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Agoraphobia and Interpersonal Relationships: Theory and Research

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Agoraphobia and Interpersonal Relationships: Theory and Research

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APPROVAL SHEET

This thesis is submitted in partial fulfillment

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DEDICATION

This thesis is dedicated to my husband and to all the members of ABIL who participated in this study.

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I wish to express my appreciation to Professor Glenn Shean for his encouragement and support throughout my work on my masters thesis. I would especially like to thank him for his constant availability and his never ending enthusiasm for this project. I would also like to thank Professor Larry Ventis for his expertise and for opening up the avenues that made this research possible. Thanks are also expressed to Professor Lynn Gilliken for serving on my thesis committee. Finally, I would like to thank Shirley Green for her faith in this study and for helping to make this project a reality.

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Abstract

The present study examined the quality of the marital relationships of agoraphobic individuals as compared to a sample of nonclinical subjects. Comparisons between the agoraphobic group and the control group were also made on one's gender-role concept and the degree of interpersonal dependency on others. Forty-six agoraphobic subjects and 50 nonclinical control subjects completed self-report measures. Interpersonal dependency was assessed using the Interpersonal Dependence Inventory's three subscales: emotional reliance on others, lack of self-confidence, and assertion of autonomy. Quality of the significant relationship was measured with the Quality of Relationships Inventory subscales that assess the degree of social support from significant other, amount of conflict in relationship, and depth of significant relationship. The Personal Attributes Questionnaire evaluated gender-role stereotyping in subjects' self-concept with scales of Agency (masculinity) and Communion (femininity). Multivariate and univariate analyses indicated significantly higher scores for the agoraphobic group on emotional reliance on others, $F(1,70) = 15.22$, $p<.001$. The mean score for self-confidence was significantly lower for the agoraphobic group, $F(1,70) = 22.97$, $p<.001$. The agoraphobic group's mean Agency (masculinity) score was significantly lower than the control group's score, $F(1,70) = 14.85$, $p<.001$. Agoraphobic subjects' mean score for social support from significant other was significantly lower, $F(1,70) = 17.862$, $p<.001$. Agoraphobic subjects had a significantly higher mean score on level of conflict in the significant relationship, $F(1,70) = 26.672$, $p<.001$. The agoraphobic group scored significantly lower on depth of the significant relationship, $F(1,70) = 4.542$, $p<.05$. These results support spousal involvement in treatment programs for agoraphobia, and demonstrate gender role perspectives and personality characteristics that need to be addressed when treating the agoraphobic individual.

Agoraphobia and Interpersonal Relationships: Theory and Research

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The literal translation of the term agoraphobia is fear of the market place, but it is usually thought of as fear of open places (Vandereycken, 1983). The essential feature of agoraphobia according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R) is "a marked fear of being alone, or being in public spaces from which escape might be difficult or help not available in case of sudden incapacitation" (American Psychiatric Association, p. 240). Agoraphobia is characterized by avoidant behavior, with normal activities restricted. DSM-III-R distinguishes two subtypes of agoraphobia--with and without panic attacks. Panic attacks are defined as bursts of terror during which one may experience shortness of breath, heart palpitations, depersonalization or derealization, weakness in the limbs, dizziness, the threat of bladder or bowel incontinence, or nausea. These attacks are typically accompanied by a sense of doom and fear that one will die, become insane, faint, or lose control in such a

way as to be publicly humiliated. Agoraphobic people seek to flee when such attacks occur, and fear and avoid any places where flight to safety is likely to be hindered.

Most agoraphobics are markedly more fearful when alone (Marks, 1970). Many totally avoid being alone, while others require a companion when venturing beyond their "safety zone". Approximately 88% of all diagnosed agoraphobics are women and the mean age at onset is 28 years (Burns & Thorpe, 1977). The majority in treatment are married women who do not work outside the house, thus the label "housewife's disease" (Burns & Thorpe, 1977).

The most widely recognized treatment models for this disorder at present are drugs and cognitive-behavior therapy. Published evidence of the effectiveness of exposure-based behavior treatment of phobias has led some authors to claim that phobias are psychology's "greatest success story" (Rosenhan & Seligman, 1984). Several authors, however, claim that exposure treatment for agoraphobia fails to produce benefits in a significant percentage of clients.

Outcome data from several reports (Barlow, Mavissakalian, & Hay, 1981; Emmelkamp & Kuipers, 1979; McPherson, Brougham & McLaren, 1980) indicate that between 30% and 40% of agoraphobics who complete exposure treatment fail to improve. Also, of those patients who do improve, a significant proportion fail to maintain satisfactory levels of functioning at follow-up (McPherson et al., 1980). Furthermore, agoraphobic treatment programs have high dropout rates with around 12% to 30% of patients withdrawing from behavioral treatment (Jansson & Ost, 1982), and 25% to 40% withdrawing from drug treatment programs (Zitrin, Klein, & Woerner, 1980). Thus, patients who actually complete therapy in these treatment programs are a very highly selected population. Yet it is from such unrepresentative patients that clinical researchers generalize their findings to the total population.

Marital Factors in Agoraphobia

Several alternative theoretical approaches have been developed to address agoraphobia. Goldstein and Chambless (Goldstein, 1970; Goldstein & Chambless, 1978) have stressed the importance of the agoraphobic's

interpersonal relationships in the development and maintenance of problems. These authors have distinguished between two kinds of agoraphobia: simple and complex. Simple agoraphobia is a term used to define that minority of cases where symptoms are precipitated by panic attacks produced by drug experiences or physical disorders such as hypoglycemia. Complex agoraphobia defines the remaining majority of cases and is said to have as its central element the fear of fear. This fear is said to develop in individuals with low levels of self-sufficiency mainly during periods of interpersonal conflict, specifically marital strife (Chambless and Goldstein, 1982). Goldstein and Chambless's model describes the typical complex agoraphobic as a nonassertive, fearful individual who does not see herself as capable of independent function. For example, Goldstein (1970) found that most agoraphobics claimed to be in a relationship from which they wished to flee but could not because they feared independence. Goldstein (1970) also found cases in which agoraphobic symptoms developed concurrently with feelings of wanting to

break off the marriage or violate the strictness of the marriage contract.

Goldstein and Chambless (1978) have maintained that complex agoraphobia develops in stages or sequences. Agoraphobia onset is typically predated by marked levels of stress with which individuals can not cope. The authors have deduced that the agoraphobic deals with this stress in a "hysterical style". That is, when in distress, the agoraphobic focuses awareness on somatic responses and is unable to reason that the cause of the stress is in the interpersonal arena. If this style of dealing with stress lasts long enough, or is worsened by other events (e.g., life transition, illness, death of a child) the pre-agoraphobic may experience a panic attack which eventuates in agoraphobic symptoms. Hence, agoraphobia is considered in a contextual sense, the tip of the iceberg; agoraphobic symptoms begin late in the total sequence of interpersonal events.

Evidence of this model is presented by Goldstein and Chambless (1978) with data obtained from 25 agoraphobic women and 24 women with phobias of external

specific stimuli. Information was gathered on the following measures: Bernreuter Self-Sufficiency Scale, Willoughby Emotional Maturity Scale, and the Fear Survey Scale. It was found that compared to the other phobics, the agoraphobics were characterized by significantly less emotional maturity, more social anxiety, less self-sufficiency, and marked fears of responsibility, decision-making, disapproval and criticism. Moreover, the onset of agoraphobia was typically reported by the patient to have occurred during times of high interpersonal conflict and in the absence of specific traumatic events.

Torpy and Measey (1974) examined the marital interaction of 28 married women who were members of the Open Door Association, a voluntary British society for agoraphobics. The women and their husbands completed questionnaires which measured mutual perceptions, using eight bipolar scales (i.e., unintelligent-bright; generous-selfish). The couples also rated their marital satisfaction. Based on the couples combined ratings, the marriages were divided into "good marriages" (n=16) and "poor marriages" (n=12). Partners in the poor

marriages tended to misperceive each other, with the wives overevaluating the toughness and stability of their husbands. In the good marriages, however, partners tended to perceive each other quite accurately and positively. The authors suggest that some of the misperceptions may have led to an unsatisfactory marriage in some cases. Indeed, their observation that approximately 43% of the agoraphobic women in the sample reported some degree of marital dissatisfaction, confirms the relevance of this issue and suggests that such problems may be common in agoraphobia.

Pyke and Roberts (1987) examined whether a relationship exists between spousal social support and agoraphobia. The authors compared 23 married agoraphobic women to 31 matched controls on a measure of spousal support. Experimental subjects were enlisted from three chapters of a community based support group for phobics, and control subjects from two family practice clinics in a southern Ontario city. All subjects were married women between the ages of 18 and 35.

It was demonstrated that statistically significant

differences existed between the two groups on degree of spousal support. Agoraphobic subjects were calculated to have a 42% lower score for helpfulness of their husbands when compared to the control group. The authors concluded that the phobic partner's role in the interpretation and management of anxiety producing situations needs to be better understood, and that the agoraphobic should not be treated in isolation from her/his support system.

Contrary to some of these findings, Buglass, Clarke, Henderson, Kreitman, and Presley (1977) found no indication of marital conflict in 30 married agoraphobic women when compared to matched nonpsychiatric controls. Mathews, Gelder and Johnson (1981) claim that clinicians see marital conflict because they remember the dramatic but rare instances of these problems, but forget the mundane cases where marital satisfaction and spouse support were normal. Kleiner and Marshall (1985) argue that in general, agoraphobic patients may not differ from normals in overall interpersonal relations, but the interaction between their personal characteristics (e.g.,

dependence, lack of assertiveness) and marital satisfaction may be important in the development and maintenance of the phobia.

Gender-Role Stereotyping in Agoraphobia

Fodor (1974) has argued strongly that sex-role stereotyping is often central to the development of agoraphobia in married women. She believes that pre-agoraphobic women have adopted an extreme version of stereotypic female behavior, so that they become especially helpless, dependent, nonassertive, and fearful. Her theory states that these women also tend to choose men whose view of themselves is based on an extreme male sex-role stereotype. According to Fodor, agoraphobic symptoms in women develop as part of failure of one or both marriage partners to modify stereotypes. Thus, agoraphobia my be construed, as Fodor suggests, as an extension of the cultural sex-role stereotype for women.

In support of Fodor's (1974) theory, Chambless and Mason (1986) published sex role data from a large (334 female, 68 male) clinical agoraphobic population using the Personal Attributes Questionnaire (Spence &

Helmrich, 1978) as a measure of sex-role stereotyping. They found that agoraphobic symptom intensity and other measures of psychopathology were significantly inversely correlated with measures of masculinity in the female population. Femininity did not correlate significantly with symptom intensity or with psychopathology for men or women. The authors determined that the presence of femininity was no detriment; rather, the absence of the characteristics associated with "masculinity" was the relevant variable in the phobic women.

The present author also used the Personal Attributes Questionnaire (Spence & Helmrich, 1978) in an unpublished study examining sex-role stereotyping in 47 agoraphobic women. Results of the study replicated those of Chambless and Mason (1986). Inverse significant correlations were found between subject masculinity and symptom intensity. This investigation also compared agoraphobic subjects to a nonclinical control group. The mean score for subject masculinity was significantly lower for the agoraphobic group. No significant differences in femininity scores were

obtained.

Hafner (1986) has also emphasized the important role of sex-role stereotypes in the development of agoraphobia. His view is that husbands of agoraphobic women cling even more strongly to stereotypic gender role perspectives than do the wives. Milton and Hafner's (1979) report on the marital repercussions of behavioral treatment for agoraphobia showed that marital disharmony increased in 60% of 18 couples during the six months after treatment, and that increased marital disharmony was significantly associated with partial relapse during follow-up. Even those married women who responded well to behavioral therapy for agoraphobia were sometimes left with substantial marital and interpersonal problems. Hafner concluded that these data suggest that a proportion of husbands are adversely affected by the symptomatic improvement in their wives, suggesting underlying problems in the relationships which perhaps served to maintain the agoraphobia.

Support for this theory is demonstrated by Hand and Lamontagne (1976) who treated 25 agoraphobic

clients with in vivo group exposure. In half of the patients, improvement in phobic symptoms was followed by an exacerbation of marital problems. These data suggest that in a number of agoraphobics, relationship difficulties may interact negatively with the treatment of their phobia.

Spouse-Involved Treatment of Agoraphobia

Several authors advocate spousal involvement in the treatment of agoraphobics (Hafner & Ross, 1983; Goodstein & Swift, 1977; Barlow, Mavissakaliam, & Hay, 1981; Chambless & Goldstein, 1981). Barlow et al., (1981) examined the effects of a behavioral program for agoraphobics which focused only on the phobic problems, but did include the patient's spouse. Six agoraphobic women and their spouses participated. All clients showed improvements with respect to their phobic behavior, while four of the six couples showed improved marital satisfaction. In the two couples showing an inverse relationship, the husbands rated their wives' phobias as considerably less of a problem than did the women themselves. This may suggest a lack of empathy and understanding on the part of the spouse. The

authors concluded that regardless of the degree of marital satisfaction, all clients responded well to the behavioral intervention, and in the majority, the treatment appeared to improve the marriage.

These data served as a preliminary step for a larger scale study of spouse involvement in therapy for agoraphobics (Barlow, O'Brien, & Last, 1984). The authors found that 14 women who were treated with the husband as co-therapist showed greater improvement across a variety of measures than did 14 subjects treated alone. Similarly, benefits for patients on measures of social and family functioning were more rapid in the spouse group.

Kleiner and Marshall (1985) evaluated a number of treatment studies of agoraphobia, including some of the above mentioned. They concluded that involving partners in therapy, and/or employing components that deal with relationship problems, enhances the effectiveness of the intervention program. These authors also determined that "more detailed analyses of the various features of interpersonal difficulties which may cause disharmony in

relationships among agoraphobics are necessary before more precise conclusions can be made, but the evidence strongly supports that these are issues to which we must give research attention" (Kleiner & Marshall, 1985; p. 593).

Purpose of This Study

This investigation explored the assumption that interpersonal issues play a key role in the onset and maintenance of agoraphobia. The purpose of this study was to examine the quality of the marital relationship of the agoraphobic and compare it with that of a sample of nonclinical subjects. The function of one's gender-role concept and degree of interpersonal dependency on others was investigated as well.

Data were collected from current or previously symptomatic individuals who are members of agoraphobic support groups, as well as a nonclinical control group. Group means were compared between the agoraphobic group and the control group on the succeeding measures:

1) The Quality of Relationships Inventory (QRI; Pierce, Sarason, & Sarason, 1991)--a measure which employs three subscales (social support, conflict,

depth) to assess relationship-specific perceptions of one's available support as well as perceptions of interpersonal conflict and relationship depth for the significant relationship. The three subscales of the QRI are useful to this investigation because increasing evidence indicates that interpersonal conflict plays a large role in personal adjustment, and that its impact may be independent of the contribution made by perceived social support. Perceptions of depth (i.e., beliefs about commitment and security in a relationship) are believed to reflect the strength of the interpersonal bond between the two relationship participants (Pierce et al., 1991).

2) The Personal Attribute Questionnaire (PAQ; Spence & Helmrich, 1978) was employed to assess subjects' self-concept of personal gender role. The PAQ produces two well-validated measures of masculinity and femininity defined as Agency (i.e., active, superior, independent) and Communion (i.e., kind, able to devote oneself completely to others, warm), respectively. These scales are carefully constructed to rule out social desirability differences that might account for

male-female differences. A third scale, the M-F scale, contains items that have been judged to be masculine in nature, but that, contrary to those on the masculinity scale, have been rated as less socially desirable characteristics for women than for men. The M-F scale items refer to such items as dominance and aggression.

3) The Interpersonal Dependency Inventory (IDI; Hirschfeld, Klerman, Gough, Korchin, and Chodoff, 1977) was used to measure thoughts, behaviors, and feelings revolving around the need to associate closely with valued others. Three aspects of interpersonal dependency (i.e., emotional reliance on another person, lack of social self-confidence, and assertion of autonomy) are assessed by the IDI's three subscales.

Based on previously stated findings (e.g., Fodor, 1974; Chambless & Goldstein, 1982; Chambless & Mason, 1986; Torpy & Measy, 1974), the following hypotheses were made:

1) The agoraphobic group will score significantly lower on both the Agency (masculinity) scale and the M-F scale than the nonclinical group.

2) The agoraphobic group will score significantly

higher on the measure of conflict within the significant relationship than will the nonagoraphobic group.

3) The agoraphobic group will score significantly lower on measures of social support from spouse/ significant other and depth of relationship than will the nonclinical control group.

4) The agoraphobic group will score significantly lower on the measure of assertion of autonomy than will the control group.

5) Significantly higher scores will be obtained by the agoraphobic group than the nonclinical group on measures of lack of self-confidence and emotional reliance on others.

The Eysenck Lie Scale (Eysenck & Eysenck, 1963) was used as a control for possible group differences in subjects' tendency to give socially desirable responses.

Method

Subjects

Forty-six (nine men, 37 women) current or previously agoraphobic individuals were used as

clinical group subjects. Subjects were volunteers from agoraphobia support groups in the Richmond and Tidewater Virginia areas. Subjects averaged 42.70 years (SD=13.13) in age. Fifty (seven men, 43 women) graduate students in the School of Education at the College of William and Mary were used as a nonclinical control group. The mean age for these subjects was 31.80 years (SD=9.26). Subject groups were differentiated by the respondents' scores on a standardized agoraphobia questionnaire as well as by membership in the agoraphobia support group.

Measures

1. The Mobility Inventory for Agoraphobia (MI) (Chambless, Caputo, Jasin, Gracely, & Williams, 1985) was included to assess specific agoraphobic symptoms. The MI yields four global measures: MI-AAL (Avoidance Alone), MI-AAC (Avoidance Accompanied), MI-DAL (Discomfort Alone), MI-DAC (Discomfort Accompanied). Test-retest reliabilities for the measures range from .48 to .90 (median r = .76).

2. The Personal Attributes Questionnaire (PAQ) (Spence & Helmrich, 1978) was administered to measure

degree of gender-role stereotyping in subjects' self-concept. Items in this scale can be classified into three general categories: (a) "agency" traits that are stereotypically regarded as being masculine and that are socially desired to some degree in both men and women (PAQ M), (b) "communion" qualities that are stereotypically ascribed as feminine and that are positively valued in both women and men (PAQ F), (c) items for which ratings fall toward the opposite pole for the ideal men and the ideal women (PAQ M-F). Test-retest reliabilities for the subscales are .85, .82, and .78 for the PAQ M, PAQ F, and the PAQ M-F respectively. The subscales have proven to be valid and are statistically independent (Spence & Helmrich, 1978).

3. The Quality of Relationships Inventory (QRI; Pierce, Sarason, & Sarason, 1991) is a 39-item questionnaire that was used to assess quality of marital relationship. The QRI contains three subscales which measure perceptions of available support from a specific relationship, amount of conflict in this relationship, and relationship depth. Relationship-

specific social support (i.e., "To what extent can you turn to this person for advice about problems?") has proven to be distinct from general perceptions of social support (Pierce et al., 1991). The relationship depth subscale was developed to assess the extent to which the relationship is perceived as being positive, important, and secure (i.e., "How significant is this relationship in your life?"). The extent to which the relationship is a source of conflict and ambivalence (i.e., "How often does this person make you feel angry?") is measured by the conflict subscale. The subscales are moderately correlated.

4. The Interpersonal Dependency Inventory (IDI; Hirschfeld et al., 1977) uses 48 items to measure thoughts, feelings, and behaviors revolving around the need to associate closely with valued others. The IDI's three subscales assess different aspects of interpersonal dependence. Emotional Reliance on Another Person (i.e., "I do my best work when I know it will be appreciated."), Lack of Social Self-Confidence (i.e., "When I have a decision to make I always ask for advice."), and Assertion of Autonomy (i.e., "I rely

only on myself".) subscales contain agree/disagree statements. All three scales are highly internally consistent and have fared well in a series of validational studies (Hirschfeld et al., 1977).

5. The Eysenck Personality Inventory Lie Scale (Eysenck & Eysenck, 1963) was used as a brief measure of subject's tendency to give socially desirable responses.

Procedure

Subjects were given a packet containing the five measures and a consent form. Subjects filled out all questionnaires in the packet individually and turned in the consent form separately. In order to obtain an accurate account of agoraphobic individuals' degree of symptom intensity and interpersonal relationship quality at the time of agoraphobia symptom severity, agoraphobic subjects were instructed to complete the Mobility Inventory for the way they felt when symptoms were at their worst. These subjects were also requested to report the length of time since symptoms were at their worst. In addition, agoraphobic subjects were directed to fill out the Quality of Relationship

Inventory based on recollections of marital relations when symptoms were at their worst.

Control group subjects completed all questionnaires for their present situation. Subject identification and results have been kept anonymous.

Results

In order to differentiate between the agoraphobic and control groups, one way ANOVA's were performed between groups on agoraphobia symptom intensity scores with the following subscales: fears when alone, fears when accompanied, number of panic attacks in the past seven days and number of panic attacks in the past six months. A significant difference between group means was found for fears when alone, $F(1,95) = 142.195$, $p<.001$. The agoraphobic group's fears when alone score was significantly higher ($M = 72.33$) than the control group's score ($M = 35.24$). The agoraphobic group reported significantly greater fear when accompanied ($M = 53.15$) than the control group ($M = 35.24$), $F(1,95) = 100.210$, $p<.001$. The difference between means for number of panic attacks in the past seven days was significant, $F(1,95) = 6.921$, $p<.05$. The mean for the

agoraphobic group was greater (M =3.17) than the control group's mean score (M = .06). The number of panic attacks reported in the past six months was significantly greater for the agoraphobic group (M = 18.80) than for the control group (M = .34), F(1,95) = 20.522, p<.001.

A MANOVA was performed with the subject group as the independent variable and the subscales of the Personal Attributes Questionnaire, Quality of Relationships Inventory, and Interpersonal Dependence Inventory as the dependent variables. The Eysenck Lie Scale was used as a covariate of the MANOVA to control for subjects' tendency to give socially desirable responses. An overall group effect on all variables was found. Table 1 presents the overall group effect using multivariate tests of significance.

Insert Table 1 about here

Univariate F-tests provided the following results: Subjects' mean Agency (masculinity) scores were found to be significantly different between groups, F(1,70) =

14.851, $p<.001$. The agoraphobic group's mean masculinity score was significantly lower (M = 24.73) than that reported by the control group (M = 28.25). No significant difference was found between groups for traits that are masculine in nature, but are less socially desirable for women than for men. No significant difference was found between groups for Communion (femininity) scores.

Agoraphobic subjects' mean score for social support from significant others was significantly lower (M = 18.96) than that of the control group (M = 24.33), $F(1,70) = 17.862$, $p<.001$. There was a significant difference in depth of significant relationship between the groups, $F(1,70) = 4.542$, $p<.05$. Means scores were 19.22 and 21.28 for the agoraphobic group and the control group respectively. Agoraphobic subjects had a significantly higher mean score on level of conflict in the significant relationship (M = 30.11) than did the control group (M = 18.72), $F(1,70) = 26.672$, $p<.001$.

The amount of emotional reliance on others was significantly different between groups, $F(1,70) = 15.222$, $p<.001$. The agoraphobic group reported

significantly higher degrees of emotional reliance on others (M = 47.72) than was reported by the control group (M = 39.36). The agoraphobic group had a significantly higher mean score on the lack of self-confidence subscale (M = 35.70) than did the control group (M = 27.22), $F(1,70) = 22.972$, $p<.001$. No significant difference was found between the groups on the assertion of autonomy subscale. The significant Univariate F-tests are presented in Table 2.

Insert Table 2 about here

Pearson correlation coefficients were performed on the data between the lie scale and the dependent variables. The lie scale was not significantly correlated with any of the dependent variables in the study.

The mean scores for all variables in each group are presented in Table 3. As illustrated in Table 3, mean scores for agoraphobic symptoms, defined by fears both accompanied and alone, were much higher for the agoraphobic group. The same pattern is maintained with

the number of panic attacks. The standard deviations on the agoraphobic symptom scales are also much larger for the agoraphobic group than for the controls. This large variation is evidence of the wide range of both degree of symptom intensity and number of panic attacks experienced within this diverse group.

Insert Table 3 about here

Table 4 contains agoraphobic subjects' descriptive statistics.

Insert Table 4 about here

Control group subjects' descriptive statistics are presented in Table 5.

Insert Table 5 about here

Pearson correlation coefficients were performed on the data within each group. Within the agoraphobic group, a significant negative correlation was found

between the Agency (masculinity) score and alone fear (r = -.51, p< .01), indicating that lower levels of confidence, independence, and emotional strength were related to higher symptom intensity. Lack of self-confidence was negatively correlated with Agency (masculinity) scores (r = -.6468, p< .001). The significant correlation coefficients are presented in Table 6.

Insert Table 6 about here

Within the control group, a significant positive correlation was found between lack of self-confidence and fear when alone, (r = .53, p< .001). Lack of self-confidence was significantly negatively correlated with the Agency (masculinity) score, (r = -.58, p<.001). Within each subject group, subscale scores of the Interpersonal Dependence Inventory were significantly correlated. Quality of Relationship Inventory subscale scores were significantly correlated as well. The significant correlation coefficients for the control group are presented in Table 7.

Insert Table 7 about here

Discussion

Group differences were found on all three subscales of the Quality of Relationship Inventory. As hypothesized, the agoraphobic group scored significantly lower on social support from significant other and depth of relationship with significant other than did the control group. These results confirm Pyke and Roberts' (1987) findings that demonstrated significantly lower scores on degree of spousal social support for an agoraphobic group than for a nonclinical control group. The present investigation is further proof that the agoraphobic should not be treated in isolation from his/her support system. The significant member of that support system must be aware of the importance of his/her role in the interpretation and management of anxiety producing situations. The lack of social support felt by the agoraphobic individuals is an added stress to their systems. People with agoraphobia generally react to stress in a negative

manner, therefore it is important to reduce the amount of stressors in the environment. Increasing the spouses' awareness of their potential role in producing anxiety is a step toward stress reduction for the agoraphobic.

The agoraphobic group scored significantly higher than the control group on the amount of conflict in the significant relationship as well. These data correspond with findings from earlier studies. Goldstein and Chambless (1978) reported that agoraphobia tended to develop during times of high interpersonal conflict, specifically marital strife. The present investigation did not examine the development of agoraphobia. However, it was hypothesized that agoraphobia symptoms are maintained by ongoing negative interactions. The finding of increased interpersonal conflict for the agoraphobic individuals supports that hypothesis. The stress that develops as a result of marital conflict, which may precede and/or result from the agoraphobia pattern, may make treatment of anxiety difficult.

Torpey and Measy (1974) examined the marital

interactions of 28 married agoraphobic women and found that 43% of the women reported some degree of marital dissatisfaction. The present investigation is further proof of this observation, with agoraphobic individuals reporting a higher level of conflict and lower degrees of social support from the spouse and depth of the relationship than the nonclinical control group. These findings are also an additional illustration of the need for spouse involvement in therapy with the agoraphobic. The present author had the privilege of attending agoraphobic support groups during data collection and observed many spouses sitting in the back of the room. Many of these spouses stated that they did not believe that agoraphobia was a real problem for the agoraphobic individual. Many presumed that the fears were not real and were all in the agoraphobic's head. Attending a group comprised of people with the same fears and avoidant behavior made the agoraphobia more real for these spouses. Reading the literature and recognizing their roles in the maintenance of the agoraphobic symptoms (by not understanding or listening to the person attempt to

explain the anxiety) helped enlighten the spouses to their potential functions in maintaining and alleviating the agoraphobic symptoms.

Group differences were found on the Agency (masculinity) scale of the Personal Attributes Questionnaire. As predicted, the agoraphobic group scored significantly lower than controls on traits of masculinity (independent, active, superior) that are considered to be socially desirable for both men and women. In addition, a negative significant relationship was found between fear scores and masculinity scores for the agoraphobic group. Previous research has demonstrated an inverse relationship between agoraphobic symptom intensity and masculinity in a female population (Chambless & Mason, 1986). Chambless and Mason contended that the results of their study supported Fodor's (1974) assertion that sex-role stereotyping is often central to the development of agoraphobia in women. Chambless and Mason argued further that a society that does not teach women to be instrumental, competent, and assertive rather than just nurturant and expressive, is one that breeds

agoraphobic women. Although Chambless and Mason's study produced some of the most substantial findings in this field, their data can not be taken as definitive in light of their correlational nature.

Unlike the Chambless and Mason (1986) study, the present investigation employed a nonclinical group as a control. The present analysis had an agoraphobic group comprised of 20% males. The significant difference in masculinity scores between groups was found with the inclusion of males in the groups. The percentage of males in this study was not surprising given that the number of male agoraphobics in therapy and involved in support groups is on the rise. Perhaps this investigation demonstrated that these agency traits such as assertiveness and independence are lacking not only in the female agoraphobic population, but are rather, a reflection of the personal characteristics of individuals with agoraphobia.

One's self-concept and need to associate closely with valued others were measured with the Interpersonal Dependence Inventory's three subscales: emotional reliance on others, lack of self-confidence, and

assertion of autonomy. In support of the hypotheses, significant differences were found in the level of emotional reliance on others and lack of self-confidence. It was discovered that agoraphobic individuals are more dependent on valued others, and have less self-confidence than the nonclinical control group.

Results of the present study demonstrated that lack of self-confidence, which is a subscale measure of interpersonal dependence on others, is negatively related to Agency (independence, active), as assessed by the PAQ-masculine scale. The lack of positive masculine traits and the increased amount of dependency on others that both of these scales illustrate may be personality variables of individuals prone to developing agoraphobia. It is also quite possible that the relationship obtained between lower masculinity, higher dependence, and agoraphobic symptoms reflects the detrimental effects of agoraphobia and associated problems on one's sense of agency (masculinity), rather than the converse.

Assertion of autonomy was not found to be

significantly lower in the agoraphobic group as hypothesized. One reason for this finding may be that the questions on the assertion of autonomy subscale ask about respondents' amount of time spent alone, whether they rely only on themselves, and whether they want sympathy from others. The responses from the agoraphobic group could be contaminated by the agoraphobics' symptoms of avoidance of people, places, and situations where they fear a panic attack may occur. By virtue of the fact that many agoraphobics are afraid to go where there are people, such as malls, theaters, restaurants, and buses, they do spend much time alone and in many cases have to rely on themselves. This is especially the case if the agoraphobic is in a relationship with a spouse who does not understand or sympathize with the extent of the agoraphobic person's anxiety and avoidance.

Results of this study indicate that there is evidence that the interpersonal relationships of the agoraphobic individual may be a significant factor in maintaining or perpetuating the agoraphobic symptoms. The elevation of conflict and the lack of spousal

social support perceived by the agoraphobic may increase his/her anxiety. These interpersonal problems may be adding stressors to individuals who already have a hard time coping with many situations.

There is also evidence that agoraphobic individuals have personal characteristics (dependence, lack of assertiveness) that differentiate them from a nonclinical population. Whether these characteristics are inherent or develop as a result of the agoraphobia is not known. What is important is that the interactions of the person with these characteristics with a spouse who is unsupportive and uninformed about agoraphobia may be detrimental to agoraphobia symptom reduction. In their review of treatments for agoraphobia, Kleiner and Marshall (1985) concluded that in general, agoraphobic patients may not differ from normals in overall interpersonal relations, but the interaction between their personal characteristics (i.e., lack of self-confidence, dependence) and marital satisfaction may be important in the development and maintenance of agoraphobia.

The outcomes of this study have important

implications for future research in and treatment of agoraphobia. First, the results lend support to therapeutic intervention strategies which emphasize the importance of spouse involvement in treatment programs with the agoraphobic. Second, delineating personal characteristics of agoraphobic individuals such as dependency and lack of assertiveness, provides opportunities for therapists to work on these personality variables that may be contributing to the agoraphobic symptoms.

Involving the spouse in therapy will enable the therapist to deal not only with the symptoms of agoraphobia, but also with possible underlying relationship problems that may serve to maintain the person's agoraphobia. Helping couples to understand some of the dependency traits of the agoraphobic and the interaction of those with the perceived role of each partner in the relationship may help to decrease the stressors in the agoraphobic's environment. Alleviating the agoraphobic symptoms along with changing the environment will not only reduce symptom intensity but may lower stress and increase the quality

of the marital relationship as well. In support of these conclusions, Kleiner and Marshall (1985) claimed that involving partners in therapy, and/or employing components that deal with relationship problems, enhances the effectiveness of the intervention program.

More research in the area of personal characteristics of agoraphobic individuals is needed. An increasing number of studies are finding the characteristics of dependency and low self-reports of agency qualities in agoraphobic individuals. Whether these qualities emerge as a result of the agoraphobic symptoms, or are precursors to agoraphobic symptoms remains unanswered.

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Table 1

Overall Group Effect Using Multivariate Tests of Significance

Test Name	Value	df	F
Pillais	.43124	9,62	5.22329***
Hotellings	.75822	9,62	5.22329***
Wilks	.56876	9,62	5.22329***

***significant to .001

Table 2
ANOVA's For the Dependent Variables Between Groups

Variables	SS	df	MS	F
Fear-Accompanied	14797.39	1,94	14797.39	100.21***
Fear-Alone	32951.76	1,94	32951.76	142.19***
Panic Attack-7 day	232.31	1,94	232.31	6.92**
Panic Attack-6 mos.	8168.17	1,94	8168.17	20.52***
PAQ-Masculine(Agency)	234.89	1,70	234.89	14.85*
Relationship Conflict	2416.83	1,70	2416.83	26.67***
Depth of Relationship	75.48	1,70	75.48	4.54*
Spouse Social Support	449.98	1,70	449.98	17.86***
Emotional Reliance	1363.95	1,70	1363.95	15.22***
Lack Self-Confidence	1383.18	1,70	1383.18	22.97***

* significant to .05
** significant to .01
***significant to .001

Table 3
Mean Scores on Dependent Variables for Each Group

Variables	Agoraphobic		Control	
Fear-Accompanied	53.15	(16.37)***	28.30	(6.10)
Fear-Alone	72.33	(19.94)***	35.24	(8.91)
Panic Attack-7 days	3.17	(8.37) **	.06	(.31)
Panic Attack-6 months	18.80	(28.82)***	.34	(1.00)
PAQ-Feminine (Communion)	32.95	(3.50)	32.50	(3.89)
PAQ-Masculine (Agency)	23.93	(4.83) *	28.36	(3.12)
PAQ-MF	20.44	(4.97)	21.67	(2.99)
QRI-Conflict	29.76	(10.90)***	18.72	(7.88)
QRI-Social Support	19.13	(6.14) ***	24.33	(3.59)
QRI-Depth	19.32	(4.54)	21.28	(3.44)
IDI-Emotional Reliance	46.64	(10.72)***	38.64	(8.38)
IDI-Lack Self-Confidence	36.63	(11.28)***	27.40	(5.55)
IDI-Assertion Autonomy	27.46	(7.53)	25.32	(6.46)
Lie	10.67	(1.37)	10.00	(1.26)

-Parentheses contain standard deviations

*$p < .05$
**$p < .01$
***$p < .001$

Table 4

Descriptive Statistics for Measures Within the Agoraphobic Group

Variables	Mean	Std Dev	Min	Max	N
Age	42.70	13.13	19	68	46
Marital Status	1.30	.47	1	2	46
Gender	1.20	.40	1	2	46
Race	1.04	.21	1	3	46
Fear-Accompanied	53.15	16.37	25	94	46
Fear-Alone	72.33	19.94	26	104	46
Panic Attack-7 Days	3.17	8.37	0	50	46
Panic Attack-6 Mos.	18.80	28.82	0	99	46
PAQ-Masc (Agency)	23.93	4.83	13	32	46
PAQ-Fem (Communion)	32.95	3.50	23	40	46
PAQ-MF	20.44	4.97	18	37	46
QRI-Conflict	29.76	10.90	13	48	38
QRI-Social Support	19.13	6.14	7	28	38
QRI-Depth	19.32	4.54	7	24	38
IDI-Emot. Reliance	46.64	10.72	17	68	46
IDI-Lack Self-Conf.	36.63	11.28	19	80	46
IDI-Assert Autonomy	27.46	7.53	14	43	46
Lie	10.67	1.37	8	14	46

Table 5

Descriptive Statistics for Measures Within the Control Group

Variables	Mean	Std.Dev.	Min	Max	N
Age	31.80	9.26	22	57	50
Marital Status	1.52	.50	1	2	50
Gender	1.14	.35	1	2	50
Race	1.10	.42	1	3	50
Fear-Accompanied	28.30	6.10	25	60	50
Fear-Alone	35.24	8.91	26	61	50
Panic Attack-7 days	.06	.31	0	2	50
Panic Attack-6 mos.	.34	1.00	0	4	50
PAQ-Masc (Agency)	28.36	3.12	22	35	50
PAQ-Fem (Communion)	32.50	3.89	21	40	50
PAQ-MF	21.67	2.99	16	36	50
QRI-Conflict	18.72	7.88	12	46	36
QRI-Depth	21.28	3.44	8	24	36
QRI-Social Support	24.33	3.59	15	28	36
IDI-Emot Reliance	38.64	8.38	24	57	50
IDI-Lack Self-Conf	27.40	5.55	17	38	50
IDI-Assert Autonomy	25.32	6.46	14	41	50
Lie	10.00	1.26	8	13	50

Table 6

Correlations Between Dependent Variables Within the Agoraphobic Group

Measure	ALNFEAR	PA7DAY	PAQM	QRIDEPTH	QRICONF	IDIER
PAQM	-.5125**					
IDILSC		.50**	-.65**			.57**
IDIAA				-.48*		
QRISS				.63**	-.67**	
QRIDEPTH					-.39*	

*P < .01

**P < .001

Table 7

Correlations Between Dependent Variables Within the Control Group

Measure	ALNFEAR	QRICONF	QRIDEPTH	IDIER	PAQM
IDILSC	.53**			.56**	-.58**
QRISS		-.43*	.40*		
QRIDEPTH		-.57**			

*P < .01

**P < .001

Appendix A

Mobility Inventory for Agoraphobia
(Chambless, Caputo, Jasin, Gracely, & Williams, 1985)

Instructions

Read the questionnaire on the following page and fill out the answers for the way you felt when your agoraphobic symptoms were at their worst.

Please indicate how long ago symptoms were at their worst if they are not presently at their worst.
(e.g. 3 years ago, 3 months ago, etc.)

_____

If you feel that your symptoms or focus are <u>not agoraphobia</u>, check here_____, but complete the set of responses for when your own symptoms were at their worst.

1. Please indicate the degree to which you avoid the following places or situations because of discomfort or anxiety. Rate your amount of avoidance when you are with a trusted companion and when you are alone. Do this by using the following scale.

1, Never avoid
2, Rarely avoid
3, Avoid about half the time
4, Always avoid

(You may use numbers half-way between those listed when you think it is appropriate. For example, 3 1/2 or 4 1/2).

Write your score in the blanks for each situation or place under both conditions: when accompanied, and when alone. Leave blank those situations that do not apply to you.

Places	When Accompanied	When Alone
Theaters	_____	_____
Supermarkets	_____	_____
Classrooms	_____	_____
Department stores	_____	_____
Restaurants	_____	_____
Museums	_____	_____
Elevators	_____	_____
Auditoriums or stadiums	_____	_____
Parking garages	_____	_____
High places	_____	_____
Tell how high	_____	_____

	When Accompanied	When Alone
Enclosed places (i.e. tunnels)	_____	_____
Open spaces (A) Outside (i.e. fields, wide streets, courtyards)	_____	_____
(B) Inside (i.e. large rooms, lobbies)	_____	_____
<u>Riding In</u> Buses	_____	_____
Trains	_____	_____
Subways	_____	_____
Airplanes	_____	_____
Boats	_____	_____
Driving or riding in car (A) At any time	_____	_____
(B) On expressways	_____	_____
<u>Situations</u> Standing in line	_____	_____
Crossing bridges	_____	_____
Parties or social gatherings	_____	_____
Walking on the street	_____	_____
Staying at home alone	NA	_____
Being far away from home	_____	_____
Other (specify)	_____	_____

We define a panic attack as:

(1) a high level of anxiety accompanied by
(2) strong body reactions (heart palpitations, sweating, muscle tremors, dizziness, nausea) with
(3) the temporary loss of the ability to plan, think, or reason and
(4) the intense desire to escape or flee the situation. (Note, this is different from high anxiety or fear alone.)

Please indicate the total number of panic attacks you have had in the last seven days, _____
in the last six months._____

Appendix B
QRI (Pierce, Sarason, & Sarason, 1991)

The items below inquire about the kind of relationship you have with your husband or significant other. Please rate the degree to which you feel that each item fits your relationship.

Very little	Somewhat	Pretty much	Very much
-1-	-2-	-3-	-4-

1. _____ To what extent can you count on this person to listen to you when you are very angry at someone else?

2. _____ To what extent can you turn to this person for advice about problems?

3. _____ To what extent can you really count on this person to distract you from your worries when you feel under stress?

4. _____ To what extent could you count on this person for help with a problem?

5. _____ How often does this person make you feel angry?

6. _____ How significant is this relationship in your life?

7. _____ How responsible do you feel for this person's well-being?

8. _____ How much does this person make you feel guilty?

9. _____ How critical of you is this person?

10. _____ How angry does this person make you feel?

11. _____ How much would you like this person to change?

12. _____ How much do you depend on this person?

13. _____ If you could only have a small number of relationships, how much would you want your contact with this person to be among them?

14. _____ How positive a role does this person play in your life?

Very little	Somewhat	Pretty much	Very much
1	2	3	4

15._____ How upset does this person sometimes make you feel?

16._____ How much do you argue with this person?

17._____ To what extent could you count on this person to help you if a family member very close to you died?

18._____ How close will your relationship with this person be in 10 years?

19._____ How often does this person try to control or influence your life?

20._____ How often do you have to work hard to avoid conflict with this person?

21._____ How much would you miss this person if the two of you could not see or talk with each other for a month?

22._____ To what extent can you trust this person not to hurt your feelings?

23._____ How often do problems that occur in this relationship get resolved?

24._____ If you wanted to go out and do something this evening, how confident are you that this person would be willing to do something with you?

25._____ How considerate is this person of your needs?

26._____ How much do you have to "give in" in this relationship?

27._____ How much does this person want you to change?

28._____ To what extent can you count on this person to give you honest feedback, even if you don't want to hear it?

29._____ How much more do you give than do you get from this relationship?

Appendix C
Eysenck Personality Inventory
(Eysenck & Eysenck, 1963)

Instructions

Here are some questions regarding the way you behave, feel, and act. After each question is a space for answering "Yes", or "No".

Try and decide whether "Yes", or "No" represents your usual way of acting or feeling. Then circle the word "Yes" or "No"after each question.

1. If you say you will do something do you always keep your promise, no matter how inconvenient it might be to do so?..... Yes No

2. Once in a while do you lose your temper and get angry?..... Yes No

3. Do you occasionally have thoughts and ideas that you would not like other people to know about?. Yes No

4. Are all your habits good and desirable ones?... Yes No

5. Would you always declare everything at the customs, even if you knew that you could never be found out? Yes No

6. Of all the people you know are there some you definitely don't like?..... Yes No

7. Do you sometimes talk about things you know nothing about?..... Yes No

8. Do you sometimes gossip?..... Yes No

PAQ
(Spence & Helmrich, 1978)

The items below inquire about what kind of a person you think you are. Each item consists of a pair of characteristics, with the numbers 1,2,3,4, and 5 in between. Please choose the number that best describes where you fall on the scale.

1. Not at all aggressive	1	2	3	4	5	Very aggressive
2. Not at all independent	1	2	3	4	5	Very independent
3. Not at all emotional	1	2	3	4	5	Very emotional
4. Very submissive	1	2	3	4	5	Very dominant
5. Not at all excitable in a major crisis	1	2	3	4	5	Very excitable in a major crisis
6. Very passive	1	2	3	4	5	Very active
7. Not able to devote self completely to others	1	2	3	4	5	Able to devote self completely to other
8. Very rough	1	2	3	4	5	Very gentle
9. Not at all helpful to others	1	2	3	4	5	Very helpful to others
10. Not at all competitive	1	2	3	4	5	Very competitive
11. Very home oriented	1	2	3	4	5	Very worldly
12. Not at all kind	1	2	3	4	5	Very kind
13. Indifferent to others' approval	1	2	3	4	5	Highly needful of others' approval
14. Feelings not easily hurt	1	2	3	4	5	Feelings easily hurt

15. Not at all aware of feelings of others	1	2	3	4	5	Very aware of feelings of others
16. Can make decisions easily	1	2	3	4	5	Has difficulty making decisions
17. Gives up very easily	1	2	3	4	5	Never gives up easy
18. Never cries	1	2	3	4	5	Cries very easily
19. Not at all self-confident	1	2	3	4	5	Very self-confident
20. Feels very inferior	1	2	3	4	5	Feels very superior
21. Not at all understanding of others	1	2	3	4	5	Very understanding of others
22. Very cold in relations with others	1	2	3	4	5	Very warm in relations with others
23. Very little need for security	1	2	3	4	5	Very strong need for security
24. Goes to pieces under pressure	1	2	3	4	5	Stands up well under pressure

Appendix E
IDI (Hirschfeld, et al., 1977)

The following questions inquire about what kind of person you think you are. Please rate each item using the scale below.

-1- Not characteristic of me	-2- Somewhat characteristic of me	-3- Quite characteristic of me	-4- Very characteristic of me

1. _____ I do my best work when I know it will be appreciated.
2. _____ I prefer to be by myself.
3. _____ When I have a decision to make, I always ask advice.
4. _____ I would rather be a follower than a leader.
5. _____ I believe people could do a lot more for me if they wanted to.
6. _____ I can't stand being fussed over when I am sick.
7. _____ As a child, pleasing my parents was very important to me.
8. _____ I feel confident of my ability to deal with most of the personal problems I am likely to meet in life.
9. _____ I don't need other people to make me feel good.
10. _____ Disapproval by someone I care about is very painful to me.
11. _____ I am quick to agree with the opinions expressed by others.
12. _____ The idea of losing a close friend is terrifying to me.
13. _____ It is hard for me to ask someone for a favor.
14. _____ I'm the only person I want to please.

15._____ I would be completely lost if I didn't have someone special.

16._____ I get upset when someone discovers a mistake I've made.

17._____ In an argument, I give in easily.

18._____ I rely only on myself.

19._____ I easily get discouraged when I don't get what I need from others.

20._____ When I go to a party, I expect that other people will like me.

21._____ I hate it when people offer me sympathy.

22._____ I must have one person who is very special to me.

23._____ It is hard for me to make up my mind about a TV show or movie until I know what other people think.

24._____ I don't need much from people.

25._____ I'm never happier than when people say I've done a good job.

26._____ In social situations, I tend to be very self-conscious.

27._____ I need to have one person who puts me above all others.

28._____ When I am sick, I prefer that my friends leave me alone.

29._____ I have a lot of trouble making decisions by myself.

30._____ I am willing to disregard other people's feelings in order to accomplish something that's important to me.

31._____ I tend to imagine the worst if a loved one doesn't arrive when expected.

32._____ I tend to expect too much from others.

33._____ I don't need anyone.

34._____ I don't like to buy clothes by myself.

35._____ When I meet new people, I'm afraid I won't do the right thing.

36._____ Even if most people turned against me, I could still go on if someone I love stood by me.

37._____ What people think of me doesn't affect how I feel.

38._____ I would rather stay free of involvement with others than to risk disappointments.

39._____ I think that most people don't realize how easily they can hurt me.

40._____ I tend to be a loner.

41._____ I am very confident about my own judgement.

42._____ I would feel helpless if deserted by someone I love.

43._____ I don't have what it takes to be a good leader.

44._____ What other people say doesn't bother me.

45._____ Even when things go wrong I can get along without asking for help from my friends.

46._____ I have always had a terrible fear that I will lose the love and support of people I desperately need.

VITA

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