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CARE OF CLIENT WITH PANIC DISORDER : A HUMANISTIC NURSING APPROACH

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ABSTRACT

This study aims to apply the Humanistic Nursing Approach in the care of clients with Panic Disorder as the basis for the proposed desensitization program. Based on the findings of this study, the experience of the clients generalized that the Paterson and Zderads Humanistic Nursing Theory could be utilized as a care model to develop a Panic Disorder Anxiety Desensitization Program as evidenced by the client's responses in the nurse-patient relationship. The holistic and humanistic approach of this theory could be used to explore the overall condition of the client and can lead to an open relationship between the client and the researcher. From this study the patients will be able to reflect and gain knowledge on the basis of learning from self experiences and from the researcher's experiences. Furthermore, the researcher's self-made Nursing Humanistic Assessment Tool patterned for the Humanistic Nursing Theory obtained an in depth information about the client and that could be used as an adjunct for the conventional psychiatric assessment forms. Finally, the practice of humanistic nursing in clients with Panic Disorder furnished better outcomes in terms of nursing care and the development of new insights by the clients to reach their optimum human potential.

Keywords : *Humanistic Nursing Theory, Panic Disorder Anxiety Desensitization Program, Nursing Humanistic Assessment Tool, Panic Disorder, optimum human potential*

BACKGROUND AND RATIONALE OF THE STUDY

Why do some people take extreme measures to avoid something that is harmless or slightly dangerous? Why do some people develop strange habits and rituals? How much fear and caution is normal? (Kalat, 1993) It is normal to have a certain amount of fear and to avoid situations that might provoke fear. But excessive fear and caution are linked to some of the most common psychological disorders. A common disorder, panic disorder, is characterized by recurrent attacks of severe anxiety lasting for a few moments (15 - 30 minutes) to an hour. These attacks are not associated with stimulus but instead seem to occur suddenly and spontaneously. They may, however, become associated with certain situations, such as going to shopping mall or driving a car, being outside the home alone, being in a crowd or standing in a lane, being on a bridge and travelling on a bus or train (Stuart and Laraia, 2005).

When panic attacks occur frequently and interferes with the person's functional abilities at work, school, or in the family, the condition is called panic disorder. People suffering from repeated attacks, at least two unexpected panic attacks, or at least one month of persistent worry about having another attack, are diagnosed with panic disorder (O'Brien and Kennedy, 2008; Elder, 2005). Anticipatory fear of helplessness or of losing control during a panic attack is a common occurrence (Phillips, Menard and Bjornson, 2013). The individual frequently avoids situations that induce the fear, sometimes developing a phobic avoidance reaction.

In the year 1990, Panic Disorder was estimated as the 27th leading cause of non-fatal burden in the world, accounting to 1.0% of total Year Long Disaster (YLD). After a decade in the year 2000, the World Health Organization reported a slight increase in the estimated global burden of the panic disorder, accounting to 1.2% of total global YLD. In the Version 1, the estimates for

the Global Burden of Disease 2000 study, published in the World Health Report 2001 there has been a slight increase in the estimated burden of panic disorder due to improved data on prevalence of the condition (Ayuso-Mateos, 2002). The World Health Organization reported in the year 2004, that Panic Disorder is the 17th leading disabling condition by age for high income and low middle income countries, the reason for this is the occurrence of a number of new cases and the number of individuals living with the disease along with their offspring (WHO, 2008). In the United States, Panic Disorder is found in about 1-2% of all American adults, women more than men; it is rare among children. The onset of panic disorder peaks in late adolescence and mid-30s (Videbeck, 2009). In 2006, the National Institute of Mental Health states that in the U.S.A. alone 2.7% or 2.4 million of American Adults suffer from this disorder (Kneisl, 2009).

In the Philippines, psychiatry is a taboo. In spite of being an American inspired nation, plenty of Filipinos hold on to traditional and religious practices and beliefs (PPA, 2010). For this reason researches and statisticians find it hard to extract about anxiety disorder, in particular panic disorder. According to US Census Bureau International Data Base (2004), Philippines has an estimated extrapolated prevalence rate of 760, 956 people who were diagnosed and visited hospitals for proper management and an estimated extrapolated incidence rate of 1,466,108 new cases diagnosed each year. These prevalence extrapolations for Panic Disorder are only estimates and may have limited relevance to the actual prevalence of Panic Disorder in the Philippines.

The number of individuals with this particular disorder is increasing, as these patients remain untreated without proper diagnosis. As a result, the researcher chose to carry out the study to help these usually mistreated individuals. The researcher's experience as an educator and having been exposed to the psychiatric ward stimulates the interest in studying the patient with panic disorder. Also, his advocacy of the humanistic modality and being a member of the Association for the Advancement of Humanistic Psychology pushes him to explore nursing care on the basis of humanistic and existential approaches. The humanistic nursing approach is an appropriate platform for the care of panic disorder patients because it provides a more creative approach that goes beyond the conventional nursing practice. It created an environment to explore more into the world of the client and to understand experience of the client to live in that world. It also expresses the total nursing experience in all contexts. In addition, several studies have been conducted in Ireland that examined the experience of the patients regarding the process of communication by the nurses (Hanafin and Cowley, 2003). Similarly, another phenomenological study explored the process of management of nursing care, as the patient advocates and the nurses described their experience. Humanistic nursing can be applied to the examination of the nurse-patient relationship as experienced by the nurse in those situations where patients are especially vulnerable (Wu and Volker, 2012). The researcher is optimistic that through the Humanistic Nursing Approach one can understand their experience in the world of health care and the experience is the foundation for understanding the nature of nursing and the essence of a nurse (Amado, 2007).

THEORETICAL- CONCEPTUAL FRAMEWORK

Humanistic nursing practice theory proposes that nurses consciously and deliberately approach nursing as an existential experience. Then, they reflect on the experience and phenomenologically describe the calls they receive, their responses, and what they come to know from their presence in the nursing situation. It is believed that compilation and complementary syntheses of this phenomenological description over time will build and make explicit, the science of nursing.

This study is inspired and took its roots on the Humanistic Nursing Theory of Josephine E. Paterson and Loretta T. Zderad. The theory explains the concepts of Health, Human Being and Nursing in this portion in order to explain the application of the theory in this study. Nursing forms a dialogue and the phenomenological inquiry are concepts which form the backbone of this humanitarian study. Health is a matter of personal survival, process of experiencing one's potential for well-being and the quality of living and dying. It is more than the absence of disease. Well-being implies a steady state, whereas more-being refers to the process of becoming all that is humanely possible. Both the authors suggested that health is a process of finding meaning in life. They further emphasized that health is experienced in the process of living, of being involved in each moment. We become more (more-being) through relationship with

each other. When we relate authentically to another, we are experiencing health (Paterson & Zderad, 2008).

The concept of nursing in the Humanistic Nursing Theory is the ability to struggle with another through "peak experiences related to health and suffering" in which the participants in the nursing situation act in accordance with their human potential (Paterson and Zderad, 1976). Each participant shares his/her struggle using dialogue. This allows for each to engage in relationship with the other. Dialogue is nurturing the well being and more being of persons in need.

In Humanistic Nursing Theory the human being are identified. Patient becomes known as he sends a call for help regarding some health related problem. The person hearing and recognizing the call is the nurse. The nurse is a human being with a commitment to help others in relation to their health needs. Both patient and the nurse are first human beings with their own gestalt. Gestalt includes all their past experiences, all their current being, all their hopes, dreams, and fear to build up the future with the experience in their own space-time dimension. Experiences of gender, race, and religion, as well as education, work in their individualized patterns, to cope with the experience of living (e.g. past experiences with helpers) are also a part of Gestalt. In short, they exist "all-at-once".

The core paradigm of the Humanistic Nursing Theory is "call and response". According to this theory, there is a call from individuals (person), a family, and a community or from humanity for help regarding some health related issue (Kleinman, 2001). After the call is initiated a nurse, or a group of nurses, or the community of nurses hearing and recognizing that call, responds in a manner that is imitated to help the caller with the health related need of caring for him (Paterson and Zderad, 2008).

STATEMENT OF THE PROBLEM

This study aims to apply the Humanistic Nursing Approach in the care of clients with Panic Disorder as the basis for the proposed desensitization program.

This sought to answer the following questions:

1. The significant information, relevant data, and observation gathered during the following phases;
   1.1 Preparation of the Nurses to gather knowledge.
   1.2 Intuitive Knowing about the Panic Disorder Patient
   1.3 Scientific Knowing about the Panic Disorder Patient
2. What nursing diagnoses were created or known during the phase: Synthesizing Intuitive and Scientific Knowledge of Panic Disorder Patient?
3. What were the goals and interventions implemented during the last phase: Succession within the Nurse from Many to the Paradoxical form of the inquiry?
4. What were reflections of the nurse and the patient about the their experiences?

RESEARCH METHODOLOGY

A qualitative research through a case study method was used in this work. It is an intensive systematic study of an entity or entities with definable boundaries, conducted within the context of the situation and examining in-depth characteristics, culture, and interactions. This study was conducted in Maria JosefaRecio Therapeutic Center (MJRTC), a private Inhouse and Out Patient Department (OPD) facility situated at Purok III Barangay San Jose of Talamban Cebu City. The researcher utilized two structured tools in this study. Following the Phenomenological Inquiry of the Humanistic Nursing Theory the researcher entered into the client's world. All throughout the nursing situation, which covered the entire week, the researcher used his Assessment Tools during the process of relating through dialogue. The Nurse-researcher also underwent self-awareness activities taking into consideration the patient's case. Health teaching was taught regarding the cause of the disorder and the process for the improvement of one's life. The researcher could arrange for an open atmosphere for the client to share and relate her life experiences particularly during her dialogue with the researcher. The researcher and the patient spent an hour daily in therapeutic dialogues and the remaining hours on other scheduled modalities/activities. On the last day of the intensive practicum, the patient as well as the nurse reflected on the experience they had and came up with a new knowledge and understanding of oneself (Doenges, Moorhouse and Murr, 2008).

RESULTS AND DISCUSSION

First Phase - Preparation of the Nurse Knower for Coming to know the Panic Disorder Patient : In this phase, the nurse prepared himself before starting

the study. The researcher gathered information and read literatures regarding Panic Disorder. He reviewed the management and nursing care of the client with panic disorder. The researcher reconsidered his mind and behaviour regarding facing the patient for the first time. The researcher also formed a view about mentally challenged individuals and persons with mental disabilities. Having placed one's angular view in the proper professional perspective regarding a client with Panic Disorder and maintaining to be an open-minded person, the researcher then felt that he is ready to face the client. In addition, since culture and spiritual belief is a consideration in this phase, the researcher made sure that his culture and spiritual orientation are in order and that it is bracketed so that it would not affect his responses to the client so as not to contaminate the experience of the client. As he is familiar with the theory behind the client's disorder, it helped him to handle the cases properly for his research. The researcher made sure that his knowledge about the disorder is updated (Fitzpatrick and Wallace, 2006).

Second Phase - Intuitive Knowing about the Panic Disorder Patient. The researcher collected information about the patient through other sources. The researcher's main source in this phase is the client's physician, nurse and psychologist. He asked questions about the client and sorted out information that would give the researcher an impression about the client. Knowing the client in the light of other people's perspective created an apprehension on the part of the researcher but even if he felt this way it gave the researcher the urge to investigate more on the client's experience. Informations about the clients condition was gathered at the time of the admission, as well as from the diagnosis of the psychiatrist during the clients stay in the institution.

It was informed that the client has a brother who was drug abused and was admitted together with the client during those times. The major information that was revealed during this phase was the psychological tests of the client that revealed that the client was suffering from panic disorder. The attending nurse during her stay in the institution provided valued information such as the type of personality of the client and the location of the resident of the client (Murray, 2008).

Third Phase - Scientific Knowing about the Panic Disorder Patient. The following knowledge of the client is taken using the Researcher-Made Humanistic Nursing Tool. The client's name is BR, 44 years of age, female, married and a Filipino. She had 3 siblings and lives in a nuclear family. She was self-employed and a graduate of commerce. The client's religious affiliation is Roman Catholic. Upon admission the client's final diagnosis was Panic Disorder. She was able to perform activities of daily living within the constraints of her home. But she was unable to perform her duties outside the home. The usual behaviour of the client is solitary and lonely. She constantly worried about going "crazy" or losing control. In term of client's perception of cognitive abilities, she was able to comprehend basic instructions, and is able to understand own Cebuano dialect, English and Tagalog. The client remembered remote experiences as well as those that recently occurred. The patient is fearful of going outside the home because she feels something wrong will happen. The client always feels a moderate to severe form of anxiety. She verbalizes conversion of anxious feelings to a bodily symptom like "butterflies in the stomach", sweating, exaggerated responses to mild stressors, difficulty in breathing, faintness and sweating. She also reported feeling of desperation that nothing will improve her condition and has inadequacy of her purpose in life. She verbalizes to drink relaxants to calm her. The client is overwhelmed by the negative reactions of community to her disease. The client is suspicious on her neighbours' reaction to her as well as any new acquiantant in her life. She is confused regarding her role in the family. She is confused regarding self assessment and awareness of her abilities and skills. The client reported on a bowel movement of more than four times per day with dark colored stool with complaints of abdominal tenderness. With regards to the hour of sleep the client reported on sleeping past nine o'clock in the evening but was awake by around two o'clock in the early morning. However, in time of the attack occurance, she did not sleep at all. According to her when the attack occured the patient is very weak and couldn't even lift a finger. This is her common fear that during the attack no one will help her and she would fall and die on the floor. Upon interviewing the client verbally displayed an aversion towards food which caused loss of weight. There was no incident in her life that she reminds her as being fat. Finally, the client reported that during the panic

attack she felt palpitations which were mistaken as a heart attack. In 2007, she underwent thyroidectomy at Visayas Community Medical Center and was confined for five days.

During her elementary and high school years, the client was an average student with good interpersonal skills. In 1988, she graduated with Bachelor of Science in Commerce, at the University of the Visayas. Years after graduation, she applied for a sales clerk position in Robinson's Department Store. Then, for approximately 22 months (from 1991 to 1992), she worked as a domestic helper in Singapore. However, she ran away from her Singaporean employer because of her fear of being maltreated. Her fear was aggravated when her employer locked her inside his house inspite of being later rescued by the authorities in Singapore. She reported that it started with her being fearful. Her closest friend is her sister living in Singapore. She experienced the feeling of care from her sister which made her to be considered the closest among all siblings by the client. Although the client was able to socialize in her younger years, she felt that every friend will come and go, but her sister never left her. The client is not sexually active and has a stereotype perception about sex. For her, sex is for younger individuals only. The client did not report the use of contraceptive method during her productive years. Currently she performs the household work like doing the laundry, cooking and others except for grocery and buying things that required her to go outside her home.

The client was previously taking Clonazepam (Rivotril) half tablet two time daily and a multivitamin once daily but stopped taking it when her supply expired. She also reported intake of herbal coffee every morning. She does not drink alcohol and does not use controlled drugs. When the client is upset, usually due to family matters, it acts as a constant stimulus in her life, which she usually keeps it to herself. Whenever she feels bad, she just keeps herself busy with household chores. She claimed that ever since she developed this condition, she was being ignored by the family. It was only during our interactions that she openly voiced her feelings. She looks forward to see her older sister to talk to her and open up her frustrations. But since her sister went abroad, there's no one that she could talk to.

The client believes that she is living in a community that does not accept people with such mental disorder. Not only her community but also her family, especially the husband, as evidenced by their ignorance of the signs and symptoms of impending panic attack. Acceptance for her is meant for those people who value her and understood her disorder. Because of this, the client reflects an evasive attitude and withdrawal tendencies. She reported of having the feeling that she can no longer conform to society's demand, fear, paranoia and a negative perception inhibits her social interaction.

The client wishes to become well off which motivated her to work abroad. A sad event happened in Singapore wherein the client was locked up in the residence of her employer. She thought that this influenced the start of her being fearful of going outside her house. The client also complained of the failure to supervise her children outside the house. Her high levels of aspiration, impulsitivity, and satisfaction of needs add to the bulk of her failures.

Family trouble is eminent. She often fights with her husband as well as with her children for several reasons. First, causes of their conflicts were the client's inability to perform outside home. When her husband fails to perform the task, conflict burst out. Same is true for her children. She wanted them to follow her but often they do not. Her husband's vices like the chronic consumption of alcohol added up to the problem. Second cause of their conflict in the home was the ignorance of the family regarding the client's disorder. Each family member thought that the client was just overreacting or just acting to gain their attention and thus the cause of the disorder was just all in the mind. So whenever the client feels the attack, the family just laugh at the client and ignore her. Instead of caring for her, the client is made to feel neglected and disrespected. The last reason was the irritation of the family members against the complaints of the client. These problems caused the client to go under depression from the unresolved family conflicts.

The central themes of our conversations were the client's active role and the importance of the lives of those people around her. She was often apprehensive of her family after her death. Moreover at several times she reported that their neighbor or relatives did not interact with her, after she acquired the disease. She expected that the neighbor, whom she helped, should have respected her in return. Her pubescence and adolescence is somewhat very meaningful to her. She

described it as having a feeling of closeness to her temporal friends and her ability to visit places where she and her friends could explore. Her small circle of friends shared the same recount of having fun in their younger years. The client described it as a period in her life wherein happiness and luck existed. No reports of controlled drugs, or any attempts or the thought of using these types of dangerous medication were reported then.

The client narrates that her parents' low levels of emotional affinity towards their children created a milieu distance from her parents. Her younger brother was diagnosed with substance abuse and was involved clashes with the client. Sometimes her younger brother would hurt him but not to the extreme. The family was sometimes affected but managed to settle the issue within them. The client responded to the younger brother with aggression using harsh words. The client's family was just like any ordinary family. The feeling that his parents worked hard for them made the client grieve a lot during her mother's death. It was reported that the primary cause of her exaggerated fear and panicky attitude was when she was locked by her employer in his own home in Singapore but upon further assessment using the Humanistic Approach, the researcher found out that it first started when the clients' mother died. According to her, she suffered major loss and withdrew herself from the general flow of the public after her mother's death and expressed that her failure to deal with these problems and challenges in life caused major change in her life.

For the client, her feelings, her belief and everything that she has in mind are all true. She had this idea that since her feelings are true, everybody should believe her and sympathize with her. If there was a lack of sympathy, then she would feel betrayed and assume that nobody cares for her. The safest place for her is in the confines of her home. She did like adverse situations in her life. These thought troubled her and caused her sleepless nights when this thoughts come out spinning in her mind. The client also experienced a negative self attitude; she reported that because of her attitude people are treating her differently. She also complained of a difficulty in understanding herself. The client appears to be well groomed and there were no physical limitations. She dressed up appropriately with dry clothing and is neat. The client can maintain eye contact. The client has a stoop posture. There were no mannerisms observed. Client's speech was clear and sometimes when asked uncomfortable question her voice was louder. There were no barriers to communication. The client is withdrawn, and is uncomfortable in talking for long periods of time. The client manifested a blunt, emotionless disposition. On the first stage of our conversation, the client appeared to have a bland affect but on the succeeding stages the client showed dramatic but appropriate responses. Her thought processes does not contain any flight of ideas or looseness of association. There were moments during the conversations when the client suddenly shifted a topic especially when it was a sensitive issue. When the client is asked to explain a proverb, she took it concretely. She was unable to provide exact abstract explanation of the phrase. When asked to count by Serial Sevens the client was able to perform only to some extent. The client can perform complex mathematics. The client is generally oriented properly regarding time, place and person and events.

The client narrated that before admission at Maria JosefaRecio Therapeutic Center, Inc., she used to go to a market for shopping. Yet, while shopping during that time, she felt dizzy, listless, and suddenly lost her consciousness. The client was brought to Colon Police Station where she rested and went home with her husband. The instance did not happen only once. Client reported recurrence of said episodes that started on October 1, 2005. Then after nine days (October 10, 2005) the attack reoccurred. There was an absence of the symptoms and just six months (April 28, 2010) later, the client once again experienced the same attack and within a span of three months (July 2006) the same incident occurred. The latest attack occurred just recently in which client could not sleep and had trouble in her mind in which she assumed her husband and other relatives to have decided to confine her to the therapeutic center. With further conversation, the client admitted to have noticed a major change in behavior after her mother's death. According to her this was a stressful event in her life and was unable to cope up this situation. This transition in life, changes in the environment and her process of thinking plays an important role in the onset of panic disorder.

The client is hopeful that her mind will settle down and be considerably peaceful. As soon as the client was given treatment, Clonazepam (Rivotril) and multivitamins,

she started to calm down. According to her, it was the first time, since the disorder started, that she was able to sleep continuously. But as soon as the drugs prescribed by the physicians ran out, the symptoms struck her randomly.

During the attack, the patient becomes weak and loses her consciousness. The fact that she was too weak to carry herself made her even more anxious. She heavily depends for some daily task on her husband and children like shopping because this might predispose further attacks in which the client is of no control. She verbalized to have felt chest pains, difficulty in breathing, sweating, faintness and shaking during the episode. In the attempt to calm herself she tried to breathe deeply each time panic attack sets in. Moreoften, she hyperventilates because she has the perception that if slow breathing can ease the symptoms it would be that ventilating would help ease her even faster. Since hyperventilating lowers the carbon diaoxide level, it resulted in trembling and increased heart rate aggravating the panic attack. Since the condition resulted in repeated embarrassment she preferred to stay at home for the rest of her life (Agoraphobia). The client does not have any difficulty in locating the therapeutic center and avail its services because the client lives in the vicinity. But there were some financial constraints. The client spares a little budget on healthcare. According to her she saves a lot from everyday expenses and from her small business, as the stay and consultation were expensive.

Phase Four - Synthesizing Intuitive and Scientific Knowledge of Panic Disorder Patient. After the researcher gathered information about the life experience of the client, he was able to formulate appropriate nursing diagnoses for the client (Shives, 2005).

SUMMARY OF NURSING DIAGNOSES DURING THE FOURTH PHASE

- Anxiety related to fear of panic attack as evidenced by increase in vital signs, inability to sleep, sweating, fear of dying and going fanatical, difficulty in breathing, faintness and verbalization of impending sense of doom.

- Disturbed Sleep Pattern related to fear and anxiety as evidenced by verbal complaints of difficulty in sleeping and reports of auditory hallucination.

- Disturbed Thought Processes related to persistent feeling of extreme anxiety, guilt and fear as evidenced by perception of impending heart attack during panic attack, disturbed self assessment and verbalizations of auditory hallucination.

- Impaired Social Interaction related to altered thought processes, feelings of worthlessness and fear of rejection as evidence by avoidance of contact with others, reports of being misunderstood and being solitary and lonely.

- Role Performance Ineffective related with fear and anxiety as evidenced by inability to go beyond the constraints of the house, inability to shop, hyperventilation, sudden weakness and verbalization of going crazy or death outside the house was tormenting her.

REFLECTIONS OF THE NURSE AND THE PATIENT ABOUT THEIR EXPERIENCE

Client's Reflections :- After the entire week of nurse-client interaction, the patient practically applied the information that she learned during the relationship building and verbalized descriptive words of the things she grasped. She learned more about the nature of her disorder and came to realize the understanding of the complexities of the mind and applied steps to adapt and fight the behaviour that restricted her from her roles and socializing with other people. She also comes up with other behaviour of having a positive thought about herself and of other people. She understood the value of being optimistic. Lastly, she was able to differentiate herself from being a panic attack patient to what she is now, a better and more understood individual.

RESEARCHER'S REFLECTIONS:

The researcher's impression upon hearing the client's case for the first time was ambivalence for the fact that it was a difficult case. Changing the perception of the client and her fixed belief is a great challenge for the researcher. His concept of the condition regarding the patient is that it is a life long struggle. The realization was after the researcher experienced, understood and shared with the client his individual experiences. The researcher comes to the understanding that it is difficult to live and understand a patient with panic disorder as compared to a normal person. The client needs a guiding force to inspire, teach and push her to become a better person and to revert back to normal life. Her struggle to fight the condition was altogether lifted up by the client and the researcher. Using practical interventions and

humanistic approaches to the condition, the former dark and fearful moments of the client's condition was turned into an enlightened period of wellbeing. Extending helping hands, opened thoughts, a heart that understand and a positive regard is needed by the client to become more and more normal human being (Parker, 2001).

CONCLUSION

Based on the findings of this study and from his experience, the researcher was able to generalize that the Paterson and Zderads Humanistic Nursing Theory could be utilized as a care model to develop a Panic Disorder Anxiety Desensitization Program as evidenced by the clients responses in the nurse-patient relationship. The holistic and humanistic approach of this theory could be used to explore the overall condition of the client and lead an open relationship of the client. Both the researcher and the client were able to reflect on the basis of learning from self experiences and from the researcher's experiences. Furthermore, the researcher's self-made Nursing Humanistic Assessment Tool patterned about the Humanistic Nursing Theory obtained in depth information about the client and could be used as an adjunct to conventional psychiatric assessment forms (Varcolis, 2007).

Finally, the practice of humanistic nursing on clients with Panic Disorder furnish better outcomes in terms of nursing care and the development of new insights by the clients to reach their optimum human potential.

RECOMMENDATIONS

Based on the outcomes of the lived experience using the Paterson and Zderad's Humanistic Nursing Theory, the following are the researcher's recommendations:

1. Nursing interventions for clients with Panic Disorder should be grounded on the Humanistic Nursing Theory to assure that the client's thoughts, perception and ideas are not neglected and the clients are accepted with positive regard and authentic assessment.
2. The academe should emphasize and incorporate in their instruction the Humanistic Nursing Approach in making psychiatric care plans and dealing with clients as having the potential of becoming more of what they are now.
3. The use of the researcher's self - made humanistic nursing assessment tool in dealing with panic disorder and other clients with mental challenges should be encouraged.
4. Future researchers can employ the Panic Disorder Desensitization Program conceptualized by the researcher as a result of this study and the use the Humanistic Nursing Theory in performing future researches on clients with mental challenges should be encouraged.

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