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To my clients who reminded me that hope is a powerful healer, and

To my family and friends who inspired, assisted and comforted me and whose faith, love and caring I treasure,

A dream has been realized,

Thank you.

HISTORICAL VIEWS OF FEAR

"The thing of which I have most fear is fear."

(Michel Eyquem de Montaigne, 1533-1592)

"Nothing is terrible except fear itself."

(Francis Bacon, 1561-1626)

"The only thing I am afraid of is fear."

(Arthur Wellesley, Duke of Wellington, 1769-1852)

"Nothing is so much to be feared as fear."

(Henry David Thoreau, 1817-1862)

"The only thing we have to fear is fear itself."

(Franklin Delano Roosevelt, 1882-1945)

"My body reacted as though
there was a tiger waiting
around every corner to
kill me. In my head,
I knew there was nothing
to be afraid of, but
that didn't make any difference"

(an agoraphobic describing the fear of fear - Evelyne Michaels, 1979)

PREFACE

Mankind has often deliberated on the attributes of fear and the effects it may have on one's approach to life and living. "Nothing to fear but fear itself" has become a common phrase. If fear is really the only thing worthy of dread, then perhaps the agoraphobic more than most people has cornered the market on this emotion.

While psychoanalysis, client-centred and other forms of psychotherapy, drugs, hypnosis, electroconvulsive shock treatment and a form of brain surgery known as leucotomy have all been used at some point in time to treat phobias, it appears that none of these methods has achieved a great level of success. The most effective procedures seem to be those based on some form of learning theory (Kanfer and Goldstein, 1980). Furthermore, many authors writing in support of other methods have suggested the need for practice in real-life settings to occur at some point during treatment (Mathews, Gelder and Johnston, 1981). Recent developments in the field of agoraphobia are now centering on behavioural approaches which have "identified the necessary ingredient of the useful treatment of phobias (namely, exposure)" and on the use of pharmacology to alleviate the acute distress of panic attacks (Mavissakalian and Barlow, 1981).

The focus in this practicum report is on behavioural methodology used in the treatment of agoraphobia. It is also an attempt to understand something about the emotion of fear in instances where this has played havoc with people's ability to think and behave as they would like to in daily life.

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LITERATURE REVIEW

Characteristics of Agoraphobia

Historical Factors

Agoraphobia is a common problem. While phobics in general comprise between 2% and 4% of most psychiatric populations (Benjamin and Kincey, 1977), over 50% of these are diagnosed agoraphobic (Marks, 1969). An extensive survey of one town in the United States found a phobia prevalence of 77 per 1,000 population with an incidence of disabling phobic disorders being treated of 2.2 per 1,000 (Agras, Sylvester and Oliveau, 1969). Of the phobias being treated in this study, half were diagnosed as agoraphobia. Given the nature of agoraphobia in which individuals may become so isolated that they do not seek professional help, there are likely more agoraphobics living in the community who are not included in the available statistics.

The term "agoraphobia" (from the Greek agora meaning market place and the Late Latin phobia meaning flight or fear) was first coined by Westphal in 1871 to describe a condition in which individuals fear open spaces or empty streets. While the early studies of this disorder were conducted primarily with men, current research indicates that most agoraphobics receiving treatment are women (approximately 83% in the treatment studies reviewed by Jansson and Öst, 1982), and many of these women are married (Marks and Herst, 1970; Goldstein and Chambless, 1978). Agoraphobia occurs rarely in childhood (Rutter, Tizard and Whitmore, 1968 - cited in Mathews, Gelder and Johnston, 1981). It usually begins sometime between the ages of 18 and 35 years (Marks and Herst, 1970) with peak onset ages of 20 and 30 to 35 years

(Marks, 1970a; Bowen and Kohout, 1979). In addition, there is now more emphasis on the fear of crowds rather than of open spaces in the experience of modern agoraphobics.

Cognitive, Somatic and Contemporary Factors

Unlike free-floating anxiety conditions, the central anxiety associated with agoraphobia occurs, at least initially, in response to clearly-defined situations such as those involving distance away from home or another safe place or crowded, restricted or isolated environments. Specific situations often cited are stores, theatres, restaurants, line-ups or queues, hairdresser or dentist chairs, buses and trains--places in which the individual feels trapped or is afraid of fainting or of being embarrassed as the result of a panic attack. The anxiety or panic attacks associated with agoraphobia may involve both physiological symptoms such as heart palpitations (tachycardia), rapid or laboured breathing, muscle tension, sweaty palms, dry mouth, dizziness, fainting or feeling faint as well as cognitive reactions such as catastrophic thoughts of going insane, losing control, fainting, having a heart attack, or of humiliation as a result of behaving strangely in public.

Agoraphobia is usually characterized by some degree of avoidance of feared situations and often by a gradual avoidance of more places over time. This may range from avoidance of one particular location such as a shopping centre or department store to avoidance of anything outside the home. In the severest cases, an agoraphobic's fears may eventually confine him or her to one room in the home or to remaining in bed. As avoidance grows, the person becomes increasingly

isolated and deprived of social contact. The avoidance exhibited by an agoraphobic also places extra responsibility on relatives or friends to accomplish tasks which the individual no longer feels able to do. A re-organization of previous family roles and responsiblities may result from the phobic restrictions.

Anticipatory fear is also evident, since the agoraphobic may begin to panic merely at the thought of entering a fearful situation, even if the situation itself is not encountered. This "fear of fear" is compounded by repeated cognitions of a catastrophic nature and by being alone. An agoraphobic's fear of being alone may extend to being left alone at home (Marks, 1969; Snaith, 1968).

The anxiety experienced in relation to phobic situations often diminishes or may disappear entirely if the agoraphobic person is accompanied by a trusted person, frequently but not always, an adult. Occasionally, an object such as the person's car, a cane, an umbrella, or a shopping basket may produce a similar effect and be substituted for the "trusted person" (Burns and Thorpe, 1977a). Hypochondriasis (Buglass, Clarke, Henderson, Kreitman and Presley, 1977), generalized anxiety, depersonalization, depression, obsessional symptoms, and poor psychosexual function may also occur in conjunction with agoraphobia (Mathews, Gelder and Johnston, 1981).

Personality Dimensions

Goldstein and Chambless (1978) proposed two subclassifications of agoraphobia which could be useful for assessment and treatment purposes. The term "simple agoraphobia" was used to describe individuals whose symptoms related to drug experiences or physical disorders. These

persons were not expected to portray the usual personality characteristics and were expected to recover more quickly once the physical problem was under control. Most agoraphobics would fall into the second classification: "complex agoraphobia," which implies the whole syndrome not merely a simple phobia. The elements comprising the complex category were outlined as follows:

(1) "Fear of fear" as the most central phobic element.

(2) Low levels of self-sufficiency whether due to anxiety, a lack of skills, or both.

(3) A tendency to misapprehend the causal antecedents of uncomfortable feelings. For example, anxiety reliably following interpersonal conflict is interpreted as fear of being on the street alone.

(4) Onset of symptoms in a climate of notable conflict. The conflict is generally, but not necessarily an interpersonal one (p. 51).

A study done by Emmelkamp and Cohen-Kettenis (1975) addressed the relationship between phobic anxiety and external locus of control. As a result of the significant correlation found between the two, it was proposed that a lack of internal control, or learned helplessness, was the reason for avoidance of phobic situations. Rock and Goldberger (1978) found agoraphobics to be more field-dependent than other phobics on an embedded-figures test while Andrews (1966) hypothesized that agoraphobics are generally disposed to be dependent on others and show a tendency to use avoidance as a coping mechanism in stressful circumstances.

Despite these findings and suggestions, the relationship between certain personality dimensions and agoraphobia remains unclear. It may be, for example, that problems of external locus of control or

dependency arise only in relation to specific situations. Mathews, et al. (1981) pointed to various studies indicating high trait anxiety and neuroticism among agoraphobics and proposed that these characteristics might represent "a general vulnerability factor, which is not related specifically to agoraphobia" (p. 33).

The Agoraphobic Syndrome

There has been some speculation about whether or not agoraphobia stands, as a discrete syndrome, in a class by itself. One theory proposes classifying agoraphobia as a form of anxiety neurosis (Hallam, 1978). Another viewpoint favours agoraphobia as a syndrome separate and distinct from other phobic disorders and from depressive illness (Mathews, Gelder and Johnston, 1981).

Mathews et al. contend that while there appear to be similarities between various symptoms and the autonomic state of anxiety neurosis and agoraphobia, there are also differences between generalized anxiety states and agoraphobia in reaction-selection, behavioural and cognitive components. They further suggest that while generalized anxiety may precede or accompany agoraphobia, a discrete state of generalized anxiety does not resume as before once a pattern of phobic avoidance has developed. It is this avoidance factor and its determinants which appear to distinguish agoraphobia from other anxiety states. It was also noted that two long-term follow-up studies (Marks, 1971; Munby and Johnston, 1980) failed to find evidence of a clinical state of generalized anxiety or depressive illness developing after treatment in subjects originally diagnosed as agoraphobic.

Agoraphobia may be further separated from other phobic disorders

on the basis of a group of symptoms which appear to be associated with one another and not just a more severe form of other phobias. Mavissakalian and Barlow (1981) pointed out the combination in agoraphobia of a fear of outside situations with an internally-stimulated fear: the fear of losing control. Goldstein and Chambless (1978) stress that the central fear in agoraphobia is a "fear of fear" in which an individual is afraid of his/her own reactions in a particular situation rather than any harm that might be rendered by the situation itself. Agoraphobia may be distinguished additionally from other phobias by its chronicity, its tendency to fluctuate in severity, and by the occurrence on occasion of periods of spontaneous remission (Mavissakalian and Barlow, 1981).

Causes of Agoraphobia

While there are a variety of theories of agoraphobia leading necessarily to a variety of therapeutic approaches, no one cause or one group of causes for this condition has been conclusively determined. Precipitating causes are perhaps less of an issue in a behavioural approach to agoraphobia than they might be to other forms of treatment except in instances where what happened in the past appears to be having a deleterious effect on current efforts to produce or facilitate behavioural change. This may have something to do with the relative success of certain behavioural techniques used alone or in conjunction with other forms of treatment where the focus is essentially on the present, since it is usually not the "cause" or background history but the fear itself which distresses and debilitates the phobic person.

A consideration of the causes preceding or contributing to the

onset of agoraphobia is important to an understanding of the nature and development of this condition and of special concern for those involved in preventive programs and identifying individuals at risk. It is of particular importance in medical or medically-related research attempting to isolate organic problems which may be contributing to the onset and progression of agoraphobia. The relationship between cause and effect can also be significant in the evolution and choice of procedures used in treatment, especially in situations where causal factors have a bearing on the maintenance of phobic problems. From a behavioural therapist's point of view, a knowledge of possible causes is not only relevant to the choice of intervention strategies, but also to an awareness of potential physical precipitants of agoraphobia requiring specialized medical referral, and to an understanding of the informational biases, misconceptions or concerns which clients may bring with them into treatment.

Organic Factors

As far as is known, no specific organic condition or set of conditions has been isolated as a direct cause of agoraphobia. There have, however, been some suggestions made as to possible relationships between: agoraphobia and epilepsy, phobic-anxiety depersonalization syndrome and temporal lobe dysfunction, and agoraphobia-related panic attacks and the presence of mitral valve prolapse syndrome.

Mathews, Gelder and Johnston (1981) note that, based on clinical research and observation, there appears to be a strong similarity between agoraphobia and some of the symptoms and the autonomic state characteristic of anxiety neurosis. Therefore, a look first at anxiety

itself may be useful.

Smythies (1969) discussed the then known neurophysiological factors involved in the control of anxiety and fear reactions. Adrenergic activity was suggested to be the cerebral basis of anxiety. Smythies was particularly concerned in this article with anxiety studies leading to a greater understanding of schizophrenia but his suggestion that the anxiety or stress mechanism in humans might, under certain circumstances, be capable of producing stress or anxiety-inducing compounds could have implications for the treatment of various anxiety-related problems, among them agoraphobia.

Smythies also draws attention to studies illustrating that the level, in noradrenaline cells, of noradrenaline (which seems to facilitate excitement of the hypothalamic reward system in the brain) rises as a conditioned avoidance response is performed. Noradrenaline may, therefore, be the excitatory transmitter in the system which mediates anxiety and fear responses. With this in mind, an understanding of the neurophysiological concomitants of anxiety and fear could have implications for the appropriate use of pharmacology in conjunction with other forms of treatment.

A physiological model of phobic anxiety was proposed by Lader and Mathews (1968). A central feature of their formulation was level of arousal (anxiety): "A critical level of arousal would be predicted above which a repetitive stimulus would not be accompanied by any habituation, instead the level of arousal would become higher with each successive stimulus producing a positive feedback mechanism" (pp. 412-423). It may be that agoraphobics, having high levels of

anxiety, may reach a critical level of anxiety more frequently or have more difficulty habituating than those suffering from simple phobias. According to Mavissakalian (1982), these factors may indicate the use of graded as opposed to prolonged exposure during treatment, and the provision of extra supportive measures in the earlier in vivo sessions such as the company of trusted others, anxiety management techniques (e.g. paradoxical intention and self-statement training), and anti-panic medication.

Returning to the subject of possible organic factors involved in the onset of agoraphobia--Westphal (cited in Mathews et al. 1981) was perhaps the earliest writer to propose a connection between the neurotic symptoms of agoraphobic patients and epilepsy. Two of the three patients discussed in his 1871 paper had had epilepsy at an earlier point in their lives. More recently, Harper and Roth (1962) suggested a similarity between certain aspects of temporal lobe epilepsy and what they perceived as discrete syndrome within the realm of agoraphobia--the phobic-anxiety depersonalization or "calamity" syndrome. Agoraphobic patients experiencing depersonalization following severe stress were considered to be a distinct group having this syndrome. Mathews et al. (1981) questioned the validity of this syndrome. Furthermore, depersonalization remains to be clearly defined.

The mitral valve prolapse syndrome (MVP) has been studied in a psychiatric population with recurrent spontaneous panic attacks (RSPA) by Grunhaus, Gloger, Rein and Lewis (1982) and in agoraphobic patients by Kantor, Zitrin and Zeldis (1980). Grunhaus et al. found a 39% incidence of MVP in psychiatric patients complaining of RSPA.

MVP is commonly found in young women and is often associated with heart palpitations. Kantor et al. hypothesized that the palpitations and dyspnea (difficult or laboured breathing) related to MVP could lead to panic attacks and further, to agoraphobia in psychologically susceptible individuals. Their theory was supported by the finding that MVP occurred more frequently in agoraphobic women than in controls in the study conducted. It was also suggested that some individuals react to their MVP symptoms with fear and sympathetic arousal which in turn aggravates the symptoms, thus producing a feedback loop. Since anxiety reactions might vary depending upon a person's existing psychological vulnerability, some individuals become phobic under these circumstances while others do not.

If MVP is a primary source of anxiety for some people and can lead, through panic attacks, to agoraphobia, several implications for present and future treatment procedures could be considered. This information would, for example, lend further support to the need to explain the nature of palpitations and other related symptoms to phobic individuals and to be able to provide re-assurance that such symptoms are not to be feared and that certain activities do not necessarily have to be avoided because of them. Kantor et al. also suggest that the existence of MVP may indicate the use of drug therapy to alleviate panic attacks so that other forms of therapy can be facilitated. Imipramine was proposed as an appropriate medication in this case. Another study (Gloger, Grunhaus, Birmacher and Troudart, 1981) supported the use of chlomipramine in preventing a recurrence of panic attacks.

Since the palpitations of MVP may trigger panic attacks which in

turn may lead to agoraphobia, it is possible that other physiological conditions producing symptoms such as palpitations may also be implicated in some cases of phobic behaviour. Kantor et al. proposed several areas requiring further research into their relationship to agoraphobia, among them: hyperthyroidism, hypoglycemia, acute labryinthitis, and benign postural vertigo.

As yet, the possible connections drawn between agoraphobia and specific physical disorders is still a matter of hypothesis and requires much-needed further research. The fact that a relationship between various physiological conditions and the onset and development of agoraphobia has been proposed suggests the need for phobia therapists to be aware of current research and to recommend or ensure that clients seek appropriate medical examination and advice. Not only can this serve to discover possible organic contributors to the phobia, it can also help to provide necessary reassurance that physical symptoms are not the precusors of a major illness or disease.

Stressful Events

Goldstein and Chambless (1978) proposed the likelihood of a specific connection between the onset of agoraphobia and a situation of interpersonal conflict in which the relationship appears to be threatened. Solyom, Beck, Solyom and Hugel (1974) suggested that a major stressful event such as serious illness, a death in the family or a domestic crisis precedes onset of the phobia in many cases. Although no evidence of direct conditioning events was discovered in the study conducted by Solyom et al., Jansson and Öst (1982) reported more recent data indicating the presence of conditioning events in 84%

of their sample. Mathews et al. (1981) found a consistent trend in various data supporting the role of nonspecific background stress in fostering the onset of agoraphobia.

Taken in total, it appears that some form of stress, whether a critical event or a condition of some length, may facilitate the development of agoraphobia. Whether this stress acts as a conditioning agent or as a direct causal factor is a matter for clarification.

Heredity and Family Envirnoment

Several writers have considered the relationship between agoraphobia and family history, particularly a prevalence of affective disorders. There has been some suggestion that agoraphobia may cluster in families (Sheehan, 1979), that agoraphobics more often have mothers with phobic neurosis (Solyom et al., 1974), and that alcoholism may play a role in agoraphobic pre-disposition (Bowen and Kohout, 1979). On the other hand, a lack of clearly identifiable childhood precipitants has also been noted (Buglass, Clarke, Henderson, Kreitman and Presley, 1977).

Munjack and Moss (1981) examined the family histories of 68 agoraphobic subjects and found 26 with a positive family history of affective disorder which they constrasted with the 84% findings of Bowen and Kohout (1979) as well as with the findings of Buglass et al. (1977). Since their study found the agoraphobic portion of the sample to have a significantly higher prevalence of affective disorder in the first-degree relatives when compared to the miscellaneous-specific phobics and social phobics of the sample, Munjack and Moss concluded that their results confirmed the theory that agoraphobia differs

distinctly from other phobic conditions (Snaith, 1968; Marks, 1970a).

Munjack and Moss also noted that a family history of alcoholism occurred more frequently in the families of agoraphobics than in the families of the 45 other phobics investigated, but they did not determine a strong connection between alcoholism in a relative and a predisposition to agoraphobia. Bowen and Kohout (1979) found a high incidence of episodic alcoholism as well as affective disorders in the families of agoraphobics.

Mullaney and Trippett (1979) on the other hand raised the possibility of some interaction between heavy alcohol consumption and the development of phobias. In their study, of 44 phobic alcoholics reporting physical dependence, the onset of alcohol-related problems and physical dependence frequently followed the onset of phobic symptoms. It appears that the manifestion of alcohol problems occurred later in cases where the phobia was less disabling to the subject. In spite of the studies cited, any specific connection in either direction, between agoraphobia and alcoholism, appears tenuous in the absence of further research.

Antecedent parental characteristics have been considered in a number of studies. Snaith (1968) compared the home backgrounds of agoraphobic patients and patients with other phobias. The agoraphobic patients more frequently came from unstable home environments. Buglass et al. (1977) reported that while the trait of dependency did not distinguish between control and agoraphobic groups in their study, more agoraphobics than controls were aware of and resented being maternally dependent. In a study comparing agoraphobics and

social phobics (Parker, 1979), the social phobics indicated both parents as overprotective and less caring, while the agoraphobics reported less maternal care when compared with controls. In the more severe cases of agoraphobia and social phobia, the agoraphobics reported less maternal care and less maternal overprotection while the social phobics indicated more maternal care and overprotection. Thus, the results did not support the view that agoraphobics have often been overprotected by their mothers.

The concept of an "agoraphobic marriage" has also been investigated. Agulnik (1970) for example studied 50 married patients (32 females and 18 males) with symptoms of phobic anxiety, the majority agoraphobic. Phobic symptoms in almost all cases post-dated the marriage. A significant correlation of neuroticism scores was found between those couples married less than ten years but there was apparently no evidence of an increasing tendency towards neuroticism in the spouse with increasing length of marriage.

Another study (Hafner, 1977a) did find evidence of an assortative mating process in the marriages of the 33 agoraphobic women considered. Hafner presented a definition of assortative mating as a situation in which "partners choose each other on the basis of perceived attributes, some of which are pathological or at least pathogenic" (p. 233), and divided the agoraphobic wives in the study into two categories. Type I wives had high levels of both hostility and incidence of general phobic and neurotic symptoms while agoraphobic symptoms in Type II wives existed in relative isolation. Hafner speculated that direct treatment of agoraphobic symptoms in Type II wives would

more likely produce better results than the same approach to Type I wives without involvement or treatment of the spouse but, in either case, the spouse's participation would probably be beneficial.

No evidence for assortative mating was found in the study conducted by Buglass et al. (1977). The husbands of the 30 agoraphobic women studied appeared to have no distinguishing characteristics in conjunction with the current symptoms when compared to controls. Furthermore, the control group and the agoraphobic group did not differ significantly in domestic organization, social relationships and symptomatology in the children.

While some studies indicate little evidence of a specific effect on the child of a parent agoraphobic, others have considered symptoms in offsprings particularly in the area of school phobia. Berg, Marks, McGuire and Lipsedge (1974) studied the incidence of past school phobia in 786 agoraphobic women. There appeared to be some relationship between past school phobia and an earlier onset of agoraphobia at a later date and a more severe state of non-agoraphobic psychiatric symptoms but the authors concluded that school phobia only infrequently leads to agoraphobia. A more recent study by Berg (1976) investigated the incidence of school phobia in the children of 583 of the agoraphobic women surveyed in the 1974 study (Berg et al.). The agoraphobic women who had had school phobia themselves also tended to have school phobic children. It was suggested that the higher incidence of school phobia compared to what would have been expected in the population as a whole was likely related to general psychiatric disorder in the mothers rather than to agoraphobia alone.

Particularly for those who regard agoraphobia as a form of chronic anxiety (Rapp and Thomas, 1982) and for those who view phobic anxiety as an important element of the syndrome, the familial trends and genetic roots of the anxiety component take on a special significance. A review has been done of studies on the possible hereditary determinants of phobias (Delprato, 1980), while Slater and Shields' (1969) discussion on the genetic aspects of anxiety remains a major resource.

Delprato concluded that neither a learning-conditioning approach nor the concept of inherited predispositions is adequate to explain the development of fears. This author feels that while the evolutionary hypothesis has not been fully refuted, it has also not been conclusively supported and that taking an either-or view may hinder the identification of possible developmental factors contributing to fear behaviour.

Slater and Shields noted that most twin studies tend to agree on greater resemblance of monozygotic (as compared to dizygotic) twins in the areas of neurosis, anxiety, phobic or obsessional characteristics. While results such as these suggested a role played by genetic factors in predisposing some individuals to be more anxious, Slater and Shields also emphasize that environmental factors must not be overlooked.

There remain marked differences of opinion on the relationship between agoraphobia and various genetic and environmental conditions which may influence its development. It has been suggested by some that the element of anxiety in agoraphobia may be the key to a possible hereditary (and perhaps environmental) link, but in spite of

the considerable research done on agoraphobia in the last ten years, "final understanding of this condition is still elusive." (Sheehan, 1979).

Methods of Assessment and Progress Evaluation

A thorough clinical interview is the important first step to determining a subject's appropriateness for any form of treatment. The interview is utilized to assess the duration and extent of phobic avoidance, factors which ease or increase phobic anxiety, as well as the form, frequency and intensity of anxiety or panic attacks. The potential for co-operation and support from significant others must also be determined. The degree of medication use is another important consideration. The subject's perceptions concerning the onset of the phobia would be solicited at this time as well as their willingness and ability to participate in a specific course of treatment.

Once suitability has been concluded through a screening or inital assessment interview, several other means can be utilized to determine individual client state and needs. The mechanisms most commonly used for assessment and evaluation of agoraphobic fears and avoidance and related conditions are: personality inventories, psychiatric rating scales completed by therapists and independent assessors, psycho-physiological measurement, behavioural testing and client self-rating or reports.

While the results of standard personality scales such as the Minnesota Multiphasic Personality Inventory may be compared across studies, the measures used in them usually lack specificity and,

therefore, sensitivity to phobic conditions, and may not be useful in assessing outcome (Mavissakalian and Barlow, 1981). Mathews et al. (1981) also found psychiatric rating scales to be inadequate for measuring specific aspects of fears such as avoidance or subjective anxiety. Independent or "blind" assessors often become aware accidentally of treatment conditions and may not as a result be able to supply a completely unbiased rating.

Psychophysiological measurements such as those used to test the effect of the phobia on heart rate and skin conductance (galvanic skin response) may be employed during imaginal or *in vivo* exposure. In the *in vivo* situations, it is difficult to form a comparison between pre and post-treatment conditions since clients may not be prepared to enter certain fearful places prior to treatment. While pre and post-measurements may be taken more readily in imaginal exposure, repeated presentation of imaginal situations tends to lead to habituation. In addition, psychophysiological measurements can be expensive, time-consuming and inconvenient especially when applied to client practice in real-life settings.

Complex behavioural testing of what a subject can do based on a detailed hierarchy of increasingly fearful situations can take up valuable time and will sometimes be impractical if each item on a large hierarchy is tested (Mathews, Gelder and Johnston, 1981). It may be difficult to compare the results from different clients on a behavioural test and the validity of the measure depends to a great extent on the adequacy of the original hierarchy construction. The behavioural test can, on the other hand, be advantageous in that it

directly and realistically tests what a client can do. If the hierarchies are constructed on an equal interval rating scale from least distressing to most distressing items and the number of items selected is kept within workable proportions (in the range of 15 items), the behavioural test can be a very useful adjunct to other forms of measurement in the treatment of agoraphobia.

As a supplement to behavioural testing, client diaries have often been instituted to provide a reasonable measure of activities engaged in on a daily basis. Mathews, Gelder and Johnston (1981) have found time spent away from home to be a satisfactory measure of agoraphobia, particularly if time spent at work or in social visiting is excluded. Diaries can also be used to gain information on anxiety levels, use of medication, types of outings and how a client travels most successfully from place to place, alone or with someone else. While some self-report measures such as the Behavioural Diary have not been tested adequately to make a clear determination about their reliability and validity, they do serve as an indication of interest in treatment on the client's part, help the client to learn to monitor his/her own behaviour and have not been shown to be particularly unreliable or invalid. Hersen and Bellack (1976) quote studies which affirm that self-reports are often "relatively reliable . . . have some predictive power with respect to behavioural measures . . . and correlated moderately well with instruments which purport to measure conceptually related dispositions" (pp. 79-80). They may be used with some confidence especially as an alternate form of measurement. The measures on a Behavioural Diary can sometimes be plotted and averaged for evaluative

purposes and might be compared to similar measures (of avoidance and anxiety) obtained from self-rating forms such as a Fear Questionnaire.

A type of Fear Questionnaire constructed by Marks and Mathews (1979) has been described as a standard self-rating for phobic patients designed to monitor change in the areas of several accepted criteria. It was developed from earlier self-rating forms to yield scores in reference to: a main target phobia, a global phobia and a total phobia. It also contains a short questionnaire indicating the degree to which a client avoids 15 particular phobic situations (on a scale of 0 - 8) and requests a rating, again on an eight-point scale, of the five related anxiety-depression symptoms found in clinical practice. The anxiety-depression items refer to common non-phobic symptoms found in phobic patients and their rating indicates the level of general affective disturbance present. The global phobia rating (0 - 8) reflects levels of both distress and avoidance. Since this self-rating form responds to clinically accepted selection criteria and improvement indicators, it could be an effective measurement instrument for treatment program goals and expected outcomes.

Since the total phobia score of this form is made up of three sub-groups (agoraphobia, social phobia and blood-injury phobia) which can be scored separately, it also offers a check on the type of phobia being measured and on any relationship occurring between the sub-groups in the case of individual clients.

Marks and Mathews' self-rating form has been reported to be reliable and valid based on studies done to determine its rating effectiveness.

It may be used as a "minimum set of severity and outcome criteria in studies of phobic patients" (Marks and Mathews, p. 263) and is sensitive to such improvement indicators as reduction of fear and avoidance behaviour. It has also been reported that reliability coefficients of at least .8 may be obtained with this form when the test-retest interval is one week and that it may be used reliably to measure post-treatment behavioural change (Mathews, Gelder and Johnston, p. 21). The material in this form has been factor analyzed to determine its appropriateness for use with phobic patients. Criterion validity, concurrent validity and predictive validity appear to have been established. Construct validity has also been addressed. The form could be used to aid in selection of appropriate clients, to provide assessment information and base-line data, to give a post-test indication of overall treatment effectiveness and to discover at follow-up whether or not the effects of treatment have been maintained, increased or decreased over time.

While not often discussed in the agoraphobia treatment literature, consumer evaluation forms might also be used as a further check on program effectiveness. Such a form can accomplish several aims. First of all, it can act as a feedback mechanism for both clients and therapists on the clients' perception of their own behaviour change. It could also provide information on the clients' views of the usefulness of various treatment strategies. Evaluation forms could be adapted for use by both therapists and significant others in the client's environment to create a non-numerical measure (or, if ratings are added in the form of a Likert scale, a numerical measure) of

treatment effectiveness from several view points. Results would of course need to be interpreted with caution in terms of the possible social desirability of responses. By presenting an evaluation form to clients at different times, the effects of setbacks or other factors impinging on mood which could, in turn, affect response to the form, may be minimized.

Treatment Methods

Behaviour Therapy: An Overview

Contemporary behaviour therapy is characterized by "the pursuit of a scientific approach, the utilization of a psychological model of abnormal behaviour, and the therapeutic application of knowledge from general psychology and its related disciplines" (Jehu, 1983).

The empiricism inherent in behaviour therapy offers several advantages over more loosely defined methods, among them the clear definition of procedures used, the opportunity to collect data by valid and reliable means, and the rigourous evaluation of treatment wherever possible, given the specific clinical conditions. The psychological model (as opposed to the medical, disease or intrapsychic models) assumes that, unless an organic problem can be determined as the cause, abnormal behaviour is acquired in much the same way as normal behaviour, with an emphasis on previous learning and the effect of contemporary conditions. The field of psychology and other related disciplines have contributed a variety of knowledge utilized in behaviour therapy. This includes information on learning, cognition, developmental and social factors and findings in neurophysiology.

Jehu cites applied behaviour analysis, the neobehaviouristic

stimulus-response approach, cognitive behaviour therapy, and social learning theory as some of the major conceptual approaches from which behaviour theory draws in the application of treatment techniques.

In applied behaviour analysis, the emphasis is placed on changing overt behaviour and on the influence of environment. Techniques employed within this approach include positive reinforcement, shaping, extinction, time out, and stimulus control. The stimulus-response approach on the other hand may utilize such treatment techniques as systematic desensitization and flooding to overcome more private or emotional responses such as anxiety. Cognitive behaviour therapy is directed towards modifying faulty cognitions or thought processes which affect the way a person functions and which may contribute to dysfunctional behaviour. The techniques of cognitive restructuring, thought-stopping and problem-solving are often used in this approach.

Of the four approaches mentioned, Jehu suggests that social learning theory may offer the most comprehensive framework for behavioural treatment methods. The importance of antecedent experiences, environmental influences and cognitive processes are all considered in this theory with an emphasis on the effects of cognition. The cognitive processes serve a selection function in determining the significance of certain events and their ultimate influence on behaviour. In this theory, a reciprocal rather than causal relationship exists between behaviour and environment, with one influencing the other. The notion of self-efficacy plays a central role in treatment procedures since it is believed that those procedures which can foster the clients' confidence in their own ability to cope with

threatening situations will probably reduce anxiety and avoidance in relation to these and other events, and, if successful, help to maintain behavioural change in the future.

Behavioural Methods

Behavioural methods for treating agoraphobia have been used for over 20 years with varying degrees of success. Until the last 8 years or so, research into the lasting effects of treatment had been decidedly sketchy and few determinants had been isolated which would indicate why some methods have a better short or long-term success rate than others.

Some evidence has now been found to suggest that extinction models involving in vivo (or real-life) exposure techniques may reduce anxiety levels associated with phobic situations to a greater degree than imaginal flooding in short-term outcomes. In long-term outcomes, the results appear to be indistinguishable (Johnston, Lancashire, Mathews, Munby, Shaw and Gelder, 1976). The researchers hypothesize that imaginal rehearsal may increase the probability of an agoraphobic person practicing more between treatment sessions in entering feared situations. Other motivating factors may include: the actual exposure during treatment, perceived progress, and social reinforcement from therapist, friends and family (Mathews, Gelder and Johnston, 1981). Regardless of what does in fact motivate the person to practice, it seems that the practice itself is likely to be a major force in determining outcome (Johnston et al., 1976). More recently, an evaluative review of behavioural treatments for agoraphobia found stronger empirical support for direct exposure treatments compared

to methods involving indirect exposure (Jansson and Öst, 1982).

Theoretical explanations developed to explain the fear-reducing capability of exposure therapy include extinction, self-efficacy and emotional processing. Extinction consists of presenting a conditioned stimulus in the absence of an unconditioned simulus until a conditioned response is reduced or eliminated. In the case of agoraphobia, this means exposing the phobic person to a feared situation until the anxiety experienced in relation to the situation ceases or is at least diminished. Bandura's (1977) theory on self-efficacy proposes that exposure to feared situations leads to changes in a phobic person's expectations of his/her own self-efficacy or ability to cope. The theory of emotional processing advanced by Rachman (1980) suggests that phobic symptoms may be the result of fearful events being incompletely processed in the person's memory. In this view, relaxation exercises may improve the vividness of imagery presented in desensitization, which in turn enhances physiological reactions and, therefore, improves the quality of emotional processing. Exposure, too, may help to complete the emotional processing of fearful events (Jansson and Öst, 1982).

Several studies have employed a comparison of the effects of in vivo exposure (graduated or flooding) to other forms of behavioural treatment such as imaginal flooding (Emmelkamp and Wessels, 1975; Mathews et al., 1976) and cognitive modification (Emmelkamp, Kuipers and Eggeraat, 1978). In both cases, in vivo exposure led to more immediate significant results. In a study comparing the extinction-based method of flooding (imaginal and in vivo) with reinforcement-

based successive approximation (Everaerd, Rijken and Emmelkamp, 1973), both methods appeared to produce a significant improvement on in vivo measurements, phobic anxiety and phobic avoidance scales, and on the fear survey schedule. However, self-observation following treatment by prolonged in vivo exposure added little to the treatment results but did add measurably to the treatment effects of imaginal flooding. According to Jansson and Öst, these results illustrate support for direct exposure over indirect exposure methods.

A study conducted by Chambless, Foa, Groves and Goldstein (1982) compared the effects of imaginal flooding with and without the use of sedation, examined the long-term effects of imaginal flooding without further exposure treatment, explored the impact of communications training for handling conflict with significant others, and considered a comparison of in vivo exposure and imaginal flooding results. It was found that imaginal flooding without sedation was superior to an attention control placebo. In the absence of further in vivo exposure, communications training appeared to have no discernible effects. While in vivo exposure did not show a significant advantage over imaginal flooding on fear and avoidance measures, the researchers had the impression that changes produced by in vivo exposure were more consistent across clients. They also suggested, however, that imaginal flooding may still have an important role to play in effecting change and this role should be further investigated.

Cognitive re-structuring has also been applied in practice to the treatment of agoraphobia (Coleman, 1981) in conjunction with in vivo exposure and the achievement of behavioural goals agreed to by patient

and therapist. Coleman proposed that cognitive intervention should involve dealing not only with irrational thoughts about the consequences of anxiety (and leading to avoidance behaviour) but also with the label the person places on the feared situation in terms of his/her personal notion of self. He suggested that patients be advised to regard their successes in solo real-life exposure as the result of their own efforts and abilities to master the situation, not as the result of something outside themselves. They would be encouraged to overcome their dependence on "props" and "safeguards" (such as the need for the presence of a trusted person when confronting their fears), to take responsibility for their own behaviour, and to become more aware of "critical incidents" in phobic situations which trigger frightening thoughts and lead to a decision to avoid or remain in the situation. Greater awareness of their personal beliefs and outlook on the world and how this culminates in a particular behavioural response could help patients to become more task-oriented and less focused on their emotional reactions to anxiety-producing stimuli.

The cognitive-behavioural treatment of agoraphobia has been investigated by Mavissakalian, Michelson, Greenwald, Kornblith and Greenwald (1983) in comparing specifically paradoxical intention and self-statement training. While paradoxical intention appeared to produce greater changes by the end of treatment, the two treatments were equivalent in their long-term results. The researchers suggested that cognitive-behavioural strategies along with instructions to practice self-directed exposure can be effective in the treatment of agoraphobia. Further research was recommended into the use of training

to recognize and verbalize ongoing thoughts and into the use of cognitive mediational strategies to assist in the maintenance of improvements following the use and cessation of pharmacology. More investigation into patient characteristics might be useful in clarifying how attitudes and mental sets relate to the effectiveness of different cognitive strategies.

Several earlier studies considered the use of paradoxical intention (Ascher, 1981) and self-instructions or self-statements (Gelder, 1977) in treatments for agoraphobia. Ascher investigated the efficacy of paradoxical intention in overcoming the travel restriction for agoraphobia and, based on the comparative results, suggested that paradoxical intention may be a highly useful component in an overall treatment package, adding a focus on coping with a variety of environmental problems.

Gelder (1977) discussed the relationship between agoraphobia and the use of self-instructions. In studies where coping instructions were used by patients during imaginal exposure to feared situations, some evidence was found that such instructions or self-statements mainly affected behaviour in the post-treatment phase. It appeared that learned coping tactics were best put to use when the patients were encountering phobic situations on their own in daily life. If this was so, coping instructions might have a desirable effect on maintenance of improved behaviour in long-term outcomes.

The therapeutic effect of self-exposure instructions for agoraphobic patients was investiaged by McDonald, Sartory, Grey, Cobb, Stern and Marks (1979). An effort was made to evaluate the efficicacy of

self-exposure homework without therapist-initiated exposure to feared situations. Post-test and follow-up results showed a small but significant improvement in favour of the exposure group when compared to a control group receiving training in dealing with marital, family and social difficulties. McDonald et al. found support in these results for the possibility that self-exposure instructions may be enough for the treatment of some agoraphobics while recognizing that therapist-assisted exposure may be additionally required for others. The value of this kind of self-instruction would be supported by Emmelkamp and Cohen-Kettenis (1975) who suggested that an emphasis on self-direction in treatment involving gradual in vivo exposure could foster a sense of personal competence and by Benjamin and Kincey (1977) who concurred with the need for patients to take some responsibility for carrying out the treatment program in order to make it easier for them to transfer new behaviours from the therapeutic environment into their daily routines.

Another cognitive-behavioural strategy--problem-solving-- has been studied by D'Zurilla and Goldfried (1971) and Jannoun, Munby, Catalan and Gelder (1980). D'Zurilla and Goldfried defined problem-solving as a behavioural process or a form of self-control training in which an individual learns how to solve problems (through defining problems; brainstorming, priorizing and selecting solutions; developing a plan of action and evaluating results) and can then discover his/her most effective response. Problem-solving was regarded as a promising approach requiring further investigation but probably useful for cases involving a deficit in effective behaviour. In the later study

conducted by Jannoun et al., problem-solving proved to be an inferior method when compared to a home-based exposure treatment but its utility with some agoraphobics was supported by the fact that one therapist achieved equivalent results with both forms of treatment. This might also point to the importance of possible therapist characteristics involved in the effectiveness of different methods.

Lange (1979) discussed the utility of a cognitive-behavioural assertion training model for use in therapy groups. This model involved a four-stage process including: (1) identification of personal rights, (2) discrimination between unassertive, assertive, and aggressive behaviours, (3) cognitive restructuring, and (4) behaviour rehearsal (p. 158). Responsible assertive behaviour was seen as a major emphasis in this model. While not applying these methods specifically to the treatment of agoraphobics, Lange stressed the importance of learning coping skills which clients could easily transfer to their own environment--a concept considered frequently with relation to agoraphobia and its problems of self-efficacy.

A study comparing the effects of prolonged in vivo exposure, assertive training, and a combination of the two has now been conducted by Emmelkamp, Van der Hout and De Vries (1983). On phobic targets, in vivo exposure was found to produce superior results while assertive training was more effective in producing gains in assertiveness. The combined treatment group resulted in effects that were much the same as those obtained in the in vivo exposure group. Emmelkamp et al. pointed out that while self-efficacy increased by assertiveness training might increase other coping efforts, there is little evidence

to suggest that agoraphobia is the result of a lack of assertiveness. They drew attention to the study by Buglass et al. (1977) which found no difference in levels of assertion between agoraphobic women and controls. Emmelkamp (1980) also reported that the effects of gradual in vivo exposure did not appear to be influenced by level of assertiveness or by marital satisfaction in the particular study conducted.

An important area of concern to researchers studying agoraphobia has been its derivation from or effect upon marital relationships. In addition to Emmelkamp's 1980 study, several other investigators have considered marital conditions in relation to treatment. Barlow, Mavissakalian and Hay (1981), for example, viewed the spouse's perception of phobic severity as a possible variable in effectiveness of treatment. Milton and Hafner (1979) found that patients whose marriages were rated as unsatisfactory prior to treatment improved less during treatment with in vivo exposure and had a higher post-treatment relapse rate than those whose marriages had been rated as satisfactory. Barlow et al. (1981) noted in their study that phobia improvements led to improved marital satisfaction in some cases and to decreased marital satisfaction in others. It would appear that more evidence is needed in order to ascertain whether or not reduction of the phobic condition may contribute to a positive or negative change in marital harmony. If the experience of home-based programs and other treatment plans involving social reinforcement are considered, co-operation and encouragement in the client's immediate environment can be seen as important supports to therapy since

positive reinforcement of therapeutic activities and of improvement is more likely to produce and maintain desired change.

Behavioural Procedures Format

Several investigators have explored the advantages contributed by individual, group and home-based formats for treatment delivery. Hand, LaMontagne and Marks (1974) found that high cohesion groups apparently placed a different amount of social pressure on group participants which seemed to result in more significant improvements when compared to low cohesion groups. Group *in vivo* exposure also produced further gains in social skills and assertion. Another noted benefit of group over individual exposure treatments was the potential saving of therapist time. Teasdale, Walsh, Lancashire and Mathews (1977) attempted to replicate the reported improvements of the Hand et al. study but were unsuccessful. They did, however, confirm the procedure's usefulness in terms of cost-efficiency.

Liberman (1971) also discussed the merits of behavioural group therapy in providing a positive emotional climate which facilitated clients' openness to change. No significant correlation appeared to exist between the amount of symptom improvement and the amount of cohesiveness group clients expressed, but the group in which a therapist used social reinforcement skills to facilitate cohesivensess showed more cohesiveness and what was defined as greater personality change than the comparison group. Gelder (1977) suggested that social reinforcement may contribute to maintaining or increasing improvement after treatment has ended. He further proposed that while treatment in groups with a high level of cohesion may lead to better behaviour

change than situations in which little social reinforcement exists, home treatment programs which strengthen family support and encouragement for the client's efforts to overcome the problem may offer the best prognosis for continued post-treatment change.

Other studies related to aspects of group treatment for agoraphobia included Emmelkamp and Emmelkamp-Benner's (1975) investigation of the effects of historically portrayed modelling and group treatment on self-observation and the research into massed vs. spaced exposure sessions conducted by Foa, Jameson, Turner and Payne (1980). Emmelkamp and Emmelkamp-Benner found that videotaped modelling did not add to the treatment effects of self-observation and that there appeared to be no difference between self-observation administered individually or in groups. Foa et al. found massed practice to be superior to spaced in vivo exposure sessions particularly with respect to avoidance. It was suggested that this might have something to do with lack of opportunity for avoidance during short intervals between sessions.

While it appears on the one hand that variations in the practice format of in vivo exposure (e.g. individual, home-based or group) may be equally effective (Mavissakalian, 1982), there is also evidence to suggest that behavioural group interventions may have several advantages (Sansbury, 1979). Sansbury felt that various potential assets of conducting behaviour therapy in groups had been identified and sometimes supported by research. On this basis, he proposed nine hypotheses concerning the use of groups with the intent of encouraging further investigation:

Hypothesis 1. With the techniques of desensitization, modelling plus reinforcement, and flooding, group approaches to treatment will save therapist time and effort with equal or increased effectiveness.

Hypothesis 2. The availability of multiple models which display the acquisition of coping skills to a range of problems will increase member motivation to change and will enhance behavior change.

Hypothesis 3. In comparison with individual behavior therapy, a more thorough behavioral analysis is possible in behavioral group therapy.

Hypothesis 4. In comparison with individual behavior therapy, there are lessened feelings of isolation and uniqueness of individual problems experienced in behavioral group therapy, which results in a lowering of initial anxiety.

Hypothesis 5. Knowledge that others are experiencing the same treatment procedures increases feelings of confidence in the treatment and increases motivation to continue treatment.

Hypothesis 6. Having others observe one's progress increases motivation to do well, leading to increased likelihood of entering into the more anxiety-provoking aspects of the treatment.

Hypothesis 7. Discussions of anxiety-provoking topics in a supportive group environment act as a mild form of desensitization.

Hypothesis 8. In a group context, discrimination learning is enhanced because of the variety of feedback sources available.

Hypothesis 9. In comparison with individual behavior therapy, new coping behaviors learned in behavioral group therapy will generalize to a wider range of situations (p. 48).

Several forms of research have pointed to the possibility that a client may be exposed to feared situations with other forms of help than that provided by a specialized therapist or psychiatrist. Highly motivated patients can carry out in vivo exposure by themselves if properly instructed (Jansson and Öst, 1982). Husbands can be instructed to carry out in vivo exposure successfully with their agoraphobic

wives (Barlow, Mavissakalian and Schofield, 1980). A supported-exposure technique using former phobics to guide phobics into fearful situations and to teach them fear-reducing techniques has been discussed as a highly viable and low-cost approach (Ross, 1980) and the augmentation of in vivo exposure treatment for agoraphobia through the formation of neighbourhood self-help groups designed to foster cohesion and alleviate social isolation has shown positive results (Sinnott, Jones, Scott-Fordham and Woodward, 1981). In the last case, it was hypothesized that neighbourhood zoning of patients selected for group treatment might help to extend treatment and its effects into the patients' environment as is done in home-based treatments. The value of self-help groups for agoraphobics has also been supported by the sponsorship of some mental health organizations (Maccabee, 1982).

Specific home-based exposure programs utilizing the assistance of a spouse or friend have been evaluated by Mathews, Teasdale, Munby, Johnston and Shaw (1977) and by Jannoun, Munby, Catalan and Gelder (1980). Subjects of the controlled study conducted by Mathews et al. showed improvements on clinical ratings, self-report and behavioural measures after treatment and to a greater degree at six-month follow-up. Similar results were obtained by Jannoun et al. providing the same treatment but reducing therapist time in this case from 7 to 3.5 hours. In addition, the home-based programmed practice approach designed by Mathews et al. (1981) shows evidence of being as effective as therapist-assisted methods (Mavissakalian, 1982).

The usefulness of behaviour therapy, particularly of in vivo exposure, has been amply demonstrated for women who comprise the

majority of agoraphobics. Little work has been done, however, on the efficacy of this form of treatment for men. Liotti and Guidano (1976) found that agoraphobic men may not respond well to behaviour therapy particularly in those situations where they have difficulty being alone or where they are consistently preoccupied with fears about their respiratory or cardiovascular functions. In exploring the problem further, Hafner (1983) compared the reactions of matched groups of male and female agoraphobics to a standardized behaviour therapy program involving graded in vivo exposure to feared situations. The results of this study showed that while exposure-based therapy is, on the whole, less acceptable to men than to women, approximately 50% of the men do find it acceptable and persist with therapy. These men ultimately benefit as much as the women. The agoraphobic men who may not tolerate exposure therapy as well appear to be those who show a marked degree of hypochondriasis and fears of being alone. This group may require an alternative form of treatment.

Overall, it seems that in vivo exposure is regarded as an important if not essential component of behavioural treatment for agoraphobia which is highly effective for women and to a lesser degree for men. The effects of in vivo exposure may be augmented by procedural formats which foster social reinforcement for continued practice and help to reduce the phobic's feeling of isolation.

Other Methods Combined with a Behavioural Approach: Drug Therapy

The use of anti-anxiety, anti-panic or antidepressant pharmacological agents as a supplement to behaviour or cognitive-behaviour therapy has received increasing interest and attention in recent years.

Exposure methods in particular have been evaluated in combination with the use of drugs such as diazepam (Johnston and Gath, 1973; Hafner and Marks, 1976), propranolol (Hafner and Milton, 1977) and imipramine (Zitrin, Klein and Woerner, 1980).

Johnston and Gath found diazepam-assisted flooding to be more effective than flooding without the drug. Hafner and Marks, on the other hand, found no significant outcome differences between waning diazepam, peak diazepam and a placebo although waning diazepam appeared to create the least discomfort during treatment. A one-third relapse rate was recorded at one-year follow-up. In the propranolol study, the drug appeared to have an adverse effect on improvement. The imipramine group did better on outcome measures than a placebo group but showed a much higher relapse rate at a six-month follow-up. It appears that some drugs may be useful in facilitating practice in vivo but may have a negative effect on the maintenance of behavioural improvements in the long-term. The in vivo exposure itself emerges as the more significant element in treatment.

Long-Term Efficacy of Treatment

Several long-term studies have been conducted to determine changes in phobic behaviour following behavioural treatment for agoraphobia.

Hafner (1976) assessed the results of an intensive 4-day treatment program for 39 agoraphobics. The results indicated that 26 patients showed fresh symptom emergence in the follow-up period and 18% of the sample appeared to be affected negatively by treatment. There proved to be a much higher drop-out rate for those involved in individual treatment as opposed to those treated in groups.

A study done by Emmelkamp and Kuipers (1979) found that of the 70 patients considered, 75% had improved on the main phobia at follow-up 4 years after treatment. No other neurotic symptoms had developed in the interim between treatment and follow-up and no relationship could be determined between the follow-up results and external locus of control, social anxiety, depression, or the duration of the complaint at the start of treatment.

The research conducted by Munby and Johnston (1980) also indicated positive long-term outcomes. In this case, 95% of the 66 agoraphobic patients treated were re-examined five to nine years later. Patients had improved on most measures of agoraphobia compared to the pre-treatment period but it appeared that little change had occurred since the six month follow-up, according to assessor's ratings. The patient's self-ratings, however, indicated some slight improvements from six months to the later follow-up. Evidence of symptom substitution was not found in this study.

McPherson, Brougham and McLaren (1980) examined agoraphobic patients who had improved with behavioural treatment. At follow-up (an average of 4.3 years after treatment), only one of the 56 patients reported new symptom emergence, while 10 described themselves as symptom-free. Most of the others found what symptoms remained only mildly distressing or disruptive. The results suggested that improvement was maintained from treatment to follow-up on all the assessment variables.

As noted in Jansson and Öst's (1982) review, intensive exposure treatments for agoraphobia appear to have a higher relapse rate while

treatments involving extensive exposure result in more lasting improvements in the phobic condition. The reviewers also concluded that the more consistently successful treatments seemed to be those which involved direct exposure either alone or in combination with other forms of therapy. In coming to this conclusion, Jansson and Öst considered 21 different group studies involving about 400 agoraphobic patients and all utilizing some form of direct exposure treatment.

Summary

The literature not only strongly supports the use of behavioural methods in the treatment of agoraphobia but also suggests *in vivo* exposure as the specific intervention of choice. There is now further evidence that some of the strategies characteristic of cognitive-behavioural therapy (e.g. cognitive re-structuring, self instructional training and problem-solving related to self-efficacy) can be beneficial adjuncts to the basic *in vivo* component. It has been acknowledged that some agoraphobics do not respond to exposure methods and that cognitive treatments might prove useful in these cases (Mathews, Gelder and Johnston, 1981). Additionally, treatment formats which increase social reinforcement to practice and help to decrease the phobic's sense of isolation (e.g. group and home-based programs) may provide an important dimension which promotes continued improvement. These were the central features of the literature which supported the selected design and delivery of the practicum treatment program.

The value of this particular learning experience for the field of social work can be illustrated in several ways. First of all, it provides an opportunity to participate in co-therapy and to engage in

group work involving program development, implementation, operation and follow-up. It also presents a first-hand introduction to the dynamics of small groups. The prevalence of anxiety disorders and phobic conditions in the general population, makes the information related to cause and treatment gained in the practicum particularly useful for social work practice.

While the treatments used are behaviourally-focused there are several advantages to this. Other methods of treatment for agoraphobia were investigated and discarded as less effective in this case based on the literature. Behavioural methods can and often are used in conjunction with other forms of treatment. Specific strategies (such as relaxation training, discussion related to assertiveness, coping tactics and cognitive re-structuring) are well documented, clearly defined, as well as practical and can be used in a variety of situations. The context of the clients' environment was also considered important as evidenced by the involvement of significant others.

In addition, behavioural and cognitive-behavioural interventions are now being used more frequently in social work situations and their effectiveness supported in social work literature. Berlin (1982) has suggested that the cognitive-behavioural perspective of human functioning offers "an explanation of the impact of social problems on individuals and of individuals on social problems." She feels that by its emphasis on the interaction of person and environment in preventing or promoting change, the cognitive-behavioural approach "can provide a theoretical framework for all direct-practice efforts in the field of social work" (p. 225).

Thyer (1983) addresses the use of exposure therapy in the treatment of phobias and anxiety-related disorders. He refers to empirical research demonstrating the efficacy of exposure techniques over conventional psychotherapy and use of medication. He also notes that while severe depression or the presence of organic problems may contraindicate the use of exposure therapy in some cases, this form of treatment generally holds promise for improving the psychosocial functioning of clients with anxiety disorders. Since "social work, as a professional discipline, mandates the employment of practice techniques of proven efficacy whenever possible," Thyer contends that "social workers who add the theory and practice of exposure therapy to their repertoire of practice skills will be in a better position to make a social contribution to the improvement of their clients' quality of life and interpersonal functioning" (p. 82).

There seems to be little question about the potential value of behaviour therapy or cognitive-behavior therapy and their specific techniques to the field of social work practice. It remains for the social worker to apply these creatively and realistically, singly or in combination with other methods, to meet the particular needs of individual clients.

METHOD

Location and Time-Frame

The Behavioural Group Treatment Program for Agoraphobia presented in this report was organized and operated through the Psychological Service Centre (P.S.C.) at the University of Manitoba from April 7 through June 8, 1982 with follow-up sessions on July 28 and November 3, 1982. A booster session was also held at the request of the clients on June 23 in the form of a community outing. This was an informal gathering and no measurements were taken.

The sessions were held primarily at the P.S.C., with the Centre acting as a base in instances where *in vivo* exposure was instigated. Ten weekly sessions were conducted as part of the treatment phase, one each Wednesday evening except for the final session which was held on a Tuesday evening in order to accommodate a special event for one client. The sessions varied in length from two to four hours, depending on the content, with the average session running over 2 1/2 hours.

While successful treatment was not guaranteed and the program was not designed to provide a complete "cure" for agoraphobia, it was understood that the program and its therapists would endeavour to teach skills which would help the clients to cope better with and/or change their related problematic behaviour and assist them in attempting to attain their treatment goals.

Clients

The Group Treatment Program began on April 7, 1982 with seven clients, four females and three males. One female client dropped

out of the program after two weeks leaving six clients who completed the treatment phase. Although initial assessment information will be provided for the client who left, the following introductory data will be representative only of those six clients who remained in the program.

Far from being a homogeneous group, the clients presented a wide diversity of age, occupation, and marital status. They ranged in age from 20 to 66 years. Exact ages at the outset of the program were: 20, 26, 28, 30, 35 and 66 years. Two of the clients worked full-time outside the home (one male, one female); one client (female) worked part-time outside the home. Four of the clients in the program were married (one male, three females). Two of these had minor children at home; one had an adult child. The two remaining clients were single, one living at home with relatives and one living away from home.

The duration of the problem for individual clients, where this could be determined, varied considerably within the group. It ranged from approximately 20 years or more to less than two years. Precipitating events also varied. These events were ones which the clients viewed as special occurrences that seemed to precede or coincide with their earliest recollections of the problem or with difficulties such as avoidance behaviour which appeared to them to relate to their present problem. Events suggested were loss of a child and care of an elderly parent, the difficult birth of a child, a stressful vacation trip, dropping out of school as a teenager due to difficulty in understanding academic work, avoidance

of any stressful situations in childhood aided by an over-protective parent, and feigning sickness as a pre-teen in order to avoid going to school. In one case, the debilitating illnesses of both parents seemed to have made some contribution to the onset and maintenance of avoidance behaviour.

When the program began, four of the six clients were taking medication related to the problem for which they sought treatment in the group. In three cases, this involved tranquilizers only; in one case, anti-depressants had also been prescribed as well as medication for other medical problems. Two clients were not taking medication of any kind. Although the clients were not asked to cease taking medication at the outset, it was understood that they would attempt to reduce or discontinue use of medication related to anxiety in phobic situations, as the program progressed.

Previous treatment sought or administered in relation to the present problem ranged from consulting a physician to hospitalization. All clients had consulted a physician, usually the family practitioner, at some point with regard to tension, anxiety or related physical difficulties. One client had participated in an anxiety relief self-help group, had been seen by a behaviour therapist and had consulted a psychiatrist, at various times. Another had been hospitalized on the basis of a psychiatric diagnosis of schizophrenia and placed on heavy medication. This diagnosis was later reversed. One client had consulted a mental health worker and a psychiatrist at a community clinic and another had consulted a doctor, a chiropractor (for tension) and a therapist at the

Psychological Service Centre. One client had participated in a therapy group and had been seen by three previous therapists at the Psychological Service Centre for related and possibly unrelated problems. At the time of entering the group, this client was consulting another P.S.C. therapist and planned to continue concurrently with individual therapy.

The six clients who participated in the Group Treatment Program were referred from several different sources. Two were referred by their individual therapists from within the Psychological Service Centre. One was referred by a family physician, and one by a community mental health worker. One client called the Canadian Mental Health Association and was referred from there to an agoraphobia treatment program at St. Boniface Hospital. As that program had reached capacity, the client was referred to the Psychological Service Centre and then to this Treatment Group. One client learned of the program through a newspaper article and telephoned the Psychological Service Centre to inquire about it.

Therapists

The therapists who conducted the Group Treatment Program were two graduate students doing clinical work through the Psychological Service Centre under the supervision of Professor Derek Jehu. One student was engaged in a Masters practicum in Social Work. The other was in the process of obtaining a Ph.D. in Clinical Psychology.

The therapists described their role in the treatment program as that of group leaders or consultants, thus emphasizing the need for full participation on the part of the clients in making choices,

determining individual treatment goals, practising between sessions in entering fearful situations, and taking responsibility for following a course of treatment with assistance from the therapists. The clients were informed from the outset of the status and expected role of the therapists and themselves in the program through discussion and a Statement of Intent (see Appendix A).

Criteria for Admission

Potential clients were screened in advance through individual interviews. The criteria considered as the basis for admission to the program consisted of:

(a) the presence of anticipatory fear or "fear of fear" associated with phobic situations or activities and involving anxiety over losing control, going insane, cardiac arrest, fainting and/or public humiliation due to disinhibited behaviour;

(b) the occurrence of anxiety attacks or panic attacks involving some or all of the following: heart palpitations, rapid or difficult breathing, shaking, sweaty palms, dry mouth, fainting or feeling faint;

(c) the presence of avoidance behaviour--either actual avoidance of or a strong desire to avoid feared situations;

(d) anxiety occurring in relation to specific situations such as restaurants, theatres, line-ups or queues, supermarkets, department stores, shopping malls, dentist or hairdressers' chairs, and buses;

(e) the presence of client motivation as exemplified by a desire to overcome at least some of the problems or restrictions resulting from the phobia, and an initial willingness to attend the weekly group sessions, to participate in practice activities, and to complete homework assignments.

In addition to the preceding criteria, some information was also sought during the screening interviews concerning: previous treatment related to the phobia; medication taken for anxiety or for

unrelated medical problems; factors that affect the level or degree of anxiety (for example, the presence of a trusted person); the attitudes of close friends and/or family members to the phobic condition and to the potential client's participation in the treatment program; and what the person would like to be able to do if the phobia were modified or eliminated.

Assessment

Because potential clients became known to the therapists and were interviewed at varying intervals prior to the first group session, a pre-test was not conducted nor a baseline measurement established prior to the treatment phase. The first group session was, however, treated much like a pre-test in that, following brief introductory remarks, all pertinent paper-and-pencil tests and self-report forms were administered. The Behavioural Diary was instituted from the first session onwards. In the section which follows, the various instruments employed in assessment will be described, along with an indication of their temporal use and utility.

At the outset of the program, two measurement instruments were considered central to an evaluation of the initial phobic condition as well as changes occurring during and after treatment: a Fear Questionnaire and a Behavioural Diary.

Fear Questionnaire

The Fear Questionnaire used in the program (see Appendix B) was a modified version of the self-rating form for phobic patients designed by Marks and Mathews (1979). The Marks and Mathews

questionnaire was organized into sections yielding four scores: main phobia, global phobia, anxiety-depression, and a total phobia score composed of agoraphobia, blood-injury and social phobia sub-scale scores. On this form clients are asked to indicate the degree to which they would avoid 15 specified phobic situations as well as their own major area of fear, how troublesome they find five anxiety-depression symptoms (described by the authors in their article as common nonphobic symptoms indicating general affective disturbance), and how disturbing or disabling they find the present state of their phobic symptoms, on a scale of 0 - 8.

The Fear Questionnaire in its modified form (Walker, Rowan, Evans, Kelmon and Atkinson, Note 1) retains the same sections and scales as the original with some changes made to the client instructions for purposes of clarity. The spaces left on the original form for a description of other feelings or other situations were omitted as extraneous since they did not form part of any of the scores. The 15 phobic situations listed in addition to "Main Phobia" remained the same except for number 5 which was changed from "travelling alone by bus or coach" to read "travelling alone by bus." Essentially, the changes made were an attempt to "Canadianize" a report form of British derivation, to make instructions more clear, and also served to de-emphasize a medical model approach to the problem by the removal of such terms as "symptoms" and "disabling"--an important consideration in light of the behavioural learning view stressed in this program.

The only difficulties experienced in the use of this form

occurred in the Main Phobia and state of anxiety "at this moment" sections. Clients described their main phobia with great variety--from agoraphobia, to fear of fear, to attending a specific social function. Although the same main phobia was to be retained on subsequent forms, clients sometimes wanted to change it, apparently having re-evaluated the problems they found most distressing. The other difficulty may have resulted from a wording change in the state of anxiety section, from rating "the present state of your phobic symptoms" (original) to rating "the state of your anxiety at this moment" (modified) but it is likely a problem could have occurred in either case. Clients had difficulty deciding whether this meant a rating of their state while completing the form or a rating of their current state in a more general way.

Marks and Mathews (1979) described their "Brief Standard Self-rating for Phobic Patients" as "short, reliable and valid" (p. 263). The form is also sensitive to improvement occurring after treatment. The Fear Questionnaire used in the program is a modified version of this form in which the wording of some instructions has been changed for reasons of clarity but the basic intent of the questions, and the original scales, have been maintained. Although test-retest reliability and validity were acceptably established for the original form, it is recognized that these may not hold for the modification.

The Fear Questionnaire was able to provide a good general indication of fluctuations in mood and phobic behaviour as perceived by the clients as well as a measurement of change or progress over

time. The Questionnaire was completed five times--in the first, mid-point and final sessions of treatment as well as at follow-up on July 28 and November 3.

Behavioural Diary

The Behavioural Diary, a repeated, self-report record, was kept by the participants to describe activity between sessions. A modified version of the Behavioural Diary Sheet illustrated in Mathews, Gelder and Johnston (1981) was used for daily self-reports on time spent outside of the home, distance travelled (accompanied or alone), method of travel (walk, car, bus, other), medication used, and level of anxiety experienced on a Subjective Units of Discomfort (SUDS) rating scale of 0 - 100. The modified version (see Appendix C) was constructed by the group therapists in order to clarify some items and to incorporate the SUDS scale of anxiety rating developed in 1966 by Wolpe and Lazarus (cited in Kanfor and Goldstein, 1980, p. 178), which formed part of the treatment procedures. The Behavioural Diary sheets were distributed in the first session and completed by the group participants on an ongoing basis throughout nine weeks of treatment.

Mathews, Gelder and Johnston (1981) reported that time spent away from home could be a satisfactory and apparently valid measure of agoraphobia especially if time spent at work or on social visits could be excluded. It could be used as a supplement to the Fear Questionnaire providing more accurate information on the clients' actual avoidance behaviour. Scoring of this measurement necessitates consistent recording by clients and some means of separating time

spent at work or on social visits from other time spent away from home.

While the Behavioural Diary proved to be a useful tool for clients in gaining a greater understanding of their own behaviour and state of anxiety in certain situations over time, and also proved a valuable reinforcement method for encouraging clients to enter more fearful situations, it was difficult to use for an accurate indication of significant time spent out of the home. This was due to two main factors concerning record-keeping and the nature of the group itself.

Some clients, especially those already engaged in a variety of outside activity, had difficulty keeping track of the actual time spent outside. A single day might involve several trips from place to place, some of these being highly anxiety-provoking, some not. For those who worked, the workplace could be anxiety-provoking all or part of the time or not at all. Trips away from the workplace could be a major source of stress, while the workplace itself was not regarded as a major anxiety problem. For one client, a car was regarded as a safe place more or less equivalent to being at home, even while driving. For another, driving a car alone was especially stressful. For still others, any move outside their homes was regarded as a significant problem.

This information, combined with the fact that clients sometimes forgot how much time they spent engaged in a particular activity, made it difficult to set up a method of recording which would apply to everyone and produce consistent recording of data on time spent

away from home. Attempts were made to correct record-keeping problems as they were discovered but the suggestions came too late for the earlier diary sheets and were sometimes interpreted differently in the actual recordings.

As a result, no empirical validity was assumed for measures obtained from the Behavioural Diary. It was used to gain a general indication of the type and number of outside trips and variations in accompanying anxiety levels throughout the ten weeks of treatment. In order to supplement this information, a consumer evaluation form was instituted to provide more client feedback on progress perceived during and following the treatment period.

Client Evaluation Form

Similar client evaluations were completed at mid-point (May 5) and at termination (June 8). The June 8 evaluation form is reproduced in Appendix D. These forms included a look at the past as well as the present in terms of phobic state and asked for an indication of whether or not the past problems cited had increased or decreased and why. Also requested was an evaluation of different segments of the program as well as comments or suggestions.

The July 28 evaluation (see Appendix E) contained many of the same elements as the first two but worded more appropriately for follow-up. It also asked for comments on the most helpful and least helpful aspects of the program and whether or not the group treatment program was considered a valuable experience. The November 3 evaluation (see Appendix F) requested an indication of whether the problem with agoraphobia had increased, decreased or remained the

same during treatment and follow-up, and since the July 28 follow-up session. A possible explanation of change or lack of change was also requested.*

As they were designed strictly for use in this program as the need arose, validity and reliability were not established for the Client Evaluation Forms. Since several of the evaluation forms contained questions relating to perception of phobic state before treatment, it was possible to establish if responses concerning change were made in comparison with a consistent perception of pre-treatment feelings and behaviour. This tended to lend support and clarity to the client's view of his/her progress at specific points in time. The information from these forms was also useful in adding depth to the data obtained at the same time from other report forms, particularly the Fear Questionnaire and the Behavioural Diary.

The main advantages of the Client Evaluation Forms were the opportunity for clients to describe in their own words the state of their phobia before, during and after treatment, and to make a close comparison between them. From discussion it was learned that the clients found the retrospective view of pre-treatment conditions somewhat disturbing due to the anxious memories aroused. When, however, this was followed by a look at what had happened since treatment began, it was possible to feel more optimistic about the likelihood of change. For the most part, clients completed the evaluation forms in a thoughtful and realistic way, providing information on setbacks as well as progress.

*The treatment phase of the program ran for ten sessions or nine weeks. However, because, in group discussions, treatment was usually referred to as being of ten "weeks" duration, the questions on the evaluation forms were worded accordingly and the responses noted later will reflect this perception.

Supplementary Assessment Forms

In order to establish a general personality profile and provide information on individual needs to aid in weekly program planning, several other assessment forms were completed by the participants during the first treatment session. This material was not considered essential to treatment but served to add some depth and specificity to procedures used. By administering several of these forms in the final session and at follow-up (July 28), it was hoped an indication would be gained of the effects of the program on mood, anxiety, cognitive reactions, and the behavioural targets of individual treatment procedures such as relaxation training and discussion on assertiveness. Following is a brief outline of the supplementary assessment forms and when they were administered in the program.

Crown-Crisp Experiential Index. The Crown-Crisp Experiential Index (Crown and Crisp, 1979) was designed to provide a measure of general emotionality as well as measures of six sub-scale dimensions: free-floating anxiety, phobic anxiety, obsessionality, somatic anxiety, depression and hysteria. The form itself (see Appendix G) contains 48 questions with eight different questions corresponding to each of the sub-scale dimensions. The questions appear to be randomly arranged. The Index can be used with literate subjects representing a wide range of age and intelligence.

Acceptable levels of validity and reliability have been established on the basis of several criteria for the Index. Although test results are considered to be repeatable and consistent over time, they are regarded as reliable with the proviso that no major

changes in the client's life or situation have occurred between testings. The Index is designed to be used for diagnostic purposes and as a measurement of change before or after a defined intervention. While the whole form was completed, only those results applying to anxiety and depression have been reported.

The measures of interest for this program were four of the six sub-scale dimension results--those referring to free-floating anxiety, phobic anxiety, somatic anxiety and depression, with an emphasis on the first two. The hysteria component seems to be related to sociability or extraversion, particularly in young people, but there was some uncertainty in the Index Manual about how this related to the concept of hysterical personality. Obsessive behaviour was not dealt with in the context of the group. The results from these two sub-scales has, therefore, been excluded.

The free-floating anxiety dimension of the Index refers to an indefinable dread or fear of nonspecific origin, while phobic anxiety is experienced in specific situations such as those of crowds, heights, illness, enclosed spaces and going out alone. The Index is concerned with several phobic areas, not agoraphobia per se. Physiological complaints such as breathlessness, headaches, dizziness, sleep disturbance, palpitations and digestive problems are dealt with in the somatic anxiety dimension. The depression dimension focuses on sadness of mood and slowing of activity and thinking processes. All of these dimensions were scored on a scale of 0 - 16.

The free-floating anxiety sub-scale has proved reliable and valid in a variety of investigations and the phobic sub-scale has

been shown to identify phobic anxiety states particularly well. The Index as a whole, was administered in the first and last sessions of treatment (April 7 and June 8) and at the July 28 follow-up.

Depressive Behavior Survey Schedule. In the Depressive Behavior Survey Schedule (Cautela, 1977), clients are asked to rate, on a scale of one (not at all) to 5 (very frequently), the frequency of various thoughts and feelings (e.g. feelings of loneliness), somatic complaints (e.g. poor appetite), decreased activities, decreased enjoyment of activities, increased undesirable activities (e.g. crying), and problems in decision-making, concentrating and relating. The Depressive Behavior Survey Schedule is reproduced in Appendix H.

The results of the Schedule in the six sub-categories described were tabulated as a percentage of a maximum possible rating (M.P.R.) based on the actual number of responses made by each individual times the highest possible rating (5) on a scale of 1 - 5. The maximum possible rating was derived from actual responses rather than from the total number of responses required in each category of the test because, in many cases, items were omitted as not applicable and, in one case in particular, some items were rated twice with subsequent items left blank, making consistent scoring difficult if not impossible. Also, there is a wide variance in the number of items which fall into each sub-category (22 in one instance, three in another) making a percentage of ratings a better method

for comparison between the sub-categories.

Because of the omissions and differences in rating, the results of the Schedule are compared with some caution. In the group data, comparisons are made only between individual results which were consistent--with the number of responses and the maximum possible ratings for the selected sub-categories being equal to the number of responses required and to the maximum score possible if the Schedule were completed in full. Results on this Schedule were obtained on April 7 (first treatment session), June 8 (last treatment session) and at follow-up (July 28).

The problems involved in the use of this Schedule could be the result of several factors. There were items on the Schedule related to activities in which some clients were not engaged, notably items referring to not enjoying school or not enjoying work. In responding to these items, a client might give a rating based on their feelings if they were engaged in the particular activity or leave the item blank or mark it "not applicable" if they felt the question was inappropriate for them. Attempts were made to correct this problem when it was discovered, however, not all clients followed instructions consistently (e.g. instead of marking the item "not applicable," they might just leave it blank). A second factor to be considered was the fact that this form was completed at the same time as several others probably making the experience more tiring when combined with high anxiety levels. A third factor involved the nature of the form itself. Items are spaced fairly close together and there are 43 of them making completion of the form

somewhat more difficult especially for those with sight problems. Two of the clients needed reading glasses for close work. One of these quite often forgot to bring them. This information becomes a little more significant when compared with the results of other forms completed at the same time. Similar problems were encountered, for example, with the Social Anxiety Survey Schedule which has 34 items, rated on a like scale. Few, if any, ommissions were discovered in the other forms completed.

Social Anxiety Survey Schedule. The Social Anxiety Survey Schedule (Cautela, 1977) requests a rating of anxiety or discomfort level on a one to five Likert scale (none at all to very much). These ratings are applied to 34 situations such as being with males or females, speaking to groups, lulls in conversations, and situations requiring assertive behaviour. The Schedule can actually be divided into 15 sub-categories related to different aspects of various social situations, with the 34 items sometimes falling into more than one sub-category.

For the purposes of this program, the Social Anxiety Survey Schedule (see Appendix I) was used only to obtain a general idea about decreases or increases in anxiety or discomfort levels across the 34 items during treatment and follow-up. The form was administered in the first session (April 7) and last session (June 8) of treatment and on July 28 (follow-up).

Assertive Behavior Survey Schedule. Clients were asked to rate (on a one to three basis) the degree of assertiveness they would express in various social situations listed in Section I of

the Assertive Behavior Survey Schedule (Cautela and Upper, 1976). Information is also sought on the feared and anticipated consequences of assertive behaviour (Section III) and on how clients would respond to significant others when they feel they are giving more than they receive (Section IV). The three possible responses in Section IV were given an arbitrary rating of 6, 12 or 18 depending upon the degree of assertiveness of the chosen response. The responses in Section I were added to produce a total rating from 6 (properly assertive) to 18 (nonassertive). Section II requested anticipated responses to assertive behaviour with a particular individual. This Section was not rated for the purposes of this program.

The Assertive Behavior Survey Schedule (see Appendix J) was used to gain some insight into the effects of a session focusing on aspects of assertiveness. It was administered in the first and last treatment sessions (April 7 and June 8) and at follow-up (July 28). To some degree, the responses to Section III acted as a check on the responses to Section I since a client might respond assertively in Section I based on new information learned during treatment but might still indicate, in Section III, a fear and anticipation of several consequences to behaving assertively.

Cues for Tension and Anxiety Survey Schedule. Another vehicle for assessment is the Cues for Tension and Anxiety Survey Schedule (Cautela and Upper, 1976) which provides information on automatic responses, voluntary motor responses, and behaviour related to panic attacks. This Schedule (see Appendix K) was administered only once, in the first treatment session. It was used to gain some background

material for relaxation training and to help clients to increase their awareness of physiological responses to anxiety and stress.

Significant Other Evaluation Form. In order to provide some "outside" feedback, an Evaluation Form for Signicant Others was devised by the group therapists (see Appendix L). This form was handed out on July 28 along with a return envelope. Clients were requested to give it to someone close to them and in a position to observe changes in their phobic behaviour. Preferably, although not necessarily, this form would be distributed to those significant others attending an earlier group meeting whose co-operation in providing feedback had already been assured.

With the exception of the Crown-Crisp Experiential Index, the supplementary assessment forms have not undergone rigorous, published testing for validity and reliability. Those forms administered in the first and last sessions of treatment and at follow-up (Social Anxiety, Depressive Behavior and Assertive Behavior Survey Schedules) were used to provide a further indication of the effects of the program on client mood and some behavioural targets. The Cues for Tension and Anxiety Survey Schedule was administered only once, at the beginning of treatment, to obtain information of each client's state of tension and anxiety and how clients coped with these problems on an individual basis. This data was sought for use in the relaxation training component initiated later in the program. While all of these forms have been utilized frequently and found valuable in clinical practice, only face validity was assumed for assessment purposes in light of the lack of more in-depth testing. As with the

Client Evaluation Forms, validity and reliability were not determined for the Significant Other Evaluation Form which was designed to meet the needs of this particular program and not subjected to prior testing.

Treatment

Assumptions of Treatment

The particular methodology chosen for this program was based on the supportive literature previously discussed. The program was, therefore, designed and organized around several assumptions.

First of all, it was assumed that *in vivo* exposure is a central, if not necessary, part of the process of treatment for agoraphobia. If the fear of a given phobic situation is to be reduced, and in order to minimize or overcome the restrictive effects of the phobia, the fears must be confronted and the resultant anxiety diminished in real-life settings. Skill-learning and the development of new cognitions related to anxiety and general life experience were viewed as helpful and sometimes necessary adjuncts to the *in vivo* aspect of therapy.

It was also assumed that the clients must be motivated to some degree to overcome their agoraphobia and that other circumstances in their lives were neither offering greater rewards nor were in some way preventing them, physically or psychologically, from the necessary behavioural change. This form of treatment places the bulk of responsibility on the client for his or her own actions and choices. At the same time, it was also recognized that environmental influences could make the process of change more difficult.

The support of significant others was seen as beneficial in the development and particularly in the maintenance of desired new behaviours. The focus of the program was, however, assumed to be the group's participants and agoraphobia as a separate behavioural issue, apart from other family or personal problems.

The Group Treatment Program was not designed to effect a "cure." It was hoped that the clients would gain enough skills and information to enable them to take charge of their own situations to a greater extent. It was further expected that providing this kind of treatment on a group as opposed to individual basis would afford a stronger degree of emotional support, increase motivation, and lessen the sense of isolation usually experienced by agoraphobic persons.

The therapists assumed the roles of group leaders, consultants or educators and morale supporters, stressing the importance of the client's part in overcoming the problem. It was hoped that any potential dependency on the therapists might, thus, be avoided or diminished. Occasional setbacks were regarded as a normal aspect of behaviour change, and repeated, self-directed practice was considered the foundation-stone for the reduction of fear.

Intervention Strategies

Exposure treatments are generally based on an extinction model whereby clients are exposed to a phobic situation until extinction of the phobic reaction occurs. It seems to be accepted that complete eradication of phobic reaction may not occur during treatment although an effort is made to ensure that the intense anxiety experienced in relation to phobic situations is substantially reduced. Complete

extinction of the phobia appears to have much to do with the length of treatment and/or the amount the phobic person practices in vivo exposure during, between and after treatment sessions with emphasis on the second condition.

Gradual in vivo exposure refers to the exposure of the phobic individual to fearful situations in real-life settings based on a graduated hierarchy of increasingly difficult circumstances compiled in advance with input from the client. The client is expected to remain in each situation long enough to notice a significant reduction of phobic anxiety.

The total treatment package for this program was built around the central method of gradual in vivo exposure and was intended to facilitate self-directed practice. Several procedures were employed to this end and were introduced at various strategic points in the program as follows:

Statement of intent. In lieu of a behavioural contract, a Statement of Intent (see Appendix A) was read and signed in the first treatment session. This statement was designed to provide a general outline of the activities proposed as well as expectations for clients and therapists in the program. Provision was also made for some flexibility in the order, timing and nature of events where this might be needed.

Discrimination training. Program participants were taught how to rate their anxiety levels on a Subjective Units of Discomfort Scale (SUDS) of 0 - 100 (Wolpe and Lazarus, 1966 cited in Kanfor and Goldstein, 1980, p. 178). The use of this scale was initiated in

the first session and reinforced through practice in subsequent sessions. The same scale was used for recording of anxiety levels in the Behavioural Diary.

Specification of individual target goals. In the second session of treatment, the clients were asked to construct a hierarchy of eight to ten phobic situations which they wished to master. The goals of the hierarchy were rated on the SUDS scale according to the amount of anxiety they produced. The target goals having a rating of 50 SUDS or more were to form the basis of *in vivo* practice. The group leaders attempted to establish some consensus of goals which could be applied to *in vivo* experiences organized for later group sessions. The individual hierarchies were reviewed at the end of treatment and at follow-up (July 28), when the clients were asked to rate the phobic situations again according to their current perceptions of the discomfort experienced in regard to those situations. At follow-up they were also asked to indicate those targets they felt they had accomplished satisfactorily.

Cognitive re-structuring. This procedure was utilized to some degree throughout the course of treatment. Efforts were directed towards the identification of catastrophic thinking about the results of anxiety and automatic thought patterns related to a lack of self-efficacy. In order to help the participants identify dysfunctional thoughts and emotions contributing to their phobia, a triple-column daily record sheet was handed out during one of the middle sessions. This method of recording was based on the concepts of Weekes (1978) and was illustrated and described by Coleman (1981). Completion of

the form was considered optional for this program.

Cognitive re-structuring procedures were also supplemented by the use of several other hand-outs. The client manual outlined in Agoraphobia: Nature and Treatment (Mathews, Gelder and Johnston, 1981) provided useful background information on causes, effects and treatment of agoraphobia.

Tactics for coping with panic and anxiety. The pertinent tactics were taught before in vivo exposure was initiated in treatment, beginning with the second and third sessions. They were also reinforced for use in self-directed practice. "Tactics for Coping with Anxiety" (Marks, 1978) and "Ten Rules for Coping with Panic" (Mathews, Gelder and Johnston, 1981) were used as handouts to supplement instruction in coping skills. Participants were asked to fill in the appropriate spaces on the anxiety sheet (see Appendix M) and to read the rules for coping with panic frequently at home. They were also requested to select the phrases or coping mechanisms most helpful to themselves, and to transpose these onto a card which could be carried with them as they practiced. The complete list of rules is reproduced in Appendix N. One of the participants offered to have the shorter version of rules for coping with panic reduced to wallet-size, one for each group member (see Appendix O).

Relaxation training. This procedure was initiated in the third session, prior to in vivo exposure. Utilizing the methods of Bernstein and Borkovec (1975) for progressive relaxation, training commenced with the tension and relaxation of 16 muscle groups. Written instructions were provided (see Appendix P). Part of several

sessions thereafter were devoted to further steps in relaxation training (seven muscle groups, four muscle groups, recall with counting), leading to a modified version of the exercises which could then be used in a wide range of daily activities. The imagining of a pleasant scene was suggested as a way of diverting stressful or distracting thoughts.

In vivo exposure. In vivo exposure was instigated in the group in the fourth session of treatment. Thereafter, participants were encouraged (as a homework assignment) to practice entering the target phobic situations specified in their hierarchies beginning with an item with a moderate SUDS rating. If the first target could be accomplished with ease, targets higher on the scale were to be attempted in practice. The clients were instructed to remain in the phobic situations until their anxiety diminished.

In vivo exposure in the group involved a number of excursions of varying lengths including: a trip through K-Mart with the group disbursing to various sections of the store followed by coffee together in the Mall after waiting in line to purchase refreshments (April 28); meeting at a restaurant for dinner followed by a car ride and then a tour (individually) through Zellers Shopping Centre (May 5); a bus trip involving one transfer followed by a tour (individually) through the Mall and various stores of the St. Vital Shopping Centre, followed by a snack together at the Woolco Grill (May 26); a tour first together then separately or in pairs through the University Dafoe Library (June 2).

A booster session between the end of treatment and the July 28

follow-up was held at the request of the program participants. This took the form of an outing to the Museum of Man and Nature. Two group members were unable to attend but the other four and the group leaders met at the Museum, toured most of the exhibits (pace set on an individual basis) and followed this with coffee at the Museum cafeteria.

Assertiveness training. One session of treatment (May 12) was largely devoted to a film on responsible forms of assertion and a discussion of how this related to the lives and attitudes of the program participants. Several popular and readily available books on assertiveness were recommended for reading. A copy of the "Bill of Assertive Rights" from one book (Smith, 1975) was distributed and discussed.

Support of significant others. In recognition of the importance of significant others to the maintenance of motivation and practice, the sixth session of treatment (May 19) was set aside for the involvement and instruction of a spouse, immediate relative, close friend or other significant person of each participant. The clients were asked to extend the invitations; several offered to bring refreshments. One client chose not to invite anyone, one asked a mental health worker to attend and the others invited their spouses. It was hoped that this meeting would help to ensure a better understanding on the part of significant others about the nature of agoraphobia, their role in effecting improvements, and the efforts which participants would have to continue to make after the group treatment had ended.

To facilitate this educational process, information from the Mathews, Gelder and Johnston (1981) Client Manual concerning the possibility of setbacks and the Partners Manual (same authors) concerning encouragement from others and what to do about panic, was distributed and discussed. A copy of the article "The Living Hell of Agoraphobia" (Michaels, 1979), written by an agoraphobic about her particular experience with the problem and with overcoming it, was handed out for further reading. Questions on this material or about the program were answered.

The significant others present at this meeting were asked for feedback concerning their view of the program and its effects on the participants to that date. Most had noticed positive changes; some felt the changes were quite important and expressed their pleasure at what had occurred. The significant others were told how the clients rated their anxiety levels on the SUDS scale and were asked to give an indication of their own levels of anxiety during the meeting. This proved to be somewhat of a revelation to the clients since the anxiety levels of the guests (like their own) fluctuated at different points in time. During this session, the guests present were asked if they would be willing to provide feedback after the follow-up session in July. All agreed.

RESULTS

Individual Subjects

This section will provide a general description of presenting problems related to the phobia, expectations of treatment expressed

by subjects in the screening interview, the results of assessment procedures used to clarify phobic conditions, progress during treatment, and the individual outcomes reflected at termination of the group program and at follow-up.

In order to preserve confidentiality and protect the privacy of the subjects, identifying information has been excluded from these descriptions. The names used are not the actual names of the subjects involved. Background information which was not discussed in the group setting has been omitted here but may be found in a modified, anonymous form in the Clients Section of this report or has been retained on file at the Psychological Service Centre.

Several basic principles have been used in tabulating the results of assessment procedures. In the few cases where subjects rated an item between points on the rating scale (e.g. between "not at all" and "a little"), the rating was placed in the higher of the two categories, with the exception of the Fear Questionnaire where half ratings were accepted. All decimal points in percentages were rounded off. For purposes of comparison and clarity, results throughout treatment and, where applicable, follow-up have been tabulated together according to the assessment procedure used and the subject under consideration. Thus, all tables relating to Subject A begin with the number 1, all tables relating to Subject B begin with the number 2, and so forth. Pertinent information from the Cues for Tension and Anxiety Survey Schedule (April 7 only), client evaluations, in-session discussion, and significant others is described as it occurred or became known. A summary of final results is provided

in the outcome sections for each subject.

Subject A

Anne described her problem as a fear of fainting or losing control especially in situations involving line-ups or queues, crowded places, or driving a car. Department stores and restaurants were particularly anxiety-provoking for her. Whenever possible, she would avoid going into these distressing situations alone, but often felt she must force herself to do so. Even when accompanied by her husband, she could feel highly anxious under certain circumstances and had developed some mechanisms to assess her ability to cope. When entering a restaurant, for example, she would first check out the number of people present and the location of windows and exits to help overcome the feeling of being trapped.

Anne felt that, prior to the onset of the phobia, she had been a very independent person who enjoyed socializing with friends and working outside the home. While continuing to work part-time in her area of expertise, she was now experiencing a good deal of anxiety in relation to work and was increasingly fearful of having a panic attack. She was also finding it more difficult to go into restaurants or shopping centres without hyperventilating, feeling sick, dizzy or panic-stricken, and to cope with her children and a normal, daily routine without being afraid she might pass out.

At the same time, Anne was having trouble relaxing and falling asleep and was becoming quite depressed about her condition and the restrictions it caused. She had begun to withdraw from friends as she was afraid of someone seeing her in a state of panic. Outside

activities had dwindled and she found herself not wanting to go into work and fearful of moving outside her home. Anne's phobic behaviour created a further dilemma in the contrast between what she wanted to do and what she felt able to do. While recognizing her tendency to set very high standards for herself, Anne's fears seemed to be preventing her from achieving even a reasonable sense of confidence and self-esteem in areas which had previously been rewarding.

As Anne was unable to discover an adequate rationale for her fears, she began to wonder if she was physically or mentally ill and sometimes had disturbing thoughts of death and dying. At one point, she worried that she might have cancer, and since she had experienced chest pains, the possibility of a heart problem had occurred to her. Medical examination had turned up no physiological basis for these concerns.

By way of helping herself, Anne had already sought out reading material which might help her to understand and overcome her phobia. As she was overweight, she began to diet and developed a strong interest in health food and nutrition. In situations she could not avoid, she had learned to create imaginary conditions to avert her sense of panic. She would, for example, when out alone, pretend that her children were with her and remind herself that she must not faint in order to get them home safely.

Anne wanted to enter the Group Treatment Program for Agoraphobia in the hope that this would help her to return to her former self, where she could go out freely without fear. She also did not like

taking medication and wanted to find an alternative method of relaxation. She felt that she might, in a group setting, become further depressed or acquire new fears by hearing about the experiences of others, but was willing to take the chance. While her husband found her condition difficult to understand, he was supportive of her and of her desire to seek treatment.

Assessment and Progress

Subject A's results on the Fear Questionnaire are tabulated in Tables 1.1 and 1.2. Decreases can be observed throughout treatment on the agoraphobia, blood-injury and total phobia scores. The social phobia score increased and decreased slightly during this time period, while the state of anxiety 'at this moment' rating remained the same. The anxiety-depression score decreased at mid-point (May 5) and rose again at termination (June 8) but remained lower than the result from the first session. At follow-up (July 28) all scores were lower than those obtained at termination. Subject A was not present at the November 3 follow-up.

Table 1.1

Subject A: Scores on Anxiety-depression, Phobia Sub-scales and Total Phobia Dimensions of the Fear Questionnaire

Dimension	Score: Treatment April 7	May 5	June 8	Follow-Up July 28	Nov. 3
Anxiety Depression	26	12	19	14	-
Sub-scores making up total phobia					
Agoraphobia	22	19	18	12	-
Blood-injury	28	23	21	16	-
Social	11	15	14	10	-
Total Phobia	61	57	53	38	-

Note: Scores were measured on a scale of 0 - 40.

Table 1.2

Subject A: Ratings on State of Anxiety 'At this Moment' on Fear Questionnaire

	Rating: Treatment April 7	May 5	June 8	Follow-Up July 28	Nov. 3
State of Anxiety 'at this moment'	3	3	3	2	-

Note: State of anxiety was rated on a scale of 0 - 8.

Results for Subject A on the four selected sub-scale dimensions of the Crown-Crisp Experiential Index are found in Table 1.3. All scores decreased from April 7 (first session) to June 8 (termination) with increases from termination to follow-up. All scores at follow-up

are lower than those achieved in the first session with the exception of the somatic anxiety dimension where the score is slightly higher.

Table 1.3

Subject A: Scores on Four Sub-Scale Dimensions of the Crown-Crisp Experiential Index

Sub-scale Dimension	Treatment Score		Follow-up
	April 7	June 8	Nov. 3
Free-floating anxiety	15	13	14
Phobic anxiety	12	8	9
Somatic anxiety	10	6	11
Depression	11	7	9

Note: Score range on the Index = 0 - 16.

Tables 1.4 and 1.5 contain results from the Depressive Behavior Survey Schedule. The number of responses were not consistent in Category IV and these results are not discussed. Categories I, II and V show decreases April 7 to June 8. Category III shows an increase while Category VI remains the same. At follow-up, Category I declined from the termination result while Categories II, V and VI increased. Category III remained the same for this time period. Comparing results at April 7 and July 28, two of the scores decreased, two increased and one remained the same. In general, the thoughts and feelings category declined consistently, while the others fluctuated at various points. The actual number of responses made at each level of frequency on the Schedule is represented in Table 1.5 which shows an overall decline in perceived frequency of depressive

behaviour from April 7 to July 28.

Table 1.4

Subject A: Ratings as a Percentage of the Maximum Possible Rating (M.P.R.) on the Six Sub-Categories of the Depressive Behavior Survey Schedule

	Sub-category	April 7 M.P.R.	%	June 8 M.P.R.	%	July 28 M.P.R.	%
I	Thoughts and feelings	110	58	110	48	110	43
II	Somatic complaints	40	53	40	48	40	50
III	Decreased activities	20	45	20	55	20	55
IV	Decreased enjoyment of activities	15	47	10	60	10	70
V	Increased undesirable activities (e.g. crying)	15	60	15	47	15	60
VI	Problems in decision-making, concentrating and relating	15	40	15	40	15	47

Note: The Maximum Possible Rating (M.P.R.) is based on the actual number of responses made in each category x the highest possible rating (5) on a scale of 1 - 5. One item in Category IV referring to not enjoying school was rated on April 7, marked not applicable on June 8, and left blank on July 28. All other items were rated.

Table 1.5

Subject A: Total Number of Responses at Each Level of Frequency on the Depressive Behavior Survey Schedule

Level of Frequency	Total Number of Responses April 7	June 8	July 28
Not at all	8	6	9
A little	12	21	16
A fair amount	12	9	10
Frequently	7	3	5
Very frequently	4	3	2

Results from the Social Anxiety Survey Schedule are shown in Table 1.6. All 34 items of the Schedule are rated at each date. There appears to be a trend toward fewer items being rated in the two highest levels of discomfort or anxiety at termination (June 8) and follow-up (July 28).

Table 1.6

Subject A: Total Number of Responses at Each Level of Discomfort or Anxiety on the Social Anxiety Survey Schedule

Level of Discomfort/Anxiety	Total Number of Responses		
	April 7	June 8	July 28
None at all	12	3	5
A little	6	17	19
A fair amount	2	5	4
Much	9	6	3
Very much	5	3	3

Responses to Sections I, IV and III of the Assertive Behavior Survey Schedule are represented in Tables 1.7 and 1.8. Assertiveness scores improve in Section I. In Section IV, the responses run from nonassertive to assertive, to a mid-point between the two. The number of consequences anticipated declines at termination and returns to its original level at follow-up.

Table 1.7

Subject A: Assertiveness Scores in Sections I and IV of the Assertive Behavior Survey Schedule

Schedule Section	Score April 7	June 8	July 28
Section I	13	12	9
Section IV	18	6	12

Note: Assertiveness is rated on a scale of 6 (properly assertive) to 18 (nonassertive) in Section I. Section IV is rated 6, 12, or 18 in degrees of assertiveness depending upon the response selected.

Table 1.8

Subject A: Number of Consequences to Assertive Behaviour Selected in Section III of the Assertive Behavior Survey Schedule

Schedule Section	Number of Consequences April 7	June 8	July 28
Section III	2	1	2

The consequences Subject A anticipated or was afraid of in response to assertive behaviour were: "being yelled at" and "having the person reject you in other ways" (April 7); "being yelled at" (June 8); "being yelled at" and "having the person reject you in other ways" (July 28).

On the Cues for Tension and Anxiety Survey Schedule (April 7)

Subject A noted that tension or anxiety for her could be indicated by a tense feeling in the back of the neck, shoulders and stomach, by the heart beating fast or pounding, face feeling flushed or hands trembling. Sometimes, her stomach would feel nauseous, she would have trouble with her speech, find herself breathing fast or heavy,

feel dizzy and as though she were going to choke or faint. In order to try to get rid of tension or anxiety, Subject A would breathe slowly through the nose and attempt to distract herself or work off the feeling.

On the Client Evaluation Form (May 5), Subject A reported that she had made some progress in overcoming her phobic problems since treatment began. She felt that she could now cope better with her children and with a normal daily routine. She had been able to enter shopping centres and restaurants without the same intensity of worry and had found herself feeling depressed less frequently. She thought she had gained a better understanding about how to relax. During discussion in the May 5 session, Subject A was pleased to report having made a trip to the lake and attended a show at the Theatre Centre for the first time since this problem started.

On the June 8 evaluation form, Subject A again reported that progress had been made, throughout the ten weeks of the treatment program. She found she could go shopping and into restaurants and remain at home alone with her children now with little difficulty. She was able to feel easier having company for dinner and talking on the phone. She was coping better with particular people whom she had previously found troublesome. In the final session, she was feeling especially good about her life and noted that, having been released from some of her anxiety, she was now able to enjoy her children more and had been able to appreciate how beautiful they are.

On July 28, Subject A indicated that progress had been made during the ten weeks of treatment with the same basic changes indicated on

June 8. Since the termination session, she had also realized that her panic attacks had become fewer and farther apart during treatment. Between treatment and follow-up she felt on the whole she had improved but noted that setbacks still occurred. She suggested that her acceptance of stress and learning to relax with it had contributed to the progress made since treatment ended.

The Significant Other Evaluation Form returned shortly after the July 28 session indicated that Subject A's time spent away from home had increased and anxiety had decreased compared to before the group treatment program. The respondent (Subject A's husband) felt Subject A was much better, and was very satisfied with both the program and Subject A's progress. A note added to the form indicated that Subject A was gaining self-confidence, becoming better able to cope with stress situations and was not easily discouraged by setbacks.

Although Subject A did not attend the November 3 follow-up due to illness, she completed and sent in an evaluation form. From April 7 through July 28, she felt her problem with agoraphobia had decreased. Since follow-up (July 28), her problem with agoraphobia had more or less remained the same but had also fluctuated up and down. While panic did not occur as frequently, this left her unprepared and nervously anticipating the times when it did. She attributed some of the difficulty to having passed the anniversary date of the onset of her agoraphobia and to the effects of a prolonged physical illness occurring since July.

Outcome

When Subject A came to the first treatment session she was so

nervous she could not remain sitting in the waiting room. She rated her anxiety level at that point at 100 SUDS and had to take medication to calm herself. During treatment, according to her diary, she very rarely took medication to accomplish tasks even those that she had originally rated as producing much anxiety. By July 28, she had attained all the goals on her individual hierarchy and had observed a reduction of the anxiety she felt in conjunction with those situations. As indicated through feedback, some of her self-confidence had been restored. From never being able to relax, she found herself able to reduce tension and sleep better more often, without using medication. Although setbacks occurred, she did not allow these to discourage her. She had also been able to confide in a friend who had not known about her phobia and who was willing to be of help.

After the July 28 follow-up, Subject A began to have attacks of nausea and dizziness and was discovered to have a disorder of the inner ear. While she was expected to recover from this, it was likely to be sometime before she could trust her sense of balance completely or be free of the side-effects. She was to avoid going out as much as possible for a while. Naturally, Subject A found this very discouraging in light of the progress she had been making earlier. As some of the symptoms of this problem were similar to her phobic reactions, she wondered if the same problem had occurred before (unknown to her) and had triggered the onset of agoraphobia. Despite this major setback, however, Subject A reported that she still thought she would eventually succeed in being free of her phobic difficulties.

Subject B

Barry described his major concern as the increasing restrictions imposed on his daily life due to fear of losing control, having a panic attack and being embarrassed. He was finding it very difficult to go to work or even to go out at all. Crowded places such as restaurants and line-ups were especially problematic for him. Going into movie theatres, shopping malls, banks, and participating in social functions all produced a great deal of anxiety which he attempted to avoid. Because he was able, to some degree, to set his own hours at work, his avoidance had extended on occasion to work situations. Barry had also begun to feel uneasy when left alone at home.

Fear of physical ailments was another cause for concern. Barry reported that any unusual symptoms such as chest pains frightened him to the point where he would slow down or stop what he was doing for fear of "something bad happening," even after repeated assurances from his physician that his ailments were not based on a medical disorder.

By the time of the screening interview, Barry felt that his problem had become increasingly unmanageable and debilitating. He suffered from chronic anxiety and experienced panic attacks several times a week. These panic attacks usually included chest and arm pains, increased heart rate, nausea and sweating.

Barry was deeply concerned about the strain placed on his marriage particularly by his tendency to avoid outside activities. His wife liked to go out and he did not. He was also very worried

about the effect his condition might have on his offspring. Barry viewed his phobic behaviour as a kind of character weakness preventing him from engaging in activities that others seemed to find easy. His sense of self-esteem was very low.

Initially, Barry was afraid to enter the treatment group as he thought he would be susceptible to the fears of others and might acquire new problems. He recognized, apparently from past experience, that he was vulnerable to suggestion. This became evident even in his reaction to questions about the nature of his fears. He later reported that some phobic situations, especially line-ups or queues, became worse for him after these inquiries.

After some re-assurance and despite his obvious anxiety, Barry decided he would try the group program. He still had many misgivings but hoped the program would help him to become "more normal" and enable him to engage in outside activities without experiencing extreme anxiety.

Assessment and Progress

Subject B's results on the Fear Questionnaire are tabulated in Tables 2.1 and 2.2. Decreases can be observed throughout treatment on the anxiety-depression, agoraphobia, blood-injury, social phobia and total phobia scores as well as the state of anxiety 'at this moment' rating. At follow-up (July 28) all scores were higher than those obtained at termination. The state of anxiety remained the same. Compared to July 28, the November 3 scores and rating were all lower. Scores at termination and both follow-up sessions were all substantially (minimum seven points) lower than those recorded for

the first session.

Table 2.1

Subject B: Scores on Anxiety-depression, Phobia Sub-scales and Total Phobia Dimensions of the Fear Questionnaire

Dimension	Score: Treatment April 7	Treatment May 5	Treatment June 8	Follow-Up July 28	Follow-Up Nov. 3
Anxiety Depression	36	30	22	25	16
Sub-scores making up total phobia					
Agoraphobia	37	28	19	20	14
Blood-injury	37	35	30	33	25
Social	36	34	20	28	13
Total phobia	110	97	69	81	52

Note: Scores were measured on a scale of 0 - 40.

Table 2.2

Subject B: Ratings on State of Anxiety 'At this Moment' on Fear Questionnaire

	Rating: Treatment April 7	Treatment May 5	Treatment June 8	Follow-Up July 28	Follow-Up Nov. 3
State of Anxiety 'at this moment'	8	6	6	6	4

Note: State of anxiety was rated on a scale of 0 - 8.

Results for Subject B on the four selected sub-scale dimensions of the Crown-Crisp Experiential Index are found in Table 2.3. All scores decreased from April 7 (first session) to June 8 (termination) with the exception of the depression dimension which remained the same. Increases occurred from termination to follow-up with the exception of the phobic anxiety dimension which did not change. All scores at follow-up are lower than those achieved in the first session except for the depression dimension which rose two points.

Table 2.3

Subject B: Scores on Four Sub-Scale Dimensions of the Crown-Crisp Experiential Index

Sub-scale Dimension	Score: Treatment April 7	Score: Treatment June 8	Follow-up Nov. 3
Free-floating anxiety	15	12	14
Phobic anxiety	15	11	11
Somatic anxiety	12	10	11
Depression	9	9	11

Note: Score range on the Index = 0 - 16.

Tables 2.4 and 2.5 contain Subject B's results from the Depressive Behavior Survey Schedule. The number of responses were not consistent in Category IV and these results are not discussed. All the other categories show decreases April 7 to June 8. Categories I, II, V and VI show increases June 8 to July 28 while Category III remained the same. Comparing results at April 7 and July 28, all results decreased. The actual number of responses made at each level of frequency on the

Schedule is represented in Table 2.5 which shows a decline in perceived frequency of depressive behaviour April 7 to June 8 with a slight increase July 28.

Table 2.4

Subject B: Ratings as a Percentage of the Maximum Possible Rating (M.P.R.) on the Six Sub-Categories of the Depressive Behavior Survey Schedule

	Sub-Category	April 7 M.P.R.	%	June 8 M.P.R.	%	July 28 M.P.R.	%
I	Thoughts and feelings	110	79	110	43	110	52
II	Somatic complaints	40	68	40	55	40	58
III	Decreased activities	20	75	20	45	20	45
IV	Decreased enjoyment of activities	15	53	10	30	10	40
V	Increased undesirable activities (e.g. crying)	15	80	15	33	15	47
VI	Problems in decision-making, concentrating and relating	15	100	15	67	15	80

Note: The maximum possible rating (M.P.R.) is based on the actual number of responses made in each category x the highest possible rating (5) on a scale of 1 - 5. On June 8 and July 28, one of the items in sub-category IV was marked "not applicable." This referred to not enjoying school.

Table 2.5

Subject B: Total Number of Responses at Each Level of Frequency on the Depressive Behavior Survey Schedule

Level of Frequency	Total Number of Responses April 7	June 8	July 28
Not at all	5	15	11
A little	5	11	12
A fair amount	4	8	4
Frequently	8	5	10
Very frequently	21	3	5

Results from the Social Anxiety Survey Schedule are shown in Table 2.6. All 34 items of the Schedule were rated at each date. Considerably fewer items were recorded in the highest level of discomfort or anxiety at termination (June 8) with a slight increase again at follow-up (July 28).

Table 2.6

Subject B: Total Number of Responses at Each Level of Discomfort or Anxiety on the Social Anxiety Survey Schedule

Level of Discomfort/Anxiety	Total Number of Responses April 7	June 8	July 28
None at all	3	4	2
A little	2	9	13
A fair amount	0	5	3
Much	3	10	8
Very much	26	6	8

Responses to Sections I, IV and III of the Assertive Behavior Survey Schedule are represented in Tables 2.7 and 2.8. Assertiveness scores improve in Section I. In Section IV, the responses run from nonassertive to properly assertive. The number of consequences anticipated increases June 8 and again July 28.

Table 2.7

Subject B: Assertiveness Scores in Sections I and IV of the Assertive Behavior Survey Schedule

Schedule Section	Score April 7	June 8	July 28
Section I	18	6	6
Section IV	18	6	6

Note: Assertiveness is rated on a scale of 6 (properly assertive) to 18 (nonassertive) in Section I. Section IV is rated 6, 12 or 18 in degrees of assertiveness depending upon the response selected.

Table 2.8

Subject B: Number of Consequences to Assertive Behaviour Selected in Section III of the Assertive Behavior Survey Schedule

Schedule Section	Number of Consequences April 7	June 8	July 28
Section III	1	2	4

The consequences Subject B anticipated and was afraid of in response to assertive behaviour were: "being yelled at" (April 7); "being yelled at" and "having the person reject you in other ways" (June 8); "being yelled at," "being given a dirty look," "having the person refuse to talk to you" and "having the person reject you in

other ways." (July 28)

On the Cues for Tension and Anxiety Survey Schedule (April 7), Subject B noted that tension or anxiety for him could be experienced in forehead, neck, chest, shoulders, stomach and other parts of the body. Anxiety could produce sweating, rapid or pounding heart beat, flushed face, clammy skin and trembling in hands or legs. Sometimes, his stomach would feel like he had just stopped in an elevator, sometimes nauseous. He had found himself gripping an object tightly, scratching, nail-biting, grinding his teeth, having trouble with speech, feeling as though he were going to choke or faint when highly anxious. In order to try to get rid of tension or anxiety, Subject B would take medication or try to remove himself from the distressing situation.

On the Client Evaluation Form (May 5), Subject B reported that progress made in overcoming his phobic problems since treatment began was a yes-and-no situation. He had gone to restaurants and had been in anxious situations but found himself now looking at them or approaching them in different ways. In some cases, he noticed more motivation to stay in the situation and not leave until his anxiety went down. However, in other situations, he found that his fear of physical ailments (e.g. chest pains or heart palpitations) would prevent him from going on. Stores were still very anxiety-provoking. Subject B was frustrated by his lack of progress and difficulty in doing relaxation exercises or reading tactics when confronted by frightening physical sensations. Thus, while some progress was perceived, some of his phobic reactions remained quite disturbing.

During discussion in the May 5 session, Subject B reported having already visited a restaurant in self-directed practice. He had also been to the zoo (a special goal).

On the June 8 evaluation form, Subject B reported that some progress had been made, throughout the ten weeks of the treatment program. He felt that he had probably doubled the time spent out of his home doing things that he had feared. He thought he was finding his job less stressful at times due to his change in attitude and said his relationships with others had improved. In the final session discussion, Subject B shared that he had had a bad week prior to the meeting. Several members of the group noted that despite this, he still looked better (less anxious) than he had previously.

On July 28, Subject B indicated that progress had been made during the ten weeks of treatment in overcoming his phobic problems. He felt the program had helped him to go out and to do some things he was afraid of doing before. Since the termination session, he found setbacks occurring quite frequently. He had found his anxiety attacks more frequent and his use of medication had increased. His distress in relation to outside activities had increased. Subject B attributed his setbacks possibly to not reading the assigned material or doing relaxation exercises on a regular basis. He felt perhaps the loss of group support had made him less motivated to challenge his fears. Some added stresses in his daily life might also have contributed to his increased anxiety.

The Significant Other Evaluation Form returned shortly after the July 28 session indicated that Subject B's time spent away from home

had increased and anxiety had decreased compared to before the group treatment program. The respondent (Subject B's wife) felt Subject B was much better, and was very satisfied with both the program and Subject B's progress.

On November 3, Subject B felt his problem with agoraphobia had decreased on the whole from April 7 through July 28. Since the July 28 follow-up, his problem with agoraphobia had decreased. In the month previous to November 3 he had found himself feeling more confident and able to cope with many situations even though with some difficulty. He had reduced his consumption of medication per month by more than two-thirds since pre-treatment. He had travelled out of province with a friend and had been to several movies and a football game. He had been in a number of restaurants alone and coped quite successfully. He was also pleased to report that he had played a key role in a special family celebration which, in spite of having to take medication to relax himself, left him feeling happy and gratified that he was able to go through with it.

Outcome

Subject B was late for the first treatment session at 7:00 p.m. A call to his home revealed that he had left for the meeting at 5:30 p.m. The group leaders were later advised that he was wandering the halls of the building in a state of panic, unable to come in to the meeting. While one leader continued to conduct the session, the other went to look for him, finding him leaning against a wall for support. He was encouraged to attend the session and after a brief trip out the door, joined the session and was immediately put to work filling out

assessment forms. He placed his child's picture in front of him as a symbol of motivation and encouragement. Although there was little interaction as yet between the participants at this point, several turned and indicated their support and understanding of what he was experiencing. He was able to remain in the session and notice some reduction in his anxiety level.

By July 28, Subject B had attained many of the goals on his individual hierarchy, several of the major ones using no medication, and had noticed the upper limit of his anxiety in these situations had decreased. A few of his 100 SUDS items, notably travelling on buses, had not yet been accomplished but he was beginning to work on this. He had made a new friend in the group.

After the July 28 follow-up, Subject B began to notice a clear increase in his sense of self-esteem which corresponded with accomplishing important goals, reducing medication, having fewer anxiety attacks, and a general change in attitude towards his problem and life in general. He looked better and felt better for the most part. He was pleased with his progress.

Subject C

By the time she inquired about the treatment group, Carole had found her social life becoming quite restricted. She felt depressed and frustrated at her inability to do things which had previously seemed easy and she worried that she might remain like this forever. Carole found it extremely difficult to enter crowded places such as department stores or malls, line-ups or queues and most restaurants on her own. She could only go shopping alone if the store was not

crowded. She would have her husband accompany her into crowded situations whenever possible. Travelling by bus, especially during rush-hour was a distressing problem for her, particularly as this was the means she most often used for getting to and from work. Crowded buses were terrifying to Carole and she dreaded standing in line.

Carole was also afraid to walk any distance alone either from her office or from home. Social gatherings were difficult for her because she always felt very nervous, sick and shaky. She feared fainting or having an anxiety attack in public and the embarrassment this would cause. She also found that her ability to concentrate was lower when she was encountering fearful situations. While she had continued to force herself into situations that provoked a high anxiety level, Carole found she could not avert her fears and had begun to avoid selectively some of those places that distressed her. Unfortunately, the places and circumstances eliminated were sometimes those which would usually have been enjoyable or associated with leisure activity.

Carole described her husband as very supportive of her and pleased that she might find a means of counteracting her anxiety. Carole herself hoped that the treatment group program would help her to reduce her anxiety in crowded, social situations and enable her to have lunch out with her friends, be able to go into stores as well as restaurants without her current distress, to travel without fear of panic, and to lead a more normal, everyday existence.

Assessment and Progress

Subject C's results on the Fear Questionnaire are tabulated in Tables 3.1 and 3.2. Decreases can be observed throughout treatment

on the anxiety-depression, agoraphobia, blood-injury and total phobia scores as well as the state of anxiety rating. The social phobia score rose and fell slightly at May 5 and June 8. At follow-up (July 28), all scores and the rating of anxiety were higher than at termination, with the anxiety-depression and blood-injury scores rising the most, seven points and nine points respectively. Compared to July 28, the November 3 scores and rating were either lower or remained the same with the exception of the blood-injury and total phobia scores which increased slightly. The anxiety-depression and agoraphobia scores showed the greatest decrease through treatment with both scores increasing after termination but still remaining lower than those obtained in this first session.

Table 3.1

Subject C: Scores on Anxiety-depression, Phobia Sub-scales and Total Phobia Dimensions of the Fear Questionnaire

	Score				
	Treatment			Follow-Up	
Dimension	April 7	May 5	June 8	July 28	Nov. 3
Anxiety-depression	21	20	9	16	13
Sub-scores making up total phobia					
Agoraphobia	21	17	8	10	10
Blood-injury	20	16 1/2	11	20	22
Social	20	23	21	22	21
Total Phobia	61	56 1/2	40	52	53

Note: Scores were measured on a scale of 0 - 40.

Table 3.2

Subject C: Ratings on State of Anxiety 'At this Moment' on Fear Questionnaire

	Rating				
	Treatment			Follow-Up	
	April 7	May 5	June 8	July 28	Nov. 3
State of Anxiety 'at this moment'	6	5 1/2	3	4	3

Note: State of anxiety was rated on a scale of 0 - 8.

Results for Subject C on the four selected sub-scale dimensions of the Crown-Crisp Experiential Index are found in Table 3.3. All scores decreased April 7 (first session) to June 8 (termination) with the exception of the depression dimension which increased by one point. The depression dimension decreased again by one point at follow-up, while somatic anxiety remained the same and free-floating anxiety increased by two points. The phobic anxiety dimension decreased consistently from April 7 to July 28 with scores of 12, 8 and 6 at the points of assessment. All scores at follow-up are lower than those recorded in the first session with the exception of the depression score which is the same.

Table 3.3

Subject C: Scores on Four Sub-Scale Dimensions of the Crown-Crisp Experiential Index

Sub-scale Dimension	Score: Treatment April 7	Score: Treatment June 8	Follow-up July 28
Free-floating anxiety	14	8	10
Phobic anxiety	12	8	6
Somatic anxiety	6	2	2
Depression	8	9	8

Note: Score range on the Index = 0 - 16.

Tables 3.4 and 3.5 contain Subject C's results from the Depressive Behavior Survey Schedule. One item in Category IV referring to not enjoying school was marked "not applicable." The results from this category (decreased enjoyment of activities) remained the same April 7 to July 28. The results on all the other categories show decreases April 7 to termination (June 8) and then show increases June 8 to follow-up with the exception of Category III (decreased activities) which remained the same for these two dates. Comparing the results from April 7 and July 28 (follow-up), the thoughts and feelings category and the decreased activities category show lower figures, Category VI increased six points and the others showed no change.

The actual number of responses made at each level of frequency on the Schedule is represented in Table 3.5 which shows a decline in perceived frequency of some depressive behaviours April 7 to June 8 with a slight increase July 28.

Table 3.4

Subject C: Ratings as a Percentage of the Maximum Possible Rating (M.P.R.) on the Six Sub-Categories of the Depressive Behavior Survey Schedule

	Sub-category	April 7 M.P.R.	%	June 8 M.P.R.	%	July 28 M.P.R.	%
I	Thoughts and feelings	110	47	110	34	110	38
II	Somatic complaints	40	30	40	28	40	30
III	Decreased activities	20	55	20	35	20	35
IV	Decreased enjoyment of activities	10	40	10	40	10	40
V	Increased undesirable activities (e.g. crying)	15	53	15	47	15	53
VI	Problems in decision-making, concentrating and relating	15	67	15	53	15	73

Note: The Maximum Possible Rating (M.P.R.) is based on the actual number of responses made in each category x the highest possible rating (5) on a scale of 1 - 5. One item in Category IV referring to not enjoying school was marked "not applicable." All other items were rated.

Table 3.5

Subject C: Total Number of Responses at Each Level of Frequency on the Depressive Behavior Survey Schedule

Level of Frequency	Total Number of Responses April 7	June 8	July 28
Not at all	8	16	13
A little	13	21	20
A fair amount	17	4	6
Frequently	4	1	2
Very frequently	0	0	1

Note: One item was omitted across all three dates.

Results from the Social Anxiety Survey Schedule are shown in Table 3.6. On April 7 one item was marked "not applicable" but all 34 items were rated June 8 and July 28. More items were recorded in the two highest levels of discomfort or anxiety at termination than at April 7. While the number of recordings at these levels decreased from June 8 to July 28, the number at follow-up remained somewhat higher than the equivalent recordings from the first session.

Figure 3.6

Subject C: Total Number of Responses at Each Level of Discomfort or Anxiety on the Social Anxiety Survey Schedule

Level of Discomfort/Anxiety	Total Number of Responses		
	April 7	June 8	July 28
None at all	3	3	0
A little	7	6	7
A fair amount	11	6	12
Much	9	10	11
Very much	3	9	4

Note: The number of responses are those given across all 34 items of the Schedule at each date with the exception of April 7 when one item to do with stuttering was marked "not applicable."

Responses to Sections I, IV and III of the Assertive Behavior Survey Schedule are found in Tables 3.7 and 3.8. Assertiveness scores decrease slightly towards more assertiveness in Section I and improve in Section IV. The number of consequences anticipated remains the same April 7 to July 28.

Table 3.7

Subject C: Assertiveness Scores in Sections I and IV of the Assertive Behavior Survey Schedule

Schedule Section	Score April 7	June 8	July 28
Section I	13	14	14
Section IV	18	6	6

Note: Assertiveness is rated on a scale of 6 (properly assertive) to 18 (nonassertive) in Section I. Section IV is rated 6, 12, or 18 in degrees of assertiveness depending upon the response selected.

Table 3.8

Subject C: Number of Consequences to Assertive Behavior Selected in Section III of the Assertive Behavior Survey Schedule

Schedule Section	Number of Consequences April 7	June 8	July 28
Section III	2	2	2

The consequences Subject C anticipated and was afraid of in response to assertive behaviour were, in all three cases: "being yelled at" and "having the person reject you in other ways."

On the Cues for Tension and Anxiety Survey Schedule, Subject C indicated that she feels tension in the forehead, chest and stomach. Anxiety could produce a rapid or pounding heart beat, trembling in the hands and nauseous feeling in the stomach. Sometimes, she would find herself biting her nails, feeling dizzy or faint or breathing heavily when highly anxious. In order to try to get rid of tension or anxiety, Subject C would engage in a physical activity to distract herself or escape it by going to sleep, depending upon the circumstances

producing the stress.

On the Client Evaluation Form (May 5), Subject C reported that progress made since treatment began was a yes-and-no situation. She had found her determination to enter fearful situations was stronger and she could control herself better once in the situation but her anticipatory fear was still high. She still had strong doubts about her ability to completely rid herself of agoraphobia.

During discussion in the May 5 session, Subject C reported having gone to Winnipeg Square in self-directed practice. Shopping centres, especially crowded ones, were high on her SUDS anxiety level and an important item on her target list so this represented a significant accomplishment.

On the June 8 evaluation form, Subject C reported that some progress had been made throughout the ten weeks of treatment in overcoming her phobic problems. She felt that she was better able to cope with her feelings in fearful situations, that her drive to enter these situations was stronger and her determination to conquer agoraphobia had become much higher. She found she could enter phobic situations with more confidence, return to the situation sooner even if her SUDS level had been high and was not as discouraged by setbacks as before.

In the final session discussion Subject C noted that she would miss the planned booster session on June 23 because she would be away vacationing for a month in Eastern Canada. She was a little concerned about this trip since her agoraphobia appeared to begin on a previous vacation in the eastern part of the country, but was pleased to note that she felt able to go and the idea did not worry

her nearly as much as it might have done previously.

On July 28, Subject C once again indicated that progress had been made during the ten weeks of treatment. Once again, this had much to do with gains in determination and confidence. She felt she was "beginning to see the light at the end of the tunnel." Since the end of treatment she found she had improved somewhat, could ride a bus more easily even when having to stand due to the crowd. She also noted that her anticipatory fear could still be high in some situations but that she could usually cope with it. Subject C felt she had experienced a slight setback in some situations since returning from holidays. She felt this was due to being conditioned to react anxiously to particular places such as Eatons or The Bay. The places which used to produce a high SUDS level were still difficult for her in some ways while entering a new place with similar characteristics was easier (e.g. another large department store or shopping centre). She felt the conditioned responses to specific locations would take longer to eradicate. Movies were still a problem. On the other hand, Subect C's vacation had gone very well, with little if any difficulty experienced.

The Significant Other Evaluation Form returned following the July 28 follow-up indicated that Subject C's time away from home had increased and her anxiety had increased compared to before the group treatment program. The respondent (Subject C's husband) felt Subject C was much better, and was very satisfied with both the program and Subject C's progress. The notation of increased anxiety might have been an error in recording or may have been indicative of Subject C's

greater efforts to challenge fearful situations more often, thus increasing her general level of anxiety. A note appended to the form suggested that the respondent felt the main benefit of the program to Subject C had been the realization that she was not alone with this problem and her subsequent determination to cope better and fight to overcome her fears.

On November 3, Subject C felt her problem with agoraphobia had decreased from April 7 through July 28. Since the July 28 follow-up session, her problem with agoraphobic had again decreased. She had noticed that her phobia tended to come and go in phases--sometimes she could do anything with little or no anxiety, sometimes she had setbacks. Subject C had found, however, that even her setbacks were easier to deal with because she knew they would pass if she kept returning to the problem situation. If she had a high SUDS level, she still tended to leave sometimes but felt easier about re-entering the situation again than she had before. In the month previous to the November 3 session, she had been able to take a week's trip on her own to a large city in another province, something she would not have previously contemplated. While she had on returning experienced a slight setback particularly in shopping and taking the bus, she was still feeling pleased that her October trip had gone successfully and was generally happier about what she was now able to accomplish.

Outcome

Subject C came to the first session on her own as the meeting was held just a short drive from her point of departure. Like the rest of the participants, she was highly anxious at the outset but calmed

down markedly by the end of the session.

By July 28, Subject C had been able to enter shopping centres, department stores, theatres and crowded buses on her own, to stand in lines and go for a walk by herself. All of these items had been on her individual hierarchy placed at a SUDS anxiety level of 50 or more. The upper limit of her anxiety level in these situations had now decreased and she noted that sometimes her SUDS could be very low under the same circumstances. In addition to her successful vacation trip, Subject C had also been able to participate in a dance recital before an audience.

After the July 28 follow-up and in spite of some setbacks, Subject C noted a definite change in her response to phobic situations. She was able to travel on her own without complications and she felt generally more optimistic about her chances of completely overcoming the phobia. She had recommended the group treatment program concept to her physician for others who might be dealing with agoraphobia. Subject C felt that the program had been most helpful in increasing her motivation and providing encouragement to practice. She felt her most significant accomplishment was a more positive outlook and increased self-confidence.

Subject D

When Darryl entered the treatment group, his life had become very restricted. He rarely communicated with his family and had lost contact with all of his friends. He felt he had lost a purpose in life, a reason to do anything at all. Gradually, over time, Darryl had stopped going to places outside his home such as movie theatres,

stores and restaurants because being in these places caused him to feel extremely anxious and because going out any place in particular no longer seemed essential or important to him.

Darryl described his most fearful situations as line-ups or queues and any crowded or large open places. Going out in general, even for a walk, produced intense distress. Activities such as these were anxiety-provoking if he was only thinking about them and he feared getting into a state of panic when he would feel light-headed, shaky and have difficulty breathing. He also feared speaking to people in a crowd and, to some degree, answering the telephone.

Darryl had withdrawn from many outside activities when still living at home with his family. While there, he had apparently not been challenged much to engage in outside social activity. By the time he applied to enter the treatment group, he was living away from home but was even more cut off from social contacts. Inquiries were being made on his behalf for a work training program and he hoped he would be able to participate in it when the time came. At this point, however, he was very anxious and unsure of himself.

Darryl hoped the treatment group might help him to become more independent and responsible for himself. He wanted to be able to meet people, to socialize and to engage in a variety of outside activities without experiencing acute anxiety. He particularly wanted to be able to find and hold down a job although he was not certain what kind of job he would like. Apart from overcoming his fears, he had no specific goal in life.

Assessment and Progress

Subject D's results on the Fear Questionnaire are tabulated in Tables 4.1 and 4.2. Decreases are shown throughout treatment on the agoraphobia and social phobia dimensions. The state of anxiety rating remains the same at May 5 and decreases at June 8. The anxiety-depression, blood-injury and total phobia scores show increases at mid-point (May 5) and decreases again at termination (June 8). At follow-up (July 28), all scores and the anxiety rating were higher than at termination with the exception of the blood-injury score which was slightly lower and the anxiety-depression score which remained the same. Compared to July 28, the November 3 scores were all higher except for anxiety-depression which was unchanged. The state of anxiety rating was lower. Comparing April 7 (first session) and November 3 (last follow-up session) all scores were lower except for the anxiety-depression score which was the same on both dates.

Table 4.1

Subject D: Scores on Anxiety-depression, Phobia Sub-scales and Total Phobia Dimensions of the Fear Questionnaire

	Score				
	Treatment			Follow-up	
Dimension	April 7	May 5	June 8	July 28	Nov. 3
Anxiety Depression	23	26	23	23	23
Sub-scores making up total phobia					
Agoraphobia	36	32	20	23	27
Blood-injury	23	31	21	19	22
Social	38	36	26	32	30
Total Phobia	97	99	67	74	79

Note: Scores were measured on a scale of 0 - 40.

Table 4.2

Subject D: Ratings on State of Anxiety 'At this Moment' on Fear Questionnaire

	Rating				
	Treatment			Follow-Up	
	April 7	May 5	June 8	July 28	Nov. 3
State of Anxiety 'at this moment'	6	6	4	6	4

Note: State of anxiety was rated on a scale of 0 - 8.

Results for Subject D on the Crown-Crisp Experiential Index are found in Table 4.3. All scores decreased April 7 (first session) to June 8 (termination) and all scores increased again at follow-up with the exception of free-floating anxiety which remained the same. With the exception of the depression score which is the same, all scores at follow-up are slightly lower than those recorded in the first session.

Table 4.3

Subject D: Scores on Four Sub-Scale Dimensions of the Crown-Crisp Experiential Index

	Score		
	Treatment		Follow-up
Sub-scale Dimension	April 7	June 8	July 28
Free-floating anxiety	10	9	9
Phobic anxiety	10	4	9
Somatic anxiety	9	4	6
Depression	9	7	9

Note: Score range on the Index = 0 - 16.

Subject D's results from the Depressive Behavior Survey Schedule are contained in Tables 4.4 and 4.5. The results in Categories II, III and IV show decreases April 7 to termination (June 8). Categories I and V remained the same. Category VI increased. From termination to follow-up, Categories I and VI decreased, Category III increased and the other results remained the same. Comparing the results from April 7 and July 28, all categories show decreased results with the exception of V and VI which are the same.

The actual number of responses made by Subject D at each level of frequency on the Schedule is represented in Table 4.5 which shows a slight increase in perceived frequency of some depressive behaviours at June 8 and a slight decrease again at July 28.

Table 4.4

Subject D: Ratings as a Percentage of the Maximum Possible Rating (M.P.R.) on the Six Sub-Categories of the Depressive Behavior Survey Schedule

	Sub-Category	April 7 M.P.R.	%	June 8 M.P.R.	%	July 28 M.P.R.	%
I	Thoughts and feelings	110	52	110	52	110	47
II	Somatic complaints	40	43	40	38	40	38
III	Decreased activities	20	65	20	50	20	55
IV	Decreased enjoyment of activities	15	73	15	60	15	60
V	Increased undesirable activities (e.g. crying)	15	60	15	60	15	60
VI	Problems in decision-making, concentrating and relating	15	60	15	67	15	60

Note: The maximum possible rating (M.P.R.) is based on the actual number of responses made in each category x the highest possible rating (5) on a scale of 1 - 5.

Table 4.5

Subject D: Total Number of Responses at Each Level of Frequency on the Depressive Behavior Survey Schedule

Level of Frequency	Total Number of Responses April 7	June 8	July 28
Not at all	7	7	7
A little	10	16	17
A fair amount	16	11	14
Frequently	9	6	3
Very frequently	1	3	2

Subject D's results from the Social Anxiety Survey Schedule are shown in Table 4.6. On July 28 one item was not rated. All 34 items were rated April 7 and June 8. More items were recorded in the two highest levels of discomfort or anxiety on April 7 than at termination with a slight move towards less discomfort at July 28. Overall, there was very little change.

Table 4.6

Subject D: Total Number of Responses at Each Level of Discomfort or Anxiety on the Social Anxiety Survey Schedule

Level of Discomfort/Anxiety	Total Number of Responses April 7	June 8	July 28
None at all	0	0	0
A little	2	2	2
A fair amount	4	5	4
Much	4	6	10
Very much	24	21	17

Note: One item was not rated on July 28.

Subject D's responses to Sections I, IV and III of the Assertive Behavior Survey Schedule are found in Tables 4.7 and 4.8. Assertiveness scores decrease in Section I towards more assertiveness. In Section IV, the scores are the same at April 7 and June 8 with an improvement shown at July 28. The number of consequences anticipated remains the same April 7 to July 28.

Table 4.7

Subject D: Assertiveness Scores in Sections I and IV of the Assertive Behavior Survey Schedule

Schedule Section	Score April 7	June 8	July 28
Section I	15	14	10
Section IV	18	18	6

Note: Assertiveness is rated on a scale of 6 (properly assertive) to 18 (nonassertive) in Section I. Section IV is rated 6, 12 or 18 in degrees of assertiveness depending upon the response selected.

Table 4.8

Subject D: Number of Consequences to Assertive Behavior Selected in Section III of the Assertive Behavior Survey Schedule

Schedule Section	Number of Consequences April 7	June 8	July 28
Section III	1	1	1

The consequence Subject D anticipated and was afraid of in response to assertive behaviour was, in each case: "being yelled at."

On the Cues for Tension and Anxiety Survey Schedule (April 7), Subject D experienced tension in the face and various parts of the body other than the neck, chest, shoulders or stomach. When anxious,

he had found himself sweating, trembling in the hands, legs and arms. He had felt his face flush and his heart beat faster. Sometimes, his stomach would feel nauseous and he would find himself gripping an object tightly, scratching his neck and face and biting his nails in response to stress. He might also feel as though he was going to choke and have difficulty breathing or speaking clearly. In order to get rid of feelings of tension or anxiety, Subject D usually chose to wait it out until it passed.

Subject D indicated on the May 5 Client Evaluation Form that he felt some progress had been made in overcoming his phobic problems. He had found he was beginning to take more responsibility for self-improvement and was engaging in more outside activity.

During in-session discussion on May 5, Subject D reported that he had established a jogging regime for himself and had recently been able to run during the middle of the day when more people were around rather than early in the morning. He had also visited a shopping centre in self-directed practice.

On the June 8 evaluation form, Subject D said he had made progress in overcoming his phobic problems during the ten weeks of treatment. He felt the program had helped him to go out more and to talk more in social situations. He was now concentrating more on the present and forgiving both himself and others more easily for past difficulties.

By this point in time, Subject D had started a job training program. He was talking and smiling more in the group sessions and was happy to have accomplished a 100 SUDS target (the job) and to be off welfare. He felt that in an ironic way, his fears helped him to

concentrate on his job as he tended to do more work rather than socializing with the other members of the crew. He was still unsure about what he wanted to do with his life but thought he would probably know soon.

On July 28, Subject D indicated once again that progress had been made during the ten weeks of treatment. He felt the program had got him away from home and out in the world and had motivated him to try to change. He had begun to realize the nature of his problems and how to deal with his fears. Since the last group session, he had gradually lost interest in keeping a behavioural diary but would still occasionally take a SUDS rating and use his skills for coping with panic. While some problems, he realized, were going to require more time, he had noticed he was feeling more relaxed at work and felt he was improving.

The Significant Other Evaluation Form for Subject D indicated that his anxiety had deceased, his time spent away from home had increased, and he was generally much better when compared to before the treatment program. The respondent felt very satisfied with the program and with Subject D's progress.

On November 3, Subject D felt that his problem with agoraphobia had decreased from April 7 through July 28 and again since July 28. He was no longer staying at home as often as before and his anticipatory fear was not as severe. He still found it difficult to meet new people but felt he was improving in this regard. His work habits had improved a great deal and he noticed he was more relaxed and could think more clearly as a result.

Outcome

Subject D was very nervous and shy in the first session of treatment. He had had to force himself to come as he was extremely anxious about being with a group of people. He spoke very little and answered any questions in the briefest way possible.

As treatment progressed, Subject D gradually became more relaxed with the others and began to interact more frequently in conversation. He went on a few practice outings between sessions with two other group members. Occasionally, he would initiate a dialogue completely on his own. He also began to smile more, something he did not do early in the program. It seemed as though he began to gain some sense of himself as an individual, and furthermore as a social individual, with choices and decisions to make. He indicated that he was now taking more responsibility for himself and recognizing his personal role in overcoming his own problems. One of his past frustrations had been that people did not tell him things and did not consult him about plans or projects in which he might like to participate. He was now beginning to recognize a need for asserting himself in order to be included.

By July 28, Subject D had attempted all of the high SUDS targets on his individual hierarchy and had noticed his anxiety decreasing a little in these areas. Most importantly to himself, he was beginning to take some initiative, relate some of his feelings (e.g. anger, frustration, embarrassment) to others, and generally assert himself more. He felt he was more comfortable being and talking with people and large, open spaces had become less fearful.

By November 3, Subject D was feeling quite pleased with his accomplishments. From a shy, socially isolated person, he had emerged as more confident and motivated to engage in outside activities and to create goals for himself. After being jobless and on welfare, he had not only succeeded in holding a job but had also proven himself to the point where he was made Lead Hand of his work crew. While he had moved back home for a time (seemingly a step backward on his road to independence), he had decided to do this in order to save money so that later he could have his own apartment. Although he recognized that he had more work to do on some of his problems, he considered the realization an accomplishment in itself. This combined with his other achievements added an important dimension to his life which had not been there before.

Subject E

Edward described his problem as a fear of being nervous, or of losing control and experiencing a panic attack. When having a panic attack, he would feel dizzy, shaky and nauseous. As a result, he rarely went outside, relying on family members to buy his clothes and shop for other necessities. About once every two months, he would go out to get a haircut but needed medication to help him do so. Edward said he felt very nervous about meeting other people and had few friends. One of his significant friends had been an agoraphobic.

For about two years, Edward had felt quite depressed about his condition and said he used to fear death. He sometimes worried about having a heart attack. If he remained at home, he felt relaxed and had little trouble communicating on the phone. Any outside activity

made him highly anxious and he generally avoided it. He did not have a job and occupied himself by painting and doing carpentry work. He had made many renovations and repairs to the inside of the house. He had noted, on the rare occasions he ventured outside, that he was able to go farther on a bicycle than on foot without feeling nervous. He had tried to learn to drive a car a few years earlier but eventually gave up.

In order to help himself with this problem, Edward had done some reading and especially appreciated the works of Claire Weekes on agoraphobia. He also listened to relaxation tapes and was practicing meditation. He felt that anyone who tried to help an agoraphobic must be caring and sincere.

Edward hoped the group program would help him to get out more and therefore facilitate his forming new relationships. He felt this would alleviate some of his anxiety and stabilize his state of mind. (He had described his state of mind as up one day and down the next). If he could overcome his agoraphobia, his goals were to get a job, find a girlfriend and buy a car.

Assessment and Progress

Tables 5.1 and 5.2 contain Subject E's results on the Fear Questionnaire. Decreases are shown throughout treatment on the agoraphobia and total phobia scores and on the state of anxiety rating. The anxiety-depression score decreased at mid-point and went up again at termination but still remained much lower than the score obtained in the first session. The blood-injury score varied only slightly during treatment while the social phobia score decreased at mid-point

and rose again slightly at termination. At follow-up (July 28), all scores were either the same (agoraphobia) or lower than the scores at termination. At the November 3 follow-up, anxiety-depression and blood-injury scores increased very slightly while social phobia and total phobia declined very slightly. The agoraphobia score was zero. State of anxiety ratings remained the same June 8 to November 3.

Table 5.1

Subject E: Scores on Anxiety-depression, Phobia Sub-scales and Total Phobia Dimensions of the Fear Questionnaire

Dimension	Score: Treatment April 7	Treatment May 5	Treatment June 8	Follow-up July 28	Follow-up Nov. 3
Anxiety Depression	18	5	9	4	6
Sub-scores making up total phobia					
Agoraphobia	12	8	3	3	0
Blood-injury	9	7	9	0	2
Social	18	12	13	8	7
Total Phobia	39	27	25	11	9

Note: Scores were measured on a scale of 0 - 40.

Table 5.2

Subject E: Ratings on State of Anxiety 'At this Moment' on Fear Questionnaire

	Rating: Treatment April 7	Treatment May 5	Treatment June 8	Follow-up July 28	Follow-up Nov. 3
State of Anxiety 'at this moment'	6	4	3	3	3

Note: State of anxiety is rated on a scale of 0 - 8.

Subject E's results on the four selected dimensions of the Crown-Crisp Experiential Index are shown in Table 5.3. With the exception of the depression dimension, all scores decreased April 7 to June 8 and either decreased again at follow-up or remained the same. The depression score went up on June 8 and decreased again slightly on July 28.

Table 5.3

Subject E: Scores on Four Sub-Scale Dimensions of the Crown-Crisp Experiential Index

Sub-scale Dimension	Score: Treatment April 7	Score: Treatment June 8	Score: Follow-up July 28
Free-floating anxiety	11	7	7
Phobic anxiety	8	7	7
Somatic anxiety	4	3	3
Depression	4	7	6

Note: Score range on the Index = 0 - 16.

Subject E's results from the Depressive Behavior Survey Schedule are contained in Tables 5.4 and 5.5. Two items in Category IV referring to not enjoying school and not enjoying work were omitted, presumably because Subject E felt they were not applicable to his situation. The results from this category (decreased enjoyment of activities) remained the same April 7 through July 28. All other category results either decreased at June 8 or remained the same as they were at April 7 with the exception of Category V (increased undesirable activities) which increased at June 8. Comparing June 8

and July 28, all results either increased or remained the same except for Category V which went down. At July 28, compared to the first session (April 7), Categories III and VI increased and the others were lower or remained the same.

The actual number of responses made at each level of frequency on the Schedule is found in Table 5.5 which suggests a low perceived level of frequency of depressive behaviour throughout treatment and follow-up.

Table 5.4

Subject E: Ratings as a Percentage of the Maximum Possible Rating (M.P.R.) on the Six Sub-categories of the Depressive Behavior Survey Schedule

	Sub-category	April 7 M.P.R.	%	June 8 M.P.R.	%	July 28 M.P.R.	%
I	Thoughts and feelings	110	35	110	28	110	35
II	Somatic complaints	40	33	40	25	40	30
III	Decreased activities	20	20	20	25	20	25
IV	Decreased enjoyment of activities	5	40	5	40	5	40
V	Increased undesirable activities (e.g. crying)	15	27	15	33	15	20
VI	Problems in decision-making, concentrating and relating	15	33	15	33	15	40

Note: The Maximum Possible Rating refers to the actual number of responses made in each category x the highest possible rating (5) on a scale of 1 - 5. Two items in Category IV were omitted. All other items were rated.

Table 5.5

Subject E: Total Number of Responses at Each Level of Frequency on the Depressive Behavior Survey Schedule

Level of Frequency	Total Number of Responses April 7	June 8	July 28
Not at all	19	25	19
A little	18	15	19
A fair amount	4	1	3
Frequently	0	0	0
Very frequently	0	0	0

Note: Two items were omitted across all three dates.

Results for Subject E from the Social Anxiety Survey Schedule are contained in Table 5.6. More items were recorded in the two highest levels of discomfort or anxiety at termination (June 8) than at April 7. A decrease is shown at the same levels on July 28 with the July 28 recordings being slightly less in terms of level of discomfort or anxiety than those of the April 7 first session.

Table 5.6

Subject E: Total Number of Responses at Each Level of Discomfort or Anxiety on the Social Anxiety Survey Schedule

Level of Discomfort/Anxiety	Total Number of Responses April 7	June 8	July 28
None at all	7	10	5
A little	18	13	17
A fair amount	4	4	8
Much	2	4	2
Very much	4	3	2

Responses to Sections I, IV and III of the Assertive Behavior Survey Schedule are represented in Tables 5.7 and 5.8. Assertiveness scores decrease to a properly assertive score at June 8 and July 28. A properly assertive score of 6 is shown for each date in Section IV. The number of consequences to assertive behaviour remains the same at all three assessment points.

Table 5.7

Subject E: Assertiveness Scores in Sections I and IV of the Assertive Behavior Survey Schedule

Schedule Section	Score April 7	June 8	July 28
Section I	10	6	6
Section IV	6	6	6

Note: Assertiveness is rated on a scale of 6 (properly assertive) to 18 (nonassertive) in Section I. Section IV is rated 6, 12, or 18 in degrees of assertiveness depending upon the response selected.

Table 5.8

Subject E: Number of Consequences to Assertive Behaviour Selected in Section III of the Assertive Behavior Survey Schedule

Schedule Section	Number of Consequences April 7	June 8	July 28
Section III	1	1	1

The consequence Subject E anticipated and was afraid of in response to assertive behaviour was, in all three cases: "being yelled at."

On the Cues for Tension and Anxiety Survey Schedule (April 7), Subject E indicated that he often felt tension in the face and forehead.

Anxiety often produced a warm or flushed feeling in the face, clammy skin, trembling or shaking in the hands and neck, and a nauseous feeling in the stomach. Sometimes, he would find himself biting his nails, having trouble with his speech, feeling dizzy or breathing rapidly in response to stress. To try to get rid of tension or anxiety, Subject E would usually sit and let it pass.

On the Client Evaluation Form (May 5), Subject E indicated progress had been made in overcoming his phobic problems since treatment began. He felt he was getting out a lot more and learning how to cope with anxiety without the use of tranquilizers. He suggested that his improved state of mind had something to do with the relaxation exercises learned in the program.

In discussion during the May 5 session, Subject E reported that he had gone to a shopping centre in self-directed practice and had experienced a very low anxiety rating. He had also attended a Bible lecture with his brother. When he began to have a panic attack at the lecture he left, but was gradually able to work it through and return for the rest of the session.

Subject E reported on the June 8 evaluation form that some progress had been made during the ten weeks of treatment in overcoming his phobic problems. He was able to leave his home more often without the use of tranquilizers and had made a friend. He found himself happier and feeling more at peace. In discussion during the session, he indicated that he had not gone out much during the previous week but was still pleased with his progress and optimistic about the future. He had managed to attend the June 2 group session without taking

tranquilizers--the first time he had done this.

On the follow-up evaluation form (July 28), Subject E again indicated that progress had been made during treatment since he was now more relaxed and getting outside more than before. Since treatment ended he had noticed a slight improvement which he attributed to a greater sense of motivation which prompted him to leave his home more often.

The respondent to Subject E's Significant Other Evaluation Form reported that he was much better and that his anxiety had decreased and his time spent away from home had increased compared to before the group treatment program. The respondent also felt very satisfied with Subject E's progress and with the treatment program.

On the evaluation form (November 3), Subject E felt his problem with agoraphobia had decreased from April 7 through July 28 but had remained the same since then. His agoraphobia score on the Fear Questionnaire at this time was zero. Presumably, he felt he had completely overcome the problem. Subject E reported that, since July, he had gone on an out-of-province trip with a friend, got his beginners drivers license and had gone to a football game. He had also discussed the possibility of jobs in construction work with a neighbour who had contacts in this field.

Outcome

When he came to the first session, Subject E had been almost exclusively confined to his home for some time, making trips out about once every two months with the aid of tranquilizers. It took nine treatment sessions before he was able to interact in the group without

using medication. His mood fluctuated up and down and he missed having direct social contact with people other than his family.

By July 28, Subject E had accomplished the 100 SUDS goal on his individual hierarchy (speaking with a group of people) without the use of medication. He had also accomplished several other items such as taking a bus and shopping and had noticed a significant reduction in his anxiety level. He had also added some new situations to his list not envisaged before, e.g. going to a concert, going to a movie, going to the airport, going to a football game, going fishing and going to the beach. Many of these items produced a very low SUDS rating. While few of these activities were done by himself, they were done with a new friend, with someone other than a member of his family. For Subject E, this was a gain in itself since it meant he was no longer so socially isolated.

After the July 28 follow-up, Subject E continued to remain the same. He had accomplished a long trip by car with a friend and was beginning to take action on learning to drive and to consider the possibility of jobs. He had also succeeded in speaking to a woman he had met about sharing some outdoor activities. He had not yet found a job or gone for a job interview or considered moving away from home but did feel more in charge of himself and recognized his role in making personal choices.

Subject F

Frances was becoming increasingly isolated from friends when she inquired about the treatment group, and often felt frustrated and depressed. While she thought she had been coping with her problem to

some degree, she had great difficulty going out alone. When she did leave her home, even if accompanied, she experienced intense anxiety.

Frances described her most fearful situations as being alone, driving alone, and being in crowded places and line-ups or queues. She mainly feared being in a state of panic in which she would feel faint and extremely short of breath (aggravated by asthma). The anticipation of an outside activity was very anxiety-provoking and, at times, she would become angry and irritable in response to her fears and the restrictions they caused.

Frances did not talk about her problems with her friends. She would try to cover up her feelings and make excuses when invited out. Sometimes she found it difficult to do ordinary tasks around the home. When she did go out to a social function, she became extremely nervous and described the drive home as a nightmare. Once home, she was usually able to calm down and relax.

Frances said that her family were willing to help her and did as much as they could. Her husband was supportive of her and her wish to seek treatment but he did not regard her fears as being as serious as she did. He apparently did not mind her remaining at home or doing things for her if she found it difficult to go out.

For several years, Frances felt she had conquered her agoraphobia but had experienced a flare up the previous Spring. She hoped that by attending the treatment sessions, she might be able to reduce her anxiety again to the extent where she could become a little more independent, be able to go out alone occasionally and to drive the car by herself.

Assessment and Progress

The results for Subject F on the Fear Questionnaire are tabulated in Tables 6.1 and 6.2. With the exception of blood-injury, all scores increased at mid-point (May 5). The blood-injury score increased slightly at mid-point, decreased June 8, and decreased again at follow-up (July 28). The anxiety-depression, agoraphobia, social phobia and total phobia scores decreased at June 8 and again at follow-up. The state of anxiety rating remained the same at May 5, decreased to three at June 8 and remained at three July 28. The anxiety-depression and agoraphobia scores were slightly higher at termination than those recorded for the first session but all scores and the rating were lower at follow-up than in the first session. Subject F was not present at the November 3 session.

Table 6.1

Subject F: Scores on Anxiety-depression, Phobia Sub-scales and Total Phobia Dimensions of the Fear Questionnaire

Dimension	Score: Treatment April 7	May 5	June 8	Follow-Up July 28	Nov. 3
Anxiety-depression	10	12	11	8	-
Sub-scores making up total phobia					
Agoraphobia	14	20	15	9	-
Blood-injury	16	15	9	6	-
Social	12	13	8	7	-
Total Phobia	42	48	32	22	-

Note: Scores were measured on a scale of 0 - 40.

Table 6.2

Subject F: Ratings on State of Anxiety 'At this Moment' on Fear Questionnaire

	Rating				
	Treatment			Follow-up	
	April 7	May 5	June 8	July 28	Nov. 3
State of anxiety 'at this moment'	6	6	3	3	-

Note: State of anxiety was rated on a scale of 0 - 8.

Subject F's results on four sub-scale dimensions of the Crown-Crisp Experiential Index are presented in Table 6.3. The free-floating anxiety score decreased at termination and again at follow-up. The phobic anxiety score decreased slightly at termination and increased slightly at follow-up. Depression increased at termination and decreased at follow-up, and somatic anxiety decreased at termination and rose slightly again at follow-up. All scores at follow-up (July 28) were lower than those recorded on April 7 with the exception of phobic anxiety which was slightly higher.

Table 6.3

Subject F: Scores on Four Sub-Scale Dimensions of the Crown-Crisp Experiential Index

	Score		
	Treatment		Follow-up
Sub-scale Dimension	April 7	June 8	July 28
Free-floating anxiety	10	9	5
Phobic anxiety	11	9	12
Somatic anxiety	9	5	6
Depression	7	8	3

Note: Score range on the Index = 0 - 16.

Tables 6.4 and 6.5 contain Subject F's results from the Depressive Behavior Survey Schedule. Items were omitted or invalidated in all categories except Category IV. In Category I, four items were omitted or invalidated on April 7 and one item on June 8. In Category II, one item was omitted or invalidated on each of April 7 and June 8. In Category III, the same problem occurred with two items on April 7. In Category IV, one item was omitted or invalidated on each date and the same occurred in Category V on April 7. Some of the items omitted or invalidated referred to not enjoying school, feeling tired without any reason, feeling guilty and feeling anxious. Subject F either missed rating particular items or invalidated the results on particular items by rating them twice at different levels of frequency.

Possible explanations for the inconsistency of results are difficulty in reading the Schedule in which items were spaced closely together, difficulty in concentrating due to medication intake or other distractions and possibly a misunderstanding of instructions. It appears that as Subject F became more familiar with completing the Schedule (or perhaps, as her anxiety decreased), the number of omissions decreased. On July 28, only one item was missed in a category where most other members of the group omitted some items or marked them "not applicable."

The results in Table 6.5 must be considered with the various omissions in mind. On April 7, a total of 34 responses were clearly marked; on June 8 there were 38; and on July 28 there were 42. A total possible of 43 items could be rated on the Schedule. While the number of responses increases at July 28, there is still a downward trend in the level of frequency.

Table 6.4

Subject F: Ratings as a Percentage of the Maximum Possible Rating (M.P.R.) on the Six Sub-Categories of the Depressive Behavior Survey Schedule

	Sub-category	April 7 M.P.R.	%	June 8 M.P.R.	%	July 28 M.P.R.	%
I	Thoughts and feelings	90	30	95	28	110	25
II	Somatic complaints	35	43	35	40	40	38
III	Decreased activities	10	20	20	30	20	25
IV	Decreased enjoyment of activities	10	40	10	30	10	20
V	Increased undesirable activities (e.g. crying)	10	20	15	40	15	27
VI	Problems in decision-making, concentrating and relating	15	20	15	20	15	27

Note: The Maximum Possible Rating (M.P.R.) refers here to the actual number of valid responses made by Subject F in each category x the highest possible rating (5) on a scale of 1 - 5. A variety of items were omitted or invalidated (see explanation which precedes Table 6.4).

Table 6.5

Subject F: Total Number of Responses at Each Level of Frequency on the Depressive Behavior Survey Schedule

Level of Frequency	Total Number of Responses April 7	June 8	July 28
Not at all	21	21	27
A little	7	13	14
A fair amount	6	4	1
Frequently	0	0	0
Very frequently	0	0	0

Note: A variety of responses were omitted or invalidated at each date, but particularly April 7 and June 8 (see explanation preceding Table 6.4).

The results for Subject F on the Social Anxiety Survey Schedule are contained in Table 6.6. On April 7 and July 28 one item referring to "giving a talk to a group of 30 or more" was omitted apparently in error. All items were rated on June 8. June 8 ratings indicate as well a slight increase in level of discomfort or anxiety over the other two assessment dates when the two highest levels are considered.

Table 6.6

Subject F: Total Number of Responses at Each Level of Discomfort or Anxiety on the Social Anxiety Survey Schedule

Level of Discomfort/Anxiety	Total Number of Responses		
	April 7	June 8	July 28
None at all	22	15	23
A little	7	13	6
A fair amount	4	2	4
Much	0	4	0
Very much	0	0	0

Note: The total number of responses at each date is 33 (April 7), 34 (June 8) and 33 (July 28) out of a possible total of 34.

Responses to Sections I, IV and III of the Assertive Behavior Schedule are found in Tables 6.7 and 6.8. Assertiveness scores increase towards less assertiveness in Section I and decrease towards greater assertiveness by July 28 in Section IV. The number of consequences anticipated is two at April 7 and one at June 8 and July 28. In Section I, Subject F made up a new response to one item. The new

response was scored according to the level of assertiveness it expressed.

Table 6.7

Subject F: Assertiveness Scores in Sections I and IV of the Assertive Behavior Survey Schedule

Schedule Section	Score April 7	June 8	July 28
Section I	11	13	14
Section IV	18	18	6

Note: Assertiveness is rated on a scale of 6 (properly assertive) to 18 (nonassertive) in Section I. Section IV is rated 6, 12 or 18 in degrees of assertiveness depending upon the response selected.

Table 6.8

Subject F: Number of Consequences to Assertive Behavior Selected in Section III of the Assertive Behavior Survey Schedule

Schedule Section	Number of Consequences April 7	June 8	July 28
Section III	2	1	1

The consequences Subject F anticipated or was afraid of in response to assertive behaviour were: "being yelled at" and "having the person reject you in other ways" (April 7) and "having the person reject you in other ways" (June 8 and July 28).

On the Cues for Tension and Anxiety Survey Schedule (April 7), Subject F indicated that she often experienced tension in the stomach. In response to anxiety, she would find herself holding something tight (like a steering wheel or the arm of a chair) and breathing rapidly or

heavily. To get rid of the feeling of tension or anxiety, she would take deep breaths, talk to herself, or if at home, listen to relaxation tapes.

On the May 5 Client Evaluation Form, Subject F indicated that she felt progress had been made in overcoming her phobic problems since she could now go out alone, go to the store to shop, go to the bank and drive somewhere alone. She was learning to cope with her anxiety or panic and found the relaxation techniques particularly useful. She felt she was not yet "out of the woods" but thought if she persisted in using the new knowledge she would succeed. She expected that the resolution of a problem at home would enable her to cope better. In discussion on May 5, she reported she had driven herself alone to the hairdressers (two hierarchy items).

Subject F again reported that she had made progress on June 8. In completing the evaluation form she indicated that she could now go out alone, still with anxiety, but not so afraid of this feeling. She felt she had learned to use her coping tactics successfully. A note on her diary sheet indicated that she was glad she made it to the final treatment session and had not let herself or the group leaders down. (She had not attended the previous session on June 2). She found her anxiety decreased as the session progressed and she enjoyed hearing about the accomplishments of the others. In the June 8 session she was reportedly feeling good about it all.

On July 28, Subject F again felt some progress had been made in overcoming her phobic problems during the ten weeks of treatment, as evidenced by her response on the evaluation form. She felt she had

learned some skills for coping with agoraphobia and realized she was not alone with this problem, which meant a great deal to her. She thought she had improved since June 8 because of the knowledge and therapy gained from the group sessions. Although she did not attend the June 23 booster session, she phoned to advise that at that time she had been going out everyday and had been to a concert, shopping at a department store and to the hairdressers twice. She had had a moment of panic at the hairdressers but noticed that it soon passed. A few days before the July 28 follow-up, she had accomplished a trip to the lake with her husband by car by setting up a series of successive approximations for herself. She hoped to go back to the lake in future and try to get herself in the water. Both these activities represented an anxiety level of over 50 SUDS for her.

On the Significant Other Evaluation Form, the respondent indicated that Subject F's time spent away from home had increased, her anxiety had decreased and she was "the same" when compared to before the group treatment program. A notation added beside "the same" indicated that she was "a little better." The respondent was very satisfied with the program and with Subject F's progress.

Subject F was unable to attend the November 3 follow-up due to a long bout with pneumonia complicated by asthma. This had apparently created quite a setback for her and she was feeling depressed when she spoke to one of the group leaders on the phone. Feedback was requested from her whenever she felt able to provide it and forms to facilitate her communication were mailed out. Although she readily agreed to complete the mailings, no response had been received five

months later. One phone call was made to her during this time but she was just leaving to go to the doctor. It was suggested that she phone the Psychological Service Centre and leave a message as to the best time to return her call, as she was at this point anxious to discuss what was happening with the group and with herself. As far as is known, no message was left. Further information on Subject F's setbacks or progress is, therefore, unavailable.

Outcome

Subject F was brought to the first session by her husband who waited with her in the waiting room until the program got underway. She was visibly nervous and had difficulty getting down the hall from the waiting room to the meeting room. She attended most but not all of the treatment sessions and was unable to come to the booster session (June 23) or to the November 3 follow-up. By her own report she almost did not succeed in making it to the termination session although was ultimately glad she attended.

She came to the meeting on May 26 after some encouragement but arrived late, got part way down the hall from the waiting room and had to stop to catch her breath. Her breathing was laboured and she was visibly shaken. As the rest of the group were all highly anxious in response to the bus trip planned for the session, Subject F's noticeable anxiety served to heighten the general anxiety in the room which, in turn, increased her distress. She decided to leave as she did not think she could accomplish the bus ride. Her decision was accepted and she was invited to join the group later (by car) if possible for a snack at the shopping centre. A time was arranged but Subject F

did not meet us there. She was surprised to be "let off the hook" so easily but it was explained that only she could determine her readiness to accomplish the task. Subject F often sought out reassurance before attending the various sessions. She often felt she could not come but, in many cases, she did manage to arrive and usually became more relaxed as the sessions proceeded.

By the July 28 follow-up, Subject F reported that she had accomplished several of her goals with a reduced anxiety level and had added a new item (going to the lake). She was pleased with the knowledge she had gained and with having been able to go out more although only in a few instances did she go out entirely on her own. Less anxiety was, however, experienced in relation to situations which had previously bothered her, accompanied or not.

Although she found the sessions a source of motivation and encouragement, Subject F sometimes found it difficult to keep up with the rest of the group. This was most evident in in vivo exposure activities when she tired easily due to asthma, being out of shape (her own suggestion) and being less agile than the others. She was quite out of practice in walking for an extended period of time. All these factors heightened her anxiety in response to new situations. There were also other factors in her life that she indicated could be adding to an emotional drain and, possibly, impeding her progress and her ability to concentrate on the tasks at hand.

Subject F appeared to recognize the need to boost her determination and also her need to be supported emotionally in doing so. While sometimes appearing torn between different choices, she effectively

utilized the group and its leaders to bolster her wish to succeed in overcoming her phobia on many occasions.

Subject M

By the time she was interviewed for the treatment group, Margaret hardly ever left her home. She had even begun to panic in the house and spent many days sitting in the corner of the chesterfield in a state of depression. On the rare occasions she did go outside, she was always accompanied, usually by her husband and kept the trips as short as possible.

Margaret described her most fearful situations as being alone or being in crowded places, any situations outside her home. She suffered from chronic anticipatory fear of having a panic attack in which she would faint or be unable to help herself. She also feared a variety of illnesses.

Margaret said her husband supported her efforts to find help although he found some aspects of her condition difficult to understand. She wanted to be able to get out and do things. She was tired of having these fears and hoped she could overcome the problem to the extent that she would feel less anxious and depressed, be able to go out with ease and to visit with her children and friends.

Assessment

As Subject M dropped out of the program before May 5, the second assessment date, assessment data is only available from the first session. This information is presented in Tables 7.1 through 7.8.

Table 7.1

Subject M: Scores on Anxiety-depression, Phobia Sub-Scales and Total Phobia Dimensions of the Fear Questionnaire

Dimension	Score: Treatment April 7	Treatment May 5	Treatment June 8	Follow-up July 28	Follow-up Nov. 3
Anxiety Depression	22	-	-	-	-
Sub-scores making up total phobia					
Agoraphobia	34	-	-	-	-
Blood-injury	22	-	-	-	-
Social	18	-	-	-	-
Total phobia	74	-	-	-	-

Note: Scores were measured on a scale of 0 - 40.

Table 7.2

Subject M: Rating on State of Anxiety 'At this Moment' on Fear Questionnaire

	Rating: Treatment April 7	Treatment May 5	Treatment June 8	Follow-up July 28	Follow-up Nov. 3
State of anxiety 'at this moment'	8	-	-	-	-

Note: State of anxiety is rated on a scale of 0 - 8.

Table 7.3

Subject M: Scores on Four Sub-Scale Dimensions of the Crown-Crisp Experiential Index

Sub-scale dimension	Score: Treatment April 7	Treatment June 8	Follow-up July 28
Free-floating anxiety	14	-	-
Phobic anxiety	14	-	-
Somatic anxiety	11	-	-
Depression	10	-	-

Note: Score range on the Index = 0 - 16.

Table 7.4

Subject M: Ratings as a Percentage of the Maximum Possible Rating (M.P.R.) on the Six Sub-Categories of the Depressive Behavior Survey Schedule

Sub-Category	April 7 M.P.R.	April 7 %	June 8 M.P.R.	June 8 %	July 28 M.P.R.	July 28 %
I Thoughts and feelings	100	65	-		-	
II Somatic complaints	40	73	-		-	
III Decreased activities	20	50	-		-	
IV Decreased enjoyment of activities	10	40	-		-	
V Increased undesirable activities (e.g. crying)	15	60	-		-	
VI Problems in decision-making, concentrating and relating	15	60	-		-	

Note: The Maximum Possible Rating (M.P.R.) refers here to the number of responses made by Subject M in each category times the highest possible rating (5) on a scale of 1 - 5. Two items in Category I were omitted or invalidated and one item in Category IV referring to not enjoying school has been omitted. All other items were rated.

Table 7.5

Subject M: Total Number of REsponses at Each Level of Frequency on the Depressive Behavior Survey Schedule

Level of Frequency	Total Number of Responses April 7	June 8	July 28
Not at all	6	-	-
A little	7	-	-
A fair amount	9	-	-
Frequently	15	-	-
Very frequently	3	-	-

Note: The total number of responses is 40 out of a possible total of 43.

Table 7.6

Subject M: Total Number of Responses at Each Level of Discomfort or Anxiety on the Social Anxiety Survey Schedule

Level of Discomfort/Anxiety	Total Number of Responses April 7	June 8	July 28
None at all	12	-	-
A little	9	-	-
A fair amount	5	-	-
Much	0	-	-
Very much	7	-	-

Note: The total number of responses is 33 out of a possible total of 34. The item "when I talk and people look bored" was omitted.

Table 7.7

Subject M: Assertiveness Scores in Sections I and IV of the Assertive Behavior Survey Schedule

Schedule Section	Score April 7	June 8	July 28
Section I	13	-	-
Section IV	6	-	-

Note: Assertiveness is rated on a scale of 6 (properly assertive) to 18 (nonassertive) in Section I. Section IV is rated 6, 12, or 18 in degrees of assertiveness depending upon the response selected.

Table 7.8

Subject M: Number of Consequences to Assertive Behaviour Selected in Section III of the Assertive Behavior Survey Schedule

Schedule Section	Number of Consequences April 7	June 8	July 28
Section III	1	-	-

The consequence Subject M anticipated and was afraid of in response to assertive behaviour was: "being yelled at."

On the Cues for Tension and Anxiety Survey Schedule, Subject M indicated she often experienced tension in her forehead and neck. Anxiety would cause her heart to beat faster and to pound and various parts of her body would shake or tremble. Sometimes, her stomach would feel nauseous, she would grind her teeth and feel faint or dizzy. In order to rid herself of tension or anxiety, she would take a few deep breaths and let the shaking pass.

Subject M returned one Behavioural Diary Sheet. She had made three brief trips outside her home, all of them with her husband.

Outcome

Before the third treatment session, Subject M developed a virus and could not attend. The second session was the last she attended. Subject M said that she almost did not make it even to the first session and had only done so with strong encouragement from a friend.

Telephone contact was maintained with either Subject M or her husband for several weeks. After the treatment sessions had ended, a letter was sent to Subject M recommending the St. Boniface Hospital program as a source of assistance for the future. Apparently, some communication had already occurred between the Hospital and Subject M when we last spoke with her.

Group Results

The results of the group as a whole will be discussed in three ways: the results from the standard assesment forms, graphed in Figures 1.1 through 3.5; the general results on perceived progress from specially prepared Client and Significant Other Evaluation Forms (see Tables 8.1 to 8.3); and the results from the evaluation forms indicating the most significant aspects of the program from the participant point of view and the satisfaction of significant others with the program and the participants' progress in the program (see Tables 9.1 and 9.2).

Standard Assessment Forms

There is no one way to isolate consistencies or changes across the group as a whole on these measurement forms. As mentioned earlier in the report, the group was far from homogeneous in terms of the types of people who participated. They varied widely in age,

background and duration of the problem. Both males and females, married and single, employed and unemployed were represented. The individuals in the group were also diversified in the perceived level of phobia and related problems each brought to the treatment program. Based on some feedback from the participants themselves, it would seem that the completion of these forms was strongly influenced by how each individual was feeling in general at a particular time and by the state of their phobic problems during the preceding week or day. A broader awareness of progress, or lack of progress, over time, became more evident in the Client Evaluation Forms on which the participants had an opportunity to take a retrospective view of their phobic problems and to make a self-assessment in their own words.

As with any self-report forms, there is a risk of the participants engaging in an exercise of social validation when determining their responses. By combining evaluations with the standard forms, it was hoped that a double check might be provided on the way individuals responded over the course of time. The group leaders stressed, at each assessment point, the importance of being as accurate as possible since this would aid in planning subsequent parts of the program and in developing material for possible future programs. By and large, it was felt that the responses on the evaluation forms were realistic and not merely what participants might have thought the leaders wanted to hear. It can only be assumed that the results from the standard forms are essentially representative of the individuals' perceptions of their phobia, related feelings and activities at given points in time. If avoidance still appeared to be high at the close

of treatment but an individual felt less concerned about the phobia or felt he/she would now avoid situations less if choosing to do so, this was necessarily regarded as progress in view of the program's emphasis on personal responsibility and decision-making. To begin with, the amount of outside activity an individual was already engaged in was quite different in each case so the amount of change had much to do with personal expectations. Sometimes these expectations were based on what people wanted to do, sometimes on what they felt they should be doing and sometimes on both. Occasionally, it appeared that an individual's expectations of him/herself changed somewhat throughout treatment.

With this in mind, the results from the standard forms are presented as follows: the five scores from the Fear Questionnaire (Figures 1.1 to 1.5), the four selected dimensions of the Crown-Crisp Experiential Index (Figures 2.1 to 2.4), and the five sub-categories of the Depressive Behavior Survey Schedule which were rated the most consistently across subjects (Figures 3.1 to 3.5). Subject F has been excluded from the results of the Depressive Behavior Survey Schedule except for Category VI (Figure 3.5) due to the number of omissions on her form. Results from the Social Anxiety Survey Schedule have been excluded because items were missed by four subjects at one point or another.

On the Fear Questionnaire, the agoraphobia sub-scale score was the central item of concern for this program. Although there is a little variation during treatment for Subject F, the agoraphobia scores of the other five subjects decreased consistently throughout treatment

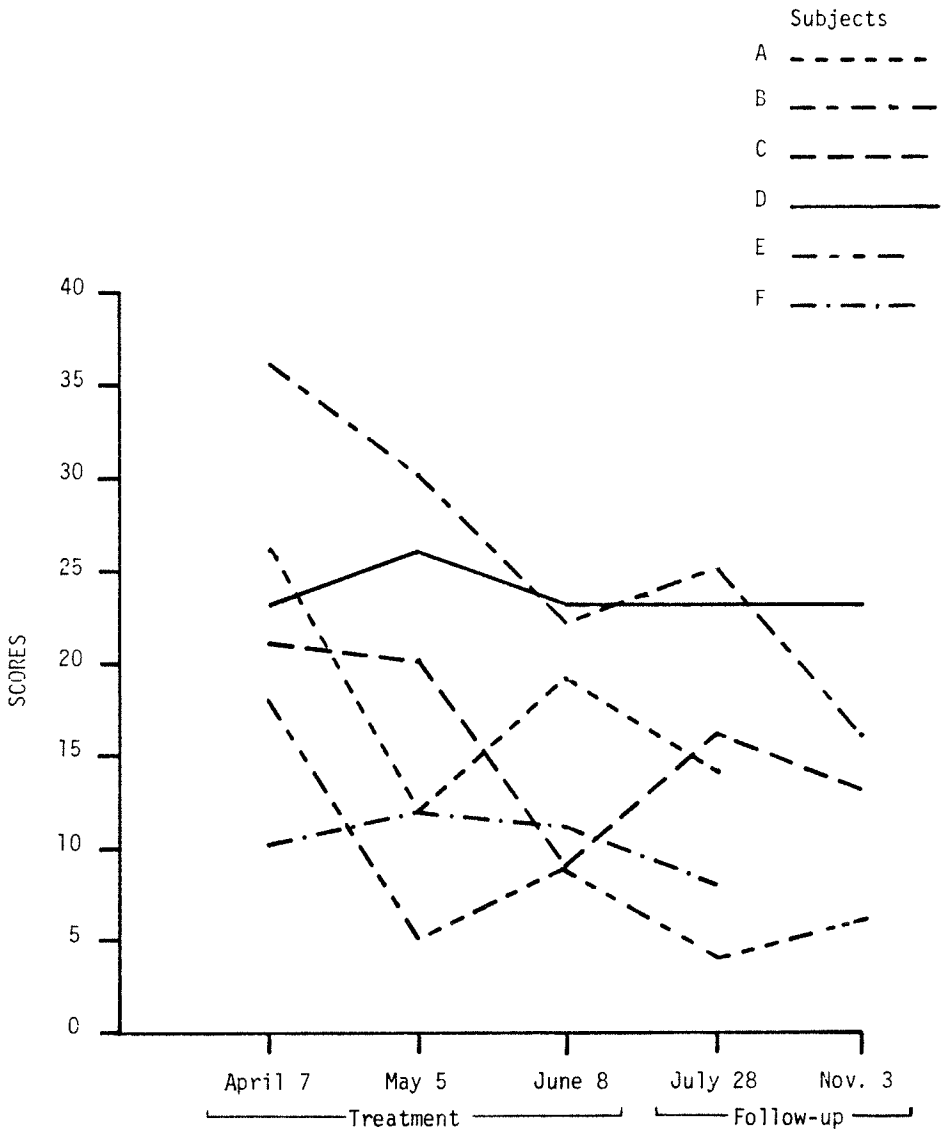

Figure 1.1

Scores on the Anxiety-Depression
Sub-Scale of the Fear Questionnaire

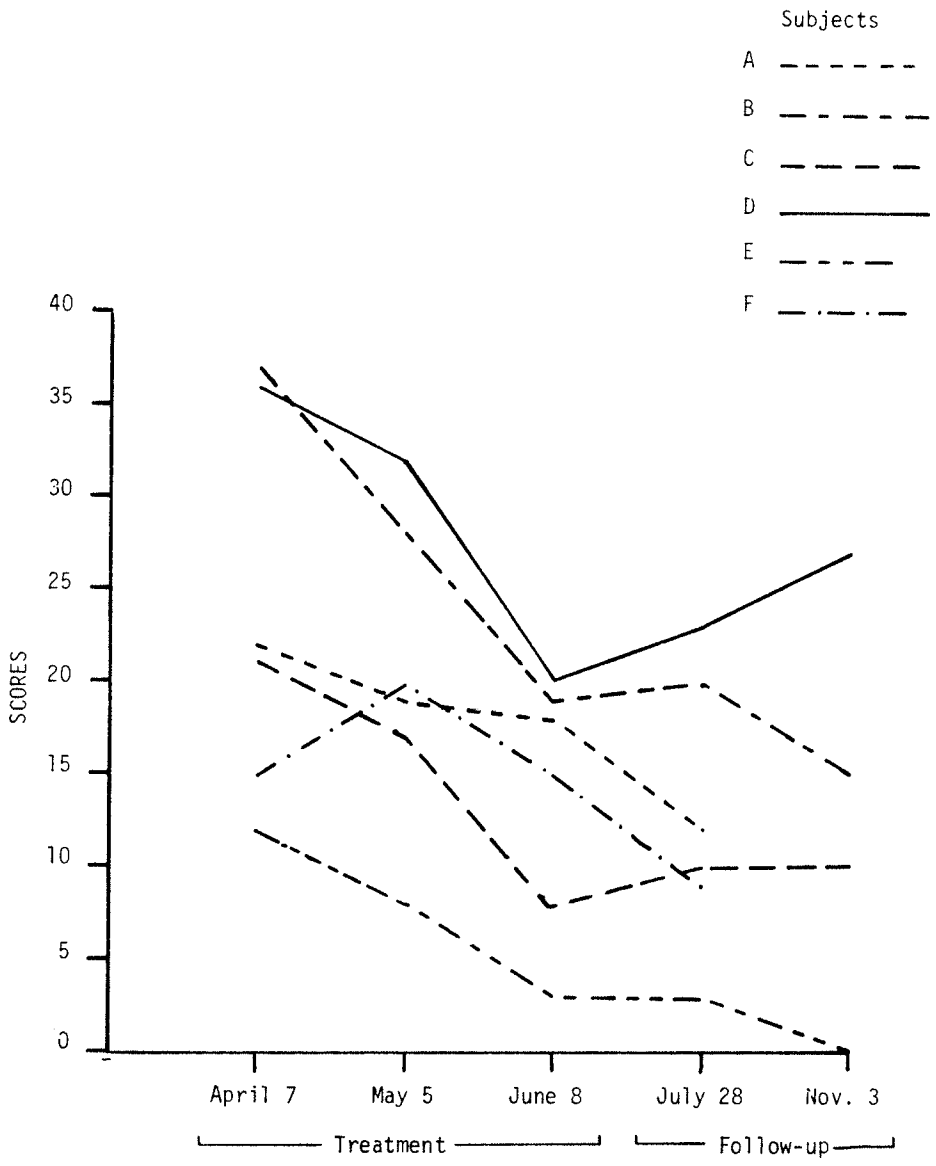

Figure 1.2

Scores on the Agoraphobia Sub-Scale
of the Fear Questionnaire

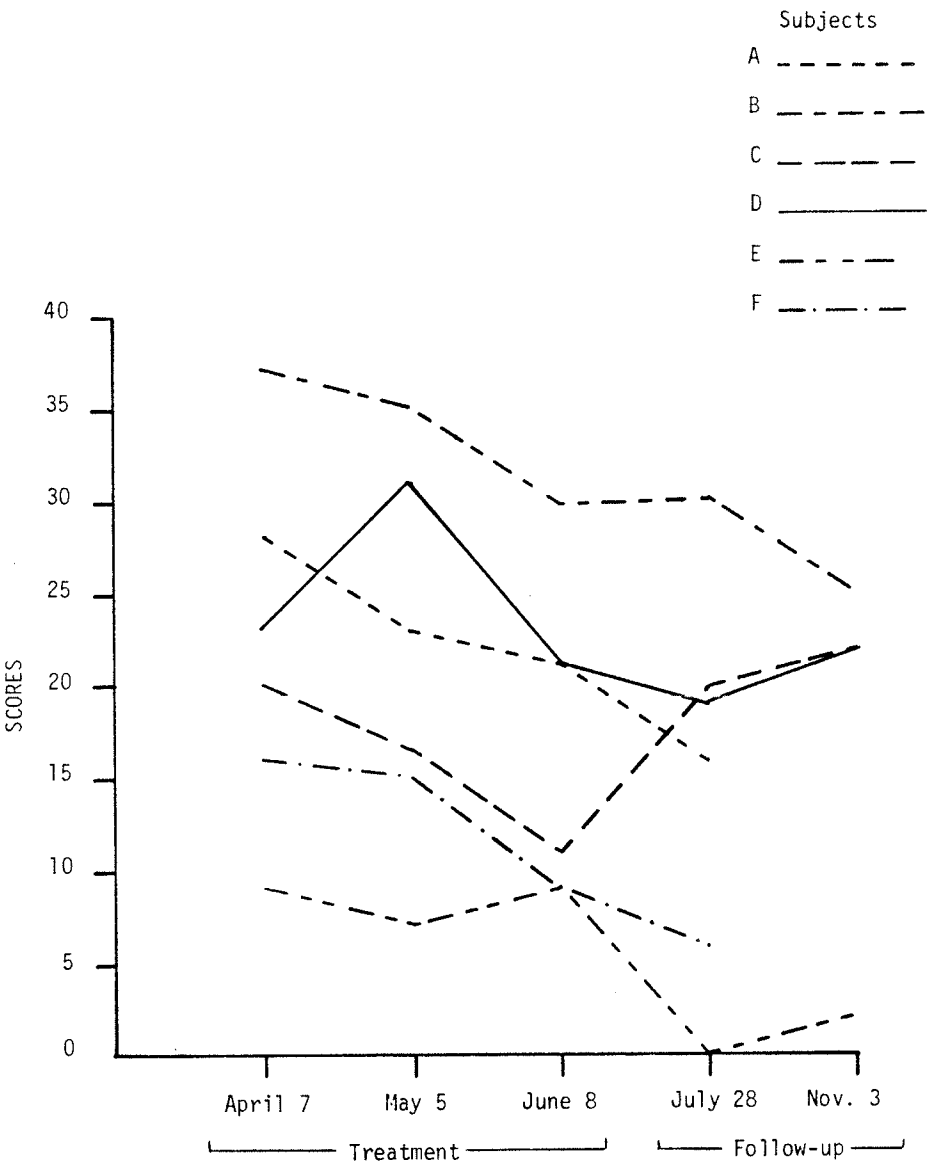

Figure 1.3

Scores on the Blood-Injury Phobia
Sub-Scale of the Fear Questionnaire

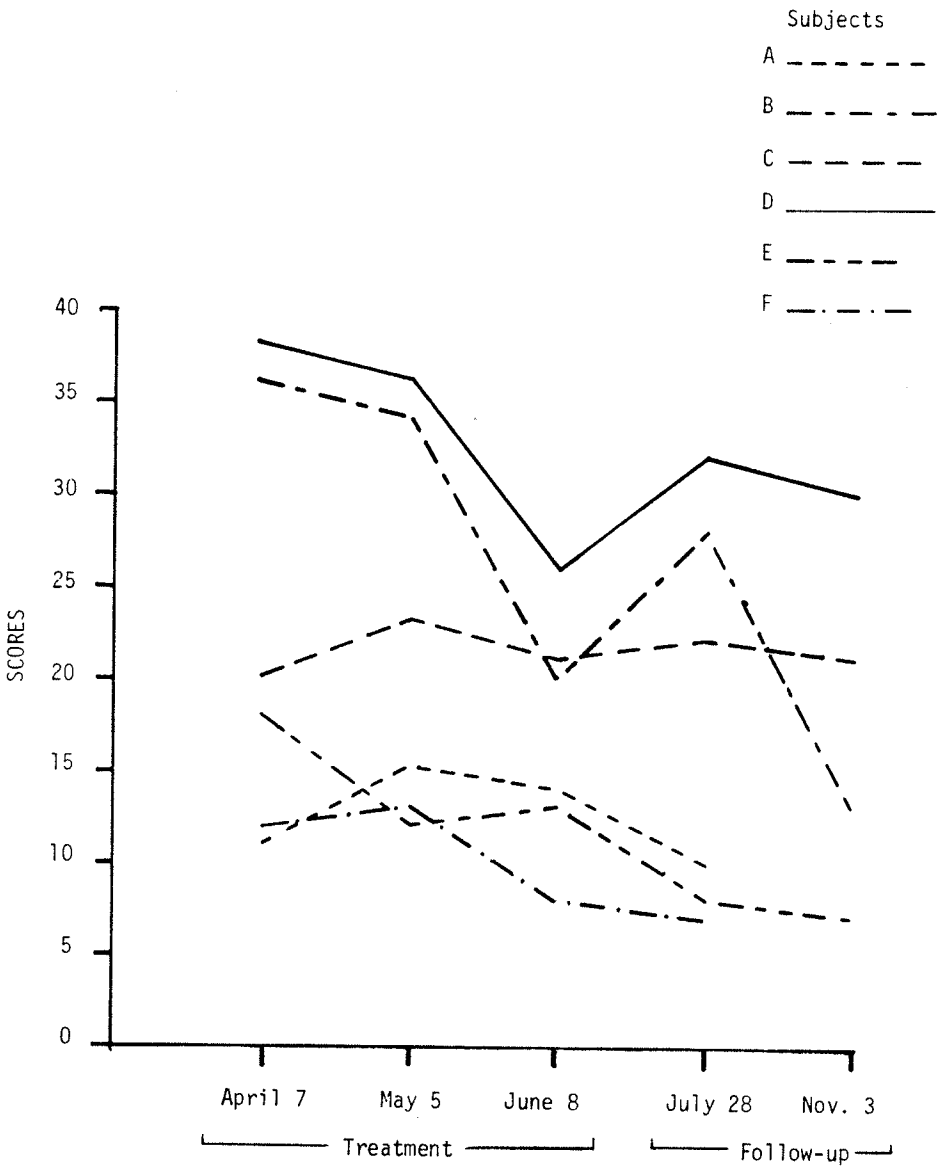

Figure 1.4

Scores on the Social Phobia
Sub-Scale of the Fear Questionniare

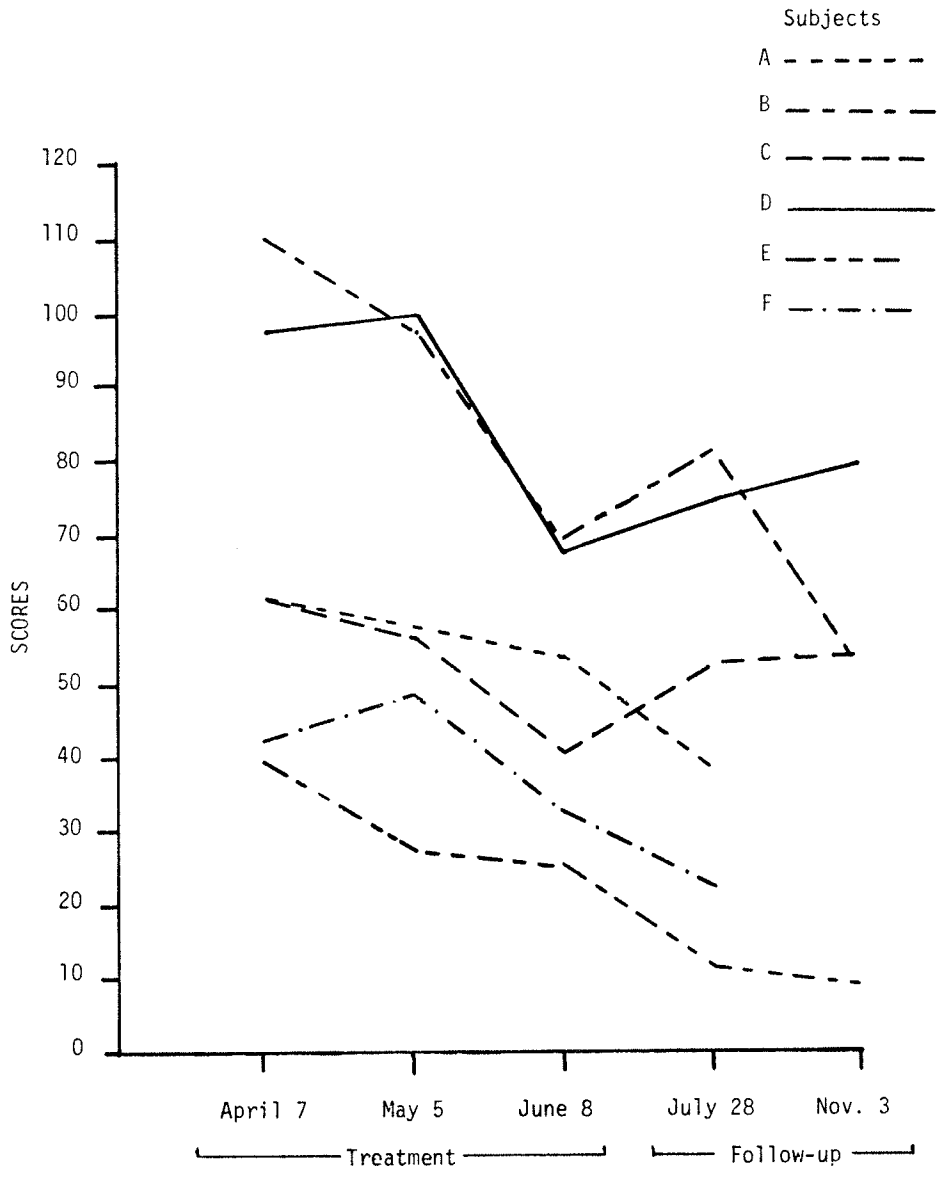

Figure 1.5

Total Phobia Scores on the Fear Questionnaire

(see Figure 1.2). The scores of four of the subjects increased slightly at follow-up (July 28). The scores for the other three subjects either decreased from or remained the same as the scores obtained at the July 28 follow-up.

The scores of three of the four subjects who attended the November 3 follow-up decreased again or remained the same. The score for Subject D increased at November 3. The increases particularly at July 28 could be attributed in part to the loss of group support and the resultant fear of loss of motivation. The one increase at November 3 may be for the same reason but it is also possible that outside factors contributed in either case.

Figures 1.1, 1.3, 1.4 and 1.5 provide a general indication of the relationship between agoraphobia, mood (Figure 1.1) and two other common phobias (Figures 1.3 and 1.4). Blood-injury phobia and social phobia tended to run high in this group. Both seemed to be affected positively for most subjects by the treatment for agoraphobia. This may have something to do with phobia treatment in a group which could contribute to a decreased sense of social isolation. The blood-injury phobia response is a little more difficult to explain but might relate to a general decrease in anxiety and a lessening fear of such agoraphobia indicators as chest panics associated with impending cardiac arrest or the feeling of going insane.

The fact that anxiety-depression scores varied up and down at different points of treatment and follow-up could be indicative of the questionnaire's sensitivity to changes in mood. All scores were, however, lower at the final point of assessment when compared to the

beginning of treatment with the exception of Subject D whose scores went up and then returned to their former level. Probably, of all the subjects, Subject D had the most difficulty articulating his feelings.

The Crown-Crisp Experiential Index has been described as a "brief, conveniently administered, reasonably valid and reliable measure of personality for use in screening and research " (Crown and Crisp, 1979, p. 4). The results have been considered with this in mind--a general indication of several personality characteristics which could be regarded as "symptoms" if severe. Generally speaking, the free-floating anxiety and phobic anxiety scores are the highest for this group among the dimensions selected for consideration.

On the phobic anxiety scale, Crown and Crisp (p. 16) found that female phobic scores tend to be aligned with age, peak scores falling into the age range 35 - 39, whereas there is no relationship between age and scale scores for males in the study conducted. Only one of the females in the group falls within this age range. All the initial female scores are approximately equivalent. It should be remembered that the phobic anxiety dimension is a composite of phobic characteristics and may not relate to agoraphobia exclusively. It appears that, for this group, where phobic anxiety exists, free-floating anxiety also exists to an approximately equal or greater degree.

On the free-floating anxiety dimension all the subjects' scores are lower at July 28 than at April 7 but vary, from a decrease of one point to a decrease of five points. Phobic anxiety scores at July 28 are all lower when compared to April 7 with the exception of Subject F

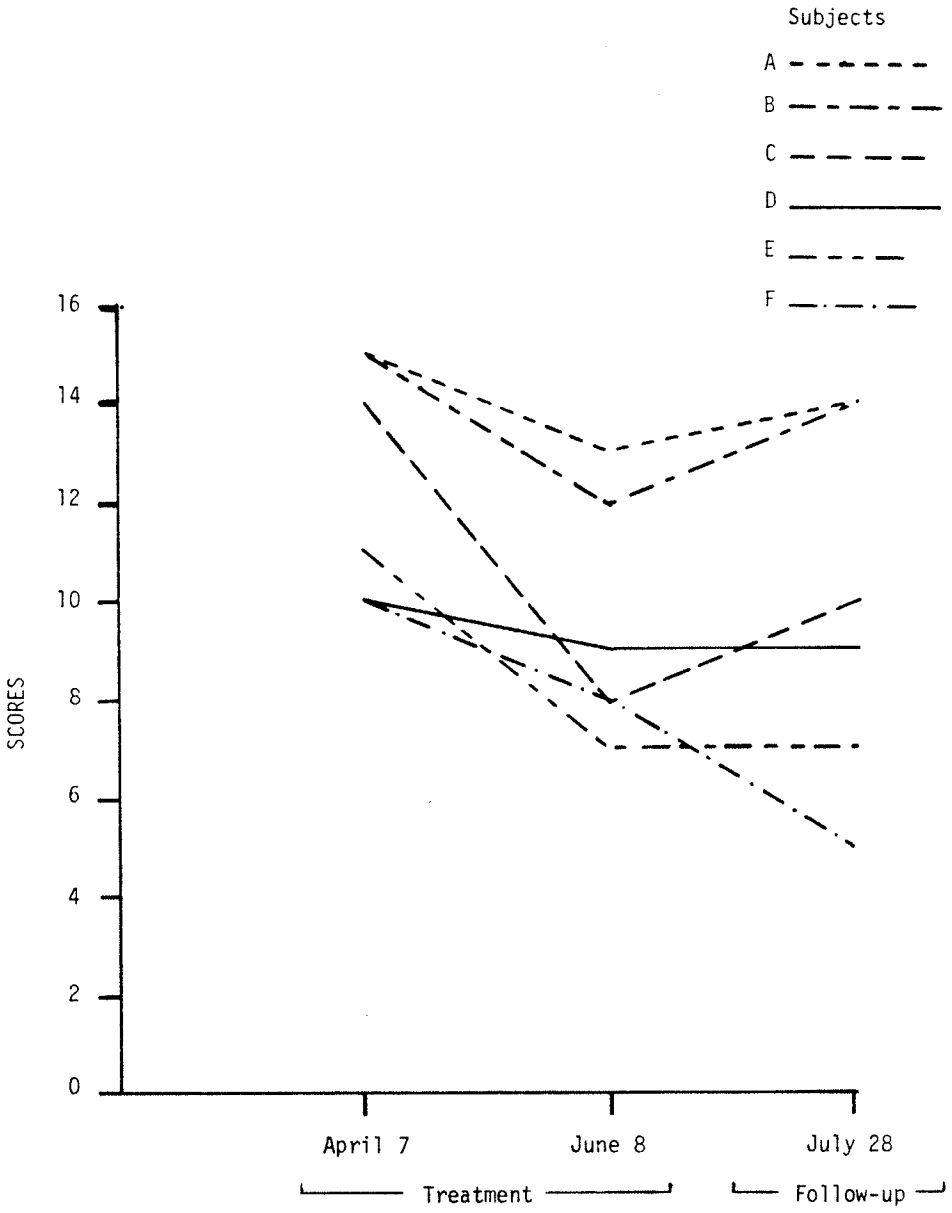

Figure 2.1

Scores on the Free-Floating Anxiety
Sub-Scale of the Crown-Crisp Experiential Index

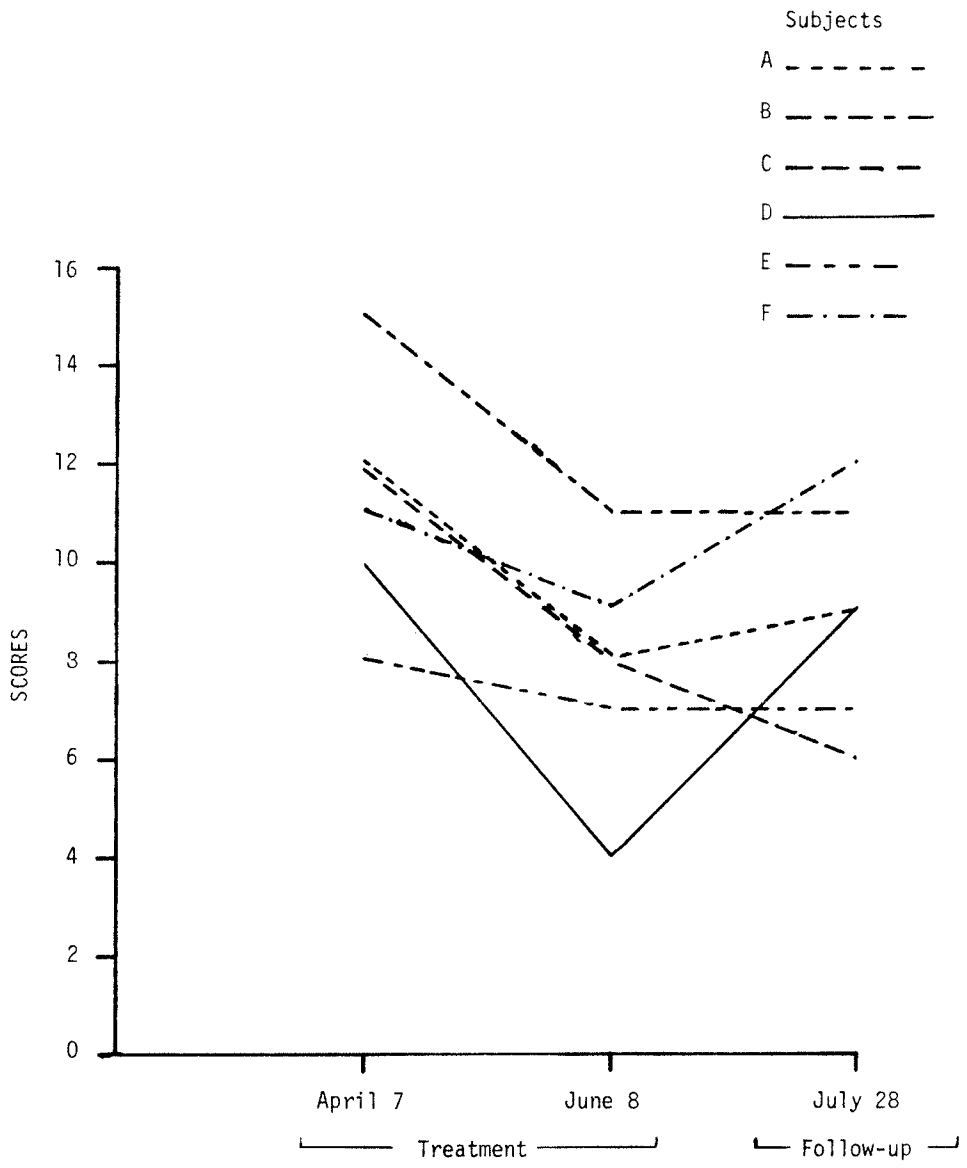

Figure 2.2

Scores on the Phobic Anxiety
Sub-Scale of the Crown-Crisp Experiential Index

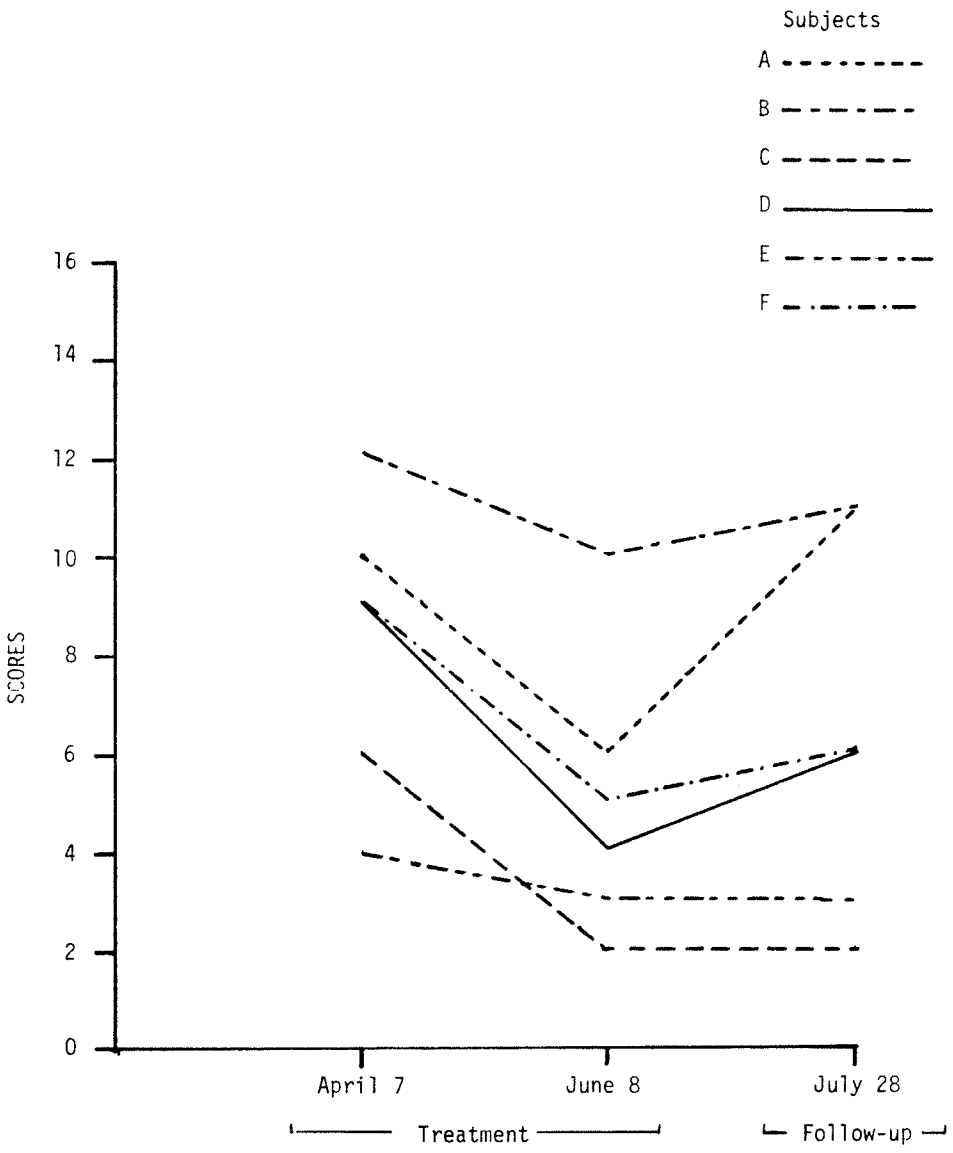

Figure 2.3

Scores on the Somatic Anxiety
Sub-Scale of the Crown-Crisp Experiential Index

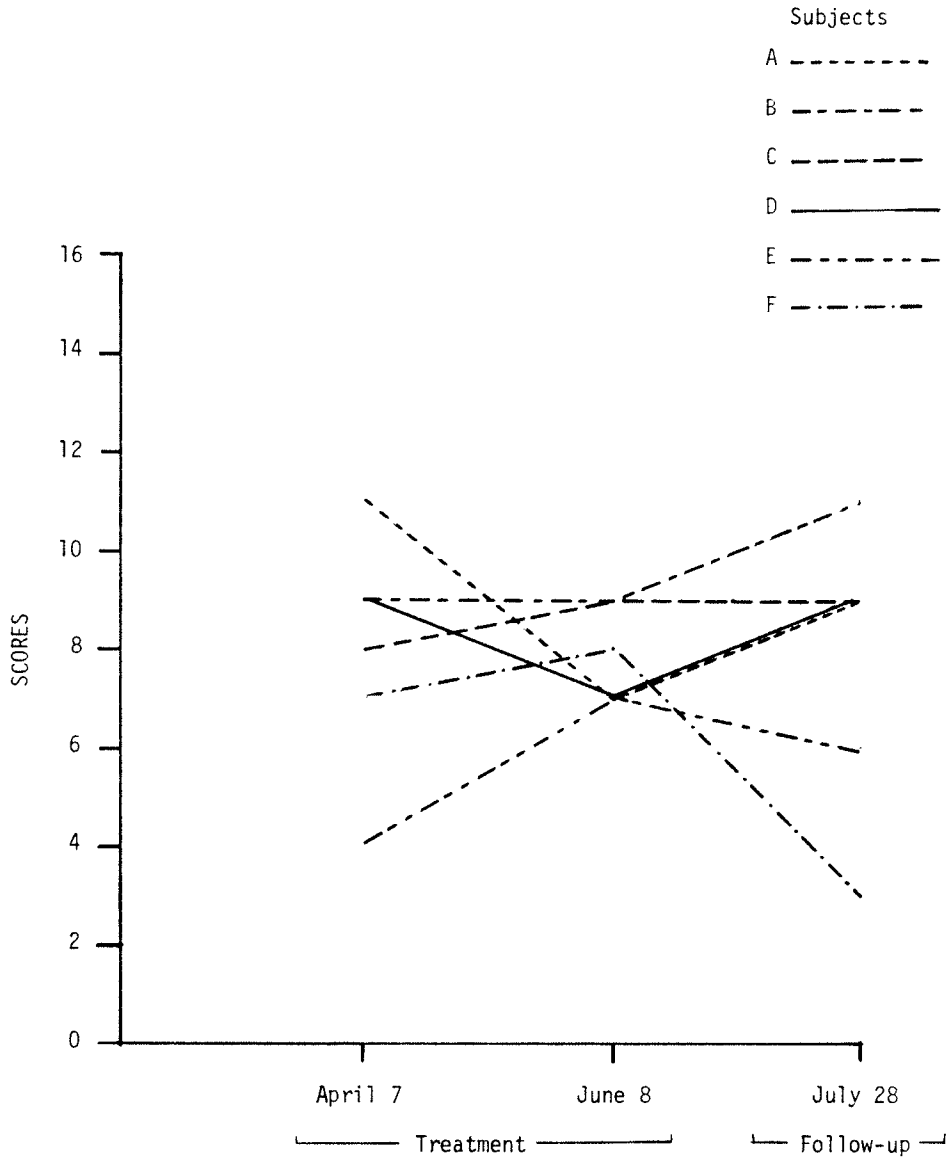

Figure 2.4

Scores on the Depression
Sub-Scale of the Crown-Crisp Experiential Index

whose score increased by one point. The others decrease anywhere from one to six points. Somatic anxiety scores all decrease at July 28 except for Subject A whose score increased by one point. At July 28, two subjects' depression scores decreased, two increased and two remained the same when compared to April 7. With the possible exception of Subject D, it would appear that this group is slightly more phobic and anxious than depressed, according to the Index.

On the Depressive Behavior Survey Schedule, Subject F has been excluded from the comparison except for the results from Category VI due to inconsistency of response. Category IV has been excluded as all but one subject omitted items in this area. In the areas of depressive behaviour under consideration a few trends can be isolated (see Figures 3.1 to 3.5).

In Category I (thoughts and feelings) the perceived frequency of depressed behaviour appeared to decrease or remain the same comparing April 7 and July 28. In Category II (somatic complaints), comparing April 7 and July 28, the problem appeared to decrease for four subjects and remained the same for one. In Category III (decreased activities), the problem appeared to decrease for three of the five subjects being considered and increased for two at July 28. In Category V (increased undesirable activities), ratings at July 28 were the same in three cases and lower in two cases. In Category VI (problems in decision-making, concentrating and relating), the problems appeared to increase in four cases, decrease in one, and remained the same in one case, when comparing July 28 to April 7 recordings.

Putting these results together, it would appear that if the

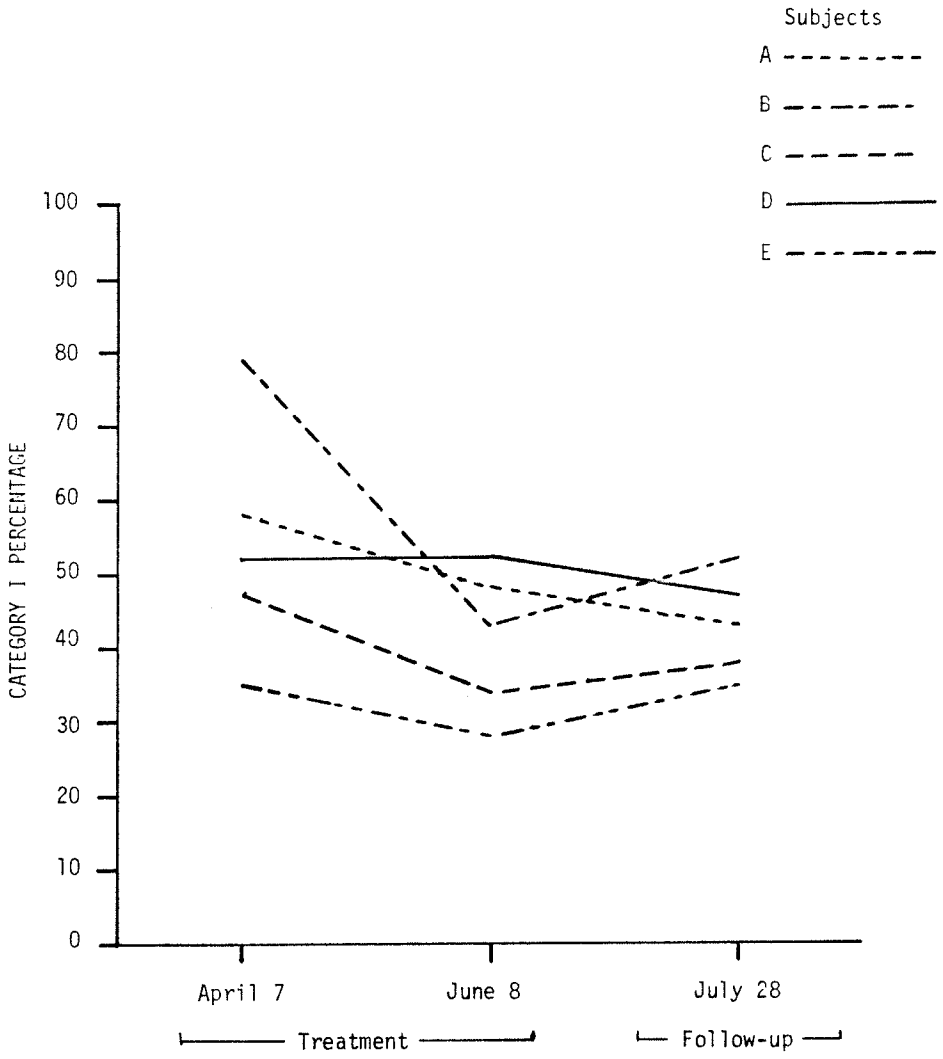

Figure 3.1

Ratings as a Percentage of Maximum Possible Score on the 'Thoughts and Feelings' Sub-Category of the Depressive Behavior Survey Schedule

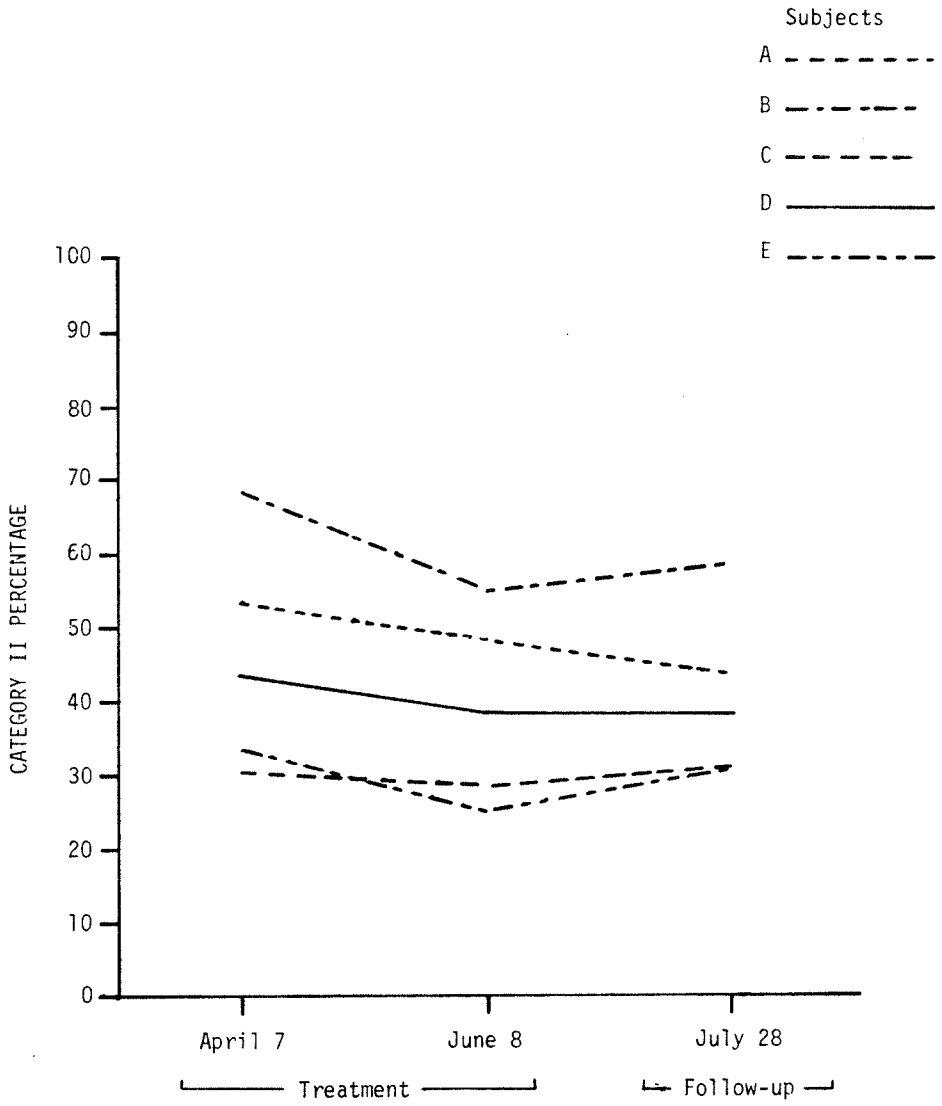

Figure 3.2

Ratings as a Percentage of Maximum Possible Score on the 'Somatic Complaints' Sub-Category of the Depressive Behavior Survey Schedule

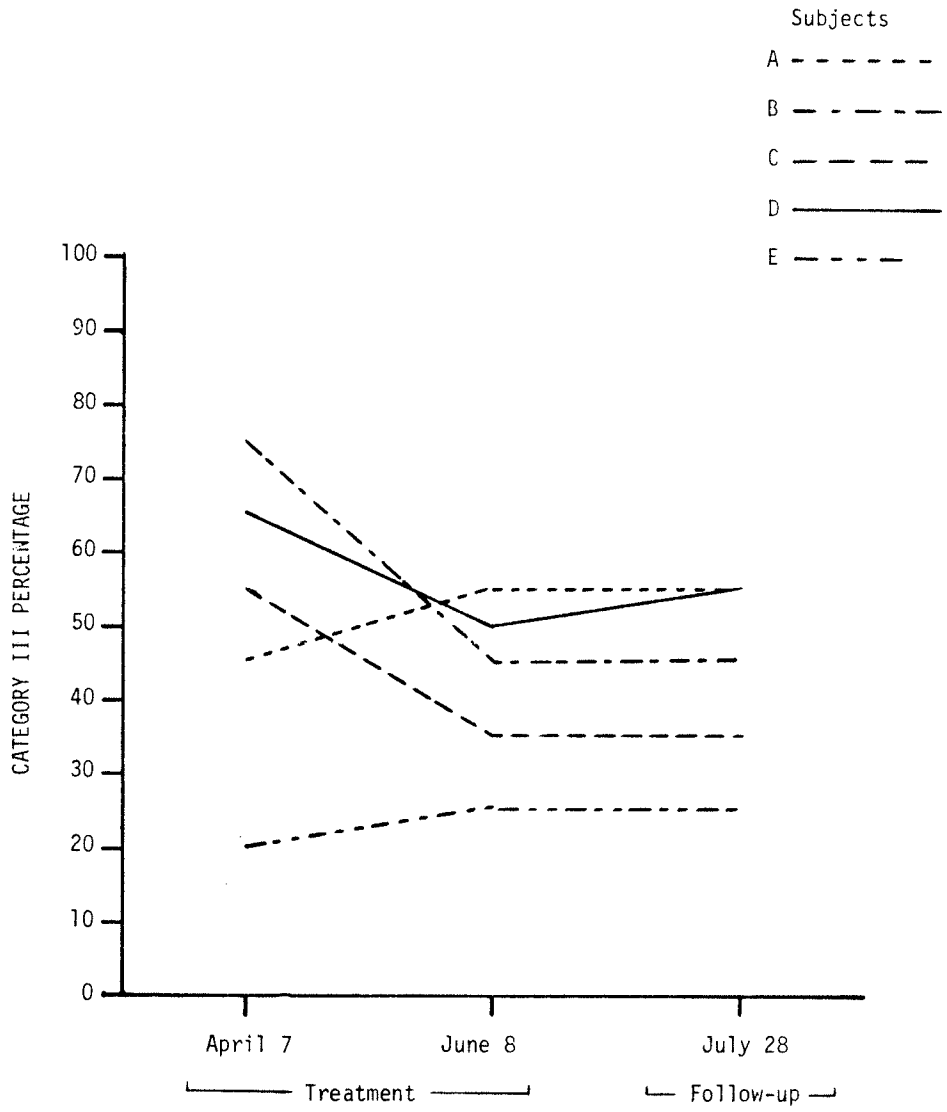

Figure 3.3

Ratings as a Percentage of Maximum Possible Score on the 'Decreased Activities' Sub-Category of the Depressive Behavior Survey Schedule

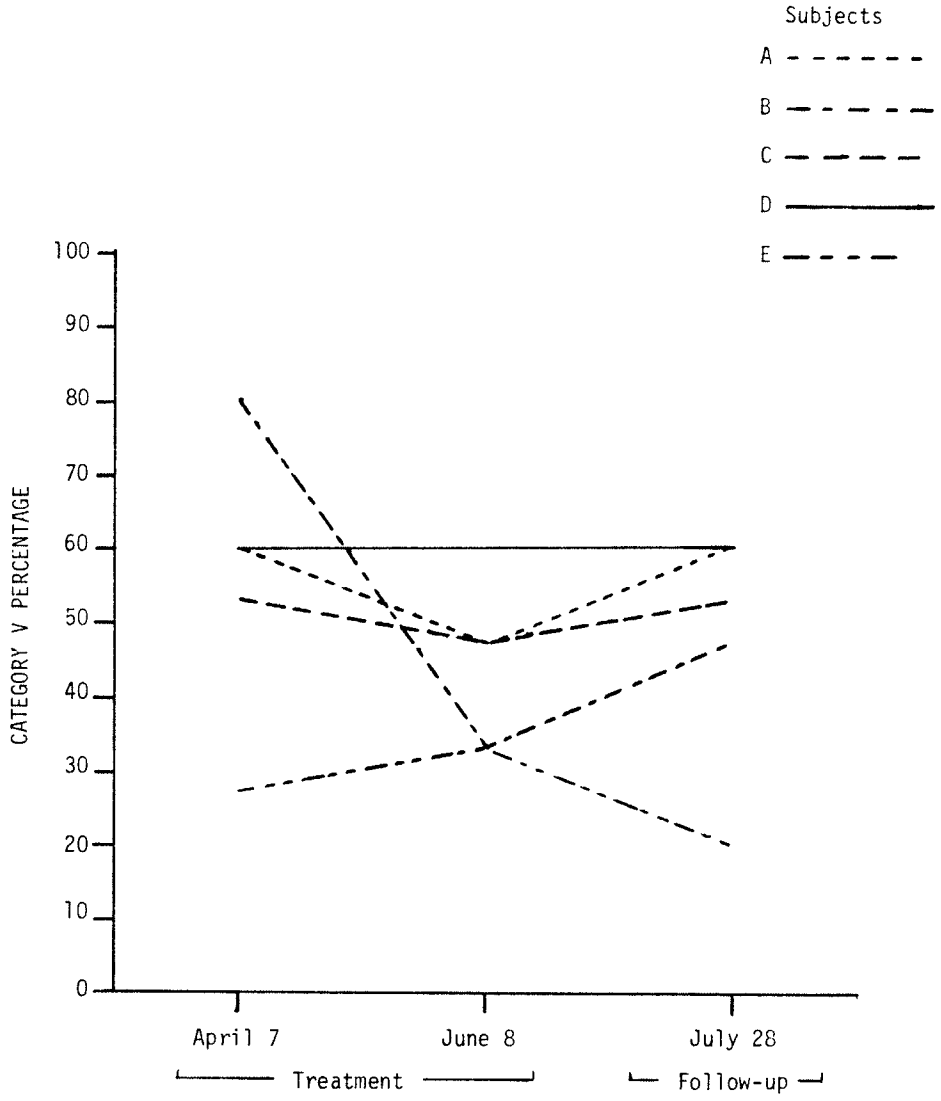

Figure 3.4

Ratings as a Percentage of Maximum Possible Score on the 'Increased Undesirable Activities' Sub-Category of the Depressive Behavior Survey Schedule

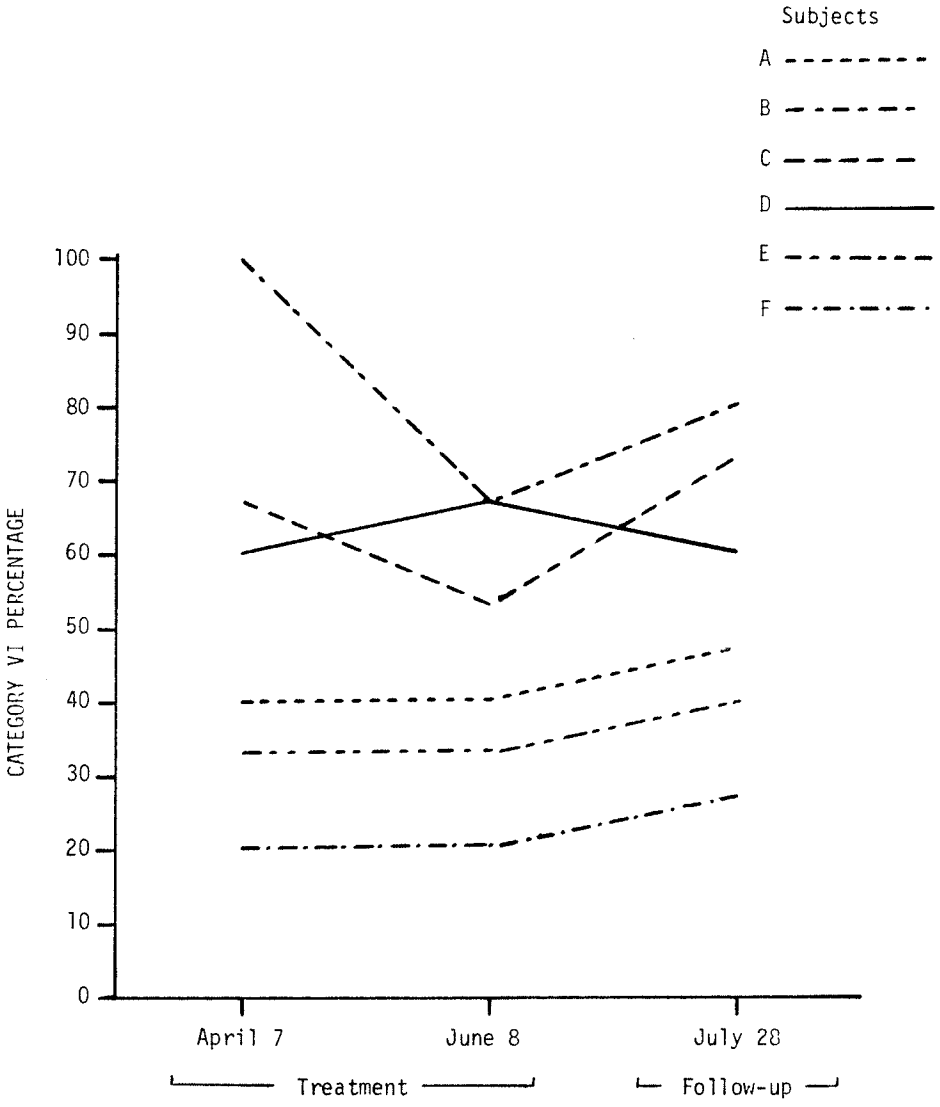

Figure 3.5

Ratings as a Percentage of Maximum Possible Score on the 'Problems in Decision-Making, Concentrating and Relating' Sub-Category of the Depressive Behavior Survey Schedule

treatment program was having an effect on the dimensions of this Schedule, the dimension most positively affected was Category I (thoughts and feelings). The least positive effect overall was in Category VI, where only one subject indicated a decrease in problems involving decision-making, concentrating and relating.

The Social Anxiety Survey Schedule provided a general idea of those social situations which bothered people most. While there was some variation from point to point in the level of discomfort an individual thought an item might cause, the most consistently and highly difficult situations for the majority of subjects appeared to be those involving public speaking--particularly to a large group.

The Assertive Behavior Survey Schedule was used to provide some feedback on the assertion problems experienced by the subjects and on the effects, if any, of the session devoted primarily to a film and discussion on assertiveness. Since a full assertiveness training program was not part of the program package, it was not expected that the subjects would develop a much more assertive approach in all their dealings. It was hoped that some of the concepts of assertion would be recalled at least, as a beginning step. In some cases, this appeared to be what happened although it was evident from the differing responses and the consequences feared or anticipated that some subjects were weighing this knowledge against their current feelings and what they actually felt able to do.

Evaluation Forms

As the progress results from the Client and Significant Other Evaluation Forms have already been discussed, only brief responses requiring a single check mark are tabulated for comparison purposes in

this Section. Tables 8.1 through 8.3 are representative of client and significant other responses to perceived progress at the various assessment points. Table 8.1 contains the client responses to progress in overcoming phobic problems during treatment as they were recorded at May 5, June 8 and July 28. Table 8.2 represents the significant other responses to several aspects of progress as this was considered after July 28. The November 3 evaluation was worded differently and has therefore been tabled separately for responses related to the treatment period and for the period between July 28 and November 3 (see Table 8.3). Two subjects were not present on November 3 but one mailed in an evaluation form. This subject's response has been included in the Table.

Table 8.1

Brief Responses from Client Evaluation Forms Re: Progress During Treatment

Subject	Progress May 5 Yes	May 5 No	June 8 Yes	June 8 No	July 28 Yes	July 28 No
A	X		X		X	
B	X	X	X		X	
C	X	X	X		X	
D	X		X		X	
E	X		X		X	
F	X		X		X	

Note: Subjects B and C responded both "yes" and "no" at May 5.

Table 8.2

Brief Responses from Significant Other Evaluation Forms
Re: Anxiety, Time Spent Away from Home, and General Client Progress

	Anxiety			Time Away from Home			General Progress		
Subject	Increased	Same	Decreased	Increased	Same	Decreased	Not Better	Same	Much Better
A			X	X					X
B			X	X					X
C	X			X					X
D			X	X					X
E			X	X					X
F			X	X				X	

Note: Significant Other Evaluation Forms were returned after the July 28 follow-up. The above responses are comparing the subjects state at this point to before the group treatment program.

Table 8.3

Brief Responses from November 3 Client Evaluation Forms Re: State of Problem with Agoraphobia

Subject	State of Problem with Agoraphobia: Treatment Plus July 28			July 28 to Nov. 3		
	Decreased	Increased	Same	Decreased	Increased	Same
A	X[a]					X[a]
B	X			X		
C	X			X		
D	X			X		
E	X					X
F	-	-	-	-	-	-

Note: Subjects A and F were not present November 3. Subject A's mailed-in responses (a) have been recorded.

Table 9.1 represents participant responses to various components of the program in terms of usefulness for each individual. Table 9.2 contains the level of satisfaction with the program and with subject (participant) progress indicated by significant other respondents.

The most useful components for the majority of participants appear to be the dinner outing, the shopping centre visits, the bus trip (for those who went), the assertion film and the homework assignments (reading and in vivo practice). The visit to the University of Manitoba Library was not a high anxiety item for one participant and was, therefore, perceived as less useful. Diary keeping was not a popular item in general according to in-session discussions. Most participants found it useful over time for understanding fluctuations in their own behaviour and anxiety levels.

Table 9.1

Number of Participants Rating Program Components at Three Levels of Usefulness

Program Component	Not Useful	Moderately Useful	Very Useful
Group discussions		3	3
Tactics for coping with panic/anxiety		2	4
Relaxation techniques		3	3
Keeping a diary	1	2	3
Visit to shopping centre (Zellers)			6
Dinner outing			6
Learning to rate anxiety (0-100)		2	4
Establishing goals (hierarchies)		3	3
Homework assignments		1	5
Responsible assertion film		1	5
Bus trip[a]			4
Visit to St. Vital Shopping Centre[b]		1	4
Session with spouses/friends		2	4
Visit to University of Manitoba Library	1	2	3
Visit to shopping centre (K-Mart)[c]		1	5

Note: Two subjects did not go on the bus (a) and one subject did not visit St. Vital Shopping Centre (b). Their responses (if any) to these itmes have been excluded. The responses to the final item (c) were taken from the May 5 evaluation form. All other items were included on the evaluation form of June 8.

Table 9.2

Levels of Satisfaction of Significant Others with the Program and with Subject Progress

	Program			Subject Progress		
Subject	Not at all Satisfied	Moderately Satisfied	Very Satisfied	Not at all Satisfied	Moderately Satisfied	Very Satisfied
A			X			X
B			X			X
C			X			X
D			X			X
E			X			X
F			X			X

Note: The Significant Other Evaluation Form was returned after July 28 follow-up session.

The July 28 evaluation form asked for a written response concerning most helpful and least helpful aspects of the program. The "most helpful" items cited were: various group *in vivo* experiences, coping skills, relaxation training, group discussions, being with other people, and group leadership. The "least helpful" items were: keeping a diary, *long* walks, shortage of discussion on private problems and physical ailments, and some parts of relaxation training (one participant felt this produced only a minimal change in tension).

In response to the question: "Was the group treatment program a valuable experience for you?" all participants responded "yes" (as opposed to "no" or "sometimes").

At the November 3 follow-up opinions were sought from the four

group participants present on the most important, valuable or useful aspects of the program. All four were in agreement on the following: going out together (group in vivo outings), information regarding coping tactics, relaxation techniques, the support system provided by the group (creating motivation, making friends), and the group leadership (with emphasis on encouragement provided). These participants had also noticed what they described as a personal change of attitude toward their problem. They felt this represented a significant form of progress--a sense of optimism that the problem could be overcome.

Conclusion

The behavioural group approach described in this report offers several benefits not always available in other agoraphobia treatment methods. It is, for example, relatively inexpensive and less consuming of therapist time in terms of the number of clients served than individual and long-term programs. Also, the educational aspect of the program can be both supportive and realistic, allowing clients the opportunity to make informed choices about target goals and participating in treatment procedures.

In this program, clients are dealt with in a straight-forward manner with an emphasis on increasing self-direction and self-awareness in relation to the phobic problem. Since more responsibility may be assumed by the phobic person in the process of treatment, the transfer of new knowledge and activity into the individual's immediate environment is more easily facilitated. This approach also helps to minimize the possibility of clients becoming dependent upon the therapists for ongoing direction and guidance. Clients are also prepared in advance for the possibility of intermittent setbacks as part of the process of change. By doing so, it is hoped that they will be able to react to them with less extreme distress and discouragement, knowing that a setback can be temporary and need not indicate a total or permanent loss of progress.

All essential information disseminated in the program is clear and concise and can be prepared in the form of handouts. The participants can keep these to consult in the future or share with relatives and friends to whom they wish to explain the phobia. In this way the

therapists' knowledge of the phobia is transferred to the clients who, in turn, can use this information to increase the level of understanding of those around them.

While the treatment format can be relatively simple--centering on group in vivo exposure and self-directed practice--elements of other techniques such as cognitive restructuring, assertion training and relaxation training can be built in to accommodate a variety of needs. By providing treatment in a group, the benefits of the basic treatment package are enhanced by increasing actual social contact and alleviating feelings of isolation, strengthening social reinforcement and motivation to practice, and broadening the phobic's knowledge base through the sharing of individual experience. In this program, an attempt was made to foster a partial continuation of these group effects by involving significant others in the educational process and making them aware of things they could do to facilitate practice endeavours.

The practicum program, as outlined, accomplished essentially what it set out to do. No dramatic "cures" were guaranteed and none were produced, but, on the whole, each participant made some significant steps toward the ultimate goal of overcoming the phobia and its debilitating effects. Also, a perception of progress and the feeling of optimism this induced was experienced by everyone at some point in time.

While it appears that some participants made more progress than others, the fact that pre-treatment activity and avoidance levels varied considerably within the group must be noted in evaluating the

results. Each person began treatment at a different stage in the behavioural continuum so the definition of progress assumed an individual meaning in terms of personal circumstances, goals and expectations. Also, environmental factors played a larger, continuous role during treatment in some cases than in others. In two cases, unexpected medical problems confounded the maintenance of post-treatment levels of change.

Setbacks were not unusual in this group. Each participant had at least one. The effect these had varied with the individual but, since behavioural fluctuations were not unexpected and had been discussed, most participants came to view them as less threatening and less frustrating over time. Some also began to notice that these reversals did not set them back as far as before or erase all effects of progress.

All of the participants had had some form of professional advice in relation to the phobia prior to entering this program. Many had also undergone some kind of previous treatment either for the phobia or its related effects. As far as can be determined from comments and discussion, this program was perceived as a more direct and constructive form of assistance in clarifying phobic problems, providing appropriate support, and in helping individuals to overcome avoidance behaviour.

From the viewpoint of both therapists and participants, group _in vivo_ exposure was the most directly beneficial element of the treatment program overall. Combined with this were the tactics for coping with panic and the cohesive effects of the group itself,

contributing to increased motivation to practice and reduced social isolation. The encouragement provided by the group leaders was also identified as an important program resource. The group leaders probably served a catalytic function in melding disparate experiences into a mutual sense of purpose and support and in helping participants to keep their individual progress levels in perspective.

Although at least one enduring friendship was formed within the group, the diversity of age, experience, environment and home locale likely mitigated against a group relationship extending beyond the treatment sessions. When together, the participants had their phobia, the efforts to overcome it and the support of the group leaders in common. In this sense, they formed a cohesive group, concerned with one another's feelings and accomplishments in mastering the phobia. It was not the intent of the group program to foster continuing post-session contact between the participants but, if a goal had been to develop an ongoing self-help group, extensive advance planning would probably have been needed to facilitate the process in light of the disparities mentioned.

The program participants were selected in part on the basis of existing motivation to alleviate or eliminate the phobia. Thus, the desire for change was present from the outset. The function served by the group experience was one of increasing motivation to do something specific about the problem, in this case, confronting fearful situations more frequently in self-directed practice. An even stronger motivating factor was created in the optimism generated by the experience of progress. It was evident that a sense of hope and self-confidence

did much to change the participants' views of the phobia and their efforts to deal with it.

As they began to relax more with each other in the sessions, the participants shared their feelings more easily. At the outset, several individuals had been very concerned about the possibility of acquiring new fears if exposed to the worries of other agoraphobics. Although this posed a slight problem for one member at least, the difficulty was of short duration. It seemed to be realized that sharing concerns could have more benefits than drawbacks. By the end of treatment, a number of individuals thought they would have appreciated more opportunity for discussion of personal problems--an indication of the growing comfort level within the group. It appears that all the benefits of group therapy outlined in Sansbury's nine hypotheses (1979) were borne out to some degree in this experience.

The phobic fluctuations often observed in research and practice were evident in the reports of the program participants as was the central phobia characteristic described by Goldstein and Chambless (1978) as "fear of fear." Low levels of self-sufficiency or self-esteem were also present in relation to the phobic condition. The participants had difficulty initially in differentiating between levels of anxiety (they generally considered their phobic anxiety to be consistently high). As treatment progressed, an awareness of changing anxiety levels increased as individuals began to pay more attention to their reactions in different situations.

Although some appeared to be better than others in attributing the phobic response to situations other than those in which they felt

fearful, everyone, at some point, was confused about the source of the fear. The experience of extreme anxiety or panic is often overwhelming and may limit the ability to concentrate or think clearly. When this is combined with a lack of knowledge about the phobia and a sense of being alone with the problem, it is not surprising that phobic individuals may have difficulty drawing a connection between their heightened anxiety level in a particular situation and other events or circumstances not immediately apparent.

Although conflict per se was not identified as the major contributor, all the participants noted some dimension of stress surrounding the onset of the phobia or the onset of avoidance behaviour. While for some the earlier stressful events still held a place of separate and special significance in their lives (e.g. death in the family), for others these events were only important insofar as they represented the start of the phobic problem.

The assessment procedures tapped a number of areas which the program did not endeavour to treat directly. It was evident that high levels of generalized or free-floating anxiety were present in all participants and that other phobias, notably social and blood-injury fears, figured in varying degrees. Some form of depression had also been experienced by most participants but did not, on the whole, match the feelings of anxiety in level or intensity. Treatment appeared to have some effect on these areas but, like the state of agoraphobia itself, the levels of other measured fears or emotions fluctuated at various points. The presence and variation of other fears, anxiety and depression could be attributed to several factors,

operating singly or in combination: ongoing traits of personality, the extended effects of agoraphobia, and outside events not necessarily related to the phobia but adding to a general level of distress. The therapists were aware, in some instances, of other events which may have impinged on contemporary stress levels for the individuals concerned and may also have affected their mood and perception of the phobic condition at different points in time.

While the group program, as described, was effective in facilitating changes in phobic behaviour, it is possible that some alterations to the content and format might enhance the benefits of this kind of behavioural treatment for similar agoraphobic clients. The intent of these suggestions is not to make treatment more complex but rather to round out the usefulness of a group-based intervention to meet specific individual needs.

Although treatment in a group has a number of decided advantages over individual treatment for agoraphobia, a few drawbacks are created when the group varies widely in age and experience as this one did. When discussions of phobic problems and in vivo activities are organized in a group and when the program itself is operated on a time-limited basis, flexibility is necessarily restricted to some degree. Although adjustments were made to accommodate individual needs wherever possible, the program inevitably functioned for the most part in terms of the majority. It was recognized that some participants might have benefited more by a longer, slower approach to treatment, particularly in situations where pre-treatment avoidance levels were high, where the agoraphobic condition was of long duration or where outside factors

seemed to impinge on treatment effects.

Group in vivo exposure was difficult for everyone at some point due to the high levels of anxiety it produced. For those who had been engaged in only small amounts of outside activity prior to treatment, the high anxiety levels were compounded by the strain of unaccustomed exercise. A slower approach to treatment might help to alleviate this problem by applying a more gradual introduction to in vivo exposure.

While the duration of the problem may or may not affect an individual's ability to change avoidance behaviour, it is possible that attitudinal response patterns may be more firmly established in situations where the phobia has continued over many years. The importance of the cognitive changes accompanying changes in phobic avoidance behaviour cannot be underestimated. Michaels (1979) notes in her article that she began to feel she was on the road to recovery when she noticed she was no longer thinking constantly about the phobia and was able to concentrate fully on an ordinary activity without worrying about when and where she might have her next anxiety attack. This change of thinking marked a significant step in progress after some time spent in behavioural treatment and following a year of phobic disturbance. A similar though less dramatic attitudinal change was noted by several group members in the final follow-up session. It may be that each individual will arrive at this point at different and unpredictable times. If how quickly this happens is at least partially a factor of duration of the problem and events occurring outside treatment which affect a person's mood, it could be beneficial to put an equal or greater emphasis on program components which will

encourage participants to focus on the cognitive aspects of change. This may mean providing additional assistance to help participants resolve personal problems which seem to be adding to their general, daily stress level. It might also indicate a valuable role to be played by such procedures as cognitive restructuring and problem-solving.

Cognitive restructuring was utilized on a group basis in this program to help the participants recognize the thought patterns which tend to accompany and amplify phobic avoidance. However, a greater emphasis on this aspect would likely have been useful in some cases. Problem-solving training was not built in to the program from the outset and there are indications from the results (on the Depressive Behavior Survey Schedule, for example), that all of the participants could have benefited from some skill-learning in this area.

Hafner (1983) has suggested that men who are pre-occupied with physical ailments and who fear being left alone may find in vivo exposure a less acceptable form of treatment than women or than men who do not display these characteristics. Where these difficulties exist, it may be helpful to provide extra input aimed at clarifying the role of emotional and physical factors acting in concert in maintaining heightened anxiety levels and the role of the individual in deciding to take charge of his own reactions. Where the amount of time needed by one individual is too great or the content of extra input inappropriate to be dealt with on a group basis, individual therapy could be conducted as a supplement to the group program.

While most of the suggested alterations could be accommodated in

a group approach, individual therapy provided by a therapist who is supportive of the behaviour group treatment program might be advantageous in some situations. It could, for example, help to foster the appropriate cognitive changes more rapidly and allow some participants the extra assistance needed to help them keep pace with the group as a whole. Individual therapy could also be utilized to deal with marital or parenting problems or other difficulties which may be unique to one person's circumstances but not of concern to the rest of the group. One participant in this program was receiving therapy on an individual basis as well as attending the group sessions. The individual input was in this case complementary to the group approach and no doubt facilitated directly or indirectly the improvements in phobic behaviour.

The recent literature indicates a current trend towards the use of anti-panic medication as an adjunct to in vivo exposure in the treatment of agoraphobia. The emphasis in this group was aimed at taking less or no medication to combat anxiety and as such seemed to be in agreement with the desire of most participants to be rid of anxiolytic medication altogether. While anti-panic medication may help especially in severe cases, to get the person back into the phobic situation to begin with, the question of possible dependency on the drug still arises. Another issue to be considered is the discrepancy between urging an individual to use their own skills and resources in confronting fearful situations and then giving them medication to help them do so. In order for phobic persons to regain confidence in their ability to cope with their fears, it seems that the use of anti-panic

medication would also have to be phased out at some point. Drug therapy may be useful at the beginning of treatment but should probably be used sparingly since it may actually hinder the changes in phobic patterns of thinking which seem to play a crucial role in process of emotional recovery.

Mathews, Gelder and Johnston (1981) suggested that cognitive therapy may be particularly useful in instances where individuals do not respond to exposure treatments. They also recognized the need for future research to determine more clearly what specific mechanisms will facilitate exposure practice, help to reduce or control the experience of anxiety, and lead to the reduction of fear and avoidance in exposure to phobic situations. While the effectiveness of this form of treatment (notably, in vivo exposure) has been supported favourably by empirical data, the causes and characteristics of agoraphobia and the role of therapist, client mood and environment, in relation to treatment outcomes, are still a matter of speculation to a large degree. Perhaps a more holistic approach in research and practice would augment the benefits now achieved by behavioural exposure treatments. In this sense, an understanding of agoraphobia and its effects on thought, emotion, action, and environment--on the total person--could provide the knowledge base necessary for understanding a wider range of behavioural problems.

APPENDICES

Appendix A: Statement of Intent

AGORAPHOBIA TREATMENT GROUP

Group Leaders/Consultants: Rayleen De Luca
Ruth Anthony

Psychological Service Centre
University of Manitoba
Telephone Number.....474-9222

Participants in the Agoraphobia Treatment Group and the Group Leaders/ Consultants will be meeting on a regular weekly basis beginning on:

WEDNESDAY, April 7th,1982
at
7:00 p.m.
at the
Psychological Service Centre
in the
Fletcher Argue Building, Room 109
University of Manitoba

All future sessions will be held at the same time and location unless otherwise agreed to and planned for in the group.

It is understood that this therapy program is time-limited, and will consist of approximately 8 to 10 sessions. Participants will be asked to complete assessment forms, to keep their own records in the form of diaries, and to complete homework assignments as part of the course of treatment. The weekly meetings will include discussion, skill learning to prepare participants to cope with anxiety and, when appropriate, practice sessions. Follow-up information will be requested from the participants after the treatment sessions have ended.

It is further understood that the Group Leaders/Consultants named above are graduate students working under the supervision of Professor Derek Jehu at the Psychological Service Centre of the University of Manitoba.

* * * * * * * * * * * * * * * * *

I have been informed that personal information regarding my treatment is confidential and may only be shared and used in conjunction with other professional consultants for the purpose of aiding my treatment. The data collected in this treatment program may be used for report purposes, however, any details that may reveal my identity will be excluded. While successful treatment is not guaranteed, the Group Leaders/Consultants will endeavour to assist each participant in attaining his/her treatment goal.

I have read, understand, and agree to the group treatment plan and the additional information related above.

Participant's Name:_____
(please print)

Participant's Signature:_____

Signatures of Group Leaders/Consultants:_____

Date:_____ _____

Appendix B: Modified Fear Questionnaire

Name _____ Age _____ Sex _____ Date _____

Choose a number from the scale below to show how much you would avoid each of the situations listed below because of fear or other unpleasant feelings. Then write the number you chose in the space opposite each situation.

0	1	2	3	4	5	6	7	8
Never avoid it.		Sometimes avoid it.		Avoid it about 50% of the time.		Avoid it most of the time.		Always avoid it.

---

1. Main fear you want treated (describe in your own words on the line below and then place a number in the space to indicate how often you would avoid it).

   _____

2. Injections or minor surgery . . . . . _____
3. Eating or drinking with other people. . . . . _____
4. Hospitals . . . . . _____
5. Travelling alone by bus . . . . . _____
6. Walking alone in busy streets . . . . . _____
7. Being watched or stared at. . . . . _____
8. Going into crowded stores . . . . . _____
9. Talking to people in authority. . . . . _____
10. Sight of blood. . . . . _____
11. Being criticised. . . . . _____
12. Going alone far from home . . . . . _____
13. Thought of injury or illness. . . . . _____
14. Speaking or acting to an audience . . . . . _____
15. Large open spaces . . . . . _____
16. Going to the dentist. . . . . _____

How would you rate the state of your anxiety at this moment on the scale below?

0	1	2	3	4	5	6	7	8
No fears or anxiety present.		Slightly uncomfortable. Interferes with my life sometimes.		Moderately uncomfortable. Interferes with my life about 50% of the time.		Definitely uncomfortable. Interferes with my life most of the time.		Extremely uncomfortable Interferes with my life always.

Please circle one number between 0 and 8 above to indicate the state of your anxiety.

Now, choose a number from the scale below to show how much you are troubled by each problem listed, and write the number in the space opposite each problem.

0	1	2	3	4	5	6	7	8
Hardly at all.		Slightly troublesome.		Moderately troublesome.		Definitely troublesome.		Extremely troublesome.

---

1. Feeling unhappy or depressed . . . . . _____
2. Feeling irritable or angry . . . . . _____
3. Feeling tense or panicky . . . . . _____
4. Upsetting thoughts coming into your mind . . . . . _____
5. Feeling you or your surroundings are strange or unreal . . . . . _____

BEHAVIOURAL DIARY

DATE	TIME		MEDICATION	ANXIETY (0 - 100)	DESTINATION AND/OR PURPOSE OF TRIP	WHO WENT WITH YOU?	DID SOMEONE MEET YOU?	DID YOU GO ALONE?	TRANSPORT			
	OUT	BACK			(with approximate distance from home)				WALK	CAR	BUS	OTHER (please describe)

NAME:_____ June 8, 1982

1) Describe briefly how agoraphobia affected your life before these group meetings started (e.g. things you could not do; state of mind; relationships with others, etc.)_____

2) Do you feel you have made some progress in the past ten weeks in overcoming the problems stated above? YES_____ NO_____

IF YES, briefly describe in which ways._____

IF NO, can you suggest any reasons why?_____

3) Have you found the following experiences worthwhile or useful to you?

	NOT USEFUL	MODERATELY USEFUL	VERY USEFUL
Group Discussions	____	____	____
Tactics for Coping with Panic/Anxiety	____	____	____
Relaxation Techniques	____	____	____
Keeping a Diary	____	____	____
Visit to Shopping Centre (Zellers)	____	____	____
Dinner Outing	____	____	____
Learning to Rate Anxiety(0 - 100)	____	____	____
Establishing Goals(Hierarchies)	____	____	____
Homework Assignments	____	____	____
Responsible Assertion Film	____	____	____
Bus Trip	____	____	____
Visit to St. Vital Shopping Centre	____	____	____
Session with Spouses/Friends	____	____	____
Visit to U. of M. Library	____	____	____

COMMENTS OR SUGGESTIONS: _____

Appendix E: July 28 - Client Evaluation Form

NAME:_____ July 28, 1982

1) Describe briefly how agoraphobia affected your life before you began to attend the group meetings. (e.g. things you could not do; state of mind; relationships with others, etc.)

_____

_____

_____

_____

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_____

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_____

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_____

2) Do you feel you made some progress in overcoming the problems stated above during the ten weeks of the group treatment program?

YES____ NO____

IF YES, briefly describe in which ways._____

_____

_____

_____

_____

IF NO, can you suggest any reasons why?_____

_____

_____

_____

3) What parts of the group treatment program were most helpful to you?

_____

_____

_____

_____

4) What parts of the group treatment program were least helpful to you

_____

_____

_____

_____

5) What has happened to you since the group meetings ended? Do you feel you have improved, remained the same, experienced some setback as far as agoraphobia is concerned?_____

_____

_____

_____

_____

_____

_____

6) Depending upon your answer to question #4 above, can you suggest any reasons for the change or lack of change mentioned?_____

_____

_____

_____

_____

_____

7) Was the group treatment program a valuable experience for you?

YES____ NO____ SOMETIMES____

PLEASE USE THE REVERSE FOR ANY OTHER COMMENTS YOU MAY HAVE ABOUT THE PROGRAM AND FOR ANY SUGGESTIONS YOU WOULD LIKE TO OFFER FOR IMPROVING FUTURE PROGRAMS. THANK YOU.

Appendix F: November 3 - Client Evaluation Form

NAME:_____ November 3rd, 1982

1. During the 10 weeks of the treatment program plus the follow-up session in July, do you feel your problem with agoraphobia:

   Decreased _____ Increased _____ Remained the Same _____

2. Since we last met (at tne follow-up session in July), do you feel your problem with agoraphobia has:

   Decreased _____ Increased _____ Remained the Same _____

3. Would you please describe briefly the changes (if any) you have noticed in your agoraphobia or in the way you cope with it OR suggest some reasons why no change has occurred if this is the case, since July:

_____

_____

_____

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_____

_____

THE FOLLOWING QUESTIONS ARE CONCERNED WITH THE WAY YOU FEEL OR ACT
THEY ARE ALL SIMPLE. PLEASE TICK THE ANSWER THAT APPLIES TO YOU.
DON'T SPEND LONG ON ANY ONE QUESTION.

1. Do you often feel upset for no obvious reason? *Yes..... No.....*
2. Do you have an unreasonable fear of being in enclosed spaces such as shops, lifts, etc? *Often..... Sometimes..... Never.....*
3. Do people ever say you are too conscientious? *No..... Yes.....*
4. Are you troubled by dizzyness or shortness of breath? *Never..... Often..... Sometimes.....*
5. Can you think as quickly as you used to? *Yes..... No.....*
6. Are your opinions easily influenced? *Yes..... No.....*
7. Have you felt as though you might faint? *Frequently..... Occasionally..... Never.....*
8. Do you find yourself worrying about getting some incurable illness? *Never..... Sometimes..... Often.....*
9. Do you think that 'cleanliness is next to godliness'? *No..... Yes.....*
10. Do you often feel sick or have indigestion? *Yes..... No.....*
11. Do you feel that life is too much effort? *At times..... Often..... Never.....*
12. Have you, at any time in your life, enjoyed acting? *Yes..... No .....*
13. Do you feel uneasy and restless? *Frequently..... Sometimes ..... Never.....*
14. Do you feel more relaxed indoors? *Definitely..... Sometimes..... Not particularly.....*
15. Do you find that silly or unreasonable thoughts keep recurring in your mind? *Frequently..... Sometimes..... Never.....*
16. Do you sometimes feel tingling or pricking sensations in your body, arms or legs? *Rarely..... Frequently..... Never.....*
17. Do you regret much of your past behaviour? *Yes ..... No.....*
18. Are you normally an excessively emotional person? *Yes ..... No.....*
19. Do you sometimes feel really panicky? *No..... Yes.....*
20. Do you feel uneasy travelling in buses or the Underground even if they are not crowded? *Very... ... A little..... Not at all.....*
21. Are you happiest when you are working? *Yes..... No.....*
22. Has your appetite got less recently? *No..... Yes.....*
23. Do you wake unusually early in the morning? *Yes..... No ...*
24. Do you enjoy being the centre of attention? *No..... Yes.....*

NAME:_____ AGE____ SEX_____ DATE:_____

25. Would you say you were a worrying person? *Very..... Fairly..... Not at all.....*
26. Do you dislike going out alone? *Yes..... No.....*
27. Are you a perfectionist? *No..... Yes. ....*
28. Do you feel unduly tired and exhausted? *Often..... Sometimes..... Never.....*
29. Do you experience long periods of sadness? *Never..... Often..... Sometimes.....*
30. Do you find that you take advantage of circumstances for your own ends? *Never..... Sometimes..... Often.....*
31. Do you often feel 'strung-up' inside? *Yes..... No.....*
32. Do you worry unduly when relatives are late coming home? *No..... Yes.....*
33. Do you have to check things you do to an unnecessary extent? *Yes..... No.....*
34. Can you get off to sleep alright at the moment? *No..... Yes.....*
35. Do you have to make a special effort to face up to a crisis or difficulty? *Very much so..... Sometimes..... Not more than anyone else.....*
36. Do you often spend a lot of money on clothes? *Yes..... No.....*
37. Have you ever had the feeling you were going to pieces'? *Yes..... No.....*
38. Are you scared of heights? *Very..... Fairly..... Not at all.....*
39. Does it irritate you if your normal routine is disturbed? *Greatly..... A little..... Not at all.....*
40. Do you often suffer from excessive sweating or fluttering of the heart? *No ..... Yes.....*
41. Do you find yourself needing to cry? *Frequently..... Sometimes..... Never.....*
42. Do you enjoy dramatic situations? *Yes..... No.....*
43. Do you have bad dreams which upset you when you wake up? *Never ..... Sometimes..... Frequently.....*
44. Do you feel panicky in crowds? *Always..... Sometimes..... Never.....*
45. Do you find yourself worrying unreasonably about things that do not really matter? *Never..... Frequently ..... Sometimes.....*
46. Has your sexual interest altered? *Less..... The same or greater.....*
47. Have you lost your ability to feel sympathy for other people? *No..... Yes.....*
48. Do you sometimes find yourself posing or pretending? *Yes ... No .....*

PLEASE CHECK THAT YOU HAVE ANSWERED ALL THE QUESTIONS

Name _____ Date _____

Rate each behavior on the five point scale from not at all to very frequently. Make your best guess as to how you feel in general about a behavior.

	Not at all	A little	A fair amount	Frequently	Very Frequently
1. I feel lonely					
2. I have a poor appetite					
3. I feel like killing myself					
4. The future looks hopeless					
5. I feel tired without any reason					
6. I don't want to have sex					
7. I don't feel like working					
8. I am bored					
9. I don't enjoy being with people					
10. I feel guilty					
11. I have trouble making up my mind					
12. I feel dizzy					
13. I am a failure					
14. I have trouble falling asleep					
15. I don't sleep through the night					
16. Things appear hopeless					
17. Nobody cares about me					
18. I cry					
19. I am sad					
20. I don't feel like going out					
21. I'm afraid to stick up for my rights					
22. I wish I were dead					
23. I don't seem to enjoy anything					
24. I have trouble concentrating					
25. I feel inadequate					
26. Noise bothers me					
27. My heart beats fast					
28. I feel helpless					
29. I wake up very early in the morning before I want to					
30. I feel I can't cope with life					

	Not at all	A little	A fair amount	Frequently	Very Frequently
31. I don't enjoy my work					
32. My family doesn't give me pleasure					
33. My stomach bothers me					
34. I don't enjoy school					
35. I don't know how to relate to people					
36. I sit and stare, doing nothing					
37. I am not lovable (likeable)					
38. I am worthless					
39. I am a bad person					
40. I want to hurt other people					
41. I feel anxious					
42. I am going to panic					
43. I tend to be pessimistic					

Appendix I: Social Anxiety Survey Schedule

Name _____ Date _____

Rate each situation on how much anxiety or discomfort you usually experience.

	None at all	A little	A fair amount	Much	Very much
1. Talking to a female my own age					
2. Talking to a male my own age					
3. Talking to a female 10 years older					
4. Talking to a male 10 years older					
5. Talking to a female 10 years younger					
6. Talking to a male 10 years younger					
7. Being at a party with strangers					
8. Being at a party with acquaintances					
9. Being at a party with friends					
10. Being at a party with relatives					
11. Giving a talk to a group of 5 or less					
12. Giving a talk to a group of 10 or less					
13. Giving a talk to a group of 20 or less					
14. Giving a talk to a group of 30 or less					
15. Giving a talk to a group of 30 or more					
16. Talking to a male smarter than I am					
17. Talking to a female smarter than I am					
18. Talking to a male better looking than I am					
19. Talking to a female better looking than I am					
20. When I am with someone else and there is a lull in conversation					
21. I say something I don't intend as funny and people laugh					

	None at all	A little	A fair amount	Much	Very much
22. Someone says to me, "That's a stupid remark"					
23. When I talk and people look bored					
24. I don't get invited to a party that my friends are invited to					
25. Someone sitting next to me on a plane, bus, or train starts a conversation					
26. I walk in late to a party or classroom or meeting and everyone looks at me					
27. I am with a group of males and females and I stutter					
28. I am with a group of males and females and I fumble over my words					
29. I give my opinion and someone disagrees					
30. I make a statement of fact and someone says I'm wrong					
31. I should complain to a store-keeper or salesperson about a mistake or bad merchandise					
32. My closest friend tells me that I am acting silly					
33. I drop a glass in a crowded restaurant and it makes a loud crash					
34. In a group someone asks for my opinion and everybody looks toward me					

Appendix J: Assertive Behavior Survey Schedule

Name _____ Date _____

I. What would you do in the following situations? Indicate by circling number 1, 2, or 3.

A. In a restaurant, you have ordered your favorite meal. When it comes, it is not cooked to your liking.

1. You tell the waitress that it is not cooked to your taste or liking and have her take it back and cooked to your taste or liking.
2. You complain that it is not cooked to your taste or liking, but you say you will eat it anyway.
3. You say nothing.

B. You have been waiting in line to buy a ticket. Someone gets in front of you.

1. You say it is your turn, and you get in front of him.
2. You say it is your turn, but you let the person go before you.
3. You say nothing.

C. In a supermarket, you are waiting in line at the checkout counter. Someone gets in front of you.

1. You say, "I'm sorry, but I was here first," and you take your turn.
2. You say, "I'm sorry, but I was here first," but you let the person go ahead of you.
3. You say nothing.

D. In a drugstore, the clerk has been waiting on someone for about five minutes. He finishes, and it is now your turn, but he starts to wait on someone else.

1. You speak up to say it is your turn, and you take it.
2. You speak up to say it is your turn, but also say that you will let the other person go ahead of you.
3. You say nothing.

E. In a department store, the clerk talks on the phone for at least ten minutes while you are waiting.

1. You say, "Will you please wait on me now? I've been here for ten minutes."
2. You say, "Hurry it up, I've been waiting ten minutes."
3. You say nothing.

F. At the dry cleaners, you notice that your shirt (or other clothing) is not properly cleaned.

1. You say that your clothes are not properly cleaned and that they will have to do them over again.
2. You say that your clothes are not properly cleaned but that you'll take them anyway.
3. You say nothing.

Score _____

II. What do you think will happen if you assert yourself in situations in which you are afraid to do so (for example, speaking up when an injustice is done to you by any of the following)?

A. mother

B. father

C. son or daughter

D. best friend

E. employer or immediate supervisor

F. clerk in a store

G. waiter or waitress in a restaurant

H. boy friend

I. girl friend

J. wife

K. husband

III. In instances where you are afraid to speak up when an injustice is done to you, check which of the following consequences you anticipate and are afraid of:

A. Being yelled at ( )

B. Being given a dirty look ( )

C. Having the person refuse to talk to you ( )

D. Having the person reject you in other ways ( )

IV. With certain important people in your life you feel you give more than you receive, and in these situations you usually:

A. Tell the other person you think the situation is unequal and you expect more from them.

B. Tend to avoid the person or give him less.

C. Do nothing.

Appendix K: Cues for Tension and Anxiety Survey Schedule

Name _____ Date _____

Individuals have different reactions that indicate to them that they are tense or anxious. Check below the ways that apply to you.

1. You feel tense in
   a. your forehead ( )
   b. back of your neck ( )
   c. chest ( )
   d. shoulders ( )
   e. stomach ( )
   f. face ( )
   g. other parts ( )
2. You sweat ( )
3. Your heart beats fast ( )
4. You can feel your heart pounding ( )
5. You can hear your heart pounding ( )
6. Your face feels flush or warm ( )
7. Your skin feels cool and damp ( )
8. You tremble or shake in your
   a. hands ( )
   b. legs ( )
   c. other_____
9. Your stomach feels like you are just stopping in an elevator ( )
10. Your stomach feels nauseous ( )
11. You feel yourself holding something tight (like a steering wheel or the arm of a chair) ( )
12. You scratch a certain part of your body ( ) Part that you scratch_____
13. When your legs are crossed, you move the top leg up and down ( )
14. You bite your nails ( )
15. You grind your teeth ( )
16. You have trouble with your speech ( )
17. You feel like you are going to choke ( )
18. You feel faint ( )
19. You feel dizzy ( )
20. You find yourself breathing fast or heavy ( )

When you feel tense or anxious, what do you do to get rid of the feeling?

1. Compared to before the group treatment program, how would you rate _____ now?

   Not at all better _____
   The same _____
   Much better _____

2. Compared to before the group treatment program, do you feel that the time spent away from home for _____ has

   Increased _____
   Stayed the same _____
   Decreased _____

3. Compared to before the group treatment program, do you feel that _____'s anxiety has

   Increased _____
   Stayed the same _____
   Decreased _____

4. How satisfied are you with the program

   Not at all satisfied _____
   Moderately satisfied _____
   Very satisfied _____

5. How satisfied are you with _____'s progress

   Not at all satisfied _____
   Moderately satisfied _____
   Very satisfied _____

TACTICS TO COPE WITH ANXIETY

(1) I must breathe slowly and steadily in, and out, in, and out, and gradually learn to deal with this situation. I feel terrible at the moment, but it will pass.

(2) I feel horribly tense. I must tense all my muscles as much as I possibly can, then relax them, then tense them again, then relax them until slowly I feel easier in myself.

(3) I'm thinking of the worst possible things which might happen to me. Let's see if they are so bad after all. Let me imagine myself acutally going crazy and being carted off to a mental hospital, or fainting on the sidewalk, or just plain dropping dead. How vividly can I paint those scenes to myself? Let me start with the the ambulance taking me away while I froth at the mouth and spectators laugh at me in the street... or (make up your own scene of horror)_____

_____

_____

(4) What can I do? I have to stay here until I can tolerate this panic, even if it takes an hour. Meanwhile, let me experience the fear as deliberately and fully as possible.

(5) I have to get away, but I know I must remain here.

(6) I feel awful. I could feel better if I imagined something pleasant. For me that would be lying in the warm sun, listening to the sound of the waves or (make up your own pleasant scene)_____

_____

_____

(7) These sensations are ghastly, but maybe I can transform their meaning. This pounding of my heart, it could be because I've just been running a race and that's also why I'm breathing so heavily now. This dizziness in my head, that's because I got up suddenly a moment ago or (make up your own transformation)_____

_____

_____

(8) I am so terrified but I will get over this in time.

(9) I will never get over this, I think, but that's just the way I feel, and in time I will feel better.

(10) I am so embarrassed, but it's something I'll have to get used to.

Appendix N

TEN RULES FOR COPING WITH PANIC

1. Remember that the feelings are nothing more than an exaggeration of the normal bodily reactions to stress.

2. They are not in the least harmful or dangerous--just unpleasant. Nothing worse will happen.

3. Stop adding to panic with frightening thoughts about what is happening and where it might lead.

4. Notice what is really happening in your body right now, not what you fear might happen.

5. Wait and give the fear time to pass. Do not fight it or run away from it. Just accept it.

6. Notice that once you stop adding to it with frightening thoughts, the fear starts to fade by itself.

7. Remember that the whole point of practice is to learn how to cope with fear--without avoiding it. So this is an opportunity to make progress.

8. Think about the progress you have made so far, despite all the difficulties. Think how pleased you will be when you succeed this time.

9. When you begin to feel better, look around you, and start to plan what to do next.

10. When you are ready to go on, start off in an easy, relaxed way. There is no need for effort or hurry.

Appendix O

RULES FOR COPING WITH PANIC
SUMMARY

1. The feelings are normal bodily reactions.
2. They are not harmful.
3. Do not add frightening thoughts.
4. Describe what is happening.
5. Wait for fear to pass.
6. Notice when it fades.
7. It is an opportunity for progress.
8. Think of what you have done.
9. Plan what to do next.
10. Then start off slowly.

Appendix P: General Guidelines for Relaxation Techniques

Preparation: Visit washroom if need be. Remove constraints such as watches and shoes. Remove eyeglasses and contact lenses. Dim lights. Make sure whole body is supported in a reclining position. Keep eyes closed. Don't talk. Don't move unnecessarily.

Amount of time for tensing and relaxing:

TENSE: 5 to 7 seconds (5 seconds only for feet)

RELAX: 30 to 40 seconds to start
this may be increased to 45 to 60 seconds in practising

SIXTEEN MUSCLES GROUPS, IN ORDER, AND TENSING SUGGESTIONS FOR EACH GROUP:

(N.B. Dominant hand is the one you normally use most often.)

1. Dominant hand and forearm. (To tense: make fist, don't raise arm).
   RELAX
2. Dominant biceps or upper arm. (To tense: press albow down, don't raise lower arm or hand, don't bend elbow.).
   RELAX
3. Nondominant hand and forearm. (To tense: same as #1 above).
   RELAX
4. Nondominant biceps or upper arm. (To tense: same as #2 above).
   RELAX
5. Forehead or upper part of face and edge of scalp. (To tense: lift eyebrows toward top of head). **RELAX**
6. Central part of face i.e. upper cheeks, eyes and nose. (To tense: squint eyes and wrinkle up nose). **RELAX**
7. Lower part of face i.e. lower cheeks and jaws. (To tense: bite teeth together and pull back corners of the mouth). **RELAX**
8. Neck and throat. (To tense: pull chin down toward the chest while trying to prevent chin from actually touching the chest).
   RELAX
9. Chest, shoulder and upper back. (To tense: take a deep breath and hold it pulling the shoulder blades together as much as possible).
   RELAX (exhale)
10. Abdominal / stomach muscles. (To tense: tighten the muscles of the abdomen and stomach region, attempting to make them hard. Take a a deep breath and hold it while doing this.)
    RELAX (exhale)
11. Dominant thigh or upper leg. (To tense: try to make the large top muscle of the thigh feel hard and tight. To do this try to make the large top muscle and the 2 smaller ones underneath the thigh pull against each other. Take a deep breath and hold it while doing this.
    RELAX (exhale)
12. Dominant calf or lower leg. (To tense: pull toes up toward head. Take a deep breath and hold it while doing this.).
    RELAX (exhale)
13. Dominant foot. (To tense: point toes, turn foot inward and curl toes. Do this just enought to feel tightness under the arch and ball of the foot. Take a deep breath and hold it while doing this).
    RELAX (exhale)
14. Nondominant thigh. (To tense: same as #11 above).
    RELAX (exhale)
15. Nondominant calf. (To tense: same as #12 above).
    RELAX (exhale)
16. Nondominant foot. (To tense: same as #13 above). **RELAX** (exhale)

REFERENCE NOTE

and

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