The effect of therapist's gender on outcome of behavioral treatment with agoraphobics

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The effect of therapist's gender on outcome of behavioral treatment with agoraphobics

Tiffany, Linda Williamson, Ed.D.
The College of William and Mary, 1987
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THE EFFECT OF THERAPIST'S GENDER
ON OUTCOME OF BEHAVIORAL TREATMENT
WITH AGORAPHOBICS

A DISSERTATION
PRESENTED TO
THE FACULTY OF THE SCHOOL OF EDUCATION
THE COLLEGE OF WILLIAM AND MARY IN VIRGINIA

In partial fulfillment
of the requirements for the degree
Doctor of Education

COMMITTEE MEMBERS
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Respectfully submitted by
Linda Williamson Tiffany
November 1987
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DEDICATION

This work is dedicated to the memory of Brownie, who loved me unconditionally and believed, years ago, that I would be writing something like this.

Stanley A. Brown

1896 - 1965
THE EFFECT OF THERAPIST'S GENDER
ON OUTCOME OF BEHAVIORAL TREATMENT
WITH AGORAPHOBICS

Linda Williamson Tiffany, Ed.D.

The College of William and Mary, 1987
Advisor: Kevin E. Geoffroy, Ed.D.

This is a descriptive study of the relationship between gender of therapist and the effectiveness of behavioral treatment with agoraphobics. Participants for this study included fifty-six clients (28 males and 28 females) divided into matching pairs (male and female), 20 pairs were assigned to female therapists and 8 pairs were assigned to male therapists. Client progress was measured pre and post treatment with the Fear Questionnaire and Beck Depression Inventory.

Results indicate that male and female clients progress equally well in behavioral treatment for agoraphobia. However, gender of therapist significantly impacts on progress; male and female pairs progressed significantly more with female therapists than pairs assigned to male therapists. It is possible that preferred traits in counselors based on cultural stereotypes may influence client perceptions of behavioral therapists and thus influence treatment outcome.
CHAPTER I

STATEMENT OF THE PROBLEM

The problem of this study concerns the relationship between gender of therapist and the effectiveness of behavioral treatment with agoraphobics.

NEED FOR THE STUDY

Agoraphobia has received considerable attention throughout the mental health literature (Chambless and Goldstein, 1982). There are conflicting theories about why people become agoraphobic, who becomes agoraphobic, how to treat agoraphobics, and who will respond best to which treatments. A recurrent theme in the literature is an attempt to distinguish male and female differences in relation to incidence, prevalence and treatment of this disorder.

Researchers disagree on whether males are as likely to become phobic as females (Agras, Sylvester, and Oliveau, 1969; Eaton, Meyer, and vonKorff, 1984; Marks and Herst, 1970; and Mullaney and Trippett, 1979). Other areas being explored for male and female differences include looking at what is actually feared in phobic situations (Hafner, 1983), and analyses of apparent differences in response rates to behavioral treatment of the disorder (Mavissakolian, 1985; Hafner, 1985).

Males apparently do less well in treatment for agoraphobia than females (Hafner, 1983; Mavissakolian, 1985). Throughout counseling literature studies indicate
that males prefer different characteristics in ideal counselors than females (Greenberg and Zeldow, 1980; Subich, 1983; Heatherington and George, 1984). These preferences appear to be related in part to differential relationship needs of male and female clients, and the potential effect of sex-role in relation to willingness to exhibit fear and show trust for the therapist.

The studies indicating poorer response to treatment for male agoraphobics used a therapist-assisted exposure method in treatment (Hafner, 1983; Mavissakolian, 1985). This treatment entails a therapist accompanying the agoraphobic clients into the feared situation and assisting the clients in managing the level of anxiety experienced. These researchers concluded that this treatment may not be appropriate to some males based on the significant difference in effectiveness of treatment and the significantly higher numbers of male drop-outs from treatment. One variable not looked at in these studies was the impact of gender of therapist on response rates of subjects. It is possible that gender of therapist may be a variable that, when intermeshed with differential relationship needs and sex-role effects, is related to the poorer response in male subjects. The purpose of this study is to investigate the relationship between gender of therapist and effectiveness of behavioral treatment of agoraphobia.
THEORETICAL RATIONALE

The theoretical rationale for this study was based on the learning theory of neuroses put forth by Joseph Wolpe. Wolpe defined fear habits, or neuroses, as unadaptive habits acquired through learning with anxiety as their core feature. Anxiety was defined as the organisms' pattern of autonomic responses experienced in connection with threatening situations (Wolpe, 1976). Wolpe believed that fear habits (both adaptive and unadaptive) were maintained in one or any combination of three major subdivisions of nervous system activity. These subdivisions were autonomic, cognitive, and motor activities (1976).

Wolpe believed fear habits, or phobias, stemmed from two types of learning: cognitive learning and classical autonomic conditioning (Wolpe, 1981). Cognitive learning of neurotic fear is purported to be based on misinformation taken in by the organism from the environment. This misinformation can be in the form of wrong beliefs instilled by parents or others in the individual's environment. An example of this cognitive misinformation would be a person's belief that the feelings of light headedness and heart racing indicate that s/he is going to "pass-out," "go crazy," or "die." Wolpe's research in this area centered on historical information drawn from case histories of his clients (Wolpe and Wolpe, 1981).
The other manner in which organisms may acquire neurotic fear is through classical autonomic conditioning. It is in this area that Wolpe conducted the majority of his animal research in the induction of neuroses. Wolpe's interest in the development of neurotic fear habits began in the 1940s while he was working in the South African Medical Corps with soldiers suffering from war neuroses. Treatments emanating from a psychoanalytic model were ineffective in treating these neuroses; Wolpe began to consider learning as a possible theoretical base from which to generate a treatment strategy (Wolpe and Wolpe, 1981).

Wolpe built on the work done by Jules Masserman (1943) involving the induction of experimental neuroses (fear responses) in cats. The cats in Masserman's studies were conditioned to press a treadle when they heard a bell and were rewarded each time by food. After this behavior was learned, Masserman introduced conflict into the situation by subjecting the cats to a shock while they were trying to reach the food. The conflict that ensued was between the cats' choice to resist fear and satisfy hunger or to withdraw from the food to avoid fear. Several neurotic reactions were observed in response to this conflict. Cats exhibited rapid breathing and heart rate, trembling, pupil dilation, and phobic aversions to the bell sound. From these studies, Masserman concluded that conflict was a component of neurotic fears.
Wolpe's replications of Masserman's cat studies yielded the same results. In the studies Wolpe used twelve domestic cats. The cats were housed in large cages in a room one floor above the experimental room. The cats were transported to the experimental room in small carrier cages and then placed in slightly larger experimental cages. The cats in Wolpe's studies, however, were divided into two groups.

The cats in one group were subjected to treatments similar to those in Masserman's study. These cats were placed in the rear section of the experimental cages. Immediately following a buzzer sound, food pellets were dropped into the food box in the front of the experimental cages. The cats were soon conditioned to approach the food box upon hearing the buzzer. The next phase of the experiment consisted of initiating the buzzer sound but when the cats approached the food box they were administered grid shocks.

The other group of cats were put in identical experimental cages in the experimental room, however, food pellets were never given. Instead, treatment consisted of exposing them to a loud "hoot" from the armature of an automobile horn immediately followed by grid shocks. These cats were conditioned after only two trials to exhibit avoidance behaviors (climbing the cage sides, lifting their paws from the grid) upon hearing the hoot.

The cats in both groups displayed neurotic symptoms
(pupil dilation, rapid breathing, muscular tension) not only while being placed in the experimental cages but also upon seeing the other stimuli along the experimenter's route (the carrier cage, the hallway down to the experimental room, the experimental room). Wolpe believed these reactions to associated stimuli were due to a generalization of the fear.

The major value of Wolpe's induction of neuroses in cats was the discovery that conflict was not a necessary component in the acquisition of neurotic fear (Wolpe, 1958). What was necessary was an anxiety producing event associated with a set of conditions. Holding with Wolpe's theory of two types of learning taking place, this anxiety producing event may be caused by a noxious stimulation (pain, extreme physical or mental discomfort) or an irrational belief about the event.

Wolpe's later work with this two-factor base of neuroses revolved around the antecedents of phobic anxiety. To investigate this proposal Wolpe had an assistant select 40 cases from his files whose major complaints were unadaptive fears. An analysis of the bases for the 40 neurotic fears yielded 26 found to be classically conditioned and 14 to be cognitively based. Two cases had both cognitive and classically conditioned bases (Wolpe, 1981).

Wolpe used these two cases of agoraphobia to illustrate his two-factor base of unadaptive fear (Wolpe, 1981). The first case involved a 35 year old married woman who had been
afraid to be alone for three years. The onset of her agoraphobia occurred during her pregnancy; she was home alone, in bed reading when she realized she was bleeding heavily. She was unable to stay home alone without anxiety from that time on. The client knew intellectually that the danger was associated with the special circumstances of her pregnancy and that her fear was irrational. This agoraphobia was based on emotional conditioning.

The second case of agoraphobia was based on cognitive misinformation. This case involved a 29 year old married woman who was afraid to go out alone because she experienced physiological symptoms of dizziness and tingling sensations. Her family history revealed a number of relatives suffering from periods of emotional disorder. This woman interpreted her physical symptoms as a sign that she was going crazy. She lost her fear when she was shown that these symptoms were brought on by hyperventilation.

Agoraphobia has been given much attention by Wolpe throughout his writings on fear neuroses. He sees it as a severely debilitating phobia that is apparently more common in women than men and he has repeatedly termed it the "housewives' disease" (Wolpe, 1976; Wolpe and Wolpe, 1981). Wolpe's case studies of the two agoraphobic women each give an example of a specific, identifiable antecedent of the initial panic reaction; however, in a general analysis of
agoraphobics, Wolpe posits the initial panic to be a result of frightening fantasies of independence taking place unconsciously in the minds of dependent, unhappily married housewives. Wolpe gives little information on male agoraphobics. This is probably a result of the scarcity of male agoraphobics on his caseload. This scarcity must have led Wolpe to believe that there are gender differences in acquisition of phobias because his experiments in induction of fear neurosis (phobia) did not distinguish between male and female cats. This study investigated gender differences in response to behavioral treatment of agoraphobia.

SAMPLE AND DATA GATHERING PROCEDURES

Participants for this study included fifty-six clients (28 males and 28 females) divided into matching pairs (male and female), 20 pairs assigned to female therapists and 8 pairs assigned to male therapists at the Centers for Behavioral Medicine in Richmond, VA and Rockville, MD. Clients were diagnosed and treated for agoraphobia in a 16 week structured phobia program consisting of 1-1/2 hour group and 1 hour individual sessions using in-vivo, supported exposure treatment each week.

After obtaining permission from agency administrators, records of therapists who agreed to participate in this study were surveyed for potential client participants. Client files were selected on the basis of the following:
Each male/female pairing was matched for same therapist and use or non-use of antidepressant medication.

The measures used in this study included an instrument designed to measure change in avoidance behavior and severity of phobic symptomology, an inventory for measuring depression, and a therapist rating of reduction of agoraphobic avoidance. All client files contained scores from the avoidance scale and symptom scale and a depression inventory gathered from the clients at the intake session and the final group session in week 16 of the program. The therapist rating of reduction of avoidance behavior was completed at the end of the 16 week program.

**DEFINITION OF TERMS**

The following are definitions of terms offered within the context of this paper.

**AGORAPHOBIA** - A complex phobia that is characterized by avoidance of situations in which the individual believes s/he will experience a panic reaction.

**ANTIDEPRESSANT MEDICATION** - A psychotropic medication that has been found to have an effect on panic in phobic individuals. The most common antidepressant used in research on phobias is imipramine.

**BEHAVIORAL TREATMENT OF PHOBIAS** - The following are behavioral treatment methods used in treatment of phobias:
DESENSITIZATION - A behavioral technique used in treating phobias. The process involves exposing the phobic individual to ever increasing amounts of the feared situation (either in the actual situation or in imagination) while teaching the individual relaxation techniques to reduce anxiety.

GRADED EXPOSURE - A method for breaking exposure to the feared object or situation down into a series of steps ranging from least fear response to highest fear response in the actual situation.

IN-VIVO - A term used to denote actual presence in the feared situation as opposed to imagining the feared situation.

THERAPIST ASSISTED, SUPPORTED EXPOSURE, OR PROLONGED EXPOSURE OF A DYNAMIC TYPE - Names used for a treatment for phobias that entails graded exposure to the feared situation or objects with the therapist present to assist the phobic individual with reducing his or her fear.

COMPLEX PHOBIA - An irrational fear of a panic feeling in a situation or situations. It is not the situation that is feared; it is the fear of the noxious, panicky feeling which causes the individual to avoid those situations.

SIMPLE OR SPECIFIC PHOBIA - An irrational fear attached to one specific situation or object that causes that situation or object to be avoided.

SOCIAL PHOBIA - A complex phobia that is characterized by a fear of failure to perform in a social situation. The fear is attached to a panicky feeling that will inhibit social performance.
LIMITATIONS OF STUDY

A major limitation of this study is the small sample size. There are small numbers of male agoraphobic clients in treatment for their phobia. A survey of the three year period from 1984 - 1986 at the Centers for Behavioral Medicine in Rockville, MD and Richmond, VA yielded a total of 265 persons entering treatment whose primary diagnosis was agoraphobia; of these 265, only 73 (or 27.5%) were male. The study results are generalizable only to the limited population of males in supported exposure treatment for agoraphobia. The results are not generalizable to other treatments for agoraphobia nor are they generalizable to mental health treatment in general.

A second limitation of this study is the socio-economic status of the sample. The Center for Behavioral Medicine is a private mental health organization with no sliding scale fees available. It is, therefore, necessary for clients to pay from $90.00 to $150.00 per week for treatment unless their insurance reimburses them. This monetary consideration limits the access of lower income individuals to treatment. Clients are predominantly upper middle class status.

A third limitation is the possibility that male and female therapists in this study hold different beliefs about male and female clients and these beliefs may impact on their interpersonal style in treatment. However, the
The purpose of this study was to determine whether gender of therapist in supported exposure treatment is a variable affecting outcome. The results may indicate areas of future research to explain that relationship.

**GENERAL HYPOTHESES**

1. Male agoraphobic subjects in behavioral treatment with male therapists will exhibit greater improvement than male subjects with female therapists as measured by The Fear Questionnaire, the pre-post treatment measurement of avoidance and severity of symptoms (Marks and Mathews, 1979) and The Beck Depression Inventory (Beck, Ward, Mendelson, & Erbaugh, 1961).

2. Female subjects in behavioral treatment for agoraphobia will improve significantly regardless of therapist's gender.

3. Male and female subjects matched for severity of agoraphobic symptoms with the same male therapists will exhibit similar rates of improvement.

4. Female subjects matched for severity of agoraphobic symptoms with male subjects with the same female therapist will exhibit significant improvement in agoraphobic symptoms and symptoms of depression.
ETHICAL CONSIDERATIONS

1. All therapists were advised of the nature of this study and were asked for permission to use their client outcomes. All therapist identities remained anonymous.

2. Scores obtained from client files were coded anonymously. This precaution precluded the necessity of requesting permission from subjects to conduct this research.

3. Because data had already been collected and treatment completed over the past six years it was not necessary to have approval from the Human Subjects Committee. Staff at the Centers for Behavioral Medicine are encouraged to use research data available to generate publishable material.
CHAPTER II
HISTORICAL CONCEPTS

Learning theory has been extensively applied in the explanation for acquisition of phobias. Seligman (1972) noted that, as in prepared classical conditioning, phobias:

1. can be acquired through one trial learning
2. are selective
3. are resistant to extinction
4. may be learned non-cognitively

Watson's conditioning of Little Albert to fear white, furry objects is an example of a phobia induced through classical conditioning (Watson and Rayner, 1920). In this study, Watson and Rayner presented a child, Albert, with a white rat at the same time a metal pipe was struck with a hammer; this caused Albert to become afraid. After a few repetitions, Albert began to experience a fear reaction to the white rat automatically. This fear generalized to other white, furry objects.

Wolpe's later studies using cats demonstrated the ability to classically condition fear responses in animals. Cats were subjected to grid shocks when placed in a small experimental cage. After few repetitions the cats began to exhibit fear responses immediately upon being placed in the cages. The fear also generalized to the experimental lab room and to the pathways leading to the room.

Eysenck, (1964) and Gray (1971) repeated Watson's original Albert experiment with new subjects but were not
successful. They were also unsuccessful in conditioning fear to other stimuli such as wooden ducks or aprons instead of white rats. These findings lead to an expansion of the original classical conditioning model.

They began looking at the process of socialization in terms of classical conditioning in an effort to explain why certain subjects condition more easily than others. Socialization was chosen because Eysenck believed that anxiety worked as the mediating drive; Gray believed the mediating drive was fear of punishment. They found that introverted people tended to have surplus reaction and to be over socialized. Extroverts were harder to condition, had lower rates of socialization, and had fewer phobic fears.

Eysenck (1965) graphed introversion-extraversion against existing neuroticism. Measurement of neuroticism was based on lability and intensity of reactions in certain people. Stability and instability were based on sympathetic and parasympathetic balance within the autonomic nervous system (the system that controls heart rate, perspiration, etc.). Figure 1 shows the results of his findings. He concluded that a phobia would likely develop in persons with introverted behavior patterns and with labile autonomic nervous systems. Eysenck made no distinction between males and females.

Throughout the literature on phobias, agoraphobia in particular has been defined repeatedly as a pathology associated with women.
Wolpe, among others, describes agoraphobia as the "housewife's disease." Theorists concur that the most common form of agoraphobia occurs in married women who are non-assertive, dependent, and who are fearful of leaving bad relationships (Fodor, 1974; Goldstein and Chambless, 1978; Wolpe, 1976; Wolpe and Wolpe, 1981). Wolpe believes that the agoraphobia is a result of the housewives' fantasies of the consequences of leaving the marriage. The more they fantasize, the more anxiety becomes attached to the fantasy, and the more fearful they become of leaving (Wolpe and Wolpe, 1981).
Although females make up a disproportionate number of agoraphobics in treatment, 64% to 95% (Marks, 1970; Marks and Herst, 1970), general population studies have found equal numbers of males and females suffering from agoraphobia (Agras, et al, 1969; Mullaney and Trippett, 1979). A study of substance abuse programs found 33% of the male participants were severely agoraphobic and, or socially phobic with an additional 37% having moderate symptoms of the phobias (Mullaney and Trippett, 1979).

**CRITIQUE**

The first issue that must be addressed regarding phobias is their classification in the neuroses. Eysenck's belief that persons with high neuroticism and introversion were likely to become phobic was based on the grouping of phobic persons with anxiety state patients; this grouping may have been premature. Jasin (1981) administered the Minnesota Multiphasic Personality Inventory (MMPI) Social Introversion Scale to agoraphobics, anxiety neurotics, and depressives and found agoraphobics scoring significantly lower on social introversion than the other groups. This difference may indicate that agoraphobia is separate from the anxiety neuroses.

In addition, the assumption that agoraphobia is particularly associated with women does not tie into the two-factor theory of unadaptive fears. The original experiments on which classical learning are based did not
note differences in male and female subjects. A complete theory of the etiology of agoraphobia and potential differences in response to treatment for males and females must account for innate differences between them. Positing "intrapsychic fears of freedom" as a predisposing factor in women is incongruent with learning theory's demand for empiricism.

The case illustrations in the literature present female clients but this is also not necessarily an indication that agoraphobia is a pathology associated mainly with women. The scarcity of male agoraphobics on caseloads does not logically lead to the conclusion that there are gender differences that would impact on the likelihood of becoming phobic nor the potential for males to respond differently to treatment than females. Historically, women have been more likely to seek treatment than men and, thus, have shown disproportionate numbers on clinical caseloads.

**Phobias**

The third edition of the Diagnostic and Statistical Manual for Mental Disorders (DSM III) defines phobias in terms of a subset of anxiety disorders in which there are "persistent and irrational fear(s) of a specific object, activity, or situation... (that results in the phobic person having) a compelling desire to avoid the dreaded object, activity, or situation" (American Psychiatric Association, 1980. p255). (parenthetical added)
Rachman (1968) views phobias as excessive fear reactions to given objects or situations that are both persistent and unadaptive. They reach psychiatric proportions when they begin to incapacitate normal, social functioning. Since virtually any neutral stimulus may be experienced at the time a fear reaction is evoked, the possibilities of attachment of phobic anxiety to objects or situations are endless.

Rycroft (1968) posits phobias as the simplest forms of neurotic anxiety. He distinguishes phobias from anxiety neuroses because phobic anxiety appears to attach itself to specific objects or situations, whereas, anxiety neuroses are characterized by generalized, free-floating anxiety.

The phobic reaction consists of three main components. 1. The subjective component entails a feeling of intense fear or panic; the individual feels as if s/he is going to go crazy, to suffocate, or to die. 2. The autonomic component consists of the physiological changes taking place as a result of the fear. These changes may include rapid heart beat and respiration, increased perspiration, trembling, and weakness. And, 3. The motor response component that results in either flight or the feeling of being "frozen" (Rachman, 1968).

A number of theorists believe that a phobia consists primarily of a fear of the fear; that is, the phobic person is fearing that out of control feeling in certain
situations, the situation or object is secondary (Chambless and Goldstein, 1982; Weekes, 1979). Rycroft agrees with the fear of the fear component of phobic anxiety. He believes that the phobic person who is anxious in crowds, or fears heights, is not frightened of what is happening in the present but, instead, fears what s/he imagines might happen in the future (1968). The phobic person is afraid that if that panicky, out-of-control feeling comes s/he may lose control and start screaming, pass out, or possibly hurl him or herself off a building. Rachman termed this a secondary fear drive that is reduced when the individual retreats from or avoids the phobic situation. He believes that this reduction in fear reinforces the avoidance and, thus, maintains the phobia (1968; 1974).

There are numerous ways to categorize phobias. Categorizing them according to childhood or adulthood onset helps to focus in on the more serious cases. Childhood phobias are, for the most part, short-lived and tend to subside on their own. Phobias attained in adulthood tend to be more serious and persist longer (Rosen, 1976).

A breakdown of adult onset phobias yields a delineation of simple and complex phobias. A simple or specific phobia may be defined as one in which the aversive stimulus is readily identified and specified. Examples of common simple phobias are: animal phobias, insect phobias, and water phobias. In a complex phobia, the person suffers a
pervasive anxiety attached to several interrelated types of stimuli (Rachman, 1968). Included in complex phobias are agoraphobia, claustrophobia, and social phobia. In a survey of 225 phobic patients, all phobics could be categorized as either agoraphobic, claustrophobic, socially phobic, or specific (Neiger, 1981).

Simple phobias occur quite frequently in the general population. Few people with simple phobias seek treatment because their phobic situations are easily avoided and, thus, are not seriously debilitating (Rachman, 1968).

Serious fears are also common. A survey conducted by the University of Vermont found almost one out of ten people in the general population had serious fear (Rosen, 1976). Another study conducted by Geer (1965) of 134 State University of New York psychology students yielded 35% of the students having one or more serious fears; less than 2% of the students reported no fears at all. It is important to note that these studies were conducted on both males and females. The Vermont study yielded equal numbers of males and females reporting serious fears. The New York study results were weighted toward females; however, Geer (1965) attributes this to the impact of males socially being trained not to show fear in situations.
There is no obvious weighting of female versus male clients suffering from claustrophobia, social phobias, or simple phobias. There is a higher number of females than males presenting agoraphobia. Learning theory posits classically conditioned and, or cognitive learning as critical to the development of neurotic fears. Yet unexplained is the reason that learning connected with agoraphobia should differ between females and males; however, two clear distinctions have been noted: 1. Females make up a disproportionate number of agoraphobics on counselor caseloads, and, 2. Males do not respond as well as females to behavioral treatment of agoraphobia. Social phobias and claustrophobia, like agoraphobia, are considered complex phobias and there are no distinctive male or female patterns. Therefore, the difference does not appear to be a result of variables associated with the learning of simple versus complex phobias. It is therefore a puzzle as to why more numbers of females report being agoraphobic and why males have more difficulty unlearning their agoraphobia.

AGORAPHOBIA

The name agoraphobia was used by Westphal (1871) in describing three male patients exhibiting anxiety while walking down streets or across open spaces. Historically agoraphobia has been reported as a disorder associated with males. Legrand duSaule (1885) and Cordes (1871) reported
cases of male agoraphobics and went on to note that cases involving females were uncommon and that agoraphobia was a disorder associated primarily with males. Research within the past decade indicates that this may not be the case.

Today, people who suffer from agoraphobia are terrified of being in grocery stores, shopping malls, standing in lines or open spaces, driving, etc. Their terror centers around losing control, that is, passing out, going crazy, screaming, dying, or making fools of themselves. What is feared is not the situation per se, it is the fear of the panicky, out-of-control reaction in the situation. This process has been referred to as a fear of the fear (Weekes, 1979). The physiological manifestations of this fear reaction include dizziness, noodle legs, light-headedness, heart pounding, hyperventilation, numbness in limbs, and feelings of unreality, among others. Fear of loss of control is another such fear reaction. Phobic people imagine themselves jumping from high places or driving off bridges; the fact that they could even think these things scares them and thus, they become fearful of their own thoughts (Badding, 1985).

Age of onset of agoraphobia is between 18 and 35. A notable characteristic of client histories is the prevalence of a major life stressor within a year prior to onset of the phobia. The stressor may include a death of a relative or close friend, birth of a child, a major move or job change,
or the prolonged stress of living in an unhappy relationship (Foia, Stekette, and Young, 1984; Last, Barlow and O'Brien, 1984). Apparently, the stress builds and the body physically reacts to this stress. This reaction is termed a General Adaptation Syndrome which indicates that the body's organs and glands are adjusting in response to the stress. Stress reactions apparently reflect the amount of wear and tear caused on the body by life (Selye, 1978). It is common to suffer a tension headache as a result of a minor amount of stress; should the body react proportionately to a great deal of stress, the result might be several of the physical symptoms associated with the panic attack. When this physical reaction occurs, the person is likely to be doing one of several things; that is, s/he may be driving, standing in a line, riding an elevator, etc. It is at this point that one may draw on Wolpe's two-factor theory of unadaptive fears for explanation.

When the person feels this intense physical reaction, s/he assumes s/he is in danger of passing out, "going crazy", or dying (cognitive misinformation). The other dynamic operating is that s/he is in a specific situation while feeling a great deal of terror; the wild feeling becomes associated with the specific situation (classical conditioning). The next time the person enters the situation where the original attack took place s/he not only is still under stress, but now adds: "The last time I was
here I felt....What if it happens again?” This triggers the second panic and reinforces the association of the situation with the feeling of panic. It appears that once a person has experienced one or more panic attacks s/he becomes hyperalert, or sensitized (Weekes, 1979) so that any physical sign of anxiety may trigger another panic. The person becomes agoraphobic when s/he constricts his or her life to avoid these feelings of panic.

Agoraphobia may be broken down into categories of simple and complex. Symptoms of simple agoraphobia are usually precipitated by panic reactions to the effects of drugs or physical disorders. People with simple agoraphobia usually recover quickly when the original disorder is controlled. Complex agoraphobia is more serious and entails the interrelated elements previously mentioned. They are:

1. fear of the fear
2. low levels of self-sufficiency
3. cognitive misunderstanding of symptoms
4. onset of symptoms after a period of major conflict or stress (Goldstein and Chambless, 1978, p51).

Throughout the literature, agoraphobia has been defined repeatedly as a pathology associated with women. Wolpe, among others, describes agoraphobia as the "housewives' disease." Theorists concur that the most common form of agoraphobia occurs in married women who are non-assertive, dependent, and who are fearful of leaving bad relationships (Fodor, 1974; Goldstein and Chambless, 1978; Wolpe and Wolpe, 1981). Wolpe believes that the agoraphobia is the
result of the housewives' fantasies of the consequences of leaving the marriage. The more they fantasize, the more anxiety becomes attached to the fantasy, and the more fearful they become of leaving (Wolpe and Wolpe, 1981). Goldstein and Chambless based their conclusions regarding female incidence of agoraphobia on historical analysis of 36 cases of agoraphobia (12 males and 24 females) using data collected from the Bernreuter Self-Sufficiency Scale (Wolpe, 1973), the Willoughby Emotional Maturity Scale and a Fear Survey Schedule (Hallam and Hafner, 1978) administered to all clients prior to treatment. Individuals with agoraphobia were compared with those suffering from general phobia and were found to score significantly lower on self-sufficiency, expressiveness, aggressiveness, and significantly higher on fear of taking responsibility, making decisions, disapproval, rejection, criticism, and loss of control (Goldstein and Chambless, 1978).

General population studies of incidence and prevalence of agoraphobia have yielded conflicting results regarding the male/female ratio of agoraphobics. Agras, Sylvester and Oliveau (1969) interviewed a random sample of the household population of the Burlington, Vermont area. A total of 325 persons were interviewed using a Fear Survey Schedule. Results indicated that 6 out of 1000 individuals were found to be agoraphobic, and equal numbers of females and males were represented in that finding.
In 1984, the National Institute of Mental Health conducted an extensive general population study of the incidence of DSM III diagnostic categories in subjects in five major, metropolitan areas. This study involved interviewing over 3,500 individuals either residing in households or in institutions in these areas. Results indicated a significantly higher incidence of female agoraphobics than male agoraphobics; the percentages of incidence ranged from 5.3 - 12.5 percent for females and 1.6 - 5.2 percent for males.

Researchers have investigated the difference in male/female incidence. Mullaney and Trippett (1979) administered four instruments (The Fear Survey Schedule, Survey of Social Inadequacy, and two clinically rated items used to assess social and agoraphobias) to 102 alcoholics. Results indicated that in the male alcoholic subjects surveyed 13.1% were fully agoraphobic, 25% were fully socially agoraphobic, and 38.6% and 34.5% evidenced borderline agoraphobia (meaning they felt panic but did not totally avoid) and social phobia. Onset of the phobia preceded the alcohol problem in a significant number of subjects.

In looking at other gender specific factors associated with phobias the literature indicates that male agoraphobics consistently do less well in behavioral treatment than females (Mavissakalian, 1985; Hafner, 1983). Mavissakalian
studied ten male and fifty-two female agoraphobics who participated in a 2x2 factorial study comparing treatments of therapist-assisted exposure and treatment with anti-depressant medication. To assess patterns between sexes a group of ten females was individually matched with a group of ten males on the basis of age and treatment; analysis of variance revealed no significant differences between the two groups at pretreatment, significant differences on a Fear Questionnaire - Agoraphobia (Marks and Mathews, 1979) scores post treatment, and significant differences on the Fear Questionnaire - agoraphobia score at one month follow-up. Females responded consistently better to treatment than males.

Hafner (1983) placed 18 men and 49 women with agoraphobia in behavior therapy using graded exposure, in-vivo treatment to the feared situations. Eight of the men (44%) either dropped out or refused treatment because of unmanageable anxiety; six of the women (12%) dropped treatment for reasons unrelated to anxiety. Males staying in treatment progressed as well as females. However, the high dropout rate of males indicates that behavior therapy based on in-vivo graded exposure may be unacceptable for male agoraphobics. The fear noted by males during treatment was that of losing control and jumping from high bridges or moving vehicles or abusing individuals around them either physically or verbally; women expressed coping with a
feeling of panic as the major preoccupation during treatment. One possible explanation for the higher incidence of drop-outs in males may be association with the fear that the therapist may not be able to control them and, thus, they may do self harm.

In efforts to explain these outcome differences, researchers have attempted to find other gender specific variables in male and female agoraphobics. In the Naviessikalian (1985) study agoraphobic subjects were administered personality scales in addition to the Fear Questionnaire and found male agoraphobics indistinguishable from females on the basis of assertiveness, extraversion-introversion, phobia, anxiety and depression. (This was the study yielding significantly poorer response rates to behavioral treatment in males.) Hafner (1981) looked at twenty male and twenty female agoraphobic cases matched for age, marital status and duration of illness to determine any differences with regard to personality, symptoms and response to treatment. Clients were administered the Fear Survey Schedule, a Hostility and Direction of Hostility Questionnaire (Caine, Foulds and Hope, 1967), and a Standard Middlesex hospital questionnaire (Crown and Crisp, 1966). Results indicated that male agoraphobics whose central fear was being away from their spouses had the poorest prognosis and also scored significantly lower than other subjects on the direction of hostility scale. The researchers posit
that this has a connection to initial separation anxiety (fear of being away from mother).

CRITIQUE

Demographic information on agoraphobics offers little explanation for who becomes phobic. The majority of agoraphobics are married (71%) however the majority of the general population of that age range is also married. There is conflict in the literature over the marital stability of agoraphobics; however it is pertinent to note that reduction of sex drive is associated with the agoraphobic syndrome. Approximately 28% of agoraphobics are employed, 48% of whom would change jobs if they were not agoraphobic. Of the unemployed, 83% stated they would work if they were not agoraphobic (Burns and Thorpe, 1977 (a)).

Literature on family characteristics offers no conclusive data. Studies of monozygotic twins yielded significant correlations on high fear scores in all areas except agoraphobic factors (Mathews, 1981). Three major personality factors are found in agoraphobics:

1. Constant state of alertness
2. Passive-dependent attitudes
3. Tendency toward sexual inhibition

However, these factors may well be a result of the agoraphobia and have little to do with the cause. Gender differences were not noted in this research.

Although some studies of clinical cases of agoraphobia yielded disproportionate numbers of females (50% - 85%), the
Agras' study indicated equal numbers of male and female agoraphobics in the general population. Agoraphobia was originally referred to as a male disorder; more recently that opinion has changed. Whether it is gender specific remains in question. The results of the National Institute of Mental Health study indicated that females did predominate the number of individuals suffering from agoraphobia across the test sites with 5.3% - 12.5% of the females compared with 1.5% - 5.2% of the males suffering with the syndrome. However, it may be relevant to note that males exhibited a disproportionately high percentage of the population suffering from alcohol abuse/dependence with figures of 19.2% - 24.9% of the males compared with 4.2% - 4.8% of the females diagnosed with this syndrome.

It is possible that males may be masking the agoraphobic symptoms with alcohol. Human studies have produced substantial data suggesting a correlation between anxiety and alcoholism. Steer and Hassett (1982) studied groups of substance abusing and non-abusing mental health patients and found that substance abusing patients were more likely to have anxiety and paranoid ideation as syndromes. Curlee and Stern (1973) studied 100 alcoholic versus non-alcoholic males. Alcoholic males scored significantly higher on the Minnesota Multiphasic Personality Inventory in areas of fear of closed spaces, fear of open spaces, and fear of heights. Mullaney and Trippet's 1979 study of
alcohol treatment programs that yielded 13.1% of males in treatment were fully agoraphobic and an additional 38.6% of the males were borderline agoraphobic brings the argument for difference in prevalence of agoraphobia in males and females into question.

The characteristics of dependency and low assertiveness have been labeled as feminine. Theorists have apparently made the leap that because these are also characteristic of agoraphobics then agoraphobia must be a female's disease.

Thyer, et al administered a fear survey schedule to a sample of 104 females and 37 males diagnosed as either simple phobia (64), social phobia (20), agoraphobia (34), obsessive compulsive disorder (11), or panic disorder (12). Results indicated no clear gender differences on total scores of subjects. In fact, when males and females were asked to choose 10 stimuli they feared most out of a 108 item pool, they chose 9 common items (Thyer, Tomlin, Curtis, Cameron and Nesse, 1985).

Complex agoraphobia is a severely debilitating disorder. The inability to leave home without feelings of terror is a common result of this condition. It is difficult to make generalizations about lack of assertiveness, the dependency issues, and the low levels of self-sufficiency of agoraphobic clients because the disorder itself leads to such situational psychological problems. It is difficult to be independent and assertive when one is
terrified of the consequences of leaving home.

Chambless and Mason (1986) looked at sex-role stereotyping in male and female agoraphobic patients in an effort to clarify the gender differences in response to behavioral treatment that Hafner (1983) found. Subjects for this study consisted of 334 females and 68 male clients diagnosed as agoraphobic with panic attacks. Subjects were administered a number of measures of fear, social avoidance, and mobility along with the Eysenck Personality Questionnaire (Eysenck and Eysenck, 1975), a Personal Attributes Questionnaire (PAQ) (Spence and Helmreich, 1978), and the Beck Depression Inventory (Beck, Ward, Mendelson and Erbaugh, 1961). Results indicated no sex differences between men and women on frequency of panic prior to treatment. However, sex-role measures indicated that higher masculinity traits (e.g. instrumentality, being active or superior) were strongly associated with lower pathology. When masculinity was controlled for, there was no correlation between gender and avoidance. Thus, male and female differences on agoraphobic avoidance were not necessarily based on gender; the trait of masculinity appeared to be the impacting factor. Interestingly, the traits associated with femininity (e.g. expressivity and kindness) had no impact on avoidance (Chambless and Mason, 1986).
The studies involving outcome of treatment of agoraphobia indicate that males do consistently poorer than females when involved in behavioral treatment and males were more likely to drop treatment than females. Focusing on male/female differences in personality features or prevalence of agoraphobia may be blinding theorists to some basic logic about why men respond differently to behavioral treatment. The only significant variable in treatment outcome for males in Hafner's study of male and female agoraphobics was the correlation between central fear of being away from spouse and poor response to treatment. The researchers posited this to be separation anxiety; this is not in keeping with learning theory.

The questions of whether male agoraphobics are different from female agoraphobics, and how are they different remain essentially unanswered. It is possible that external factors rather than internal factors may influence the differential response rates in males. The studies to date have not looked at gender of therapists as a possible variable affecting client response to behavioral treatment.

DEPRESSION AND AGORAPHOBIA

Clinical descriptions of depression have been around for as long as written history. Hippocrates termed it "melancholia" and posited that this condition was related to the amount of black bile in an individual's brain. Throughout the ensuing several hundred years the bile theory gave
way to theories implicating phlegm, humours, and, finally, at approximately 200 A.D., purely psychological features as related to development of melancholia.

In the 1920s Freud began case studies of depression and concluded that melancholia was a reaction to loss (1957). He compared melancholia with the mourning process noting similarities such as lack of interest in activities, loss of capacity to love, and inhibition of activity; he added the characteristics of self reproach and a feeling of doom to melancholia. Freud saw loss of someone or something from the person's external world as being the precipitant to mourning; melancholia entailed the reaction to loss of control of self, that is, loss of ego.

The concept of loss of control is a central theme in the work of Martin Seligman on the connection between learned helplessness and depression (1975). Seligman used two groups of dogs in his experiments. The first group had been used in an earlier experiment that exposed the dogs to electrical shock while they were held in inescapable harnesses (helpless conditions); the second group of dogs were not previously exposed to experimental conditions. The dogs were then placed in a shuttle box made with two compartments; the dogs could escape or prevent shock by jumping the barrier into the second compartment. The naive dogs learned after two trials to avoid the shock. The dogs that had previously been exposed to helpless conditions danced
around on the shock grid for about thirty seconds then just laid down and whined rather than attempt avoidance. Seligman generalized his theory of learned helplessness to depressed individuals. He noted that these individuals are slow to initiate responses, believe themselves to be powerless and hopeless, and see their futures as bleak.

Seligman later connected learned helplessness to agoraphobia. He noted that phobics often panic at just the thought of their phobic situation; he believed that it was not the actual control but perceived control that influenced their panic. More recent theorists have also linked complex phobias such as social phobia or agoraphobia with Seligman's concept of learned helplessness in depression. They describe a cycle of initial panic that comes suddenly and a fear of that panic returning which leads to avoidance, dependence and helplessness because they are unable to predict or control when the next panic will come (Goldstein and Chambless, 1978; Goodwin, 1983).

The relationship between depression and agoraphobia remains unclear. Depression has been sufficiently common and severe in patients diagnosed as agoraphobic that some theorists believe that agoraphobia may be a form of depression (Goodwin, 1983). Mendel and Klein (1969) studied 25 patients with agoraphobia. Two findings have lead them to view agoraphobia as separate from generalized anxiety disorders and more consistent with affective disorders.
First, all of the five patients who were able to tolerate an antidepressant medication (imipramine) showed moderate to marked improvement in their agoraphobic symptoms. Second, upon investigation of the panic process they noted that phobic avoidance is not the issue to use in classifying agoraphobia as an anxiety disorder; rather, it is the fear of panic attacks that occur even in the absence of phobic situations that should link agoraphobia with affective disorders.

Other theorists believe that the link between depression and agoraphobia should be made because many of the symptoms are the same for both syndromes. Roth et al. studied patients presenting diagnoses related to primary mood change; these subjects were divided into three groups: Those suffering from, 1. anxiety (N=68), 2. depressive illness (N=62), and 3. a doubtful group because neither anxiety nor depressive illness were prominent. The purpose of this study was to demonstrate certain problems in classification of affective disorders. The researchers posited a true line of demarcation between the two syndromes. A standard intake item sheet was used which included information on a range of symptoms associated with anxiety states and depressive illnesses, and items relating to family history, medical history, occupational and social adjustment. Lowest interrater reliability in 29 of these cases was .86. Data from groups 1 and 2 were then compared
for distribution of depressive and agoraphobic symptoms. Depressive symptoms such as pessimistic outlook, ideas of guilt, and agitation were common to both groups; and, anxiety symptoms of "dizzy attacks" and mild agoraphobic symptoms were commonly found in the depressive group (Roth, Gurney, Garside, and Kerr, 1972). In another study of 35 outpatients diagnosed as anxiety disordered and 101 patients diagnosed as having major depression or dysthymic disorders, were administered the Beck Depression Inventory; sadness and loss of sex drive were the only two symptoms that distinguished the two groups (Steer, Beck, Risking, and Brown, 1986). Buglass et al. studied thirty agoraphobic women compared to normal controls; any subject with evidence of primary depressive mood changes was excluded. Of the remaining subjects, 50% of the agoraphobics exhibited symptoms of depression as opposed to .03% of the controls (Buglass, Clarke, Henderson, Kreitman, and Presley, 1977).

There is some speculation that agoraphobia may be secondary to major depression. Sadler (1984) cited two case studies in which major depression predated agoraphobic symptoms; the agoraphobic symptomology improved 1-2 months after the depression lifted. Jarrett and Schnurr (1979) tested 68 psychiatric patients and 12 non-psychiatric controls; results indicated that patients exhibiting anxious and depressed symptomology scored significantly higher on
measures of agoraphobia than the non-anxious and non-depressed controls.

Proper diagnosis is essential to treatment of any disorder. With the lack of distinction between the two syndromes, the risk of misdiagnosis is obvious. Mendel and Klein (1969) screened 423 patients seeking inpatient and outpatient treatment at a hospital. Patients were initially diagnosed through a 50 minute interview with a resident psychiatrist. Of the 25 patients Mendel and Klein found to be agoraphobic, 7 of them (28%) had been diagnosed as suffering reactive depression.

It appears that there is a sizable overlap between the symptoms of the agoraphobia and depressive illness. Not only at issue is whether one should be the primary diagnosis or secondary diagnosis; misdiagnosis is a genuine risk. It would appear to be prudent to test for both syndromes if the diagnostician suspects that either is present.

CRITIQUE

Apparently depression has been plaguing the human race for centuries. In spite of its longevity as a clinical entity, depression is still not fully understood. This is probably due to the lack of concrete knowledge about human emotion in general. Freud's views of depression stemming from loss of ego sound tangentially similar to Seligman's learned helplessness model. Both of these concepts overlap
with the loss of control in depression and, interestingly enough, in agoraphobia.

The distinction between depression and agoraphobia is sometimes unclear. Agoraphobia is classified as an anxiety disorder, whereas depression is classified as an affective disorder. Eysenck, (1977) originally classified agoraphobics with anxiety state patients on the basis of social introversion and neuroticism; however, Jasins (1981) found agoraphobics scoring significantly different from anxiety state patients on the M.M.P.I. Social Introversion Scale.

The arguments that are in favor of agoraphobia being an affective disorder vary in strength. Mendel and Klein (1969) believe that because both disorders respond to treatment with antidepressant medication, they must be linked. This is hardly empirical when one considers that bed wetting problems also respond to low doses of antidepressant medication. Many studies have found considerable overlap between agoraphobic and depressive symptomology. In fact, using the Beck Depression Inventory, only two of the twenty-one symptoms (sadness and loss of libido) distinguished agoraphobics from depressives.

Jarrett and Schnurr (1979) and Sadler (1984) speculated that agoraphobia may be secondary to major depression. This may be possible, or, since a major depressive episode is also a major stressor, it may be the stress of the episode itself that brings about the onset of the agoraphobia.
In consideration of the mixed research on the link between depression and agoraphobia it would be wise to keep both syndromes in mind when investigating either. One could speculate that a change in symptomology of either clinical syndrome might impact on symptomology of the other.

**GENDER AND TREATMENT FACTORS**

Behavioral treatment for agoraphobia involves exposing clients to situations they perceive as noxious. This process involves not only the agreement of client and therapist on what exposure is necessary, it entails the actual doing of the task. Negotiation, direction, and trust are necessary components in this process. Effran and Caputo (1984) emphasize that: "Behavior therapy, like all other psychotherapy, is not simply action - it is action contextualized by a specific, negotiated social contract" (p235). They go on to note that "slippage" in behavioral treatment results from the therapist getting caught up in the client's panic; behavior therapists may feel "callous" or "ruthless" while holding the client to his or her agreed upon exposure to a fearful situation.

Perrson, Alstrom, and Nordlund (1984) conducted a study looking at satisfaction rates for clients in behavioral treatment. They studied 103 agoraphobic women assigned randomly to one of four treatment groups. Subjects were asked to complete an Experience in Therapy Inventory (Perrson, et al, 1984) after two initial sessions with a
therapist. Patients meeting with therapists using prolonged exposure or supportive therapy in-vivo were more satisfied with their therapists than those who received relaxation or educational therapy. Positive associations between outcome and initial experience with therapist were found in the prolonged exposure group. The prolonged exposure and in-vivo groups considered their therapists more assured and knowledgeable and believed they provided better therapeutic contact than the other groups believed of their therapists. The authors concluded that in behavioral treatment a good client-therapist relationship was important to positive outcome.

Rabavilas, Boulougouris, and Perissaki (1979) conducted a study evaluating therapist's qualities relative to change in 36 neurotic patients (13 phobic and 23 obsessive-compulsive patients) involved in in-vivo treatment. Patients were administered a rating form which included sixteen descriptive statements gathered from research on most frequently reported characteristics of therapists (Gardner, 1964). Results indicated that therapist's respect, understanding, and interest toward patients were significantly related to positive outcome; and, a therapist's style reflecting gratification of dependency needs, permissiveness, neutrality and tolerance were found to be significantly related to poorer outcome in treatment. The authors viewed these differences in outcome as a result
of an interactive effect between therapist's style and behavioral technique. They concluded that the relationship between therapist and client is an important variable in behavioral treatment of phobias and obsessive-compulsive disorders.

Gender of therapist may also be relevant in behavioral treatment. Somerville, Remm, and Spudic (1980) studied snake phobic undergraduates; they looked at the impact of gender of model as it relates to subject's approach behavior. They found that both males and females exhibited greater approach behavior in the presence of an experimenter of the opposite sex; this was demonstrated even more when male subjects were tested by female experimenters. It is important to note that snake phobia is a specific phobia; gender of therapist in treatment of complex phobia has not yet been a subject of research.

Differences in preference between male and female subjects in the areas of ideal counselor, expectations of counselors, and competence of counselors has been researched (Fletcher, 1983; Greenberg and Zeldow, 1980; Heatherington and George, 1984; Subich, 1983). Fletcher studied thirty company administrators and sixty undergraduates for differences in attitudes toward male and female interviewers. He found that subjects saw same-sex interviewers as more likely to understand them; male subjects believed that interviewers would be less competent at interviewing regardless of
gender; and males believed female interviewers would be less likely to have aggressive styles. These findings indicate that male subjects operated on sexual stereotypes (Fletcher, 1983).

Heatherington and George (1984) looked at thirty-six counselors each interacting with one male and one female client. Gender of therapist and client were significantly related to perceptions of each other at intake. This study looked at how verbal communication is used to define relative power and control. Results indicated less favorable ratings of male clients by counselors of both sexes; this may be a result of a higher incidence of "complementary patterns" (rapid fire question-answer exchanges that indicate a client is in a one-up position) in male client-therapist relationships. Less favorable ratings of male clients have been found in novice as well as experienced therapists (Parloa, Waskow, and Wolfe, 1978; Wentworth, 1977). Greenberg and Zeldow (1980) looked at male and female differences in ideal therapist. Thirty-six males and forty-six females were asked to rate their ideal therapist on the Adjective Check List (Gough and Heilbrun, 1965). Women consistently preferred a therapist who fit male sex-role stereotypes (confident, controlling, aggressive); males preferred therapists who were more consistent with female sex-role stereotypes (nurturant, affiliative, deferent). These results indicate a potential
bias arising from differential relationship needs of male and female clients.

**CRITIQUE**

Historically behavioral treatment was seen as a mechanistic type of treatment that entailed an "expert" (the therapist) prescribing regimented behavioral tasks for the client to perform. More recently, it has become apparent that the therapist's interpersonal style can significantly impact on treatment outcome.

In the study conducted by Perrson et al (1984) that consisted of agoraphobic women rating their experience in therapy it was found that initial experience with the therapist was associated with positive outcome in a prolonged exposure treatment. And, in the in-vivo or prolonged exposure treatments these women considered their therapists more assured and knowledgeable than those in an educational or relaxation form of therapy; this study did not indicate the gender of therapists involved. It is possible that this could be a significant variable to consider. In the study conducted by Somerville et al (1980) gender of therapist significantly impacted on the willingness of snake phobic subjects to approach their feared situation. And, male subjects were impacted by gender of therapist even more than female subjects were. Both males and females exhibited greater approach behavior in the presence of an opposite sex experimenter; however,
this is not necessarily positive in treatment. In the process of in-vivo supported exposure the phobic must learn to control panic in situations that have been broken down into progressive degrees of difficulty. If too difficult of a step is tackled before the client is capable of managing the panic it could set back the progress that has been made. In terms of learning principles, the inability to handle the more difficult step could reinforce the danger of panicking and set back the progress already made.

Other studies indicate that having the same gender therapist as clients is relevant to whether the subjects felt understood (Fletcher, 1983). In that same study, Fletcher found that male subjects believed that interviewers in general (regardless of gender) were less competent, and that female interviewers would be less aggressive. Of interest is that in Greenberg and Zeldow's study (1980) females preferred therapists who fit male stereotypes (confident, aggressive, controlling) and males preferred therapists who fit female stereotypes (nurturant, warm, respectful). In supported-exposure treatment for agoraphobia, it is essential for a therapist to be in control of the in-vivo practice. That is, she or he must feel confident that s/he can handle the client should the client panic, and the therapist must hold the client to his or her agreed upon task.
It is possible that a number of factors combined to create a non-therapeutic environment for male clients involved in in-vivo treatment with female therapists. Male subjects view interviewers in general as less competent than female subjects view them; add to this the findings that male subjects perceive female interviewers as less aggressive and that male clients prefer warm, respectful, nurturant therapists. And, finally, consider with those variables that in-vivo supported-exposure treatment of agoraphobia requires a strong, assertive stance on the part of the therapist, regardless of therapist's gender. It is possible that gender of the therapist when intermeshed with the attitudes and beliefs of male clients will significantly impact on these male clients' willingness to trust their therapist to accompanying them into their phobic situations. Without these necessary practices, progress on agoraphobic symptoms will be significantly impaired.

**SUMMARY OF RESEARCH AND RELATIONSHIP TO PROBLEM**

Joseph Wolpe's two-factor learning theory of fear neuroses adequately explains the process of becoming agoraphobic. However, a pure approach to the theory would not explain the different patterns of incidence of agoraphobia or response to treatment in males and females. Positing intrapsychic fears of freedom in dependent housewives does not fit with behavioral theory's requirement for empiricism.
and it offers no explanation for different outcomes in treatment.

In looking at other factors impacting on outcome, researchers have found that male clients have different preferences in ideal therapist than females. Male clients tend to want a nurturant, affiliative therapist while females prefer a more confident and controlling therapist. Studies of snake phobics indicated different responses for males and females depending on gender of therapist. Apparently males were more likely to exhibit approach behavior to the snake when paired with a female therapist.

Behavioral treatment of agoraphobia calls for a directive and controlling therapist. The therapist not only negotiates a behavioral goal set toward approaching a feared situation, s/he also holds his or her client to this goal. One must consider the impact of a directive, aggressive, behavioral therapist on a male client whose preference in therapist may be one who fits female sex-role stereotypes. Add to this the condition of having a female behavioral therapist exhibiting aggressive, directive qualities. The impact on the male client may be two fold: 1. He may be less willing to exhibit fear in front of the female (and drop out of treatment); or, 2. He may not feel he is receiving the nurturance and understanding that he may believe is ideal in a therapist.
Past research has uncovered the fact that males do not respond as well to behavioral treatment of agoraphobia as females. These studies have not looked at the impact of gender of therapist. The purpose of this study is to examine the effect of therapist's gender on male and female agoraphobics in behavioral treatment.
CHAPTER III

METHODOLOGY

POPULATION AND SAMPLE

The population from which participants for this study were selected consisted of agoraphobic clients who sought treatment at the Centers for Behavioral Medicine in Baltimore, MD, Richmond, VA and Rockville, MD. Center clients are generally adults who come from urban environments. The Centers for Behavioral medicine make up a private organization and do not use sliding scale fees. Clients pay between $90 to $150 per week for treatment; this fee scale eliminates lower income groups. Clients at the Centers are representative of the upper middle class population.

Participants for this study included 56 clients (28 males and 28 females) divided into matching pairs (male and female); twenty pairs had been in treatment with female therapists and 8 pairs had been in treatment with male therapists at the Centers for Behavioral Medicine. Clients were diagnosed and treated for agoraphobia in a sixteen week structured phobia program consisting of 1-1/2 hour educational groups and 1 hour in-vivo individual sessions using supported exposure each week.

DATA COLLECTION

After obtaining permission from agency administrators, records of therapists who agreed to participate in this
study were surveyed for identifiable client participants.

The following procedure was used for selecting cases:

1. **Group leader** - Each Center holds lists of clients involved in groups. The first step in data collection was to survey each group for potential male/female pairs.

2. After finding male/female participants in the same group, the participants were matched for same individual therapist.

3. The next matching entailed checking for use or non-use of medication. If a subject was taking antidepressant medication, s/he was matched with another subject using medication.

4. All pairs were then compared on the basis of pretest scores on the Fear Questionnaire. Scores on the Fear Questionnaire reflect severity of symptoms and avoidance. These scores are represented on a Likert Scale ranging from 0 (no avoidance) to 8 (definitely avoided) for a total of 5 questions; severity was based on the following groupings:

- **Mild** - Score 0 - 13.3
- **Moderate** - Score 13.4 - 26.7
- **Severe** - Score 26.8 - 40

Individuals seeking treatment at the Centers for Behavioral Medicine complete a 24 item Fear Questionnaire.
(FQ) on intake and completion of the sixteen week program. This instrument provides a main phobia scale (FQ-T), three phobia subscales for agoraphobia (FQ-AG), blood and injury phobia (FQ-BI), and social phobia (FQ-SOC) (Marks and Mathews, 1979). The Fear Questionnaire also includes a Self-Rating of Severity scale (SRS) and an Anxiety-Depression scale.

Client pairs of self-ratings of severity of general symptomology of phobia, anxiety and depression, and general phobia category (agoraphobia, social phobia, and blood and injury phobia) pre-treatment and post-treatment were collected. All ratings were then coded according to male or female client; names were not used. In addition to the scores from the FQ, each client's file contained numerical scores from the Beck Depression Inventory gathered at intake and completion of the 16 week program, and a therapist rating of progress in treatment that was scored only at completion of the 16 week program. The Beck Depression Inventory (BDI) is a 21 item self-report inventory consisting of 21 questions each of which represents a symptom of depression. Each question is composed of four alternate statements rating severity from 0 - no symptomology to 3 - severe symptomology. The BDI is scored by summing these ratings. The total score can range from 0 to 63. Although subjects were not matched for severity of depressive symptomology, pre and post treatment BDI scores
were collected as further evidence of clinical change. The therapist ratings of progress in treatment were based on a Likert scale ranging from 0 - no progress to 8 - totally cured. These ratings were collected on each pairing.

As a matter of professional courtesy therapists were asked to voluntarily participate in this study. It is organization policy to make files readily available for research purposes. All therapist names and client names were coded for male/female groupings.

TREATMENT

Phobic people enter the Center for Behavioral Medicine's phobia program after an evaluation interview with a Center Director. During this interview, the director explains the program and learns about the clients' phobic symptomology. As part of this interview, perspective clients are asked to fill out a Fear Questionnaire (Marks and Mathews, 1979) and The Beck Depression Inventory (Beck, et al, 1961). The Fear Questionnaire is a one-page self rating form that measures phobic symptomology. The Beck Depression Inventory is a 21 item self-rating form that measures depth of depression and reflects clinical changes in depression over time. After evaluation, clients are assigned to a specific sixteen week group and an individual therapist.

The program consists of two parts. The first entails 1-1/2 hour group meetings held weekly for sixteen weeks;
these meetings are conducted by either a psychiatrist, social worker, or professional counselor and each meeting follows a specific format of topics outlined as part of the standard phobia program. The groups are educational and cover topics that are relevant to phobias. These groups are attended by six to ten phobic persons and their support persons whenever possible.

The second part of the program entails a one-hour session with the phobic clients and their individual therapist. During these sessions, the therapist and each client break a feared situation down into manageable parts and practice each part using specific cognitive techniques to deal with the fear experienced in the situations. As clients begin to trust that they are able to control their panic, they practice on more and more difficult tasks.

During the final group in the program clients are asked to fill out another Fear Questionnaire and Beck Depression Inventory. At that point, clients and therapists assess the need for additional sessions. There are monthly follow-up groups for clients who wish to attend and individual therapy sessions, if desired.

Therapists at the Centers for Behavioral Medicine must train with experienced Center therapists prior to seeing clients. Each therapist in training must go through a sixteen week group in addition to accompanying other therapists on their individual sessions with clients. The
purpose of this training is to insure the therapist's understanding of the process of graded, supported exposure which entails the breaking down of a fear situation into manageable pieces and helping clients to reduce their anxiety in those situations with specific behavioral techniques.

**INSTRUMENTATION**

The Fear Questionnaire (FQ) (Marks and Mathews, 1979) is a one-page self-rating form that monitors change in patients' phobic symptoms; the instrument takes approximately 5 - 10 minutes to complete. There are essentially four measures on this form: a main target phobia rating which indicates severity of avoidance; a global phobia rating which indicates distress and avoidance; a Fear Questionnaire which consists of 15 items divided into categories of symptoms associated with agoraphobia (AG), blood and injury (BI), and social phobia (SOC), in addition to an anxiety-depression scale. Scales for all measures are based on a 0 - 8 Likert Scale with 0 representing little or no symptomology (distress or avoidance) to 8 which represents severe symptomology (total avoidance of severe disturbance).

The instrument's validity has been established through factor analysis of responses of three groups of phobics from different geographic locations. The original Fear Questionnaire was constructed by Marks and Herst (1970) in
an attempt to eliminate rarely encountered situations that overloaded previous Fear Surveys. One thousand phobics from a nationwide British phobic club were administered this new questionnaire. Factor analysis of these responses led to a second revision. Marks et al (1977) subjected this revision to a factor analysis of responses of 171 phobic patients being treated in London. A similar but independent item pool was subjected to a third factor analysis on phobic patient responses in Oxford. The results of these analyses yielded four factors, three phobic (agoraphobia, social phobia, and blood and injury phobia) and an anxiety-depression factor. Thirty-one items were eliminated due to low factor loading, leaving twenty-two fear and eight anxiety-depression items. The final revision came after a test for reliability in a clinical population. The form was administered to twenty phobic patients twice, one week apart; ten item subscores that correlated at lower than .05 were eliminated leaving an instrument with the following test-retest reliability:

<table>
<thead>
<tr>
<th>Factor</th>
<th>r</th>
</tr>
</thead>
<tbody>
<tr>
<td>FQ-AG</td>
<td>.89</td>
</tr>
<tr>
<td>FQ-BI</td>
<td>.96</td>
</tr>
<tr>
<td>FQ-SOC</td>
<td>.82</td>
</tr>
<tr>
<td>FQ-T</td>
<td>.93</td>
</tr>
<tr>
<td>anxiety-depression-</td>
<td>.82</td>
</tr>
</tbody>
</table>

To test the sensitivity of the instrument to clinical improvement after treatment 26 phobic patients being treated in-vivo by nurse-therapists were administered the Fear Questionnaire prior to and after treatment. Analysis of
variance pre-post yielded significant improvement on main phobia (7.0 - 3.8), global phobia (5.7 - 3.1), total phobia (36.5 - 26.6), and anxiety-depression (18 - 12); agoraphobia and social phobia subscores also indicated significant improvement (14 - 8 and 16 - 13 respectively).

The Beck Depression Inventory (BDI) (Beck, et al, 1961) is a 21 item, self-report instrument designed to measure depth of depression and to reflect changes in clinical depression over time. The BDI was factorially constructed from observations and records of depressed patients. The resultant inventory was administered to 226 other depressed patients to determine its validity. In addition, a team of four psychiatrists observed the patients in a blind study and diagnosed them according to diagnostic category and depth of depression. Agreement over ratings of depression and degree of depression using a 4 point scale (0-none, 1-mild, 2-moderate, 3-severe) yielded the following:

<table>
<thead>
<tr>
<th>Agreement Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete agreement</td>
<td>56%</td>
</tr>
<tr>
<td>3 of 4 agreement</td>
<td>41%</td>
</tr>
<tr>
<td>2 of 4 disagreement</td>
<td>2%</td>
</tr>
<tr>
<td>3 of 4 disagreement</td>
<td>1%</td>
</tr>
</tbody>
</table>

This indicates agreement within 1 degree on the 4 point scale in 97% of the cases.

Odd-even reliability yielded .86 correlation and test-retest intervals at two and six weeks indicated parallel changes in patients' symptoms and scores. Comparison of the interviewers' scores with the inventory scores also yielded high degree of correspondence.
Validation included comparison of the Beck's none, mild, moderate, and severe categories with the Mann-Whitney U Test (a depth of depression measure). They found that differences in depth of depression in the categories of none, mild, and moderate were significant at the .0004 level; differences between moderate and severe categories were significant at the .02 to .1 level.

The questionnaire consists of 21 items related to symptom and attitudes of depression:

- mood
- pessimism
- sense of failure
- lack of satisfaction
- guilty feeling
- sense of punishment
- self hate
- self accusations
- self punitive wishes
- crying spells
- irritability
- social withdrawal
- indecisiveness
- work inhibition
- sleep disturbance
- loss of appetite
- weight loss
- somatic preoccupation
- loss of libido

Numerical values from 0 to 3 are assigned to indicate degree to severity. Scoring consists of adding the numbers circled in response to the 21 questions. Results are scaled as follows:

<table>
<thead>
<tr>
<th></th>
<th>NONE</th>
<th>MILD</th>
<th>MODERATE</th>
<th>SEVERE</th>
</tr>
</thead>
<tbody>
<tr>
<td>mean</td>
<td>10</td>
<td>18.1</td>
<td>26.1</td>
<td>32.7</td>
</tr>
<tr>
<td>s.d.</td>
<td>6.6</td>
<td>10.1</td>
<td>8.9</td>
<td>11.5</td>
</tr>
</tbody>
</table>

RESEARCH DESIGN

The design for this study was a descriptive study. Changes in Fear Questionnaire responses and Beck Depression Inventory scores between male and female clients who had been matched with same male or female therapist were
compared to determine whether the variance in progress between male and female clients is related to gender of therapist.

**GENERAL HYPOTHESES**

1. Male agoraphobic subjects in behavioral treatment with male therapists will exhibit greater improvement than male subjects with female therapists as measured by The Fear Questionnaire (Marks and Mathews, 1979) and The Beck Depression Inventory (Beck et al, 1961).

2. Female subjects in behavioral treatment for agoraphobia will improve significantly regardless of therapist's gender.

3. Male and female subjects matched for severity of agoraphobic symptoms with the same male therapists will exhibit similar rates of improvement.

4. Female subjects, matched with males for severity of agoraphobic symptoms, will exhibit greater rates of improvement with female therapists than male subjects with female therapists.

**STATISTICAL TECHNIQUE**

The first procedure involved a 2 x 2 factorial experiment in which analysis of variance was applied to the following groups:

1. Male clients with male therapists and male clients with female therapists.
2. Female clients with male therapists and female clients with female therapists.

The second procedure involved a cross-tabulation of therapist's ratings categorized according to gender of therapist and gender of clients. Frequency counts for each cell were changed to percentages. A Chi-squared test was then applied to these percentages to determine whether cell differences were significant. Therapist's ratings of clients' progress were divided as follows:

- 0-1-2 - no change in phobic symptoms
- 3-4-5 - moderate change in phobic symptoms
- 6-7-8 - great changes in phobic symptoms to totally cured

<table>
<thead>
<tr>
<th></th>
<th>0-1-2</th>
<th>3-4-5</th>
<th>6-7-8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male client/male therapist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male client/female therapist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female client/male therapist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female client/female therapist</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Summary of Methodology**

The methodology for this study was designed to establish whether gender of therapist impacts on the progress of male and female clients in supported-exposure treatment of
agoraphobia. Subjects were matched for severity of agoraphobic symptoms, use or non-use of medication, and therapist administering treatment in a 16 week structured program for phobias conducted by the Centers for Behavioral Medicine. An analysis of variance of pre and post treatment scores on Marks' Fear Questionnaire was conducted to determine if there was significant difference in response to treatment between male and female agoraphobic clients.
CHAPTER IV

ANALYSIS OF RESULTS

The sample for this study consisted of 56 subjects (28 females and 28 males) divided into matching pairs on the basis of matching for use and non-use of medication and severity of symptoms on the Agoraphobic Symptomatology Score (AG score) of the Fear Questionnaire (FQ). The AG score severity ranges were broken down as follows:

- **Mild** - Score 0 - 13.3
- **Moderate** - Score 13.4 - 26.7
- **Severe** - Score 26.8 - 40

Each subject had been administered the Fear Questionnaire and the Beck Depression Inventory at the beginning of a 16 week phobia treatment program. The Fear Questionnaire yields four measures of phobia related issues. The first is a Main Phobia scale; this rating was disregarded from the data because of its general wording. The question read as follows:

"1. Main phobia you want treated (describe in your own words)........................................................

(avoidance rated 0 - 8)

Although all subjects were diagnosed as agoraphobic, the main phobia situations varied from driving to grocery shopping, with some respondents listing more than one "main phobia."
The second rating on the FQ consists of three phobia subscales for Agoraphobia (AG), Blood and Injury (BI) and Social phobia (SOC). The scores for each of these phobias are determined by adding the ratings for the appropriate questions. For the purpose of this study, only AG results were used.

The Anxiety-Depression scale (FEEL) is a measure designed to express the emotional impact of the phobia. This score is derived from adding scaled responses to questions regarding depression, anger, and panic.

The final scale of the FQ, the Self-Rating of Severity or Global Phobia score (RATE) indicates present state of phobic symptoms. This consists of a single rating on a Lickert Scale ranging from 0 - no phobia present to 8 - very severely disturbing/disabling.

The second instrument used in this study was the Beck Depression Inventory (BECK). The BECK was used to measure level of general depression. Since the literature indicates a link between anxiety and depression it seemed prudent to include any possible changes in general depression that may be linked with changes in phobic symptoms.

Post testing took place at the end of 16 weeks of treatment. Post-test data collected from client files consisted of FQ and BECK scores, in addition to a rating of client progress (THERRATE) taken from termination summaries prepared by each client's therapist at the end of treatment.
The THERRATE is a single digit rating on a Lickert Scale ranging from 0 - no improvement to 8 - totally cured.

The analysis of results will be organized as follows:

**Demographic Data** - A general summary of subjects, severity of symptoms, use or non-use of medication and number of dropouts.

**General Findings** - A preliminary analysis of overall pre and post test changes for all subjects on the FQ.

**Fear Questionnaire** - An analysis of variance of pre and post test scores on the FQ scales controlling for variables of client gender, medication and therapist gender.

**Beck Depression Inventory** - An analysis of variance of pre and post scores controlling for variables of client gender, medication, and therapist gender.

**Therapist Ratings of Improvement** - A comparison of ratings controlling for gender of therapist and gender of client to see if gender influenced rating of progress.

**Intercorrelation of Test Results** - A comparison of changes in FQ scales, BECK, and THERRATE to determine the degree of correlation between the changes in each.

**DEMOGRAPHIC DATA**

The sample of 56 male and female agoraphobics was broken down into 16 subjects (29%) treated by male therapists and 40 subjects (71%) treated by female therapists. Of the 56 subjects, 8 (14.30%) fell into the mild AG range, 36 (64.28%) into the moderate AG range, and 12 (21.43%) into a severe symptomology AG range. (Table 1).
Fourteen subjects were on medication throughout treatment; forty-two subjects were treated with the supported exposure method only. Five subjects, all male, and all in treatment with female therapists, dropped out of treatment prior to completion of the 16 weeks.

**TABLE 1**

**Pre-Test Agoraphobia Score**

<table>
<thead>
<tr>
<th>VALUE</th>
<th>FREQUENCY</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>1</td>
<td>1.8</td>
</tr>
<tr>
<td>6</td>
<td>1</td>
<td>1.6</td>
</tr>
<tr>
<td>7</td>
<td>2</td>
<td>7.1</td>
</tr>
<tr>
<td>8</td>
<td>1</td>
<td>8.9</td>
</tr>
<tr>
<td>10</td>
<td>2</td>
<td>12.5</td>
</tr>
<tr>
<td>13</td>
<td>1</td>
<td>14.3</td>
</tr>
<tr>
<td>14</td>
<td>4</td>
<td>21.4</td>
</tr>
<tr>
<td>15</td>
<td>5</td>
<td>30.4</td>
</tr>
<tr>
<td>16</td>
<td>3</td>
<td>35.7</td>
</tr>
<tr>
<td>17</td>
<td>3</td>
<td>41.1</td>
</tr>
<tr>
<td>20</td>
<td>6</td>
<td>51.8</td>
</tr>
<tr>
<td>21</td>
<td>1</td>
<td>53.6</td>
</tr>
<tr>
<td>22</td>
<td>5</td>
<td>62.5</td>
</tr>
<tr>
<td>23</td>
<td>1</td>
<td>64.3</td>
</tr>
<tr>
<td>24</td>
<td>5</td>
<td>73.2</td>
</tr>
<tr>
<td>26</td>
<td>3</td>
<td>80.4</td>
</tr>
<tr>
<td>27</td>
<td>1</td>
<td>83.9</td>
</tr>
<tr>
<td>29</td>
<td>2</td>
<td>87.5</td>
</tr>
<tr>
<td>30</td>
<td>2</td>
<td>92.9</td>
</tr>
<tr>
<td>31</td>
<td>3</td>
<td>94.6</td>
</tr>
<tr>
<td>34</td>
<td>1</td>
<td>96.4</td>
</tr>
<tr>
<td>35</td>
<td>1</td>
<td>98.2</td>
</tr>
<tr>
<td>39</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

**GENERAL FINDINGS**

Preliminary analysis of overall pre and post test changes shows significant improvement for all subjects in areas of agoraphobic symptomology, anxiety/depression,
global ratings, and general depression (.000). This indicates that male and female agoraphobic subjects, regardless of gender of therapist or use or non-use of medication improved significantly in treatment at the Centers for Behavioral Medicine in the 16 week program (Table 2).

TABLE 2
T-Test for Overall Changes from Pre to Post Tests

<table>
<thead>
<tr>
<th></th>
<th>Pretest Mean</th>
<th>S.D.</th>
<th>Posttest Mean</th>
<th>S.D.</th>
<th>T</th>
<th>2-Tail Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fear Questionnaire</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AC</td>
<td>20.25</td>
<td>7.70</td>
<td>8.27</td>
<td>6.48</td>
<td>9.94</td>
<td>.000</td>
</tr>
<tr>
<td>FEEL</td>
<td>20.04</td>
<td>9.73</td>
<td>9.63</td>
<td>8.33</td>
<td>7.72</td>
<td>.000</td>
</tr>
<tr>
<td>RATE</td>
<td>5.78</td>
<td>1.73</td>
<td>2.74</td>
<td>1.41</td>
<td>10.44</td>
<td>.000</td>
</tr>
<tr>
<td>BECK</td>
<td>16.57</td>
<td>9.30</td>
<td>7.86</td>
<td>8.05</td>
<td>8.16</td>
<td>.000</td>
</tr>
</tbody>
</table>

n = 51

The next step in looking at these general results was to control for variables of client gender, medication, and therapist gender to determine which, if any, may impact on the rate of improvement. Table 3 indicates overall change in AG score factoring out variables of medication and therapist gender, leaving only impact of client gender.
### Table 3

**T-Test for Overall Changes in AG Score by Client Gender**

<table>
<thead>
<tr>
<th>Group</th>
<th>Gender</th>
<th>Mean Change</th>
<th>T Value</th>
<th>2-Tail Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group 1</td>
<td>Male Client</td>
<td>10.78</td>
<td></td>
<td>-.89</td>
</tr>
<tr>
<td></td>
<td>n=23</td>
<td></td>
<td></td>
<td>.380</td>
</tr>
<tr>
<td>Group 2</td>
<td>Female Clients</td>
<td>12.96</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>n=28</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Gender of client does not make significant difference in improvement rates of AG symptoms.

**Table 4** indicates results of overall changes in AG when medication is used as the main variable and client and therapist gender are controlled. Results indicate no significant change in AG score with use or non-use of medication.

### Table 4

**T-Test for Overall Changes in AG Scores with Use or Non-Use of Medication**

<table>
<thead>
<tr>
<th>Group 1</th>
<th>Medication</th>
<th>Mean Change</th>
<th>T Value</th>
<th>2-Tail Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>No medication</td>
<td>n=37</td>
<td>11.14</td>
<td>-.92</td>
<td>.372</td>
</tr>
<tr>
<td>Group 2</td>
<td>Medication</td>
<td>14.21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n=14</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
And, finally, Table 5 shows overall changes in AG score when gender of client and medication effects are controlled for and therapist gender is studied for impact. The results show a significantly higher rate of improvement in AG symptoms with female therapists as opposed to male therapists (.005).

**TABLE 5**

<table>
<thead>
<tr>
<th>T-Test for Overall Changes in AG Score by Therapist Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean Change</td>
</tr>
<tr>
<td>-------------</td>
</tr>
<tr>
<td>Group 1</td>
</tr>
<tr>
<td>Male Therapist Cases</td>
</tr>
<tr>
<td>n=16</td>
</tr>
<tr>
<td>Group 2</td>
</tr>
<tr>
<td>Female Therapist Cases</td>
</tr>
<tr>
<td>n=35</td>
</tr>
</tbody>
</table>

**FEAR QUESTIONNAIRE**

As mentioned previously, the Fear Questionnaire consists of three separate ratings, the AG Symptom scale, and anxiety/depression scale, and a global phobia scale. The AG scale is used to determine diagnosis as Agoraphobic. For the purpose of this research the AG score is treated as the most relevant measure of change. However, the results of the other two scales will be included in this section. An analysis of variance for each of these scales was run controlling for factors of client gender, medication, gender of client same as gender of therapist (same sex), and therapist gender. Table 6 illustrates these analyses of the AG score results.
<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>Degrees of Freedom</th>
<th>Mean Square</th>
<th>F</th>
<th>Signif. of F.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Sex</td>
<td>60.10</td>
<td>1</td>
<td>60.10</td>
<td>.81</td>
<td>.373</td>
</tr>
<tr>
<td>Medication</td>
<td>96.30</td>
<td>1</td>
<td>96.30</td>
<td>1.31</td>
<td>.258</td>
</tr>
<tr>
<td>Same Sex</td>
<td>171.60</td>
<td>1</td>
<td>171.60</td>
<td>2.38</td>
<td>.129</td>
</tr>
<tr>
<td>Therapist Sex</td>
<td>748.97</td>
<td>1</td>
<td>748.97</td>
<td>12.42</td>
<td>.0001*</td>
</tr>
<tr>
<td>Therapist Sex With</td>
<td>698.91</td>
<td>1</td>
<td>698.91</td>
<td>11.64</td>
<td>.0001*</td>
</tr>
<tr>
<td>Client Sex</td>
<td>3.87</td>
<td>1</td>
<td>3.87</td>
<td>.06</td>
<td>.801</td>
</tr>
<tr>
<td>Main Effects</td>
<td>708.98</td>
<td>2</td>
<td>354.49</td>
<td>5.90</td>
<td>.005*</td>
</tr>
<tr>
<td>Explained</td>
<td>880.57</td>
<td>3</td>
<td>293.52</td>
<td>4.89</td>
<td>.005</td>
</tr>
<tr>
<td>Residual</td>
<td>2822.41</td>
<td>47</td>
<td>60.05</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication With</td>
<td>75.24</td>
<td>1</td>
<td>75.24</td>
<td>1.02</td>
<td>.318</td>
</tr>
<tr>
<td>Same Sex</td>
<td>212.30</td>
<td>1</td>
<td>212.30</td>
<td>2.88</td>
<td>.096</td>
</tr>
<tr>
<td>Main Effects</td>
<td>330.40</td>
<td>2</td>
<td>165.20</td>
<td>2.24</td>
<td>.118</td>
</tr>
<tr>
<td>Explained</td>
<td>347.74</td>
<td>3</td>
<td>115.91</td>
<td>1.57</td>
<td>.209</td>
</tr>
<tr>
<td>Residual</td>
<td>3314.28</td>
<td>45</td>
<td>73.65</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication With</td>
<td>528.79</td>
<td>1</td>
<td>528.79</td>
<td>10.54</td>
<td>.002*</td>
</tr>
<tr>
<td>Client Sex With</td>
<td>19.85</td>
<td>1</td>
<td>19.85</td>
<td>.40</td>
<td>.533</td>
</tr>
<tr>
<td>Therapist Sex</td>
<td>1179.53</td>
<td>1</td>
<td>1179.53</td>
<td>23.51</td>
<td>.000*</td>
</tr>
<tr>
<td>Main Effects</td>
<td>1322.64</td>
<td>3</td>
<td>440.88</td>
<td>8.72</td>
<td>.000*</td>
</tr>
<tr>
<td>Explained</td>
<td>1605.16</td>
<td>7</td>
<td>229.31</td>
<td>4.57</td>
<td>.001</td>
</tr>
<tr>
<td>Residual</td>
<td>2056.84</td>
<td>41</td>
<td>50.17</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The first section of Table 6 illustrates the analysis of variance in changes of AG score broken down by client sex, medication, same sex, and therapist gender. Results indicate that therapist gender is the only variable that significantly impacts on change in AG symptoms (.001). According to these results, gender of client was not significantly related to outcome of treatment (.37) nor use or non-use of medication (.26) nor matching client for same sex therapist (.13).

When therapist gender and client gender are looked at as the source of variation, the 2nd section shows results of a main effects significance of .005; however, further analysis proves therapist gender again to be the significant variable involved (.001). Studying main effects of use of medication with matched gender variable yields no significance (3rd section).

However, the final section of Table 6 illustrates an interesting interaction. Apparently, the only time medication shows a significant effect on AG outcome (.002) is when it is run in combination with gender of therapist and gender of client. However, controlling for this number of variables breaks groups of 16 pairs and 40 pairs into four each leaving numbers in cells too small to trust. Again, gender of client has no significant impact on outcome, and therapist gender is consistently significant.

The FEELING score of the Fear Questionnaire is a measure of anxiety/depression attached to phobic symptom-
Table 7 represents the results of analysis of variance run contrasting variables of client gender, medication, etc.

As Table 2 indicated, subjects exhibited significant improvement in FEELING scores (.000) pre to post testing. In Table 7 we note that the variables of client gender, medication, same sex therapist, and therapist gender have no significant impact on improvement when looked at individually. When therapist gender is controlled, client gender becomes barely significant; and, when medication, client gender, and therapist gender are controlled both client gender and therapist gender reach levels of significance. This can be explained in the same manner as the significance of medication in Table 6; that is, this many variables breaks 16 and 40 pairs into too many cells to trust significance.

The last picture of the FQ is a present state or global phobia rating (RATE). Table 8 illustrates analysis of variance of pre and post RATE scores, again, looking at various combinations of variables. Although subjects improved significantly on RATE scores, apparently client gender, therapist gender and medication have had no significant impact on these changes.
<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>Degrees of Freedom</th>
<th>Mean Square</th>
<th>F</th>
<th>Signif. of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Gender</td>
<td>305.61</td>
<td>1</td>
<td>305.61</td>
<td>3.48</td>
<td>.068</td>
</tr>
<tr>
<td>Medication</td>
<td>12.44</td>
<td>1</td>
<td>12.44</td>
<td>.13</td>
<td>.718</td>
</tr>
<tr>
<td>Same Sex</td>
<td>.92</td>
<td>1</td>
<td>.92</td>
<td>.01</td>
<td>.922</td>
</tr>
<tr>
<td>Therapist Gender</td>
<td>146.47</td>
<td>1</td>
<td>146.47</td>
<td>1.61</td>
<td>.211</td>
</tr>
<tr>
<td>Therapist With</td>
<td>176.95</td>
<td>1</td>
<td>176.95</td>
<td>2.03</td>
<td>.161</td>
</tr>
<tr>
<td>Client Gender</td>
<td>362.72</td>
<td>1</td>
<td>362.72</td>
<td>4.16</td>
<td>.047*</td>
</tr>
<tr>
<td>Main Effects</td>
<td>512.15</td>
<td>2</td>
<td>256.08</td>
<td>2.94</td>
<td>.063</td>
</tr>
<tr>
<td>Explained</td>
<td>513.01</td>
<td>3</td>
<td>171.02</td>
<td>1.96</td>
<td>.133</td>
</tr>
<tr>
<td>Residual</td>
<td>4012.71</td>
<td>4</td>
<td>87.23</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication With</td>
<td>4.81</td>
<td>1</td>
<td>4.81</td>
<td>.05</td>
<td>.825</td>
</tr>
<tr>
<td>Same Sex</td>
<td>21.26</td>
<td>1</td>
<td>21.26</td>
<td>.22</td>
<td>.642</td>
</tr>
<tr>
<td>Main Effects</td>
<td>29.56</td>
<td>2</td>
<td>14.78</td>
<td>.15</td>
<td>.859</td>
</tr>
<tr>
<td>Explained</td>
<td>106.70</td>
<td>3</td>
<td>35.57</td>
<td>.37</td>
<td>.777</td>
</tr>
<tr>
<td>Residual</td>
<td>4363.50</td>
<td>45</td>
<td>96.97</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication With</td>
<td>228.02</td>
<td>1</td>
<td>228.02</td>
<td>2.67</td>
<td>.110</td>
</tr>
<tr>
<td>Client Gender With</td>
<td>549.78</td>
<td>1</td>
<td>549.78</td>
<td>6.44</td>
<td>.015*</td>
</tr>
<tr>
<td>Therapist Gender</td>
<td>531.28</td>
<td>1</td>
<td>531.28</td>
<td>6.23</td>
<td>.017*</td>
</tr>
<tr>
<td>Main Effects</td>
<td>806.62</td>
<td>3</td>
<td>268.87</td>
<td>3.15</td>
<td>.035</td>
</tr>
<tr>
<td>Explained</td>
<td>971.50</td>
<td>7</td>
<td>138.79</td>
<td>1.63</td>
<td>.155</td>
</tr>
<tr>
<td>Residual</td>
<td>3496.71</td>
<td>41</td>
<td>85.33</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### TABLE 8

**Analysis of Variance**  
**Change in HATE Scores**

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>Degrees of Freedom</th>
<th>Mean Square</th>
<th>F</th>
<th>Signif. of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Gender</td>
<td>0.00</td>
<td>1</td>
<td>0.00</td>
<td>0.00</td>
<td>.987</td>
</tr>
<tr>
<td>Medication</td>
<td>2.23</td>
<td>1</td>
<td>2.23</td>
<td>0.05</td>
<td>.820</td>
</tr>
<tr>
<td>Same Sex</td>
<td>3.84</td>
<td>1</td>
<td>3.84</td>
<td>0.90</td>
<td>.347</td>
</tr>
<tr>
<td>Therapist Gender</td>
<td>0.25</td>
<td>1</td>
<td>0.25</td>
<td>0.06</td>
<td>.812</td>
</tr>
<tr>
<td>Therapist With</td>
<td>0.15</td>
<td>1</td>
<td>0.15</td>
<td>0.03</td>
<td>.857</td>
</tr>
<tr>
<td>Client Gender</td>
<td>0.63</td>
<td>1</td>
<td>0.63</td>
<td>0.14</td>
<td>.708</td>
</tr>
<tr>
<td>Main Effects</td>
<td>0.74</td>
<td>2</td>
<td>0.37</td>
<td>0.08</td>
<td>.920</td>
</tr>
<tr>
<td>Explained</td>
<td>4.58</td>
<td>3</td>
<td>1.53</td>
<td>0.35</td>
<td>.793</td>
</tr>
<tr>
<td>Residual</td>
<td>203.34</td>
<td>46</td>
<td>4.42</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication With</td>
<td>0.19</td>
<td>1</td>
<td>0.19</td>
<td>0.05</td>
<td>.825</td>
</tr>
<tr>
<td>Same Sex</td>
<td>9.96</td>
<td>1</td>
<td>9.96</td>
<td>2.61</td>
<td>.113</td>
</tr>
<tr>
<td>Main Effects</td>
<td>10.76</td>
<td>2</td>
<td>5.38</td>
<td>1.41</td>
<td>.255</td>
</tr>
<tr>
<td>Explained</td>
<td>10.78</td>
<td>3</td>
<td>3.59</td>
<td>0.94</td>
<td>.429</td>
</tr>
<tr>
<td>Residual</td>
<td>172.04</td>
<td>45</td>
<td>3.82</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication With</td>
<td>3.60</td>
<td>1</td>
<td>3.60</td>
<td>0.97</td>
<td>.332</td>
</tr>
<tr>
<td>Client Gender With</td>
<td>5.25</td>
<td>1</td>
<td>5.25</td>
<td>1.34</td>
<td>.255</td>
</tr>
<tr>
<td>Therapist Gender</td>
<td>3.89</td>
<td>1</td>
<td>3.89</td>
<td>0.99</td>
<td>.326</td>
</tr>
<tr>
<td>Main Effects</td>
<td>7.50</td>
<td>3</td>
<td>2.50</td>
<td>0.64</td>
<td>.596</td>
</tr>
<tr>
<td>Explained</td>
<td>21.59</td>
<td>7</td>
<td>3.09</td>
<td>0.78</td>
<td>.604</td>
</tr>
<tr>
<td>Residual</td>
<td>161.22</td>
<td>41</td>
<td>3.93</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
BECK DEPRESSION INVENTORY

The Beck Depression Inventory was used as a measure of change in general depression. The apparent link between anxiety and depression implies that change in Agoraphobic symptoms should have an impact on depression. As previously mentioned (Table 2) post BECK scores indicate a significant overall improvement in general depression scores for the subjects. Table 9 illustrates the analysis of variance in the BECK results. No variable, nor any combination of variables, can explain the improvement in BECK scores.

THERAPIST RATINGS OF CLIENT IMPROVEMENT

At the end of treatment therapists prepare a termination summary that includes a rating of client progress. The rating is based on a Lickert scale from 0 - no improvement to 8 - totally cured. Tables 10 - 12 show the results of these ratings. Table 10 indicates the breakdown of ratings assigned to all clients. Note that 68% of these ratings fall between 4 and 7. This high percentage range made the original breakdown of scores 1-2 3-5 6-8 impractical due to the small numbers of clients rated on the lower end of the scale. In order to use a Chi Square test cell signs must be greater than 5.
<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>Degrees of Freedom</th>
<th>Mean Square</th>
<th>F</th>
<th>Signif. of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Gender</td>
<td>56.74</td>
<td>1</td>
<td>56.74</td>
<td>1.03</td>
<td>.316</td>
</tr>
<tr>
<td>Medication</td>
<td>42.67</td>
<td>1</td>
<td>42.67</td>
<td>.77</td>
<td>.385</td>
</tr>
<tr>
<td>Same Sex</td>
<td>7.42</td>
<td>1</td>
<td>7.42</td>
<td>.13</td>
<td>.718</td>
</tr>
<tr>
<td>Therapist Gender</td>
<td>117.01</td>
<td>1</td>
<td>117.01</td>
<td>2.17</td>
<td>.148</td>
</tr>
<tr>
<td>Therapist Gender</td>
<td>124.75</td>
<td>1</td>
<td>124.75</td>
<td>2.30</td>
<td>.136</td>
</tr>
<tr>
<td>Client Gender</td>
<td>93.95</td>
<td>1</td>
<td>93.95</td>
<td>1.73</td>
<td>.195</td>
</tr>
<tr>
<td><strong>Main Effects</strong></td>
<td><strong>206.90</strong></td>
<td><strong>2</strong></td>
<td><strong>103.45</strong></td>
<td><strong>1.91</strong></td>
<td><strong>.160</strong></td>
</tr>
<tr>
<td>Explained</td>
<td>214.32</td>
<td>3</td>
<td>71.44</td>
<td>1.32</td>
<td>.280</td>
</tr>
<tr>
<td><strong>Residual</strong></td>
<td><strong>2494.66</strong></td>
<td><strong>46</strong></td>
<td><strong>54.23</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication</td>
<td>6.45</td>
<td>1</td>
<td>6.45</td>
<td>.11</td>
<td>.746</td>
</tr>
<tr>
<td>Same Sex</td>
<td>35.57</td>
<td>1</td>
<td>35.57</td>
<td>.59</td>
<td>.448</td>
</tr>
<tr>
<td><strong>Main Effects</strong></td>
<td><strong>44.82</strong></td>
<td><strong>2</strong></td>
<td><strong>22.41</strong></td>
<td><strong>.37</strong></td>
<td><strong>.693</strong></td>
</tr>
<tr>
<td>Explained</td>
<td>47.06</td>
<td>3</td>
<td>15.69</td>
<td>.26</td>
<td>.855</td>
</tr>
<tr>
<td><strong>Residual</strong></td>
<td><strong>2853.53</strong></td>
<td><strong>47</strong></td>
<td><strong>58.01</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication</td>
<td>39.81</td>
<td>1</td>
<td>39.81</td>
<td>.65</td>
<td>.423</td>
</tr>
<tr>
<td>Client Sex</td>
<td>32.42</td>
<td>1</td>
<td>24.67</td>
<td>.41</td>
<td>.528</td>
</tr>
<tr>
<td>Therapist Sex</td>
<td>36.70</td>
<td>1</td>
<td>67.90</td>
<td>1.11</td>
<td>.297</td>
</tr>
<tr>
<td><strong>Main Effects</strong></td>
<td><strong>95.27</strong></td>
<td><strong>3</strong></td>
<td><strong>31.76</strong></td>
<td><strong>.52</strong></td>
<td><strong>.670</strong></td>
</tr>
<tr>
<td>Explained</td>
<td>279.42</td>
<td>7</td>
<td>39.92</td>
<td>.66</td>
<td>.708</td>
</tr>
<tr>
<td><strong>Residual</strong></td>
<td><strong>2621.17</strong></td>
<td><strong>43</strong></td>
<td><strong>60.96</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 11 shows breakdowns of male and female therapist ratings into 0 - 4 and 5 - 8. The cell sizes were too small to use a Chi Square statistic, and a Fisher's Exact Test, designed for small cell numbers, indicates no significant bias in ratings given to either gender client by male or female therapists.

### TABLE 10
General Therapist Ratings of Improvement

<table>
<thead>
<tr>
<th>Value</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cum Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3.6</td>
<td>3.8</td>
<td>3.8</td>
</tr>
<tr>
<td>2</td>
<td>4</td>
<td>16%</td>
<td>7.1</td>
<td>11.3</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>5.4</td>
<td>5.7</td>
<td>17.0</td>
</tr>
<tr>
<td>4</td>
<td>7</td>
<td>12.4</td>
<td>13.2</td>
<td>30.2</td>
</tr>
<tr>
<td>5</td>
<td>10</td>
<td>17.9</td>
<td>18.9</td>
<td>49.1</td>
</tr>
<tr>
<td>6</td>
<td>6</td>
<td>86%</td>
<td>14.3</td>
<td>64.2</td>
</tr>
<tr>
<td>6.5</td>
<td>1</td>
<td>1.8</td>
<td>1.9</td>
<td>66.0</td>
</tr>
<tr>
<td>7</td>
<td>10</td>
<td>17.9</td>
<td>18.9</td>
<td>84.9</td>
</tr>
<tr>
<td>7.5</td>
<td>2</td>
<td>3.6</td>
<td>3.8</td>
<td>88.7</td>
</tr>
<tr>
<td>8</td>
<td>6</td>
<td>10.7</td>
<td>11.3</td>
<td>100.0</td>
</tr>
<tr>
<td></td>
<td>3 missing</td>
<td>5.4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

mean 5.368  std 1.944  minimum 1.000  maximum 8.000
TABLE 11
Therapist Rating of Client Improvement
Therapist Gender/Client Gender

<table>
<thead>
<tr>
<th></th>
<th>Female Clients</th>
<th>Male Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female Therapist Ratings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rated 0-4</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Rated 5-8</td>
<td>15</td>
<td>2</td>
</tr>
<tr>
<td>Chi Square</td>
<td>.03770</td>
<td>Significance .8461</td>
</tr>
<tr>
<td>Male Therapist Ratings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rated 0-4</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Rated 5-8</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Fisher's Exact Test</td>
<td></td>
<td>One-Tail</td>
</tr>
<tr>
<td></td>
<td>.37762</td>
<td>Two-Tail</td>
</tr>
<tr>
<td></td>
<td>.60839</td>
<td></td>
</tr>
</tbody>
</table>

TABLE 12
Mean Therapist Rating of Client Improvement
Controlling Therapist Gender with Client Gender

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>S.D.</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female Therapist</td>
<td>5.54</td>
<td>1.87</td>
<td>38</td>
</tr>
<tr>
<td>Female Client</td>
<td>5.95</td>
<td>1.63</td>
<td>20</td>
</tr>
<tr>
<td>Male Client</td>
<td>5.08</td>
<td>2.06</td>
<td>18</td>
</tr>
<tr>
<td>Male Therapist</td>
<td>4.93</td>
<td>2.12</td>
<td>15</td>
</tr>
<tr>
<td>Female Client</td>
<td>4.75</td>
<td>2.12</td>
<td>8</td>
</tr>
<tr>
<td>Male Client</td>
<td>5.14</td>
<td>2.27</td>
<td>7</td>
</tr>
</tbody>
</table>

Female therapists rated progress of female clients higher than progress of male clients and male therapists rated male clients' progress higher than that of females. In general female therapists rated female clients higher than male therapists and male therapists saw males as responding better to treatment. These results are minor tendencies; as stated before, the small cell sizes makes it impossible to draw any statistical significance from these tendencies.
INTERCORRELATION OF TEST RESULTS

The Fear Questionnaire and the BECK were chosen as instruments for this study because of an apparent connection between anxiety and depression that has been noted in the literature. For that reason, one could expect the changes in AG scores to correlate with changes in BECK scores. In addition, the FQ has two other measures, the global phobia and feelings scales that should correlate highly. Table 13 illustrates the correlation between these instruments and the therapists ratings of improvement.

TABLE 13

<table>
<thead>
<tr>
<th>Change in AG</th>
<th>Change in BECK</th>
<th>Change in Feeling</th>
<th>Change in Rate</th>
<th>Change in Therapist Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>.29</td>
<td>.40</td>
<td>.36</td>
<td>.19</td>
<td></td>
</tr>
<tr>
<td>P=.017</td>
<td>P=.002</td>
<td>P=.005</td>
<td>P=.092*</td>
<td></td>
</tr>
</tbody>
</table>

It is interesting to note that the only measurement that does not correlate with symptom improvement is the therapist's perception of change.

RELATION OF FINDINGS TO HYPOTHESES

1. Male agoraphobic subjects in behavioral treatment with male therapists will exhibit greater improvement than male subjects with female therapists as measured by the Fear Questionnaire and the Beck Depression Inventory. False. Male agoraphobic subjects in behavioral treatment with male therapists did not exhibit greater
improvement than male subjects with female therapists. Table 5 indicates that same sex therapist makes no significant impact on subject improvement (.129).

2. Female subjects in behavioral treatment for agoraphobia will improve significantly regardless of therapist gender.
   True. Female subjects improved significantly regardless of therapist gender (Table 2).

3. Male and female subjects matched for severity of agoraphobic symptoms with the same male therapists will exhibit similar rates of improvement.
   True. Male and female subjects exhibited similar rates of improvement with male therapists. The impacting factor is not gender of client (Table 6).

4. Female subjects, matched with male subjects for severity of agoraphobic symptoms, will exhibit greater rates of improvement with female therapists than male subjects with female therapists.
   False. Both male and female subjects exhibited significantly greater improvement of agoraphobic symptoms with female therapists than with male therapists (Table 6).
CHAPTER V
SUMMARY AND IMPLICATIONS

Summary
This study was designed to examine the relationship between gender of clients in behavioral treatment for agoraphobia in relation to the gender of therapists treating them. This research was necessary because of the evidence to support a difference in treatment outcome between male agoraphobics and female agoraphobics in behavioral treatment (Hafner, 1983; Mavissakalian, 1985; Hafner, 1985).

Methodology
Participants for this study consisted of male and female agoraphobics divided into matched pairs and assigned to either male or female therapists. The beginning sample included 20 pairs assigned to female therapists and 8 pairs assigned to male therapists at the Centers for Behavioral Medicine. All subjects were treated in a 16 week structured phobia program that included individual treatment as well as group sessions on a weekly basis.

The measures used in this study included the Fear Questionnaire, the Beck Depression Inventory, and a therapist rating of improvement of agoraphobic symptoms. Pre and post test results were compared to determine differences in improvement of symptomology. An analysis of variance of pre and post treatment scores on the Fear Questionnaire and the Beck was conducted to determine if
there was significant difference in response to treatment between male and female agoraphobic clients.

**CONCLUSIONS**

General findings indicate that both males and females improve significantly in behavioral treatment for agoraphobia. However, contrary to expected results, there was no significant difference between response to treatment on the basis of client gender.

Gender of therapist, however, had significant impact on outcome of treatment. Apparently agoraphobic clients improved significantly more when assigned to female therapists than if assigned to male therapists.

Use or non-use of medication apparently had no impact on outcome of treatment when looked at as a separate variable. When examined as one of three variables, medication proved to interact in some way with gender of client and therapist. It is possible that controlling for all three variables made cell sizes so small that the significance of medication statistic could not be trusted.

The Fear Questionnaire has good internal validity among the three scales used for this study. The AG score change significantly correlated with the change in feeling and in global phobia rating ($P = .002$ and $P = .005$ respectively) (Table 13). In addition, the apparent link between anxiety and depression is evident in the correlation between the BECK with the AG scale ($P = .017$).
A final interesting note is that the therapists rating of client progress does not correlate with changes that clients are reporting. Therapists are apparently more conservative in their estimates of improvement. It is impossible to measure the difference in "attitude" has in relation to phobic symptoms. Most phobia therapists are not phobic and may, therefore, believe that clients had further to go before being rated 8-"totally cured". However, clients may be experiencing so much relief from significant improvement in symptoms that they consider their new phobic limits as "almost cured".

RELATIONSHIP TO PAST RESEARCH

Differences between male and female agoraphobics have been given considerable attention in the literature. Disagreements on incidence of agoraphobia in addition to differences in response to behavioral treatment between male and female agoraphobics have been cited throughout the literature. Factors such as preferences in ideal counselors, use or non-use of medication, and sex-role stereotypes held by clients have been studied in an effort to explain some of these differences.

There have been conflicting reports on incidence of agoraphobia in males and females within the general population. Agras, et al (1969) conducted a general population study in the Vermont area and found 6% of the respondents were agoraphobic with no significant difference between
numbers of male and female agoraphobics. In 1984 the
National Institute of Mental Health conducted an extensive
study of diagnostic categories of populations in three major
cities in the United States. Results indicated a signif-
icantly higher incidence of agoraphobia in females than in
males (5.3 - 12.5% and 1.6 - 5.2% respectively). It may be
prudent to note that incidence of alcoholism was reported at
opposite significance. This is an important consideration
when one looks at research conducted by Mullaney and
Trippett (1979) of males in alcohol treatment. The results
indicated that 13.1% of males in alcohol treatment were
clearly agoraphobic and 38.6% were borderline agoraphobic.

The sample for this study was drawn from three Centers
for Behavioral Medicine. Over a three year period, 298
agoraphobics applied for treatment in the group and in-vivo
program. Of those clients, 215 (72%) were female and 83
(28%) were male. These figures approximate the percentages
indicated in the N.I.M.H. study. The significance of this
number is questionable because:

1. All clients voluntarily applied for treatment
   at the Centers and represent a certain upper
   middle class section of the population whereas
   the N.I.M.H. study included the general
   population including all income levels.

2. There is no way to measure how many
   agoraphobics in the Centers' catchment area
   are in treatment for alcoholism instead of
   their agoraphobia.
3. Females have, historically, been more likely to seek treatment than males.

The gender factor that did impact on this study was that of gender of therapist. During that period of time, thirty female therapists and ten male therapists were responsible for treating these 298 agoraphobics. Female therapists outnumbered male therapists three to one.

The different response rates for male agoraphobics in behavioral treatment from female agoraphobics are also in question. Mavissakalian (1985) and Hafner (1983) have noted gender differences in male and female agoraphobics. In the Mavissakalian study, ten matched pairs of male and female agoraphobics were administered the Fear Questionnaire pre and post-treatment. No significant differences were reported pre-treatment; however, at one month follow-up, females had responded consistently better to treatment than males. In the Hafner study of eighteen male and forty-nine female agoraphobics the males completing treatment did not differ in progress from females. It is significant to note that Hafner questioned the appropriateness of behavioral treatment for males because eight of his male sample (44%) dropped treatment citing unmanageable anxiety as the reason; of the six (12%) of the females dropping treatment, all cited reasons unrelated to anxiety for discontinuing treatment.

This study also reported no significant difference in response to treatment between male and female agoraphobics.
In fact, results indicate that matching for same sex therapist, use or non-use of medication, and client gender, had no relationship to outcome of treatment. The significant variable in this study was gender of therapist. Regardless of gender of client or medication use or non-use, males and females responded equally well to treatment. However, males and females treated by female therapists improved significantly over males and females treated by male therapists. An interesting note is that five male clients (18%), all treated by female therapists dropped treatment prior to completion of the program. The Mavissakalian and Hafner studies did not report gender of therapist as a variable that they controlled for. It would be interesting to examine the results, especially in the Mavissakalian study, to see if gender of therapist could explain some of the outcome difference.

Some question remains as to why gender of therapist would impact on outcome of behavioral treatment of agoraphobia. In looking at the literature on what clients perceive to be ideal counselor traits, some gender differences among clients appear. Somerville, et al (1980) studied snake phobic undergraduates and found both male and female snake phobics exhibited greater approach behavior in the presence of an experimenter of the opposite sex. This research could explain a difference in male agoraphobics' response to treatment if they were more likely to approach
the phobic situation with an opposite sex therapist than with a male therapist; however, this logic breaks down when trying to explain why female clients also fared significantly better with female therapists. It is possible that because Somerville used a stereotypically loaded object, snakes, there were other external factors impacting on the likelihood of approach/avoidance. In addition, an anxiety reaction attached to a snake is far different from fearing a panic attack attached to driving or shopping where one expects to lose control and die, pass out, or go crazy.

Fletcher interviewed thirty executives and sixty undergraduates to find differences between males and females in their perceptions of ideal counselors, expectation of counselors and perceived competence (1983). All subjects believed that same-sex interviewers were more likely to understand them. Of interest is that male subjects believed interviewers to be less competent than female subjects did, regardless of interviewer gender; and, male subjects believed that female interviewers were less likely to have aggressive styles. In thinking about in-vivo treatment of agoraphobia, the therapist must be aggressive and controlling. It is possible that when a male client is assigned to a female therapist he expects her to be slightly incompetent and non-aggressive. If this is true, he is likely to be surprised by the aggression and control the female behavioral therapist exhibits. Whether this can impact on
outcome needs further study.

Greenberg and Zeldow (1965) asked thirty-six male and forty-six female clients to rate ideal therapist on the Adjective Check List (Gough and Helbrun, 1965). Women consistently preferred therapists fitting male sex-role stereotypes (confident, controlling, aggressive) while males preferred therapists who were more nurturant, affiliative and deferent. Again it is interesting to speculate whether a female therapist, who is expected to be nurturant and affiliative, involved in behavioral treatment, which demands an aggressive, controlling, confident stance, does not encompass the best of both worlds for male and female agoraphobic clients. Perrson et al studied 103 agoraphobic women in four methods of treatment. Results indicated higher satisfaction rates in supported and prolonged exposure groups and these women attributed this satisfaction to having therapists who were more assured, knowledgeable and with whom they had good therapeutic contact (1984). This study did not look at therapist gender as a variable; it would be interesting to see if that impacted on clients' perception of therapists.

Behavioral treatment of agoraphobia involves an agreement between clients and therapist on what in-vivo task is necessary to be performed each week in treatment. This process involves negotiation, encouragement, direction, and trust. Effran and Cabuto (1984) noted that slippage in
behavioral treatment resulted from the therapist getting caught up in the clients' panic instead of holding him or her to the agreed upon task. It would follow that success in treatment depends on an intricate relationship that involves a trusting, nurturant relationship that is also controllingly safe to a client who fears loss of control to the point that it severely restricts his or her life. This study leaves unanswered how therapist's gender may impact on that relationship and how that, in turn, may impact on outcome of treatment.

**IMPLICATIONS FOR FUTURE RESEARCH**

This study is, apparently, one of the only studies of response to treatment differences in agoraphobics that controlled for therapist gender. More studies are needed to determine whether this is consistent with other treatment studies. Some of the Centers for Behavioral Medicine had more female staff members than males, and one Center was entirely male. It is possible that some Center dynamic among staff could influence attitude in carrying out treatment.

Another variable that needs closer attention is use or non-use of medication. Researchers finding significantly higher progress of clients on medication may wish to scrutinize the sample for gender of therapist since medication shows significance in this study only as a result of interaction with therapist gender.
FURTHER CONSIDERATIONS

The results of this study imply some startling tendencies in treatment of agoraphobics by male or female therapists. The significant progress of phobics with female therapists over those with male therapists could be a controversial issue. There appears to be no tangible explanation for this difference, especially when one considers that supported exposure treatment involves a very precise treatment plan.

Two issues may be related to this difference in outcome. The first relates to personality characteristics of the male clients. Consider that only male clients with female therapists dropped treatment. It is possible that males holding a more machismo attitude may be less likely to admit to or exhibit fear with a female therapist; future research should include personality assessment to determine the extent to which male/female personality characteristics impact on the likelihood of male agoraphobics to complete treatment with female therapists. It is important to note that the number of male dropouts may have caused an artificial rise in scores for the group assigned to female therapists. The second issue involves potential personality differences between male and female therapists. Future research should be aimed at determining whether there are differences in male and female personality traits in supported-exposure therapists, and if those differences impact on therapeutic outcome.
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These consist of pages:

Appendix A  Fear Questionnaire

Appendix B

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