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A RETROSPECTIVE PROFILE OF AGORAPHOBIA:
GRADUATES OF CHICAGO'S TERRAP, 1978-1980

By

Mona H. Berman

A Thesis Submitted to the Faculty of the Graduate School
of Loyola University of Chicago in Partial Fulfillment
of the Requirements for the Degree of
Master of Arts

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VITA

The author, Mona Hecktman Berman, is the daughter of Jordan P. Hecktman and Marlene Moschel Hecktman. She was born July 13, 1956, in Chicago, Illinois. On June 25, 1978, she married Andrew Alan Berman.

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In September, 1980, she was granted a graduate assistantship at Loyola University of Chicago, and in January, 1982, she was awarded a master of arts in guidance and counseling.

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CHAPTER I

INTRODUCTION

The entity known as Phobia, derived from the Greek work phobos, meaning flight (and from the Diety of the same name who could provoke fear in one's enemies), has been present in society and described in the literature since the 4th century B.C.

In its strictest definition, a phobia is a pathological fear. Rachman (1968) describes a phobia as an excessive fear reaction which is both persistent and unadaptive. An individual intellectually knows that what they fear is irrational and of minimal or no danger, yet cannot overcome it. As a result, there is a displacement of anxiety from some object or situation to another type of object or situation which then becomes feared (Eaton, Peterson and Davis, 1976). This phobic object or situation then symbolizes the original object or situation and a person begins to substitute fear for anxiety.

Rowe (1975) describes anxiety as a diffuse, unpleasant uneasiness halmarked by feelings of apprehension, personal threat, and fearfulness. This is manifested by the activation of the sympathic nervous system which stimulates various regions of the body resulting in rapid heart beat, sweating, dry mouth, rapid respiration, churning stomach, tight chest, etc. Anxiety is similar to fear in that both are responses to danger and provoke similar physiologic reactions, however, anxiety differs from fear in that anxiety is intra-psychic in origin, is the

response to an unknown or unrecognized threat or underlying conflict, and is chronic (Rowe, 1975).

In order to alleviate the anxiety provoked by a particular object or situation, a fear is substituted and thus, anxiety is reduced by avoiding the feared element, leading to the creation of a phobia.

Since approximately 1850, many types of phobias have been identified and investigated. However, phobias present among the general public for many years have gone unidentified and uninvestigated. Agoraphobia despite its long known existence was one such phobia that has only recently been identified as a significant problem.

Rock and Goldberger (1978) describe agoraphobia (otherwise known as fear of the market place) as a severe phobic disorder that broadly appears to be a complex of multiple and generalized fears centering around the fear of unfamiliar surroundings and being alone. Rohs and Noyes (1978) see agoraphobia as a common and disabling disorder and distinguish it from other well-defined phobias. Furthermore, the DSM-III describes agoraphobia as involving multiple fears including those of travel, crowds, closed spaces and heights. In her book called Simple Effective Treatment of Agoraphobia, Claire Weekes agrees that agoraphobia refers to the fear of open spaces, but further defines it as:

> a condition in which a person suffers incapacitating fear away from the safety of home, particularly when in crowds or isolated places--anywhere where the sufferer cannot make a quick escape or get help quickly should his fears as he thinks, grow beyond him. It includes fear of traveling, especially in a vehicle he cannot stop at will.[1]

---

[1]Claire Weekes, Simple Effective Treatment of Agoraphobia (New York: Hawthorne Books, Inc., 1978), p. 8.

Finally, Arthur Hardy, M.D., founder of Terrap (an organization dedicated to helping agoraphobics) believes the prominent feature of the agoraphobic's condition is related to being in a situation for which there is no escape or outlet. This creates as he feels, a morbid fear of many things, places or situations. Such situations or places include distance from home, supermarkets, elevators, escalators, freeways, crowds, parties, theaters, airplanes, doctors, bridges, and others. These situations or places may produce a phobic reaction for the agoraphobic, which is relieved for the individual if they can get to anywhere that for them represents a "safe place."

It is apparent among individuals who are experts in the field that a single unequivocal definition of agoraphobia does not exist, however, certain aspects are consistent which help to create a foundation that is descriptive of all agoraphobics. Marks (1969) and Snaith (1968) respectively describe the foundation more concisely as the fear of public places, particularly if they are too crowded or too empty, and a fear of being away from a place that represents safety.

Purpose of the Study

The present investigation was designed to study those individuals who have sought the help of Chicago's Terrap program. Since this program is specifically defined as a phobic treatment center, it is considered appropriate to label this population as agoraphobic.

The purpose of studying this population was to develop an accurate profile which can then be applied to agoraphobics in general and paralleled with what has been written about and studied in the existing literature. It is hypothesized that this study will demonstrate that

the characteristics of this population are consistent with the population of agoraphobics in general, while at the same time ellucidate certain characteristics that may add to one's knowledge of the specific population.

Subjects

Seventy-four subjects from different areas of the Midwestern United States, ranging in age from 23 to 63 years, including both males and females, single and married and of various occupations were studied.

Instrument

The instrument used to study this population was an in-depth questionnaire that is completed by all Terrap applicants prior to acceptance into the program. From these questionnaires, data has been collected and analyzed.

Definition of Terms

For the purpose of this study, several terms are used extensively. The following section includes definitions for these terms.

Phobia: Phobia, as it applies to the present study is a fear in which an intense fear reaction is inappropriately triggered by a stimulus which to other individuals seems innocuous.

Anxiety: Anxiety is produced by the feared stimulus. Anxiety is a physiological reaction that produces one or more various symptoms which may include sweaty palms, fluttery stomach, generalized warmth, rapid heart beat, trembling, rubbery knees, dry mouth, difficulty in swallowing, tightness in chest, hyperventilation, stiff neck, headache, dizziness, nausea or vomiting, diarrhea, and a feeling of paralysis.

Panic attacks: Panic attacks will be defined to include the symptoms of anxiety, while adding to that one or more of the following: feelings of doom, feelings of going insane, urges to run or get away from a particular situation, the need to return to an area that represents safety, depersonalization or disorientation.

Agoraphobia: Agoraphobia will be operationally defined as a fear that is so generalized that it encompasses many situations, places and things. These include but are not limited to open spaces, closed spaces, distance from home, grocery stores, theaters, bridges, crowds, travel, driving and any place where one feels trapped or feels that there is no escape route.

Precipitating factor: Precipitating factor is herein defined as that circumstance which was occurring on or about the time of phobic onset.

Terrap: Terrap is a self-help organization devoted to aiding agoraphobics. Terrap demonstrates and teaches an individual how to reduce or overcome disabling anxiety provoking stimuli. This term will be defined more extensively in Chapter Three.

Limitations of the Study

As in any in-depth study of a self-report questionnaire, the reliability of answers given to questions cannot be accurately assessed because of possible problems with personal bias of applicants, as well as possible exaggerations and/or omissions of answers given. Therefore, this presents a significant limitation to the present study. Other limitations inherent to this study are the fact that the questionnaire contains, in some places, questions which are somewhat vague

and confusing in their wording so as to possibly be misleading or misunderstood by an applicant. This problem was unavoidable as the questionnaire was designed by Terrap prior to this retrospective study, and served as the screening instrument.

Organization of Study

Chapter One has presented a brief introduction about anxiety, phobias and agoraphobia, as well as the statement of purpose, description of the sample population, the setting, procedure used, the limitations of the present study, and definitions of terms.

Chapter Two of this thesis presents a review of the most current literature as it relates to the present investigation.

Chapter Three will present a detailed description of the Terrap Program as well as a comprehensive description of the sample population and the methods used to collect and construct the data.

Chapter Four will contain the results obtained from the various analyses of the raw data. It will focus on certain demographic data including age of applicant, age of onset of phobia, sex, occupation, marital status, referral source, average number of children, education, and others. Furthermore, a review of the remainder of the questionnaire will be undertaken in an effort to isolate other variables that appear to be unique to other agoraphobics. Rating scales were developed that applied to answers given to each specific question, thus making the study more objective. Questionnaire responses were coded and analyzed in order to construct a hierarchy of characteristics, thus making the profile more informative. This profile was constructed with the intention of paralleling what has already been studied and documented in

the literature.

The final chapter will contain a discussion of the results obtained from this study as well as the presentation of their implications and suggestions for future study.

CHAPTER II

REVIEW OF THE LITERATURE

This chapter includes several sections. First a number of studies are discussed which focus on general issues related to the agoraphobic. Next the chapter reviews those efforts which have specifically attempted to develop a profile of agoraphobics. Following that section, the investigator will present profile data as it was generated by the review.

A number of studies, while focused on issues other than characteristics of agoraphobic populations do provide relevant information that is descriptive of their samples.

Hafner (1977b) studied the husbands of agoraphobic women and their influence on treatment outcome with the purpose of demonstrating that husbands can impede symptomatic improvements in their wives, especially if the husband is hostile.

All 33 agoraphobic women in the sample thusly were married. A minimum duration of illness required in order to participate was nine months. Most of the women had a variety of phobic and neurotic symptoms in addition to their agoraphobia. The mean agoraphobic symptom duration was 9.5 years, and the mean duration of marriage was 12.7 years.

In an investigation by Hand, Lamontagne (1974) that examined treating agoraphobics by group exposure using flooding and in vivo techniques, whether patients would help or hinder one another during

group exposure in vivo was studied. This was accomplished by examining two groups (structured and unstructured) with varying degrees of social cohesion so as to clarify the role of social cohesion as a facilitator of improvement during treatment and follow up. Results obtained from this study are not relevant to the present study yet the characteristics of their sample population are. Twenty-five chronic agoraphobic outpatients (who were referred by doctors inside or outside of the hospital) were randomly assigned to one of the two differing conditions. In this sample, 16 of the 25 subjects were women. The mean age was 35 with a range of 17 to 56. The mean phobic duration of this sample was 8.5 years with a range of 1.5-26 years. Twenty-one of the subjects had received previous treatment for their phobias. Different types of treatment received included pharmacotherapy, desensitization and psychotherapy. In addition, nine patients indicated previous treatment for non-phobic problems and many demonstrated current personality problems apart from their phobias.

Twenty-one out of the 25 subjects were married, and of those married, only seven regarded their marriage to be satisfactory. Eleven patients were working before treatment; eight of those being very restricted in terms of the locale to which they could travel, and usually needing a companion.

Gelder and Marks (1966) carried out a controlled trial of behavior therapy in 20 patients with severe agoraphobia. Their purpose for this study was to demonstrate that behavioral therapy should not be recommended indiscriminately for all agoraphobic patients. Treatment and control groups were utilized and behavior therapy consisted of

graded retraining in combination with systematic desensitization. The control group received treatment based on re-education psychotherapy. Results of their study are not relevant to the present investigation however, characteristics of their sample population were. The mean age of the agoraphobic sample was 34.5 years, and the mean duration of illness was seven years. In addition, 16 out of the 20 individuals were married.

Three quarters of the individuals were unable to leave the house unaccompanied and various combinations of intense fears of going out alone into open spaces, into shops, crowds, cars, trains, streets, etc. were expressed. In addition to their phobias, patients in both groups presented other symptoms such as depression, feelings of depersonalization, and obsessions. Also, three quarters of the sample population expressed sexual difficulties. These symptoms however were much less incapacitating than their phobias.

Gelder and Marks found no significant pattern of premorbid personality, yet they described seven individuals in each group to be anxiety prone while also showing neurotic childhood traits. Moreover, interpersonal problems were found to be common in both groups.

Finally, no significant differences were found between the two agoraphobic groups in terms of age of symptom onset, age at treatment, symptom duration, initial severity of phobia, type of symptoms experienced, degree of general anxiety, social relationships, occupation, leisure activities and sexual relationships.

Marks and Gelder (1966) researched 139 adults from the Maudsley Hospital in London who presented themselves with phobia as the main

complaint. The purpose being to gain knowledge about age at onset in phobias which had not been previously reported in adults. Patients were classified into four groups according to the nature of their fears. The four groups consisted of patients with specific animal phobias (n = 18, 17 females, one male), patients with specific situational phobias (n = 12, nine females and three males), patients with social anxieties (n = 25, 15 females and three males), patients with agoraphobia (n = 84, 73 females and 11 males).

Their findings indicated that agoraphobic fears were often associated with specific situational or social phobias. Additionally, their observations indicated that agoraphobia is often associated with such psychiatric symptoms as generalized anxiety, depression and obsessions.

A bimodal distribution demonstrated peaks of agoraphobia at late adolescence and at age 30, with the emergence of agoraphobia starting at any time from late childhood to early life. Moreover, their study indicated that agoraphobia not only was the most common type of phobia in this sample, but that they presented themselves for treatment more often in their middle-ages which was slightly higher than those with other phobias yet not markedly different.

Conclusions of the study were that there was no significant differences in the ages in which all four groups sought treatment in adult life, however, the age of onset differed between the phobic groups with most animal and insect phobias beginning before the age of five while most other varieties starting after age ten.

In a widely documented study on the investigation of phobias,

Snaith (1968) compared and contrasted agoraphobic patients with patients suffering from discreet phobias by determining if the two types of phobias arise in the same way, as well as how they differ from each other in certain fundamental respects.

All subjects in the study were personally seen by the author of the study. A control group was used to survey fears among the general population consisting of 100 volunteers ranging in age from 15 to 65 years. Forty-eight patients were studied with regard to agoraphobia and discreet phobias. The 48 subjects were then placed in one of two categories: group one consisted of those who suffered primarily from agoraphobia, and group two consisted of those patients whose primary fear was focused on a specific object or situation. Data was collected from the experimental group by means of case histories, anxiety rating scales, and an adapted self-rated fear schedule. Data from control subjects was collected by the completion of the Phobia Schedule and the Eysenck Personality Inventory.

The results obtained regarding the agoraphobic sample are relevant to the present study as they include characteristics of the population studied. These results will be mentioned here, however, results pertaining specifically to characteristics of individuals with discreet phobias, and conclusions of the study will be excluded as they do not apply specifically to the present investigation.

Twenty-seven of the 48 patients in the experimental group were agoraphobic with the mean age being 37.67 years. In addition, 17 of the agoraphobic subjects were female and 10 were male.

Snaith's study revealed that agoraphobic patients were more

likely to have come from unstable family backgrounds. Also found was the variability of onset of illness in terms of onset beginning with a panic attack versus an insidious onset. In addition, also reported was both a tendency towards gradual improvement as well as fluctuations in severity of symptoms. Also, periods of total remission were highly reported.

High levels of generalized or free-floating anxiety was reported as the most outstanding symptom for agoraphobics. Additionally, agoraphobic patients reported that the dread of these panic attacks and various other somatic symptoms often led to their reluctance to venture beyond secure situations.

Depression was seen as common, yet in more of a fleeting rather than a chronic manner. None were considered to be primarily depressed.

Depersonalization and derealization were fairly common among subjects yet it was generally found that these symptoms usually occurred during the height of a panic attack. There was no incidence found of fugues, amnesia, or hysterical conversion symptoms for this group.

The primary fears experienced by this group consisted of fears of going away from home, fears of travelling, traffic, being alone, narrow streets, wide open spaces, hills, and eating or drinking in public. Additionally, fears were shown to increase when the subjects felt ill.

Since this study used a control population, it is interesting to note the finding, that certain fears in the general population are quite common and certain ones have shown to be very rare. The fears

that were shown to be most rare in the general population included those fears that gain prominence in the symptomatology of the agoraphobic patient.

Roberts (1964) conducted a follow-up study on married women who had become housebound as a result of their phobic anxiety symptoms. The study was done to determine the homogeneity of the group, as well as what proportion of those women improved during follow-up. Data included case records of married women who had been admitted to the psychiatric in-patient unit of St. George's Hospital from 1946 to 1962. Forty-one cases were selected for use. These cases indicated that the women had been housebound prior to admission for periods ranging from three months to 15 years. Follow-up periods ranged from one and a half to 16 years. Part of the results obtained from this study were objective and factual in nature, and described characteristics of the group prior to follow-up. Since this information is relevant to the present investigation, it will be cited here, however, results regarding follow-up are excluded, but can be found elsewhere.

Roberts reported features which were shown by the majority of patients and seemed to constitute characteristics of the group. Thirty-four patients developed initial symptoms between the ages of 20 to 40. Anxiety was the major symptom in all cases. Patients indicated that it was the fear of the panic attack and/or high levels of anxiety which caused them to feel as though they would faint, collapse, feel embarrassed, lose control, etc. This encouraged their avoidance behavior. Twenty-eight or 70% reported that the onset of their illness began with a panic attack, and could easily recall under what

circumstance and where the attack first occurred.

Sixteen of the 33 women experienced derealization or depersonalization during their panic attacks, while 11 of these women had been sufficiently depressed to have received electro-convulsive therapy.

Sixty percent of the patients were able to recall precipitating factors associated with their first panic attack; a number of these women reporting onset after an organic illness. Most patients reported a fluctuation in symptoms since the time of onset, with an increase in symptoms as additional environmental stress occurred in their lives. However, three patients reported symptomatic improvement associated with increased stress.

Fifteen patients (40%) demonstrated a family history of neurotic illness in first degree relatives. Additionally, subjects themselves characteristically had been anxiety-prone; 50% had at least one well-marked neurotic trait, usually in the form of a childhood phobia. Also found was the absence of depressive mood swings in their premorbid personalities, yet nine subjects were found to be obsessive to some extent.

With only two exceptions, all subjects had good work records. Additionally, although only nine patients indicated dissatisfaction with their marriage, 53% indicated sexual maladjustment of some form.

Roth (1959) studied 135 patients who he labeled as having the Phobic Anxiety Depersonalization Syndrome (and who suffered from phobic anxiety depersonalization symptoms) and compared them with a control group consisting of individuals who suffered from symptoms characteristic of neurosis as well as individuals who suffered from temporal lobe

disturbances. The latter group aforementioned served as the control group consisting of 50 patients suffering from other neurosis and 50 individuals suffering from a physical illness (temporal lobe disturbance) who had never had any type of psychiatric illness. This study sought to assess the possibility that identical physiopathological mechanisms underly depersonalization whether it occurs in association with "functional" psychiatric disorders or with definable cerebral lesions.

The study included 100 items relating to early life, family background, previous personality, heredity, features of the illness and patterns of adjustment. Of his findings relevant to the present study, Roth found that 83% of the phobic patients experienced onset of illness around a precipitating event of a calamitous or threatening nature. A further 13% reported onset with pregnancy or childbirth. This percentage of clear cut precipitating events that were reported was significantly greater than that found in the control group.

Additionally, the symptoms of depersonalization were clearly associated with phobic anxiety but it was found to vary in regards to severity. Moreover, it was found that individuals with phobic anxiety proved to be more dependent, immature, obsessional and anxiety-prone in comparison with other neurotics, while obsessional and compulsive checkings were found to be rare in phobics.

Goldstein and Chambliss (1978) reported on the existing models for understanding agoraphobia and suggested a complex behavioral model for treatment which includes a combination of the necessary and sufficient factors for its formation. Their theoretical assertion was

derived from their own clinical experience as well as from research and observational reports from other settings. All of the individuals were outpatients with phobias being their presenting problem, and were seen at the Behavior Therapy Unit of the Department of Psychiatry of Temple University. The clinical observations were supported by data obtained from 32 agoraphobic clients and 36 clients with phobias of some type of external stimuli. For clients that were not currently in therapy, information was gathered retrospectively from the therapist's recollections or from files. Scales that were routinely administered before treatment were the Bernreuter Self-Sufficiency Scale, the Willoughby Emotional Maturity Scale, and the Fear Survey Schedule. From these, a number of relevant items were selected for analysis.

Their results indicated that the agoraphobic group did not differ statistically from the external-stimuli phobic group image or sex ratio. The former group was comprised of seven men and 25 women with a mean age of 34.3 years; the latter group consisted of 12 men and 24 women with a mean age of 38.06 years.

In their study, Chambliss and Goldstein presented a consistent picture of agoraphobics being more susceptible to unassertiveness, marked social anxieties (including fear of criticism and responsibility, and being disapproved of), dependency, and repressive response style. In addition, their study demonstrated that agoraphobics and external stimuli phobics can be readily differentiated on the basis of having fears of the consequences of being afraid. The former group feared losing control, fainting, becoming or being mentally ill, and heart attacks. Their study also noted that often the first outbreak of

agoraphoic symptoms occurs after a clear conditioning event, such as a failed marriage, death of significant other or illness which results in high anxiety and panic attacks.

Lastly, from their research, Chambliss and Goldstein made the distinction between simple and complex agoraphobia. The simple agoraphobic is one whose illness is not the result of such personality characteristics as unassertiveness, dependency, social anxieties or repressive response style, but instead is usually the result of a physical condition such as hypoglycemia, an endocrine imbalance, or a frightening experience with hallucinogenic drugs. On the other hand, complex agoraphobics demonstrated the underlying characteristics mentioned above with the most prominent features being the fear of fear as the central phobic element, low levels of self-sufficiency (due to anxiety, lack of skills or a combination of both, a tendency to misinterpret anxiety, and the emergence of symptoms occurring in a climate of conflict; usually an interpersonal one.

The results of this data differentiated agoraphobics and phobics on the basis of fears of the consequences of being afraid, that those individuals with complex agoraphobia can be discriminated from those with other phobias on the basis of less self-sufficiency and that the onset of complex agoraphobia occurs during times of high interpersonal conflict. It was not proven however that complex agoraphobics are less able to connect causal antecedents to their responses due to a lack of sufficient objective information.

Agoraphobia is much more common than is generally believed by the layman. This is nowhere more evident than in the literature that

indicates its prevalence. In a comprehensive review of the available literature on agoraphobia by Marks (1970), done from a descriptive standpoint, numerous associations were described. The review was completed because nothing of that type had been previously attempted up to that point. Marks reports the estimated prevalence of agoraphobia in the general population is 6.3 per 1000 (from a Vermont sample). It is also pointed out that approximately 2/3 of all agoraphobics seen by psychiatrists are women in both America and Britain. Also, in his own study from the Maudsley Hospital, Marks (1966) reports a mean age of onset as 24 years (which differs slightly from a nation-wide survey on agoraphobia which he conducted in Britain), and ranging in ages between 18 and 35 with a rare exception of onset in childhood. Marks estimates that a great majority of individuals with agoraphobia experience onset after puberty, with peaks at 20 and 30 years of age. These statistics are consistent with other studies. He also found that most patients come for treatment in their 30's with a mean age of treatment being 34 (Marks, 1966).

In his review and comprehensive description, Marks found that most agoraphobics come from stable backgrounds unlike the background of psychopathic individuals where broken homes are frequent. However, he reports that even among family members of agoraphobics the incidence of psychiatric disorders ranges from 21% to 40%. This compared similarly with a study by Harper and Roth (1962) in which it was found that the incidence of neurosis in the family of phobics was 33%. This was significantly higher than the control group consisting of temporal lobe epileptics.

Marks reports that agoraphobic patients are not unusual in intelligence, education or occupation. The basis of his findings comes from his agoraphobic sample as revealed through their questionnaires (1970).

Additionally, he points out the difficulty in noting what can or should be called a precipitating event yet nonetheless states that a substantial number of agoraphobics have symptom emergence after a major change in their life situation (i.e., serious illness in the patient or relative, bereavement, engagement, marriage, childbirth, leaving home. etc.). At the same time he notes that the presence of or nature of the precipitating event does not correlate with the subsequent course of the agoraphobia. Also, the mode of onset can be gradual or sudden (usually in the form of a panic attack). The course of agoraphobia, once it has begun, is often characterized by remissions and exacerbations of varying duration.

The main features of agoraphobia that are reported by Marks are fears of such things as going out into the open, including streets, shops and crowds as well as closed spaces such as elevators, theaters, or church. Travel on subways, trains, buses, ships, and airplanes (but not usually cars) have also been described. Other fears included going on bridges, into tunnels, having haircuts, fear of heights, and of remaining alone at home or leaving home. It is interesting to note that these fears can occur in combination and are often associated with other somatic symptoms such as generalized anxiety, feelings of panic, depression, obsessions and depersonalization. Certain social fears are also found with this condition such as the fear of being stared at, and fears of trembling, blushing, eating, or signing one's name in front of

other people. In fact, Marks reports that it is exceptional for an agoraphobic to find it easier to travel alone. He supports this with results obtained from his sample of agoraphobics in Britain in which he found that 65% of the phobic individuals felt better when traveling with someone, while only 5% reported it easier to venture out alone. Marks speculates that because of this need for companionship, agoraphobics generally desire the presence of a trusted companion, and as a result, dependency often develops.

He discussed useful strategems that aid the phobic in feeling less panic when outside the safety of one's home to include walking sticks, umbrellas, suitcases, shopping carts, folded newspapers or sucking on candy. Also mentioned was that when agoraphobics go to the theater or church, they feel less frightened if seated near the aisle and close to an exit so they could leave quickly if they suddenly felt panicky. Lastly, Marks reports there is no known organic disease that tends to be present in agoraphobics as compared with a control population.

Other investigators in medicine and psychology have studied characteristics of agoraphobic populations. One investigator, Claire Weekes (1970) surveyed 528 agoraphobic men and women in Great Britain and Ireland that she had previously or was currently treating by remote direction. Treatment by remote direction includes cassette recordings that are sent to agoraphobics around the world allowing the individual to receive aid without the direct contact of a therapist. This survey was done to assess the patient's estimation of his or her own progress in terms of Weekes' specific therapeutic approach. The ages of those surveyed varied from 14 to 17 years. Her findings of the survey were

very typical of characteristics she had found among agoraphobic populations in general. Of the 528 subjects surveyed, 60% of those individuals had been phobic for ten or more years and 27% for 20 or more years. She thus labeled this population as chronically agoraphobic.

The gender ratios are clear and reasons have been speculated for the differences. In Weekes' sample, 91% of the subjects were women and 51% of those women were single. However, more recent studies show that the majority of agoraphobic females are married (Goldstein and Chambliss, 1978; Popler, 1977; Weekes, 1978). Of the 42 men in her sample, 16 were single. Also, in her survey, Weekes found that 78% of the women were occupied by home duties, 12% part-time work, and 10% worked full time away from home. Only 5% of the males in Weekes' study were retired.

The main fears expressed by her subjects were typical of agoraphobics in general. They consisted of fears of crowded places, traveling from home (either alone or accompanied by another person), fear of collapsing, fainting, panicking, standing in line, falling, or feeling paralyzed in the streets. Less frequently reported fears were fears of being alone in the house, death, childbirth, physical illness, going mad, feelings of unreality, losing a loved one, harming others, depression, persisting thoughts and various others. Only 5% complained of sexual problems. The most common fears reported among the male population studied were physical illness, domestic stress in adult life, loss of loved ones, difficulty or pressure at work, domineering parents or unhappy alcoholic parents, sudden occurrence of frightening symptoms outside of their home (i.e., dizziness or heart palpitations), nervous disposition, illegitimacy, World War II, and finally, the strain of

looking after an elderly parent(s). Five percent gave no apparent cause for the emergence of their agoraphobia.

Weekes found that the majority of her subjects became ill in their twenties or thirties. Sixty-five percent of the sample had sought previous treatment from one or more psychiatrists and 30% had sought the help of general practitioners only. The different types of treatments administered included psychotherapy, hypnosis, behavioral therapy, electro-convulsive therapy and pharmacotherapy. Of those that sought previous treatment, 55% reported that they received no help from previous therapy, 6% were helped temporarily and 24% reported that they received a little help. Of the 15% that were positively helped, those individuals still indicated a need for additional help.

In 1970, aside from compiling a comprehensive review on agoraphobia, Marks and Herst surveyed 1,200 nationwide members of an agoraphobic club in Britain called The Open Door. The purpose of this survey was to discern characteristics of that population as they were associated with treatment and ability to work. Questionnaires relating to the individual's psychiatric and social status were sent out to 1,500 members and results were compiled from the 80% of the questionnaires that were returned. The sample included two groups; one that had never received treatment for their phobia and the other group having received either aid from a psychiatrist or a general practitioner.

Of this population, 95% were female and 80% of these women were married. Also in 1975, Marks estimated that 66% of all agoraphobic patients seen by psychiatrists were women. The mean age of responders was 42 years while the mean agoraphobic symptom duration was 13 years.

It was also found that the average age of onset of the agoraphobia was 29 years of age. Average time to seek help from the onset of the phobic illness was 17 months to a general practitioner and 34 months to a psychiatrist. Only 5% of this surveyed population indicated that they had not sought any type of medical aid for the phobias. Ninety-five percent of the population indicated that they had seen a general practitioner, 67% had been seen previously by psychiatrists, and 15% had seen a spiritual or religious healer for the problem.

Less than 1/5 (19%) of the respondents had relatives with similar phobias. The most common phobias of this sample included speaking to an audience, crowds, trains and heights. Fifty-six percent of the population indicated that they specifically avoided streets and open spaces, and 32% reported an uneasiness in streets and open spaces, while 12% reported that they had no fear of streets at all.

With regard to family life, the mean number of children of respondents in this study was 1.8. In addition, 15% of the population had some higher education, and 17% had been psychiatric inpatients due to their phobia.

Marks and Herst concluded their sample population was representative and that the results obtained were a fair assessment of the population's characteristics. Other results of this study were found, yet do not relate specifically to the present investigation.

Buglass, Clarke, et.al. (1977) studied agoraphobic housewives and explored various clinical symptoms of married agoraphobic women in the context of their marital and social situation. Aspects of their lives were compared with various aspects of a control group.

Thirty agoraphobic subjects were compared with a "normal" control group of the same size. The agoraphobic's husbands were similarly compared with the husbands of the control group. The 30 agoraphobic women used as subjects were referred to the outpatient clinics of Edinburgh. The control group was selected from the register of the Department of General Practice in the University of Edinburgh. The women in the agoraphobic and control groups were matched on age, sex, social class, and marital status. Procedures used to conduct this study consisted of three interviews; the first being a conjoint interview conducted by a sociologist in the couple's home, the second being a separate interview with the husband and wife by a psychiatric team members, and lastly, the administration of the Cornell Medical Index, the Eysenck Personality Inventory, and a Semantic Differential test. Characteristics irrelevant to the present study will not be mentioned here, yet much of the social and marital information obtained from comparisons between the agoraphobic and control groups of women are worth noting.

Results indicated a great variability in the severity of their phobia; eight out of 25 patients who, at their worst were able to leave their homes unaccompanied for 30 minutes or less were able to pursue their normal activities on a better day (though not always anxiety free). Additionally, out of the 26 patients who were having menstrual cycles, aside from many reporting malaise during the premenstrual week, premenstrual exacerbation of the agoraphobia was experienced by only 10.

The most common fears cited by the agoraphobic women was the fear of becoming physically ill. This was often accompanied by the fear of causing a public disturbance in the process. In addition, in five

cases, the relation to the event that preceded the onset of the phobia, and the onset of the phobia itself were equivocal. Fifteen patients experienced background stress prior to onset and in nine of the 15 subjects named above, a recognizable neurotic syndrome was present that had preceded the onset of phobia from a few days to eight years. Only seven patients identified discreet events that occurred at the time of onset and of those, only two were specific. No evidence of either background stress or specific versus nonspecific events was demonstrated for eight patients.

Associated symptoms found among this group were depression, anxiety, and significantly more phobics reported depersonalization experiences, yet, control subjects reported experiences of depersonalization also indicating marked differences in past depersonalization history. Additional obsessional symptoms associated fears and phobias were reported by 28 of the 30 patients. The most commonly elicited were fear of heights and enclosed places. Others included fears of animals, fears of acting out impulses, being alone, and fear of fear (developing a panic reation).

Relating to their past medical history, the average number of anasthetics ever received was 1.8 for the agoraphobic population. This was slightly higher than that of the normal control group. Also, six patients reported at least one previous clear-cut episode of agoraphobia before the present attack, yet both patients and controls were similar in terms of non-phobic psychiatric illness after the age of 16 (i.e., mild depression or anxiety). There was no significant difference in regards to previous inpatient or outpatient hospitalization between the

two groups of women except for the frequency of gynecological illness in which 20 phobics as compared with 12 controls reported previous inpatient care for such disorders.

With regard to family history, 10 of the phobics came from homes containing others who were not part of the biological family (step parents, adopted siblings, etc.), as compared with one control. Also, there was no evidence of an excess of psychological disorders among phobic patient's parents or excessive drinking by the fathers. However, a slight excess of patients with at least one phobic sibling was shown, especially for male siblings in the phobic group. In addition there was no excess of childhood phobias in the offspring of agoraphobics; 18% of the phobics' children and 25% of the controls' children were rated as phobic (not agoraphobic however). Moreover, no difference was found between phobics and controls in regards to having a special relationship with their mothers, yet ambivalence towards mother was significantly greater in the phobic group. The investigators hypothesized that this significance may be due to the phobic patient feeling dependent on their mother while at the same time resenting their dependence.

Dependency was assessed by the investigators by questions directed to elicit a history of separation anxiety after age eight, symptoms, and freedom to choose clothes only after reaching age 18. No differences were found between the two groups.

Lastly, sexual development was studied in both the phobic and control group. Results demonstrated no difference between length and onset of menarche yet the phobic group complained of dsymenorrhoea

(painful menarche) more often than controls. In addition, sexual adjustment and satisfaction prior to the onset of the agoraphobia was similar with that of the control group, however, after the onset of illness, 16 of the phobic women reported loss of libido as compared with only one control subject.

SUMMARY

There are certain characteristics which have been consistent in the studies reviewed. These characteristics include the facts that agoraphobia affects more women than it does men, and more married individuals than it does single. In addition, it seems to be consistently found that agoraphobia rarely begins in childhood, more often presenting itself between the ages of 18 to 30, however, this range is somewhat variable in that many people indicated the presence of agoraphobic symptoms prior to its actual onset. It was found in the majority of studies that the average age in which the agoraphobic individual seeks help appears to be approximately 35 years of age, and on the average, these individuals have suffered agoraphobic symptoms for about nine years.

Furthermore, not only have many individuals suffered from the symptomatology of agoraphobia, but, many studies show that most have received previous treatment for their phobia. Those indicated by the literature included electro-convulsive therapy, psychotherapy, hypnosis, pharmacotherapy, and various types of behavioral therapy. It was also evident that a great majority of agoraphobics seek medical attention from general practitioners. Although the majority of these people eventually seek some type of psychiatric assistance, they do so after

first consulting a general practitioner and generally report few if any benefits.

Also consistently reported were common fears experienced by most agoraphobic individuals. These consisted of the following: fears of going out alone in open spaces, closed in spaces, shops, cars, crowds, trains, streets, travelling, traffic, eating or drinking in public, elevators, airplanes, and others. As a result of confronting these fears and experiencing adverse reactions which often results in high levels of anxiety, commonly cited were fears of losing control, fainting, becoming mentally ill, having a heart attack, and causing a public disturbance. In addition, most individuals reported anxiety as being their most outstanding symptom, and that it is the dread of such panic levels of anxiety that increase their avoidance behavior, and as a result, keep them fearful.

Other symptoms that are commonly found to be associated with agoraphobia are depression, obsessions, feelings of depersonalization or derealization, sexual maladjustments, and high levels of generalized anxiety. Moreover, many agoraphobic individuals have reported treatment sought for problems other than their phobia. In addition, interpersonal problems were frequently cited. These included dependency, immaturity, repressive response style, unassertiveness and marked social anxieties. Also, subjects were almost always found to be anxiety prone and demonstrated childhood neurotic traits. However, no significant premorbid personality problem seems to be present.

Most of the studies consulted indicated that the precipitating factors that are most often associated with onset of the phobia revolve

around a major change in the agoraphobic's life situation. These include but are not limited to the death of a significant other, an organic illness, pregnancy, childbirth, marriage, divorce, after something of a threatening or calamitous nature, and work related problems. In addition, most studies report variability in terms of onset by panic attack versus onset of a gradual nature. There does not seem to be one consistent mode of onset among individuals, yet once the phobia begins, most people report fluctuations and remissions of symptoms, with fluctuations being most prominent during or after an illness.

Although many studies indicate that a small amount of individuals have relatives with similar phobias, research also points out that there is no organic illness associated with agoraphobia. Useful strategems or security symbols often carried by the phobic individual include sucking candy, suitcases, newspapers, umbrellas, canes, and shopping carts. Additionally it is rarely reported that agoraphobics find it easier to travel alone while the majority of individuals occupied their time with home duties, and only a small minority worked full time.

Inconsistently reported in the literature was the degree to which agoraphobics experience marital satisfaction. While many studies indicate that most agoraphobics are dissatisfied with their marriage, others report satisfactory marriages. Additionally there was discrepancy in terms of the background of agoraphobics. Some studies found a significant relationship between agoraphobia and unstable family backgrounds, while other studies indicate that agoraphobics come from very stable backgrounds.

In summary, the material reviewed here suggests that the

description above might be characteristic of the agoraphobic individual. While this is not meant to be all inclusive, it does provide some specific information that is useful in evaluating a client regarding agoraphobic tendencies and gives the reader a more detailed picture of the agoraphobic problem and characteristics that often accompany it.

CHAPTER III

PROCEDURES

This chapter will provide the reader with a comprehensive definition and description of Terrap. This is considered valuable not only for understanding the Terrap program itself, but because it provided the information from which the data was collected. In addition, this chapter contains the subjects, setting and procedure used in this study.

Terrap is a 16 year old program which has helped individuals who suffer from fears, anxieties and phobias, especially agoraphobia. Terrap was developed by a psychiatrist named Dr. Arthur B. Hardy, who had been studying agoraphobia for almost 10 years. Terrap originated in California and has now spread throughout the United States in which currently 22 different Terrap centers are located under Dr. Hardy's supervision.

Terrap is a contraction for the phrase "territorial apprehensiveness" and came about originally as a non-profit organization to help inform individuals of the problem of agoraphobia (since many individuals were suffering from agoraphobic symptoms and did not know it had a name). The name Terrap evolved because the problem involves territory as well as people being apprehensive about getting a distance from home. It was thus called Territorial Apprehensiveness and shortened to Terrap Incorporated. Aside from the non-profit aspect of Terrap

which currently sends out newsletters to agoraphobics all over the country, another aspect is that Terrap conducts, for a fee, therapeutic courses for agoraphobics.

Many individuals are attracted to Terrap because it is a specialized course that specifically helps agoraphobics and has had very positive results. In a popularly read magazine article, printed material revealed "80% of Terrap patients materially improved."[2] In that same article, Dr. Hardy explains his belief that agoraphobia is a behavioral problem rather than a mental illness. Therefore, with an educational/behavioral orientation, the Terrap program is based on a combination of desensitization and relaxation techniques which are taught to agoraphobics. The individuals are helped to recognize different levels of anxiety which are rated from 1 (calm) to 10 (panic levels of anxiety). In slow and unthreatening steps, and often with the help of a support person, the individuals are urged to confront their fears while retreating if the level of anxiety goes up past a 3 (each person being in touch with what their different anxiety levels feel like). When the individual's level of anxiety goes up past a #3, the person retreats, discusses his or her reactions, sensations, feelings, etc., and tries once again when they have come down to a calmer level of anxiety.

Since there do not seem to be any magical cures for agoraphobia, much of the solution also comes from agoraphobics being able to see

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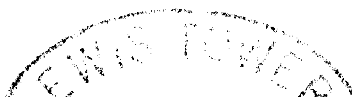
[2] Family Circle Magazine, Prisoner of Fear, by Katherine Barrett, May 13, 1980.



that they are not alone with their fears, and that they are not mentally ill. Through involvement with Terrap, they are able to see that there are many others who suffer from the same problem, for a significant part of the Terrap course is conducted in groups. In a personal interview with Dr. Hardy at the Chicago Terrap Center in November, 1980, Hardy told the investigator, "...the group helps. They encourage each other tremendously. It is especially helpful in the beginning when everyone is loaded with or paralyzed with fear... So they see people with the same problem and that don't look like crazy people. They begin to believe they don't look crazy."[3] These group meetings probably entertain the most important aspect of the individual's experience with Terrap. That involves taking the phobic individuals out into real life situations to help them come face to face with the things that cause them the most fear.

Terrap centers generally offer either a 16 week course that meets twice a week or conducts two-week intensive programs that run eight hours a day, Monday through Friday. The cost of either course is one thousand dollars. In addition, Dr. Hardy offers a correspondence course that has proven to be successful as well.

As Terrap is a self-help educational program, the basic goal of Terrap is to help agoraphobics learn relaxation responses in place of the anxious ones that they have come to associate many situations with. The course does not focus on insight therapy; it is focused on

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[3] Personal interview with Dr. Arthur B. Hardy at the Chicago Stress Center, November 20, 1980.

desensitization techniques, disinhibition training and assertiveness training. Terrap encourages a support person, friend, or spouse to accompany the agoraphobic to the Terrap sessions. The theory behind this is that as the agoraphobic begins to become more assertive and open, it is important for the person closest to them to be able to understand what is happening. Also, by attending the sessions, the support person can be enlightened to better understand the agoraphobic's experiences.

In the same interview previously mentioned with Dr. Hardy at the Chicago Terrap Center, he commented on what percentage get better as a result of Terrap. He clarified that his results were based on clinical impressions rather than on statistics. He divides graduates of the program into five categories. He feels that the first 20% (or two out of 10 people), "...will catch on to what the problem is, it is meaningful to them, they know what to do and they're off and running after about a month...or two months...you get post cards from them from all around the world...and then other than that we don't see them because they don't want to have much connection with us or anyone that has the problem, because they don't want it to rub off on them...it's like they've graduated from college and what the hell do you want to go back to college for?" Hardy feels that the next 20%, "...will go through the whole course and then they'll sort of sink in the course, and then they'll begin to pick up and start doing things themselves, and they do fine; so there's 40% of the people that we see that do really well through the course." Dr. Hardy feels the third 20% does in fact get better yet has more of a struggle. He said, "...it takes

them a year or two years, and most of them need extra help...They'll need individual psychotherapy, they'll need marital therapy...family therapy...or some kind of guidance and direction..." The fourth 20% has to struggle even harder. Hardy does not feel that they get a complete recovery, but instead, "...they do get enough recovery so that they can go to the store, do their shopping...they can get by with a little alcohol or a few tranquilizers...and they settle for that." Lastly, Dr. Hardy feels that the last 20% are failures and he has been unable to account for the reason. He speculates that this may be due to the fact that some of these people have "schizoid" tendencies and that "...their thinking is so inaccurate and mixed up and bizarre...that I don't think you can change their cognitive position enough to do it for them, at least I haven't been able to. Maybe someday we can when we know more about it."[4]

The Chicago Terrap Program has been in existence for four years and is currently housed at 2530 North Lincoln Avenue. The directors are Bonnie Rudolph, Ph.D., and Beth Weissman, Ph.D.

Subjects

Subjects for this study consisted of 78 agoraphobic individuals (58 females and 16 males) between the ages of 25 and 63, both single and married, and of various occupations. Criterion for selection was having completed Chicago's Terrap Program. Subjects were from different areas of the Midwestern United States and were judged to be agoraphobic by criterion established by Terrap Incorporated on the basis of

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[4]Ibid.

information obtained from the in-depth questionnaire that is completed prior to acceptance into the program. The criterion was assessed by qualified psychologists prior to this study (See Tables 1, 2, and 3).

Methods

The method for collecting data for this study involved a comprehensive review and analysis of the subjects' in-depth questionnaires. The data that was collected was coded and assembled into various scales and categories developed by the investigator as they specifically related to each question; with the exception of occupation categories which were taken from Baer and Roeber (1951).

Data was then treated so that means and percentages could be calculated and reported. Data collection and data analysis were both carried out by the investigator. Permission to study these questionnaires was granted by the administrators of Chicago's Terrap Program. In addition, as a result of the investigator's work with Chicago's Terrap Program, the questionnaires were available for review.

The last three pages of the in-depth questionnaire were disregarded for the purposes of the present study as the questions asked were intended to screen out those persons with problems unrelated to agoraphobia. In view of the fact that the sample population for this study was judged to be agoraphobic, eliminating these items was believed to be appropriate.

CHAPTER IV

RESULTS

This chapter presents the data from the present investigation. The data are presented in the order in which the items appeared on the questionnaire. This allows the reader to easily refer to the questionnaire while evaluating the data. The questionnaire is in Appendix A, page 77.

Demographic Results

From a sample population of 74 agoraphobic subjects, 16, or 21.62% were males and 58 or 78.38% were females. Among the male population, the average age was 34.31 years while the average age of agoraphobic onset was 24.94 years. For the female population, the average age was found to be 36.47 years with an average age of agoraphobic onset being 25.75 years. Additionally, the mean agoraphobic symptom duration for males was found to be 9.38 years and 10.84 years for females.

For the total population, 73% were married, 17.6% were single, 8.1% were divorced or separated, and 1.4% were widowed. When separated by sexes, the results showed that a greater percentage of females, as compared to males were married at the time the data was recorded, while the percentage of both divorced and single males was greater than that of the female population (See Figure 1).

Subjects came from seven midwestern states and one southern

Table 1

Average Age and Marital Status by Percentage of Subjects Separated by Sexes

Sex	Average Age	Married	Divorced	Single	Separated	Widowed
Male = 21.62%	34.31	50%	12.5%	37.5	0	0
Female = 78.38%	36.47	79.31	5.17	12.07	1.72	1.72

Table 2

Residence of Subjects According to Sex
(Percentages)

	Illinois	Iowa	Wisconsin	Indiana	Missouri	Florida	Michigan	Kansas
Males	62.5	6.25	12.5	18.75	0	0	0	0
Females	72.41	1.72	10.34	5.17	3.45	1.72	3.45	1.72

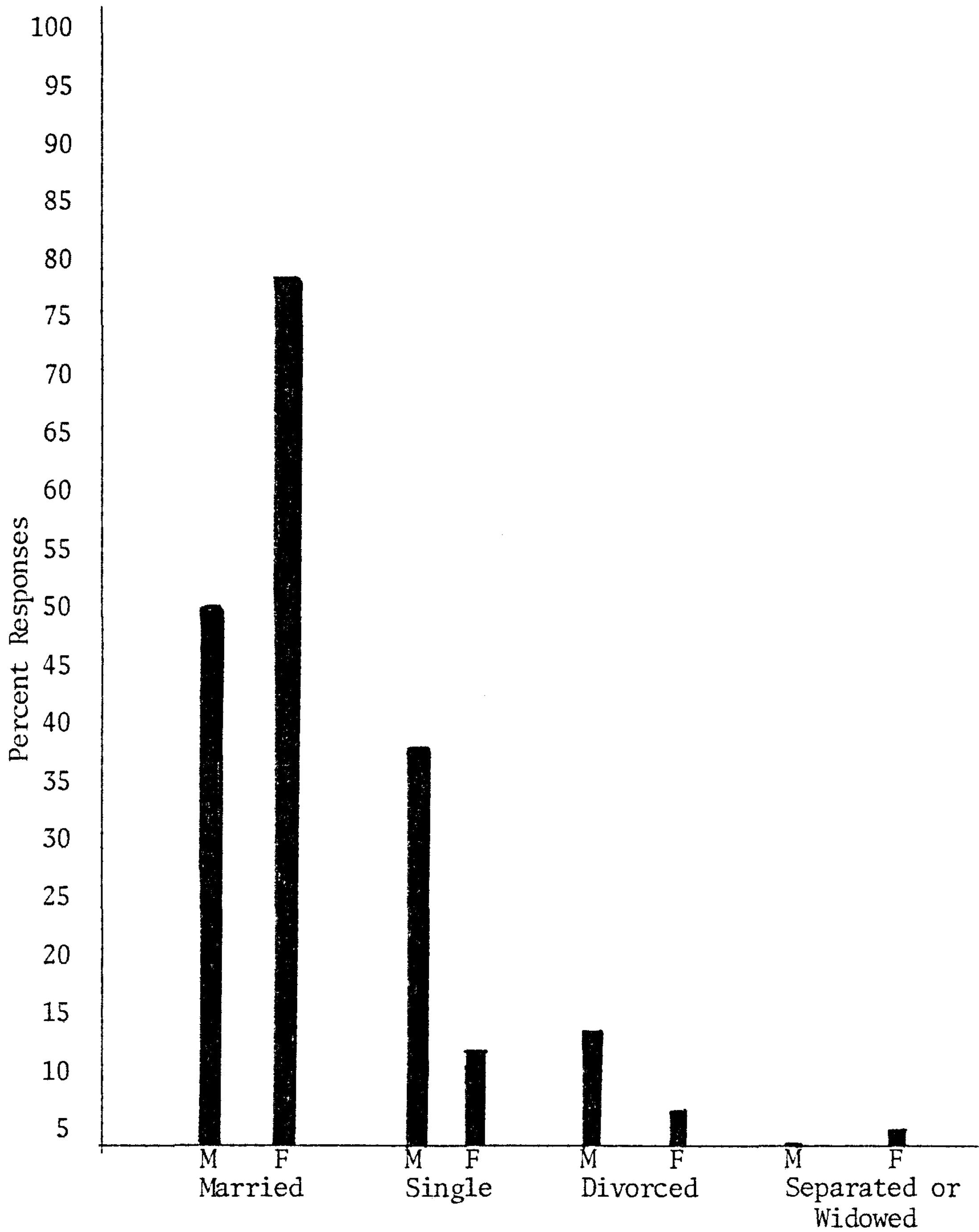
Table 3

Occupation of Subjects According to Sex
(Percentage)

	Professional, Technical & Managerial	Clerical & Sales	Mechanical Work	Unemployed	Service	Housewife	Student	Retired
Male	56.25	18.75	18.75	6.25	0	0	0	0
Female	12.06	17.24	1.72	0	5.17	50.0	5.17	1.72

Figure 1

Marital Status of Subjects Separated by Sex



state (See Table 2), with an average number of children being 1.00 for male subjects and 1.43 for female subjects. Also, of the 74 subjects examined, 39.19 were housewives, 21.62% had professional, technical or managerial skills, 17.57% were clerical or sales workers, 5.41% worked in a mechanical capacity, 4.05% worked in a service capacity, 4.05% were students, 1.35% were retired, and 1.35% reported that they were unemployed. In addition, 5.41% of the sample population gave no answer to this question (See Table 3).

In addition, when educational background was assessed, 52.7% of the subjects were found to have had some college or post college education. The remaining 47.3% of the subjects either had the equivalent of some high school education or did not respond to the question. Four individuals did not respond.

Phobic Onset

When asked under what circumstances their phobia began, subjects provided information that was categorized by the investigator into ten groups. Based on the limited scope of the questionnaire, it was impossible to effectively categorize responses in a research oriented system. Thus, the data indicated only where the phobia first began. The leading circumstances under which the phobic condition first began were found to be as the subject was driving (17.6%), while the subject was at work (13.5%), in public places such as restaurants, banks, shopping centers and while using public transportation (14.9%) and finally, in circumstances such as hospitalization after an abortion, involvement in a car accident, etc., which were considered to be, by the subject, emotionally stressful (16.2%). Other less common

circumstances under which the phobia presented itself included while at school (6.8%), while in church (5.4%), within various social situations (8.1%), while in one's home (10.8%) and finally, while crossing a major street (4.1%). Only two respondents did not give an answer for this question.

Regardless of the situation under which the phobia first began, 74.3% of the subjects reported that their problem started with a sudden panic attack, while 18.9% denied such an occurrence. In addition, 6.8% were unsure as to whether or not they experienced a panic attack at the onset.

Subjects, when asked about having experienced similar symptoms prior to the present onset answered yes 56.8% of the time and no 43.2% of the time. Since the time of the onset of their agoraphobia, 31.1% of the subjects overall believed that their condition had improved, and there appeared to be little difference between males and females with regards to improvement. By contrast, 43.2% actually felt that their condition had worsened since their phobia first began. Of the remaining subjects, 4.1% and 16.2% felt either their phobia remained the same or fluctuated respectively. Four individuals gave inappropriate responses to the question by merely answering yes, or no, thus, it was not clear to what they were referring.

In evaluating responses to the question of restriction as it related to their agoraphobia, 14.9% of the total sample population (6.3% males and 18.5% females) believed that they were less restricted when alone than when accompanied by others. On the other hand, 68.9% of the sample population indicated that they felt better when

accompanied by others. When separated by sex, it was found that within this group (accompanied by others), 62.5% were males and 75.9% were females. Finally, 16.2% of the sample population noted that this situation varied depending on how they were feeling on a particular day. Additionally, when questioned about their reaction to venturing out alone beyond what they considered to be their safety limits, 67.6% of the sample population described their reaction as being severe. The investigator categorized responses as severe when they evoked a panic attack or very high levels of anxiety resulting in various uncomfortable physical symptoms. Moderate levels of anxiety were expressed by 27.3% of the sample population. The types of reactions experienced by these individuals were uncomfortable but tolerable levels of anxiety. Only 1.4% of the sample population indicated that their reactions towards venturing out alone were mild, consisting of low levels of anxiety and mild emotional discomfort. In addition, three individuals either gave inappropriate answers or did not answer the question at all.

Medical History

The medical history of the 74 agoraphobic subjects indicated that the vast majority did not present themselves as having unusual case histories. Most childhood diseases that individuals had consisted of such common diseases as chicken pox, mumps, measles, pneumonia, and rubella. In addition, only a very small number had any type of complication associated with any specific disease. Few subjects had serious illnesses or injuries, and most operations were performed for routine surgeries such as appendicitis, tonsillitis, gynecological

problems and hernias. Most of the subjects reported that hospitalizations were related to the above mentioned surgeries or for childbirth. Finally, the subjects appeared to be in good health and took few medications, the most common of which was a minor tranquilizer.

Precipitating Factor

The most common precipitating factors found among the sample population, as seen in Table 4, were marital problems (29.73%), separation from loved ones (24.32%), problems with parents or in laws (20.27%), financial problems (14.86%), and work related problems (12.16%). Less common precipitating factors were social pressures, death of a family member, being newly married, being ill, after childbirth, having a sick family member, leaving home, ending a significant relationship, after a bad drug experience, having a career dilemma, after an abortion, and problems with school and with children.

Exacerbating Situations

Several items were selected to be reported here because they were most frequently cited as those that produced panic for the phobic individual when rated on a scale from one to six (one indicating no problem and six being a panic state.) Therefore, statistics quoted here are for that group of subjects who rated themselves a six for each specific situation listed.

For the male population, 56.25% felt panicky when in a situation in which they felt trapped, 50% indicated a panic reaction to displaying severe symptomatology in public, and 37.5% responded that they felt panic on an airplane. For the female population, the most frequently indicated situations that produced panic when rated on the

Table 4

Precipitating Factors Associated with Agoraphobic Onset According to Sex

	M	F	M & F
Marital Problems	43.75%	27.59%	29.73%
Financial Problems	0%	18.96%	14.86%
Abortion	0%	1.72%	1.35%
After Childbirth	6.25%	5.17%	5.40%
Newly Married	0%	10.34%	8.11%
Ended Relationship	0%	3.45%	2.70%
Ill Family Member	6.25%	5.17%	5.40%
Social Pressures	0%	12.07%	9.46%
Work Related Problems	18.75%	10.34%	12.16%
Separation from Loved Ones	43.75%	18.96%	24.32%
In Law-Parent Problems	31.25%	17.24%	20.27%
Death of a Family Member	0%	12.07%	9.46%
Subject Illness	12.5%	6.90%	8.11%
Leaving Home	6.25%	3.45%	4.05%
After Drug Experience	6.25%	1.72%	2.70%
Career Dilemma	12.5%	0%	2.70%
School Problems	6.25%	0%	1.35%
Problems with Children	6.25%	0%	1.35%

same scale were: 56.9% when in a situation in which she feels trapped, 46.55% in regards to the fear of having a reaction in public, and 46.55% when driving alone on the freeway.

Finally, it is worth noting that for this population, those situations which were cited most often as causing little or no problem included signing one's name in front of another, crossing bridges, remaining alone, going through a supermarket line and eating in a restaurant. Interesting to note is the fact that, for males, driving on a freeway was considered to be of little or no problem by 43.75% for that specific item. Total percentages for all items responded to can be found in Appendix B, page 91.

Symptoms

In reviewing the symptomatology, several items were cited as being those symptoms that have the most severe effect on the agoraphobic individual during a panic attack. These symptoms were those rated by individual subjects as a five on a severity rating scale of one to five (one indicating no effect and five indicating severe effect).

The symptom rated as most severe by both males and females was a rapid and heavy heartbeat and was indicated by 56.76% of the individuals. Additionally, 41.89% rated dizziness or lightheadedness as severe, 40.54% indicated feeling shaky inside and out as having a severe effect, and weak or rubbery knees was found to be severe in 39.19% of the subjects. Symptoms most often cited as having the least effect were a stiff neck, 56.76%, headaches, 52.70%, and nausea or vomiting, 48.65%. Total percentages for all items responded to can be found in Appendix C, page 93.

Internal Sensations and Feelings

When subjects were asked to rate their internal sensations and feelings on a scale from one to five (one being none and five being intense), certain sensations and feelings were most prominent. In looking at the population as a whole, the most intense sensations experienced included fear of losing control of oneself indicated by 48.65%, feeling of doom or apprehension indicated by 32.43%, sensitivity to rejection indicated by 31.08%, the urge to run, scream or jump indicated by 29.73%, and worrying about getting help when away from home, which was indicated by 29.73%. The sensations that were least bothersome were changes in colors, tastes or sounds, 81.08%, feelings that one doesn't hear, see, taste, or feel things as others do, 68.92%, and feelings of numbness in arms or legs, 50%. Total percentages for all items responded to can be found in Appendix D, page 95.

Previous Attempts at Cure

Among the male population, 81.25% had sought some form of previous therapy prior to seeking help from Terrap while 18.75% had not. Similarly, 75.86% of the female population responded that they also sought previous help while 24.14% sought none. A statistic on the nature of the previous therapy that was sought by the sample population is not available to the reader as many individuals failed to indicate this on their questionnaire. Of those that did indicate the type of therapy that was previously sought, psychotherapy, pharmacotherapy and behavioral therapy were most popular.

Previous attempts to resolve their problem aside from therapy included self-help methods such as reading psychology books and seeking

religious support. Psychology books were read by 74.32% of the total sample population while 25.68% did not. Also, 48.65% of the sample population turned to religion for help, while on the other hand, 51.35% did not.

Additionally, 79.73% of the sample population indicated that they carried a security symbol of one form or another. The most common support was a tranquilizer, carried by 47.3%. Other frequently mentioned objects were gum, carried by 14.86% of the subjects, hard candy, carried by 13.51% of the subjects, and cold drinks, carried by 10.81% of the subjects. Other less common security symbols included alcohol, smelling salts, medication, cigarettes, antacids, rosary, plastic bag or bucket, paper notes from a friend, marijuana, food, toilet paper, needlepoint, sunglasses and keys. Of the sample population, 20.27% indicated that they carried no security symbol at all.

Dependency

Of those female members who were married, 19.30% admitted that they were most dependent on their spouse. In the male population, of those who were married, 75% found their spouse to be their main source of dependency. There were 17.3% of the married women who depended upon their child whereas none of the males indicated such dependency. Other people upon whom married females depended were: analysts, girl-friends, and the woman's mother. Only 4.35% indicated that they did not have anyone upon whom they felt dependent. Additionally, 25% of the married males reported that they depended on no one.

Of the single population, including divorcees, widows and those separated and non-marrieds, the most common person depended upon by

both males and females was the person's mother. There were 33.3% of the single females and 37.5% of the single men who so responded. Both males and females indicated that they depended upon a close companion of the opposite sex. Single females indicated this 25% of the time and single males 25% of the time. Additionally cited as a source of dependency for single women was her girlfriend and also cited for men was the person's father. Furthermore, 33.33% of the single women and 12.5% of the single males indicated that they were dependent upon no one. It should be noted that combined percentages may exceed 100% as many respondents indicated more than one person upon whom they depended.

Closeness

When questioned about their reaction to being alone, cut off, or separated from those close to them, 65.2% of the female population indicated that they would be terrified of such an occurrence, 8.62% indicated it would cause them no significant problem as long as they were at home, and 8.62% indicated it would be no problem at all. Of the female population, 1.72% indicated that they could manage but did not like the idea and 1.72% of the female population indicated it would be a relief because they would not have to push themselves to do the things that they did not want or felt that they could not do. Additionally, 12.07% of the female population indicated that they could not answer the question because they did not know what their reaction would be under such circumstances.

For the male population, 56.25% indicated their reaction would be one of being terrified at being alone or cut off from those close to them, 18.75% indicated it would be no problem for them at all, and

6.25% did not know how they would react under such circumstances. In addition, 12.5% of the male population did not answer the question.

When questioned about whether closeness to another person was a problem for them, 53.45% of the females and 50% of the males indicated that this was a concern. In almost all cases, the problems revolved around the dependency that often accompanied closeness. On the other hand, 39.65% of the females indicated that closeness to another person was no problem, and 31.25% of the males indicated the same. One female and two males gave no answer to this question.

When asked about their ability to maintain versus lose their identity when in a close relationship with another person, 37.93% of the females and 25% of the male population indicated that they lose their identity when involved with another. On the other hand, 58.62% of the females and 43.75% of the males felt that they maintained their identity when involved with another person. Of the total sample population, 6.76% were unsure of this while three males did not answer the question at all.

Background and Family

In assessing the individual's family, cultural, and religious background, responses given by the subjects were often times incomplete. Therefore, it was possible to fully appreciate only the stability of the primary family. This was in response to whether or not a subject came from a home in which their background was stable (this category includes those parents who lived together in reasonable harmony) versus an unstable background (parents being divorced, separated or having other particular problems).

Of the total population, 78.38% of the individuals indicated that they came from a stable background in which their parents had a reasonably happy marriage. Those individuals whose responses indicated that they came from unstable backgrounds that included parental suicide, alcoholism by one or both parents, divorced or separated parents totaled 21.62%. It is interesting to note that of this group, 5.40% of the individuals had a parent(s) who was alcoholic.

When the sample population was asked about family history of nervous breakdown, 20.27% remarked that someone in their family had suffered at least one nervous breakdown while 79.73% indicated that there was no such history in their family. In addition, only one female subject indicated that she had suffered a nervous breakdown prior to seeking help from Terrap. However, when questioned about whether other family members had experienced difficulties similar to that of the respondents, 62.16% indicated that others in their family have experienced similar symptoms while 37.84% responded no.

Fears

Subjects were asked to respond on a scale of one (low) to five (high) to those objects, situations and experiences that were so disturbing that they created fear or other unpleasant feelings. It was reported by 68.92% that losing control was very disturbing, 54.05% of the subjects indicated that speaking in public was very disturbing, and the prospect of having a surgical operation was reported as being very disturbing by 52.70%. Several items appeared to be of no disturbance for the individual. It was indicated by 64.86% that nude men or women caused no disturbance, 52.70% reported thunder as causing no disturbance,

and sirens were reported by 51.35% as causing no disturbance.

The next chapter will present the conclusions of these results and related recommendations.

CHAPTER V

DISCUSSION

Phobias have been present in society and described in the literature since the fourth century B.C. In its strictest definition, a phobia is a pathological fear that is both persistent and unadaptive. The individual who has a phobia intellectually knows that what they fear is irrational and of minimal or no danger, yet cannot overcome it. As a result of this condition, there is a displacement of anxiety from some object or situation to another type of object or situation. This phobic object or situation then symbolizes the original object or situation and the person begins to substitute fear for anxiety.

Many different types of phobias have been identified and investigated, however, some types of phobias have not. Agoraphobia is one such phobia that has only recently been identified as a prevalent problem.

Agoraphobia was operationally defined as a fear that is so generalized that it encompasses many situations, places and things including open spaces, closed spaces, distance from home, grocery stores, theaters, bridges, crowds, travel, driving and any place that one feels trapped.

The present investigation was undertaken to study those individuals suffering from agoraphobia who sought the help of Chicago's Terrap Program. This was done with the intention of developing a

character profile to be applied to agoraphobics in general and to be paralleled with what has been documented in the existing literature. It was hypothesized that the population studied here would be consistent with agoraphobics in general, while at the same time ellucidate certain characteristics that may add to one's knowledge of the specific population.

Seventy-four subjects (16 males and 58 females), primarily from the Midwestern United States were sampled. These individuals were both single and married, of various occupations and ranged in age from 23 to 63 years.

In-depth questionnaires were filled out by applicants prior to their acceptance into the Terrap Program and were analyzed. The method of collecting data involved a comprehensive review and analysis of these questionnaires. This data was later coded and assembled into various scales and categories that were developed by the investigator. Moreover, the data was treated so that means and percentages could be calculated.

In the population studied here, the percentage of males was 21.62% while that of females was 78.38%. This female predominance agrees with that which was consistently found by Hand and Lamontagne (1974), Marks and Gelder (1966), Snaith (1968), Goldstein and Chambliss (1978), Weekes (1970) and Marks (1970). In all studies reviewed, anywhere from 60% to 90% of the population were female. It appears that despite current trends of the increasing numbers of working women, speculations for this predominance rests upon the assumption that women are more prone to developing agoraphobia because society

provides for women the social acceptance of the role of raising children and taking care of the home. Therefore, their home becomes a setting of safety and shelter. On the other hand, men, for whom society provides the role of wage earner, must most often work away from home, and therefore are not afforded the same sense of security.

The development of this sense of security is further supported by the institution of marriage, in which women have certain societal roles. This was apparent in the current study where 73% of the total population were married and from which the greater proportion were females. This characteristic is prevalent as well in the literature (Hand and Lamontagne, 1974; Goldstein and Chambliss, 1978; Popler, 1977; Weeks, 1978(a,b); and Marks, 1970). Furthermore, this speculation is supported by the fact that in the present study more males were divorced and single when compared with females.

The sample population investigated appeared to be quite similar to other groups of agoraphobics who have been studied in terms of the age of the sample population. With the exception of a study done by Marks and Herst in 1970 in which the average age of agoraphobics studied was 42, the average age of respondents in the present study was in agreement with all other studies reviewed (Hand and Lamontagne, 1974; Marks, 1966; and Marks and Gelder, 1966). Furthermore, the mean agoraphobic symptom duration found among the studies aforementioned correlates closely with that which was found in this investigation. Moreover, the age of onset of agoraphobia for the individuals in the present study falls within all of the ranges of ages given in previous studies (Marks and Gelder, 1966; Roberts, 1964; Marks, 1966; and Weekes, 1978b).

It is possible to speculate that because the differences found between males and females in this study with respect to the age of agoraphobic onset and symptom duration were minimal, and despite the greater percentage of reported females with agoraphobia, that the occurrence of agoraphobia is not as influenced by gender as it may seem. Furthermore, because of societal stereotypes, there may in actuality be more male agoraphobics than are statistically represented. It seems, therefore, that some other factors are important influences in a person's development of agoraphobia. It has been hypothesized by Solyom, Silberfeld and Solyom (1976) that agoraphobia can be seen as an early attachment behavior, made more tenuous by the presence of an overprotective mother. It is also interesting to note that individuals often times suffered with symptoms for approximately ten years. This leads one to believe that agoraphobia has been unrecognized or mistaken for other problems and/or it is a chronic problem with significant treatment failures.

Also interesting to note is that the age of agoraphobic onset corresponds to a time in an individual's life in which he or she seeks out independence. However, if the agoraphobic had an overprotective mother, they could find themselves in a situation of dependence, fostered by feelings of inadequacy, inability to be self sufficient and with fears of responsibility. Ultimately, when separation from parents or spouse is imminent, the agoraphobic may find it difficult to separate due to the creation of a conflict between the desire to separate while at the same time feeling incapable of doing so.

There has not been much written about occupation and its

relationship to agoraphobia in the current literature, therefore, consideration of that relationship here is purely speculation. In the present study, 47.3% of the sample population were either housewives, retired, unemployed or did not answer the question. In comparison, Weekes (1970) found that 78% of her female sample were occupied by home duties. Although no certain conclusions can be drawn about such relationships, it is possible to speculate that those individuals who have no place to go on a daily basis are more susceptible to the development of agoraphobia. However, it must be realized that more research is needed to demonstrate this more soundly.

In its strictest definition, those individuals characterized as having a neurosis of one form or another, including phobias, tend to be of the more educated, upper middle and upper classes (Rowe, 1975). However, in the present study, there was no difference found between those who were highly educated and those who were not. Furthermore, the percentage of people who were professionals and considered to be more educated was small. This finding is consistent with the findings of Marks (1966, 1970). This leads one to believe that agoraphobia may not be a typical neurosis, if one at all.

The onset of agoraphobia appears to be significantly traumatic for the individual so that it is not easily forgotten. This is demonstrated not only in the present study where only 2.70% of the sample population could not recall where the onset first occurred, but also in the literature (Roberts, 1964). The reason the onset seems to be so well remembered is the fact that for the greatest percentage of subjects in the present study, their phobia began with a panic attack

which is characterized by physical and emotional symptoms that are often foreign, severe, uncontrollable and frightening for the individual. This was first described by Roberts (1964), and was later supported by Snaith in 1968 and Marks in 1970 who also describe the panic attack in many of their subjects studied.

Buglass, Clarke, et.al. (1977) found that 20% of their sample population had experienced at least one clear cut agoraphobic difficulty prior to their study. In the present investigation, the percentage was much higher. The underlying implication of these results is that those individuals are susceptible to agoraphobia because of possible underlying personality traits which may activate agoraphobic like symptoms prior to manifesting the complete agoraphobic syndrome. Others have made similar observations and have gone further in describing agoraphobic personality types as being unassertive, having marked social anxieties, being dependent, and having repressive response styles (Goldstein and Chambliss, 1978). It should be noted that these personality factors are said to be present throughout the individual's life and prior to the onset of agoraphobia and serves as a significant factor in the development of agoraphobia.

The clinical course of agoraphobia seems to be characterized by remissions and exacerbations. This was found to be true in previous investigations as well as in the present study (Roberts, 1964; Snaith, 1968; Marks, 1970; and Buglass, Clarke, et.al., 1977). This also seems to be related to the interaction between the underlying personality characteristics of the agoraphobic and the different reoccuring life situations. The exact circumstances which either improve or

worsen the agoraphobic's symptoms are not precise, however, it must be kept in mind that this entity has fluctuating severity and is very likely the result of both environmental and psychological factors.

Since the nature of a panic attack makes it a frightening experience for the individual, many agoraphobics find they are less restricted outside of their area of security when accompanied by another person. This was demonstrated in the present study as well as in the literature (Hand and Lamontagne, 1974; Gelder and Marks, 1966; Marks, 1970). Furthermore, in the present investigation, of those who felt better when accompanied by others, the greater percentage were females. In general, it is understandable to believe that in a situation of personal crisis, an understanding companion could help to mollify the situation and provide assistance if necessary. Moreover, a greater percentage of the sample population believed their agoraphobic reaction was most severe when they ventured beyond their boundary of security alone. However, this is not the case in all circumstances as some of the respondents in the present investigation preferred to venture out alone. The investigator believes that this too is understandable because then the individual does not place himself in a situation that would be embarrassing, would make one feel dependent on another or unable to do what is best for themselves. Others however (Marks, 1970), have found that the desire to venture out alone is the exception rather than the rule. Finally, there were those individuals from the present investigation whose feelings on this matter varied depending upon the situation and how they were feeling on a particular day.

From the literature reviewed, there is no evidence given connecting previous medical history with agoraphobia. The only exception seems to be the higher number of individuals who receive gynecological attention. The reason for this seems clear because the greater percentage of reported agoraphobics are women. However, in the present study as well as others, individuals sampled appeared to be in good health. Therefore, no medical predisposition seems to have been identified in relation to agoraphobia, however, this possibility cannot be entirely ruled out.

The observations regarding those events as indicated by respondents to be precipitating factors in the onset of their agoraphobia concur with subject responses in studies by Roth (1959), Chambliss and Goldstein (1978), Marks (1970) and Buglass, Clarke, et.al. (1977). The results obtained from the present investigation are similar to other studies in that the precipitating event is considered to be stressful, however, those stressful events reported in other studies may differ somewhat from those described here. Therefore, it seems worthwhile to consider the possibility that these "so called" precipitating events were in actuality merely a catalyst for the expression of the agoraphobic syndrome. This speculation takes into account the cumulative effect of prior stressful situations on the unassertive, dependent and anxious personality that the agoraphobic has been described to possess (Gelder and Marks, 1966 and Goldstein and Chambliss, 1978). Consequently, no specific precipitating event can be described as being the cause of agoraphobia because, for some individuals, the event is a major stress or life change, while for others, it may be of

lesser magnitude. The determining factor therefore seems to be based upon the individual's susceptibility at a particular time and place.

Thus far, it seems apparent that the agoraphobic personality typifies the need of an individual to feel in control of the situations in which he finds himself. Therefore, it is not surprising that there is considerable agreement between the present study and those previously reviewed with respect to those situations which exacerbate the agoraphobic syndrome (Buglass, Clarke, et.al., 1977; Marks, 1970; Marks and Herst, 1970; Roberts, 1964; Snaith, 1968; and Gelder and Marks, 1966). That is to say that a high percentage of subjects indicate that some of the most disturbing situations are those in which the person is likely to feel trapped, likely to display symptomatology in public and/or have a physical or emotional illness. Why is it the agoraphobic feels the need to be in control is not completely understood. Whether or not it is a compensatory mechanism for the agoraphobic's feelings of dependency, fear of panic in a stressful situation, or some underlying immaturity will require further research.

The hallmark of the agoraphobic syndrome is its hyper anxiety state. This state is described by its very typical and consistent symptomatology which often times consists of tachycardia, hyperventilation, dizziness, lightheadedness, weak knees, sweating, numbness and tingling in hands, trembling, feeling feverish, dysphagia, tightness in chest and others. Furthermore, aside from generalized feelings of sympathetic nervous system over activity, subjects often describe various internal sensations as well. These involve feelings of depersonalization, feelings of doom or apprehension, derealization,

and feeling as if they may go crazy. It seems obvious that these feelings are the result of the combined effect of biological, environmental and psychological input.

The chronicity of agoraphobia is obvious when one reviews not only the mean symptom duration, but also the varied attempts at cure sought by people suffering from agoraphobia (Hand and Lamontagne, 1974; Weeks, 1970). Over 50% of subjects in studies reviewed here had sought some form of previous therapy prior to that which was reported in the various studies (Weekes, 1970 and Marks, 1970). In the present study, 76% of the sample population had sought some form of therapy prior to seeking help from Terrap. These included pharmacotherapy, psychotherapy, and different forms of behavioral therapy. Additionally, a good percentage of individuals in the present study sought to resolve their problem through self-help methods such as reading psychology books or seeking religious help. Finally, a major percentage of the sample population at the time they were asked felt the need to carry various objects that served as a security symbol for them; the most common of which was valium. This need was also discovered by Marks in 1970 when he found that certain strategems were described as being useful in decreasing the amount of panic experienced by the agoraphobic individual.

There seems to be three messages conveyed within the statistics relating to the various attempts at care. First of all, the long duration of agoraphobic symptoms and the fact that many of the individuals in the present sample population as well as those in other studies sought previous help is an indication that agoraphobia continues to be

an entity that is difficult to recognize, poorly understood by laymen and many professionals and has a high rate of treatment failure. Second of all, because individuals sought help for their problem through reading and religion there seems to be an indication that professional people in general are not solely capable of curing the problem. Finally, despite the therapeutic methodology utilized by an individual, the fact that so many individuals must carry a security symbol forces one to recognize that the present forms of therapy available are less than optimal. Continued research into therapeutic modalities for the treatment of agoraphobia is essential if there is ever to be a hope for permanent cure.

As has been previously indicated in the literature, the agoraphobic is often described as having, among other things, a dependent personality type (Roth, 1959; Chambliss and Goldstein, 1978; Marks, 1970). It has also been shown from the present investigation and others that most agoraphobic individuals are more comfortable outside what they perceive as their boundary of security when they are accompanied by another person whom they feel that they can trust. The present investigation concurs in finding that among married subjects, the spouse tends to be most depended upon. Also among the single population the most common person depended upon was the person's mother, with others being a close friend or a companion of the opposite sex.

The most significant aspect of these findings is the fact that dependency is an integral part of the agoraphobic syndrome as well as an underlying personality trait. Moreover, by being dependent on

another individual, the agoraphobic requires companionship in order to gain mobility and to do the things that he or she might otherwise be unable to do. In view of this, the agoraphobic fosters his dependency and perpetuates the agoraphobic syndrome. The end result, unfortunately may be a disease that is more severe and more difficult to cure. Therefore, it seems that to achieve greater success in treatment, the agoraphobic must be made to understand the nature of his or her dependency and helped to regain independence.

Another characteristic related to both dependency and the need for companionship is that of closeness, which is unrepresented in the literature. For the purposes of the present investigation, this characteristic comprises three elements; being cut off from others, the ability to form close relationships, and the ability to maintain one's identity in a close relationship. The greatest percentage of both males and females indicated that being cut off from those that are close to them is an unfavorable situation and forming close relationships with others is often problematic. It seems reasonable to believe that this is the case, again, because of the agoraphobic's underlying dependency needs, immaturity and marked social anxieties. Furthermore, it has been shown by Buglass, Clarke, et.al. (1977), that despite dependency needs, the agoraphobic is often times ambivalent and resentful of this situation. Therefore, it can be inferred from this that this ambivalence may affect their ability to form close relationships with others. In addition, despite the previous observations and the understanding of the underlying agoraphobic personality traits, the greater percentage of respondents in the present study

indicated that they were capable of maintaining their own identity when closely involved with another person. This was an interesting observation in that it seems to conflict with the previously described difficulty these individuals seem to have in forming close relationships with others. The implications here may be twofold. First of all, in view of the fact that the results were obtained from a self report questionnaire, it is possible that either respondents consciously or unconsciously did not see themselves in this way. Secondly, it is also possible that this is not expected to be a problem among agoraphobics and may be one significant element of ego strength that serves as a valuable resource in their ability to cope with this problem. These speculations require further investigation.

Like many forms of mental illness, the relationship between overt agoraphobic problems and family or genetic background remains controversial. The literature does not agree universally about the nature of the family background that produces agoraphobia (Buglass, Clarke, et.al., 1977; Harper and Roth, 1962; Marks, 1966; Roberts, 1964; and Snaith, 1968). In the present study, more than 75% of the individuals sampled indicated that they grew up in a stable background in which their parents had a reasonably happy marriage. Additionally, greater than 75% of the sample population indicated that there was no history in their family of nervous breakdown. Keeping this in mind, it is reasonable to conjecture that those individuals who grew up in homes with stable backgrounds were in a position to develop dependency, immaturity, marked social anxieties, and repression because of their sheltered and highly secure environment. On the other hand, those who

grew up with a single parent, alcoholic parent(s) or in a house where one of the parents committed suicide would possibly have had to be more independent, mature and assertive in order to survive, and thus are less likely to develop agoraphobia.

Despite the fact that family background remains controversial, 20.27% of the population in the present study indicated that someone in their family had suffered from at least one nervous breakdown. This finding was slightly less than that which has been previously reported (Roberts, 1964; Marks, 1966, Buglass, Clarke, et.al., 1977; and Harper and Roth, 1962). This tends to support the possibility that agoraphobia may be genetically influenced. This is also supported by the finding that 62.16% of the sample population in the present investigation indicated that other family members had experienced similar symptoms to that of the agoraphobic syndrome. The possibility of a hereditary relationship with regards to agoraphobia continues to be an important area of exploration for investigators.

Finally, the basis for the description of a phobia is an irrational fear that is both persistent and unadaptive. Unlike other discreet phobias, agoraphobic fears most often involve those situations in which the person feels trapped, out of control, or seriously threatened by emotionally or physically (Gelder and Marks, 1966; Snaith, 1968; Roberts, 1964; Goldstein and Chambliss, 1978; Marks, 1970; Marks and Herst, 1970, Weekes, 1970(a,b); and Buglass, Clarke, et.al., 1977). This was also obvious in the present study and helps to clarify how it is that agoraphobia manifests itself as it does. That is to say that in the setting of the discreet phobias, the individual is more

easily able to avoid the specific feared object. On the other hand, for the agoraphobic, fears are of such varied and numerous situations that in order to avoid them, ultimately means to avoid going beyond what an individual perceives as his or her area of safety.

SUMMARY

Phobic evaluation questionnaires of 74 agoraphobics were reviewed in this investigation. Of this group, 58 were females and 16 were males with the average age being approximately 35 years with 73% of the total population being married. The average age of agoraphobic onset was found to be approximately 25 years, with an average symptom duration of approximately 10 years.

Subjects predominantly came from the Midwestern United States and nearly 50% of those subjects were either housewives, retired or unemployed. In addition, there was little difference found between those considered to be highly educated (professionals) and those who were not (non-professionals).

For the greatest percentage of subjects, their agoraphobia was heralded by a panic attack. They could easily recall where their first episode of panic began because it is characterized by physical and emotional symptoms that are often frightening, severe and uncontrollable. It was also indicated by respondents that their agoraphobia was marked by exacerbations and remissions of varying duration. Furthermore, in view of the frightening nature of the panic attack, the majority of agoraphobics sampled here seemed to feel more comfortable in the presence of another when venturing beyond what they perceived as their boundary of security.

The possibility that agoraphobia is related to underlying present or past medical illnesses was investigated. It was found that aside from gynecological problems, the sample population was in relatively good health.

The onset of agoraphobia was found to be precipitated by a multitude of events or situations considered to be stressful in nature. It is believed that these stressful events act in conjunction with the agoraphobic personality makeup which is characterized by unassertiveness, dependency, immaturity and marked social anxieties. It therefore seems that the precipitating event serves as a catalyst working upon the cumulative effect of prior stressful events to initiate the full agoraphobic syndrome.

From the present study, those situations which most frequently served to exacerbate the agoraphobia were those in which the person felt trapped, likely to become symptomatic in public, out of control, or likely to become physically or emotionally ill. These feelings seem prominent because of the underlying personality characteristics of the agoraphobic.

The most frequent symptoms experienced by the sample population were typical of the hyper-anxiety state which typifies the agoraphobic syndrome. These included tachycardia, hyperventilation, dizziness and lightheadedness. Internal sensations and feelings were also found to be present among the sample population, the most common being a fear of losing control, feelings of doom or apprehension, sensitivity, urges to scream or jump, and excessive worry. Depersonalization, an internal sensation reported commonly in the literature was not reported with

great frequency by this sample population.

The great majority of individuals sampled here had sought some form of therapy prior to seeking help from Terrap. These not only included psychotherapy, pharmacotherapy, and forms of behavioral therapy, but also, psychological texts and religious support. Additionally, a major percentage of the sample population was found to have the need to carry some form of security symbol, the most common of which was valium.

The agoraphobic has been described as having, among other things, a dependent personality, requiring them to have someone they feel they can depend on for companionship. This serves as an additional source of security. This was found to be true in the population studied here, yet, it was also discovered that despite this need for dependency resentment often accompanied such feelings and thus, ambivalence was created. This also creates difficulty in establishing close relationships with other individuals while at the same time creates for the agoraphobic the fear of being left alone. In contrast to what is believed to be typical of agoraphobics in general, the sample population here indicated that they experienced no loss of identity when closely involved with another person. Speculations for this finding contends that either the answers given were distorted due to the self-report nature of the questionnaire or that it is an unidentified ego strength.

Although no genetic or environmental basis for the transmission of agoraphobia has been conclusively established, it does seem that those individuals who grew up in stable households when both parents

lived together in reasonable harmony, developed more dependency, immaturity, and social anxieties and were therefore more likely to develop agoraphobia than those who grew up in households where the parents were divorced, separated, or had other particular problems. This implies that an unstable household, while seemingly disadvantageous, may provide a relatively strong basis for independence. Furthermore, despite the fact that approximately 20% of the sample population indicated a family history of nervous breakdown, a large percentage indicated that family members had experienced similar symptoms to those of agoraphobia. This leaves open the possibility that in fact there is some genetic basis for the development of agoraphobia.

Finally, the problem, for the agoraphobic, unlike the problem for the sufferer of a discreet phobia is that their fears are of numerous situations which, in order to avoid, ultimately leads to significant limitations in the agoraphobic's life style.

At the outset, the goal of this investigation was to develop a personality profile from the questions analyzed in the Phobic Evaluation Questionnaire and parallel that profile with that which has been documented previously. With only few exceptions most of the results presented in this study were quite similar to those found by others.

LIMITATIONS AND RECOMMENDATIONS

Limitations of this study have been presented previously. Some of the more salient features includes personal bias of applicants and investigator, exaggerations and/or omissions of answers given by respondents, and vague or confusing wording in the questions asked. The most significant limitation of the present study was that the

questionnaire was predesigned and was thus, unchangeable.

At this time, recommendations for future study, evaluation and treatment seem appropriate. In the future, questionnaires such as that which was examined here should be constructed with more specificity and clarity so that the evaluation process of an agoraphobic is more precise. With greater precision in defining the characteristics of agoraphobia, the diagnosis and treatment of this very common problem will be more exact. The fact that agoraphobic is so common, the fact that agoraphobics are so dependent, immature and anxiety prone, and the fact that so many individuals feel the need to carry a security symbol is a mandate for more effective treatment. Keeping in mind the underlying personality characteristics of the agoraphobic and the uncertain relationship of its onset to family background also indicates the need to recognize early, those individuals who may later develop agoraphobia. In this way, the ultimate goal should be to decrease the incidence of agoraphobia rather than have to deal with a prevalent problem.

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APPENDIX A

PHOBIC EVALUATION QUESTIONNAIRE

IDENTIFICATION DATA

NAME_______________ DATE_______________

ADDRESS_______________ SEX_______ AGE_______

_______________ OCCUPATION_______________

CITY STATE ZIP MARITAL STATUS_______________

TELEPHONE_______________ NO. OF CHILDREN_______________
AREA CODE

HOW WERE YOU REFERRED?_______________ DATE OF BIRTH_______________

____

I STATEMENT OF PROBLEM

1. Give the date of onset of your phobic condition.

2. Where and under what circumstances did your phobias begin?

3. Did your problem start with a sudden panic attack?

4. Have you had any symptoms similar to these prior to your present difficulty?

5. How has your condition changed since the original onset?

6. How restricted are you alone? How restricted are you when you are with someone?

7. Describe your reaction if you venture beyond your limits alone.

II MEDICAL HISTORY

1. List childhood diseases you know you had. Note any compli cations incurred as a result of these illnesses.

2. List any serious illness you have had and explain any complications.

3. List all serious injuries, periods of unconsciousness, or head injuries. Have you ever fainted, or have you ever had any seizures of any kind?

4. List all operations you have had.

5. Have you ever been hospitalized? Explain.

6. List all drugs you are taking, their dosages, and tell how often and why you take them.

6. Explain in some detail your previous attempts to get help with these phobic problems and the results of help. (Use the back of the opposite page if space here is insufficien

II MEDICAL HISTORY (CONT.)

7. Explain your circumstances at time of onset - such as marital situation, family relationship, employment relationship, in-law relationship, any upsetting or emotional events which were happening, i.e. financial problems, moving, separation from loved ones, loss, etc. (Use the back of the opposite page if space here is insufficient.)

III EDUCATIONAL BACKGROUND

1. List the highest grade you completed in school.

2. (Circle one.) Were you on the average an:

   A-student B-student C-student D-student

3. Are you aware of any learning difficulties, or difficulties in paying attention, or difficulties in understanding written material or instruction, or difficulties in hearing, or reading? If so, please explain.

-4-

IV Please indicate on the scale 1 to 6 below the degree to which you are affected by the following situations. Add comments on the back of the opposite page if the question does not apply appropriately.

1. No problem
2. Prefer not to
3. Can with someone
4. Can but am uncomfortable
5. Can but very apprehensive
6. Cannot without producing panic

	1	2	3	4	5	6
1. Can you sit in the middle of a row of people such as in a movie of church?						
2. Can you go into unfamiliar places?						
3. Can you use elevators?						
4. Can you allow yourself to get into a situation where you feel trapped?						
5. Do you fear having a reaction in public?						
6. Can you eat in restaurants?						
7. Can you stand crowds?						
8. Can you tolerate heights?						
9. Can you tolerate closed-in places?						
10. Can you cross bridges?						
11. Can you fly in airplanes?						
12. Can you go to parties?						
13. Can you go through the line in supermarkets?						
14. Can you sign your name in front of someone?						
15. Can you drive the freeways alone?						
16. Can you shop in a department store?						
17. Can you stand being alone?						

Comment below or on the back of the opposite page on any other fears or situations not mentioned here.

V SYMPTOMS

Some of the following symptoms occur during a panic attack. Please evaluate them according to their effect when you are having an attack and indicate your answers on the scale 1 to 5 below. Add comments on the bottom of this page or the back of the opposite page.

1. No effect
2. Mild effect
3. Medium effect
4. Strong effect
5. Severe effect

	1	2	3	4	5
1. Fluttery stomach					
2. Sweaty palms					
3. Warm all over					
4. Rapid or heavy heartbeat					
5. Tremor of the hands					
6. Weak or rubbery knees or legs					
7. Shaky inside and/or out					
8. Dry mouth					
9. Lump in throat					
10. Tightness in chest					
11. Hyperventilation					
12. Stiff neck					
13. Headache					
14. Dizzy or light-headed					
15. Nausea or vomiting					
16. Diarrhea					
17. A feeling of being unable to move					

VI INTERNAL SENSATIONS AND FEELINGS

These are various sensations that some phobics have. No one has all of these sensations. Indicate on the scale of 1 to 5 below how frequently or how severe they are for you. Make comments on the bottom of the page or the back of the opposite page.

1. None
2. Mild
3. Moderate
4. Severe
5. Intense

	1	2	3	4	5
1. Urge to run or scream or jump					
2. Feeling of doom or apprehension					
3. Feelings of numbness in arms or legs					
4. Sensations of disintegration or going to pieces					
5. Fear of going crazy					
6. Feelings of being different from others					
7. Feelings that you do not see, hear, taste, feel things as other people do					
8. Feelings of being cut off or withdrawn from others					
9. Colors, tastes or sounds have changed					
10. Depression					
11. Feelings that you are the only one like yourself in the world					
12. Are you sensitive to rejection?					
13. Do you worry about getting help away from home?					
14. Do you fear losing control of yourself?					

VII PREVIOUS ATTEMPTS AT CURE

1. Have you seen a therapist for this condition? ___Yes ___
   If so, please tell what kind of therapy it was and how much benefit you derived from it. Include names and addresses of the therapists.

2. Have you tried self-help by reading psychology books? If so, what has helped? ___Yes ___N

3. Have you turned to religion? If so, how much has it helped? ___Yes ___No

4. Do you carry a security symbol: Pills, tranquilizers, gum, water, candy, alcohol? ___Yes ___No
   If so, what?

VIII DEPENDENCY

The nature of this problem makes it necessary that you be dependent on'someone. Please explain the attitude of this person toward your problem. If this is other than your spouse, give spouse's attitude also.

IX CLOSENESS

Comment below (and on the back of the opposite page if space is insufficient) about your reaction to being alone or cut off, separated from those close to you.

IX CLOSENESS (CONT.)

Comment below as to whether you feel that closeness to another person may be a problem to you. Use back of opposite page if necessary.

When you get involved with someone, comment as to the degree to which you are able to maintain your own identity, or do you get so totally involved, you lose your identity?

X BACKGROUND

Give brief statements of family: mother, father, brothers, sisters. Tell of their culture, family standards, morals, ambitions, religion, etc. Have you or has anyone in your family had a nervous breakdown? Use back of opposite page if necessary.

XI FAMILY

In almost all cases there have been other family members who have had similar difficulties. Often they hide this fact, however. In thinking about it, do you know of anyone in your family with similar fears? Explain.

Is your family or are you:	YOU	ORIGINAL FAMILY	PRESENT FAMILY
1. Highly critical of self or others?			
2. Fearful of what others think?			
3. Desirous of pleasing others?			
4. Demanding?			
5. Perfectionistic?			
6. Inclined to excessive worry?			
7. Likely to take on problems of others?			
8. Overly sensitive?			

XII The items on this questionnaire refer to things and experiences that may cause fear or other unpleasant feelings. Make a check in the column that describes how much you are disturbed by it nowadays.

1. Not at all 2. A little 3. A fair amount
4. Much 5. Very much

	1	2	3	4	5
1. Open wounds					
2. Being alone					
3. Being in a strange place					
4. Loud voices					
5. Dead people					
6. Speaking in public					
7. Dentists					
8. Thunder					
9. Sirens					
10. High places					
11. Strangers					
12. Receiving injections					
13. Journeys by train, bus, or car					
14. People in authority					
15. Crowds					
16. Large open spaces					
17. Sick people					
18. Being criticized					
19. Being in an elevator					
20. Witnessing surgical operations					
21. Angry people					
22. Blood					
23. Enclosed places					
24. Prospect of a surgical operation					
25. Feeling rejected by others					
26. Airplanes					
27. Being ignored					
28. Darkness					
29. Premature heart beats (missing a beat)					
30. Nude men or women					
31. Lightening					
32. Making mistakes					
33. Looking foolish					
34. Losing control					
35. Fainting					

XIII Please answer each question by putting a check in the appropriat box. Work quickly and do not ponder too long about the exact shade of meaning of each question. There are no right or wrong answers and no trick questions. ANSWER EACH QUESTION.

		NEVER	SOMETIMES	FREQUENTLY	ONLY WHEN NERVOUS
X00X	I hear strange voices in my head speaking to me.				
019X	Sometimes the world becomes very bright as I look at it.				
PX685	There are some people trying to do me harm.				
X15X	When I look at people they seem strange.				
X28X	I sometimes feel that I have left my body.				
XX117	My hands or feet sometimes feel far away.				
X35X	I have often felt that there was another voice in my head.				
A78D	My thinking gets all mixed up when I have to act quickly.				
A140	I get more frightened now when I am driven in a car by others.				
0X6D	I feel rays of energy upon me.				
X62X	Foods smell different than they used to.				
A080X	Strange people or places frighten me.				
X52X	I can no longer tell how much time has gone by.				
A116D	I often become scared of sudden movements or noises at night.				
0X25D	Pictures sometimes appear to be alive and to breathe.				
A138A	I know that most people expect a great deal of me.				
0X30D	My sense of hearing is now more sensitive than it has ever been.				
A108A	I am very painfully shy.				
A114D	I am constantly keyed up and jittery.				
X17X	Now and then when I look in the mirror my face changes and seems different.				
X14X	When I look at things like tables and chairs they seem strange.				
X12X	Sometimes the world seems unreal.				

XIV Indicate the meaning of the following:

1. A rolling stone gathers no moss.

2. When the cat's away, the mice will play.

3. A stitch in time saves nine.

4. People who live in glass houses shouldn't throw stones.

Please indicate whether, in your opinion, the following statements are "True" or "False":

1. A pen is like a pencil because they are both used for writing rather than because they are both like sticks.......................TRUE FALSE

2. A fly is like a tree because they are both living things rather than because they both require humans............................TRUE FALSE

OBSESSIVE - COMPULSIVE INFORMATION

Please rate the following questions:

0. No
1. Sometimes, but I can get it out of my mind easily.
2. Yes, frequently and it is difficult to get out of my mind.
3. It is with me nearly all the time and I have great difficulty getting it out of my mind.
4. Yes, constantly with me in some form, I can't get it out of my mind and if I don't do something about it I become very upset until I do.

		0	1	2	3	4
1)	Do unpleasant or frightening thoughts or words ever keep going over and over in your mind?					
2)	Do you ever get tunes, numbers, or words running through your mind that you can't get out?					
3)	Do you ever have persistent imaginings that your children or family might have an accident or that something bad might happen to them?					
4)	Do you feel that contact with germs, dirt, or body secretions will contaminate you and require frequent washing?					
5)	Are you compulsively neat and clean?					
6)	Do you ever have to do things over and over again before they seem just right and you can stop?					
7)	Are you super-punctual?					
8)	Do you ever count things over and over in your mind?					
9)	Do you have to turn things over and over in your mind for many times before you are able to decide about what to do?					
10)	Do you have doubts about a lot of things you do and have trouble making decisions?					
11)	Do you try to avoid changes in your house or work or the way you do things?					
12)	Do you often get afraid that you might be developing some sort of serious illness?					
13)	Do you have any other thoughts that are like obsessions or things you are compelled to do?					

Explain all answers rated 2, 3, or 4 on the back of the opposite page.

An obsession is an idea, an emotion (an impulse), temptation, or a thought that persists in the mind and cannot be dismissed by a conscious process. It is not influenced by logic or reasoning and is distinctly unwanted.

A compulsion is an action or behavior carried out by impulse which if not repeated will cause uncomfortable anxiety. It is not influenced by logic or reasoning and is usually inconvenient.

Some of the more common forms of obsessions and compulsions are listed below. Evaluate on a scale of 0 (doesn't apply) to 4 (severe) the ones that apply to you.

1. Superstitions

	0	1	2	3	4
a) 3 on a match					
b) black cats					
c) walking under ladders					
d) open umbrellas inside					
e) breaking mirrors					
f) knock on wood					
g) step on a crack					
h) Friday 13th					
i) others					

2. Magic

	0	1	2	3	4
a) magic wands					
b) rabbit's foot					
c) 4 leaf clover					
d) lucky charm					
e) numbers					
f) crossing fingers					
g) wish on a falling star					
h) others					

3. Religious beliefs

	0	1	2	3	4
a) Sin					
b) Heaven					
c) Hell					
d) Punishment					
e) no free will					
f) others					

4. Compulsions

	0	1	2	3	4
a) locking doors					
b) washing hands					
c) orderly					
d) super-clean					
e) check furnace and stoves					
f) others					

5. Impulses

	0	1	2	3	4
a) remove clothes					
b) to run					
c) to say obscene words					
d) to buy					
e) to jump					
f) unusual sex					
g) daredevil					
h) smash things					
i) others					

6. Perfectionism

	0	1	2	3	4
a) overly neat					
b) table set just so					
c) crooked pictures					
d) bottles lined up					
e) laundry folded just right					
f) window shades lined up					
g) others					

APPENDIX B

1		2		3		4		5		6	
M	F	M	F	M	F	M	F	M	F	M	F
12.5	15.52	6.25	8.63	6.25	12.07	43.75	20.69	12.5	18.96	18.75	34.48
18.75	5.17	0.0	5.17	12.5	36.21	25.0	25.86	37.5	22.41	6.25	12.06
31.25	36.21	6.25	5.17	0.0	12.06	37.5	18.96	18.75	17.24	6.25	15.52
0.0	0.0	6.25	13.79	0.0	0.0	12.5	13.79	25.0	22.41	56.25	56.9
6.25	1.72	0.0	1.72	0.0	1.72	6.25	6.90	37.5	15.52	50.0	46.55
43.75	27.58	0.0	3.44	12.5	24.14	37.5	17.24	0.0	17.24	6.25	17.24
18.75	13.79	18.75	8.62	6.25	8.62	31.25	25.86	18.75	22.41	6.25	31.03
37.5	27.58	18.75	12.07	0.0	10.34	18.75	10.34	25.0	12.07	6.25	29.31
18.75	17.24	6.25	12.07	6.25	6.89	12.5	29.31	37.5	25.86	25.0	17.24
50.0	39.65	12.5	5.17	0.0	15.52	25.0	22.41	18.75	5.17	0.0	12.07
31.25	18.96	12.5	8.62	0.0	12.07	12.5	13.79	6.25	15.51	37.5	25.86
31.25	27.50	31.25	5.17	12.5	18.96	12.5	27.58	31.25	18.96	0.0	8.62
43.75	29.31	6.25	1.72	0.0	15.52	43.75	17.24	6.25	20.69	6.25	27.59
75.0	70.69	12.5	5.17	0.0	0.0	0.0	13.79	12.5	6.90	6.25	5.17
43.75	15.51	0.0	6.90	0.0	6.90	18.75	5.17	12.5	10.34	25.0	46.55
31.25	24.14	25.0	1.72	12.5	18.96	12.5	22.41	25.0	18.96	0.0	24.14
37.5	51.72	12.5	18.96	0.0	3.45	25.0	12.08	31.25	10.34	0.0	10.34

APPENDIX C

1	2	3	4	5
18.92	33.78	16.22	22.97	6.76
18.92	20.27	18.92	12.16	25.68
13.51	10.81	22.97	27.03	22.97
1.35	6.76	9.46	24.32	56.76
21.62	17.57	18.92	20.27	21.62
8.11	14.86	17.57	22.97	39.19
6.76	12.16	8.11	36.48	40.54
28.38	12.16	27.03	13.51	16.22
37.84	18.92	13.51	14.86	14.86
12.16	12.16	18.92	32.43	25.67
24.32	12.16	9.46	24.32	25.67
56.76	17.57	4.05	6.76	10.81
52.70	12.16	14.86	10.81	8.11
6.76	16.22	16.22	21.62	41.89
48.65	16.22	16.22	8.11	8.11
54.05	16.22	8.11	9.46	12.16
44.59	9.46	14.86	17.57	14.86

APPENDIX D

1	2	3	4	5
10.81	17.57	24.32	18.92	29.73
6.76	16.22	22.97	28.38	32.43
50.0	10.81	22.97	6.76	8.11
24.32	16.22	12.16	31.08	16.22
20.27	20.27	20.27	12.16	28.38
10.81	20.27	13.51	31.08	25.67
68.92	10.81	4.05	5.40	9.46
33.78	17.57	12.16	18.92	18.92
81.08	9.46	1.35	2.70	5.40
6.76	25.67	29.73	20.27	18.92
27.03	12.16	14.86	24.32	25.67
1.35	9.46	33.78	24.32	31.08
13.51	5.40	24.32	29.73	29.73
8.11	5.40	13.51	27.03	48.65

APPROVAL SHEET

The thesis submitted by Mona H. Berman has been read and approved by the following committee:

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The final copies have been examined by the director of the thesis and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the thesis is now given final approval by the Committee with reference to content and form.

The thesis is therefore accepted in partial fulfillment of the requirements for the degree of Master of Arts.

10-14-81
Date

Director's Signature