it affects the individual at many levels ... emotionally, socially, environmentally, and physically. Very sparse information is available that can shed any light on the college experiences of these students or on the environmental, psychological, and academic barriers they may face. This study seeks to examine the unique college experiences of students diagnosed with Panic Disorder with Agoraphobia and to determine what their particular academic and psychosocial needs are, and what environmental barriers, if any, they have encountered during their college careers.

Services

Research indicates that students with disabilities often experience isolation, lack of self confidence (Serebrini et al., 1993) and difficulty with career decisions (Fass, 1992). However, these students are expected to advocate on their own behalf which means that they need to have the skills and confidence to request the accommodations they need. Equally important, they need to know what services are available. Orientation, awareness, and personal development programs are traditional methods of introducing students to services, enhancing their survival skills, and fostering networking opportunities for them.

The Dean of Students Office, Services for Students With Disabilities (SSD), has the responsibility for coordinating services for students with disabilities at Virginia Polytechnic Institute and State University (Virginia Tech). The primary focus of this office has been on providing academic accommodations to these students. Efforts to fully support the psychosocial and career development needs of these students have been hampered by the increasing demands for *academic accommodation* services. This increase is based in part on the growing number of diagnosed students with a wide variety of disabilities who have chosen to ask for accommodations through the SSD office. In 1987, SSD had approximately 52 students who had self-identified to the office and were in need of services versus approximately 350 students for the Fall 1998 who have requested services (SSD, 1998).

The *academic accommodations* typically received at Virginia Tech are as follows: notetakers, scribes, taped texts, readers, test accommodations, assistance with registration,

taped lectures, interpreters, and access to technology and campus facilities. While this is a list of broad accommodations, individuals with psychiatric disabilities may need other services individually tailored to their specific disability. Without exploring the needs and unique characteristics endogenous to the subpopulations of psychiatric disorders (i.e., Bipolar Disorder, Anxiety Disorders, Schizophrenia, etc.), colleges and universities may never be able to adequately accommodate those students who have been diagnosed with a specific psychiatric disability. An additional factor to consider in providing accommodations is that the concept of providing services to students with psychiatric disabilities elicits various reactions from college personnel. Some fear that this population will take an inordinate amount of staff time, while others fear that these students will cause excessive disruptions on campus, or they simply fear the disability itself (Jacobs & Glater, 1992). Unger (1992) cites that it is the attitudinal barriers (of student affairs professionals) that have a direct impact on providing services to students diagnosed with psychiatric disabilities which results in limited access. While providing adequate accommodations and meeting the needs of students diagnosed with psychiatric disabilities is tantamount in meeting the letter of the law, educating faculty and staff about these needs and services is also equally important.

Statement of the Problem

Much of the research and documentation that surround the study of college students with psychiatric disorders is extremely broad in focus and tends to group all

psychiatric diagnoses together when reporting outcome studies. The research literature that is devoted to the study of the college student diagnosed with Panic Disorder with Agoraphobia is limited in scope and nature. The majority of the literature is devoted to the physiological and behavioral ramifications of the disorder or treatment modalities. A review of the extant literature reveals that there is no substantive research available that provides insight into the college experiences of the student diagnosed with Panic Disorder with Agoraphobia.

In summary, it is safe to say that there is not enough pertinent information readily available to enlighten college and university faculty and staff about the experiences of college students diagnosed with Panic Disorder with Agoraphobia. Specifically, little is known about: (1) the academic, psychosocial, and environmental needs of these students (2) what disability related barriers these students may have experienced (3) what coping mechanisms are typically employed, and (4) what services and accommodations these students have found to be the most effective while they were enrolled in college.

Need for the Study

A review of the extant literature reveals that there are no specific references or empirical research done that addresses the effect that college has on students diagnosed with Panic Disorder with Agoraphobia. While the existing literature on Panic Disorder with Agoraphobia is abundant, it primarily addresses the clinical nature of the disorder or the therapeutic interventions employed. With the increasing number of psychiatric disabilities being reported on college campuses today, it is important that campus service

providers learn to respond to the uniqueness of each disorder rather than providing a rubber stamp list of services or accommodations that seeks to assist all psychiatric disabilities. It would be remiss of college or university service providers to assume that the needs of students with Panic Disorder with Agoraphobia would be the same as those of a student diagnosed with Bipolar Disorder or other psychiatric disorders because of the different symptomatology and psychosocial manifestations.

This study attempts to identify the perceptions that students have who are diagnosed with Panic Disorder with Agoraphobia from an academic, psychosocial, and environmental perspective. The outcomes of this study should prove beneficial in providing insight and direction to college and university service providers such as disability counselors, student health and counseling staff, residence hall staff, teachers, and rehabilitation counselors as to the specific needs of the student diagnosed with Panic Disorder with Agoraphobia. In addition, this study will provide a rich personal description of how college students with this disorder react to their college environment and to any disability related barriers that might possibly affect their success in college.

Purpose of the Study

This study seeks to examine the unique college experiences of students diagnosed with Panic Disorder with Agoraphobia and to determine what their particular academic, environmental and psychosocial needs are, and what disability related barriers, if any, they have encountered during their college careers.

The general purpose of this qualitative study is to identify the effect college has had on individuals diagnosed with Panic Disorder with Agoraphobia through the following venues: (1) by identifying the academic, psychosocial, and environmental needs of each student and (2) by identifying what disability related barriers the student may have experienced in each of the three preceding categories (3) identifying the coping mechanisms used by the student, and (4) to identify what services and accommodations the student found to be the most effective. This information should prove beneficial for individuals who work with students diagnosed with psychiatric disabilities, especially with Panic Disorder, in providing much needed insight into the needs and services from which these students can best benefit.

Methodology

This is a qualitative study which utilizes the in-depth interview method as the primary tool for gathering relevant data and synthesizing the material into a format that is progressive and logistical. A total of eight subjects will be interviewed. The first two subjects interviewed will be used in the pilot study to help restructure the surveys and questions the researcher intends to use with the other six subjects. All subjects interviewed will have a formal diagnosis of Panic Disorder with Agoraphobia from a qualified professional.

Further, the researcher will:

1. Synthesize the extant literature.

2. Formulate a list of variables that define the categories: environmental, psychosocial, and academic.

3. Outline the components and theories surrounding Panic Disorder with Agoraphobia.

4. Outline the components of environmental needs and barriers as they relate to an Ecosystems model of Student Development theory.

5. Outline the components of academic and psychosocial needs and barriers as they relate to students diagnosed with psychiatric disabilities through a review of the relevant literature.

6. Outline the services, accommodations, and rights that individuals diagnosed with a disability are allowed under the law.

7. Conduct an in-depth interview with six (6) college subjects who have been previously identified as having Panic Disorder with Agoraphobia to gather common themes and patterns about their college experiences.

8. Conduct an in-depth background survey which will provide additional information on each subject's academic, environmental, and psychosocial needs and on any barriers encountered.

Research Questions

1. *What do students diagnosed with Panic Disorder with Agoraphobia perceive to be the environmental needs and barriers in the college setting?*

a. What are the environmental needs?

b. What barriers did the student encounter at school?

c. What barriers did the student encounter off campus?

d. What factors exacerbated each student's condition?

e. What coping mechanisms did the student employ?

2. *What do students diagnosed with Panic Disorder with Agoraphobia perceive to be the academic needs and barriers in the college setting?*

a. What are the academic needs?

b. What barriers did the student encounter at school?

c. What effect has the disability had on the student's choice of major and future career goals?

d. What factors exacerbated each student's condition?

e. What coping mechanisms did the student employ?

3. *What do students diagnosed with Panic Disorder with Agoraphobia perceive to be the psychosocial needs and barriers in the college setting?*

a. What are the psychosocial needs?

b. What barriers did the student encounter at school?

c. What barriers did the student encounter off campus?

d. What factors exacerbated each student's condition?

e. What coping mechanisms did the student employ?

4. *What kinds of treatment did the student have before coming to college?*

5. *What types of services, related to the disorder, (i.e. counseling, support groups, health services, etc.), or accommodations did the student utilize during college?*

6. *Which services and/or accommodations were found to be the most effective?*

7. W*hat services did the student need but not find available, if any?*

8. *What were the common experiences of the subjects in this study?*

Definitions

1. *Panic Disorder* - is characterized by sudden episodes of acute apprehension or intense fear that occur "out of the blue" without any apparent cause. Intense panic usually lasts no more than a few minutes, but, in rare instances, can return in "waves" for a period of up to two hours. During the panic itself, any of the following symptoms can occur: shortness of breath or a feeling of being smothered, heart palpitations, dizziness, unsteadiness, or faintness, trembling or shaking, choking, sweating, nausea or abdominal distress, feelings of unreality - as if "you're not all there" (depersonalization), numbness or tingling in hands and feet, hot and cold flashes, chest pain or discomfort, fears of going crazy or losing control. At least four of these symptoms are present in a full-blown panic attack, while having two or three of them is referred to as a limited-symptom attack. Symptoms would be diagnosed as Panic Disorder if one either: 1) has had four panic attacks in a one-month period or 2) has had one panic attack followed by a month of continual worry about having another (Bourne, 1990).

2. *Panic Disorder with Agoraphobia* - the word itself means fear of open spaces; however, the essence of Agoraphobia is a fear of panic attacks. Individuals with Agoraphobia are afraid of being in situations from which escape might be difficult or in

which help might be unavailable if you should suddenly have a Panic Attack. Individuals

with Agoraphobia tend to avoid a variety of situations not so much because of their

inherent characteristics, but because these are situations from which escape might be

difficult or embarrassing in the event of panic (i.e., crowded public places such as grocery

stores, department stores, restaurants; enclosed or confined places such as tunnels,

bridges, or the hairdresser's chair; public transportation such as trains, buses, subways,

planes; being at home alone). Fear of embarrassment plays a key role. Most agoraphobics

fear not only having Panic Attacks but what other people will think should they be seen

having a Panic Attack (Bourne, 1990).

3. *Comorbidity* - the existence of a second (or perhaps multiple) disorder in conjunction

to the primary diagnosis (e.g., Primary diagnosis: Panic Disorder with Agoraphobia;

additional diagnosis of Major Depression -Single Episode).

4. *"Safe Majors" or "Safe Careers"* - terms coined by the researcher that will be used to

explain the analysis of the data collected in this study. The researcher hypothesizes that

students diagnosed with Panic Disorder with Agoraphobia choose degree programs or

majors and career paths that will not put them in compromising positions that might

predispose them to situations that have been known to produce high levels of anxiety (i.e.,

jobs that require a lot of travel, jobs that require presentations before a large group, jobs

that require mandatory attendance to frequent social functions). These terms, in part, are

derived from supported evidence that the most common feature of Agoraphobia is anxiety

about being far away from home or far from a "safe person" (usually a spouse, partner,

parent, or anyone to whom the person has a primary attachment) (Bourne, 1990).

5. *Accommodations* - federal and state laws require that qualified university students with disabilities be provided an equal opportunity in institutions of higher education (public and private). Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, and the Virginians with Disabilities Act of 1985 mandate access to individually prescribed accommodations for students with any type of disability. In addition to these legal justifications for support services, unique opportunities for advanced career preparation and personal growth found only in higher education environments offer compelling reasons for the provision of needed support services. Through the provision of services and accommodations, students with disabilities have a chance to circumvent what might otherwise be a barrier to academic, career, and personal success (Reilly & Roth, 1996).

6. *Floating prompts* - are researcher techniques (McCracken, 1988) utilized in qualitative research in which the researcher attempts to obtain information from the subject in an unobtrusive manner. These prompts may include, subtle body language (i.e., raising one's eyebrow at the end of the respondent's utterance to prompt them to expand upon their testimony); repeating the key terms of the respondent's last remark with an interrogative tone; contrast prompts (e.g., what is the difference between categories "x" and "y"?); category questions (e.g., determining how the respondent identifies an activity or event according to the key actors, central action, dramatic structure, important props, necessary audience, ascribed roles, designated critics, social significance, cultural significance, and the consequences of good and bad performances); having the subject recall exceptional

incidents; auto-driving (e.g., where the subject is asked to comment on a picture, video, or some other stimulus, and to provide his or her own account of what they see there).

7. *Barriers* - A barrier can be anything, material or immaterial, that acts to obstruct or prevent passage (Morris, 1969). Barriers for students with psychiatric disabilities generally refers to obstacles that prevent them from gaining access to educational programs or experiences. These barriers may be physical (e.g. elevators, size and location of a classroom, medication side effects, etc.) or psychological (e.g. student's perceptions of other people, things, or places, perceptions of how others view them, or negative consequences based on personal choices or preferences). The barriers described in this study are the obstacles or challenges encountered by the student in both their personal and academic environment. It is the negative meaning that the student attaches to particular things, persons, or places that makes them a barrier.

Limitations

1. The data collected from the small sample size and the restricted geographical area limit generalization of the results to other individuals diagnosed with Panic Disorder with Agoraphobia.

2. Some subjects may have participated in other forms of intervention (i.e. individual, group, and/or psychopharmacological therapy) or other activities which would influence the results of this study.

3. Subjects will be asked to rely on long-term recall which may not be entirely accurate.

4. Researcher effects and bias may influence the outcomes of any data generated. This in turn may affect the quality of the interview which will rely upon the ability and willingness of the students to articulate perceptions and to share accounts of experiences which are personal and confidential in nature.

Overview of the Dissertation

This qualitative study will be organized around five chapters. Chapter One includes an introduction to psychiatric disabilities with particular emphasis on students diagnosed with Panic Disorder with Agoraphobia, research questions, the purpose of the study, definition of terms, and the limitations of the study. Chapter Two contains a review

of the literature pertinent to the study of students diagnosed with Panic Disorder with

Agoraphobia. Chapter Three focuses upon the methodology used to conduct the

qualitative study. This chapter will focus on the design of the study, the participants, the

interview protocol and process, and the data analysis procedures that were employed. The

results of the study, based upon an analysis of the data, will be summarized in Chapter

Four. Chapter Five will provide a discussion of the results, present conclusions, and

provide suggestions for future research for practitioners in the field of providing services

and accommodations to students who have been diagnosed with Panic Disorder with

Agoraphobia.

CHAPTER 2

REVIEW OF RELATED RESEARCH AND LITERATURE

Definition

Panic Disorder with Agoraphobia is classified as an Anxiety Disorder. According to the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV), Anxiety Disorders include Panic Attacks, Agoraphobia, Panic Disorder with or without Agoraphobia, Agoraphobia without history of Panic Disorder, Specific Phobia, Social Phobia, Obsessive-Compulsive Disorder, Posttraumatic Stress Disorder, Acute Stress Disorder, Generalized Anxiety Disorder, Anxiety Disorder due to a general medical condition, Substance Induced Anxiety Disorder, and Anxiety Disorder not otherwise specified (American Psychiatric Association, 1994). Levitt (1967, p.1) contends that...

> It is difficult to dispute the contention that anxiety is a "pervasive psychological phenomenon" of modern society. The world seems literally to drip with it. It begins in infancy with a fear of the unknown and the yet unexperienced of life, winds its way painfully through countless occurrences, large and small, and concludes with a fear of that unknown which is death. It is not that the emotion itself is of recent origin, or that it is somehow of greater significance today than it has been in the past. Surely fear is as old as human existence and belongs to no particular era or culture.

The concept of fear and anxiety have long been regarded as fundamental human emotions. The concept of fear can be traced back to ancient Egyptian hieroglyphics and the term "anxiety" has been noted in the work of the medieval Arab philosopher, Ala ibn Hazm, of Cordova. Sigmund Freud, however, is undoubtedly, the most important contributor to our present understanding of anxiety phenomena. Freud not only regarded

anxiety as the fundamental problem in all neurotic symptom formation, but he felt understanding anxiety was also essential to the development of a comprehensive theory of human behavior (Spielberger, 1972).

In order to gain a full understanding of the nature of Panic Disorder with Agoraphobia, both Panic Disorder and Agoraphobia must be defined. The DSM-IV (Americian Psychiatric Association, 1994) defines Panic Disorder as the presence of recurrent, unexpected panic attacks followed by at least one month of persistent concern about having another panic attack, worry about the possible implications or consequences of the panic attacks, or a significant behavioral change related to the attacks. These attacks are not due to the direct physiological effects of a substance (e.g., Caffeine Intoxication), a general medical condition (e.g., hyperthyroidism), or they are not better accounted for by another mental disorder (e.g., Specific or Social Phobia, Obsessive-Compulsive, etc.).

A panic attack that is unexpected (spontaneous, uncued) is defined as one that is not associated with a situational trigger - it occurs "out of the blue." For there to be a diagnosis of Panic Attack, at least two unexpected attacks must occur; however, most individuals have considerably more. Individuals may also have situationally predisposed attacks - those more likely to occur on, but not invariably associated with, exposure to a situational trigger. Less commonly occurring attacks are situationally bound attacks which occur almost invariably and immediately on exposure to a situational trigger. The frequency and severity of Panic Attacks vary widely from one a week to several a day and from frequent attacks separated by weeks or months or less frequent attacks over many years.

The DSM - IV (American Psychiatric Association, 1994) criteria for Panic Attack includes a discrete period of intense fear or discomfort. During this period, four (or more) of the following symptoms develop abruptly and reach a peak within 10 minutes:

1. palpitations, pounding heart, or accelerated heart rate
2. sweating
3. trembling or shaking
4. sensations of shortness of breath or smothering
5. feeling of choking
6. chest pain or discomfort
7. nausea or abdominal distress
8. feeling dizzy, unsteady, lightheaded, or faint
9. derealization (feelings of unreality) or depersonalization (being detached from oneself)
10. fear of losing control or going crazy
11. fear of dying
12. paresthesias (numbness or tingling sensations)
13. chills or hot flushes

One's symptoms would be diagnosed as Panic Disorder if either (1) the individual had four panic attacks in a one-month period or (2) they had one panic attack followed by a month of continual worry about having another. Panic Disorder, by itself, does not involve any phobias. Panic does not occur because a person is thinking about, approaching, or actually entering a phobic situation; instead, it occurs spontaneously and unexpectedly for no apparent reason (Bourne, 1990).

Individuals with Panic Disorder tend to display characteristic concerns or attributions about the implications or consequences of the Panic Attacks. For instance, some fear that the attacks indicate the presence of an undiagnosed, life-threatening illness (e.g., cardiac disease, seizure disorder), or they may fear that the attacks are an indication that they are "going crazy", "losing control", or are emotionally weak. When the attacks are recurrent, individuals may significantly change their behavior like quitting their job,

deny the fear of having another attack, or deny concerns about the consequences of their panic attacks. Implications or concerns about the next attack are often associated with development of avoidance behaviors that may meet criteria for Agoraphobia, in which case, Panic Disorder with Agoraphobia is diagnosed. Agoraphobia is anxiety about being in places or situations from which escape might be difficult or embarrassing or in which help may not be available in the event of having an unexpected or situationally predisposed Panic Attack or panic-like symptoms. Examples might include being outside the home alone; being in a crowd or standing in a line; being on a bridge; and traveling in a bus, train, or automobile. These situations are avoided or else are endured with marked distress or with anxiety about having a panic attack or panic-like symptoms. Many individuals may avoid certain settings unless there is the presence of a companion (i.e. spouse, child, parent, or close friend) (American Psychiatric Association, 1994).

Comorbidity Features

Major Depressive Disorder occurs frequently (50%-65%) in individuals with Panic Disorder and in approximately one-third of individuals with both disorders, the depression precedes the onset of Panic Disorder. Individuals with Panic Disorder may develop a Substance-Related Disorder as a consequence by treating their anxiety with alcohol and medications. Comorbidity with other anxiety Disorders is common, especially in clinical settings and in individuals with more severe Agoraphobia (Social Phobia has been reported in 15%-30% of individuals with Panic Disorder; Obsessive-Compulsive Disorder in 8%-10%; Specific Phobia in 10%-20%; and Generalized Anxiety Disorder in 25%). Panic Disorder Without Agoraphobia is diagnosed twice as often as Panic Disorder With Agoraphobia. Panic Disorder With Agoraphobia is diagnosed three times as often in

women as in men (American Psychiatric Association, 1994). A study, comparing 96

women and 58 men diagnosed with Panic Disorder with Agoraphobia by Turgeon,

Marchand, and Dupuis (1998) found that women reported more severe agoraphobic

avoidance when facing situations or places alone, more catastrophic thoughts, and more

body sensations. Also, women more often had a comorbid social phobia or posttraumatic

stress disorder. The lower agoraphobic avoidance of the men was associated with alcohol

use. There were no differences between genders in other dimensions, including

depression, situational and trait anxiety, stressful life events, social self-esteem, marital

adjustment, and drug use.

The Origins of Panic Disorder

Following is an outline of *causal* and *developmental* factors in Panic Disorder that

provides a comprehensive collection of theories and modalities (Klerman, 1993):

<u>Causal Factors</u>

Genetic Factors: Studies show the risk of developing Panic Disorder is 15-17% in first
degree relatives of Panic Disorder patients. The risk for development in identical twins is
24-31%. This indicates that panic disorder may be genetically transmitted.

Psychoanalytic Theories: Panic apprehension may be the emergence of deeply rooted
primarily aggressive unconscious conflicts that originated in traumatic experiences in early
childhood.

Learning and Behavior Theories: After the original spontaneous panic attack, further
attacks may occur through conditioning in the situations where anxiety has been
experienced. Phobic avoidance may develop as patients seek to prevent further panic
attacks. Panic attacks may arise when anxiety is conditioned to internal stimuli, for
example, heart palpitations.

Cognitive Theories: Panic attacks may develop when a person misinterprets the
significance of certain bodily sensations as an impending medical emergency. This leads to

heightened anxiety and greater nervous arousal, setting up a positive feedback loop. The rapidly escalating anxiety leads to a panic attack.

Childhood Separation Anxiety or Behavioral Inhibition: School phobia and other childhood anxiety disorders may be early forms of Panic Disorder. Children of parents with Panic Disorder are more likely to exhibit fear and withdrawal in unfamiliar situations.

Parental Attitudes and Behavior: Patients with Panic Disorder often describe their parents as overprotective, restricting, controlling, critical, frightening, or showing rejection.

Developmental Factors

Provocation Studies: Injection of sodium lactate can provoke panic attacks, possibly by stimulation of the locus ceruleus in the brain stem. Carbon dioxide, yohimbine, caffeine, and other agents have provoked panic attacks in Panic Disorder patients. These agents have been useful in studying the characteristics and mechanisms of panic attacks. There are studies, however, that indicate that subjects with Panic Disorder can safely undergo vigorous exercise of such intensity to result in significant lactate production with the chances of panic being small (Martinsen, Raglin, Hoffart, Friis, 1998).

Biological Markers: Panic Disorder patients may have abnormalities in monoamine oxidase, serotonin uptake, alpha2-adrenoceptor and 2H-imipramine receptors in platelets, and serotonin or norepinephrine metabolism. This may support the role of neurotransmitter abnormalities in panic disorder.

Animal Models: Animal studies have implicated activation or abnormality of several brain structures within the limbic system during anxiety states.

Brain Imaging: During PET scans, abnormal cerebral blood flow patterns have been observed in the parahippocampal and hippocampal regions of the brain in Panic Disorder patients.

Nocturnal Panic Attacks: Increased sleep latency, decreased sleep time, decreased sleep efficiency, and increased rapid eye movement have been observed in Panic Disorder patients.

Neurotransmitter Theories: Increased activity or reactivity in the noradrenalin or serotonin neurotransmitter systems may cause or relate to panic attacks. A subsensitivity of the benzodiazepine receptor could decrease the effect of GABA, an inhibitory neurotransmitter. An excess or deficit of a naturally occurring substance operating on the benzodiazepine receptor may exist.

Suffocation Alarm Theory: A suffocation alarm system within the brain may be hypersensitive to an increase in carbon dioxide level. This produces sudden respiratory distress followed by hyperventilation, panic, and the urge to flee.

Life Events: Significant life events involving a loss or threat within the previous 12 months may contribute to the development of Panic Disorder.

Personality Factors: Patients may have unassertive, fearful, dependent, passive, anxious, or shy, hyperpersonality traits which precede the development of Panic Disorder.

The debate surrounding the origin of Panic Disorder - a biological versus a psychological disorder - is a controversial subject that has divided the research of Panic Disorder. While human behavior has a biological basis at the nerve cell level, Panic Disorder also involves distorted thought and behavior patterns. The following theory by Kernodle (1995) includes both biological and behavioral theories. He proposes that the components of Panic Disorder, Panic Attack, Anticipatory Anxiety, and Agoraphobia, are associated with three distinct areas of the brain which include the brain stem, limbic system, and frontal cortex. The Panic Attacks are triggered by stimulation of areas in the brain stem that control the release of adrenaline and stimulation of the locus ceruleus produces most of the physical symptoms of panic. Certain antidepressants seem to block panic attacks by reducing the firing rate of the locus ceruleus.

The limbic system, which involves the emotion of rage, arousal and fear, is suspected to be the location for Anticipatory Anxiety. This area houses large quantities of benzodiazepine receptors so benzodiazepine medications are most effective in the limbic area. Paths that link the brain stem with the limbic system can produce Anticipatory Anxiety following a panic attack and vice versa. The limbic system is also affected by changes in blood flow caused by hyperventilation. Relaxation and abdominal breathing

decrease Anticipatory Anxiety by quieting the limbic system and blocking a potential

trigger path for a panic attack. Amen (1996), a psychiatrist, has pinpointed an area of the

brain surrounding the limbic system called the basal ganglia that shows abnormalities on

the right side of the basal ganglia in his patients diagnosed with Panic Disorder. He is able

to identify these abnormal pathways through Single Photon Emission Computerized

Tomography which is a sophisticated nuclear medicine study that looks at brain activity

(or metabolism) and blood flow.

   Agoraphobia, a learned behavior pattern, is probably located in the frontal cortex.

Cognitive-behavioral treatments appear to be the most effective at this higher level of the

brain. Discharges from the brain stem may be interpreted by the frontal cortex as a

dangerous, life-threatening event, and hence the possibility for associations between the

panic attack, environment, and thoughts may occur. Descending paths from the frontal

cortex enable catastrophic thoughts to stimulate the brain stem and possibly cause a panic

attack (Kernodle, 1995).

   Barlow and Craske (1989) identify three major components of anxiety and panic

which include *physiologic, thought*, and *behaviors*. They state that the *physiologic*

component involves the physical feelings or symptoms such as muscular tension, a rapid

pulse, difficulty breathing, a nervous stomach, frequent or excessive sweating,

tremulousness, headaches, stomachaches, etc. The *thoughts* or statements that one tells

oneself involve the sense of impending doom, thoughts that something terrible is about to

happen, a sense of danger, and a great deal of worrying about the present and the future.

It is the anticipation of the worst and the apprehension about what is going to happen. It

is the feeling that events could proceed uncontrollably or that one may not have control

over their reactions. It is a feeling of helplessness in the face of uncertainty. The *behavior*

involves disruption of performance, such as when anxiety reaches a level that interferes

with the ability to do a good job, to concentrate, or to give a speech. Behavior also

involves escaping from or avoiding certain places or events where anxiety or panic is

expected to occur.

Clum (1990), a professor and head of the Anxiety Disorders Clinic at Virginia

Polytechnic Institute and State University, states that there are several reasons for

concluding that panic disorders are more psychological or cognitive in nature and are only

minimally related to a genetic predisposition: (1) The evidence that supports a genetic

predisposition is weak, being based solely on the rates of occurrence of the disorder in

families. The same data could also be interpreted as supporting learned anxiety responses.

(2) A large percentage of the general population has panic disorder - it is highly unlikely

that such a large segment of the population would have what might be termed a mild

genetic predisposition. (3) Even individuals who develop frequent panic attacks have

periods without attacks. For people with a genetic predisposition to panic, factors other

than genetics must be playing a more central role to produce the waxing and waning of

symptoms.

Windmann (1998), states that in sharp contrast to the most commonly held belief

on a metatheoretical level that cognitions actually emerge from brain processes,

psychological models of panic try to explain panic and anxiety without referring to

neurobiological processes, whereas biological theories postulate neurobiological

dysfunctions, for example, in neurotransmitter systems without showing how and why

these lead to panic-specific sensations and cognitions (and not to any other cognitive

disturbance). Further, he states that neuroscience has progressed considerably in recent years. For many cognitive processes, translations into neurobiological terms and models already exist, at least hypothetically. Windmann feels that it is advantageous to combine cognitive and neurobiological explanations instead of giving preference to either a purely mentalistic or a purely materialist view while simultaneously neglecting or rejecting the alternative perspective. Hence, cognitive dysfunctions described by psychological models of panic might in fact arise from neurobiological dysfunctions proposed by biological models and a functional, dynamic process should be outlined to explain how subjective experience of irrational fear might be produced by the brain.

Characteristics

There are a host of primary and secondary characteristics listed by the DSM-IV that are associated with Panic Disorder with Agoraphobia. *Primary characteristics* include:

> **A.** Both (1) and (2): (1) *recurrent unexpected Panic Attacks* (a discrete period of intense fear or discomfort, in which four (or more) of the following symptoms developed abruptly and reached a peak within 10 minutes: 1) palpitations, pounding heart, or accelerated heart rate; 2) sweating; 3) trembling or shaking 4) sensations of shortness of breath or smothering; 5) feeling of choking; 6) chest pain or discomfort; 7) nausea or abdominal distress; 8) feeling dizzy, unsteady, lightheaded, or faint; 9) derealization (feelings of unreality) or depersonalization (being detached from oneself); 10) fear of losing control or going crazy; 11) fear of dying; 12) paresthesias (numbness or tingling sensations); 13) chills or hot flushes); (2) *at least one of the attacks has been followed by 1month (or more) of one (or more) of the following:* (a) persistent concern about having additional attack (b) worry about the implications of the attack or its consequences (e.g., losing control, having a heart attack, "going crazy") (c) a significant change in behavior related to the attacks;

B. The presence of Agoraphobia (Anxiety about being in places or situations from which escape might be difficult (or embarrassing) or in which help may not   be available in the event of having an unexpected or situationally predisposed Panic Attack or panic-like symptoms. Agoraphobic being in a crowd or standing in a line; being on a bridge; and traveling in a bus, train, or distress or with anxiety about having a Panic Attack or panic-like symptoms, or require the mental disorder, such as Social Phobia (e.g., avoidance limited to social situations because of fear of embarrassment), Specific phobia (e.g., avoidance limited to a single situation like elevators), Obsessive-Compulsive Disorder (e.g., avoidance of dirt in someone with an obsession about contamination), Posttraumatic Stress Disorder (e.g., avoidance of stimuli associated with a severe stressor), or Separation Anxiety Disorder (e.g., avoidance of leaving home or relatives).

C. The Panic Attacks are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g. hyperthyroidism).

 D. The Panic Attacks are not better accounted for by another mental disorder, such as Social Phobia (e.g., occurring on exposure to feared social situations), specific Phobia (e.g., on exposure to dirt in someone with an obsession about contamination), Posttraumatic Stress disorder (e.g., in response to stimuli associated with a severe stressor), or Separation Anxiety Disorder (e.g., in response to being away from home or close relatives).

Secondary characteristics include: constant or intermittent feelings of anxiety that are not focused on any specific situation or event; excessively apprehensive about the outcome of routine activities and experiences, particularly those related to health or separation from loved ones; less tolerant of medication side effects and generally need continued reassurance in order to take medication; loss or disruption of important interpersonal relationships; demoralization in which many individuals become discouraged, ashamed, and unhappy about the difficulties of carrying out their normal routines; may experience frequent absences from work or school for doctor and emergency-room visits leading to unemployment or dropping out of school; and depression .

Treatment

There is no general consensus at to what causes Panic Disorder with Agoraphobia or how to diagnose or treat it effectively. A diagnosis is generally derived by taking into account one's self-report of symptomatology. The diagnosis is made by assessing current behaviors and by taking a comprehensive look at one's past history in accordance with the primary classification system used in the DSM-IV. Few assessment tools are available and these generally just support the presence of anxiety in the individual. These anxiety scales are rarely used alone to give a diagnosis of an anxiety disorder. The comorbidity of depression is just another complicating factor that sometimes makes a true diagnosis difficult. Recent studies indicate that women constitute 59 percent of the pure Panic Disorder cases and 89 percent of panic disorder with Agoraphobia. Approximately 85 percent of agoraphobics are women (American Psychiatric Association, 1994).

The origin of Panic Disorder is still under debate since there is no single cause of anxiety of depression. It is believed that physical and environmental triggers may combine to give rise to anxiety, depression, or manic depression in certain people. While some scientists believe that anxiety is a learned response, that people are taught to fear situations or objects, some psychoanalytic theories suggest that anxiety stems from an unconscious conflict, an illness, fright, or emotionally laden event that happened to the person as a child. Certain life events and the way an individual learns to respond to them may make a person more likely to experience depression. It has also been proven that some medication taken for other illnesses can cause depression or mania, as can a medical illness. It has been demonstrated that stress can bring on depression or mania in susceptible individuals and scientists are learning the importance of genetics and brain

biochemistry or biochemical imbalances as playing a significant part of the problem (Long, 1995).

The debate surrounding the origin of Panic Disorder with Agoraphobia - a biological versus a psychological disorder - is a controversial subject that has divided not only the research but the treatment of Panic Disorder as well.   A host of theories from genetic predisposition, chemical factors, physical problems, stress, learned vulnerabilities, and depression (Clum, 1990) have been linked with the casual factors leading to Panic Disorder. The complexity of these theories, or combination of these factors, make a single method of treatment appear absolute in lieu of these variables.

Treatment for individuals with Panic Disorder with Agoraphobia is generally a combination of pharmacological and psychotherapeutic interventions. Drug treatment is typically limited to antidepressants and/or tranquilizers. Therapy approaches may range from 1) "uncovering" psychotherapies aimed at identifying and dealing with the conflict and stresses that may contribute to the development of panic attacks; 2) exposure techniques aimed at reducing or eliminating the avoidance behaviors associated with panic attacks; and 3) psychotherapy aimed at teaching techniques for coping directly with the symptoms of panic (Clum, 1990).

The treatment phase for Panic Disorder with Agoraphobia can be a monumental and painstakingly slow task as comorbidity with the other Anxiety Disorders and major Depressive Disorder often exists. Major Depressive disorder occurs as frequently as

(50%-65%) in individuals with Panic Disorder. Separation Anxiety Disorder in childhood

has also been associated with this disorder (American Psychiatric Association, 1994).

SECTION 504 AND

THE AMERICANS WITH DISABILITIES ACT (ADA)

The Legal Sanctions that Protect Students with Psychiatric Disabilities in the

Educational Setting

The context in which the majority of research and statistics gathered about

students with disabilities is a result of the data compiled by disability service provider

offices or an office which serves in a similar capacity on college and university campuses.

It must be noted that the facts and figures generated from these offices are based on the

number of students who have chosen to disclose their disability(s) to these offices and who

may, after producing professional documentation of a disability, be requesting

accommodations.   An accurate picture of the number and types of different disabilities

that actually exists on college and university campuses is never truly evident since students

reserve the right whether or not to disclose the nature of their disability.

Prior to entering institutions of higher education, students with disabilities may

have received the educational benefits of the Individuals with Disabilities Education Act

(IDEA), formerly known as the Education for All Handicapped Children Act of 1975.

These individuals have greater expectations concerning the substantive and procedural

protections of disability-related legislation and anticipate continued benefit through federal

mandates as set forth in college and university settings covered under the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1973. A growing awareness of protections available under these federal legislations has increased the amount of litigation relating to disability issues (Gehring, Osfield, & Wald, 1994). These protections and prior knowledge of legislative mandates are not always common knowledge for individuals who have been diagnosed with a psychiatric disability. The reason lies in the fact that most psychiatric disabilities do not have an onset until late adolescence or early adulthood (18 to 25 years of age). Students who manifest symptoms before the age of 18 are generally not diagnosed until they are older because often times, their symptoms are viewed as typical "acting out" adolescent behavior or a "stage" they are going through.

The landmark event that has raised the country's conscience to the problem of discrimination against individuals with disabilities is the passage of Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. sec. 794, as amended by Section 111(a) of the Rehabilitation Act Amendments of 1974. Kaplan (1978) states that before this act, there were a few scattered federal provisions concerning discrimination against individuals with disabilities, such as 20 U.S. C. sec. 1684, which prohibits discrimination against blind persons by institutions receiving federal funds. There also existed a few constitutional equal protection cases on discrimination against students with disabilities in public elementary and secondary schools, as noted in *PARC v. Pennsylvania* (1971).

Section 504, as applied to postsecondary education, generally prohibits discrimination on the basis of handicap by any institution receiving federal funds. Prohibiting discrimination on the basis of handicap in admissions and recruitment falls

under Section 84.42 of the implementing regulations, 45 C.F.R. Part 84. A fund recipient, with regard to admission, may not: (1) apply limitations on "the number or proportion of handicapped persons who may be admitted (sec. 84.42 (b) (1)); (2) make use of any admissions criterion "that has a disproportionately adverse effect "on the handicapped, unless the criterion, as used, is shown to predict success validly and no alternative, nondiscriminatory criterion is available (sec. 84.42 (b) (2)); or (3) make a preadmission inquiry about whether the applicant is handicapped, unless the recipient needs the information in order to correct the results of past discrimination and to overcome past conditions which resulted in limited participation by the handicapped (secs. 84.42 (b) (4), 84.42 (c)).

It is important to note that these prohibitions apply to discrimination directed against "qualified handicapped" persons. A handicapped person is qualified if he or she meets the academic and technical standards requisite to admission or participation in the recipient's educational program or activity" (sec. 84.3(k) (3)). While the regulations do not prohibit an institution from denying admission to a person with a disability who does not meet the institution's "academic and technical" admissions standards, they do prohibit an institution from denying admission on the basis of the disability as such (Kaplan, 1978).

Definitions and Scope

Section 504

Section 504 of the Rehabilitation Act of 1973 defines a person with a disability as someone who (1) has a physical or mental impairment that substantially limits one or more major life activities (functions such as performing manual tasks, walking, seeing, hearing,

speaking, breathing, or learning); (2) has a record of physical or mental impairment; or (3) is regarded as having a substantially limiting physical or mental impairment, even though the impairment is insubstantial or a reflection of the attitudes of others or nonexistent [104.3(j)]. The following list of disabilities is provided: "The term includes...such diseases and conditions as orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, and emotional illness... Environmental, cultural, and economic disadvantages are not in themselves covered; nor are prison records, age, or homosexuality" (32 C.F.R. Part 104, Appendix A (3)).

Section 504 is modeled after the language of Title VI of the Civil Rights Act of 1964 (42 U.S. C. 2000d) which prohibits discrimination on the basis of race, color, or national origin in any educational program or activity receiving federal financial assistance (Gehring, 1983). It is important to note that Section 504 applies only to discrimination against qualified individuals with disabilities, and that the statues and the regulations do not impose any obligation on colleges to admit or rehabilitate unqualified persons with disabilities. Moreover, institutions are not required to make major changes in an academic program in order to accommodate a student with a disability (Redden, 1985).

The Americans with Disabilities Act (ADA)

The ADA extends Section 504 of the Rehabilitation Act's anti-discrimination prohibition to all private and public colleges and universities regardless of receipt of federal funds. The ADA was signed into law on July 26, 1990 with the implementation date for private college and universities (covered under Title I) being July 26, 1992 and an

implementation date of January 26, 1992 for public colleges and universities (covered under Title II). Colleges and universities already covered by the Rehabilitation Act of 1973 were not dramatically affected by the implications of the ADA since most of the ADA terms, concepts, and definitions come directly from the implementing regulations of Section 504. However, unlike elementary and secondary education where evaluation, identification, provision of special services, and funding are the legal obligation of the parents and educational institution, the provision of services to students with disabilities in postsecondary education places the legal obligations on the student with the disability (rather than parents), postsecondary institutions, and sometimes the state vocational rehabilitation agency (Frank & Wade, 1993).

Not since the Rehabilitation Act of 1973 has any one piece of legislation brought about so much change in higher education for persons with disabilities as the ADA. While it significantly expanded the rights of persons with disabilities, it has also been greatly misunderstood by higher education administrators. The ADA is not an affirmative action statute. It is intended to assure equal opportunity, full participation, independent living, and economic self-sufficiency for people with disabilities. The ADA provides expanded coverage and stronger enforcement. The enforcement mechanism allows individuals the right to initiate litigation requesting courts to enjoin institutions to cease discriminatory practices. In addition, the U.S. Attorney General may bring suit for monetary damages, civil penalties up to $100,000, and attorney fees. Each title of the ADA addresses a specific area of discrimination with includes: Title I - Employment, Title II - Public Services in State and Local Governments, Title III - Public Accommodations and Services

Operated by Private Entities, and Title IV - Miscellaneous Provisions (Gehring, Osfield, & Wald, 1994).

Academic, Environmental, and Psychosocial Barriers and Characteristics

Academic Barriers and Characteristics

While all college students may encounter academic difficulty from time to time, students with disabilities typically experience these difficulties in greater magnitudes. Students that have what is known as *hidden disabilities*, such as hearing deficiencies, legal blindness, cardiac conditions, learning disabilities, attention deficit disorder, cancer, and psychiatric disorders may experience certain academic problems:

- difficulty carrying through with routine or uninteresting tasks
- difficulty with impulse control
- difficulty with sustaining attention
- difficulty with organization
- restlessness
- distractibility
- marked discrepancy between achievement and potential
- processing deficits
- long and short-term auditory and visual memory deficits

Many students diagnosed with a disability, regardless of the specific type of disability, frequently report academic difficulties which are related to poor study skills and the lack of adequate support systems such as tutoring. Frequently cited study skills problem areas include:

- organizing and budgeting time

- initiation and sustaining consistent effort on a task

- note-taking and outlining

- integration of information from various sources

- test-taking strategies

- memorization and self-rehearsal strategies

- use of the dictionary, thesaurus, and other self-help handbooks,

- use of the library and research skills

Academic difficulties generally lead to low grade point averages, suspensions and higher

dropout rates (Reilly & Roth, 1996).

Academic accommodations under Section 504 and the ADA for psychiatric disabilities

Postsecondary institutions are under a legal obligation to provide academic adjustments

and auxiliary aids for qualified individuals with a record of a disability. According to

Silva(1997), the influx of students with psychiatric disabilities has created one of the

greatest challenges facing postsecondary disability services offices. The problem is that

there is no "across the board" blueprint for determining the appropriate accommodation

for each student. Weiner (1997) states that students with psychiatric disabilities present a

challenge to service providers that is unmatched by any other population. It is not as

simple as providing an academic adjustment or eliminating an architectural barrier so that

the student has equal access to a program. Students with psychiatric disabilities are trying

to find a balance between an illness that directly affects their ability to receive an education

and the stress of school work that can exacerbate the symptoms of their illness. These

problems are compounded in that psychiatric disabilities are often unpredictable. The

student never knows when they will be up or down. Often times, students with psychiatric

disabilities seek disability services only when they are at their lowest. Then, it may be too late.

Accommodations for students with psychiatric disabilities may be as simple as providing extra time on tests and assignments, a separate classroom for taking tests, a reduced course load, tutoring, and regular feedback from faculty. However, it may be difficult for a professor to understand the reason for an accommodation since the disability is "invisible". Many individuals equate "invisible" disabilities with attitudes of "you look fine to me" (Silva, 1997). This can sometimes raise faculty concerns or questions when the accommodation is requesting "reasonable absences from class" generally associated with relapses or medication complications.

Providing accommodations should be an individualized process, states Duffy (1994), that begins with an intake interview. The student should actively engage in the request for services and be encouraged to express their needs and identify accommodations that will assist them in achieving their goals. A reasonable accommodation is a modification or adjustment to the environment that provides equal access to individuals with disabilities. The accommodation simply removes a barrier to participation. Disability service providers should know, understand, and fully comprehend the nature of the disability by forming partnerships with mental health professionals or other qualified individuals on one's campus (Silva, 1997). Students with psychiatric disabilities should be accommodated according to their individual limitations and needs. Unger (1992) recommends individually tailoring accommodations to fit each student and suggests the following accommodations as considerations:

- Orientation assistance

- Course selection assistance

- Alternative testing (extended time, distraction-free room)

- Notetakers, readers, tape recorders

- Seating modification

- Allowing beverages in class (due to medication side effects)

- Peer support

- Late withdrawals or incompletes

- Time management/organization development

- Disability-related counseling

- Special topic courses (e.g., college survival, career exploration, personal psychology)

While students with psychiatric disabilities may be willing to disclose the nature of their disability to the Disabilities Service Office on their campus in order to legally receive certain accommodations, the student is not required to disclose the nature of their disability to their professors. Some students choose not to disclose their disability to their professors for fear of being penalized or stigmatized. A psychiatric disability, according to Duffy (1994), is often devitalizing, leaving an individual feeling condemned and isolated from the mainstream of daily life. Trying to attain a sense of independence becomes a significant struggle. While independence can often be achieved through education, access to postsecondary opportunities continues to be a problem for those with psychiatric disabilities. Among the most difficult factors that contribute to limited access are negative attitudes.

Environmental Barriers and Characteristics

Careful inspection of the causal and developmental factors that have been used to explain and guide the treatment of panic disorder leaves one speculating as to the best theory or techniques to employ. This is particularly true when counseling individuals in the college setting. Many of these theories do not take into account the multiplicity of issues that surround effective delivery of services to students within the college environment. Historically, counselors have focused on intrapersonal and interpersonal client phenomena and confining their practice to *within* the office practice (Conyne, 1975). Conyne states that people, however, simply do not function in isolation. Counseling clients while ignoring their environmental setting denies an important part of their reality; environments contribute strongly to experience. Lewin (1936) symbolically defines this relationship of person and environment as $B=f(P \times E)$, where behavior is a function of the interaction between a person (P) and their environment (E). Banning and Kaiser (1974) expanded upon this relationship through the development of the Ecosystem Model. Their model views the environment rather than the person (student), as the client. Hurst (1987) lends credence to this model by noting that the initial focus in the student development movement to provide students with the knowledge, skills, and attitudes necessary to adapt to educational environments, displayed a fundamental weakness in the face of the recognition that sometimes the deficit is in the environment and not the student. The campus, rather than the student, becomes the client and the target for intervention. This is an ecosystems approach.

Conyne (1983) suggests the employment of an environmental design for college and university counseling centers rather than relying on the traditional person change model. While the person change model is compelling and useful, it represents only a

partial helping approach. The environmental design, termed the "campus environmental

design," provides a set of change strategies that can effectively complement or extend

more common person change efforts. It is a strategy for changing human environments.

Conyne (1983, pp. 434-435) defines eight broad categories of human environmental

conditions which could be targeted for change:

1. *Physical settings* - built and natural physical properties of a campus (e.g., lighting, space, distances, buildings, parking facilities, and green spaces).

2. *Academic settings* - opportunities afforded by the campus for the formal teaching-learning-research process (e.g., activities occurring in classrooms, laboratories, and in study areas).

3. *Social settings* - formal and informal opportunities provided by the campus for meeting others, giving and getting support, forming relationships, and for being alone and private (e.g., student activities programming, student organizations, counseling services, and residence hall events).

4. *Cultural settings* - formal and informal opportunities available on campus for gaining understanding of cross-cultural phenomena, aesthetic appreciation, and exposure to variety in artistic experiences (e.g., international houses, concerts, and poetry readings).

5. *Organizational settings* - existing campus organizational structures that have responsibility for maintaining and delivering services and functions to campus inhabitants (e.g., academic departments, student affairs offices, and the physical plant).

6. *Administrative conditions* - the stated policies, procedures, and practices of the college or university as well as its unarticulated norms and standards (e.g., admissions procedures, counseling center client assignment procedures, and general expectations of how a university student "should behave").

7. *Basic resources* - the campus provision of basic living requirements, such as adequate housing for the residential campus, food services, recreational opportunities, transportation and parking systems, heat in winter, and financial aid for needy students (e.g., residence hall rooms, union food services, confidential rooms for counseling, bus services, and playing fields).

8.   *Ecological climate* - a summative perception, similar to the general personality of an individual, that the institution has acquired over time, derived from its physical, academic, social, cultural, organizational, and administrative conditions (i.e., such phrases as "preppy school,: party school," "cow college," "tech school," a "warm intellectual atmosphere," or a "challenging liberal arts environment").

While an ecosystem or environmental design approach is typically not seen as an intervention model to be applied to students diagnosed with psychiatric disabilities, it is one that can provide insight into the campus experiences of these students. Students with Panic Disorder with Agoraphobia, who are resistant and fearful of situations that are not familiar to them, are forced to cope with a strange, new environment when they start their college experiences. This pervasive disorder can affect every aspect of their college lives from being in the classroom, to roommate situations, to where they study, to what they major in. An environmental design appears to be a logical way of looking at how students diagnosed with Panic Disorder with Agoraphobia are interacting with their environment and what behaviors they engage in order to function in their educational setting.

Psychosocial Barriers and Characteristics

        Weiner and Wiener (1996) acknowledge that while there are certain needs common to disability groups in general, each disability group may exhibit unique needs depending upon the nature and severity of the disability. Furthermore, within any given disability group there will be individual differences among students with regards to their needs and concerns.

        Weiner and Wiener (1996) surveyed students with psychiatric disabilities in order to identify personal and social/emotional areas of concern and found five prevailing themes or overriding issues that affected their functioning on a variety of academic and social tasks:

- *Problems with focusing attention and organization* - Instrumental tasks such as writing essays, doing class presentations, and preparing for exams were difficult.

- *Low self-esteem* - Difficulties occured in performing social tasks and losing friends as a result of their illness as well as having their confidence shaken after each crisis. While these students appeared to set high expectations for themselves, there was the fear of being evaluated and laughed at, and at the same time, not wanting people to be cognizant of their fears.

- *Problems with trust* - Social tasks such as developing close friendships, inviting a student to do something with them, or asking a peer for assistance presented difficulty because of their hesitancy in trusting others. Fear of embarrassment and shame around their illness inhibited their interpersonal skills.

- *Stigma* - Reluctance to disclose their disability to professors was related to both a fear of stigma and their desire to prove that they could do the work on their own. Advocating for themselves was of concern because of what they perceived as the stigma of their disability.

- *High levels of stress* - Personal concerns included the nature and chronicity of their illness, fear of relapse, side effects of medications, hassles with vocational rehabilitation and family benefits workers, social anxiety, lack of friends, therapy abuse, deadlines, and self-disclosure. Many were worried about finding a job and living independently, dating, getting married, and supporting a family.

Kleiner and Marshall (1987) studied the personal characteristics, stress factors, and type of conflicts related to the onset of phobia (fear) of individuals with Agoraphobia. Their results indicated that pre-agoraphobics tended to be dependent, socially anxious, and unassertive individuals. Prior to the development of the phobia, most of the subjects in their study experienced severe interpersonal conflict and a moderate degree of general stress arising from sources other than interpersonal difficulties. In the year preceding the first panic attack, the majority (84%) experienced severe and prolonged marital or relationship conflict. Other common stress factors were family conflicts (64%), divorce (26%), marriage (22%), social isolation (22%), death of a loved one (22%), and relocation of residence (18%). All of the subjects reported precipitants which involved more than one stressor with at least one being of an interpersonal nature.

The DSM-IV (American Psychiatric Association, 1994) defines psychosocial or

environmental problems as a negative life event, an environmental difficulty or deficiency,

a familial or other interpersonal stress, an inadequacy of social support of personal

resources, or other problems relating to the context in which a person's difficulties have

developed. These problems are grouped together under the following categories in the

DSM-IV(American Psychiatric Association, 1994, pp 29-30):

- Problems with primary support group - e.g., death of a family member; health
  problems in family; disruption of family by separation, divorce, or estrangement;
  removal from the home; remarriage of parent; sexual or physical abuse; parental
  overprotection; neglect of child; inadequate discipline; discord with siblings; birth of a
  sibling

- Problems related to the social environment - e.g., death or loss of friend; inadequate
  social support; living alone; difficulty with acculturation; discrimination; adjustment or
  life-cycle transition (such as retirement)

- Education problems - e.g., illiteracy; academic problems; discord with teachers or
  classmates; inadequate school environment

- Occupational problems - e.g., unemployment; threat of job loss; stressful work
  schedule; difficult work conditions; job dissatisfaction; job change; discord with boss
  or co-workers

- Housing problems - e.g., homelessness; inadequate housing; unsafe neighborhood;
  discord with neighbors or landlord

- Economic problems - e.g., extreme poverty; inadequate finances; insufficient welfare
  support

- Problems with access to health care services - e.g., inadequate health care services;
  transportation to health care facilities unavailable; inadequate health insurance

- Problems related to interaction with the legal system/crime - e.g., arrest; incarceration;
  litigation; victim of crime

- Other psychosocial and environmental problems - e.g., exposure to disasters, war, other hostilities; discord with nonfamily caregivers such as a counselor, social worker, or physician; unavailability of social service agencies

Additional Problem Areas Related to Psychosoical Issues:

Career Development Problems and Issues

There are many factors that can mediate the relationship between a student's disability and career development, including such influential factors as: age of onset of disability, individual perception of disability, self-concept, decision making skills, gender, and counselor knowledge and awareness. Unfortunately, most traditional career development theories were intended for the general population and have limited applicability to people with disabilities. Many of the assumptions underlying traditional career theories fail to fully integrate key disability issues such as limited work socialization, adjustment to disability, and change in self-concept. These theories provide limited guidance for counselors working with people with disabilities (Conyers, 1995).

Additionally, students with disabilities tend to have limited vocational exposure and may limit themselves when evaluating career choices. Often they may adopt society's stereotype that only certain vocations are appropriate, or they may be adjusting to a disability recently acquired (Bryan & Becker, 1980). Students with disabilities often have not had experience making decisions or developing information-gathering skills; and other barriers in accessibility, transportation, attitude, and communication, as well as physical barriers, only tend to further complicate matters (Blosser, 1980). According to Serebrini, Gordon, and Mann (1994), students with disabilities may also find moving into the

working world threatening for several reasons: limited work experience, loss of

supportive campus programs, physical access, attitudinal and communication barriers, and

problems securing personal assistance.

Students must possess several underlying skills in order to develop a career

goal and a plan to pursue it: investigatory behavior; the ability to identify, collect, and

analyze relative information; and the use of innovative and unique methods for dealing

with problems (Blosser, 1980). If students with disabilities are encouraged to function

independently during their college years, the transition from college to the world of work

may prove less intimidating (Serebrini, Gordon, & Mann, 1994).

Coping Strategies

Billings, Cronkite, & Moos (as cited in Borden et al., 1988) define the term

coping as cognitions and behaviors that serve to appraise the meaning of stressors, to

control or reduce stressful circumstances, and to moderate the affective arousal that often

accompanies stress.

In an attempt to examine the coping strategies of individuals who experience panic

attacks, Borden, Clum, Broyles, and Watkins (1988) discovered that a greater proportion

of panic subjects reported using coping strategies such as talking to a physician or

psychologist, mental distraction, taking medication, reading, getting fresh air, and

changing positions. The findings of this study suggest that individuals who experience

panic attacks engage in varied coping strategies before receiving treatment. These

strategies appear to include some forms of help seeking, distraction, and physical activity. The majority of the subjects in the study indicated that they engaged in the following coping strategies: telling one's self that the attack/anxiety would pass, talking to a friend or family member, reasoning out what is wrong, and mentally distracting one's self. While the coping repertoires appeared to be necessary, they were not sufficient for improvement.

CHAPTER 3

METHODOLOGY

The purpose of this chapter is to describe the methodology and procedures of the study. Topics that will be discussed in this chapter include the following: (a) justification for the type of research methodology; (b) the population and sample; (c) the instruments used in the study; (d) data collection procedures; and (e) the methods of analysis.

Research Method

The purpose of this study was to examine the nature and the scope of the college experiences of students who have been diagnosed with Panic Disorder with Agoraphobia. The subjects for this study consisted of a select group of upperclassmen (sophomores, juniors, seniors, and graduate students) at Virginia Tech.

For purposes of this study, the qualitative in-depth interview method was considered the most appropriate form of data collection. The research of Guba and Lincoln (1985) suggests that the ability to tap into the experience of others in their own natural language, while utilizing their value and belief frameworks, is virtually impossible without face-to-face and verbal interaction with them. The in-depth interview allowed the researcher to understand how a person thinks, feels, and acts while interacting within their environment - specifically, the college environment.

Patton, as cited in Brown (1994), considered the in-depth interview as an appropriate method of qualitative inquiry because the purpose of interviewing was to find out what was on someone's mind. Participants can be interviewed to find out from them things one could not directly observe. Patton further asserted that one cannot observe everything, such as how people have organized the world and the meanings they attach to what goes on in the world. Asking questions is one way the researcher can compensate for this. He stated that the purpose of interviewing is to allow the researcher to enter into the other person's perspective.

Population and Sample

Description of Participants

The participants chosen for this study met three criteria for selection. The first was the existence of Agoraphobia with Panic Attacks (diagnosed by a qualified professional), the second was the ability to provide a detailed description of their lived experiences of the disorder while they were enrolled in college and earlier recollections (elementary and high school) if deemed relevant to their college experiences, and the third criteria was that they must be either sophomore, junior, senior, or graduate level status and currently enrolled in college. Eight students were interviewed for this study. Of these eight students, two subjects (a freshman and a graduate student) were interviewed solely for the pilot study and their responses were not included as a part of the results.   A small sample size of six subjects was chosen based on the relevant sample size of Anxiety Disorders reported on Virginia Tech's campus. According to M. D. Tessnear (personal communication November 16, 1998), the Cook Counseling Center at Virginia Tech saw

approximately 1,800 students in an academic year. Of this number, approximately fifteen

(15%) percent of these students were diagnosed with an Anxiety Disorder. No

differentiation in the recordkeeping was made between the specific types of Anxiety

Disorders that were treated. Additionally, for the Fall 1998 semester, S. P. Angle

(personal communication, November 16, 1998) reported that the Dean of Students Office,

Services for Students with Disabilities, provided services for approximately forty-four

students with psychiatric disabilities. Of this number, approximately forty-eight percent

(48%) or 21 students had a diagnosis of an Anxiety Disorder.

Three of the subjects who participated in this study were referred by Dr. George

Clum, a professor at Virginia Tech and private clinical psychologist in Blacksburg,

Virginia. Dr. Clum runs the Anxiety Disorders Clinic in the local vicinity and is qualified

to diagnose individuals with Panic Disorder with Agoraphobia. He has published

extensively in the area of Anxiety Disorders and depression.   Dr. Clum (personal

communication, November 16, 1998) informed the researcher that his office does not keep

a record of the number of clients who specifically have Panic Disorder with Agoraphobia

that are seen for services.

The other three subjects who participated in the study were referred by Virginia

Tech's Cook Counseling Center. These subjects had all been diagnosed by the staff

psychiatrist and had received counseling and medication at some point as a part of their

treatment. The six students who were selected by Dr. Clum's clinic and the Cook

Counseling Center were not legally entitled to services and accommodations in the

classroom since none formally self-identified as a student with a disability through the

Dean of Students office.

Comorbidity in addition to the diagnosis of Panic Disorder with Agoraphobia was not a factor for selection in the study. The researcher and Dr. Clum mutually agreed to select subjects whose main diagnosis was Panic Disorder with Agoraphobia and not to rule out subjects with secondary characteristics (i.e. obsessive-compulsive behaviors, depression, etc.) as this might limit the number of subjects available to participate in the study.

Description of Setting

All selected subjects in this study were currently enrolled as students at Virginia Tech. Virginia Polytechnic Institute and State University, popularly known as Virginia Tech, is nestled in scenic southwestern Virginia. Located in Montgomery County, Blacksburg is now Virginia's largest incorporated "town," offering easy access to practically all of the amenities of life. The campus lies on a plain between the Blue Ridge and the Allegheny Mountains stretching 2,100 feet above sea level. The area is noted for its natural beauty, a healthy atmosphere, and outdoor recreational opportunities.

Virginia Tech is well positioned to become the model land-grant university of the 21st century. Founded in 1872, Virginia Tech offers about 70 bachelor's degree programs and 120 master's and doctoral degree programs through the Graduate School and the Virginia-Maryland Regional College of Veterinary Medicine (White, 1997). Enrollment figures for the Fall 1998 semester peaked at an all time high of approximately 25,600 graduate and undergraduate students. Undergraduates comprise approximately 80 percent of this total population (Muffo, 1998).

Institutional Climate For Students With Disabilities

The number of students with disabilities has increased markedly at Virginia Tech over the past ten years. Likewise, the number of these students who have requested services through the Dean of Students Office, Services for Students With Disabilities (SSD) has grown from 52 in 1987 to approximately 600 (not all of these students had a formal diagnosis of a disability) in 1998. This increase in students requesting services has not been accompanied with a proportionate increase in program funding level. Consequently, services for students with disabilities have focused primarily on the provision of academic and physical accommodations. Very little has been done to support the psychosocial or career development of students with disabilities.

A 1995 fall survey of students with disabilities at Virginia Tech conducted by the Dean of Students Office, and consistent with the literature, revealed that students with disabilities make frequent use of many academic support services and less than optimal use of personal and social services offered by colleges and universities (Satcher & Adamson, 1995). Respondents to the survey reported in the written comments section of the survey that they found the survey itself to be informative. More than half of the respondents reported that they were not aware of several services, especially those that address psychosocial development, and indicated that they would have utilized these services had they known that they were available (Pendergrass, 1997).

Data Collection Procedures

Rationale

The decision to conduct a qualitative study as opposed to a quantitative one was driven by the research and plausibility of the literature generated by McCracken (1988).

Based on a review of the literature that detailed the different qualitative methods readily available (Stewart & Shamdasani, 1990, Stake, 1995, Strauss & Corbin, 1990, and Silverman, 1993), the researcher believed that the "*long interview*" method, as described by McCracken (1988), was the most applicable in generating the necessary data which answered the research driven question, "How do students diagnosed with Panic Disorder with Agoraphobia negotiate college?"

McCracken (1988) argues that the *long interview* is one of the most powerful methods in the qualitative armory. For obtaining certain descriptive and analytic purposes, no instrument of inquiry is more revealing. This particular method can take one into the mental world of the individual to glimpse the categories and logic by which he or she sees the world. It is also capable of taking one into the lifeworld of the individual to see the content and pattern of daily experience. Without a qualitative understanding of how culture mediates human action, one can know only what the numbers reveal from quantitative research. The *long qualitative interview* is useful because it helps one to situate these numbers in their fuller social and cultural context.

Participant subject interviews occurred in three phases. Each interview lasted approximately one and a half hours to three hours in length. Audiotapes were made of each session and transcribed, which allowed data analysis to occur throughout the entire interview process. The process and protocols utilized in each phase are described in the *Data Collection Procedures* section of this chapter.

Construction of the Protocol, Open-ended questions, and Survey

The Protocol and Open-ended questions

McCracken (1988) suggests that the solution for sustaining subject testimony in an unobtrusive way to open, nondirective questions, is through the use of *floating prompts*. These may consist of simple body language techniques (i.e., raising one's eyebrow at the end of the respondent's utterance to prompt the subject to return to a verbal utterance and expand upon it) or by simply repeating the terms of the respondent's last remark with an interrogative tone. For purposes of this study, the following prompts were used to guide the interviewing process of subjects (See APPENDIX C):

(1) A planned prompting strategy is a "category" question in which the investigator will want to know how the respondent defines the event's *key actors, central action, dramatic structure, important props, necessary audience, ascribed roles, designated critics, social significance, cultural significance,* and the *consequences of good and bad performances.* These event areas were used to code and organize the testimonies given by each respondent in the study and were viewed as the main emerging categories.   The researcher further defined the realms of each category (See APPENDIX G).   Subjects were asked the following open ended question(s) in anticipation of soliciting the above mentioned categories: "Tell me about your first Panic Attack (before and at college) and how it has affected you."

 (2) The most important planned prompt is the "contrast" prompt (e.g., what is the difference between categories "x" and "y"?). The contrast questions should be restricted first to terms that the respondent has introduced. They should be placed in the interview at the very end of each question category so that they are not asked until, and unless, the material they are designed to elicit has failed to surface spontaneously. Subjects in this

study were asked at the end of their interview, "How does your Panic Disorder differ now from your earlier experiences?"

(3) Another planned prompting strategy is to ask respondents to recall exceptional incidents in which the research topic was implicated. The investigator must help the respondent report the results of this new distance by asking such questions as "What was most striking about the incident? Why, precisely, was it surprising? What, exactly, did it contradict?"   McCracken (1988) states that when the surface of social life is broken open by a "strange event", cultural categories and relationships prove suddenly visible. This floating prompt was utilized by the examiner by asking the following question: "Tell me about a specific incident involving your Panic Disorder that really stands out in your mind while you have been a college student and why was this incident so striking?"

(4) A final prompting strategy used in this study was "auto-driving." This technique is highly obtrusive but often extremely useful. The respondent is asked to comment on a picture, video, or some other stimulus, and to provide his or her own account of what they see there. In most cases, it is the investigator who prepares the stimulus material. Subjects, however, can use a variation of this and prepare his or her own stimulus (a video of their living environment, or a diary of their experiences as an example). For this particular floating prompt, subjects were asked to read Bourne's (1990) four subpersonality types (See APPENDIX F), pick one or two subtypes they felt best described their own personality and then answered the following question: " How does the subpersonality type(s) you have chosen affect you in your environment, psychosocially, and academically?" The subjects were given a handout that listed a set of

variables that described what is meant by the terms *environmental, psychosocial, and academic* (See APPENDIX D).

Bourne's (1990) work in the field of anxiety disorders concludes that human beings are not only diverse but complex, with multifaceted personalities. These facets are referred to as subpersonalities which play their own distinct role and possess their own voice in the complex workings of consciousness, memory, and dreams. The most common subpersonality types that tend to be prominent in people who are prone to anxiety are : the Worrier, the Critic, the Victim, and the Perfectionist. Bourne (1990) has based his four subpersonality types on Wilson's (1996) descriptions of the "Worried", "Critical", and "Hopeless" Observers in his book *Don't Panic*: *Taking Control of Anxiety Attacks.* Since Bourne (1990, p.153) states that these four subpersonality types are the "most common subpersonality types that tend to be prominent in people who are prone to anxiety", both E. J. Bourne (personal communication, October 16, 1998) and R. R. Wilson (personal communication, October 16, 1998) were contacted for validation purposes. Wilson (personal communication, October 16, 1998) states that the "Worrier" is typical of 100% of all individuals who have been diagnosed with Panic Disorder just by the nature of the definition of Panic Disorder. Approximately 41-91% of the people who have been diagnosed with Panic Disorder are also clinically depressed. People who are clinically depressed feel hopeless, hence his descriptor of the "Hopeless" observer. The "Critical" observer is based on the self reports from clients diagnosed with Panic Disorder that engage in critical, negative self-talk which results in low self-esteem and low motivation. Individuals with Panic Disorder also have *anticipatory anxiety* which in turn generates negative and/or critical self-talk. Bourne (personal communication, October 16,

1998) states that while he has not done any empirical research to validate his four

subpersonality types as the "most common subpersonalities", he simply uses the four

coined types in an heuristic manner for his clients to be able to categorize their self-talk.

The Survey

Conyne's (1983) eight (8) *Human Environmental Conditions* (See Chapter 2, page

47) were used to develop a survey which included a combination of open-ended questions

and simple check lists that provided insight into how the student with Panic Disorder with

Agoraphobia described what their environmental needs and barriers were. The survey

was taken from a modified version developed by the researcher and the SSD staff that is

presently being used to screen students who are referred to the Dean of Students office

due to academic difficulties. The screening questionnaire addressed the following areas:

background information (i.e. name, address, S.A.T. scores, educational level of parents,

etc.), study skills, socialization, health issues, psychological issues, learning difficulties (i.e.

reading, writing, language, math), and attention deficit difficulties.

Methods of Analysis

Phase I Data Collection

The initial phase of data collection consisted of a pilot study in which the

researcher presented the survey (See APPENDIX A) to SSD staff members, two students

who had been diagnosed with Panic Disorder with Agoraphobia, and the researcher's advisor in order to receive feedback and clarification about the content and purpose of the item. The survey was then restructured to reflect any changes that were unclear or not relevant (see APPENDIX B). The pilot group was also shown a list of definitions for the terms, *academic, psychosocial*, and *environmental* which included a list of descriptive variables the researcher used to characterize each term. The pilot group was asked to provide feedback to the researcher in reference to the variables used to define the three terms. Changes were made accordingly.

The two pilot subjects were asked to participate in the in-depth interview process by responding to the survey, protocol, and open ended questions. The pilot study served as a guide to further formalize questions and make adjustments in the interviewing process where problems arose. The researcher determined that the pilot studies were not producing enough information to address McCracken's (1988) floating prompts, namely *ascribed roles* and *cultural significance*. The researcher, therefore, added an additional questionnaire, *The Family Background Questionnaire* (Bourne, 1990, See APPENDIX H) that helped to glean enough information to address these two particular categories.

Also, during this phase, the six (6) subjects chosen for the study were asked to sign a contract of participation (See APPENDIX E). At this time, the subjects were asked if there were any questions regarding the nature of the study and confidentiality concerns were addressed. The subjects were informed that they would receive a $20.00 stipend at the completion of their interviewing sessions with the researcher. A summary of the study will be provided for each subject upon request.

Phase II Data Collection

During Phase II, participants in the study were asked to respond orally to the survey as the researcher asked each question in the same standardized fashion. Part I of the survey was administered by the researcher. Part II of the survey consisted of a list of categories (under the headings of *learning disabilities*, *attention deficit*, and *psychiatric*) and the subject was asked to place a check mark by any items they feel described them or was a problem area for them. This section of the survey was audiotaped and the researcher also took field notes.

Phase III Data Collection

During the final phase of data collection, the subjects were asked to respond to the protocol questions listed in APPENDIX C. After this exercise, the subjects were asked to read Bourne's (1990) descriptors of the four subpersonality types (See APPENDIX F). Subjects were then asked if they felt that at least one, and no more than two of the descriptions were an accurate description of themselves. Subjects were then given a sheet of paper that listed the variables that helped define the following categories: *academic, psychosocial*, and *environmental* (See APPENDIX D). If the subject closely identified with at least one or more of the descriptions, they were asked to pick the one that most closely fit their personality and then answered the following questions:

(1) Based on the description that you picked, how does this impact you in the educational setting?

(2) Based on the description that you picked, how does this impact you psychosocially?

(3) Based on the description that you picked, how does this impact you environmentally?

Analysis of Data

To analyze the data from this qualitative study, the researcher used specific systematic procedures which included the coding of all raw data collected through in-depth interviewing, field notes, and a formal survey. The recording and coding of data began on the first day of contact with the subject. After each interview with the subject, the researcher reviewed the notes and audiotapes to identify the emerging themes and categories. The researcher determined the categories, relationships, and assumptions that informed the subject's view of the world in general and the topic in particular.

A professional typist transcribed the audiotapes verbatim and the researcher physically coded the categories and emerging themes that were implicated through McCracken's (1988) *floating prompts:* the event's key actors, central action, dramatic structure, important props, necessary audience, ascribed roles, designated critics, social significance, cultural significance, and the consequences of good and bad performances. The researcher listened to these tapes at successive time intervals to reassess the prevalent themes and categories.   Comparisons and contrasts of between data of subjects were reviewed and noted as well as the agreement or contradiction of interview data with the formal survey and the review of the literature data.

Chapter IV

Findings of the Study

The purpose of this chapter is to present the relevant information obtained through the personal in-depth interviews. The individual case study analyses in this chapter are structured as follows: the first section contains a profile summary of each student which includes biographical data, the subject's history of Panic Disorder with Agoraphobia, comorbid disorders, and a personality type chosen from Bourne's (1990) four profiles (See APPENDIX F). The second section contains a narrative summary, guided by McCracken's (1988) "Floating Prompts," (*the event's key actors, central action, dramatic structure, important props, necessary audience, ascribed roles, designated critics, social significance, cultural significance, and the consequences of good and bad performances*) of the major categories that emerged from the transcribed interviews, field notes, and checklists. These categories were coded and based on the descriptors the researcher used to define McCracken's (1988) prompts. The *floating prompts* were used as a device for the researcher to organize and structure the content of the in-depth interviews of each subject. The researcher added one additional floating prompt, *Employment Issues*, due to the wealth of information that each subject volunteered on this topic. The narrative summaries are supported by the subjects' thoughts, feelings, and spoken words. Direct quotations were used to illustrate each specific floating prompt. The third section is a list of the academic, environmental, and psychosocial barriers that each subject identified through checklists and/or from their personal interviews. Additionally, the coping mechanisms, avoidance behaviors, and services and accommodations each student

commented upon were listed to demonstrate the scope and range that Panic Disorder with

Agoraphobia has had on each subject, as well as a way of looking at the similarities and

differences between each subject.

The students in this study remained anonymous because of the extremely personal

nature of the reported data. In order to further protect the anonymity of the subjects,

specific data such as former colleges attended and majors were not reported in the profile

narratives since all subjects were currently students at Virginia Tech at the time of the

interviews. Several of the subjects specifically asked the researcher not to mention their

majors since they felt they might be identified based on their narratives of recent classroom

experiences. Narrative accounts using direct quotations offered by the students were used

at various times to illustrate points and to describe their personal experiences.

The participants in this study were assured of their anonymity and of the

confidentiality of their interviews. Only first name pseudonyms were used to identify the

participants in this study. Table 1 (see page 192) provides a brief summary of the

individual profiles.

PROFILE SUMMARY

<u>Biographical Information</u>

Name: Mary

Educational Status: Graduate Student

Race: Caucasian

Sex: Female

Age: 33

<u>History of Panic Disorder</u>

Mary experienced her first Panic Attack at the age of eleven. She stated that she had always been "an anxious child." Mary was able to recall the specific event:

I remember hitting my head on a wall, because I didn't know what was

going on. I was feeling this horrible terror. I got these feelings...I used to

call them 'not me feelings' because I didn't know how else to describe it.

Mary stated that she never thought about the above incident again until she was around seventeen years of age and had another Panic Attack. This attack lasted approximately 15-20 seconds but it was extremely frightening for Mary. She began to engage in obsessional thinking over the Panic Attack.

When Mary was in college as an undergraduate, she was in a bathroom stall in her dormitory when a fellow female student accidentally kicked in the stall door hitting Mary on the head. This blow to the head induced a Panic Attack and Mary stated this was the event that marked the beginning of her problems with certain phobias and Agoraphobia. "I didn't become real phobic until I got slammed on the head in college because then I

started feeling dizzy which I never felt before." Mary's thinking patterns were soon consumed with such words as, "What if I get dizzy when I do this or what if I get dizzy when I do that...then what if I get panicky?"

During her late twenties and early thirties, Mary's Agoraphobia escalated to the point of keeping her completely homebound for several years. She ordered a self-help program from an infomercial she saw televised but found that the exercises the package instructed her to perform only exacerbated her anxiety. She has tried a variety of antidepressants/antianxiety medications and benzodiazepems but many of them have had the side effect of making her feel "dizzy". The only medications that she has found that help her to relax and relieve the dizziness are Prozac and Ativan. Mary has seen several doctors for the dizziness and for the anxiety. She is currently in counseling with a local therapist and feels she is making significant progress. At present, Mary is having only one Panic Attack every one to two years, which typically occurs during the middle of the night. She worries daily, however, about when the next Panic Attack will occur.

Mary has chosen not to disclose her disability to the Dean of Students, Services for Students with Disabilities office upon the advice of her therapist. While several of her instructors had suggested that she ask for accommodations (i.e. extended time on assignments, may be late to class, etc.) through the Dean of Students Office, Mary commented that her therapist felt otherwise:

> "I wouldn't do that because you don't want to ...you know, you're getting
> better. And...it may not look.... He told me an example of somebody who
> wanted to have special provisions and it kinda didn't...jive...It just didn't go
> over very well. Just didn't go over too well with the department. The

professors and this woman (who was having Panic Attacks) were saying...she had needed special accommodations. And she just...he urged her to just go ahead and do it... "You can do it." And she did it just normally without the accommodations and she did fine. And he was just saying you don't really need any special accommodations and...you may not want to do that just because some of the faculty might not...not be very receptive to that.

Comorbid Disorders

Mary stated that she is plagued by periodic bouts of clinical depression. "Anxiety has kept me isolated from the world a long time...about ten years. I'm just now recovering. I feel isolated and I'm lonely." Mary felt that much of her depression is a result of low self-esteem and lack of self-confidence. Her current relationship with her live-in boyfriend is very stressful for her as she is trying to move out and find another place to live but her lack of friends is making it extremely difficult for her to find a roommate. She commented that her depression is not quite as severe now as it was in the past when she was extremely Agoraphobic to the point of not being able to leave the house. At that point in time, Mary recounted that she was... "crying all the time and throwing up from crying so much."

There is no history of Panic Disorder in Mary's immediate family but she volunteered that her oldest sister has depression and feels that her mother suffers from depression as well.

Personality Profile

Mary describes herself as a combination of several personality types but primarily as the Critic (See APPENDIX F):

> It's hard...You know the *Worrier* was me really big time. But since I've
>
> been recovering, I would say the *Critic* and the *Perfectionist*. I know it
>
> says they are cousins...close cousins, but...I don't know which one is more.
>
> They are kind of the same. I'll have to pick the *Critic*.

1. **Key actors**:

Key persons mentioned in relation to the subject's experience with Panic Disorder with Agoraphobia

Mary was able to vividly recount several incidents which identified the key actors surrounding her history of Panic Disorder. The key persons that were mentioned as being currently involved in her life in relationship to her Panic Attacks include her ex-boyfriend, her therapist, and an intimidating instructor. Mary feels she is being negatively impacted by her live-in ex-boyfriend and one of her instructors. Her therapist, however, was viewed as having a positive effect on her and equipping her with the tools she needs to cope with her Panic Disorder with Agoraphobia.

During her earlier experiences with Panic Disorder, Mary talked about total strangers and her parents serving as the key actors. Before attending graduate school, and during some of her worst battles with Agoraphobia, Mary made several references about going to complete strangers' homes for help when she was experiencing Panic Attacks. As a child and young teenager, Mary appeared to confide more in her mother about the anxiety she was experiencing. While her father was aware of her condition, he remained aloof and uninvolved in any of her treatment. Neither of her parents appeared overly concerned or worried about her problems with anxiety. This made Mary angry, especially since her father was a mental health professional and he was aware that she was experiencing anxiety and Panic Attacks.

2. **Central action**:

Symptomatology of anxiety and panic

Mary was able to verbally reconstruct a memory of one of her most recent Panic
Attacks while she was attending graduate school at Virginia Tech:

There was one particular professor that I had that was very intimidating
and I told all of my professors, "If I'm late it is because I am having a lot
of anticipatory anxiety" and they were all fine with it except one. It took
me an hour and a half to get to her class one time and it's (the class) only
10 minutes away. From the time I left to when I actually got to her class, it
was an hour and a half later. I left 30 minutes early so I was an hour late to
class because I had so much anxiety. I kept stopping. Like I would stop at
the library and try to get myself relaxed and then I would think 'OK, are
you ready, go...OK, let's go!' And usually that works, but that particular
day, nothing was working and I stopped at the library, I stopped at the
(therapist's) office, I stopped at the police station. I've never stopped at
the police station! I talked to this woman and I told her how I was feeling.
I just felt like I couldn't get control of my feelings.

The typical physical sensations, thoughts, feelings, and actions that Mary
experiences during a Panic Attack include:

Before I had any coping skills at all, I used to just get...I used to get this
hot rush, this hot heat all over my body. A hot flash. My palms would get
sweaty and right then, 'On no! Here it comes!' And then I'd just start
"*What If*ing" right then. With like, "*What if* it gets worse? Oh no, this is
happening again. *What if* I go crazy?" I'd call out for somebody to come
in and sit with me or talk to me or something.

3. **Dramatic structure**:

Perceived level of anxiety and/or fear during an episode

During Mary's undergraduate years, she would react to her Panic Disorder with Agoraphobia by fleeing the scene. "I mean, I can think of times when I was so anxious I would get up and leave classes". The Agoraphobia became so debilitating that she began to withdraw from people, places, and things. "The most significant thing I can think of is when I was like at rock bottom, and I wasn't in school then." She further explained that, "Anxiety has kept me isolated from the world a long time - about ten years. I'm just now recovering. I feel isolated and I'm lonely."

The year Mary was accepted into her graduate program at Virginia Tech, she stated that she was unable to attend:

> I couldn't go because I could barely leave my neighborhood, let
> alone go to graduate school. So the only times I can really remember are
> the times when I was not in school because I was so dysfunctional I
> couldn't go to school.

> I would get, like on a scale of 0-10, I would get like up to an 8 1/2
> or 9 or even a little over a 9 or a 10 would be a full blown (Panic Attack).
> I would just run (flee the scene) at that point and then it would go away.

Staying over with friends one night, Mary had a panic attack and was unable to wake anyone up at 3 o'clock in the morning. The intensity of the Panic Attack was overwhelming for her:

> Nobody could help me because everybody was dead asleep. And here I
> was having...and right in the midst of this panic, and ...I wanted to go into

the kitchen and just get a knife and just stab myself with it. Not because I

wanted to die, I just wanted to get my mind onto something else.

Something that was so significant that I'd have to stop being scared. But I

didn't want to die.

4. **Important props**:

Things, people, or places viewed as comfort zones or areas to avoid

Mary stated that having someone around to talk to while she is having high anxiety

is a way for her to divert her thinking about the attack. Mary admitted to a fear of

"being alone." Additionally, Mary stated that she always tries to carry peanut butter

crackers around with her or something to snack on since the panic symptoms mimic

hypoglycemia. When questioned if she had ever been checked for hypoglycemia, Mary

revealed to the researcher that all the medical testing she has had done for hypoglycemia

was negative.

5. **Necessary audience**:

Individuals who the subject confides in or vents to or avoids

When Mary was younger, she confided in her parents about the problems with

anxiety but they made light of her Panic Attacks. She found this very upsetting, especially

since one of her parents is a mental health professional. "I used to tell them all the time

how I would feel. 'Am I normal? Is this OK? Am I going crazy?'"

As an undergraduate student, Mary would even confide in complete strangers:

Whatever I was doing, I would get out of the situation. If I was

driving, I would pull over and go to a total stranger's house and knock on

the door and tell them I was feeling light-headed, and I was feeling sick and

I needed some help.

6. **Ascribed roles**:

<u>Perceived role of the subject</u>

Mary describes her role in her family as the "baby, cute and silly one", the

"youngest", and that she was "not taken seriously" by her family members.

7. **Designated critics**:

<u>Things, places, or individuals that the subject views as having a negative influence on them</u>

Instructors - Mary emphatically declared that intimidating instructors or people in

authority positions have a negative impact on her. "I just feel like...I guess I have a little

bit of a problem with...difficulty with authority. Even in asserting myself." She went on

to give three specific examples of how she is negatively impacted by persons in authority

and by intimidating instructors:

I told you about the professor that was intimidating to me and I

know that she is to a lot of other students too. That was a source of my

anxiety, and it's harder for me to get to her class on time.

I mean, I ran into it a lot as an undergrad. But I never told anybody

back then that I had an anxiety problem. I always told them I had a vertigo

problem and that it would keep me from being able to go to class. And

they just didn't want to hear about it. You're either here (in class) or

you're failing.

I took this independent study class where I was working with kids.

But part of the research was I had to drive an hour and a half to go to this

place to conduct the research. And with my Agoraphobia I thought, 'I'm

not doing that.' So I couldn't go. And I would tell him (professor) I was

too dizzy to go. And then he ended up giving me a "D" in the class. And I

thought...I mean, he did all this research on brain injuries and how they

affect people, and he's just like...I mean...and I saw his book in the library

the other day and I just remember...When I saw his name on that book, I

was just like, "There's that idiot!" I felt like he penalized me because I

have a disability, even though he didn't know it was anxiety. I feel like...I

just felt like people would be more understanding if you had an inner ear...a

physical problem than an emotional one. So I just didn't tell anybody then.

Physical setting - Mary was able to cite a specific situation of how a physical

setting had a negative influence on her:

As an undergrad I used my inner ear problem to get a temporary handicap

sticker so I could park in a handicap lot on campus. And...I just...I don't

know. I don't want ...I guess I don't want special treatment, but that's just

something that I personally need. Because when I'm sitting in class and I

think, well, you have to think of escape routes, right? So I don't know if

it's just me, but I've always wanted to be able to park near the building. I

mean, sometimes I've parked right in front of the grocery store where it

says NO PARKING. I stuck my flashers on because in my mind I can get

out first. You can get out fast and first. That's why I always want to park

near the building. You can't very well go in and say, "Excuse me Parking

Services, I have anxiety. Can I please park wherever I want to?" Maybe

not in a handicap place, but at least, you know, wherever I can go. You

know, they're gonna think, "Well, deal with it." You know? And they're

probably right. I should just deal with it and park way far away. But that

has always been something that I've always needed and I continue to break

that rule and take a chance on getting a ticket everyday.

Boyfriend - Mary feels that her relationship with her ex-boyfriend is a very

stressful situation, one where she is constantly agonizing over how she should proceed

with the relationship. Mary still lives in an apartment with her ex-boyfriend, even though

they have not been intimate for almost two years:

We've been together four years and I'm telling him he needs to

move on because I'm not sure if I love him because I'm dependent on him

and he's kind of been...or if I'm not cutting the strings there or if it's

because I really love him and want to be with him. And I think a lot of it's

dependency. So that's real stressful for me. Because by him leaving, I'm

sort of facing one of my fears of being alone. And that's a big, big fear of

mine.

When asked about whether or not her ex-boyfriend has been understanding about

her anxiety disorder, Mary stated, "He didn't used to be. He used to be like, 'Just...just

don't be that way! Just stop!' But he's gone to counseling with me a couple of times and

he understands it a lot better."

Parents - Mary expressed some animosity toward her father and viewed his lack of

involvement or lackadaisical attitude to be another negative impact on her ability to cope

with her anxiety:

Whenever I had them (Panic Attacks) real bad, they were always bad. You

know? Uh...when I was agoraphobic I was in college so I wasn't living at

home. But I would talk to them (parents). I would just tell them what I

felt like and he (father) would just say, "That's a Panic Attack"...that's all.

Just real, kind of clinical, you know?

When Mary would have problems with anxiety and panic, her parents would

respond with:

"No, It's just anxiety." It's just all they would ever say to me. "It's

just anxiety..." all the time. And I used to think maybe it's not just

anxiety. This is something terrible. That kind of makes me angry now

because...I mean, here (my parent) is a (mental health professional) and

their own daughter is suffering from anxiety. I guess, because I wasn't

really dysfunctional, I was going to school, I never missed, you know...I

was on the honor roll, I had friends..I was real outgoing and everything and

I was fairly popular and I was...you know, and I went out all the time. But

I was miserable with anxiety.

8. **Social significance**:

Impact on the subject's social life

Mary states that as an undergraduate her social life was very constricted. While

she did join one local civic group and a sorority, she was able to attend functions only on a

sporadic basis:

If I did something, I only did it once and then I would be too

anxious to do it again. And I would be scared I was going to have a Panic

Attack. Or if it was further than a mile away from the house, I wouldn't go

when I was in college.

I joined a sorority. I joined...I worked at the student information

desk where I was interacting with lots and lots of kids all the time. Cause

they always...it was always in the main area there at the student union. Uh,

I was real active. But at the same time I was really lonely. Cause I kept

thinking, "People don't like me." Or, "People can tell I'm anxious," or

something like that. I was so different all the time.

Mary states that as an undergraduate she rarely went out with her friends to

socialize due to the high levels of anxiety she was experiencing and a phobia she had about

riding in elevators:

I didn't...I know why I didn't go out with them a lot. Cause they used to

lock the door at one o'clock in the morning. And if they locked the door

to the stairs, you have to take the elevator up. So I would avoid going out

at night because I knew my friends would stay out past 1 a.m.

9. **Cultural significance**:

Family background, values, customs, beliefs, etc. that play a role in the disorder

On a *Family Background Questionnaire* filled out by Mary, she indicated the

following information: at least one of her parents seemed excessively prone to worry; her

parents cultivated an attitude of caution, suspicion, or distrust about the outside world; her

parents were overly critical or demanding of her which made her feel put down or

diminished, hurt or rejected, and ashamed or guilty. In her family, feelings and impulses

were denied if she expressed anger or fear. Mary felt insecure growing up due to

excessive criticism by her parents as they made her feel ashamed, guilty, and neglected.

Mary dealt with her feelings of insecurity by becoming very dependent on her family.

Mary recalled the events leading to her decision to attend a particular undergraduate

college:

> I chose (Name of College) because it was supposed to be a really good
>
> school and I was a really good student in high school. I was in the honor
>
> society. I was a (State) scholar. I mean, my parents basically told me
>
> that's where I should go. So I did whatever they said. That's how I lived
>
> my life. My parents made my decisions for me. So I applied there, and
>
> when I got accepted you know, I'm not gonna turn them down. So I went
>
> there and I was really miserable. I was really anxious a lot.

10. **Consequences of good and bad performances**:

Rewards and punishments as a result of good and bad performances

Mary's view on deciding to come to graduate school is positive, even though she

has encountered some difficulties:

> I'm actually feeling less anxious cause I'm busy. I have a goal, a
>
> purpose. There were so many years there between college and graduate
>
> school where I just couldn't find a job. And even if I did, I would start, I
>
> would be there and then I started getting so anxious I couldn't go to work
>
> anymore, so I would quit because of my anxiety. So I never really kept a

job, I never really had any purpose, and that was anxiety-producing. So I think this graduate program, even though it's stressful, is really good for me.

Mary recalled a situation that resulted in negative consequences for everyone because she feared losing the affection of her boyfriend and facing rejection or humiliation from her friends if she disclosed to them that she was having a Panic Attack. During the middle of a Panic Attack, while Mary was staying at her boyfriend and his sister's apartment, she tried to first wake up her boyfriend, then his sister, and finally his sister's boyfriend:

And you know, I felt so stupid cause I'm waking up all these people at 3 o'clock in the morning, or whatever time it was, and my heart is pounding and I feel like I'm gonna go nuts. And...and then he's like, "What's wrong? What's wrong?" And I told him (boyfriend) what happened. Or I didn't tell him at first. I told him I was dizzy because I was embarrassed about it. I always hid it from people. That's what I told (my boyfriend). "I'm feeling real dizzy right now." But I wasn't. I was panicking. And later on I told him the truth. I said I was really having a Panic Attack. I just didn't want to tell you because I was scared you wouldn't like me anymore, or whatever.

Mary admitted that she showed a lack of awareness about personal safety issues while she was exhibiting high levels of anxiety and panic. If Mary began having signs of anxiety while she was driving, she would pull her car off the road and stop at a stranger's house and ask for help:

In fact, I know it was stupid, but in the midst of my anxiety, I

thought, "I don't care." You know? I didn't go to just any house that

would have, you know, that looked kind of like in a rough neighborhood or

anything. I would stop at a house that just looked like a normal house

with normal people and knock on their door and tell them how I was

feeling. They'd let me come in and give me a drink of water and...if I could

just sit there and talk to somebody, it would distract me enough where I

could just go, "OK, OK, now I can go finish what I was doing." But when

I was really bad off, it (Panic Attacks) would happen again five minutes

later and I'd have to stop somewhere else again.

In the classroom, Mary fears negative repercussions if she tries to participate in

classroom activities. The influence of negative self-talk is also quite evident:

I tend to like to ask questions and stuff and then I'll say, "Ugh!

You ask so many questions! Nobody else asks all these questions.

STOP!" Or I'll say something that's really funny and everybody will

laugh. And sometimes I'll say something I think is funny and nobody will

laugh. And then I'll go, "Ugh! You screwed up! You said something

stupid. Just sit here and be quiet and shut your mouth and listen to the

professor and learn and, you know, quit trying to be the whatever." And

that goes on a lot. And I'm always thinking, "Oh gosh, What does the

teacher think? What do my classmates think of me?" It's like an

obsessional thing that I do.

11. **Employment issues:**

<u>The effects on choice of major and employment issues</u>

When Mary was asked if she thought her Panic Disorder with Agoraphobia affected her choice of major she remarked:

> Oh well, I'll tell you this. I always wanted to be a vet. And I spend so much of my life being anxious and not concentrating on life that I didn't do the vet stuff. You know, I didn't get into biology and the sciences and...you're supposed to really start off...you're really supposed to start young if you want to go into that. I was too busy being anxious. If I had my life to live over, I'd probably either go to vet school or law school. And the reason I don't go to law school is because I'm so sensitive. I feel like I would never make it. I don't mean I wouldn't make it as in that I'm not a strong person, I'm not intelligent. I mean that I couldn't take all the competitiveness, the politics, the real assholes that are in there for the money. You know, it's just like...the people I think would just drive me nuts. Not literally, but you know what I'm saying.

When Mary was asked to recall any occupational problems she had encountered, she commented:

> I must have had a zillion jobs in college. Because I would get one and quit it. If I didn't like it, I'd quit. If...If I was anxious and couldn't get there...if I did like the job, I'd start talking to myself about, "Oh my gosh! What if I get a Panic Attack!" So I got to the point where I couldn't go to work. So I had so many. I think I had 13 jobs in undergrad. Like working as a waitress, or working in a pet store, or vet office. I didn't leave

because I didn't like the job a lot of times, it was just because I started to

get so anxious. I couldn't go anymore.

The researcher then asked Mary what her future goals for employment were:

Maybe I just know how to deal with kids. Cause I really like them

and I want to help them. And if I meet somebody who's like me when I

was a kid, I'd say, "You need to get some help. And let me tell you about

anxiety so you don't spend your life like I did."

Mary stated that she could not think of any jobs that she would not want to hold

because of her Panic Disorder with Agoraphobia but she felt that she would not be able to

accept a job that requires traveling.

Barriers in the Academic Setting

- interrupts or intrudes on others
- impatient, low frustration tolerance
- trouble sustaining friendships or intimate relationships ("trouble meeting people my type")
- difficulty with authority (professors who are not understanding of her Panic Disorder)
- poor organization, often has piles of stuff
- chronically late, always in a hurry
- chronic procrastination
- chronic sense of underachievement
- mood swings
- chronic problems with self-esteem
- self absorption (preoccupation with health and well being)
- impulsiveness
- high level of frustration and low tolerance - impatient
- distractibility (especially in testing situations)
- marked discrepancy between achievement and potential

Barriers in the Environmental Setting

Physical settings:
- lack of parking space near classroom buildings (in case she needs to leave quickly due to her anxiety)
- lighting - too bright- overly sensitive to lighting
- cannot ride elevators due to phobias
- classrooms above the second floor are problematic due to phobias - cannot escape quickly if she needs to

Academic settings:
- afraid to say too much or participate in class for fear that other students or teacher will think poorly of her- others might think she is "stupid"

Social settings:
- joined a sorority but she always felt, "People don't like me or people can tell I'm anxious. I was so different (from other people) all the time."
- lack of participation in activities and organizations - feels she does not know people well enough to participate

Cultural settings:
- no problems reported here

Organizational settings:

- chose not to seek out accommodations from the Dean of Students office because her therapist told her it might be detrimental to her academic career

Administrative conditions:
- policies and procedures in the classroom - felt absences or being late to class should not be a problem or issue with professors since they knew she had Panic Disorder
- difficulty meeting some of the requirements of the class (particularly at the undergraduate level) if they involved a lot of travel

Basic resources:
- cannot acquire a parking pass near all of the buildings on campus that she has to frequent

Ecological climate:
- Mary chose her first undergraduate college because it was a prestigous university and her parents wanted her to go there. She decided to transfer to a smaller college because she was having great difficulty with her Panic Disorder. Mary chose Virginia Tech because she heard that it was a good school, it offered the major she was interested in, and she did not have to take the Graduate Record Examinations to get in.

Barriers in the Psychosocial Setting

Problems with primary support group:
- problems with ex-boyfriend - she feels the reason she still lives with him is because of dependency issues
- lack of friends

Problems related to the social environment:
- fear of living alone
- socialization with acquantainces

Occupational problems:
- difficulty obtaining and maintaining a job due to Panic Disorder with Agoraphobia
- difficulty with traveling in a car

Coping Mechanisms

- made up excuses for her absences from class - said her absences were due to vertigo (not anxiety)
- feels professors have been penalizing her due to her disability even though she has not disclosed her disability to the professor. Instead, she talked about the head injury and dizziness
- lied about disability to get a parking decal so she could park near her classrooms
- avoidance of elevators

- isolated self - would not go out socially to avoid feelings of anxiety
- transferred to a smaller college due to size of first college
- blaming her lack of friends and first choice of major on the Panic Disorder
- feels she is an outgoing person yet she had stayed home and isolated for years
- stays with boyfriend - she is dependent on him (afraid to be alone)
- when she becomes panicky, she just "runs out" - flees the scene.

Avoidance Behaviors

- elevators
- classes
- concerts
- social gatherings
- leaving the house (at the peak of her agoraphobia)

Services and Accommodations Used

- off campus counseling - Panic Disorder clinic
- tutoring
- need for a separate room for test taking
- health services - medical

PROFILE SUMMARY

Biographical Information

Name: Sam

Race: Caucasian

Sex: Male

Educational Status: Undergraduate

Age: 21

History of Panic Disorder

Sam began having what he termed "small" or "mini" panic attacks which started in the Spring 1998 semester. Sam had constant gastrointestinal problems with his stomach and a fear that he would vomit while sitting in class or riding with someone in the car. These episodes were always accompanied by extreme levels of nervousness.

Sam admitted to missing classes on a regular basis during the Fall 1998 semester due to anxiety and stomach distress. Most of the classes he missed were early morning classes. Sam indicated that he felt there was more of a chance he would not feel physically well in the mornings. He also stated that he was more "afraid" in the mornings. His first full-blown Panic Attack did not occur until the Fall of 1998. Following the full-blown attack, Sam resigned from school. He stated, "I just couldn't go back to class after that." Sam has decided to finish his education by enrolling in internet classes. He is taking only nine credits this semester because he feels that he needs to "take it easy" since the big Panic Attack.   At this point in time, he does not intend to go back into the classroom.

Sam has been working with a psychiatrist from his hometown and also seeing a local therapist in the Blacksburg area. He is currently taking an antidepressant/antianxiety which he feels has been helpful. Sam has only had one full-blown Panic Attack but he worries constantly that he will have another one.

<u>Comorbid Disorders</u>

Sam indicated that the reason he first went to see a psychiatrist was because he was having "sexual problems." Since he had poor eye contact with the researcher and the topic area appeared to be somewhat awkward for him, the researcher did not press him for further clarification. Sam stated that he did not know that he was suffering from anxiety at the time until he mentioned to his doctor about the full-blown attack he had experienced in class. His doctor explained to him that he had experienced a Panic Attack. Sam divulged that the reason he had been seeing a psychiatrist was mainly to focus on the "sexual problems more than the Panic Attacks." At this point of the conversation, Sam decided to confide in the researcher about his history of Obsessive-Compulsive Disorder (OCD):

I guess I should explain a little bit better. I guess it wasn't totally sexual problems. It was being around people. I also had, well still have, the Obsessive-Compulsive Disorder. And it was just sexual in nature. Like, I was afraid to be around people because I was afraid I might hurt them like in a sexual way. Like I might touch them or something.

The researcher discovered that Sam had started experiencing problems with OCD while he was in high school. Sam did not seek treatment until the same semester that he had his first full-blown Panic Attack. He had only been in treatment for the OCD for a short time before he had the full-blown attack. Sam elaborated by stating:

> In college it started to change over. When I was in high school, I had problems with driving, and what I was afraid of was like, um, hitting another car or something. So I was like having ritual behaviors as far as like where I would drive and I didn't want to drive unless I had to. But then in college that eased back and then it started to go into this thing about being around people. And that went on for like two years. And then, finally, the beginning of this school year, last semester around October was when I finally went and saw somebody about it.

Sam never told his mother about the OCD until after he was officially diagnosed with the disorder.

Personality Profile

Sam most closely associates with the *Worrier* (APPENDIX F) personality profile:

> I would say probably the *Worrier* characterizes me the most. The only thing that I would add is that I'm like the *Victim* in that it says favorite expression is, "I can't" and "I'll never be able to." I'd say that type of expression like, "I'll never be able to...go back into the classroom" or whatever. But I'd say I mostly fit the *Worrier*.

1. **Key actors**:

Key persons mentioned in relation to the subject's experience with Panic Disorder with

Agoraphobia

Sam described himself as more of a loner in the classroom. He stated that he did

not really associate with any of the students in his classes because:

I don't really know how to explain it...like a fear...like the people in

the class might be - might look down on me as a student. If something did

happen, if something happened to me, I guess they wouldn't be nice to me.

They wouldn't want to help me.

Sam did confide in his mother some information about his OCD. Her response to

his problems was "normal" according to Sam. "I mean (she was) not really surprised.

Just I don't know. Cause I'd been kinda telling my Mom that I had some problems and

um...so when I did find out what they were, it wasn't like a total surprise. It was fine."

Sam's father passed away several years ago and his step-father died one year ago.

Sam stated that, "They were all gone before any of the problems started."

Sam continues to work with the psychiatrist from his hometown and a local

therapist. He chose to see a psychiatrist from his hometown because it made him feel

"more comfortable."

2. **Central action**:

Symptomatology of anxiety and panic

Sam started out with what he deemed "mini-attacks" while sitting in the classroom

and described his experiences as: "After the mini-attacks, where I'd feel like I was gonna

throw up, [I was] just less likely to go to class after that if I felt like I had any stomach problems."

Since Sam has only had one full-blown Panic Attack, he was able to recall in detail the events that occurred on that day:

> Well I guess back in October when I had that Panic Attack, I was in the classroom. It was a normal feeling that I've had before that I might throw up. Except this time I got nervous, super nervous, and my heart started to beat real fast and I started to sweat a lot. And it was just...I could tell it was just kicking me. You know my heart was beating fast and it would come and go and I was sitting there. And see it's a fear of like, like I might throw up but that also I can't leave the classroom. It's like I feel like I'm locked in there. It's like if I leave I'll be embarrassed or something, or won't be able to come back. So I feel like I'm locked in there, and it's like it comes and it goes. Like I'll kind of mentally calm myself down. Like you know, "This isn't a big deal" or whatever. And it would come back on. And that was for like a whole class period.

3. **Dramatic structure**:

Perceived level of anxiety and/or fear

Sam never returned to classes after his first Panic Attack. He received a medical resignation from school and he is currently taking classes via the internet. As Sam lamented, "I just couldn't go back to class after that."

4. **Important props**:

Things, people, or places viewed as comfort zones or areas to avoid

While taking classes at Virginia Tech, Sam always sat near the door so that if he became ill, he could leave quickly. "Instead of having to walk across the classroom, this would be the less embarrassing way to leave." Sam also stated that he had avoided riding in cars and eating in restaurants for fear of becoming sick at his stomach and vomiting. Since taking medication, he has noticed an improvement in his OCD behaviors and less anxiety about eating out:

Back when it was bad, like having to go somewhere in somebody's car...like somebody driving me somewhere - like I was afraid of that. Or having to take somebody somewhere. Just afraid because like if somebody drives me somewhere, like I go to eat with somebody or something, and I go in their car. I didn't know how to deal with situations. What if I get sick or whatever? And it's the same thing like if I'm driving. Like if I drive somebody somewhere. What if I get sick there? It's a fear of like what to do.

5. **Necessary audience**:

Individuals who the subject confides in, vents to, or avoids

Sam decided to go see a therapist from his home town because he felt "more comfortable" with someone from that area. He also confided in his mother about some of the difficulties he has encountered. Sam stated that his mother did not seem to be surprised about the problems that he was having because she knew that he had issues with driving and riding in other peoples' cars when he was in high school.

Sam avoids most social situations except for the nights he plays in a band with his friends. He has avoided social situations which involve dating, driving, riding in a car with others, or going out to eat.

Shortly after Sam started experiencing the "mini Panic Attacks" in the classroom, he disclosed this information to several of his professors:

> I did tell a couple of my professors that I had Panic Attacks. And specifically in relation to like having a test, I would request if I could take the test not in the classroom with other people and they usually allowed me to do that.

Sam was not aware that he could ask for formal accommodations such as taking his tests in a separate room by disclosing the nature of his disability to the Dean of Students office.

6. **Ascribed roles**:

Perceived role of the subject

Sam described his role in the family as "I was the kid. My brother was the smart one."

7. **Designated critics**:

Things, places, or individuals that the subject views as having a negative influence on them

Sam was unable to produce much information in the area of things, places, or individuals that negatively impacted him other than eating in restaurants and riding in a car, except for situations where professors singled him out in the classroom. "Um, certainly like individual, like if the teacher calls on me. Or if he...[makes me] go to the

board of something." Sam also mentioned that the lighting in the classroom was sometimes a factor that negatively impacted him:

> I would say that the lighting is...that back when I went to class, I
> would feel less anxiety if the lighting was dimmer and not so bright. I
> guess it just kinda ties back into the whole, like, sort of being seen. That
> somehow if the light's dimmer...I mean, I know it doesn't really make
> sense, but if it's dimmer it would be less likely for me to be seen by others.
> Or it wouldn't be as much of a distraction, I guess.

8. **Social significance**:

<u>Impact on the subject's social life</u>

Sam indicated that he did not associate with his classmates and he did not take the opportunity to get to know many students at Virginia Tech other than his roommates and the members in his band. Sam has never dated but is hopeful that he will someday:

> Well, that's something I'm trying to work on now. Um, haven't
> done any dating, but now as I'm sort of working through these problems, I
> think I'm more capable of it. I mean, like before when the OCD was bad,
> it was like being around people was bad. So you know, going on a date or
> something was kind of an impossibility then. But now, it's becoming more
> of a possibility.

While Sam is a member of a band which places him in very social situations, he still does not reciprocate:

> The thing is, though, usually people come up there just like, "Yeah,
> yeah", I mean, I like it cause they'll be like, "Yeah, that was good. Ya'll

are good." But it kinda leaves me - I don't know what to say. So it's

kinda like I just let it go. I'm like, "Yeah". I'm like, "Thanks" or

whatever. But I don't continue the conversation.

9. **Cultural significance**:

Family background, values, customs, beliefs, etc. that play a role in the subject's

Panic Disorder

On the *Family Background Questionnaire*, Sam indicated that he grew up feeling

insecure but he was unable to offer any suggestions as to why he feels this way when

prompted by the researcher. Sam did not offer any information about his deceased father

and step-father or how the deaths affected him.

10. **Consequences of good and bad performances**:

After taking an antidepressant for some time, Sam has found that he has less

anxiety and has continued to play in the band:

One is that I play in a band. And like we play out, like gigs and

stuff at the bars. And my fear has been like just that I'll be up on stage,

that I'll have to throw up. You know, I'll get nervous. And I haven't

gotten nervous on stage like that. So this was like the first time that we'd

played out in front of people was after that first big Panic Attack. And like

I was worried all day, like anticipatory anxiety, like I might have one. But

when the time came I didn't have one. This first coping technique that I

first used with the band was the first time that we played out and I was so

afraid that I was going to have a Panic Attack...the way I coped with that

was I told one of the band members that I wasn't feeling good. And I

actually took a trash can up on the stage in case I had to throw up. So I

dealt with that like that. And that went fine. And then after that with the

band, I've dealt with it like if I get sick, I just go to the bathroom. Just

kind of like, "Stuff happens."

11. **Employment Issues:**

The effects on choice of major and employment issues

When Sam was asked if he thought that his Panic Disorder has had an effect on his

choice of major or in getting a job, he responded with:

I would say the only thing that, not necessarily the Panic Attacks,

but just my shyness and talking to people...um, I sort of kind of thought

about possibly being a teacher, but that and then with the Panic Attacks on

top of it, pretty much limits me there. But other than that, I don't really

think about...I guess think about getting a job.

Sam admitted that even though he is very close to graduation, he had not gone to

the Career Services center nor had he written a resume. Sam stated that he had thought

about a couple of options for after graduation which include:

I would say, well I mean, ultimately I mean I'd like to play in a

band. I mean, you know, that's what I'd really like to do. I guess like a

normal job...like possibly like an editor or something like that - like for a

publishing company or something. I've thought about going to graduate

school but I don't know if I'll be able to now, just because of the Panic

Attacks.

Working in a field related to his major versus playing in a band was not viewed as a comfort zone for Sam; rather, he stated that, "Well, I guess it's not a matter of comfort, it's just a matter of fun. Playing in a band...I mean, you get to make music and play it for other people and make money, I mean, it's fun."

Barriers in the Academic Setting

- difficulty reading and comprehending word problems in math
- inability to recognize common social cues (difficulty reading other's body language or gestures)
- avoids group activities
- negative self-talk (fears, failure, panic)
- repetitive motion (i.e. tics, rocking, fidgeting)
- avoidance behavior
- difficulty with attending classes
- difficulty interacting with others
- feelings of fear or anxiety
- difficulty initiating interpersonal contact
- difficulty carrying through with routine or uninteresting tasks
- difficulty with sustaining attention

Barriers in the Environmental Setting

Physical settings:
- would feel less anxiety if the lighting in the classrooms was dimmer - being seen by others is anxiety producing and this would be a distraction for him

Academic setting:
- having to go to the blackboard if the teacher calls on him is anxiety producing
- talking in class if the teacher asks him a question is anxiety producing

Social settings:
- did not participate in any student activities
- never attended any residence hall events

Cultural settings:
- attended some concerts and a poetry reading but this was before his first full-blown Panic Attack. He stated that there was some feelings of anxiety about being in close proximity to people due to his OCD

Organizational settings:
- no problems reported here

Administrative conditions:
- no problems reported here

Basic resources:
- no problems reported here

Ecological climate:
- Sam chose Virginia Tech because of its name. "More people will know Virginia Tech than they will a small college."

Barriers in the Psychosocial Setting

Problems related to the social environment:
- unable to make social contact with people even though he plays in a band which is always in large social gatherings

Education problems:
- uncertain about whether or not he will ever be able to attend graduate school since he has not been back in the classroom after having his first full-blown Panic Attack
- cannot take classes in the regular classroom - he must take all of his classes via the internet in order to graduate due to his Panic Disorder with Agoraphobia

Occupational problems:
- feels that his shyness, problems talking with people, and his Panic Attacks may prevent him from obtaining certain types of jobs like teaching
- even though he is a senior in college, he has not done a resume, gone to Career Services, or thought about applying for any jobs other than wanting to play in a band he just recently started with

Coping Mechanisms

- avoiding and skipping classes, instead, he hopes to graduate by taking only internet classes
- sits near the door in all of his classes (when he was in regular classes)
- told professors he was having stomach problems and that he might have to get up during class and leave rather than telling them he had Panic Disorder
- took a trash can up on the stage with him while performing in a band just in case he got sick and had to vomit
- tells people he does not feel well if he has anticipatory anxiety so he will not have to participate in an activity
- avoids thinking about getting a job because of the Panic Attacks

Avoidance Behaviors

- group activities
- taking classes (after the first full-blown Panic Attack) unless they are offered via the internet
- being around people (due to the OCD)

- driving
- driving with other people
- thinking about employment opportunities related to his major

Services and Accommodations Used

- has meet with faculty members for some help with classwork
- campus counseling center
- campus health services
- independent psychiatrist
- clinic for Panic Disorders

PROFILE SUMMARY

Biographical Information

Name: Michael

International student

Sex: Male

Educational Status: Graduate Student

Age: 30

History of Panic Disorder

Michael's first Panic Attack occurred in March of 1996. He has only had four

Panic Attacks, all of which have occurred in the morning while he is sleeping (between

6:00 to 8:00 a.m.). Michael stated that he would wake up feeling extremely anxious and

immediately go into a Panic Attack. While he has only had four Panic Attacks, he worries

daily about when the next one will occur. Michael did not seek treatment for his Panic

Disorder until one year after he had his first Panic Attack. He is currently only taking 1/4

of the prescribed amount of medicine issued by his psychiatrist for anxiety and sleeping

difficulties. He is afraid of medication addiction and feeling "different" if he takes a higher

dosage. Michael stated when a person takes medication, "You always lose something."

Comorbid Disorders

Michael disclosed to the researcher that he has had Obsessive-Compulsive

Disorder since early childhood and sporadic bouts of depression. The depression was at

its peak when he moved to Virginia several years ago. Michael is an international student

who has only been in the United States for several years; his English is somewhat broken but understandable.

Personality Profile

Michael stated that the *Perfectionist* (APPENDIX F) profile best describes his personality:

Because you know, I was thinking because I am different (from other people). I have to always be perfect in every sense. I'm very idealistic. I should do for society, you know, things for society and so I have to be perfect. I cannot be like other people. Everything should be perfect with me. In my life, everything should be perfect.

Michael stated that it was his family that "drove me to be perfect." Michael has a 4.0 cumulative grade point average at Virginia Tech.

1. **Key actors**:

Key persons mentioned in relation to the subject's experience with Panic Disorder with

Agoraphobia

      Michael stated that he has made very few friends at Virginia Tech. The other

graduate students that he has coffee with on a daily basis are not really considered to be

"close friends" of his. Michael stated that he was able to maintain close friendships while

he was working on his masters degree at another institution. He attributed his lack of

close friends here at Virginia Tech to several factors: (1) "People very, seem to be very

strange"; (2) "I have some friends here but they are students like me. They need the

support too"; (3) he has never dated because, "I'm so perfectionist, I cannot find the

perfect woman"; (4) he avoids forming close friendships because he feels it will only add

more anxiety: "If you socialize, do extra things, then maybe you know...how can I say,

you slow down. You don't want to do too many things. You want a plain life...simple";

(5) "In my social life I try to forget all academic things. Of course I cannot do it anymore.

Here something always comes up because... graduate study is harder";   (6) "Maybe

because of me. I start giving less time for socializing. I started worrying about academic

things"; and (7) even the people that he has met from his native country seem different

and strange to him.

      Since Michael lives alone, he feels he has had to seek out the help of complete

strangers when he has a Panic Attack. He will usually frequent a public place, such as

Burger King restaurant, in order to be in the company of others in case something terrible

should happen to him when he has a Panic Attack.

2. **Central action**:

Symptomatology of anxiety and panic

Michael indicated that his first Panic Attack at Virginia Tech was probably the

most striking of all of the Panic Attacks he has had. The very first Panic Attack, however,

was very traumatic for him:

> My first Panic Attack... yes, at that time I didn't know what was
>
> that. I didn't know. I was thinking that nobody knows. It was a very
>
> phenomenal thing, and nobody knows what that thing is. And so, it
>
> affected me a lot. I stopped working. I didn't work(study) for two months
>
> or something.

The second Panic Attack followed almost one year later right before he had

qualifying exams at Virginia Tech and Michael called 911 for help. This was the one Panic

Attack that sticks out in his mind as being the most significant because other people were

observing him while he was having the attack:

> They took me to a hospital. Then, first they said that something
>
> was wrong with my heart. Something wrong physically. Because they
>
> take me [by] 911...it [the Panic Attack] was seen by the others also. So I
>
> guess, this was, I think always about that. First one [Panic Attack] I didn't
>
> know what was going on, and I was thinking I am getting crazy, or that I
>
> am dying. But this time I know what this is...many people have that...

also.... I am OK with that. And I say "What to do?" [translation - there is nothing I can do about the situation].

3. **Dramatic structure**:

Perceived level of anxiety and/or fear

Michael had pretty much resigned himself to the fact that he will always have Panic Attacks because he believes it is a part of his personality. He mentioned several times that "I like myself a lot" yet he experiences low self-esteem which is evident in statements such as: "I think I have to know my limits. I have limits. I cannot do. So far I couldn't do so I don't think I will do good things so I have to accept" and "I have no support here. I am alone." While he spoke of acceptance of his Panic Disorder, it was evident that he worries daily about when the next attack will occur. He also suffers from bouts of clinical depression and engages in obsessional thinking and ritualistic behaviors to ease his anxiety level. Michael's feelings of hopelessness and resignment to the anxiety he is feeling are evident in the following statements:

> I like myself a lot. But you know, before the qualifying exam here, at that time I was having very difficult troubles. For example, when I look in the mirrors, I was seeing somebody else. Very stressful at that time. But gradually I became better. Before that I was also thinking, really I was thinking, 'I like myself.' Now, even I accept Panic Disorder, I say "That's OK, but that's my personality, what to do?" That ...my personality brings that Panic Disorder, you know, so what to do? I accept it.

I think that this is personality, I guess, you know? I'm very,...I

think my personality is suitable to have Panic Attacks I guess. I have also

Obsessive-Compulsive, you know? For example, before going to sleep, my

room must - everything should be in order. Actually, everything is not in

order. During day, I postpone. I say, "OK, I can do that later", but when

you go to sleep, that's the last time. And for example, last night, I know

why I wash my hands, I don't know, before going to bed, three or four

times. When you touch something before going to bed, you have to go and

wash your hands. Even when I was a kid, I was doing that a lot. I had a

lot of cracks in my hands [from washing his hands so often] when I was a

kid. And, now I am fine, but in my stressful times...

4. **Important props**:

Things, people, or places viewed as comfort zones or areas to avoid

Michael was very emphatic about the lack of support from his academic

department, as well as a communication barrier between him and the support staff.

Because of this lack of support, he does not bother to ask for assistance or advice when he

needs it:

Especially in my (academic) department, support is lacking like

hell. I mean I cannot talk to the secretary there. Once I tried to ask

something a couple of times...I don't know...you see their face... [laughing,

they don't understand what you are asking] you say "OK, don't worry

about that!"

5. **Necessary audience**:

Individuals who the subject confides in or vents to or avoids

Michael has a small group of friends that all frequent a coffee shop on campus each day for about a thirty minute coffee break. He stated that he has told his friends that he has problems with Panic Attacks and several of the friends have admitted to experiencing "similar problems." However, Michael does not feel that he has formed close ties with his cohorts:

> Well, I have no support here. I am alone. I don't have any family
> here. I have some friends here but they are students like me. They need
> the support, too. No support for me. I am by myself. Nobody says, "You
> did a good job - very nice."

Michael has been awarded a teaching assistantship at Virginia Tech. He has been successful so far in avoiding any teaching situations in the classroom. When asked to teach a class in his professor's absence, Michael told his professor, "No." He did not divulge to his professor that he has Panic Disorder. His professor told Michael that this would not be a problem since there were other graduate students who could fill in:

> No, I didn't tell him but I said, "I don't feel confident at this time."
> I feel I have to face that, you know. I think next time I will face that if any
> other opportunities occur. I make myself, you know but I'm a very gradual
> person. I look always...my process is slow, gradual, and next time I will do
> that (teach).

6. **Ascribed roles**:

Perceived role of the subject

Michael, on the *Family Background Questionnaire*, described himself as "important' and as a "loved one." He also described himself as an "idealist," a "perfectionist," and different from other people.

7. **Designated critics**:

Things, places, or individuals that the subject views as having a negative influence on them

Michael described a host of factors that have had a negative impact on him and have exacerbated his anxiety. These factors included unsupportive faculty, a fear of lecturing in front of a class, side effects of medication, and relaxation techniques that he learned through the counseling center that increased his anxiety levels:

Professors - When questioned about support from his academic advisor, Michael responded with, "No. I don't think that, no. Advisors always look unsatisfied. I don't get [support from] them."

Teaching - "For example, my instructor was going somewhere for a seminar or a conference and he asked me if I can teach for his class because I am TAing the class. I told him...I said, 'No' because I am afraid, you know. It would make me anxious. And talking to people, always I have fear, you know."

Medication - "It helped, really, but there was a host of side effects. It slowed me down and feeling tired everyday. I decided to quit. I don't believe in, you know, medication. I was yawning a lot and really sleepy, you know, and I couldn't take it, I felt silly, you know? It makes also change in my appetite, like you don't eat. I became monster. I

stopped soon, I took enough for four or five days and then I said that's it. I am not going to...you always lose something, you know?"

Counseling Advice - "There was a class meeting thing for doing that. I didn't go. The only advice was I think was breathing from nose, deep breathe from nose. But I don't want to do that because while you do that you become more stressful. You say, 'OK,' I mean it reminds you that you are having an attack. Now you know I'm not in the techniques...don't try to think of that, try to think of something else. But, most of the time, you cannot do. But maybe you can, slow it down. I don't know."

8. **Social significance**:

Impact on the subject's social life

Michael stated with conviction that he had never dated even though he was 30 years of age. He felt that his personality was the key reason for his lack of a relationship: "No. I have no date.. I'm so perfectionist, I cannot find the perfect woman. REALLY!"

When asked if he might possibly date in the future: "It [dating] should be [laughs] for normal people but...yes, I guess it will be maybe, but I have to, you know, tell myself not to find a perfect one[female]."

Michael had gone to the Cranwell Center for international students on campus but he felt he had found no support there. "Even people from [my country] are strange to me, it seems. Very strange. I don't know why." When referencing other students that he had met through his classes here at Virginia Tech, he concluded that:

They are not very close friends of mine. I cannot make friends.

Maybe because of me. I start giving less time for socializing. I started

worrying about academic things. Maybe because of that. But when I came

here, I can say that people are different.

9. **Cultural significance**:

Family background, values, customs, beliefs, etc. that play a role in the subject's Panic

Disorder

Michael felt that his parents have had a tremendous influence in his life and on how

he should view the world. While many of his values and beliefs may be somewhat

unrealistic and obviously exacerbate his anxiety, he holds himself to very high ethical

standards, a strong work ethic, and perseverance in his field of study. When Michael

referenced his parents' influences, he stated that, "Yes. They always...yeah, actually they

drove me to be perfect. For example, being a good person, it is very, in our family, it's

very strong. I mean they have to be good person, you know. They have no [other] way."

Michael indicated that his parents cultivated an attitude of caution, suspicion, and

mistrust of the outside world and they denied him the opportunity to freely express

feelings and impulses.

10. **Consequences of good and bad performances**:

Michael had developed his own philosophy about working and dealing with his

anxiety at the same time:

You slow down. You don't want to do things...you become...you

make yourself invisible, you know. You slow down. You don't do too

many things. You are afraid to, of course...a little bit. You don't want too

many things to think about. If you socialize, do extra things, then maybe

you know...how can I say, you slow down, you know. You don't want to

do too many things. You just want to specialize or something and say,

"No, I don't want to." Some people do a lot of things. They are a member

of that thing or a member of that club, but you don't want too many things

to think about. You want a plain life...simple. And that's what I want.

Michael was somewhat unrealistic about how he will handle a teaching assignment

the next time he is asked to teach. He admitted to experiencing severe performance

anxiety when having to speak in front of other people, yet he is convinced that since he

feels he has now accepted his Panic Disorder as a part of his life, he will be able to "will"

himself to teach, given the next opportunity:

He [his professor] said there is other people he can also ask [to

teach the class]. Otherwise, I will teach you know. I mean, maybe I will

have a lot of anxiety but I will definitely teach. But since he said there are

other people, I said "No." I don't want the extra anxiety.

11. **Employment Needs**:

The effects on choice of major and employment issues

Michael stated that he felt he was majoring in his chosen field and that his Panic

Disorder had no effect on his choice of major. Michael had always wanted to major in his

current choice of profession since he had been a young child: "I like my field very much

from my heart." Michael expressed great concern over job competition in his major and

the level of performance he would have to maintain in order to obtain and maintain a job

in his field, particularly in the United States:

> You know here, for example, you have to work really hard to stay
>
> in the US... to stay in your job. That is also my source of stress. I feel I
>
> am going to work in [his country] if I finish my Ph.D., but sometimes I also
>
> say going back and working there [in his country] also seems to me
>
> difficult. Stay here - no people - strange country with strange people. So
>
> you are always thinking, "Should I do this, should I do that?" That is also
>
> a part of anxiety and depression. I think if I am going to stay here, I have
>
> to do the BEST.

Michael is perhaps unrealistic about his choice of profession in his major since he

has a fear of public speaking which dates back to his undergraduate years. This fear of

public speaking coupled with the fact that he refuses to take medication and follow

through with any ongoing therapy does not make him a good candidate for a teaching

position within an university setting. He admitted to the researcher that wanting to teach

in a university setting appeared to be a "contradiction." Michael had also convinced

himself that he may not be very successful in many of his endeavors because he knew he

had limitations and he felt that he must accept his fate. Unfortunately, this resignation to

fate may preclude him from striving to achieve higher goals and aspirations:

> I think now I'm going to work for a university. But you know, it
>
> seems...in [my country] I cannot, but here you know, it is very difficult.
>
> That is why I am always saying "I have to do good things." But I think I
>
> have to know my limits. I have limits. I cannot do. So far I couldn't do

[teach] so I don't think I will do good things, so I have to accept. I have

started accepting it.

- difficulty reading new words or inability to "sound out" (phonetically) the word
- poor vocabulary, difficulty with word retrieval
- mental restlessness
- internal sense of anxiety or nervousness
- negativity
- constant unexplained anxiety
- concentration problems
- feelings of fear or anxiety
- restlessness
- long and short term auditory and visual memory deficits

Barriers in the Environmental Setting

Physical settings:
- No problems reported

Academic settings:
- No problems reported

Social settings:
- feels there are less social events here than in his country
- not involved in any activities or organizations
- feels he cannot find people to socialize with

Cultural settings:
- no social ethnic support
- feels there is was no support from the Cranwell Center
- does not attend cultural events because he feels he does not have the time - his graduate program is too demanding of him.

Organizational settings:
- language barrier with the support staff in his program of study
- lack of support from academic advisor/staff

Administrative conditions:
- No problems reported

Basic resources:
- lack of food native to his country

Ecological climate:

- Michael chose to attend Virginia Tech because he felt the graduate school had a good reputation in his field of study. Location was also a consideration for him because he did not want to attend a school in the Northern area. The size of the institution has not been overwhelming for Michael and he stated that he liked a larger institution because, "More people - you know for me, the more people the better. I mean the town would be bigger. Things going on would be more than a smaller college. Bigger is better."

Barriers in the Psychosocial Setting

Problems related to the social environment:
- inadequate social support
- living alone, no family here in the United States
- friends are not considered to be close friends
- lack of support from his faculty advisor
- has never dated

Occupational problems:
- threat of job loss - feels he has to work really hard and be the "best" because it is harder to acquire and retain a job here in the United States than it would be in his country.
- unable to perform basic level teaching skills in his chosen profession

Coping Mechanisms

- avoids going to go to sleep for fear that he will have another Panic Attack
- seeks out strangers when he is having a Panic Attack
- takes only 1/4 of the amount of medication that is prescribed for him because he fears medication addiction or that it will affect his mental faculties
- stopped studying in school for two months after he had his first Panic Attack
- called 911 when he had his second Panic Attack, thinking he was dying
- tries to think about something else when he is having an attack
- ritualistic behaviors (OCD)
- tells himself that his personality is the reason he has Panic Disorder so there is nothing he can do about his disorder
- tries to make himself "invisible" by slowing down and not doing too many things that might make him become stressed (for example, socializing).
- thinks he is incapable of doing "good things" so he accepts his limitations
- lying to professor as to the reason he could not teach in class

Avoidance Behaviors

- afraid to go to bed because he might have a Panic Attack
- taking medication

- not following through with counseling suggestions
- dating
- teaching
- socializing
- avoids attending cultural or aesthetic events for fear it will cut into his devotion to academic work

Services and Accommodations Used

- campus counseling services
- campus staff psychiatrist
- campus health services

PROFILE SUMMARY

Biographical Information

Name: Frances

Race: Caucasian

Sex: Female

Educational Status: Graduate Student

Age: 28

History of Panic Disorder

Frances was not diagnosed with Panic Disorder with Agoraphobia until the Fall 1998 semester. She states that she has had Panic Attacks since the 9th grade. The Panic Attacks in the 9th grade became so debilitating that the only public places she ventured out to were church and school. Because of her daily anxiety level and gastrointestinal problems, Frances vomited almost on a daily basis. Her mother took her to the family physician who "accused me of being anorexic." Frances currently takes Xanax (an antianxiety medication) four times a day for her Panic Disorder with Agoraphobia. She reported having several Panic Attacks during the Fall 1998 semester. Frances stated that her Panic Disorder with Agoraphobia is more debilitating now than it has been in the past.

Comorbid Disorders

Frances reports that she had Obsessive-Compulsive Disorder (OCD) around the age of six to eight. The ritualistic behaviors somewhat subsided while she was in high school but she felt that she still engaged in obsessional thinking. Frances has had, and still

continues to have, bouts of depression. The more Agoraphobic she became, the more

depression she experienced. Frances' doctor has never treated her for depression, only the

Panic Attacks. While they have discussed the possibility of treating her with an

antidepressant to treat both the anxiety and the depression, she has never wanted to switch

medications since the Xanax appears to be beneficial.

Personality Profile

Frances stated the she fits the profile of both the *Critic* and the *Perfectionist*

(APPENDIX F).

I mean, those are both so much like reading about myself. Anyone

that's ever lived with me would say that the *Perfectionist* is like, "Oh my

God!" Cause the house has to be a certain way, and everything I do. The

Victim would be maybe me if I'm really, really depressed. That's how I'd

feel. But not generally. But it would be a hard toss-up to choose between

the *Perfectionist* and the *Critic*.

1. **Key actors**:

Key persons mentioned in relation to the subject's experience with Panic Disorder with Agoraphobia

  In recounting her experiences with Panic Disorder with Agoraphobia, Frances gave a vivid description of her early problems with anxiety and how she manifested her OCD. It appeared that her mother played a significant role in her life as well as her church. Most of her OCD rituals involved her mother having to check and recheck the thermostat in their house and a bedtime ritual where the mother would have to say, "Good night. I love you. Good-bye." before Frances could go to sleep at night. The church played a very strong role in Frances' life as her mother would take them to church weekly. Frances mentioned several times throughout the interview that the, "voice of the church" was very important to her. Frances indicated that her father worked a lot during most of her younger years and he did not know what was occurring in her life as far as her problems with anxiety and OCD.

  Frances left home at the age of seventeen to marry. Her marriage soon turned into an abusive relationship both mentally and physically. Her now ex-husband was unfaithful to Frances for most of their marriage. Frances indicated to the researcher that she never disclosed the physical abuse to her parents or in-laws. She did, however, tell her parents about her ex-husband's infidelities. Frances, on several occasions, mentioned that she valued the words of her "extended family" (ex-in-laws) and the church, "Their voices are very important." Both the church and Frances' in-laws felt she was making a huge mistake by choosing to leave home and her husband to go and live on Virginia Tech's

campus to finish out her junior and senior year of college. They told her that it was "not her wifely duty." Frances claimed that once she separated from her husband, her in-laws used her decision of going away to college against her as an excuse to justify why she left her husband: "Well, she did use those two years just running around."   Frances implied that the reason she chose to leave her husband and go away to college was, "To get away from him and the whole area because it was not healthy."

Teachers or professors who appear to have authoritative personalities or who are unstructured in the classroom setting tend to invoke panic and anxiety in her. Frances recounted two specific incidents that supported these claims.

2. **Central Action**:

Symptomatology of anxiety and panic

When Frances started having Panic Attacks in the 9th grade, she would vomit on a daily basis. She had these "attacks" of anxiety each day during the school week but did not usually have any Panic Attacks on the weekends unless her mother took her out in public. Frances was only able to go to the shopping mall once that year. The only places that she ventured out to were church and school. As a teenager and young adult, she experienced the following symptoms: feeling "hot and start to sweat" and problems with concentration. "My dilemma was should I get up and leave (the classroom)? If I did get up, I would think 'people are noticing, they know why, they'll think I'm weird!'" Frances stated that she does not like to be around people when she has a Panic Attack. She would rather be alone:

I would get very, you know, heart racing, very sweaty, very shaky, tingling in my hands and feet, and then very nauseous. And the nausea would not go away immediately. That could last. I mean, the entire day I would be nauseous even after one event in the day. I find, even now, that if I get really anxious in the morning, I'll get a headache in the evening. I didn't have headaches then but I do now when I get anxious.

3. **Dramatic structure**:

Perceived level of anxiety and/or fear

Frances supplied the researcher with detailed account of what physically and mentally occurs during one of her Panic Attacks:

That fight-or-flight thing where I'm just so aroused, usually lasts until I'm out of the situation. If it's any type of confrontation then it was all day, you know, with the classes and that kind of thing. I mean, I would be anxious the entire day and I don't think I really liked the level of arousal that I was usually always at. But then when I would go home and be in my room, because I would stay in my room a lot, I would be able to calm down physically but the nausea would be there all the time. And sometimes then I wouldn't sleep and I would go for days and it would be so hard for me to go to sleep at night. I would go to sleep at like 3:00 a.m. and get up so early. I would sleep like three hours a night or something because I was just so worried about everything. And worried that the next day I was going to have a Panic Attack in a class and not be able to leave.

Because it was like a general anxiety almost all the time, but then the

attacks would be...it would be hard to see where one ends and one begins

because I would have them so many times throughout the day. And the

most I think was five - I had five in a day.

Frances stated that the Panic Attacks she presently encounters appear to occur

more frequently at night. "This time around, this little cycle of them, I would wake up

with them. I would wake up in the middle of a Panic Attack, just thinking about what I

had to do that day."

4. **Important props**:

Things, people, or places viewed as comfort zones or areas to avoid

The reason Frances chose Virginia Tech's graduate program was because at the

time of her entrance, Virginia Tech did not require her to take the GREs or interview with

a committee: "I was too petrified to take the GREs. I was too petrified to do the

interview. And from what I understand, they've changed this program so that now they

are interviewing. It affected why I chose to come here instead of Radford."

Since attending Virginia Tech as an undergraduate and now as a graduate student,

Frances indicated that she has had great difficulty with conducting normal school functions

(i.e. paying for classes, purchasing tickets, etc.) due to the waiting lines that typically

occur in some buildings or at academic and social events:

Like with Burruss (Hall) with all the lines there's no way. I mean, I

get so scared, um, I might get in the wrong line, I might do all these things,

or get lost - that's another thing. I'm pretty good with that. I did get lost

during my orientation for undergrad, and the reason I got lost was because

I was having a Panic Attack and just started wondering around without

even really looking at the map.

Frances recalled two incidents in particular buildings on campus that have had such

a negative impact on her that she either avoided these buildings completely or only

frequented them if it was absolutely necessary. The first incident occurred at a cultural

event that was held in Burruss Hall which she had attended with her boyfriend:

When we got there, they had set up like the laser part (lights) in

front of our seats. Well, that would entail asking to be moved. Well, I

can't do that because I'm already so anxious. So the guy I'm dating, that

was another thing. He was like, "What is this? I don't understand?" And

then I said, you know, I can't stand being in this building, and then we

talked about it. And he went and talked with someone and had us moved.

I don't like that, though. I don't like feeling like I can't do it. But just

being there in that room... it was awful.

The second incident that Frances recalled was the difficulty she experienced in the

dining halls:

That was hard, too. Because the lines and then when I'd get in

there I would already be so anxious about it, then I would start worrying

about really dumb things like I'm not going to get a seat, my [meal] card is

gonna be messed up. It's not gonna work or something like that.

In the classroom setting, Frances likes to sit near the front of the room in her

classes. This is considered her comfort zone area. She stated that it is better if she cannot

see anyone else because she will be more likely to talk in class if she cannot see if anyone

else is looking at her. She stated that if she cannot see their reaction to whatever she is saying, she is more likely to talk in class:

> It's about judgment...if I can't see them, I can't see if they are judging what I am saying like "Oh God, there she goes again, or boy I'm bored." Just people looking at me makes me really nervous, - like in presentations. It's just hell for me to get through a presentation.

As far as the classroom environment is concerned:

> A couple of the rooms are just too small and I feel like I'm going to suffocate in there. And the desks are so close. I like a lot of boundary. I don't know, I have a large boundary space, so while I'm in there I'm thinking about that too. Because I do get very anxious about like physical boundaries. I don't like being that close. And it also feels when it's that close sometimes that everybody can really look at you, and that's part of my anxiety is the feeling like I'm judged. So they really can't see you then if you're really far away. And people hated the classes where there are like 300 people in a class, but I loved it because you know I could sit way...you know [laughs]. Well, I was probably sitting in the front, but just so I wouldn't see...I don't know. I didn't feel like so many people were right on me or something. That's another thing. - I always do sit near the door in case I have to get out.

Frances implied that there were at least four persons that were considered to sources of comfort for her, her parents, her boyfriend, and her therapist. When discussing her parents, Frances stated that:

I don't want to move away or anything like that. I like being near

enough to my parents but I don't have to see them all the time. Something

weird is going on there that I just don't like, you know? Roanoke is the

farthest away that I'd ever want to live.

Frances stated that she does have difficulty disclosing personal information about

herself to fellow classmates but she does not mind talking to her therapist. She feels very

"safe" and "comfortable" and "relieved" after a session.

Frances' current boyfriend is very sympathetic about her Panic Disorder and very

accommodating. On one occasion she stated that they were supposed to go to a play and

she "begged out." At first he was upset with Frances and then he realized that it was

probably due to the fact that she had never been to that location before. "I won't know

what to do when I get there...where to sit." Big auditoriums make Frances really nervous

and insight on the boyfriend's behalf prompted him to go to the auditorium after he

bought the tickets to find out where they would be sitting in advance to make her feel

more comfortable.

5. **Necessary audience**:

Individuals who the subject confides in or vents to or avoids

While Frances has confided in her therapist and her boyfriend about her Panic

Disorder, she has never disclosed to any of her professors. Frances does feel, however,

that she might benefit from some classroom accommodations:

I think with testing I need to do that [have testing

accommodations], especially after yesterday [Frances had taken a test the

day before she came in to interview with the researcher and reported

problems with anxiety and concentration]. It's so hard for me to

concentrate because I'm already anxious and I get in there and I just hear

everything like the pencils, and just the people! I don't know. It's just

very hard for me to do that (take a test with people in the same room).

And I know I've studied it. I think I did pretty well on it (the test). I think

I need to just be in a room by myself. I would not have even considered

that...I don't even know if I would have known that was available when I

was an undergrad.

Frances was not aware that she would be eligible for testing accommodations if

she presented the Dean of Students office with documentation of her disability.

Frances has never told her parents that she was in a physically abusive marriage,

only that her ex-husband "cheated" on her:

Part of it was, you know, the perfect family. You don't show your

emotions in public. Part of it was the church. If I would have said

something, then the response would have been, "Well, I can see why he

(ex-husband) would be so frustrated with you and why that would

happen." There is also the shame. I have always been a feminist and have

always been outspoken about that. It's so interesting all the speeches that I

have done when I've had to do it -that pertains to domestic violence and I

had a professor once say, "Boy you're one of those that just would never

let a man abuse you!" And I was thinking, "Boy, you don't know what I

go through!"

6. **Ascribed roles**:

On the *Family Background Questionnaire*, Frances describes her role in the family as the "scapegoat" and the "caretaker." Frances views herself as a feminist. She sees herself in a helping role in the future in that she would like to work with sexually abused adolescents.

7. **Designated critics**:

Things, places, or individuals that the subject views as having a negative influence on them

Frances recalled specific settings and incidents of things, places, and individuals that have had a negative impact on her which include certain classroom settings, the architectural design of the counseling center, and a professor whose demeanor is authoritative and his classroom style is very unstructured:

- *Classroom*: Presentation, a lot of group work, um...especially with this personal growth group thing that's very difficult because you're supposed to reveal like personal stuff and I'm NOT gonna do that. And so then that causes a little bit of discord between everyone...I don't know. That's an issue. Another thing that I don't like is that I can't concentrate on what's being said with so many people around, like if I need to talk to the professor. And a lot of the professors it's different than when you're an undergrad. It's like you really can't meet with them as much. And they say try to schedule something like right after class or something, but there are so many people around, I just can't. And I might be embarrassed about what I'm gonna ask. Like I don't know something that he went over or she went over and then I don't want the whole world knowing that.

- *Counseling Center*: I think it's very interesting the architect that made the building for the new counseling center. The first thing I thought when I walked in there was that I felt so exposed. I was like someone in counseling did not consult with them on how to do this building. Because when you walk in, you know, there are all these windows and it's just so open. And it's weird, like I don't like close things but I don't like that openness where everyone can see me, that kind of thing.

- *Professors*: (Graduate School) -The professor is very authoritarian, unstructured. You never know what he is going to do or call on you and he does some really weird things. I have to force myself to go to his classes. I was petrified that he was going to say something to me or put me "on the spot" during class.

(High School) - One teacher in particular was authoritarian and he was an alcoholic. You never knew when he as going to go off. He reeked of alcohol. On one occasion I had forgotten to bring a pencil to class and when I asked him if I could be excused from class to go get my pencil, he went "off" on me and brought me to tears. I almost cried every time I had to go into his class.

8. **Social significance**:

Impact on the subject's social life

Frances' problems with OCD and Panic Disorder have plagued her since early childhood and continue to affect her social life even now. While in high school, Frances indicated that her OCD and anxiety played a large role in her ability to do well in school or

to concentrate. She stated that she was always worrying or obsessing about her boyfriend. She believed that her boyfriend had to do things a certain way or she would think, "He is going to leave me." Frances also indicated that she used this same line of obsessional thinking with her husband for awhile.

Frances married at age 17 and after attending a community college for two years, she moved on campus to finish her education at Virginia Tech. She was in an abusive marriage and stated that, "My education was not important to him, but it was something that sort of got me out of his hair so that he could do whatever he wanted - run around without being caught." Her in-laws said it was not "her wifely duty to leave her husband and live on campus" but Frances stated that she knew "I was never going to get out (of the relationship), if I didn't get my education."

Frances indicated that as an undergraduate, the only time she would go out socially was when she was drinking a lot or had used marijuana. Today, Frances stated that she rarely goes out to socialize. She currently has a boyfriend but has not made any friendships in graduate school. She also currently works but does not socialize with anyone from work, either. She stated that there was one woman at work who she talked to some but "she was a little weird." In referencing her thoughts on socializing now as a graduate student:

Well, I think the big thing on this campus is the drinking and the
partying and that kind of thing. And I don't like the way things are set up
to socialize. Because I don't want to do that, but I would like to be able to
socialize but it just seems that...I don't know. What's offered a lot of times

are in the auditoriums and I don't like being in there, so I'm already going

to feel uncomfortable, so I just won't go.

9. **Cultural significance**:

<u>Family background, values, customs, beliefs, etc. that play a role in the subject's Panic</u>

<u>Disorder</u>

Frances stated that her mother suffered with anxiety, depression, and certain

phobias. Her father has had bouts of depression and some problems with phobias as the

result of a serious car accident he was involved in. One of Frances' sisters also has a

history of depression. From the *Family Background Questionnaire*, Frances indicated

that both of her parents seemed excessively prone to worry and overly concerned about

potential dangers that could befall her. Her parents cultivated an attitude of caution,

suspicion, or distrust. Frances indicated that she should "only trust the family." She feels

that her parents were overly critical and demanding of her, which made her feel put down

or diminished, hurt or rejected, ashamed or guilty, and angry or rebellious. As a child, she

was punished for openly expressing her feelings and impulses. Her father would become

angry or avoid her when she attempted to express her feelings. Crying was not tolerated

and neither was anger. Frances indicated that she felt insecure growing up due to

excessive criticism by her parents, excessive punishment, her parents making her feel

ashamed, her parents making her feel guilty, sexual abuse (not by immediate family), and

parental alcoholism (in her extended family - ex-in-laws). Frances responded to her

feelings of insecurity by becoming very dependent emotionally on her family, leaving home

early (married right after high school) and by becoming angry and rebellious. Frances

stated that while she was growing up, her family's view on seeking psychological help

was, "Anything that dealt with counseling was hogwash. If you had a problem you took it

to God and that was the end of it."

10. **Consequences of good and bad performances**:

Frances relayed a specific situation that recently occurred in the classroom while

she was part of a group presentation:

I had a presentation [in class] and I botched it. And that was like

one of the worst [Panic Attacks] that I felt happened during that time. And

it was in front of everyone. And I really lost focus. Like I cannot focus

and I really start to stutter and stammer and...and it was...I think it was

even after I had been on medication. It wasn't really warm in the room,

but I was sweating. And it got to the point where I really just could not

read and I just kind of stopped for a second. I was doing it with a group of

other people and they're just kind of looking at me like, "What is going on

with you?" And I know I was thinking, "Oh my God. We're gonna make

a bad grade because of me." And then I was really angry at myself about

that. I finally finished it and then sat down and I was just devastated

because everyone in the room, I felt, was looking at me. I felt like I had let

the group down and I was very angry because I did most of the work for

the group and it looked like I was so unprepared to the professor, I

thought. Because here I am the one who...it's not like they [the other

members in her presentation group] were slackers, it's just that I usually do

try to get it 'cause I want to know exactly what's gonna happen before I

get up there. I felt so exposed to everyone then.

11. **Employment Issues**:

The effects on choice of major and employment issues

Frances definitely feels that her Panic Disorder with Agoraphobia is a factor in the

types of jobs she pursues and in her choice for an academic study. Frances' choice of

major will typically place her in settings where she will have to deal with the public. This

has been a source of discomfort for her but she is hoping that with time and practice of

interacting with the public, she will be able to overcome her insecurities. Frances

projected her fears about interviewing for a job and working with the public in the

following statements:

But there have been times when it really was hard and I thought,

"What am I doing? Why am I in this field?" Maybe I should just be doing

like research, or maybe I should just be doing something where I'm with

books all day. And part of the reason, too, with my jobs, I haven't been

like preferred, it's been that when I interview, it's horrific. I cannot

interview well. And I always say it was divine inspiration that I got the job

that I have now, because I have never done an interview well and that was

the only time in my life I have done one well. So I'm in jobs where they

just need a warm body. Because they don't care how bad I sound. My

resume was really good, but when I get in there...ugh...I just can't hardly

get through it. I had an interview during that time that I did go to this past

year and I told a woman later, I said... That was the only time when I have felt I was so panicked that I almost just...It was almost a joke. I almost said, "This is a joke. I'm leaving. I'm just wasting your time and mine." I had stumbled around so much through it, it was just crazy and I know I wasn't going to get it.

Frances indicated that her work history has been very sporadic and that she has felt somewhat inadequate in her job roles:

The last job I was in I had to go to court a lot, and that was really hard. To have to speak in court. There were a couple [of] times...It would come out - it [her voice] sounded like a little child. People think I look so young anyway, you know they think I'm young. And then, I'm in there talking about this family and trying to do something with an adolescent. I looked like such a fool in front of the judge because I'm stumbling, and sputtering, ...

A lot of it I think I was underqualified for kind of things, but then some of it was...the past one where I worked for a year and a half - it was hell, but I stayed with it. I do like my job now. And it's pushed me to be a lot more independent, I think. Or trust my instincts more about doing things but some of the other things, it was just...I don't know. I just really don't click well with people.

Barriers in the Academic Setting

- inability to change from one task to another
- lack of organization for notes and other materials
- difficulty scheduling time to complete short and long term assignments
- poor comprehension and retention of material read
- difficulty reading new works or inability to "sound out" (phonetically) the word
- difficulty understanding the wording on objective tests
- difficulty taking notes in class
- problems with capitalization, spacing, and punctuation
- difficulty concentrating in lectures
- poor vocabulary, difficulty with word retrieval
- problems with grammar
- difficulty with aligning problems, number reversals, confusion with symbols in math
- difficulty with reasoning in math
- impatient, low frustration tolerance
- driven (find it hard to relax)
- must be moving in order to think
- mental restlessness
- internal sense of anxiety or nervousness
- trouble sustaining friendships or intimate relationships
- avoids group activities
- difficulty with authority
- overwhelmed by management of everyday living
- poor financial management
- chronic sense of underachievement
- inability to recognize success or failure
- mood swings
- chronic problems with self-esteem
- sense of impending doom
- negativity
- test anxiety
- constant unexplained anxiety
- short-term memory difficulty
- time management problems
- concentration problems
- difficulty screening stimuli (problem solving in new environments)
- distractibility
- pacing
- avoidance behavior
- difficulty interacting with others
- speech patterns may be rambling, halting, weak, or pressured
- feelings of fear and anxiety

- difficulty initiating interpersonal contact
- difficulty with sustaining attention
- difficulty with organization
- restlessness
- distractibility
- marked discrepancy between achievement and potential
- long and short-term auditory and visual memory deficits
- organizing and budgeting time
- note-taking and outlining
- integration of information from various sources
- test-taking strategies
- memorization and self-rehearsal strategies

Barriers in the Environmental Setting

Physical settings:
- some of the classrooms are too small and make her feel like she is going to suffocate
- desks are too close together in some rooms and she needs large physical boundaries
- small classes of people - puts her more on the spot than a large classroom would
- needs to sit in the front of the room so others cannot see her
- has to sit near a doorway

Academic settings:
- problems with classroom presentations
- problems with group work situations
- difficulty sharing personal information about herself with others in the classroom
- difficulty scheduling time to meet with professors
- difficulty concentrating on class lecture with so many students in the class
- embarrassed to ask professor to repeat information she missed in class with other students standing around

Social settings:
- feels the campus is conducive to drinking and partying and she doesn't feel she has adequate access to alternative social lifestyles
- cannot attend functions held in the auditorium due to her Agoraphobia
- feels "exposed" when she walks into the counseling center because of the architectural layout of the office

Cultural settings:
- becomes anxious if she has to stand in line to obtain tickets to events
- social gatherings in buildings like Squires and Burruss make her anxious or induce Panic Attacks
- does not like to ask strangers if she needs assistance or directions at large events

Organizations settings:
- has difficulty standing in lines in Burruss for any purpose such as paying fees, registration, etc.

Administrative conditions:
- interview panels to get into graduate school are extremely anxiety producing

Basic resources:
- cannot attend football games due to the crowds
- standing in lines for food service is anxiety producing

Ecological climate:
- Frances attended a community college for the first two years and then transferred to Virginia Tech for her last two years. The reason she chose to come to Virginia Tech was the location of the school. "It was the closest to where I lived." The reason she chose to go to Virginia Tech's graduate school was because she did not have to interview to get into her major and she did not have to take the Graduate Record Examinations.

<u>*Barriers in the Psychosocial Setting*</u>

Problems with primary support group:
- problems with her parents
- disruption of family by separation
- divorce
- sexual and physical abuse

Education problems:
- feels that school "doesn't have to be this difficult" but her Panic Disorder exacerbates her educational problems

Occupational problems:
- interviewing for jobs
- stressful work schedule
- speaking before a group

Economic problems:
- financial problems in the past when she was married and going through a separation and divorce

Problems with access to health care services:
- problems with access to adequate health care when she first came to Virginia Tech
- medical complications

Coping Mechanisms

- anger and rebelliousness
- use of alcohol and recreational drugs
- left home at an early age and married
- lists a host of academic difficulties/barriers, yet she has always had a remarkable GPA in college
- missed or was late to certain classes due to anxiety and feeling nauseous
- left ex-husband "on the run because he was abusive"
- quit numerous jobs
- vomiting (as a young child and adolescent)
- ritualistic behavior and obsessional thinking
- moved onto campus while her husband stayed home since she felt this was the only way she could finish her education and get out of an abusive marriage
- hiding the the abuse that was going on in her life from her parents
- avoids confrontations
- over compensates in group presentations by doing the majority of the work for the group thinking that this will give her more control of the situation and lessen her anxiety

Avoidance Behaviors

- skipped classes or was late to classes where she had to give presentations or speeches
- skipped classes (math) she felt she was not competent in
- large auditoriums
- shopping malls
- stores, especially Wal Mart
- Post Offices
- movie theaters
- social gatherings
- dating
- buses (university transit system)
- some restaurants
- job interviews
- library
- job interviews

Services and Accommodations Used

- tutoring
- study groups
- counseling services
- health services

- outside agency - counseling for Panic Disorder

PROFILE SUMMARY

Biographical Information

Name: Sally

Race: Caucasian

Sex: Female

Educational Status: Undergraduate

Age: 20

History of Panic Disorder

Sally stated that she started having Panic Attacks on a regular basis approximately two weeks before she started attending classes at Virginia Tech. She recalled two "panic-like" incidents that might have been the onset of Panic Attacks from her senior year in high school. The first incident, during her senior year of high school, involved a situation when she was donating blood. She fainted and then went into convulsions. She described this incident as "a big huge deal." Approximately two weeks later, she was in a store shopping with her aunt and she experienced the same feeling of "faintness" she had when she had donated blood. Sally stated that after she left home to attend Virginia Tech, she experienced Panic Attacks on a daily basis, sometimes several times a day. She was put on both Klonopin and Paxil to control the Panic Attacks. Sally only stayed at Virginia Tech for one semester. She moved home with her parents and attended a college (for two semesters) near her parents' home. Sally stopped taking her medications for about 1 1/2 years because she started feeling somewhat better. However, after returning to Virginia Tech for the Fall 1998 semester, she has recently (one week before she interviewed with

the researcher) decided to restart her medications because she is still experiencing Panic Attacks. She indicated that she now has fewer Panic Attacks than before, but the duration of each attack is much longer. The majority of the Panic Attacks that she has occur at night.

Comorbid Disorders

Sally reported no problems with depression or other comorbid disorders.

Personality Profile

Sally feels that the *Worrier* (APPENDIX F) best describes her personality:

I just worry about everything. That just basically fits the description of me. *"What If"* is like my favorite thing. I know I'm fine. I just went and got this physical and the doctor told me I'm fine, but *"What If"* there's something he didn't see and yeah, granted nothing bad has happened to me yet, but *"What If"* this next time something really happens that totally...I know deep down I'm fine, but just there's always that chance that something could be really wrong and it's just waiting to happen. So I worry about that all the time.

1. **Key actors**:

Throughout Sally's interview she referred to her parents and friends that she depended on. Sally, however describes herself as not being a dependent person. Sally had developed an extremely dependent relationship with her parents during her first semester at Virginia Tech. She indicated that she had called her parents every day. "I would be happy if I went two days without calling them." Sometimes Sally would be so distraught over the phone that her parents would drive 5 hours to pick her up and take her home to be with them. Sally stated that, "They were scared I was going to kill myself because I would get so upset."

2. **Central action**:

Symptomatology of anxiety and panic

Sally manifests the majority of her anxiety symptoms in physical maladies and has a strong need for dependence on individuals or caretakers that will be there for her during times of high anxiety. She was able to recall several incidents that revealed how her Agoraphobia began to consume her life and how she became obsessed about a cadre of physical sensations related to her anxiety:

> I had no idea what it was and I was just afraid that something was
> like physically wrong with me, you know. And I was going to go away to
> school and I was going to have no one there to take care of me. I was
> going to end up walking to class one day and like die on the way to class,
> and there would be no one there. And that was my big fear. And so it got

to the point where I didn't want to leave my room. I didn't want to go

anywhere by myself. My whole freshman year I did not go into the library

but one time, because the one time I went in there I had a really bad anxiety

attack. I could not go back in there. I never ate in Owens because every

time I would walk in there, the lights would look really weird to me and I'd

start to have an attack. I'd go in there, I'd grab my food and I'd leave.

Never ate in there.

    I'm really paranoid about my body in like how my body reacts to

things (especially medication). Like every couple of months I get like a

new obsession and right now that's my obsession. I'm really sensitive to

things that happen with my body and how my heart beats and stuff like

that.

3. **Dramatic structure**:

Perceived level of anxiety and/or fear

    Sally had virtually cut herself off socially from all friends and activities her first

semester at Virginia Tech. Sally's counselor suggested that she go have a complete

physical to reassure her that her health was fine since she is overly concerned that there is

"something wrong" with her. Sally admits that she tends to take things out of context and

she states, "I'll exaggerate any little symptom that I have and make it seem like it's the

worse thing - like I'm having a heart attack or I've got cancer or a tumor." Sally's fears

and anxieties, however, were extremely devastating for her when she first left the security

of her parents' home:

I guess it was the first night that we had gotten here (at Virginia Tech), and my parents had gone already to the hotel and my roommate, which was my best friend from home, her mom was here and one of our friends had also come up to visit. And we decided we were gonna go to eat dinner in a restaurant in town. And we had gotten there and as soon as we had gotten there, I just started freaking out and I couldn't be there. I had to leave. I thought something bad was going to happen and so I had one of them just drive me back to campus and I sat in the room and waited until they got back. I had no idea what it was. And I literally thought I was dying. I thought I had done something wrong, I was dying and I just didn't know.

4. **Important props**:

Things, people, or places viewed as comfort zones or areas to avoid

Sally was able to list several areas that she avoided due to her problems with Panic Disorder with Agoraphobia. In particular, she made reference to the problems she experienced with large classroom settings and with the lighting in classrooms, in Owens Dining hall and the lighting around campus. Sally made the analogy that the lighting in Owens Dining hall is like the lighting in a grocery store, which is a place she avoided due to her Panic Disorder with Agoraphobia:

In Owens Dining hall - I don't know what it was. It just always seemed surreal, like when I went in there. It might have been fluorescent light or something, cause I know they do that. But even the lights, the

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yellow lights, that they have all around campus, they bothered me, too, like

when walking home. It just seems like things didn't seem real. And there

were classes that I literally went to, maybe a total of 3 times the whole

semester, which I ended up passing most of them, but I don't know how. I

really don't know how, cause I didn't want to go sit in a big lecture class

with you know 500 students and have something horrible [happen] and call

all this attention to myself. And, you know, just being completely

embarrassed. I didn't want that so I completely avoided staying in that

situation at all.

Sally also mentioned attending events that were conducive to anxiety where she

was likely to become too hot or overheated:

When I was at home there were a couple of concerts that I had

gone to that I did [have problems with Panic Attacks]. I went to one

during the summer and it was so incredibly hot outside. And when I get

really hot, I guess like most people do, I get really light-headed and I feel,

you know...some little symptom like that is always what set me off and

then it would continue to go into a Panic Attack.

 Comfort zone areas for Sally in the classroom were contingent upon always being

able to sit near the back of the classroom because she was less likely to be "put on the

spot". Sitting near a door or exit was not an issue for her. Another comfort zone area for

Sally was her dorm room. During her freshman year she stated that she slept excessively.

"If I was sleeping, I was safe - I didn't have anything to worry about, so I always slept."

5. **Necessary audience**:

<u>Individuals who the subject confides in or vents to or avoids</u>

Sally felt that she was able to confide in her teachers, parents, and her roommate about her Panic Disorder. She did not to seek out formal accommodations from the Dean of Students office; rather, she chose to self advocate for herself:

Teachers - I talked to a lot of them and they were really good about it. They understood." "The one teacher that didn't really seem to understand or care, I don't really remember it's been so long, was one class that I failed. So, I don't know. I think I felt more comfortable around the teachers that understood what I was going through and so it made it easier for me to go to class. Like I knew that if I felt horrible that I could get up and leave and they wouldn't, you know...

Parents - They were very supportive, I think. They joke about it now but I think that they were just annoyed at the fact that I called them all the time. Like I would call them crying all the time. And so my Dad said, 'If you ever go back there, don't call me crying. Cause I'm not going to answer the phone!' I did. I took a lot out on them, or I expected a lot from them. Because they were the only people that I know really understood, for the most part, what I was going through.

Roommate - I knew my roommate did [understand her problems with Panic Attacks]. She was my best friend. She knew everything about me, but she couldn't help me like my Dad could help me. He's some one that I depend on so much.

Support Services -   No, no. I didn't want it to be a big deal. I

didn't want it to be anything more than it was and I didn't want to feel

helpless in that sense, like they're doing something special for me. I just

figured, you, know, I'll tell them and if they understand, then they do and if

they don't, then there's nothing I can do about it.

6. **Ascribed roles**:

Sally described her role in the family as the "oldest child" and the "leader." "I

always thought I was very independent. I mean I don't really depend on people, but just

knowing that they (parents) were there always made me feel a lot more secure."

7. **Designated critics**:

Things, places, or individuals that the subject views as having a negative influence on them

Sally indicated to the researcher that she feels her Panic Disorder is exacerbated

more at nighttime. She currently has most of her Panic Attacks at night. She tried to

justify this statement by reasoning that she feels she does not have her mind on anything

right before she goes to bed and she is "more prone to worry about things." When she

first started having Panic Attacks, they occurred during the day. Sally stated that:

I had this thing between night and day...like at night, I felt more

invincible because it was dark and I felt more hidden, not out in the open.

And I think one of my big fears was everyone was going to see me and I

was going to make a big fool out of myself. At night I was more incognito

and during the day I was more open to everyone being able to see me.

Another situation that Sally felt was having a negative influence on her was living at home with her parents. She told her parents that even though she was still having Panic Attacks at home, she might as well go away to school because she would not be having as good a time at home or she would not be having the same experience as going away to school if she stayed with them. "That was one of my reasonings for coming back to Tech."

8. **Social significance**:

Impact on the subject's social life

Sally stated that, "I lead a boring life." While she does go out socially and sporadically dates, she has never been involved in a long term relationship. She tends to surround herself with friends she can "depend on" in times of crisis or high anxiety. Sally expounded upon several situations involving how her Panic Disorder has affected her social life:

Sally had gone to a "going away party" for all of her friends who had graduated from high school and were leaving for college. She had a Panic Attack at the party and had to ask one of her friends to drive her home. The same thing happened again when she was supposed to say good-bye to another one of her friends, "I don't know if that was my way of trying to avoid having to say good-bye to my friends that I had been with, people that I had depended on for so long."

 Sally stated that she had never had any serious dating relationships while attending high school. When she left Virginia Tech and went home to a local college, she dated one of her best friends for about 3 months:

That was probably about one of the most in-depth relationships I

have had. Anytime I would have a problem, I would call him. I called him

all the time crying, whatever. He was always there for me. He helped me

out in anyway. He would come to see me or just make sure that anything

he could do to help me out, he would do. He was just someone that I felt

safe with. Just like I feel safe with my parents. I could be around him and

not have anxiety as much. I mean every once in awhile...but because I felt

safe, and I knew that if something went wrong, he would know what to do

to take care of me. And that's how I kinda picked the people that I was

going to associate with at the time. If I knew that they could take care of

me, and I felt safe around them, then I would hang out with them,

otherwise, I would try to avoid being in that situation.

9. **Cultural significance**:

Family background, values, customs, beliefs, etc. that play a role in the subject's Panic

Disorder

On the *Family Background Questionnaire*, Sally indicated that her parents were

somewhat overly critical or demanding of her. She responded to this criticism by feeling

ashamed or guilty. Sally felt that she grew up feeling insecure and that her parents

contributed to this by making her feel ashamed. She responded to her feelings of

insecurity by becoming very dependent on her family. She experienced great difficulty

leaving home to attend college.

After Sally left Virginia Tech and started attending a college in her hometown, she decided to stop taking her medications. After returning to Virginia Tech, she found that she needed to go back on the medications:

> Well, it was kind of their [parents] idea in the beginning. And they just wanted anything to make me feel better. So they were fine with it [taking medication]. The second time when I just started doing it...actually when I came back here, even though I was still kind of having the Panic Attacks, I didn't mention anything about it to them, because I didn't want them to think it was going to be like how it was my freshman year. Because there's no way that it will be, but I didn't want them to be like, you know, disappointed since I had already gone off it [medication] at home. So, I saw a counselor and I didn't tell them that I was seeing the counselor and I didn't tell them that I had gone to see the doctor and everything like that , and another psychiatrist. So, I finally told them [so mother's insurance could cover her expenses]. They want me to do anything that will make me better and I realize that now. I didn't want to feel like a failure, like I couldn't do it on my own.

10. **Consequences of good and bad performances**:

Sally has just recently started to venture out on her own and she has found that she does not necessarily have a Panic Attack or anxiety in all social situations. She is perhaps overly optimistic, however, about this new found freedom:

I used to at first [have problems with traveling]. I didn't want to go

anywhere, I couldn't ride in a car. And I went, actually, on a 19 hour trip

this past summer with my family and I thought it was going to be horrible

and I told them I don't want to go, it's going to be bad, you know. I can't

even drive like an hour without freaking out. But I went and I did fine.

And now I can go anywhere.

Sally feels that if she has too much free time on her hands with nothing to occupy

her mind, then she is more prone to having a Panic Attack:

I think I've learned a lot how to control them by some of the

breathing techniques and things like that that the first counselor I saw had

taught me. I also know now that if I get up and do something - get my

mind off of it - then it'll go away. And back then, I would just give up and

lay there and just dwell in it. I know that I can't do that now. I've learned

how to deal with each one and so I don't have them as often or the same

situations I would have had them in before. But when I do have them now,

they do last longer than what they would have before.

11. **Employment Issues**:

The effects on choice of major and employment issues

Sally is very optimistic about her career options and she does not feel that her

Panic Disorder will prevent her from working in certain fields. She stated that her first-

hand experience with Panic Disorder should be a benefit for her if she decides to work

with people in a counseling situation because she will know "what a lot of people are

going through. I have a hands on experience with that and I would be more understanding I think. So I think it benefits me a little."

Sally stated that she would not like to have a job where, "Maybe something that I could just sit around in an office and do nothing all day, probably. I think that would be the only thing I wouldn't want to do." Having a job that engages her mentally and that does not give her too much time on her hands to think about her Panic Disorder is her personal preference. She would be more likely to have a Panic Attack if she were idle on the job. Sally cited two cases where she had previous employment and how her Panic Disorder came into play in these settings:

> The last restaurant that I worked at, I worked there for a year and a
> half. When you're there and you're waiting tables , you are really busy and
> you don't have that much time to sit there and think about the panic and let
> things get to you. But there were times...there was one particular time
> when I was hostessing instead of waiting tables and standing up there it
> echoed in this little, kind of indention thing that you're sitting back in, and
> like when people would come up to me and their voices would echo, I'd
> start to freak out. And people would be talking to me and I'd just like
> couldn't talk to them. I felt really bad. It was the first bad Panic Attack
> I'd had in a really long time, so like I'd run to the bathroom and bring one
> of my best friends with me who worked there with me too, and she knew
> everything that I'd gone through, so she tried to talk to me. So she finally
> had told one of the managers and so they let me go home. Which I felt like
> a failure going home. Like I should be able to deal with this.

No, I didn't have any Panic Attacks when I worked in the hair salon. Because it was four of us. It was really small. Everyone that went in there were just clients that had been there for years. I mean, I knew everybody and it was such a homey environment that I didn't feel unsafe at all.

Barriers in the Academic Setting

- difficulty scheduling time to complete short and long term assignments
- difficulty understanding the wording on objective tests
- impatient, low frustration tolerance
- mental restlessness
- internal sense of anxiety or nervousness
- difficulty starting projects
- enthusiastic beginning but poor ending
- chronic sense of underachievement
- inability to recognize success or failure
- mood swings
- chronic problems with self-esteem
- sense of impending doom
- negativity
- constant unexplained anxiety
- negative self-talk
- self-absorption (preoccupation with your health and well being)
- distractibility
- pacing
- avoidance behavior
- feeling of fear or anxiety
- restlessness
- distractibility
- marked discrepancy between achievement and potential

Barriers in the Environmental Setting

Physical settings:
- lighting in Owens Dining hall and the yellow lights around campus
- size of dorm rooms - some are small and dreary like a box which is depressing

Academic settings:
- no problems reported

Social settings:
- She was not currently involved in any activities but she stated that she planned to later: "I want to give myself time to get back into schooling before I did that." Sally was not involved in any activities when she went to the college near her parents' home because, "I worked most of the time there. I didn't have time to do anything."

Cultural settings:
- Large events like concerts where it tends to get very hot and stuffy tend to make her feel light-headed and may send her into a Panic Attack.

Organizational settings:
- No problems reported

Administrative conditions:
- No problems reported

Basic resources:
- Could not eat in Owens Dining hall because the lights in the room looked "really weird" to her and would send her into panic.

Ecological climate:
- Sally chose Virginia Tech because, "I came up her to visit my best friend's sister and I had a really good time. And it just seemed like a place where I'd want to be. It's beautiful here. And I was just dead set on going here. But I don't know why." The size of Virginia Tech has not been overwhelming for Sally. In fact, she stated, "Actually, I like the size because you have something new and you meet new people all the time. But of course, then again, I graduated from a class of 50. I went to a really small school."

Barriers in the Psychosocial Setting

Problems related to the social environment:
- living alone

Coping Mechanisms

- sleeping - made her feel safe - she did not have worry about anything
- dependency on boyfriend to help her cope with her anxiety
- depending on friends that made her feel safe
- excessive phone calls to parents her freshman year in college
- stayed at home with parents after her freshman year and commuted to a nearby college
- did not tell parent at first she has decided to go back on medications or has to see a counselor for her Panic Attacks because she does not want them to be "disappointed" or to think this year will be like her freshman year experiences
- very optimistic that this year will not be like her freshman year
- tries to get up and start doing something to occupy her mind when she feels like she is getting anxious

Avoidance Behaviors

- did not want to leave her room
- did not want to be by herself

- did not go to the library
- Owens Dining hall
- missed classes
- big lecture halls
- taking medications that will affect her body and produce physical sensations
- supermarkets
- shopping malls
- places where a lot of people are gathered

Services and Accommodations Used

- tutoring
- counseling services
- health services for general medical purposes
- staff psychiatrist

PROFILE SUMMARY

Biographical Information

Name: Skip

Educational Status: Undergraduate Student

Race: Caucasian

Sex: Male

Age: 19

History of Panic Disorder

        Skip was able to vividly recall his experiences with anxiety and his first Panic

Attack. Skip's family moved from another state to Virginia when he was a junior in high

school. Skip remembered suffering from depression and anxiety about being in a new

school setting. He recalled suffering from bouts of anxiety whenever he was asked to give

oral reports or presentations to the classroom during his junior year, which only escalated

during his senior hear in high school. Skip's first Panic Attack occurred during his junior

year of high school. He did not seek any help or treatment for his Panic Disorder until one

month after he had transferred to Virginia Tech. His first Panic Attack at Virginia Tech

occurred when he was sitting in a math class and the teacher asked everyone to go around

the room and introduce themselves.

        Skip is currently under the care of the university's Counseling Center psychiatrist

and seeing a university staff counselor. He takes Xanax (antianxiety medication) and

Inderal (a medication typically given for high blood pressure and/or performance anxiety).

The majority of Skip's Panic Attacks tend to be associated with giving oral reports to a

group of people or spurred by situations as simple as sitting in a circle for group discussion or going around the room to introduce each person in class. He has also experienced Panic Attacks in other social situations that involves meeting females on a social basis. Since taking his medication, Skip reported that he has not had any more Panic Attacks. He only takes the medication during the week, before he goes to classes. Skip reports that he does have some side effects from dosing this way but stated, "Yeah, they make me sleepy, but I can usually deal with it. It makes it a lot easier to participate."

Comorbid Disorders

Skip reported that he has no other comorbid disorders other than occasional bouts of depression. "I was thinking it might be, I think something call S.A.D....Seasonal Affective Disorder. Cause that happens to me. Ever since I moved it's been happening to me every year. Right around the same time. Like winter drags on too long."

Personality Profile

Skip described his personality as being the *Worrier*. He stated, "*What If* everyone sees me freaking out, what are they thinking, you know? It's always anticipating the worst. Always trying to find an escape route as soon as I go into an uncomfortable situation."

1. **Key actors**:

Persons mentioned in relation to the subject's experience with Panic Disorder with

Agoraphobia

Skip received a B+ in one of his classes which he found surprising since he had

skipped several of his classes due to his Panic Disorder:

> I'm very surprised at the grade I got in there. I think they gave me
>
> the grade based on my improvement because I told them that I was having
>
> a problem...I told them I was seeing both a psychologist and a psychiatrist
>
> for it. They understood, so. And I got a lot better about half way through
>
> [the class].

Skip waited almost three weeks before talking to any of his professors about the

problems he was experiencing. What prompted him to disclose his disability to his

professors were the constant inquiries from his fellow classmates: "All the kids around

were like, 'Hey, why weren't you in class today?' And I didn't want to tell them so I'd

make up some excuse like I wasn't feeling good, or stomach problems or something."

Other key actors that Skip mentioned that played a key role in relation to his

experiences with Panic Disorder were his teachers and classmates at his new high school:

> I had lived in another state my whole life... for 16 years of my life,
>
> and my Dad told me that we were moving to Virginia. I was like, "NO!"
>
> because I had just made like the best friends of my entire life. I hadn't had
>
> any really good friends in junior high or middle school. So when I went to
>
> high school, I met a big group of really awesome friends. And I was

having a great time and then I had to move to Virginia. That summer I

didn't meet anyone my own age. There was on one my own age in the

neighborhood. And I didn't talk to anyone when I went to school because

I went through a depression. And then I had this English class where they

said, "O.K., We're doing four oral reports this year." But I was thinking I

would be able to get over it. Well, I was a little bit late to class the first

day that we had to do presentations. And I walk in there and there's just

this "tenseness" in the atmosphere. Like all the kids in the class - it's real

quiet. And there's one girl like fidgeting around at the lectern giving her

speech, you know, kind of nervous. And I was like, "Oh No! I didn't

know it was going to be this kind of an oral report."

Skip had confided in two of his professors that he was having difficulty with Panic

Attacks and that having to give a classroom presentation in front of the class was very

stressful for him. In class one day, the professor asked the students to get up in front of

the room to talk about their projects, starting on the side that Skip was sitting on. Skip

would have been the second person to present. During the presentation of the student

who went first [Skip was to present second], Skip got up and left the room until the class

was finished. He approached his professors after class with the following conversation:

"Well, I guess you know why I left the room, right?" And they're

like, "Yep." And that was when they asked if there was anyway they could

help. If there's any exercises they could do with the psychologist to try

and help me out. I was kind of surprised that they did that to me after they

knew that I had the problem with being called on but you know they can't

just go ahead and change the entire curriculum for me. So I don't blame

them at all.

2**. Central action**:

<u>Symptomatology of anxiety and panic</u>

Skip was able to recall with great detail the series of events that occurred when he

started to have a Panic Attack. He began with an account of his reasons for skipping a

particular class at Virginia Tech and then digressed to some of his earlier experiences in

similar settings at the high school level:

About half the class is working at your desk and the other half is

getting around in a group circle. Which is something that I absolutely

dread. I couldn't handle it. Just being in a room where I see a bunch of

seats, you know, sitting around in a circle. Even when I'm in there by

myself, I start getting nervous. Usually like, "Ugh!" I remember, it's from

back in my senior year in high school, my English class. We had a small

English class - it was about 10 people. And she'd come in class and say,

"O.K. everyone, let's get in a circle." And I was like, "NOOOOO!" I

remember one time I'd went into class and I'd start getting nervous in my

first period class the days that I had my English class, which was every

other day. I would start getting nervous and my face would just start

turning red and sometimes I could get myself to like calm down. By the

time I got to English class, you know...I'd walk in and I would be fine. I'd

have myself calmed down a little bit but then my face would slowly turn

bright red and especially if we'd get in a group circle. But one time I

remember going in there, it was near the end of the year, I was like, "oh,

God. Please just let me get through this.: Cause we had to do several oral

reports in that class. And it was obvious that I hated it right from the

beginning. We did an oral report at the beginning - the second class we

ever took. Woooohhh. So I automatically found out how much I like oral

reports.

My mouth would dry up...wouldn't be able to hold the paper still -

I'd have to sit it down on something...My heart would be going a mile a

minute. And you know, of course, since I'm not moving anywhere, my

blood would just pool up real fast and just blood gushes into my head and

makes my face all red. So naturally I have a fair complexion and it shows

real easily when I get nervous. It'll happen in social situations, too. Like if

I'm on a date and just start getting nervous. I hate that.

3. **Dramatic structure**:

Perceived level of anxiety and/or fear

Skip stated that he... "could write you a book on this(problems with Panic

Attacks). I think about this everyday" which indicated that his anxiety level is constant

but is exacerbated by key events such as classroom presentations, socializing, and

anticipating being put on the spot by a professor in classes that promote classroom

discussions. Skip's reaction to feelings of anxiety is extremely physical in nature and

debilitating for him in classroom settings:

I'd start instant Panic Attack. Hands start trembling, if I tried to move my neck, my head shakes like this (demonstrated head shaking for the researcher), you know? And my face just turns bright red, and my neck...And it changes colors, like slowly over the time. Like my face might start to get a little less flushed and then my neck will start getting all bright red. "You're changing colors!" they'd [high school classmates] say it out loud so everyone in the whole class can hear it. I hated that so much!

Then at the end of that year, (senior year of high school), I was like, "Thank God, summer is here. I can relax now." But I thought about it everyday. I thought about my problem everyday and how much it's gonna affect me the rest of my life. I had vowed to myself that I was never ever going to do another oral report. And I went to , you know, the community college then. Some of the classes, we had to go around the class and introduce ourselves, and I really struggled to not make myself look like a complete "freako."

4. **Important props**:

Things, people, or places viewed as comfort zones or areas to avoid

Skip stated that he preferred to sit in the back of the classroom instead of in the front of the room because, "Everyone can see me up there and the teacher is more likely to call on you." He also sits near an exit so, "I can get out of there quick if I have to."

Skip was involved with a high school senior for approximately one semester. Looking back on the relationship, he realized that coming home to see her only served as a source of comfort for him - a way to help deal with his Panic Disorder:

As soon as Christmas break came around, that's when the break-up came. I initiated it. I was tired of this long distance mess - driving 3 1/2 hours home every weekend was just ridiculous. I just wanted someone who could relate to me and comfort me with my problems and everything and just someone to be there for me, you know, to come home to - to get away from here. But I think, about half-way through the semester, as soon as my problems started changing and getting better, I think that's when I started losing interest, you know?

Skip mentioned several areas in the physical environment that served as potentially negative influences on his Panic Disorder, which included lighting in the classrooms, Dr. Clum's Panic Disorder Clinic, Residence Hall meetings, and Owens Dining Hall. He was able to manipulate one part of the environment, his dorm room, in order to make it into a comfort zone:

Lighting: I really do not like bright lights. I much, much prefer the dark. Hate going into rooms that are completely white and cold and really bright white light, and the group of chairs in a circle. That's probably the worst room you could ever put me in. I think I'd die in that room. I think it's just that if I do turn scarlet, everyone is going to see because the light is so bright and it's right on me. I really don't like it. I really don't like

bright lights because you can see everything perfectly in the room. It's just like Ugh. If I have a Panic Attack they're going to see it all.

Dr. Clum's Panic Disorder Clinic: I would not be able to sit in a circle and become the focus of attention and have to tell people about my problem. I don't like going to people that I don't know to know about my problem. It's kind of embarrassing to me. It's kind of shaming to me so I don't think I would go to one of those [group counseling sessions for individuals with Panic Disorder] unless I took my Xanax and Inderal and then I'd have to introduce myself - Ugh. I'm not sure I'd be able to do that.

RA hall meetings: The one meeting I went to I was real nervous in it cause they had us sit in a big circle and I thought we were going to have to introduce ourselves. And I was just going to leave cause that was at the very beginning of the year, right at like the worst of my problems. But like introducing yourself, like I talked to some other people who had to like stand up and introduce themselves to different people in the hall. I didn't think that was a good idea for people like me.

Owens Dining Hall: I think at Owens Dining center, the quickest way to get to the trays and silverware and everything is walking right up the steps and right between all the tables of people who watch you as you go by. And I never go through that way. I always end up going around and getting my tray.

Dorm room: I made my room into a cave. I chose the bottom

bunk because it kind of covers, it's kind of enclosed. I mean, I've always

liked tight spaces. So I've got my bunk bed in the corner against the wall

and I've got my desk. It's a desk which has a whole back to it, and I've

turned it around and faced it to one side of the desk, so I have this one little

hole to enter in to go into my bed. And it's like a little cave in there. I've

got a little phantom light back there.

5. **Necessary audience**:

Individuals who the subject confides in or vents to or avoids

Skip described his integration into his new high school as a horrible experience.

He was unable to make any new friends and it was not until three months into the school

year, when a fellow classmate initiated a conversation with Skip, did he feel that he had

started to acclimate to his environment:

I didn't have any friends to hang out with all summer. And with

school beginning I didn't have any friends then. Not until November did I

actually...a guy in my English class, he rearranged the seats and the guy

behind me started talking to me out of the middle of nowhere. He was the

first person to talk to me. I got his number and I called him and we ended

up getting together to hang out, and then he showed me some of his

friends, and I became real good friends with all of them.

6. **Ascribed roles**:

Skip described himself as the "middle child", and the "tall and quiet one" in his family. He picked the *Worrier* (Appendix F) as the profile that best fits his personality:

That's like my main problem. You know, "What if" everyone sees me freaking out, what are they thinking, you know? It's always anticipating the worst, always trying to find an escape route as soon as I go into an uncomfortable situation. And if there's no escape route, like what could have happened on that one experience that was pretty memorable to me, where I thought I was going to have to be the first to speak? I don't know what I would do. I probably would have just went nuts right there. Probably would have sent me to a mental hospital after that! "Oh, no! My heart is starting to beat faster!" That's the first thing I think... always say that to myself. "What if I panic and lose complete control of myself?" I say that, too. "What if I'm alone and there's nobody to call?" I think about that all the time. I would get nervous every day during last summer because I would be thinking, "I'm going to have this for life! I'm going to be a bum living on the streets. What if I can't get over it? It's just going to affect the rest of my life and be miserable. What if I'm restricted from going to work for the rest of my life?" That's exactly what I think.

7. **Designated critics**:

Things, places, or individuals that the subject views as having a negative influence on them

When Skip was asked if he would have to take a Public Speaking class at Virginia Tech, he responded with, "I have no idea. I hope not." He further elaborated:

I'm assuming I will eventually. And I'm hoping I'll be able to deal with it when it comes around. I'll just have my Xanax and Inderal with me! And hopefully some more counseling with the psychologist. We do a little thing now. I'll write up a small speech and when I go in, I'll have maybe 2 or 3 people, you know starting off small here. Have like 2 or 3 people and then I just go ahead and read and just work our way through that. Slowly we're going to add more and more people in there. So I'm hoping to be able to do it that way.

The physical setup of the classroom was also a problem for Skip:

I used to get nervous the night before I'd have to go to my lab class. And that's three nights a week! Plus the four hours in the room itself. Just walking up to class, I'd get more nervous. By the time I'm in there I'm a wreck. Just dreading the moment when we'd have to get together to talk. I told them [professors], I think it was maybe three weeks into it, I said, "Look, I have a problem." I was like, "I am seeing people right now to help me with this problem I have." You know I told them all about it. You know, that when we sit in those group circles, I get nervous just getting in the circle, or just being in a room seeing the chairs like that.

Skip was able to recall an early incident in which he felt a lot of anxiety in a classroom setting where he had to give an oral presentation:

Well, one time when I was in the sixth grade, I was working on a project and I was a little bit nervous. Everyone gets nervous when they get up, even just a little bit if they have to get up in front of people. He

(teacher) mentioned something about my hands, my hand were all clammy

and spotty looking, and he made a point to tell me about that when I got

back to my desk. And I thought, "What a jerk thing to say, you know?"

I think it was just a combination of this terrible stress of this move -

and that was one of the hardest ordeals I've ever had to go through in my

life. And having to do oral reports like that also at the same time that I was

having these problems, man, I just had stress like you wouldn't believe.

And it just multiplied my senior year in my English class. That was when it

became a problem. Because I would go into class and I'd take my seat and

I would have already been nervous for 3-4 hours before that. And, oh

God, there was one guy - I hated him so much! He would point out every

single time that my face got red. Or if I was "changing color" as he said,

and they were getting a kick out of that. It really made me angry.

8. **Social significance**:

Impact on the subject's social life

Skip, a prolific storyteller, provided the researcher with a multitude of situations

that involved the impact his Panic Disorder has had on his social life. His situations range

from socially engaging in conversation with people he is not comfortable with or feels

intimidated by, dating and self-medicating with alcohol, to problems with acne:

Social Conversations: Even in social situations sometimes like I'll

start getting real nervous, and my face will start flushing a little bit and I'm

like, "Oh, No! My face is flushing." I just know it's flushing. And they're

not saying anything. And then, you know, if they're sitting over here, I

have to like put my hand right here [places his hand on his cheek as if he is

steadying his head] so I can turn my head like this to look at them. I hate

that so much! I hate it.

  Intimidation: Sometimes I get nervous in situations where I can't

understand why I'm really getting nervous. Like just the other day, but I

didn't have a Panic Attack, but you know, it was the beginnings of what

could become a Panic Attack when I let it get out of control. I went to the

mall with one of my friends and I had met a girl that I had dated over the

summer that kind of ended on a bad note and she happened to be friends

with my friend that I was there with. And it was like, "Hey!" and started

getting talking and her friend was there and I just started getting the

shakes, and I really didn't know what to say. I was like, "Why is this

happening? This kind of stuff never happened to me before in public!"

Then a guy walked by that I've always really disliked because he picked on

me one time in the lunch line my junior year when I didn't have any

friends...and he had seven of his friends there with him and he just made me

look like a total wuss in front of all his friends and everyone in the

cafeteria. I saw him walk by with one of his friends right in front of me, at

the same time that I was dealing with the situation that was right there. I

was just like, "I have to get out of here!" I stayed. I thought is would look

really awkward if I was just sitting there kind of nervous looking and said,

"Uh, I got to run to the bathroom!" or something like that. That would

look real weird like, "What's wrong with him?" See, that's what I don't want...I don't want people to know that I'm having a problem, you know? Like, I don't want people to feel bad for me or just look at me like, "Oh my God, look at him! He's turning purple!" I hate that more than anything else.

Dating: I would go home every weekend to see my girlfriend. She's not my girlfriend anymore. I think I met her two weeks before I went off to college. I think kind of I just wanted someone to come back to, you know? an excuse to leave Tech for the weekend and get away from my problems. And I think that's really what it became. The only thing that would get me through the week is the thought that I was going to go home and see my girlfriend that weekend. That was the only thing that would carry me through the week.

Self-medicating: Yeah, I do drink to get drunk sometimes. It seems to be a college thing. It makes it a lot easier to meet girls that way. And to dance, cause I can. I have the hardest time dancing - I'm so self-conscious. I didn't used to be that way. Like even in high school I could go to a dance and dance. I'd be a little bit nervous but I wouldn't be too self-conscious. Cause I'm not that bad of a dancer. I'm not a good dancer, but I'm not a bad dancer. But recently I wouldn't go out dancing unless I've had a drink or two.

Dating: I didn't start dating a lot in high school until junior or senior year in high school. They [dating relationships] were usually very

short-lived. I never really had as long a relationship as I did with the girl from last semester. But I think a lot of not dating until junior year was because I guess from 6th grade to half-way through junior year in high school, I had really, really bad acne. And that has always been a family problem. I went to a dermatologist in Virginia and he said "Accutane. That's what you need." And I took it and it's really done a good job.

      Acne: No one ever said anything to me about my acne but I was really self-conscious about it. I couldn't hear the word "zit" or "pimple" without cringing. Or like if I was watching TV and I saw like an *Oxy* commercial come on, I would immediately change it real quick. Cause I'd feel all self-conscious while I was watching it.

9. **Cultural significance**:

Family background, values, customs, beliefs, etc. that play a role in the subject's Panic Disorder

      Skip implied that both of his parents seemed excessively prone to worry and they seemed overly concerned about potential dangers that could befall him or other family members. However, while Skip's father encouraged him to explore the outside world, his mother did not. In Skip's home, he indicated that he was denied the right to freely express his feelings and impulses. While it was "O.K." for him to express anger with his mother, he, "Never let my dad see me angry." Skip indicated that he grew up feeling insecure as a result of his parents making him feel guilty. He responded to this feeling of insecurity by becoming very dependent on his family both financially and on "any praises

they would give me." Skip stated that he had difficulty with the thought of leaving home when it was time to go to college. After attending a community college for one year, he decided it was time to move out:

> I tried to get in here first...it didn't work out. So I went to a community college and worked real hard and got my grades up and got accepted finally. Also, I wasn't so sure I wanted to leave home anyway already. Everyone was all ready to leave home but I wasn't. But after about three months I decided it's time to get out of there! (Laughs) I was still living at home.

Skip was asked how his parents responded to his problems with Panic Disorder and he replied:

> I tried to tell them what a problem it was, but my Mom was like, "Oh, I used to get red faced when I had my Public Speaking course," and they would say, "Why is your face red?" and she'd say, "Just nervous."
>
> They knew I didn't like oral reports when I was a senior cause I would tell them like, "Ohhhh, I have to do this oral report!" and they're like, "Oh, don't worry. Just do this and this and this. You know, just pretend everyone out there is naked." Which embarrassed me even more sitting out there. Well, my Mom was like, "Oh, I've had these problems before. It's not a big deal." They just kind of passed it off when I told them about it.

While Skip tried to convey to his parents that he was having problems with anxiety, his parents did not become fully aware of the seriousness of his suffering until he transferred to Virginia Tech:

When it [how serious his Panic Attacks were] really hit them was Transfer Orientation - a couple days before classes began. We were in this lecture hall and the guy was saying how we have big classes here at Tech, you'll be in lecture halls, but don't be surprised if the professor comes up to you and does one of these. And he comes up to just some guy like right in front and say, "Hi! What's your name?" and makes fun of his face. And I'm like, "OH MY GOD! If he does that to me, I'm going to die." And I was sitting kind of in the middle, towards the back, so I figured that it was unlikely that he would come to me but I was terrified. And he struck up a conversation then. There was a lot of people in there, in this lecture hall. and here he was with his microphone asking this guy all about his life and everything. And he was like, "Don't be surprised if the professor does this." And he went around and did this to like 3 or 4 people in the front aisles. And I was like, "Oh my God, please don't come over here."

So, after that, we went to this group session. It was all the transferring students and their moms and dads and it was called...I forgot what it was called. But anyway, we walked in the room, and as soon as I saw the set-up of the room, I was like, "I'm not going to be able to sit in here!" And my Mom was trying to find us a spot, and there were these

tables around the room and chairs all facing each other. And I was

thinking, "Oh God. I'm not going to be able to make this." And my Mom

is leading the way, she was just going to find a spot. I was like, "Mom,

why don't we sit here" kind of in the corner towards the end that way so I

could push my chair back so people wouldn't see me. And of course she

picks right in the middle of these big desks so that everyone can see us. So

I said, "Mom, I have to go to the bathroom." And she was like, "Well,

hurry up. It's about to begin." So I went to the bathroom and I stayed

there for the whole 45 minutes that the thing went on for. And I lost my

Mom for about a half hour to 45 minutes she was wandering around

looking for me, and I was wandering around looking for her. Finally, we

met each other. I was like, "Mom, we need to talk." She as like, "Where

have you been!" She was all mad at me. I told her my problems. She was

like, "We need to go talk to your father." So we went back to my dorm.

And I thought my Dad was going to be so mad at me for waiting this long

to tell them, but I had tried to tell them before but he just wouldn't listen.

And so I explained to him the situation - what happened and how big of a

problem this has been for a long time now.

I kind of laid on my bed - not really looking at him. He was just

sitting across the room. I was just laying in bed telling him this so I didn't

have to look him in the eye. But yeah, I was kind of emotional. I told him

everything that was wrong and he was surprisingly sympathetic. He was

like, "O.K. Well, what we need to do now is get you some help." And he

was like, "You know, they have staff psychologists here that you can go see.: And I was like, "O.K. I'm going to have to set up an appointment then." In the meantime, I was taking these two herbal therapy things called Kava-Kava and St. John's Wort.

10. **Consequences of good and bad performances**:

Skip volunteered two specific situations that illustrated how he was able to perform in the classroom without going into a full-blown Panic Attack. These scenarios were what Skip considered to be close to ideal settings for him if he were to make contributions to the class:

I do really well in just a standard classroom setting when I know I don't have to volunteer unless...I mean, I don't have to go up if it's volunteer. If you want to say something you can raise your hand and say it. Plus I did excellent in my history course. It was standard classroom setting, I know I didn't have to do any oral reports, I know there was no participation grade and I could just participate anytime I wanted to. And it would be a slide show every class. So the lights were turned down so if I did get a little nervous or flushed no one would be able to see cause the lights were out. And I just felt very comfortable in that room. I participated a lot in that class. It was like a thrill for me to be able to participate.

I was really, really proud of my project. I had spent all night working on it. Well, the teacher sat down and it was all quiet as usual because everyone gets all quiet and no one likes to participate. So that's

what makes them make people participate by saying, "OK, we're going to go around the room now and have you all speak." And that's what makes me so nervous. I just wish the class would talk some because then I would be able to talk. I wouldn't feel so bad about raising my hand and participating so long as everyone else would. So it was all quiet as usual and we're just kind of sitting down there twiddling our thumbs and the professor said, "OK. How are we going to talk about these?" It was real quiet. So she was like, "OK. Do we have 2 people to volunteer to tell us about their project and we'll start discussing from that?" And I was thinking about volunteering. I was feeling kinda good because I had taken my Xanax and Inderal. Well, they said that 2 people had to volunteer so one guy went ahead and volunteered right away and talked about his project. And I was thinking the whole time, "My project is much better than that. I should really go up there and do it." So he sat down after he was done talking about it and she was like, "OK, who's next?" And it was quiet for a little while and I was just debating in my head. I was like, "I'm going to do it." So I stood up and picked up my project and you wouldn't even know that I had a problem talking in front of people because I just got right up there and told them everything all about it. They were pretty impressed with it. It became the topic of discussion for the rest of class. And it was a really good experience. 'Cause the psychologist always talks about how you can't keep putting bad experiences under you, you gotta get a whole bunch of good experiences under your belt to move on and get

better. So that was a really good one. That was when I'd felt that I had

almost completely moved out of it. But of course that was voluntary. It

wasn't something that we had to do.

11**. Employment Issues**:

The effects on choice of major and employment issues

When Skip chose his particular major, he was not aware that he would have to

give classroom presentations pertaining to his work and projects. When he realized that

presentations were a big part of the curriculum requirements, he remembered thinking:

I worried about it everyday - every single day. When I got here and

I would skip classes, I would just say to myself, "This major is not for me.

I'm not going to be able to do it. I'm not ever going to be able to present

anything.." Half-way through the semester I was able to get up in front of

people and talk - it was my job talking in front of all of them about my

project. It was such a surprise. I really began liking the work. It just kind

of turned out nicely. But I haven't had to do any oral reports yet, though.

So I don't know how I'm going to hold up on that.

I'd like to start a firm up. So I'm sure I'm going to have to present

these ideas. The thing is by not being able to get up in front of people and

talk without being nervous for so long, and now finally being able to do it.

You know, as long as I have something in my hands. As long as I can say,

"OK, this is the..." and draw the focus of attention to the project and not

my face. That way I don't have to look at them either. I can just look at

the project and say, "OK, this and this and this..." And it's a thrill for me to be able to get up there and do it.

When Skip was asked if there were any jobs that he would definitely not want to have, he responded with, "President of the United States of America. Never would you see me do that. Cause number one, I don't like politics, number two, I don't like speeches, and number three, I don't like being the bad guy."

In reference to a past summer job Skip held, he recalled situations on the job that contributed to his anxiety:

> Well, we do weddings sometimes when we get together. I bus at this restaurant. It pays really nicely. But I didn't have any problems with that. Sometimes I'll have to work at a wedding and we'll get in these little meetings, like before, and I'll get like nervous before that. We'll go around and have to tell everyone like what they're going to do. Like what their job is or whatever. I really don't like doing that. And the work is really hard and they don't pay you good when you work a wedding. So I'm getting out of that.

Barriers in the Academic Setting

- inability to change from one task to another
- lack of organization for notes and other materials
- difficulty scheduling time to complete short and long-term assignments
- poor strategies for monitoring errors in Math
- difficulty with reasoning in Math
- difficulty reading and comprehending word problems in Math
- difficulty with concepts of time and money
- interrupts or intrudes on others
- impatient, low frustration tolerance
- driven (find it hard to relax)
- mental restlessness
- internal sense of anxiety or nervousness
- poor organization, often has piles of stuff
- poor financial management
- difficulty performing tasks sequentially
- difficulty starting projects
- inability to recognize success or failure
- mood swings
- sense of impending doom
- time management problems
- negative self-talk
- self absorption (preoccupation with health and well being)
- concentration problems
- distractibility
- repetitive motion(i.e. tics, rocking, fidgeting)
- problem with turning classroom assignments in on time
- difficulty with attending classes
- difficulty carrying through with routine or uninteresting tasks
- difficulty with sustaining attention
- difficulty with organization
- distractibility
- organizing and budgeting time
- initiation and sustaining consistent effort on a task
- use of the dictionary, thesaurus, and other self-help handbooks

Barriers in the Environmental Setting

Physical settings:
- lighting in classrooms (too bright)
- stark white and cold classrooms
- classrooms that have all the chairs in a circle

Academic settings:
- activities occurring in the classroom such as sitting in a circle and having group discussions
- giving oral presentations
- large classroom with a lectern where one has to give a speech in front of the class
- large classrooms where the professor uses a "pass around" microphone to encourage classroom discussion

Social settings:
- not involved in any student activities or organizations because "I don't have the time."
- unable to attend group therapy sessions at Dr. Clum's Panic Disorder Clinic because he would have to sit in a circle and talk about his problems to others
- may not be able to schedule weekly meetings with his counselor because their schedule was so busy

Cultural settings:
- never attends any cultural events on campus because he has had no interest in what has been available. He is interested in a certain type of music (electronic music) that is "kind of obscure right now."

Organizational settings:
- when having trouble with his computer, he would have preferred that an individual come to his dorm room to troubleshoot rather than trying to do it over the phone

Administrative conditions:
- did not want to attend a residence hall meeting because the Resident Advisor was mad about people "messing around with the hall. It wasn't me but I knew who it was."
- unable to attend residence hall meetings because they always sit in a circle and introduce themselves
- feels there must be an easier way to meet people in your dorm other than having to go to group meetings

Basic resources:
- dorm room - needed to physically manipulate the room to make it into a "cave" (need to be covered or enclosed)
- Owens dinning hall -takes an alternative route to get his food to avoid passing by large numbers of other students

Ecological climate:
- Chose Virginia Tech because he liked what Tech had to offer in his particular major

<u>*Barriers in the Psychosocial Setting*</u>

Occupational problems:
- job dissatisfaction - unhappy with the pay and some problems with anxiety when fellow employees had to discuss job responsibilities in a group setting

Problems related to interaction with the legal system/crime:
- speeding ticket- felt the ticket he was issued was done so unfairly but his parents did not want him to protest the ticket in court

Coping Mechanisms

- told professors the reason he needed to skip class was due to his Panic Disorder
- when student peers would ask him why he was missing class, he would make up some excuse like "stomach problems" or "not feeling well"
- dropped a class because he found out that the class required everyone to give an oral report (this drop made him less than full-time status)
- covers his face with his hands when he talks to try and cover areas that might be turning red or flushed
- dated someone who would comfort him and be there for him so he would have a reason to come home and get away from the stressors at school
- telling himself that as long as a presentation is "voluntary" he can participate but if it is "mandatory" there is no way out and he may have a Panic Attack
- feels he can do a presentation to others if he is holding something in his hands where the object will draw attention to it and not his face
- keeps lowering the dosage of his medication because he does not want to become addicted to it or dependent on it
- generalizes that the whole class does not like giving presentation or talking into a microphone because he does not like to

Avoidance Behaviors

- classes that require oral reports
- skipping classes that have presentations
- rooms with chairs in a circle
- dating

Services and Accommodations Used

- university staff psychiatrist
- asked professors for extra help with assignments or problems with homework
- university counseling center

	Age	# Years with anxiety Symptoms	# Years Diagnosed	Presently on Medication	Comorbid Disorders	Currently in Counseling	Major Barriers
Mary	33	22	11	yes	depression	yes	lack of parking, fluorescent lighting, ¢ the second floor, participating in clas for long distances, living alone, inabili maintaining a job, authoritative prof giving oral presentations, faculty who
Sam	21	5	1	yes	OCD	yes	inability to make friends, classroom s classroom discussions, fluorescent ligl eating out at restaurants, driving, fino major, dating, giving oral presentatio
Michael	30	*10	2	no	OCD depression	no	inability to make friends, finding a jol participating in classroom discussions academic advisors, social gatherings, when he has a Panic Attack, medicati techniques, giving oral presentations
Frances	28	22	<1	yes	OCD depression	yes	participating in classroom discussions finding a job related to her major, da inability to make friends, classroom s presentations, test-taking, maintainin move too far from her parents
Sally	20	3	3	no	none	no	traveling long distances (this has imp fluorescent lighting, large social gathe dependent on a select group of friends medication, faculty who are not suppo
Skip	19	4	<1	yes	depression	yes	giving oral presentations, participatin dating, faculty who are not supportive arranged in a circle), fluorescent ligh dating

Table 1

* Denotes approximate age of onset for anxiety symptoms. Subject was only able to recall that the onset was in early childhood

CHAPTER 5

DISCUSSION, CONCLUSIONS, AND RECOMMENDATIONS

Discussion

The purpose of this study was to ascertain the unique college experiences of six Virginia Tech students diagnosed with Panic Disorder with Agoraphobia, to determine what their particular academic, environmental, and psychosocial needs were, and what disability related barriers, if any, they encountered during their college careers. This study investigated (1) the academic, psychosocial, and environmental needs of each student, (2) the disability related barriers the student may have experienced in each of the three preceding categories, (3) the coping mechanisms used by the student, and (4) what services and accommodations the student found to be the most effective. These areas of investigation were addressed through the following research questions:

Conclusions

1. *What do students diagnosed with Panic Disorder with Agoraphobia perceive to be the environmental needs and barriers in the college setting?*

The environmental needs and barriers, as defined in this section, were derived from a compilation of the researcher coding relevant environmental themes taken from the students' personal interviews and from the intake survey. The environmental categories that were considered for this study were taken from Conyne's eight (1983) descriptors (see APPENDIX D) which include: physical settings, academic settings, social settings,

cultural settings, organization settings, administrative conditions, basic resources, and ecological climate.

a. *What are the environmental needs?*

Each subject was given a copy of Conyne's (1983) environmental descriptors and the researcher asked the subject to comment on the relevance or impact each category had on the subject's experience with Panic Disorder with Agoraphobia. Reviewing Conyne's (1983) environmental descriptors with the subjects revealed certain relevant themes pertaining to the subjects' environmental needs.

Physical settings

Under *physical settings*, topics relating to lighting and classroom/campus design appeared to be two dominant themes that emerged.

Lighting: Surprisingly, four out of the six students interviewed mentioned the need for a different type of lighting in the classroom setting. Fluorescent lights were noted to be too bright and harsh. The students mentioned that dimmer lights were preferred because the intensity of the fluorescent lights tended to serve as a stimulus for invoking panic-like symptoms. The students revealed that the fluorescent lights brought attention to their presence in the classroom and hence, the more intense the lighting, the more likely that other classmates would notice that they were displaying physical symptoms of panic and anxiety. The subjects speculated that dimmer lighting would make them less conspicuous in the classroom and they would therefore be more likely to volunteer and give oral presentations or participate in classroom discussions.

Classroom and campus design: Classroom and campus design involved several aspects that were expressed as an environmental need: preferential seating, orientation to the campus, and size of the classroom.

Preferential seating - Three of the six subjects stated that they needed to sit near a doorway (exit) in the classroom in order to make a quick exit in the event they start to have a Panic Attack, experience nausea, or have some other physical distress. Two of the subjects preferred to sit in the back of the classroom because they could not be seen as readily by their classmates and because the teacher would be less likely to call on them in the back of the room. Three of the subjects stated that they preferred to sit in the front of the room. Two of these subjects commented that if they sat in the front of the classroom, then they would not be able to see others in the classroom looking at them if they spoke up in class. Having to see the body language and facial expressions of their classmates when they spoke in class made them anxious. Fear of embarrassment and of what other people will think should they be seen by others during a Panic Attack is well documented in the research (Bourne, 1990 & American Psychiatric Association, 1994). Only one subject did not feel the need to sit near a doorway or avoid being seen by his peers. He (Michael, the international student) simply stated that he preferred to sit near the front of the classroom so that he could learn better. Additionally, one unique scenario involved one of the subjects reporting that sitting in a classroom that had the seats arranged in a circle where the students were facing each other, was extremely anxiety producing for him.

Orientation to the campus - One of the students mentioned that going into a new classroom or building was very anxiety producing for her. She stated that if she were able to take a tour or visit the sites before she actually had to attend classes or some other

activity planned in those areas, then she would feel less anxious. One of the other students made a similar reference about knowing the layout of a building in advance so that she would be able to plan her escape route or find a nearby restroom. Three students mentioned that they usually retreated to a nearby restroom when they started to experience high anxiety or a Panic Attack. Hence, knowing the location of the closest restroom was important.

Size of the classroom - The majority of the subjects indicated that large classroom settings, meaning classrooms with large numbers of students in them, did not appear to be a factor that affected their Panic Disorder unless they were required to give oral presentations or expected to participate in classroom discussions. Only one subject indicated that large classrooms (heavily student populated) were anxiety producing for her. One subject commented on the need for larger classroom (physical) size because small classrooms with desks in close proximity to each other made her feel as if she were "suffocating" and that the other students were infringing on her "physical space." It was interesting to note, however, that four of the six subjects expressed that they encountered anxiety and even Panic Attacks at events such as concerts, meetings, or other events held in large auditoriums.

Academic settings

Environmental issues mentioned under the heading of *academic settings* mainly centered around the student's need for some element of control over activities which occur in the classroom. The emerging themes that evolved were a need for structure in the manner in which the class was conducted, understanding and empathetic professors, and alternatives to classroom presentations.

Structure: Several students made reference to the need for a structured setting within the classroom. Professors that lacked structure in their teaching style and were unpredictable (i.e. picking out students at random in the classroom to answer questions or asking them to engage in a discussion in front of the whole class) were considered to be classes that were threatening and anxiety producing. The subjects indicated that the need to know or anticipate what was going to happen in class on a daily basis was consequential to controlling their anxiety, as well as whether or not they attended classes on certain days.

Understanding and empathetic professors: Out of the six subjects interviewed, four of the subjects decided to disclose to their faculty members that they were having difficulty with either Panic Disorder or with anxiety. All four of the subjects reported that their faculty members were understanding and were willing to work with them regarding class attendance, turning in projects at a later date, or taking their exams at a different time or in a quiet area. Only one of the subjects reported feeling some resistance from an instructor to accommodate them in reference to a problem with attendance. Two of the subjects reported that they have never disclosed to their professors that they have Panic Disorder for fear that their professors would not be understanding or would be judgmental. Having professors that were understanding and empathetic tended to be a factor in the subject's decision to attend those classes on a regular basis. The subjects also felt they were able to approach those same faculty members for extra help on assignments and projects or to successfully self-advocate for accommodations such as testing in a quiet separate room.

Alternatives to classroom presentations: Five of the six subjects reported extreme levels of anxiety or the onset of Panic Attacks when placed in situations that required oral presentations in front of the class, having to go to the blackboard to perform a task, or

participation in classroom discussions (especially when "put on the spot" by the professor). None of the subjects were offered alternative solutions for their dilemmas. One of the subjects indicated he was very surprised that his professors would put him in that type of a situation after he had explained in detail to them the agony he suffered during oral presentations. Two of the subjects stated that one of the determining factors for deciding to come to Virginia Tech was the fact that they were not required to go through a panel interviewing process for acceptance into the graduate school such as most other universities require. The research of Barlow and Craske (1989) lends credence to the anxiety that students with Panic Disorder experience in classroom settings. They state that it is the feeling that events could proceed uncontrollably or that one may not have control over their reactions. It is a feeling of helplessness in the face of uncertainty. The behavior involves disruption of performance, such as when anxiety reaches a level that interferes with the ability to do a good job, to concentrate, or to give a speech.

Social settings

The environmental needs under *social settings* included themes relating to the need for forming friendships and the need for involvement in student life such as organizations and activities.

<u>Forming friendships:</u> Five out of the six subjects reported that they had difficulty finding people they felt were compatible with them. Several of the subjects reported that they felt lonely and "different" from most of their peers. Finding and forming friendships were seen as difficult feats for these five subjects. The one subject who did not report any difficulty with forming friendships reported that her friendships were based upon finding individuals whom she could depend on and feel safe with.

Involvement in student life: All of the subjects interviewed stated that they had not been

actively involved in any student organizations or clubs but they would like to consider

doing this in the future. All of the subjects also commented that they tended to steer away

from residence hall meetings or other events that involved group activities.

Cultural settings

      All of the subjects interviewed indicated that while they enjoyed cultural awareness

activities such as concerts and poetry readings, they did not attend these events on

campus. The majority of the students reported that their anxiety and fear of having a

Panic Attack prevented them from attending events in large conference rooms or

auditoriums. The majority of subjects also reported that avoiding activities or situations

that have induced feelings of anxiety or panic in the past was a way of safeguarding

themselves against unnecessary panic in the future. All of the subjects indicated that they

would like to attend cultural activities but felt the need to deal more adequately with their

Panic Disorder first before venturing out publicly.

Organizational settings

      Only one out the six subjects interviewed was aware that they were entitled to

formal academic accommodations through the Dean of Students office. The one student

who was aware of the services the Dean of Students office could provide was discouraged

from coming to the Dean's office by her therapist for fear that she would be retaliated

against by her professors. The majority of the subjects did, however, express a need for

certain accommodations in the classroom. The need for the subjects to be referred to the

appropriate office on campus that could authorize these accommodations was lacking.

Administrative conditions

The need for appropriate counseling (counselors trained in the area of Anxiety Disorder interventions) and medically related referrals was a concern for the subjects. One of the subjects was unable to see the relationship between ongoing counseling, relaxation techniques, and the use of medication in controlling his Panic Disorder and OCD. When the student encountered panic-like symptoms from practicing the breathing techniques he was taught and had side-effects from his medication, he decided that the two methods of intervention were not working and he terminated both treatments. Several of the subjects have comorbid disorders (i.e. depression, OCD) which may require extremely close monitoring of medications and intensive therapy. Since all of the subjects interviewed were still experiencing Panic Attacks and/or elevated levels of anxiety, it is important that students feel vested in their therapy in order to keep them motivated and willing to practice new coping strategies or continue with their medication regimens.

Basic resources

Several needs under *basic resources* were mentioned by different subjects. One was the need for parking facilities near the classroom so that, in the event the subject suffered a Panic Attack, they could quickly "escape" from campus and leave to go a "safe" place. The need for dining facilities that were not conducive to large crowds and featured dimmer lighting (unlike the bright fluorescent lighting in Owens Dining hall) was mentioned by three of the subjects, as well as the need for alternative transportation to campus since riding the campus transit system was anxiety producing for one of the subjects.

b. What barriers did the student encounter at school?

Some of the environmental barriers that the subjects encountered on campus included the following: avoidance of any activities or student transactions where there were long lines the student had to stand in; inability to attend concerts or activities held in large rooms or auditoriums; lack of pertinent information regarding campus life and activities from not attending residence hall meetings; fear of elevators; avoidance of classes that are held in big lecture halls; lack of cultural and ethnic support groups; and lack of academic support from faculty and advisors.

c. What barriers did the student encounter off campus?

Many of the environmental barriers that the student encountered on campus were experienced to a lesser degree off campus because of avoidance behaviors. The majority of the subjects interviewed indicated that they did not engage in any activities outside of school and avoided most situations that involved social interaction. Specifically, several students remarked that they were unable to eat in certain restaurants because of the physical layout of the building. Stores like Wal Mart, shopping malls, and grocery stores were also mentioned as areas that the subjects tended to avoid due to the fact that these places generally evoked anxiety.

d. What factors exacerbated each student's condition?

The subjects reported the following factors to be conditions that exacerbated their Panic Disorder: rooms that had extremely bright lights (especially fluorescent lighting), crowded rooms, crowded auditoriums, classrooms that had the chairs arranged in a circle where the students would have to face each other, classrooms that did not have available seating near an exit, having to stand in line to acquire tickets for events or to perform a transaction, being asked to go to the board by their teacher, being asked to respond to a

question in class by their teacher, being asked to disclose personal information about themselves to other students in the classroom, professors who were authoritative, professors who lacked structure in the classroom, and professors who required oral presentations as a part of their course requirements.

e. What coping mechanisms did the student employ?

The following is a list of coping mechanisms employed by the subjects interviewed: avoiding classes that require speeches, avoiding social events and student activities, taking classes via the internet to avoid going back into the classroom, telling professors and peers the reason they were not in class was due to some physical ailment rather than to their Panic Disorder, engaging in ritualistic behavior, and staying in relationships to feel safe and for dependency reasons.

2. *What do students diagnosed with Panic Disorder with Agoraphobia perceive to be the academic needs and barriers in the college setting?*

a. What are the academic needs?

For the most part, the academic needs of the subjects interviewed are mirrored in the academic barriers that they encountered. The majority of the subjects indicated a need for preferential seating in the classroom, the need for a faculty advocate, permission to take a reduced course load if needed, permission to leave the class if they start to have anxiety or some physical distress, and the need not to be put "on the spot" by their professors. Other academic needs include: tutoring, being allowed to miss class occasionally or be late to class during times of high anxiety episodes, better notes, being

allowed to take their tests in a quiet separate room, better time management skills, large blocks of time to study, and caring and understanding professors.

b. What barriers did the student encounter at school?

The individual subject's responses to academic barriers and/or difficulties that each subject experienced are listed under each subject's Profile Summary under the heading "environmental, academic, and psychosocial barriers" in Chapter Four. These responses were taken from two checklists (see APPENDICES B & D) administered to each subject. The subjects were asked to put a checkmark by any items that they felt "described them" or was a "problem area" for them. The frequency of the individual responses is discussed here to indicate what academic areas tend to be most prevalent among students with Panic Disorder with Agoraphobia. A response frequency chart is listed on page 200 (see Table 2). Only items that were checked by two or more of the subjects are included in the frequency charts. The academic and psychosocial barriers are reported together here because the researcher felt that difficulties or barriers in the psychosocial areas also directly affect academic performance.

The frequency chart listed in Table 2 (see page 200) indicated that only two subjects believed that they experienced difficulties in the areas of S*tudy Skills (*inability to change from one task to another and lack of organization for notes), R*eading* (difficulty reading new words or inability to "sound out" (phonetically) the word and difficulty understanding the wording on objective tests*)*, O*ral Language* (poor vocabulary, difficulty with word retrieval), and M*athematics* (difficulty reading and comprehending word problems and difficulty with reasoning). Half of the subjects, however, reported that they

experienced difficulty scheduling time to complete short and long term assignments under the heading of S*tudy Skills*.

The frequency chart listed in Table 3 (see page 201) lists difficulties or barriers that affect both the academic and psychosocial realms of the student. Only the academic ramifications will be discussed here.

In Table 3, only two subjects listed difficulties with the following areas: *Impulse control* (interrupts or intrudes on others); *Restlessness and Fine Motor* (driven - find it hard to relax); *Social Interactions* (avoids group activities and difficulty with authority); *Organization* (poor organization - often has piles of stuff and poor financial management); and *Self-Motivation and Assessment* (difficulty starting projects). Half of the subjects reported the following difficulties: *Self-Motivation and Assessment* (chronic sense of underachievement and inability to recognize success or failure); and *Frustration and Negative Feelings* (chronic problems with self-esteem, sense of impending doom, negativity, and constant unexplained anxiety).

Several of the subjects indicated that they felt they were capable of doing much better academically but their anxiety problems prevented them from performing at their best. Ironically, all of the graduate students had stellar academic records and the undergraduate students all had above a 3.0 grade point average. Several of the subjects also made generalized negative statements about certain classes, assignments, or professors. When the subjects did not like a certain professor, assignment, or class, then some commented that "no one else in class" liked the professor, class, or assignment. The majority of the subjects also made comments throughout the interviews that indicated that they felt they had done poorly on most of their presentations or that other classmates

probably viewed them as "weird" or "stupid." Four subjects reported that they experienced difficulties in the following areas: Impulse Control (impatient - low frustration tolerance); Restlessness and Fine Motor (mental restlessness and internal sense of anxiety or nervousness); Frustration and Negative Feelings (mood swings). These factors can be hampering for the individual, especially during classroom lectures and examinations where concentration is needed. Problems with mood swings and anxiety can also inhibit how students interact with faculty, other students, and may determine whether or not the student feels capable of attending classes.

LEARNING DIFFICULTIES IN THE CLASSROOM	
ACADEMICS	**Number of Students**
Study Skills	
Inability to change from one task to another	2
Lack of organization for notes and other materials	2
Difficulty scheduling time to complete short and long term assignments	3
Reading	
Difficulty reading new words or inability to "sound out" (phonetically) the word	2
Difficulty understanding the wording on objective tests	2
Oral Language	
Poor vocabulary, difficulty with word retrieval	2
Mathematics	
Difficulty reading and comprehending word problems	2
Difficulty with reasoning	2

Table 2

ACADEMIC AND PSYCHOSOCIAL FACTORS	
PROBLEMS WITH CONCENTRATION AND ATTENTION	**Number of Students**
Impulse Control	
Interrupts or intrudes on others	2
Impatient, low frustration tolerance	4
Restlessness and Fine Motor	
Driven (find it hard to relax)	2
Mental restlessness	4
Internal sense of anxiety or nervousness	4
Social Interactions	
Avoids group activities	2
Difficulty with authority	2
Organization	
Poor organization, often has piles of stuff	2
Poor financial management	2
Self-Motivation and Assessment	
Difficulty starting projects	2
Chronic sense of underachievement	3
Inability to recognize success or failure	3
Frustration and Negative Feelings	
Mood swings	4
Chronic problems with self-esteem	3
Sense of impending doom	3
Negativity	3
Constant unexplained anxiety	3

Table 3

c. What effect has the disability had on the student's choice of major and future career goals?

Four out of the six subjects interviewed stated that they felt that their Panic Disorder with Agoraphobia played a role in their choice of major. Two of these subjects were male and two were females. One of the males stated that he was not aware that he would have to give presentations or oral reports in his major and he had thought about changing his major because of these requirements. The other male subject stated that he had thought about teaching after graduation, but because of his "shyness" and problems with OCD and Panic Disorder, he feels this will not be a reality. He is currently taking classes via the internet because he has not been able to return to the classroom since he experienced his first full-blown Panic Attack. He stated that this is also a factor that will probably exclude him from attending graduate school.

Three out of the six subjects (all females) chose a major where they felt that their Panic Disorder experiences will be of some benefit to them; they will probably seek careers in fields that deal with counseling situations or working with the general public. Two of these females stated that they were somewhat apprehensive about working with groups of people and having to give presentations. Both stated that they will probably work with young children. Additionally, one of these females stated that she did not want to move too far from this geographic area after graduation when looking for a job (indicating she wanted to stay close to her family) and the other female stated that she might not be able to accept a job offer that required extensive travel due to her Agoraphobia.   One female stated that whatever job she accepts, it must be a position that

keeps her mentally busy so that she will not have too much idle time on her hands to think about her problems with Panic Disorder.

Of the six subjects interviewed, the three females appear to have a more extensive work history than the males. Two of the females reported having numerous jobs where they were unable to stay in the job due to their Panic Disorder with Agoraphobia. The third female, who had less job experience, was younger than the other two females, which may account for less job experience. The third female reported that she too experienced difficulty with her Panic Disorder with Agoraphobia while on the job, causing her to have to leave the job site and go to her parents' home where she felt safe. The only position she previously held where she did not experience any problems with her Panic Disorder was in a job that she described as having a "homey environment" that did not feel "unsafe." A review of the literature indicates that individuals with Panic Disorder may significantly change their behavior, such as quitting their job, denying the fear of having another attack, or denying concerns about the consequences of their Panic Attacks (American Psychiatric Association, 1994).

The three male subjects interviewed appeared to be more unrealistic in their views on future employment than the females did. For example, Michael stated that he wanted to be a university professor, yet he admitted to a fear of talking in front of students to the extent that he has not been able to substitute teach in his Teaching Assistant position. Sam stated that he thought about being a teacher but because he is shy and has problems with OCD, and Panic Attacks, he feels that this will not be an option for him. He stated that he avoids thinking about getting a job related to his major. Sam will graduate in one semester, yet he has not met with the Career Services office, nor has he thought about

writing a resume. He will, instead, continue to play with his band and hope that they will

be able to record some of their music. Skip stated that he is extremely anxious about

giving presentations and being in situations where people have to sit in a circle and each

person tell something about themselves or what they are working on. However, Skip

indicated that after graduation he would like to open up his own firm which will invariably

put him in a position for giving speeches, doing presentations, and sitting in meetings

where he will have to share information with his staff.

d. What factors exacerbated each student's condition?

Factors that appeared to exacerbate the students' academic performance as

indicated in their interviews with the researcher are as follows: lack of understanding

professors regarding the student's occasional absences from class and hesitancy to

participate in classroom discussions and presentations, being asked to go to the

blackboard, being asked to divulge personal information about themselves to other

classmates, taking tests in crowded rooms, lack of structure in the professor's class

presentation, fear of being called on in class or being put "on the spot", attending classes

in which the student feels inadequate in the material being covered, oral presentations, lack

of time to complete homework and projects, and having to ask for formal

accommodations because the student did not want to feel "helpless" or they did not want

the faculty member to think they were asking for "special privileges" or were trying to

make a "big deal" out of their academic accommodations.

e. What coping mechanisms did the student employ?

During the height of their problems with Panic Disorder with Agoraphobia, all of

the subjects skipped classes. One student withdrew from Virginia Tech and went back

home to live with her parents and attended a local college. One student attended a

community college first before coming to Virginia Tech because of his problems with

Panic Disorder. One student took almost eight years to finish her undergraduate degree

due to having to start and drop out of college. One of the students has not gone back into

the classroom since having a full-blown Panic Attack and is now taking classes via the

internet.

The majority of the students admitted to lying to their professors about the reason

for having to leave during classes or for being absent from class. Most of the time, the

students told the professor that they had some type of physical ailment such as dizziness,

headache, or abdominal distress. Five out the six subjects did think that it would probably

be to their benefit to just tell their professors that they had Panic Disorder with

Agoraphobia rather than making up excuses.

3. ***What do students diagnosed with Panic Disorder with Agoraphobia perceive to be***
the psychosocial needs and barriers in the college setting?

a. What are the psychosocial needs?

The psychosocial needs, like the academic needs, are mirrored in the barriers that

the subjects encountered. While all of the subjects expressed the need to make friends and

be able to go out socially, they all encountered extreme difficulty in forming relationships

with other students and maintaining intimate relationships with the opposite sex. The

inability to form and maintain lasting relationships with others may be due in part to the

subjects dealing with the following self-descriptors: fear of rejection, dependency issues,

need for perfection, lack of self-confidence, fear of being judged by others, the belief that others do not care, the belief that others will "look down on" or will not "be nice" to them if they should have a Panic Attack in front of them, the fear that others will not want to date them if they knew they had Panic Disorder, and low self-esteem. The research of Weiner and Wiener (1996) and Kleiner and Marshall (1987) indicated that students with psychiatric disabilities have difficulties with low self-esteem, problems with trust (developing close friendships), are reluctant to disclose their disability for fear of being stigmatized, and are dependent, socially anxious, and unassertive individuals.

The majority of the subjects indicated that they need to be in environments and relationships where they felt "safe." All of the subjects implied that they would like to make friends and be able to socialize. Half of the subjects indicated that they need to be in the company of others when they start to have a Panic Attack. Two of the subjects stated that they would rather be alone when having a Panic Attack and the sixth subject was indifferent. The researcher noted extreme risk-taking behavior on the part of three of the subjects during periods of high anxiety and/or during the middle of a Panic Attack. Two of the subjects would go out in public seeking out complete strangers for companionship in the event something terrible should happen to them when they were experiencing a Panic Attack. The third subject stated that she engaged in substance abuse as a means of coping with a bad marriage and her anxiety. She also left her husband to live on campus after several years of marriage and quit her job because she was unable to cope with the stress.

b. What barriers did the student encounter at school?

The most common themes that appeared throughout the interviews with each subject under the heading of psychosocial barriers were: *problems with primary support group, problems related to the social environment, education problems, and occupational problems*. Table 4 (see page 208) is a compilation of the responses that the subjects checked as problem areas in the psychosocial area. Only the items that were checked by two or more of the subjects are included in this frequency chart since the individual responses are listed in Chapter Four. The researcher believes that this chart does not reflect a true picture of the psychosocial barriers that the subjects have encountered. The researcher believes that the subjects tended to minimize their problem areas on this particular checklist in light of the contrary evidence revealed through each subject's testimony. For example, all the subjects have at some point and still do engage in avoidance behavior, they each expressed difficulty interacting with others, and all were still experiencing anxiety and feelings of fear at the time of the interview. The researcher also noted that the majority of the subjects recanted by making positive statements about how they had improved or were no longer having problems with their Panic Disorder with Agoraphobia, only to contradict these statements when elaborating on recent incidents that had occurred in the classroom or in their social lives.

ACADEMIC AND PSYCHOSOCIAL FACTORS	
PSYCHOLOGICAL ISSUES	**Number of Students**
Cognitive	
Time management problems	2
Negative self-talk (fears, failure, panic)	4
Self-absorption (preoccupation with your health and well being)	3
Concentration problems	3
Distractibility	4
Behavior and Physical	
Repetitive motion (i.e. tics, rocking, fidgeting)	2
Pacing	2
Avoidance behavior	3
Difficulty with attending classes	2
Psychosocial	
Difficulty interacting with others	2
Feelings of fear or anxiety	4
Difficulty initiating interpersonal contact	2

Table 4

<u>Problems with primary support group:</u>

Parents - While all six of the subjects in this study have disclosed to their parents that they have Panic Disorder with Agoraphobia, they admitted to being hesitant about disclosing all of the details of their problems with the disorder. At least three of the subjects were hesitant to tell their parents that they were having Panic Attacks and it was not until after they sought counseling that they decided to tell their parents that they had Panic Disorder. Two of the students remarked to the researcher that they had tried to tell their parents on numerous occasions about the Panic Attacks but their parents would always dismiss their problems by stating that everyone gets nervous or anxious. The only subject that disclosed information about the Panic Attacks to her parents from the onset admitted that she was now reluctant to tell her parents that she is still experiencing problems and will have to go back on the medication and seek counseling for a second time. She felt that admitting that she was still having problems with Panic Disorder would make her look like a "failure" in her parents' eyes.

<u>Problems related to the social environment</u>:

Dating - All of the subjects interviewed appeared to have recurrent problems with forming intimate lasting relationships. Of the male subjects interviewed, two of the subjects, ages 30 and 21, have never dated. These two subjects also have Obsessive-Compulsive Disorder which they feel is a factor that contributes to their problems with meeting and dating members of the opposite sex. Both subjects stated that they would like to date members of the opposite sex but felt this would only be possible after additional counseling and better management of their Panic Disorder and OCD. The third male, age 19, indicated that the longest relationship that he had ever been involved in was

for one semester. He met a junior in high school two weeks before he went away to college and went home on weekends to be with her because it was a way for him to escape the stress and anxiety he was feeling at college. He admitted that the relationship was based purely upon his need to feel safe and less anxious. He remarked that he does go out socially with his friends to clubs or bars to meet females, but he suffers high levels of anxiety and feels he must drink enough beer to get intoxicated in order to socialize.

Dating for the three female subjects in this study has also been problematic. The words "safe" and "dependent" were key words used by the subjects to describe their dating experiences. One subject, age 28, married at the age of seventeen and was divorced after several years. She reported that her ex-husband regularly committed adultery and was physically abusive toward her during their marriage. She decided to live on Virginia Tech's campus her junior and senior years of college while her husband stayed at their home. After her divorce, she stated that she "hated" dating and socializing. The only time she would go out to socialize was if she had been drinking heavily and/or smoking marijuana. She is currently dating someone who she feels is very "accommodating" and "sympathetic" about her problems with Panic Disorder with Agoraphobia. The second female, age 33, stated that she has been in several different dating relationships. She is currently living with a male whom she referred to as her "ex-boyfriend". They have lived together for four years but they have not been intimate for the last two years of the relationship. She stated that she does not know whether or not she loves him or if she is simply staying with him because she is so dependent on him and afraid to live alone. The third female, age 20, had only been involved in one "serious" relationship which only lasted about three months. She stated that this particular male was

a "close friend" and someone she felt "safe" with. She could "depend on" him, especially when she was having problems with her Panic Disorder. She also made reference to the fact that she was "afraid to be alone."

Friends - All of the subjects interviewed indicated that they had difficulty initiating conversations with others and making friends. Only one of the subjects appeared to have a group of close friends with whom she surrounded herself. These friends were people with whom she associated because she could "depend" on them. The majority of the other subjects reported that they did not go out socially on a regular basis and they had difficulty making friends because they felt "different" from other people, or they did not "click well with people," or they could not find "anybody like me." Research conducted on students with disabilities indicates that these students often experience isolation and a lack of self-confidence (Serebrini, et. al., 1993).

Educational problems:

The majority of the subjects in this study reported difficulty working with professors who they felt were not accommodating or understanding of their problems. The fact that these subjects have not been able to comfortably interact with other classmates has made it more difficult for them to feel comfortable during classroom presentations and working on group projects.

Occupational problems:

All six subjects made some reference to job dissatisfaction and stressful work schedules which tended to exacerbate their Panic Disorder. Several subjects expressed uncertainty about their ability to go out and seek jobs in their choice of major. The

application and interviewing process for obtaining a job was also seen as a possible stressful event for them.

c. What barriers did the student encounter off campus?

The majority of the subjects indicated that the barriers they faced in the non-academic setting usually revolved around not being able to attend functions or socialize with others off campus.

d. What factors exacerbated each student's condition?

The factors that tended to serve as catalysts for exacerbating the students' problems with Panic Disorder with Agoraphobia in the psychosocial setting included: going to social events such as concerts or events with large crowds of people, having other students inquire about their absence from classes, stressful job settings, dating, interacting with others (strangers), and fear of being judged or viewed as "strange" or "weird" by others.

e. What coping mechanisms did the student employ?

The students employed the following coping mechanisms: isolating themselves from others, talking to a friend or stranger about the anxiety they are experiencing during a Panic Attack, engaging in some form of substance abuse in order to feel less anxious when meeting people socially, avoiding ending bad relationships in order to feel safe, avoiding dating, not confiding in others that they have Panic Disorder with Agoraphobia for fear of being viewed as weak or a failure, and engaging in negative self-talk which leads them to believe that others are not caring and judgmental of them. The research conducted by Borden, Clum, Broyles, and Watkins (1988) revealed that students diagnosed with Panic Disorder used the following coping strategies: telling one's self that

the attack/anxiety would pass, talking to a friend or family member, reasoning out what is wrong, and mentally distracting one's self. Two of the subjects in this study indicated that they confided in complete strangers when they were not able to locate a friend or acquaintance.

4. *What kinds of treatment did the student have before coming to college?*

Four subjects had a history of Panic Attacks before starting college. Of this group, three of the subjects are females. Of these three females, two reported Panic Attacks at a very early age. One of the females reported problems with OCD at the age of six and the onset of Panic Attacks starting in the 9th grade in high school. She was not formally diagnosed with Panic Disorder with Agoraphobia until the Fall 1998 semester. The other female reported experiencing her first Panic Attack at age eleven with the next one occurring at age seventeen. She was not diagnosed with Panic Disorder with Agoraphobia until approximately one year after she started suffering from Agoraphobia. The third female did not start experiencing Panic Attacks until the latter part of her senior year in high school. After coming to Virginia Tech, she began to have Panic Attacks on a daily basis and was diagnosed as having Panic Disorder with Agoraphobia her first semester while at Virginia Tech. The male subject reported experiencing Panic Attacks while he was a junior in high school. He did not receive a diagnosis of Panic Disorder with Agoraphobia until approximately one month after he arrived at Virginia Tech (his first year was spent at a community college). Of these four subjects, only one of them received any type of treatment before coming to Virginia Tech. This subject, however,

was being treated with Ativan because of a presumed inner ear problem due to dizzy spells she reported having. It was not until she was in her second year of college that she received medical treatment for Panic Disorder.

5. *What types of services, related to the disorder, (i.e. counseling, support groups, health services, etc.), or accommodations did the student utilize during college?*

None of the subjects in this study received any formal accommodations from the Dean of Students office. Only one subject was aware that she was entitled to certain academic accommodations, but she chose not to take advantage of any services due to fear of retaliation by her faculty members. Two of the subjects (one male and one female) have not disclosed to their faculty members that they have Panic Disorder with Agoraphobia. Of the four subjects that have disclosed that they have a disability to their professors, they have been able to negotiate the following accommodations: extra time on tests, taking their tests in a quiet separate room, being late to class, occasional absences from class, and extra time to turn in some assignments or projects. Not every subject has asked for each of the aforementioned accommodations and not every subject has been able to successfully negotiate all the accommodations they have asked for.

Three of the subjects are currently in therapy at a clinic that specifically works with individuals with Anxiety Disorders. All three are currently taking medication to control their Panic Attacks. Each reports that the medication and the therapy are beneficial. All three, however, are still experiencing Panic Attacks and constant anxiety. The other three subjects have at some point been on medication and received counseling through the

university counseling services. Two of these subjects (male and female) have stopped

their medication and quit counseling. One of the subjects reported that the medication

caused too many side effects and the counseling techniques (deep breathing exercises) that

he was taught only exacerbated his Panic Disorder. The other subject reported that she

had decided one week before her meeting with the researcher to resume her medication

and to go back into counseling. The third subject is taking medication only during the

week (Inderal and Xanax) and is seeing a counselor every one to two weeks. He reported

not having seen a counselor for several weeks prior to his interview.

6. *Which services and/or accommodations were found to be the most effective?*

The services that were seen to be the most effective from the student's perspective

are the use of medication therapy and counseling. The accommodations that the students

have found effective in the classroom appear to be extra time on tests because of problems

with anxiety, distractibility, and inability to concentrate. Taking the test in a separate quiet

room was also viewed as beneficial so that the subject was free from other extraneous

variables in a crowded classroom that might serve as distracters. Being allowed to leave

the classroom if the subject felt nauseous or anxious was helpful as was being allowed to

be late for class or have occasional misses from class. Subjects that had empathetic and

caring professors felt less threatened or anxious in those classes.

Health Services was also mentioned as a resource as four of the subjects have

made frequent visits due to various illnesses and in particular, abdominal distress. Three

of the six subjects reported that they were preoccupied with self-absorption (preoccupation with health and well-being).

7. W*hat services did the student need but not find available, if any?*

None of the six subjects interviewed reported any problems with a lack of services with the exception of not being able to schedule weekly meetings with the university counseling center due to the heavy caseload of the staff psychologists. Sometimes students would have to schedule meetings every two weeks or longer. The service which appeared to be lacking was counseling services geared toward addressing Panic Disorder before the student arrived at Virginia Tech. Overall, the subjects have been pleased with the services at Virginia Tech and a nearby Panic Disorder clinic. Only one subject is currently not in counseling or taking medication to control his Panic Disorder.

Adequate and timely accommodations, however, may not have been delivered to all subjects due to the fact that five out of the six subjects were not aware that they could receive formal accommodations had they self-disclosed their disability to the Dean of Students office on campus. While some students met with resistance to faculty's prerogative in handling individual requests for accommodations, the subject may have benefited by suggestions or advice that a disability specialist could have provided to them.

8. What were the common experiences of the subjects in this study?

After analyzing the checklists, profiles, and interview transcripts of each subject, the researcher believes that the following is a list of the experiences that were common across all subjects in this study:

(1) All subjects experienced difficulties in the classroom due to their Panic Disorder with Agoraphobia. While the difficulties rarely resulted in poor grades, they were more likely to manifest themselves as self-inflicted dilemmas (i.e. chronic anticipatory anxiety about future classroom presentations or speeches, fear of criticism from faculty and peers when participating in classroom discussions, and a fear that others will notice that they were having anxiety or acting "strange" or "weird" during a Panic Attack). All students interviewed in this study missed classes over a prolonged amount of time due to their Panic Disorder with Agoraphobia. While all of the subjects later returned to classes, one of the subjects opted to take classes via the internet. Persistence in degree completion appears to be a virtue of all of these subjects.

(2) All of the subjects had concerns with the physical setting of the campus. The majority of subjects reported issues with preferential seating (i.e. sitting near the front of the room, sitting near the back of the room, sitting near an exit). Other commonalties involved avoidance of large classrooms, auditoriums, or places on campus that held events where there were large gatherings of people. A surprising phenomena that the majority of subjects appeared to share was their reaction to fluorescent or bright lighting in the classroom. The brighter the lights, the more likely they were to have anxiety or a Panic Attack.

(3) A lack of social contacts both in and out of the classroom was a common experience for all of the subjects.

(4) All subjects had tried medication to control their Panic Disorder and all subjects had reported feeling "better" while taking the medication. Only two of the subjects stopped taking their medication completely. These subjects have since resumed a medication regimen. Only one of the subjects reported adverse side effects from the medication. The majority of the subjects reported that they do not want to remain on the medication for a long period of time because they are afraid of medication addiction and/or they do not want to use the medication as a "crutch."

(5) All of the subjects sought out counseling while attending Virginia Tech. All of the subjects, with the exception of one, did not seek any treatment for their anxiety or Panic Attacks until after they arrived at Virginia Tech. The one subject who was the exception, had sought out help at another institution prior to coming to Virginia Tech.

(6) All of the subjects, with the exception of one (who sought help after about 5 or 6 months), suffered with either chronic anxiety, or Panic Attacks for over one year before seeking any medical relief or counseling.

(7) All of the subjects reported that counseling was helpful and for the most part, they all tried to use relaxation techniques when experiencing a Panic Attack or during high levels of anxiety. Two of the subjects reported experiencing more anxiety when practicing the deep breathing techniques.

(8) All of the subjects are still having difficulty with chronic anticipatory anxiety and occasional Panic Attacks. Of the three subjects with clinically diagnosed OCD, two are still engaging in ritualistic behaviors and obsessional thinking.

(9) While the majority of the subjects interviewed were optimistic about their career options, it was evident that all of the subjects have encountered significant anxiety-related

barriers that have impacted their choice of major and possible future jobs. The majority

of the subjects reported that it was important to have a job where the workload was not

too stressful and the workplace was viewed as a "safe" environment. Four of the subjects

agreed that their Panic Disorder with Agoraphobia definitely had an impact on their choice

of major. The two subjects who did not think that their Panic Disorder had an impact on

their choice of major admitted that they both had originally planned to go into the teaching

profession; however, their Panic Disorder with Agoraphobia has ruled out the possibility

of them choosing this career path. Therefore, all students in this study reported career

complications due to their Panic Disorder with Agoraphobia.

(10) The majority of the subjects in this study appeared to be "immediate" thinkers

instead of "long range strategic" planners.

Recommendations

<u>Implications for University Settings</u>

Limitations of Conclusions

The conclusions and recommendations from this study should be generalized with

care. Only a very small sample of subjects were interviewed and this population varied

widely in age and educational level. Ages ranged from nineteen years to thirty- three

years. Educational span was from sophomore level to doctoral level. It should also be

noted that generalizing conclusions and recommendations to populations in elementary

and secondary school settings may be either inappropriate or ineffective.

Legal Ramifications

Under the Americans with Disabilities Act and Section 504 of the Rehabilitation Act, students with a disability are allowed equal access to an educational program, provided that they are qualified individuals. A student with a psychiatric disorder generally qualifies as an individual with a disability since the disorder substantially limits a major life activity - learning. While the researcher concluded that the majority of the students in this study had unrealistic career expectations, caution should be exercised in providing academic advice based on these findings. Students should not be advised out of a particular major or curriculum and placed into another just because they have a disability that might preclude them from performing all of the elements of the class requirements. Instead, students should be made aware of their career options. For example, a student with Panic Disorder with Agoraphobia who has not been able to successfully give an oral presentation in a classroom setting may want to think about the job possibilities in their major that will not require them to give presentations on a regular basis. They could, for instance, choose to do research rather than teach in their field of choice. For a student who insists on becoming a teacher, in spite of their chronic issues with talking before a group of people, it is reasonable for the academic advisor to at least suggest career options and the possible repercussions if the student is unable to meet the objectives of their coursework.

While classroom assignments and projects can be modified to accommodate the student, the university is not required to alter the fundamental nature or integrity of the program. An example that demonstrates this two-fold dilemma would be a student with Panic Disorder with Agoraphobia that has difficulty giving oral speeches before a class. The instructor could allow the student to videotape their speech, give the speech to just

the professor, have the student use cue cards, or have the student turn in a written assignment instead. If a student is required to do student teaching in order to satisfy the curriculum requirement for becoming a teacher but is unable to do so because of their Panic Disorder, then this would be considered a fundamental alteration of the program. There are no reasonable substitutions for student teaching. The student in this situation may need to consider an alternative choice of major or career.

Professors should encourage students who have disclosed a disability to them to contact the disability services office on their campus. By not doing so, the professor is, in effect, assuming the responsibility of determining what specific accommodations are most appropriate for the student. The student who is referred to the disability services office will be required to provide official documentation of their disability which will clearly outline the need for certain accommodations. Then, the student and the disability services office will jointly agree upon the most appropriate accommodations for the student to use. Utilizing the disability services office can be extremely helpful, especially when the student has frequent absences from class and needs additional time on tests, assignments, and projects. The student and the disability services office can determine what is a reasonable request for the amount of time needed. The disability services office can serve as an objective third party mediator in helping both students and faculty understand the nature of the disability and how it should be accommodated. Heyward (1998), a disabilities attorney, explains that professors who make decisions without involving the proper officials run the risk of the university failing to indemnify them in the event of a lawsuit.

Disability Service Providers

A careful review of the existing research and the data gathered from the subjects' interviews has the following implications for disability service providers:

Academic needs - Formal accommodations may be needed such as testing in a quiet room, extra time on tests due to difficulty with concentration and distractibility; helping the student learn how to self-advocate in order that they can meet with faculty members to discuss what their academic needs are; and the probability of having to suggest alternative formats for presentations and speeches.

Psychosocial needs- Appropriate referrals for counseling and a medication evaluation would probably prove to be beneficial for students diagnosed with Panic Disorder with Agoraphobia. Since the majority of the subjects in this study indicated that they have difficulty forming relationships, the use of mentors or support groups may also prove beneficial.

Environmental needs- Acclimation to campus through tours or visiting classrooms before classes actually start in order to get a layout of the building might be beneficial. Advisors can help students choose smaller classes to avoid being overwhelmed.

Counselor Educators

While all of the students interviewed reported that counseling was helpful, university counseling centers are generally set up to handle short-term intervention counseling. Due to the chronic level of anxiety and the persistence of panic-like symptoms presented by the subjects in this study, it appears that referrals for long-term counseling intervention, specifically aimed at treating Anxiety Disorders, might be the most advantageous. The DSM- IV (1994) indicates that the prognosis for individuals with

Panic Disorder with Agoraphobia is chronic but waxing and waning. Additional

implications that counselor educators may need to consider are that the presence of

comorbid disorders is highly likely and resistance to medication and treatment may be a

common occurrence.

Further Research

1. A longitudinal study should be done to follow students who have Panic Disorder with

Agoraphobia to determine if students who graduate in their chosen majors tend to seek

employment in those areas or whether they search for "safe" jobs.

2. A quantitative study of individuals diagnosed with Panic Disorder with Agoraphobia

could examine the effects of academic persistence and adjustment to college between

students who choose to disclose the nature of their disability to their professors and/or use

formal accommodations and those who do not disclose or use accommodations.

3. A study could seek outcome effect on students' abilities to participate in class and/or

give oral presentations under different lighting conditions.

4. There needs to be more study on the difference between males and females diagnosed

with Panic Disorder with Agoraphobia that investigates the types of majors and career

they choose.

5. A replication of this study using subjects with other psychiatric disorders could explore

the question, "Do all subjects diagnosed with psychiatric disabilities have similar academic,

environmental, and psychosocial needs and barriers?"

Summary

A review of the literature reveals that there is very little information regarding the college experiences of individuals diagnosed with Panic Disorder with Agoraphobia. This study attempts to forage this unknown territory. The researcher feels that the outcomes and results of this study are beneficial to collegiate counselor educators, service providers, and faculty and staff who must interact with students who have diagnosed psychiatric disabilities in that it provides a three prong view (academic, psychosocial, and environmental) of the students' (diagnosed with Panic Disorder with Agoraphobia) personal experiences on a college campus. Valuable information about the needs, barriers, coping mechanisms, and utilization of services reported by these subjects can be assimilated into the existing knowledge bank of what institutions already know about students with psychiatric disabilities. Further, this information can be used as a stepping stone for colleges and universities to help provide better quality services and gain a deeper understanding of the issues that are indigenous to students diagnosed with Panic Disorder with Agoraphobia.

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SURVEY

APPENDIX A

1. How many credit hours are you carrying?
2. Are you now or have you ever been on academic probation?
3. What types of classes do you do well in?
4. What types of classes do you do poorly in?
5. What resources have you used on campus? (tutoring, study groups, writing center, teacher, counseling services, health services). Please elaborate.
6. Have you discussed your academic problems with the following: parents, professors, advisor, dean, peers

STUDY SKILLS

1. How many hour per day do you spend studying?
   a. What days of the week do you study?
   b. What time of the day do you usually study best?
2. Where do you study? Is it quiet?
3. Are you having any difficulty managing your time?
   a. Have you been late for classes?
   b. Have you skipped any classes?
   c. Have you missed appointments?
   d. Have you had difficulty getting homework and projects turned in on time?
   e. Do you have a job? How many hours per week are you working?
4. Do you feel that you are a good notetaker?
5. Do you have difficulty following directions?
6. Where do you sit in class?

SOCIAL

1. How often do you go out to socialize?
2. How often do you use alcohol or recreational drugs?
3. What organizations on Tech's campus do you belong to?
4. What are your sleep patterns like?
5. How is your health?
   a. Have you seen a doctor recently?
   b. Are you taking any medications?   How do your medications affect you?
6. Is there anything occurring outside of school that could be interfering with your academics:
   anxiety
   depression
   family problems
   money problems
   boyfriend/girlfriend problems
   roommate problems
7. Has anyone in your family ever been diagnosed with a learning disability, ADD, or a psychiatric disorder?

LEARNING DISABILITIES

Study Skills

Inability to change from one task to another
Lack of organization for notes and other materials
Difficulty scheduling time complete short and long term assignments

Difficulty completing tests and in-class assignments without additional time
Difficulty following directions

Reading

Poor comprehension and retention of material read
Difficult reading new words, particularly when sound/symbol relationships are inconsistent
Slow reading rate (takes longer to read a test and other in-class assignments)
Difficulty interpreting charts, graphs, scientific symbols
Difficulty with complex syntax on objective tests

Writing

Problems in organization and sequencing of ideas
Poor sentence structure
Incorrect grammar
Frequent and inconsistent spelling errors
Difficulty taking notes
Poor letter formation, capitalization, spacing, and punctuation
Inadequate strategies for monitoring written work

Oral Language

Difficulty concentrating in lectures, especially two to three hours
Poor vocabulary, difficulty with work retrieval
Problems with grammar

Math

Difficulty with basic math operations
Difficulty with aligning problems, number reversals, confusion with symbols
Poor strategies for monitoring errors
Difficulty with reasoning
Difficulty reading and comprehending word problems
Difficulty with concepts of time and money

ATTENTION DEFICIT

Impulse Control

Interrupts or intrudes on others
Tactless
Impatient, low frustration tolerance

Restlessness and Fine Motor

Driven
Must be moving in order to think
Trouble sitting in one place
Mental restlessness
Internal sense of anxiety of nervousness
Difficulty with printing or writing skills
Coordination difficulty

Social Interactions

Inability to recognize common social cues
Trouble sustaining friendships or intimate relationships
Tendency to be self-centered, immature
Verbally abusive, argumentative, seeks conflict
Avoids group activities
Difficulty with authority

Organization

Poor organization, often has piles of stuff
Chronically late, always in a hurry
Overwhelmed by management of everyday living
Poor financial management
Difficulty performing tasks sequentially
Successful when surrounded by organized people

Self-Motivation and Assessment

Chronic procrastination
Difficulty starting projects
Enthusiastic beginning but poor ending
Expends excessive time due to inefficiencies
Inconsistent work performance
Chronic sense of underachievement
Inability to recognize success of failure

Frustration and Negative Feelings

Mood Swings
Chronic problems with self-esteem
Sense of impending doom
Negativity
Test anxiety

PSYCHIATRIC

Cognitive

Short-term memory difficulty
Time management problems
Negative self-talk (fears, failure, panic)
Self-absorption
Concentration problems
Difficulty screening stimuli (problem solving in new environment)
Distractibility

Behavioral and Physical

Impulsiveness
Repetitive motion
Pacing
Difficulty maintaining stamina

Avoidance behavior
Disorientation
Problem with making and keeping appointments
Problem with turning classroom assignments in on time
Difficulty with attending classes

Perceptual

Auditory hallucinations
Visual hallucinations

Psychosocial

Difficulty with interactional responses
Speech patterns may be rambling, halting, weak, or pressured
Feelings of fear or anxiety
Difficulty initiating interpersonal contact
Difficulty dealing with forms and bureaucracy

APPENDIX B

SURVEY (revised)

PART I

Major_____ Academic Level_____ S.A.T. scores (Math)_____(Verbal)_____
Age_____ Race_____ Sex_____ QCA_____

1. How many credit hours are you currently taking? _____
2. Are you now or have you ever been on academic probation? YES NO Suspension? YES NO
3. What types of classes do you do well in? _____
4. What types of classes do you do poorly in? _____
5. What resources have you used on campus for additional help? (tutoring, study groups, writing center, teacher, counseling services, health services). Please elaborate.
_____
6. Have you discussed your academic problems with the following: parents, professors, advisor, dean, peers

STUDY SKILLS

1. How many hour per day do you spend studying? _____
       a. What days of the week do you study? _____
       b. What time of the day do you usually study best? _____
2. Where do you study?_____ Is it quiet? YES NO
3. Are you having any difficulty managing your time? YES NO
       a. Have you been late for classes on a regular basis? YES NO
       b. Have you skipped any classes on a regular basis? YES NO
       c. Do you find yourself missing appointments on a regular basis? YES NO
       d. Have you had difficulty getting homework and projects turned in on time? YES NO
       e. Do you have a job? YES NO   How many hours per week are you working? _____
4. Do you feel that you are a good notetaker? YES NO
5. Do you have difficulty following directions on tests or on homework assignments? YES NO
6. Where do you sit in class? _____

SOCIAL

1. How often do you go out to socialize during the week (what nights)?_____
2. How often do you use alcohol or recreational drugs? _____
3. What organizations on Tech's campus do you belong to? _____
     How often do they meet?_____
4. What are your sleep patterns like?_____
     What time do you usually go to bed/get up?_____
     Do you usually sleep all night?_____
5. How is your health?_____
       a. Have you seen a doctor recently? YES NO
       b. Are you taking any medications? YES NO   How do your medications affect you?_____
           _____
6. Is there anything occurring outside of school that could be interfering with your academics:
       anxiety
       depression
       family problems
       money problems
       boyfriend/girlfriend problems
       roommate problems

7. Has anyone in your family ever been diagnosed with a learning disability, ADD, or a psychiatric disorder? YES NO   Who? _____

PART II   (Please place a check mark by those items you think describe you or are a problem area for you).

LEARNING DISABILITIES

Study Skills

___Inability to change from one task to another (i.e. trouble finishing a project and then moving on to the next one)
___Lack of organization for notes and other materials
___Difficulty scheduling time to complete short and long term assignments
___Difficulty completing tests and in-class assignments without additional time
___Difficulty following directions

Reading

___Poor comprehension and retention of material read
___Difficulty reading new words or inability to "sound out" (phonetically) the word
___Slow reading rate (takes longer to read a test and other in-class assignments)
___Difficulty interpreting charts, graphs, scientific symbols
___Difficulty understanding the wording on objective tests (ie. multiple choice, true/false tests)

Writing

___Problems in organization and sequencing of ideas
___Poor sentence structure
___Incorrect grammar
___Frequent and inconsistent spelling errors
___Difficulty taking notes in class
___Poor letter formation (handwriting)
___Capitalization, spacing, and punctuation
___Inadequate strategies for proofreading or editing written work

Oral Language

___Difficulty concentrating in lectures
___Poor vocabulary, difficulty with word retrieval
___Problems with grammar

Math

___Difficulty with basic math operations (i.e. adding, subtracting, multiplying, dividing)
___Difficulty with aligning problems, number reversals, confusion with symbols
___Poor strategies for monitoring errors
___Difficulty with reasoning
___Difficulty reading and comprehending word problems
___Difficulty with concepts of time and money

ATTENTION DEFICIT

Impulse Control

___Interrupts or intrudes on others
___Tactless
___Impatient, low frustration tolerance

Restlessness and Fine Motor

___Driven (find it hard to relax)
___Must be moving in order to think
___Trouble sitting in one place
___Mental restlessness
___Internal sense of anxiety or nervousness
___Difficulty with printing or writing skills
___Coordination difficulty

Social Interactions

___Inability to recognize common social cues (difficulty reading other's body language or gestures)
___Trouble sustaining friendships or intimate relationships
___Tendency to be self-centered, immature
___Verbally abusive, argumentative, seeks conflict
___Avoids group activities
___Difficulty with authority

Organization

___Poor organization, often has piles of stuff
___Chronically late, always in a hurry
___Overwhelmed by management of everyday living
___Poor financial management
___Difficulty performing tasks sequentially (from start to finish)
___Successful only when surrounded by organized people

Self-Motivation and Assessment

___Chronic procrastination
___Difficulty starting projects
___Enthusiastic beginning but poor ending
___Inconsistent school performance
___Inconsistent work performance
___Chronic sense of underachievement
___Inability to recognize success or failure

Frustration and Negative Feelings

___Mood Swings
___Chronic problems with self-esteem
___Sense of impending doom
___Negativity
___Test anxiety

___Constant unexplained anxiety

PSYCHIATRIC

Cognitive

___Short-term memory difficulty
___Time management problems
___Negative self-talk (fears, failure, panic)
___Self-absorption (preoccupation with your health and well being)
___Concentration problems
___Difficulty screening stimuli (problem solving in new environment)
___Distractibility

Behavioral and Physical

___Impulsiveness
___Repetitive motion (i.e. tics, rocking, fidgetting)
___Pacing
___Difficulty maintaining stamina
___Avoidance behavior
___Disorientation (not aware of immediate surroundings - date, time, place)
___Problem with making and keeping appointments
___Problem with turning classroom assignments in on time
___Difficulty with attending classes

Perceptual

___Auditory hallucinations
___Visual hallucinations

Psychosocial

___Difficulty interacting with others
___Speech patterns may be rambling, halting, weak, or pressured
___Feelings of fear or anxiety
___Difficulty initiating interpersonal contact
___Difficulty dealing with forms and bureaucracy

APPENDIX C

Open-ended Questions

1. Tell me about your first Panic Attack (before and at college) and how it has affected you.

2. Tell me about a specific incident involving your Panic Disorder that really stands out in your mind while you have been a college student and why was this incident so striking?

3. How does your Panic Disorder differ now from your earlier experiences?

4. How does the subpersonality type(s) you have chosen affect you in your environment, psychosocially, and academically (See APPENDIX E for description of the subpersonality types)?

APPENDIX D

Descriptors of Academic, Psychosocial, and Environmental

1. **Academic**:
difficulty carrying through with routine or uninteresting tasks
difficulty with impulse control
difficulty with sustaining attention
difficulty with organization
restlessness
distractibility
marked discrepancy between achievement and potential
processing deficits
long and short-term auditory and visual memory deficits
organizing and budgeting time
initiation and sustaining consistent effort on a task
note-taking and outlining
integration of information from various sources
test-taking strategies
memorization and self-rehearsal strategies
use of the dictionary, thesaurus, and other self-help handbooks,
use of the library and research skills

2. **Psychosocial**: (American Psychiatric Association, 1994, p.29)
<u>Problems with primary support group</u> - e.g., death of a family member; health problems in family; disruption of family by separation, divorce, or estrangement; removal from the home; remarriage of parent; sexual or physical abuse; parental overprotection; neglect of child; inadequate discipline; discord with siblings; birth of a sibling
<u>Problems related to the social environment</u> - e.g., death or loss of friend; inadequate social support; living alone; difficulty with acculturation; discrimination; adjustment or life-cycle transition (such as retirement)
<u>Education problems</u> - e.g., illiteracy; academic problems; discord with teachers or classmates; inadequate school environment
<u>Occupational problems</u> - e.g., unemployment; threat of job loss; stressful work schedule; difficult work conditions; job dissatisfaction; job change; discord with boss or co-workers
<u>Housing problems</u> - e.g., homelessness; inadequate housing; unsafe neighborhood; discord with neighbors or landlord
<u>Economic problems</u> - e.g., extreme poverty; inadequate finances; insufficient welfare support
<u>Problems with access to health care services</u> - e.g., inadequate health care services; transportation to health care facilities unavailable; inadequate health insurance
<u>Problems related to interaction with the legal system/crime</u> - e.g., arrest; incarceration; litigation; victim of crime

<u>Other psychosocial and environmental problems</u> - e.g., exposure to disasters, war, other hostilities; discord with nonfamily caregivers such as a counselor, social worker, or physician; unavailability of social service agencies

3. **Environmental**: (Conyne, 1983)

1. *Physical settings* - built and natural physical properties of a campus (e.g., lighting, space, distances, buildings, parking facilities, and green spaces).

2. *Academic settings* - opportunities afforded by the campus for the formal teaching-learning-research process (e.g., activities occurring in classrooms, laboratories, and in study areas).

3. *Social settings* - formal and informal opportunities provided by the campus for meeting others, giving and getting support, forming relationships, and for being alone and private (e.g., student activities programming, student organizations, counseling services, and residence hall events).

4. *Cultural settings* - formal and informal opportunities available on campus for gaining understanding of cross-cultural phenomena, aesthetic appreciation, and exposure to variety in artistic experiences (e.g., international houses, concerts, and poetry readings).

5. *Organizational settings* - existing campus organizational structures that have responsibility for maintaining and delivering services and functions to campus inhabitants (e.g., academic departments, student affairs offices, and the physical plant).

6. *Administrative conditions* - the stated policies, procedures, and practices of the college or university as well as its unarticulated norms and standards (e.g., admissions procedures, counseling center client assignment procedures, and general expectations of how a university student "should behave").

7. *Basic resources* - the campus provision of basic living requirements, such as adequate housing for the residential campus, food services, recreational opportunities, transportation and parking systems, heat in winter, and financial aid for needy students (e.g., residence hall rooms, union food services, confidential rooms for counseling, bus services, and playing fields).

8.   *Ecological climate* - a summative perception, similar to the general personality of an individual, that the institution has acquired over time, derived from its physical, academic, social, cultural, organizational, and administrative conditions (i.e., such phrases as "preppy school, party school").

APPENDIX E

PARTICIPATION AGREEMENT/CONSENT FORM

I agree to participate in a research study conducted by Susan Angle through the Graduate School of Virginia Tech, Blacksburg, Virginia, College of Human Resources and Education. I understand the purpose and nature of this study is to examine the effects that college has on students diagnosed with Panic Disorder with Agoraphobia. I am participating in this study voluntarily. This study involves five participants in addition to myself.

The procedures to be used in this research are in-depth interviews and a survey. The time and conditions required to participate in this project will be scheduled at a time and place convenient for me and the researcher. I understand that any possible risks or discomfort to me as a participant will be minimal. Safeguards that will be used to minimize any risk and discomfort will result in a consultation with or referral to the university Counseling Center and /or to Dr. George Clum.

My participation in this research project will provide information regarding the academic, environmental, and psychosocial needs and barriers of students diagnosed with Panic Disorder with Agoraphobia which will be beneficial to student development and counselor education research, theory and practice. I understand that I will be paid a stipend of twenty dollars ($20.00) at the end of the interviews. I may receive a synopsis or summary of this research when completed by providing the researcher with a self-addressed envelope.

The results of this study will be kept strictly confidential. The information I provide will have my name removed and only a subject number or pseudonym will identify me during analyses and any written reports of the research. Audio tapes used in the data collection for this study will be reviewed by Susan Angle, the researcher, and a transcriptionist, and will be erased after one year from completion of the study.

For my participation in this research, I understand that I will not receive any kind of academic credit. If as a result of this project, the researcher or I should determine that I should seek counseling or medical treatment, services are provided through the university Counseling Center, Dr. George Clum, and the Student Health Services.

I understand that I am free to withdraw from this study at any time without penalty.

This research project has been approved, as required, by the Institutional Review Board for projects involving human subjects at Virginia Polytechnic Institute and State University.

I grant permission for any data collected to be used in the process of completing a Ph.D. degree, including a dissertation and any other future publications.

I agree to meet at the following location _____ on the following date _____ for an initial interview of one and one half to two hours, and to be available at mutually agreed upon times and places for one to two additional interview sessions.

I have read and understand the informed consent and conditions of this project. I have had all my questions answered. I hereby acknowledge the above and give my voluntary consent for participation in this project.

Should a reason arise which would prohibit my participation in this project, I understand that it is my responsibility to inform the researcher as soon as possible. I agree to abide by the rules of this project.

I understand that I will receive a copy of this participation agreement/consent form for my records. Should I have any questions about this research or its conduct, I will contact the investigator, the investigator's faculty advisor, or the Chairperson of the Institutional Review Board.

_____

PARTICIPANT   DATE   PHONE

_____

RESEARCHER   DATE   PHONE

_____

FACULTY ADVISOR   DATE   PHONE

_____

CHAIR, IRB   DATE   PHONE
Research Division

APPENDIX F

Bourne's Personality Profiles

1. *The Worrier* (promotes anxiety)

    Characteristics: Usually this is the strongest subpersonality in people who are prone to anxiety. The Worrier creates anxiety by imagining the worst-case scenario. It scares you with fantasies of disaster or catastrophe when you imagine confronting something you fear. It also aggravates panic by reacting to the first physical symptoms of a panic attack. The Worrier promotes your fears that what is happening is dangerous or embarrassing ("What if I have a heart attack?!" "What will they think if they see me?!"). In short, the Worrier's dominant tendencies include 1) anticipating the worst, 2) overestimating the odds of something bad or embarrassing happening, and 3) creating grandiose images of potential failure or catastrophe. The Worrier is always vigilant, watching with uneasy apprehension for any small symptoms or sign, of trouble.

    Favorite Expression: By far the favorite expression of the Worrier is "What if..."

    Examples: Some typical dialogue from the Worrier might include: "Oh no, my heart's starting to beat faster! What if I panic and lose complete control of myself?" "What if I start stammering in the middle of my speech?" "What if they see my shaking?" "What if I'm alone and there's nobody to call?" "What if I just can't get over this phobia?" or "What if I'm restricted from going to work for the rest of my life?"

2. *The Critic* (promotes low self-esteem)

    Characteristics: The Critic is that part of you which is constantly judging and evaluating your behavior (and in this sense may seem more "apart" from you than the other subpersonalities). It tends to point out your flaws and limitations whenever possible. It jumps on any mistake you make to remind you that you're a failure. The Critic generates anxiety by putting you down for not being able to handle your panic symptoms, for not being able to go places you used to go, for being unable to perform at your best, or for having to be dependent on someone else. It also likes to compare you with others, and usually sees them coming out favorable. It tends to ignore your positive qualities and emphasizes your weaknesses and inadequacies. The Critic may be personified in your own dialogue as the voice of your mother or father, a dreaded teacher, or anyone who wounded you in the past with their criticism.

    Favorite Expression: "What a disappointment you are!" "That was stupid!"

    Examples: Typical of the Critic's self-talk are statements such as the following: "You stupid..." (the Critic relishes negative labels). "Can't you ever get it right?" "Why are you always this way?" "Look at how capable _____ is," or "You could have done better."

3. *The Victim* (promotes depression)

Characteristics: The Victim is that part of you which feels helpless or hopeless. It generates anxiety by telling you that you're not making any progress, that your condition is incurable, or that the road is too long and steep for you to have a real chance at recovering. The Victim also plays a major role in creating depression. The Victim believes that there is something inherently wrong with you: you are in some way deprived, defective, or unworthy. The victim always perceives insurmountable obstacles between you and your goals. Characteristically, it bemoans, complains, and regrets thing as they are at present. It believes that nothing will ever change.

Favorite Expressions: "I can't." "I'll never be able to."

Examples: The Victim will say such things as: "I'll never be able to do that, so what's the point in even trying?" "I feel physically drained today - why bother doing anything?" "Maybe I could have done it if I'd had more initiative ten years ago - but it's too late now."

4. *The Perfectionist* (promotes chronic stress and burnout)

Characteristics: The Perfectionist is a close cousin of the Critic, but its concern is less to put you down than to push and goad you to do better. It generates anxiety by constantly telling you that your efforts aren't good enough, that you *should* be working harder, that you *should* always have everything under control, *should* always be competent, *should* always be pleasing, *should* always be _____ (fill in whatever you keep telling yourself that you "should" do or be). The Perfectionist is the hard-driving part of you that wants to be best and is intolerant of mistakes or setbacks. It has a tendency to try to convince you that your self-worth is dependent on externals such as vocational achievement, money and status, acceptance by others, being loved, or your consistent ability to be pleasing and nice to others regardless of what they do. The Perfectionist isn't convinced by any notions of your inherent self-worth, but instead pushes you into stress, exhaustion, and burnout I pursuit of its goals. It likes to ignore warning signals from your body.

Favorite expressions: "I should." "I have to." "I must."

Examples: The Perfectionist may provide such instructions as "I should always be on top of things," "I should always be considerate and unselfish," "I should always be pleasant and nice," "I have to (get this job, make this amount of money, receive _____'s approval, etc.) or I'm not worth much."

APPENDIX G

Floating Prompt Definitions

1. Key actors - who are the key people mentioned in relation to the subject's experience with Panic Disorder with Agoraphobia?

2. Central action - what happens when the subject experiences anxiety and panic attacks. What are the symptoms experienced?

3. Dramatic structure - what is the level of anxiety and/or fear experienced during an episode - severe, moderate, mild?

4. Important props - what things, people, or places are seen as comfort zones or areas to avoid?

5. Necessary audience - who does the subject confide in or vent to? What audiences does the subject avoid?

6. Ascribed roles - what role is assigned to the key actors (i.e. caretaker, friend, enemy, parent, etc.)?

7. Designated critics - what things, places, or actors does the subject view as having a negative influence on them?

8. Social significance - what impact does Panic Disorder with Agoraphobia have on the social life of the subject?

9. Cultural significance - what factors from the subject's upbringing (i.e. family background, customs, beliefs, etc.) play a role in the disorder?

10. Consequences of good and bad performances - what does the subject view as good and bad behavior. What are the rewards and punishments the subject recognizes as a result of good and bad performances?

APPENDIX H

Family Background Questionnaire
(Bourne, 1990)

Use the following questionnaire to reflect on your childhood. Can you identify what conditions might have contributed to your current problem with anxiety?

1. Did either of your parents suffer from panic attacks or phobias?

2. Did you have a brother, sister, grandparent, or other relative who had panic attacks or phobias?

3. Did either of your parents seem excessively prone to worry?

4. Did either of your parents seem overly concerned about potential dangers that could befall you or other family members?

5. Did your parents encourage exploration of the outside world or did they cultivate an attitude of caution, suspicion, or distrust?

6. Do you feel that your parents were overly critical or demanding of you? If so, how did you feel in response to this criticism?
___put down or diminished   ___ashamed or guilty
___hurt or rejected   ___angry or rebellious

7. As a child, did you feel free to express your feelings and impulses? How were feelings dealt with in your family?
___openly expressed   ___punished
___denied

8. Was it O.K. for you to cry? How did your parents respond when you cried?

9. Was it O.K. to express anger? How did your parents respond when you got angry?

10. What was your role in the family? How were you perceived relative to other children in the family?

11. Do you feel that you grew up feeling insecure: Which of the following might have contributed to your insecurity:
___Excessive criticism by your parents
___Excessive punishment
___Your parents made you feel ashamed
___Your parents made you feel guilty
___Your parents neglected you
___One or both parents abandoned you through death or divorce
___Physical abuse
___Sexual abuse
___Parental alcoholism

12. If you grew up insecure, how did you respond to your feelings of insecurity?
___By becoming very dependent on your family (Did you have difficulty leaving home?)
___By becoming very independent of your family (Did you leave home early?)
___By becoming angry or rebellious

APPENDIX I

Letters

Virginia Tech
152 Henderson Hall
February 1, 1999

Dr. Jane Keppel-Benson
Psychologist, Virginia Tech
McComas Hall
Blacksburg, Virginia 24061- 0108

Dear Jane:

Last semester we discussed the possibility of securing subjects for my doctoral research through student referrals that have been seen in the counseling center at Virginia Tech. The topic of my dissertation is "The Effects of College on Students Diagnosed with Panic Disorder with Agoraphobia: An Academic, Psychosocial, and Environmental Perspective". The study is a qualitative look at Panic Disorder with Agoraphobia and the subjects should probably not have to meet with me for more than two sessions (each session lasting 1 to 1 1/2 hours in length) to gather the necessary information. Each subject will be paid a stipend of $20.00 for their time. Confidentially of the subjects will be highly regarded and I will discuss this in detail with each volunteer.

I chose this particular topic to investigate because in my present position as Assistant Dean of Students, Services for Students with Disabilities, I have found that Panic Disorder with Agoraphobia is such a pervasive disorder in that it affects the individual at many levels: emotionally, socially, environmentally, and physically, that it warrants further study. Very sparse information is available that can shed any light on the college experiences of these students or on the environmental, psychological, and academic barriers they may face. This study will seek to examine the unique college experiences of students diagnosed with Panic Disorder with Agoraphobia and to determine what their particular academic and psychosocial needs are, and what environmental barriers, if any, they have encountered during their college careers.

I would like to begin advertising for subject as soon as possible and begin the interviewing process within the next one to two weeks. The subjects chosen for this study should meet the following criteria: the existence of Agoraphobia with panic attacks diagnosed by a qualified professional - (**Note** the subject does not have to be in an active phase of Agoraphobia but must have manifest these symptoms sometime within the last five years), and must be sophomore, junior, or senior level status at Virginia Tech. I will also accept students who have recently (within the last academic year) dropped out of school at Virginia Tech as long as they were upperclassmen when they dropped out.

I am attaching a copy of my release form and a letter for the subject to read which briefly details what the study is about. Should you have any questions, please feel free to contact me at 231-3789(W) or 639-2504(H). Thank you for agreeing to assist me in securing subjects for my study.

Sincerely,

Susan Angle

Virginia Tech
152 Henderson Hall
February 1, 1999

Dr. George Clum
Professor, Virginia Tech
5093G Derring Hall
Blacksburg, Virginia 24061- 0436

Dear Dr. Clum:

Last semester we discussed the possibility of securing subjects for my doctoral research through your private practice or by advertising within the Psychology department at Virginia Tech. The topic of my dissertation is "The Effects of College on Students Diagnosed with Panic Disorder with Agoraphobia: An Academic, Psychosocial, and Environmental Perspective". The study is a qualitative look at Panic Disorder with Agoraphobia and the subjects should probably not have to meet with me for more than two sessions (each session lasting 1 to 1 1/2 hours in length) to gather the necessary information. Each subject will be paid a stipend of $20.00 for their time. Confidentially of the subjects will be highly regarded and I will discuss this in detail with each volunteer.

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Sincerely,

Susan Angle

VITA

Susan P. Angle, Ph.D., N.C.C.

Assistant Dean of Students,
Services for Students with Disabilities
152 Henderson Hall
Virginia Tech
Blacksburg, VA 24061-0255
540-231-3787   e-mail: spangle@vt.edu

Education:
Ph.D. (1999), Counselor Education, Virginia Tech
C.A.G.S. (1996), Counselor Education, Virginia Tech
M.S. (1977), Guidance and Counseling, Radford University
B.A. (1976), Psychology, Radford University

Professional Experience:
Assistant Dean of Students and Coordinator, Dean of Students Office, Services for Students with Disabilities, Virginia Tech, 1995 - present
Counselor and adjunct professor (Freshman Orientation classes), Student Support Services, New River Community College, Dublin, VA, 1980-95
Psychologist, Giles Mental Health and Mental Retardation Clinic, Pearisburg, VA, 1979-80
Assistant Director of Research and Assignments for University Residential Life, University of Alabama, Tuscaloosa, Ala., 1978-79
Professor (adjunct), Psychology, Shelton State Community College, Tuscaloosa, Ala., 1978-79.

Endorsements:
National Certified Counselor, Counselor for middle school and high school levels

Publications:
Attention Deficit Disorder Coaching Model (grant), 1998, Virginia Tech
Orientation Program for Engineering Freshmen with Disabilities (grant), 1998, Virginia Tech

Presentations:
Over forty presentations that address the following topics: study skills, stress and anxiety, learning styles, Section 504 of the Rehabilitation Act and The Americans with Disabilities Act, how to tutor students with disabilities, creating barrier free environments, the Myers-Briggs Type Indicator, and career development and resume writing.