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ABSTRACT

Agoraphobia is the most pervasive and serious phobic response seen by clinicians, accounting for approximately 50 to 60% of all phobic problems. The symptoms of agoraphobia, a condition in which an individual fears entering public areas, include fears of leaving home, fainting, entering open and closed spaces, shopping, entering social situations, and traveling far from home. There is much fear generalization to additional stimuli throughout the course of the disorder. Numerous other symptoms are commonly present including panic, "fear of fear," tension, dizziness, frequent depression, depersonalization, obsessions, and stress-related physical complaints. Clinical records indicate that approximately 84% of agoraphobics seen by clinicians are female. This marked sex difference is not seen in other "neurotic" disorders such as anxiety neurosis and social anxieties. Similarities between characteristics of the feminine sex-role stereotype and the typical characteristics of agoraphobia are striking and suggest that the feminine sex-role stereotype may serve as an important etiological variable in the development of these serious symptoms. Sex-role expectations for women often lead to phobic symptoms. The influences of classical and operant conditioning, modeling, and the transmission of information are mechanisms through which female, agoraphobic-like behaviors are learned. (Author)

AGORAPHOBIA

by

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Today I would like to talk about the relationship between the social sex-role stereotype for females and agoraphobia or the fear of leaving one's home in its simplest form. As background let me note that the word "phobia" is derived from the Greek "phobos" meaning panic, fear, dread, or flight. Clinical psychologists generally assign a diagnosis of phobia when an individual avoids specific stimuli that are objectively viewed as posing no real threat. The phobic individual ususally realizes the irrationality of his/her behavior, yet continues to avoid these fear-provoking situations which elicit anxiety and panic states. Th concomitant physiological symptoms of anxiety (e.g., hyperventilation, tachycardia, tremor, sweating) usually accompany acute phobic reactions although there is a great deal of individual variation as to which physiological symptoms predominate (e.g., Malmo & Shagass, 1949).

Agoraphobia is the most pervasive and serious phobic response seen by clinicians. In fact, this disorder accounts for approximately 50% to 60% of all phobic problems (e.g., Marks, 1969). The term agoraphobia is dervived from the Greek word "agora" meaning marketplace or public place of assembly and, thus, describes a condition in which an individual fears entering into public areas. In reality, however, the syndrome is far more complex. For example, agoraphobics report not only fears of entering into public places but rather a generalized fear and avoidance response to leaving a place of refuge (almost without exception the home) and entering into the outside world. Agoraphobic symptoms tend to be more diffuse than is the case with more discrete phobias (e.g., fear of snakes). Goldstein and Stein (1977) note that "agoraphobics tend to be more generally anxious and, at times, may appear undifferentiable from such clinical syndromes as anxiety states, affective disorders, or obsessive neuroses" (p. 173).

Marks (1970) noted that agoraphobic individuals have fears not only of going out into open spaces but also of being in closed spaces, and of shopping, traveling and entering social situations especially when alone. There is much fear generalization to additional stimuli throughout the course of the disorder, and numerous other symptoms are commonly present including panic, "fear of fear", fear of fainting, tension, dizziness, frequent depression, depersonalization, obsessions, and numerous stress-related physical complaints. Furthermore, it is often observed that once the syndrome has perisisted for more than one year it tends to run a fluctuating course, with partial remissions and relapses over a long period of time. Brehony, Geller, Benson, and Solomon (1979) observed that the mean duration of symptoms was about 19 years. Individuals with these fears generally develop extreme dependence upon others to take care of them in phobic situations and report that they feel unhappy, frightened, and demonstrate little confidence in their own abilities to handle themselves in panic situations. It is interesting to notice the similarity of symptoms from person to person and Marks (1970) suggested that there is little doubt from clinical and statistical evidence that agoraphobia is a coherent clinical syndrome with a well-defined cluster of behaviors that persist together over a long period of time. In short, this is a constricting, serious psychological/behavioral problem that disrupts almost all areas of an individual's life for a very long period of time (sometimes an entire lifetime).

The observation that most agoraphobics are female (e.g., Marks & Herst, 1969; Marks, 1970; Roberts, 1964; Brehony et al., 1979) is extremely important. Fodor (1974) noted that, on the average 84% of agoraphobics seen by clinicians are female (ranging 64% to 100%) The data depicted in the following table illustrate the marked predominance of females reported as demonstrating

agoraphobic behaviors.

Table 1

INVESTIGATOR	YEAR	TOTAL N	PROPORTION FEMALE
Tucker	1956	100	.89
Bignold	1960	10	1.00
Warburton	1963	53	.89
Snaith	1963	27	.63
Klein	1964	32	.81
Roberts	1964	41	1.00
Marks & Gelder	1965	84	.89
Marks & Herst	1969	1200	.95
Brehony et al	1979	72	.89

* Table adapted from Fodor, I.G. The phobic syndrome in women: Implications for treatment. In Franks, V. and Burtle, V. (Eds.) Women in Therapy, New York: Brunner/Mazel, 1974.

The majority of agoraphobic women are married. In fact, this epidemiological observation caused Roberts (1964) to refer to the disorder as "Housebound Housewives" since most agoraphobic women defined their role as that of "housewife" or "homemaker". Interestingly, Marks and Herst (1969) observed that 60% of the respondents to their large survey (N = 1200) in Great Britain indicated that they would prefer to work outside the home. These authors identified this group as "discontented housewives" and noted that this group reported more severe symptoms of agoraphobia than women who reported being content with working only in their homes. Specifically,

this group of "discontented housewives" reported more severe phobias, more additional psychiatric symptoms, more fears of being alone, more help from other people was needed to deal with fears, more depression, and more extreme agoraphobic behaviors (e.g. avoidance behaviors). It was surprising, however, that this same group ("discontented housewifes") described their personality and behavior prior to the onset of symptoms as significantly more sociable, less anxious and more independent than did those women content with working only in the home.

More recently, Buglass et al (1977) compared agoraphobic women against a matched control group on a number of measures and found that their agoraphobic subjects (N = 30) were not significantly different from a carefully screened control group in terms of frequency of non-phobic psychiatric disorders since age 16. Additionally, physical illness requiring hospital treatment (both in-patient and out-patient) did not differ between agoraphobic women and matched controls. In short, these researchers could not find any variables on which the agoraphobic women differed from matched controls (e.g., age, sex, SES etc.) except the agoraphobic symptoms themselves.

The marked predominance of females among agoraphobics is startling in view of the absence of such clear sex differences in certain other "neurotic" disorders such as anxiety neurosis and social anxieties (e.g., Hare, 1965; Marks & Gelder, 1965). The possibility that females admit more fears than males does exist (e.g., Katkin & Hoffman, 1976) but this does not adequately explain the differential sex ratios for the various phobic disorders. Indeed, the data suggest that animal phobias and agoraphobia are the phobias of women, whereas other specific and social phobias appear more equally in men and women (e.g., Fodor, 1974; Marks, 1970). In searching for potential cause for these clinical observations one notices an interesting relationship by considering the concept of social learning of sex-role stereotypes

for females.

The agoraphobic individual has frequently been described as soft, passive, anxious, shy, dependent, fearful and non-assertive (e.g., Marks, 1970; Terhune, 1949; Tucker, 1956; Roberts, 1964). The similarity of these agoraphobic characteristics to the feminine sex-role stereotype seems clear. For example, women are viewed (by both men and women) as relatively emotional, submissive, excitable, passive, house-oriented, non-adventurous, and desiring security and dependency (e.g., Bem, 1974; Broverman, Broverman, Clarkson, Rosenkrantz and Vogel, 1970). Fodor (1974) suggested that phobic symptoms, particularly those of agoraphobia are associated with extreme helplessness and dependency, and appear related to the social expectations for women. Additionally, she notes that interpersonal "trappedness" with feelings of being dominated with no outlet for assertive behavior may further enhance the development of agoraphobia. Fodor further suggested that the agoraphobic response is an extreme and exaggerated extension of the sterotypic feminine role. Additionally, it is far more acceptable for a woman to remain home-bound than it is for a man. The role of "housewife" in this culture not only accepts many hours spent in the home but also encourages this behavior. In short, the stereotypic feminine role is typified by qualities of dependency, submissiveness, passivity, fearfulness and non-assertiveness. In contrast, the stereotypic masculine role includes such characteristics as aggressiveness, assertiveness, independence and competency (e.g., Bem, 1974). In light of this information, the concluding comment by Andrews' (1966) extensive review of the phobia literature is extremely significant. He writes that he has never heard of a phobic who has been described as "self-assertive, independent or fearless". Furthermore, the phobic individual is not only characterized by dependency relationships with others but appears to establish broad-based avoidance of activities which involve self-assertion and independence in coping with stressful situations

If there is a clear relationship between the feminine sex-role stereotype and the symptoms of agoraphobia as the data appear to suggest, then it is reasonable to hypothesize some of the following mechanisms:

A. Females are encouraged to behave in ways that "predispose" them to develop agoraphobic-like behaviors (e.g., fearfulness, dependency).

B. Females learn these behaviors through classical or operant conditioning, modeling, and the transmission of information.

As mentioned, the social sex-role for women appears to "reinforce" many hours spent in the home. And it has been only recently that women have found options other than the role of wife and mother wherein most activity takes place in the home. Thus, social contingencies have conspired to actively reward (e.g., through social support etc.) women for taking on the traditional role of wife, mother and "housewife". Also, some women who have opted for non-home oriented careers report that they have suffered some social punishment by family and friends for not meeting these "homebound" expectations of others.

Secondly, it is clear from a number of research studies that parents and other adults tend to respond differentially to male and female children (e.g., Hoffman, 1972) Specifically, it appearts that adults encourage more independent behaviors in male children whereas they are more likely to be tolerant of and reinforce (e.g., via attention and verbal support) dependent and helpless behavior in female children (e.g., Kagan and Moss, 1962). In this way operant conditioning appears to produce differential social learning histories for male and female children. The female's experiences appear to provide a history of encouragement for fearful and helpless behaviors that, perhaps, provide an experiential background upon which agoraphobic avoidance behaviors are developed.

In addition to operant conditioning, it is clear that modeling plays an important role in the acquisition of sex-role behaviors. Fodor (1974) hypothesizes

that modeling extreme sex-role behaviors (often via media models) is a critical etiological factor in agoraphobia. In fact, she concludes that agoraphobia appears to be a "natural outcome of sex-role socialization rather than an illness" (Fodor, 1978). She presents rather striking evidence of agoraphobic-like behaviors in female characters in children's readers (NOW Task Force, 1975) and one might infer the saliency of these kinds of models in inducing agoraphobic behaviors. Female characters in these children's readers were consistently portrayed as helpless, home-oriented, passive, dependent, fearful, incompetent, and prone to a variety of mishaps when compared to male characters (NOW Task Force, 1975). Similarly, Sternglanz and Serbin (1974) evaluated sex-role stereotyping in children's television programs and demonstrated that female characters compared to male characters were shown to be significantly less behaviorally active and more deferent.

Most theorists about sex-role development (including Freud, 1933; Mischel, 1966; Kohlberg, 1966) emphasize the observation of sex-appropriate behaviors by observing female and male role models. Bandura and Walters (1963) clearly demonstrated modeling to be a highly effective method for influencing the acquisition of specific behaviors. That fear responses specifically can be effectively learned via modeling is supported by a variety of sources in the behavioral literature. For example, Jones (1924) found social imitation to be an important cause of irrational fear in children. Hagman (1932) found a significant correlation between the kind and number of fears expressed by mother and child. Murphy, Miller and Mirsky (1955) demonstrated the acquisition of a conditioned avoidance response in monkeys who had observed other monkeys receive shocks but had not received shocks themselves.

Indeed, Solyom, Beck and Hugel (1974) argue that vicarious learning or modeling is the salient etiological factor in the development of agoraphobia on the

basis of their observation that mothers of agoraphobic patients (N = 47) had a significantly higher incidence of phobic neurosis than mothers of control subjects (31% versus 14%). While, unfortunately, methodological problems preclude firm conclusions regarding the relative contributions of modeling, reinforcement contingencies or genetic factors as variables in the etiology of agoraphobia, the Solyom study taken with the other data suggests that social learning histories of individuals is likely to be a major variable in the etiology of agoraphobia.

In conclusion, data regarding sex-role stereotypes (e.g., Bem, 1974) clearly suggest that the feminine stereotype consists of characteristics such as dependency, fearfulness, passivity, and low assertiveness. As such, most available female role models (both live and media images) present role-consistent behaviors as well. Andrews (1966) among others has used almost identical language to describe the "phobic personality". The similarities between characteristics of agoraphobia and the feminine sex-role stereotype is striking. This hypothesized relationship is enhanced when one considers that about 85% of all diagnosed agoraphobics are female. While the acquisition of the feminine sex-role stereotype is obviously not a sufficient cause for the development of agoraphobia (e.g., not all women who accept the traditional sex-role stereotype are agoraphobic), this set of social expectations may set a powerful background for the subsequent development of agoraphobic fears and behaviors. Social prescriptions as to what constitutes appropriate sex-role behavior is likely to interact with other variables (e.g., classical and operant conditioning histories) in the etiology of this serious psychological disorder resulting in the disruption of healthy functioning for many women.

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