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Agoraphobia in women and environmental meaning

Gelfond, Marjorie Pam, Ph.D.

City University of New York, 1988

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AGORAPHOBIA IN WOMEN
AND ENVIRONMENTAL MEANING

by

MARJORIE GELFOND

A dissertation submitted to the Graduate Faculty in
Psychology in partial fulfillment of the requirements
for the degree of Doctor of Philosophy, The City
University of New York.

1988

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This manuscript has been read and accepted for the Graduate Faculty
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Date

Susan Saegert
Chair of Examining Committee

January 28, 1988
Date

Herbert D. Saltzman
Executive Officer

Susan Saegert

Kathleen Christensen

Florence Denmark
Supervisory Committee

The City University of New York

Abstract

AGORAPHOBIA IN WOMEN AND ENVIRONMENTAL MEANING

by

Marjorie Gelfond

Adviser: Susan Saegert

This study represented an examination of women's fears and inhibitions regarding public, and outdoor environments in order to provide a basis for understanding the greater susceptibility of women to agoraphobia. It further examined women's relationship with home as a means of understanding the primary symptom of agoraphobia, which is the reluctance to leave the home.

The study utilized two comparison groups: Average women and highly independent women. Challenging the reports of earlier studies, results confirmed that there is substantial overlap between the agoraphobic and average women in terms of levels of environmental constriction, suggesting that the majority of women experience significant inhibitions about going places alone. The two groups were also similar in their sex-role identity, early experiences, and travel-related attitudes and skills. The independent women differed significantly from the others on all of these dimensions.

In looking at early childhood experiences common to girls, on the assumption that ordinary childrearing practices rather than trauma might account for the symptoms, the study builds upon prior research that has examined the cognitive and affective consequences of early

protectiveness and sex-role socialization. It was found that limited opportunity to be alone outside the home during the early years, together with a high level of parental apprehensiveness were also significant etiological factors.

The strongest predictor of phobic tendencies was found to be self-perceived lack of orientation, wayfinding, and social skills that would facilitate autonomous functioning outside the home, and negative attitudes about going places unescorted. Associated with this was identification with the stereotypical feminine role.

The findings raised the question of the degree to which social definitions of marriage, prohibitions about women traveling alone, and the practical limitations that confront women, particularly those with young children, encourage the development of agoraphobic constriction, and may serve to explain why the symptoms are most likely to appear during the childbearing years.

Future directions for research considered include an examination of the relationship of alcohol and drug dependence and of eating disorders to agoraphobia; closer examination of the phobic family unit as an etiological factor, and early environmental education as an important element in prevention.

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I am also grateful to my place of employment, the County College of Morris, whose facilities and faculty support were invaluable to this research. Chris Smith, Barbara O'Byrne, Gary Ross and Gerald Gelber equally deserves my thanks for all of their help, tangible and otherwise.

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It is my personal hope that the invaluable assistance provided by this entire cast will facilitate my own increasing resemblance to the women in this study whom I have identified as Independent.

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CHAPTER I

INTRODUCTION

It seems odd that elements of the everyday environment, to which one has been exposed throughout life, should suddenly become terrifying. Yet, in agoraphobia -- literally, a fear of the marketplace -- the individual develops a fear of public places.

Agoraphobia is widely understood to be a fear of open spaces. But, unlike openness, with its relative lack of structure, public places are characterized by implicit as well as explicit rules, constantly shifting and often ephemeral social circumstances, and such physical attributes as crowdedness and complexity, which together constitute a set of opportunities and constraints that confront the individual. This paper proposes to examine the relationship of agoraphobics with public spaces and with private spaces of home.

Agoraphobia has been studied largely by collecting individual case histories in which the information has focused on family and personality dynamics, demographic variables, and medical background, an approach that has not been especially fruitful in identifying important variables. The implicit assumptions have been that personality attributes of agoraphobic women (e.g., dependency) are constant across situations, that the disorder itself is contextless (i.e., that it occurs with relative constancy across cultures and time), and the symptoms result from a distortion of reality.

It has been one of the flaws in the general shift toward a community mental health orientation that mental disorder as a general

phenomenon is perceived to be a consequence of environmental stress interacting with individual vulnerability, but specific disorders such as agoraphobia continue to be interpreted as solely the result of flaws in personality structure. Thus, virtually all researchers have scrutinized the individual without considering the possible influence of the setting or culture. Physiological explanations attributing it to defects in neural transmission and psychodynamic explanations relating it to early childhood experiences have continued to have great appeal. Both, however, avoid the idea that environments have meaning and valence, and the latter explanation ignores the fact that environments have contemporary meanings as well as historical ones. In regarding the symptom as irrational, idiosyncratic, and ultimately inconsequential, these theories overlook the similarity of the agoraphobic's response to public places with that of normal individuals, particularly women.

This paper proposes to stand back from the thicket of individual case histories and from the conventional inquiries of the clinician. It offers an examination of agoraphobia from the broader perspective of the social history of public and private places. Because the majority of agoraphobics are women, it will focus on women's relationship with these places. And whereas the clinical literature tends to reify the fear of leaving home, treating it as if it appeared, like Athena, full-grown at birth, the present investigation will begin by using this contextual history to understand the meaning of the fear.

The following sections will present, first, an overview of the clinical research on agoraphobia, including psychoanalytic,

behavioral, general psychodynamic, and physiological studies.

In the second section, a critique of these interpretations is offered. In the final section, possible new avenues of inquiry are suggested based on a reconceptualization of the disorder. In this section, Claus Riegel's dialectical model of psychology provides the basis for a cultural interpretation. This is followed by an overview of historical changes in the meaning and character of public and private places and the possible role of these changes in agoraphobia.

A consideration of the interaction between real environmental features and psychological needs is then presented, in which the factors of overstimulation, constraint, and unfamiliarity are discussed. Finally, developmental aspects are presented, focusing on feminine sex role socialization and women's relationship with public spaces and with home.

Background

Reports of the prevalence of agoraphobia vary widely. One frequently cited survey (Agras, Sylvester & Oliveau, 1969), using a stratified sample of the residents of Burlington, Vermont, reported a rate of 6.3 per 1000. Another study (Langer & Michael, 1963) quoted the figure of 280 per 1000. Such variations in reported rates are likely to be the result of the methodological problem of defining clinical cases of agoraphobia.

Researchers are in general agreement that the vast majority of agoraphobics, roughly 90%, are women, and that the mean age of onset falls between the mid-twenties and early thirties (Marks & Gelder, 1966; Marks & Herst, 1970). No other pattern has emerged in terms of intelligence, socioeconomic status, birth order, number of siblings,

stability in the parental family, marital stability, or level of education, all of which have been examined.

Clinical Interpretations of Etiology

There continues to be no general agreement about the causes of agoraphobia. Psychoanalytic writers since Freud have treated it as a symbolic manifestation of unresolved childhood conflicts; behavioral writers have maintained the conviction that the symptom does not represent a problem, it is the problem; recent psychiatric literature reflects medical sentiment that the disorder is only secondarily psychological, and has its origins in neural dysfunction.

Surprisingly few writers have addressed the question of women's greater susceptibility. Equally surprising, there has been relatively little dialogue about the diagnostic criteria by which clinical cases are identified and differentiated from subclinical cases. And few researchers have utilized personality testing as a means of gaining a more complete profile of the agoraphobic.

The following is an overview of those ideas that have generated the most discussion and research.

Psychoanalytic Theories

Psychoanalytic writers have largely remained committed to Freud's interpretation of his own travel phobia (Jones, 1961), understanding the fear of leaving home as a fear of separation from the maternal figure.

In an elaboration of this idea, Frances and Dunn (1975) applied Margaret Mahler's notion of separation/individuation to their explanation, with the symptoms interpreted as a reiteration of an

early, imperfect separation of identity from that of the mother. Thus, as with the young child, the agoraphobic's physical separation from this mother representative is tantamount to the loss of self. These researchers have classified agoraphobia with school phobia, considering both to be "separation anxiety phobias."

Other psychoanalytic writers (e.g., Fenichel, 1945; Weiss, 1964) have emphasized Freud's perception of open spaces as disinhibiting, a circumstance he believed provoked the agoraphobic's conflicted desire to act on some forbidden impulse, usually of a sexual nature, or, on a more symbolic plane, offers itself as "the open road" out of a stifling relationship.

In general, psychodynamic writers have adopted the psychoanalytic position that the symptom concretizes anxieties about autonomy and dependence, and allows for a solution to the problem of conflict through the appearance of a relatively circumscribed symptom (e.g., Symonds, 1973; Seidenberg & DeCrow, 1983; Frances & Dunn, 1975).

Behavioral Explanations

Behavioral psychologists consider the agoraphobic's symptom to be the result of accidental conditioning, in which some aversive event becomes associated with the physical circumstances during which it occurred (Wolpe, 1970). The already heightened anxiety of the individual facilitates the conditioning, and the result, conditioned avoidance, is particularly resistant to extinction (e.g., Snaith, 1968; Scarf, 1974).

Other behaviorists (e.g., Chambless & Goldstein, 1982) view it as a "fear of fear" with the setting experienced as frightening because it offers the least possibility of support and/or the greatest

possibility of social embarrassment in the event that the individual has a panic attack.

Snaith (1968) has argued that the disorder should be considered a pseudophobia in that the multiple fears of the agoraphobic do not serve the primary function of a phobia, namely, the containment of anxiety.

Critics of behavioral theory have pointed out that the notion of accidental conditioning leaves to chance the matter of whether one develops agoraphobia, a social phobia, a canine phobia, or any other phobia related to commonly encountered phenomena. The literature does not report instances of coat phobias or coffee phobias, yet these and an infinite number of other objects appear daily under some very stressful circumstances. What accounts, then, for the selectivity of certain phobic objects over others remains to be explained.

I. M. Marks (1966), whose work on phobias offers a more theoretical and eclectic view than that of other behaviorists, has explained the propensity toward certain phobias as a consequence of the inherent qualities of certain objects, qualities that make them "prepotent targets of anxiety" for the human species, among others. He suggests great heights, depths, and open spaces as examples of such prepotent targets. Seligman echoed the same ideas in subsequent articles on biological predisposition in phobia (1972).

General Personality Research

Very few studies of personality traits of agoraphobics have been reported, and it is regrettable that findings of nonsignificant differences are rarely published. Further analysis of such studies may well have revealed differences among subgroups.

Rock and Goldberger (1978), for example, studied the relationship between field dependence and agoraphobia. Although there appeared to be no correlation for the group as a whole, there was a trend toward such a relationship among agoraphobic women, leading researchers to postulate that "...it is quite possible that phobic symptomatology would have different meanings intrapsychically and/or culturally for men and women; hence groups of phobic men and women having very similar symptom pictures would in fact show up to be psychologically different." (p. 784)

One attempt to integrate psychological and physiological factors has been made by Goldstein and Chambless (1978). They have hypothesized that agoraphobics have an hysterical cognitive style. Thus, while a number of individuals may experience anxiety-like symptoms as the result of a physiological condition or situational stress, only those with such a style will attribute the symptoms to anxiety and/or describe the panics as having occurred "out of the blue," with no apparent provocation.

Emmelkamp and Cohen-Kettenis (1975) reported significant results on a correlational measure of agoraphobia and external locus of control. The authors point out that work is needed that can demonstrate a causal relationship between the two. A discussion is also needed on the implications of this finding.

Physiological Interpretations

Perhaps the greatest amount of attention within the last few years has been devoted to physiological research, much of which remains tentative and in need of further substantiation.

A number of researchers have asserted that agoraphobia is a panic

disorder in which the fear of going out is secondary to the initial experience of spontaneous panic attacks (Leibowitz & Klein, 1982; Leibowitz et al., 1986; Thyer & Himle, 1985; Katerndahl, 1986; Charney & Heninger, 1986). The phobia is then seen as having three components, namely, the spontaneous panic, anticipatory anxiety, and avoidance behavior. Researchers have then sought to locate a physiological triggering mechanism for the panic, on the assumption that this symptom originates in the neural substrate, while the latter symptoms are psychological in nature and acquired through conditioned associations.

Among the methodologies used to explore this hypothesis are the use of electrical and chemical stimulation of structures within the central nervous system. Most notably, these studies have involved the locus coeruleus (LC), found in the pons and known to function importantly in the sympathetic branch of the autonomic nervous system. The LC contains the greatest number of norepinephrine-producing neurons in the central nervous system.

Redmond (1979) has asserted that increased activity in the LC, attributed to an excess of brain norepinephrine, is responsible for panic attacks and can be induced in non-agoraphobic volunteers through the use of either pharmacological or electrical stimulation. Conversely, agents that decrease norepinephrine production, including the tricyclic antidepressant imipramine, and monoamine oxidase inhibitors (MAOIs) such as phenelzine, reportedly block agoraphobic panic (Redmond, 1979; Klein & Fink, 1962; Lipsedge et al., 1973; Solyom et al., 1973; Sheehan et al., 1980).

Other pharmacological agents known to decrease neural transmission in the LC and recently reported to block panic include

epinephrine, clonidine, and, paradoxically, norepinephrine when applied to receptors that produce neuroinhibitors when stimulated (Sweeney, 1983).

Redmond's findings have been challenged by Hamlin et al. (1983) who found that increased levels of norepinephrine did not necessarily coincide with the experience of anxiety. These researchers have hypothesized that the problem actually originates in the erratic production of brain norepinephrine, caused by a dysfunction of the LC.

How, then, might the susceptible individual be identified? A well-documented phenomenon first reported by Pitts and McClure (1967) is the differential effect of sodium lactate infusions on agoraphobics versus normal subjects. This substance, which produces autonomic arousal, results in panic attacks for the former group, but not the latter, suggesting that agoraphobics may have a lower threshold of activation and may thus be more prone to panic under stress, whereas others would experience only more modulated and free-floating anxiety.

Comparisons of the action of imipramine on agoraphobics, mixed phobics (who had both panic attacks and other phobias), and simple phobics (who had no panic) also revealed the response of those prone to panic to be distinctive. The drug was found significantly more effective with the first two groups, leading researchers to conclude that structural differences existed in those vulnerable to panic (Zitrin, et al., 1978).

One problem with the identification of agoraphobia as a panic disorder is that not all agoraphobics are subject to panic, something acknowledged in the DSM-III system which distinguishes Agoraphobia with Panic Attacks (300.21) from Agoraphobia without Panic Attacks

(300.22). Thus, an explanation of the etiology of agoraphobia in terms of physiological antecedents of anxiety excludes the portion of agoraphobics who do not experience panic.

Further, some researchers (e.g., Marks, 1966) report cases in which increasingly frequent episodes of anxiety preceded panic attacks, contradicting the idea that anxiety represents a conditioned response to the panic attacks.

Despite this, there is evidence of a qualitative difference between panic and anxiety: Agents that block the panic have little or no effect on the anticipatory anxiety (and hence on the avoidance behavior); conversely, minor tranquilizers relieve the anticipatory anxiety without touching the panic (Klein, 1964). What the etiological significance of this is remains to be explained.

A number of other physical conditions are also known to produce anxiety-like symptoms, including Addison's disease, Parkinson's disease, hypo- and hyperglycemia, hyperthyroidism, temporal lobe epilepsy, and adrenal tumor. Also, an abnormal tendency to hyperventilate has been considered as a factor in panic (Ley, 1985).

A great deal of research has centered on cardiac functioning. Margraf, Ehlers, and Roth (1986) reported that heart palpitations occur with unusual frequency among those with panic disorder. Similarly, Pariser, et al. (1979) and Liberthson et al (1986) have suggested that anxiety disorders can result from the symptoms of mitral valve prolapse syndrome (MVPS).

Pariser has suggested a separate diagnosis for those cases of phobia and panic disorder in which MVPS is present. This is reminiscent of Roth's (1959) earlier claim that certain subtypes of agoraphobia are associated with temporal lobe dysfunction and should

be assigned a separate diagnostic label. However, these physiological theories leave unexplained the fact that a significant number of individuals who have one or another of these conditions have no anxiety-related symptoms, and one is then left to explain why the remainder develop such disorders. In one study, for example, Markiewicz, et al. (1976) found an 18% incidence of MVPS among 100 healthy young females.

In addition, the creation of such separate diagnostic groupings as "agoraphobia with MVPS" and "agoraphobia without MVPS" seem only to further muddy the etiological waters, providing no greater predictive or explanatory value.

Recent researchers (e.g., Mazza, 1986; Margraf, Ehlers & Roth, 1986; Coyle & Sterman, 1986; Schweizer, Winokur & Rickels, 1986) who have studied the relationship between one or another of these disorders and agoraphobia have concluded that such disorders are neither a necessary nor sufficient precondition for the development of a phobia.

Currently, research is under way that attempts to integrate the idea of a physiological mechanism with a coinciding fear of separation, and this will be discussed in the following section, "Commentary".

Commentary on the Clinical Research

Epistemological Bias in Clinical Investigation

In evaluating the research on agoraphobia, some general comments seem warranted. There has been considerable interpretation of mental disorder as a general phenomenon from writers outside the field of clinical psychology. Szasz, for example, although a psychiatrist,

presents a sociological analysis of the symptoms in his book, The Myth of Mental Illness (1974). In Madness and Civilization (1973), Foucault offers an historical analysis. Yet, in looking at specific disorders, only a few disorders (most notably schizophrenia, depression, and hysteria) have been similarly examined.

Thus, there has been little dissention regarding the clinicians' underlying assumption about the cause of other disorders, namely, that the problem inheres in the person, in conscious and unconscious representations of early experiences, in learned associations, current conflicts, or possibly in neurological dysfunction.

Proshansky (1976), however, has offered the caveat that research in the human sciences must grow out of the recognition that "an absolute integrity" exists in person/environment events, requiring the analysis of both person and setting (p. 63). This should apply equally well to normal and disordered behavior. The recognition of this integrity has been missing thus far in the literature on agoraphobia.

Similarly, Winkel's (1977) conception of ecological validity and its role in environmental research, and Saegert's (in press) conception of the environment as artifact and matrix as well as a physical entity lead one to conclude that clinical psychology needs to reexamine its fundamental assumptions about etiological theory, method, and context. In the study of agoraphobia, there has been almost no contextual analysis.

Neither the psychodynamic nor the behavioral theories of agoraphobia take into account contemporary environmental attributes and meanings, or historical changes in the use of space and in women's

status, changes that have affected women's relationship with the home, and their ability to use such public facilities as shopping centers, workplaces, hotel and restaurant accommodations, and public transportation. Etiological theories thereby discount the actual condition of social and environmental constraints that characterize public settings, as well as other stressful features of such places.

Instead, psychodynamic interpretations have relied heavily upon the stereotype of the home as unconsciously symbolizing mother, and of the marketplace as an out-of-doors open space -- a far cry from the contemporary shopping mall.

Behavioral explanations, conceiving of the agoraphobic's fear as the result of accidental conditioning, imply that the environment is merely a screen onto which meaning is projected, having no intrinsic meaning or history at all.

Masculine Bias in Research

The tendency to interpret agoraphobia as a disorder that is generated solely from within the individual may also be an instance of the masculine bias that certain writers have claimed permeates much clinical research. I have found the comments of Barbara Wallston, Ann Oakley and Carol Gilligan most relevant to my own evaluation of the research on agoraphobia. This research appears, in the parlance of community mental health, to blame the victim for her symptoms, if indeed they be symptoms at all.

Specifically, Wallston (1981) has characterized this bias as limiting the kinds of research questions that are addressed, the methodologies used, and the kinds of information considered to be either data or merely confounding variables. She has argued that the

masculine valuing of inner-directedness has resulted in a predilection to interpret behavior as a consequence of intrapsychic phenomena without acknowledging situational variables and person/situation interactions.

Although Wallston's discussion centered on social variables, it is equally relevant to the sociophysical environment. The emphasis on understanding only the psychic phenomena has resulted in social scientists sharing with others an inchoate sense of the influence of ordinary physical environments on people, something that would seem especially significant in understanding the agoraphobic's perception of public and home space.

In terms of the formulation of research questions, this same masculine bias has led person/environment research into the area of work settings rather than into the home. Just as Oakley (1974) observed that housework is not regarded by men in general as work, the house itself has seemed psychologically immaterial to the social scientist. Thus, in examining a "housewife's disease" like agoraphobia, even when the primary issue is the inability to leave the home, the scientist has adopted the predominating (masculine) view that the setting is only a backdrop for the psychological drama.

Finally, Gilligan (1977), commenting on subtle value judgments in the interpretation of psychological data, has remarked that women's concern with the specifics of a situation when confronted with a moral dilemma has traditionally been considered cognitively less sophisticated than men's concern with the application of universal (i.e., impersonal) principles. However, one must consider the differences in cognitive and perceptual style between men and women as possible adaptations to different environmental demands. Maladaptive

responses will then represent a lack of fit between style and environmental demands instead of being presumed to be the result of some personal inadequacy. For example, it can be predicted that househusbands and working women will both experience considerable initial stress in adapting to their new roles.

Assessing the Behavioral Approach

Traditionally, the behavioral approach has been closely identified with studies of the effect of the environment on behavior. Yet, the environment is treated in the clinical literature in a highly schematic fashion, in which individual events (stimuli) impinge upon the organism's senses and elicit a response. The fact that the agoraphobic is embedded in the environment, that the environment has various dimensions, such as degrees of familiarity, ownership, publicness, intrusiveness, and press, and that cultural factors can structure relationships between individuals with certain attributes and environments with certain features, these are specifics that behavioral theory has had difficulty incorporating.

Further, the linear paradigm in which environment constitutes the stimulus, and the person is the respondent, may not provide as adequate a model as an interactional paradigm. In fact, a critical element in agoraphobia appears to be the extent to which the individual believes herself able to or unable to actively exercise control over her environment.

Assessment of the Physiological Research

Confronted with apparently unprovoked panic and a population that appears to have little in common, many researchers have sought a

physiological explanation for agoraphobia. Because this area is relatively new, much of the conceptualizing is tentative and there is little overlap among the theories.

A diagnostic distinction is made between agoraphobia with and without panic attacks. Research is needed that can address the question of whether any physiological differences differentiate those who do and do not experience panic. At present, the majority of physiological studies examine subjects with the distinctive and dramatic symptom of panic, including those diagnosed as having "Panic Disorder" and "Agoraphobia with Panic." Very few report on subjects with agoraphobia who do not have this symptom.

Regarding the reports of those who claim that MVPS appears with significant frequency among those diagnosed as having agoraphobia, this approach diverges from the procedures of other researchers, who have eliminated prospective subjects who have any of the abovementioned disorders that result in anxiety-like states.

Another problem is a conceptual confusion among researchers, some of whom refer to the agoraphobic's panic attacks as spontaneous episodes of autonomic discharge, and some as "situationally triggered." The idea that such episodes are spontaneous resembles the characterization of idiopathic seizures as spontaneous, although identifiable stressors of a physical or emotional nature are commonly recognized. It is especially difficult to reconcile the idea of spontaneity with the observation that such attacks occur in specific types of settings.

In an uneasy synthesis of physiological and psychological theory, Leibowitz and Klein (1982) have attempted to explain agoraphobia as a fear of separation based in the neural substructure. They believe

that the locus coeruleus (LC) mediates separation anxiety in humans as well as in other animals, and that "adults with panic disorder have a lowered threshold to activation of this separation anxiety mechanism..." (p.65).

The authors draw upon research with other young primates who demonstrate fear at separation from the mother. A great conceptual leap must be made, however, in generalizing results to humans at midlife, and in presuming the the anxiety attendant upon leaving home results from the phobic's implicit association between home and the maternal figure.

The collective body of research suggests, rather, that the presence of a supportive other upon whom the person is dependent when leaving home attenuates but does not dispel anxiety. This explanation does not address either the possibility that the reaction is prompted as much by where one is going as by what one has left behind. The loss of a reassuring other should not, in short, obscure the fact that the threat is not necessarily in the separation but in the encounter with circumstances that the individual feels she may not be able to adequately deal with. Marks (1966) has also criticized the assumption of separation anxiety as the underlying cause, considering it instead as an outcome of the condition.

A final criticism of an LC-based theory of separation anxiety is that it does not explain why individuals with other phobias experience panic under circumstances that little resemble separation. Klein et al.'s (1980) assertion that claustrophobia might represent an intermediate form of vulnerability does not really clarify the issue, and neglects a consideration of what other attributes confining places

have in common with those that elicit agoraphobic anxiety.

A more general criticism of physiological theories is that they do not account for either the overwhelming overrepresentation of women among agoraphobics, or the similarities in personality among agoraphobic women that do seem to exist.

A single exception to this is Hamlin, et al. (n.d.) who, in asserting that panic disorders, including agoraphobia, reflect a dysfunction of the noradrenergic system, offer the preliminary hypothesis that such disorders may be sex-linked because women metabolize brain noradrenalin differently than men. It remains for future researchers to compare the way that male and female agoraphobics metabolize noradrenalin and to substantiate the claim that the relationship between noradrenergic functioning and agoraphobia points toward a causal sequence.

Lastly, the correlational nature of much of this research needs to be followed up by studies that can clarify the role of psychological factors, which may be simply elaborations of the original problem, but might also be its antecedents.

The Role of Historical and Cross-Cultural Factors and Environmental Press

One may assert that in many disorders, including agoraphobia, environments play a central role in evoking pathology. Numerous studies have demonstrated that institutional settings generate behaviors that are unadaptive in the the outside world (e.g., Goffman, 1961; Rosenhan, 1973; Spivack, 1973; Rivlin & Wolfe, 1977).

The significance of this work lies in the realization that environments may influence behavior in ways that are sufficiently subtle that neither the individual himself nor observers may recognize

that the behavioral determinant lies outside the person.

Just as institutions may create "institutional personalities," the cumulative effects of socialization in ordinary settings may have a similar effect. This does not argue for a position of environmental determinism. Instead, it posits that environmental press may be great under some circumstances, offering few behavioral options, or it may be very limited, and that press may be great for some individuals and not others, depending on their perceptions and socialization experiences (e.g., learned helplessness and femininity, respectively).

The subtle yet profound attributes of public settings, and the way that a culture both shapes the settings and the manner in which they are used has not been considered by those conjecturing about the causes of agoraphobia. Rather, they have concentrated on the more epiphenomenal feature of openness, obviating an inquiry into how the socialization process in this culture has structured women's relationships with public and private settings.

Theories of agoraphobia that define the disorder as a fear of open spaces typically treat "open space" as emptiness or as space defined by the distance from something, usually home. The fact that nonenclosed places may have attributes, may present constraints, or be inhospitable to certain groups, is not considered. Frances and Dunn (1975), for instance, treat space as the distance that separates a child from the object of his dependency, and interpret agoraphobia as the outcome of making this an emotionally charged situation, presumably through its use as a punishment.

The importance of recognizing the influence of environmental press and the culture that shapes it can be illustrated by two

seemingly unrelated observations, one by a psychiatrist, the other by an urban planner.

I. M. Marks (1966) related in his book Fears and Phobias that cases of "agoraphobia" (my quotations) are sometimes uncovered when urban displacement occurs, and families are relocated to new quarters. Despite the apartments being more spacious, the occupants sleep crowded in a single room. In interpreting this as individual pathology Marks overlooks the effects of socialization even while noting that the families are Hispanic. In a society such as this where physical privacy in the home is, apparently, neither possible nor desired, such instances of "agoraphobia" are, in effect, normal.

A remarkably similar observation appears in Brolin's book, The Failure of Modern Architecture (1976). Describing the relocation of families in Punjab, India, to Western-style homes that had been constructed, he relates as a typical example, "...a high Indian planning official...has three generous bedrooms at his family's disposal, but he and his wife sleep in one and their four teenage children -- two boys and two girls -- in another, while the third is vacant. Here, the "agoraphobic" symptoms are correctly attributed to the failure of architects to design buildings that accommodate the culture's notions of privacy and companionship.

Equally significant, Brolin reports that in Chandigahr, the capital of Punjab, large, Western-style parks remain a no-man's land. Women and children have been socialized to gather in front of their homes to talk and play; for women to go unescorted into these open public spaces would be seen as improper and the violator would likely experience considerable anxiety. Less explicit disapproval exists in this country, yet the agoraphobic's anxiety upon entering a

public space may reflect the implicit taboo without its source being recognized by either an observer or the individual herself.

In fact, psychiatrist Robert Seidenberg and Karen DeCrow, former president of the National Organization of Women, use the cultural residue of earlier societies that forbid women to be in public as their explanation for agoraphobia. In their book, Women Who Marry Houses (1983), they assert that because women have been forbidden since biblical times to enter the agora, their present fear is grounded in the subliminal awareness that they are still not truly welcome. The authors unfortunately fail to develop their thesis systematically, relying instead upon a pastiche of magazine articles, news reports, and studies by others to convince the reader that this is a moral and political issue, and not just a psychological one.

Problems in Classification and Conceptualization

A number of the writers have attempted to classify agoraphobia as either a subcategory of phobia or within another grouping. Snaith, for example, referred to agoraphobia as a pseudophobia because he perceived the collection of fears typical of the agoraphobic as random and unrelated. However, the problem appears to be in his definition of agoraphobia as a fear of open spaces, since he fails to note that all of the fears reported by his agoraphobic sample relate to public spaces. This underscores the need for more research to not only describe symptomatology, but identify symptom clusters and label them accurately, rather than relying, as Snaith did, upon "intuitive groupings" of fears.

Frances and Dunn's characterization of agoraphobia, together with school phobia, as "separation phobias" raises the perplexing problem

of why the reported incidence rate of school phobia indicates approximately equal numbers of girls and boys (Martin, 1974), while women comprise 90% of the agoraphobic population.

Still other writers (e.g., Hallam, 1978) have described agoraphobia as a form of masked depression. This again discounts the significance of the symptom, and, although agoraphobia is frequently accompanied by depression, one may question the wisdom of sweeping together related but distinct symptoms, particularly when it is not clear which precedes the other.

One may lastly question the significance of the symptom, conceived of by some as a fear of what one is leaving behind (e.g., Frances & Dunn) and by others as a fear of what one is going toward (e.g., Fenichel, Weiss). These are not mutually exclusive concerns, since home and non-home places can be characterized by different intensities of meaningfulness, familiarity, constraint/control, and intrusiveness, features which are not the same for all individuals. Thus, individual inquiry must form the basis of collective data, and this, in turn, may indicate differences among male vs. female, young vs. elderly, etc.

Assumptions about Discontinuity between Agoraphobic and Non-Agoraphobic Women

Beyond the assumption that the disorder is generated from within the person, another clinical assumption, especially among psychodynamic writers, has been that some atypical circumstance, most likely occurring in early childhood, and distinct from the developmental experiences of healthy individuals, can explain the disorder. This assumption that trauma rather than ordinary

socialization is the critical factor has led to the adoption of an idiographic approach to research, one that has discouraged a search for similarities among agoraphobic and non-agoraphobic women, as well as differences.

Thus, a criticism that appears with relative frequency about research on agoraphobia is the lack of normal individuals as a comparison group. Instead, most research involves single or small group studies of agoraphobics, or comparison of agoraphobics with individuals who have other types of disorders.

A factor that would seem to join agoraphobic with non-agoraphobic women is the relationship with the home environment. The apparent similarity of homesickness to agoraphobia also suggests that agoraphobics and non-agoraphobics are not distinct groups, and that individuals fall along a continuum in terms of their ability to tolerate unfamiliar settings. Further investigation is needed to identify factors related to levels of tolerance, and especially possible sex differences. One may speculate at the outset that the positive reinforcement that boys receive for exploratory behavior increases their tolerance, while the lack of such reinforcement both causes girls to avoid the unfamiliar and to structure their own home life in adulthood so that it epitomizes the familiar.

A question may also be raised about the appearance of agoraphobia during early middle age, and what developmental issues might, by way of explanation, confront women in general at this stage.

Methodological Issues in Research

That the environment continually transforms and is transformed by human activity, that such activity may be either deliberate or

inadvertent, institutionalized or informal, and that it may be abrupt or so gradual as to occur over several generations, all of these require a greater range of inquiry and the most interdisciplinary of research methodologies. One might ask, for example, whether certain ecological variables (time, place) and system variables (power, social norms) might not be contributory factors in a given disorder such as agoraphobia.

Instead, the clinician's assumption that the problem has been generated from within has led to the use of conventional diagnostic tools in building an etiological theory. These tools have included, for example, the standard psychiatric interview, questionnaires, projective devices, and an evaluation of responsivity to various chemical agents. Like the historian, who generally eschews the idea that all events need be recorded, only those deemed significant are selected. Interpretation thus becomes an intrinsic part of what would otherwise seem to be the purely objective process of documentation.

In view of the fact that individuals possess a constellation of images, attitudes, and feelings about commonplace settings that typically have not been symbolized but which nevertheless affect behavior, Proshansky (1976) has proposed that research incorporate separate methodologies to study "behavior system reactions" and "psychological system reactions." The former include behavior and experiences that are outside the person's conscious awareness. This would address the clinician's problem of using tests of conscious and unconscious processes that do not tap information that has not been symbolized at some level.

In studying behavior system reactions, Proshansky has recommended measures that yield data on the way that (s)he uses the physical

setting, the "movement patterns, locational preferences, and... sensory adaptations" (p. 65). For a study of agoraphobia, this implies the use of behavioral data and retrospective data that is largely factual in content (rather than attitudinal) regarding early environmental activities and current ones.

Campbell and Stanley (1963) have written that there is always a risk in using retrospective reports that memory will be distorted by the need to make the past congruent with present attitudes and/or socially desirable ones. Here, however, the lack of either public or individual reflection about environmental experience works to the researcher's advantage: Early environmental experiences are less likely to have suffered the revisionism to which family history is now so susceptible; memories are less likely to have been contaminated by emotional overlay, and artificial connections between past and present will not have been made. In inquiring into present attitudes, one again need be somewhat less concerned about responses being made socially acceptable since much of the subject matter has escaped moral entanglement.

Reformulating the Problem

In applying a broader perspective to the question of why women are now more susceptible than men to agoraphobia, several different lines of investigation are necessary. First, the problem needs to be examined in light of the social and historical characteristics of public environments and of the private environment of home, with particular attention to the evolution of men's and women's use of such settings. I have presented an overview of these changes in an earlier paper (Gelfond, 1983) and have summarized my findings below.

Secondly, based on the hypothesis that sex role differences may account for the higher incidence of agoraphobia among women, an examination of socialization practices, especially as they relate to girls' and boys' use of space is needed. I have summarized the prior research, but more is needed on the early and current attitudes, perceptions, and behaviors of women in general, compared to those who develop agoraphobia. I have considered factors that may distinguish these two groups, particularly an identification with the feminine role as a factor resulting in general vulnerability, and a summary of the relevant research is presented. Thus far, few controlled studies of gender identification as a determinant of agoraphobia in women have been undertaken, and the present study proposes a more systematic investigation of this.

A comparative study of agoraphobic and non-agoraphobic men's perceptions of, attitudes toward, and behavior in public and private settings may offer further insight into men's relative lack of vulnerability (offering direction for preventive measures), and may also address the question of whether agoraphobia is the same disorder in men and women. In the course of the present study, a few intriguing clues were uncovered, including the fact that a predominance of the male agoraphobics encountered were salesmen whose jobs necessitated travel, and that alcohol abuse is a common method of concealing the phobia among men.

Thirdly, the Marks study of "agoraphobia" and urban displacement, and Brolin's study of the use of public and private spaces in Chandigahr, make clear the need for future cross-cultural studies. Such studies might look at women's use of space in countries where

women have little public status and freedom, in those where social changes giving women greater freedom are taking place, and those where women enjoy relative freedom already.

Much of the research related to social and historical influences on the use of space has been descriptive. A theoretical framework is needed that can provide an explanatory model, and I have presented below an application of Claus Riegel's model of a dialectical psychology. Having set forth such a theory, it is then necessary to interview the "carriers of culture," both agoraphobic and non-agoraphobic, as a means of determining whether the attitudes, values, and prohibitions predicted by the theory are symbolized by individuals, and with what degree of clarity, and this is what I have proposed to research.

Basic Premises

There are several basic premises that underlie the proposed study. These are as follows: 1) Culture plays an important role in establishing congruence between person and setting. That congruence is psychically represented as a state of relative at-easeness. The appearance of agoraphobic symptoms may signify a lack of congruence brought about by changing social circumstances. Because the process of acculturation through socialization practices contributes to a set of attitudes and behaviors related to environments, agoraphobia among women may be explained in terms of the feminine social role which enhances her vulnerability; 2) Environments can be pathogenic, not only because of certain objectively stressful attributes, such as noise and crowding, but also to the degree that they undermine an individual's sense of competence and control; 3) agoraphobic reactions

to public and home environments are continuous with normal feminine responses.

A. Cultural Basis of Agoraphobia

The first two clinical accounts of agoraphobia appeared within a year of one another, in 1870 (Benedikt) and 1871 (Westphal). Each identified it as a man's disorder.

Today, by all accounts, it is a disorder that is considered to affect women almost exclusively. Perhaps these matters can be explained away as artifacts of research and reportage or by the greater likelihood that women will seek professional help when compared with men. Alternatively, however, it may reflect the larger dynamics of social change that were taking place at the time of the initial appearance of agoraphobia and that are occurring today.

1. Applying a Dialectical Model: Claus Riegel

In looking for a theory that can give a broader picture of psychopathology, the dialectical model of Claus Riegel (1979) serves as an appropriate reference. Riegel believed that both individually and culturally, structures and functions of the psyche develop together. This notion can be expanded to include the fact that culture proceeds in a parallel fashion, so that artifacts and activities imperceptibly acquire new attributes and meanings over time as old ones are lost.

Riegel also hypothesized that synchronization among the various individual, social, and physical elements is sometimes achieved at the expense of one or another of them. For example, the development of an intense, child-centered family life as the central element in community organization could occur only if women subordinated their

personal needs to those of the family. A social movement that strives toward the emancipation of women will then produce a state of disequilibrium both within the social system and within the individuals most affected, namely, women.

Consistent with the concept of a dialectical progression, such a "crisis of desynchrony" can produce social advancement, but there is, inevitably, an interim period of stress, particularly for cohort groups who have been socialized to adjust to conditions that now may no longer exist. The fact that rapid social change results in heightened stress has been well documented (e.g., Dohrenwend, 1973; Lauer, 1974).

One can then consider agoraphobia in light of the changes in the attributes and meanings of things and places, together with changes in social structures that involve women: The marketplace, where women were once forbidden to go, evolves into a shopping mall, the quintessential women's place. Huts, fashioned first as shelters, elaborate into homes that acquire deepening psychological importance, especially for women. Functional household objects acquire sentimental value and provide a sense of continuity, while the treasured possessions of a preceding generation become the trash of the next. New, and more specialized spaces, such as sewing rooms and separate bedrooms in the home, both support and legitimize certain activities and needs.

As social strictures governing the public behavior of women begin to loosen, women become the new and conspicuous minority participants in certain public and semi-public places. In the absence of clear-cut norms and appropriate affordances, and in the changed character of

these places brought about by women's presence, a lack of congruence may be experienced between person and setting, accompanied by a lack of at-easeness.

Equally significant, as homes have become privatized, the psychic need for privacy appears, and, simultaneously, privacy takes on a positive social value. This in turn requires the development of the capacity to be alone, a capacity that is impaired or enhanced through socialization in childhood.

2. Historical Changes in The Meaning and Character of Public and Private Places and Their Possible Role in Agoraphobia

In an earlier paper, I noted the observations by Aries (1962), George (1965), Laslett (1973), and Boulding (1977) about the rather complete integration of family and public life prior to the Industrial Revolution, as reflected in the use of home and public space. Neither architecture nor social conditions encouraged any degree of physical privacy, even among strangers, until the 19th century (George, 1965), nor any separation of public and private roles (Bensman and Lilienfeld, 1979; Rybczynski, 1987).

The gathering momentum of the Industrial Revolution in the 19th century apparently brought significant physical, social, and perhaps psychological changes. Mechanization led to the creation of dense urban environments; simultaneously, homes became places of retreat in both location and in individual design, hence, the "splendid isolation of the suburbs." Public life gradually lost its communal character, becoming instead impersonal and anonymous.

Coinciding with these changes was the transformation of the home from a predominantly patriarchal setting to a matriarchal one (Laslett, 1973).

It was thus during this period of major social transition that the first case histories of men with agoraphobia appeared in the professional literature. I have speculated that this reflected the predicament of men, who were caught between two worlds, Victorian and Post-Industrial. They were caught between the conflicting roles of public and private life, where one's business ethics, work identity, and public conduct were as far removed from those as family man as the home was from the workplace. I have also hypothesized that the growing numbers of women who experience some degree of agoraphobia are those least prepared for movement into public life, and whose situation greatly resembles that of the Victorian male.

B. The Interaction of Environmental Press and Psychological Needs as Possible Factors in Agoraphobia

1. Overstimulation and Constraint

Agoraphobia has been treated in nearly all of the literature as discontinuous with normal responses. Mathews, et al. (1981), for example, remark that, "...there is a group of agoraphobic symptoms that are associated with one another and...are probably not merely a more severe form of fears that are common in the general population" (p. 9).

I.M. Marks (1966) offers a dissenting opinion. He notes that various animals, such as mice, tend to be "agoraphobic," preferring to remain close to walls when moving about. Marks attributes this to the need to avoid overstimulation, an inborn source of anxiety, and cites the analogous behavior of humans, who typically prefer to be seated along the periphery of stadiums, restaurants, etc. for the same reason.

Proshansky, Ittelson, and Rivlin (1976) believe that physical or

social conditions that result in behavioral constraint produce stress and anxiety, particularly because of the loss of perceived control over the situation. Marks' perspective is consistent with the reports of these writers and with Milgram regarding urban environments (1970), where high population density, visual complexity, auditory assaults, crime, and the need to continually remain vigilant, cause a stress-inducing cognitive and sensory overload in those unaccustomed to such settings.

The conditions of social and physical constraint that characterize public settings have been found to be disturbing to normal individuals, and result in heightened anxiety and decreased cognitive functioning as well as in feelings of helplessness (see, for example, the review article by Saegert, 1980). Relevant to the susceptibility to agoraphobia, the anticipation of constraint, acquired through experience, is itself sufficient to induce anxiety, and this would seem to closely resemble the anticipatory anxiety experienced by phobics.

Further, individuals who are prepared for such conditions find them less distressing than others. For reasons to be discussed below, one might suppose that among those least experienced with public settings would be traditionally socialized women.

2. Familiar and Unfamiliar Settings

Virtually none of the clinical writers on agoraphobia have noted the apparent similarity of agoraphobia to the common phenomenon of homesickness. Yet, homesickness can be described as a sense of uneasiness engendered by unfamiliar surroundings, a sense that seems to differ only in degree from agoraphobic anxiety. By considering the possible relationship between the two, one can then call upon the body

of literature on ordinary responses to familiar and unfamiliar settings.

Studies of infants have revealed that even at the very earliest developmental stages, children are more at ease and unconstrained in their home, with heightened sociability evident when compared to their behavior elsewhere (Becker, 1977).

In one study that was done on children ranging in age from 39 to 63 months, it was found that children at home were more willing to initiate social interactions and better able to control play activities with other children, even when the resident child was typically shy and unassertive in other settings (Jeffers and Lore, 1979).

The same effect can be observed in adults. Studies have been reported, for example, in which college students given a task involving conflict resolution were more successful in their own dormitory room than were "visiting" negotiators (Martindale, 1971). Similarly, Esser (1970) found that psychotic individuals were more effective in controlling others' behavior in their own homes than in other places.

Pedersen (1978) substantiated the assertion of earlier writers that preference for an environment is significantly related to familiarity with it. This is consistent with the agoraphobic's ability to function in the home and immediate neighborhood with which she is familiar, and her increasing anxiety as she moves into progressively less familiar areas. Certain individuals who may be characterized as agoraphobic are able to function within an approximate radius of five miles from home, but become panicky beyond

that point. Here again, one may see this as continuous with the tendency of non-agoraphobic individuals who seldom travel further than a neighboring town, or who do not leave the county, particularly if traveling alone.

One may also speculate that nighttime alters one's experience of the landscape in one of two ways. It may either create a sense of enclosure as visibility disappears, or a sense of strangeness in familiar surroundings. Certain agoraphobics are more able to go out at night; many individuals, especially women, are reluctant to go out at night. It would be useful to clarify the perception of both agoraphobic and non-agoraphobic individuals of how darkness does affect their experience of place.

Place can either support the self and its functioning or undermine it. Familiar places tend to be supportive. As Proshansky and Kaminoff (1980) wrote, place identity contributes to self-identity through the integration of and expression of "all of the person's concerns, cognitions, preferences, attitudes, feelings, and values about physical settings...particularly those that characterize the individual's day-to-day existence" (pp. 11-12).

Conversely, setting demands are greater and more stressful in unfamiliar places, requiring increased vigilance and coping behaviors. "To the extent that we neither have the capacity to understand or to cope with settings, the reactions of individuals will be intense" (p. 13). These reactions depend on such psychological properties of settings as their level of complexity, degree of familiarity, their dangerousness and/or disturbingness, and especially on environmental security, i.e., "the extent to which physical settings evoke a sense of safety and predictability in the person as opposed to a sense of

danger, threat, and unpredictability" (p. 13). It is important to note that these properties inhere partly in the setting and partly in the person, and may thus vary among individuals.

The feelings of self-estrangement and derealization reported by agoraphobics may occur as well in the homesick. Just as the agoraphobic may require the presence of a familiar other in order to leave home, the ordinary traveler's discomfort is often relieved upon meeting strangers who share a common homeplace, and it produces a kind of emotional recentering.

That unfamiliar environments challenge the normal individual's resources may further be exemplified by the habit of many people of carrying familiar objects with them when leaving home, and by the common practice of total institutions of separating inductees from all personal possessions and familiar settings as a tool of resocialization.

Are women less tolerant of unfamiliar settings than men? None of the studies cited above examined sex differences, nor has there been a study of sex differences in the experience of homesickness. However, one might offer the preliminary speculation that boys, encouraged to explore unknown territory, will be less susceptible to homesickness than girls, who are often warned of the dangers of the unknown, and this will be discussed below in the section on "Sex Role Socialization and Women's Use of Space."

C. Personal Basis of Agoraphobia

In addition to intergenerational changes in the way women have related to public and home settings, understanding psychopathology also requires an examination of individuals over time. This

developmental history may make clear which factors contribute to specific vulnerability and which may have some preventive value.

1. The Relationship between Psychological Disorders and the Feminine Sex Role

A general body of literature exists that links traditional femininity with problems of adjustment. It has been found, for example, that women who adopt the traditional housewife role have higher rates of disorder than those with a more autonomous life-style (Bart, 1972).

Levy (1976) found that women who identified with the traditional sex role were low in both independence and nurturance. Cosentino and Heilbrun (1964) also found it to be associated with high anxiety levels, low social acceptance, low self-esteem, and poorer adjustment. Similarly, others have reported a correlation between stereotypical femininity and lack of adjustment (Kelly, O'Brien, Hosford, & Kinsinger, 1976; Kelly & Worell, 1977; Spence & Helmreich, 1978).

Such women have also been found to have lower intelligence (Maccoby, 1966) and poorer school performance (Maccoby & Jacklin, 1974).

Traditional femininity has been linked with depression (Rosenfield, 1980), dependency on others, including the need for others' approval, and with the lack of a separate sense of self (Choderow, 1974), all of which have been associated with agoraphobia. Bem (1978) has reported greater rigidity among stereotypical females, with higher levels of anxiety and self-deprecation when they performed cross-sex activities. This may also be especially relevant to agoraphobia insofar as solitary activity outside the home continues to be regarded as a masculine prerogative.

Studies of individuals with eating disorders describe the at-risk personality in much the same way, leading one pair of researchers to ask the pertinent question of what predisposes individuals with this personality type to develop one set of symptoms and not another (Frances & Dunn, 1975). They wrote, "One wonders...why a particular patient develops agoraphobia rather than the variety of other symptoms...to obtain veiled dependency. Such syndromes as anorexia nervosa and asthma, for example, often express an identical conflict" (p. 437).

I have hypothesized that the answer to this may lie in the relative lack of opportunity for the pre-agoraphobic to be alone indoors and out, and the attitude toward doing so conveyed by parents and others. This extends the assertion of Frances and Dunn that the agoraphobic symptoms result from space becoming a medium of conflict within the family. Space may become a medium of conflict also if, as Block (1978) has reported, the tendency toward greater restrictiveness and supervision occurs in the context of anxiety.

Although earlier studies reported better psychological adjustment with a more androgynous orientation, recent writers have claimed that if any advantage inheres in androgyny for women it is solely the result of the closer identification with masculine traits, and not the masculine combined with the feminine (Rendeley, Homstrom, & Karp, 1984; Bem, 1978; Jones, Chernovetz, & Hansson, 1978).

Other studies report no advantage to androgyny, but point again toward identification with masculine characteristics as correlated with better adjustment (Taylor & Hall, 1982; Anderson, 1986; Chambless & Mason, 1986) and with higher self-esteem (Long, 1986).

Few studies have discussed the possible link between femininity and agoraphobia, or have even addressed the question of why adult women are the primary sufferers of agoraphobia. One unpublished doctoral dissertation (Jasin, 1981) reported that female agoraphobics were not significantly different from anxiety neurotics and depressive neurotics on the Masculinity-Femininity Scale of the MMPI. Among the problems with this study, however, are its failure to use normal women as a comparison group, and the use of an instrument that has been standardized using pathological populations.

In an article that reviews prior research and presents a more theoretical overview of the etiology of agoraphobia, Fodor (1974) argues that overidentification with the feminine stereotype is central to the origin of agoraphobia in women. She describes her as a caricature of femininity, typified by "helplessness, dependency, and lack of assertiveness."

Relatedly, Chambless and Mason (1986) found lower identification with masculine traits among a sample of 33⁴ female and 68 male agoraphobics when compared with a normative sample. The data here showed identification with femininity traits to be significantly related to a phobia score in the clinical range.

There is a wealth of anecdotal evidence in the clinical literature that at-risk personality type for agoraphobia conforms to the traditional female role model. Most emphasize parental overprotection and the consequent dependency of the incipient agoraphobic "woman/child."

An early description by Adler (1964, orig. 1929) described her as "invariably spoiled," and another by Wolpe (1958) characterized her as "incredibly overprotected." In a later article, Wolpe wrote that,

"the commonest cases...are...of unhappily married women low in self-sufficiency...with an unrealizable fantasy of liberation from the marriage..." (1970).

Chambless and Goldstein (1981) have also referred to the agoraphobic's lack of self-sufficiency, and de Moor (1985) to her dependency. Symonds (1973) described her as having a dependent personality with "the appeal of helplessness." Seidenberg (1973), in a case study, profiles the young woman as "timid," "docile," and, while inwardly contemptuous of the traditional life style of the suburban woman, capitulating to the demand that she herself embrace it. Frances and Dunn (1975) described the typical agoraphobic as passive-dependent.

Roberts (1964), in an article on "housebound housewives" characterized his agoraphobic clients as having "traits of perfectionism, orderliness and routine."

Because of this apparently close relationship between dependency and agoraphobia, the DSM-III Manual cautions the diagnostician to rule out Dependent Personality before assigning a diagnosis of agoraphobia.

Only a few writers have considered the social psychological aspects of feminine dependency. B. Wolfe (1984) points toward powerful social sanctions imposed upon women who try to become independent, thereby predisposing them toward a feminine/dependent/agoraphobic orientation.

Brehony (1983) has hypothesized that the social conditioning of women to be passive, fearful, and unassertive contributes to this condition, and asks the salient question, "Why are not all women agoraphobic?"

The answer to this question requires a more discriminating look at women in general, particularly those who have not been encouraged to adhere to this debilitating stereotype. One may speculate that this type of socialization is not universal. Assuming it to be so may obscure differences in the socialization of agoraphobics, other neurotics, and healthy women.

Mathews, et al. (1981) have speculated without further comment that changing social roles that require women to leave the home may be a factor in the increasing number of reported cases of agoraphobia. This would seem to imply the interesting corollary, that housebound women would not have had a psychological disorder in a society that discouraged women from working and socializing outside the range of home and neighborhood.

Marks (1966) has offered a different perspective on the problem, suggesting that women do not have a special susceptibility to agoraphobia. Rather, women have been socialized to admit their fear to themselves and others, and to avoid the feared situation. One might, however, ask whether it is profitable to distinguish between the "overt" agoraphobia of the female, and the "latent" agoraphobia of the male.

2. Sex Role Socialization and Women's Use of Space

I have hypothesized that the relative lack of opportunity for girls to leave the home unescorted and unsupervised from early on constitutes not an aberration of the socialization process but a well-accepted practice that creates heightened vulnerability for girls to develop agoraphobia.

The difficulty that agoraphobic women have in going out alone, and, indeed, the widespread reluctance on the part of a great many

non-agoraphobic women to go out at night, to travel alone, eat alone in public, or to go to any public place unescorted may readily be seen to reflect back on the constraints during childhood and the attitudes conveyed to females regarding their autonomous activity outside the home. This has the potential to become a serious handicap for the majority of women who are now seeking outside employment.

Compared with boys, girls are subjected to many more restrictions and warnings. A study by Saegert and Hart (1978), for example, revealed that girls are more closely supervised outdoors than boys, are more likely to be transported from place to place, are more limited in their home range, and are more likely to be required to check in periodically.

Maccoby and Jacklin (1974) have also reported that boys receive more encouragement to explore and manipulate the environment outdoors. In a study by Harper and Sanders (1975), 3- to 5-year-old boys and girls were observed during free play periods in a nursery school. They found that boys spent significantly more time playing outside, while girls spent significantly more time indoors. When outside, boys used significantly more areas than girls and engaged in less sedentary activities than girls did.

Block (1978) has underscored the point that while parents exhibit restrictiveness toward both sons and daughters, certain differences appear. For girls, there is a closer supervision of outdoor activities, and restrictiveness occurs in a context of anxious surveillance.

Such restrictions can affect girls' cognitive development, accounting for some of the differences among girls and boys in

mathematical and spatial abilities, and can affect their perception of their own competence in functioning alone outside the home.

In their study, Maccoby and Jacklin suggested that the limitations placed on girls' outdoor activities may explain why girls do not perform as well as boys on tasks requiring spatial ability, and, subsequently, on mathematical tasks. Importantly, Nash (1975) found that these sex differences in performance, which first appeared during early adolescence, held only for subjects who identified with traditional sex roles, something that may well reflect back on those earlier experiences. This finding was also substantiated in a recent study by Signorella and Jamison (1986).

Hart and Moore (1982) have suggested that the capacity to orient oneself and to find one's way to a destination develops in a Piagetian sequence, in which orientation is initially based on the relation of concrete objects to one's body, then on fixed frames of reference, such as landmarks, and finally on abstract coordinates.

There is some evidence that women do not advance to the third level. Everitt and Cadwallader (1972), comparing husbands and wives, found that wives tended to orient themselves in relation to their home, whereas men used abstract coordinates.

Appelyard (1970) reported that the cognitive maps of females were significantly less accurate than those of males. One may predict, then, that women would be more prone to getting lost when travelling in an unfamiliar place.

This prediction has been substantiated by Bryant (1982) and Koslowski and Bryant (1977). In their studies of sense of direction, they found that a very significantly greater number of males than females had a good sense of direction. They also found that self-

reports about sense of direction provided a highly reliable indicator of actual competence in orienting oneself.

Further, they found that repeated exposure was not itself a factor in improving the accuracy of cognitive maps for those with a poor sense of direction. A more important factor was an active rather than passive engagement with the environment, typified by the contrasting role of the driver compared to the passenger in a car. Individuals who had a good sense of direction enjoyed reading maps, giving directions, memorizing details of the landscape when travelling in unfamiliar areas, even when a passenger, and finding alternate routes to a place. When lost, they became less anxious than those with a poor sense of direction.

Finally, Koslowski and Bryant noted that a positive role model is associated with a good sense of direction, and offered as an example the "hunter-frontiersman-pathfinder hero," such as Daniel Boone.

It is important to note that the sense of direction has an affective as well as a cognitive component. A number of writers have emphasized the importance of being oriented to one's sense of well-being (S. Kaplan, 1972), and, conversely, the extreme loss of well-being upon the discovery that one is lost (R. Kaplan, 1976). Although the sense of direction is seldom mentioned by psychologists, Koslowski and Bryant have demonstrated the active place that it has in one's self-concept.

These studies are significant in underscoring the role that the sense of direction plays in one's feeling of well-being when traveling outside familiar areas. In noting the collective tendency of women not to have developed this faculty, and in becoming more anxious when

lost, one may see how the anxiety and reluctance to travel may shade into agoraphobic fear.

Contributing to this also, if these findings can be generalized and combined with those on children's use of space, is the fact that "active engagement" with the environment grows directly out of early socialization practices in which positive reinforcement and good male role models work to the advantage of boys and the disadvantage of girls.

In addition to the effect on spatial abilities, the process of traditional socialization for girls may also impair their capacity to be alone. Wolfe (1978) has asserted that the development of an individuated identity requires physical separation from others, and that freedom from supervision permits both greater self-definition and enhanced self-esteem.

The constructive use of privacy is predicated on learning to be alone comfortably and by choice. Agoraphobics, however, often report an inability to be alone without anxiety. The chance to go outdoors alone and to go to school without supervision are cited by Wolfe as two of the first experiences where a child is on her own. Yet, the increased surveillance and escortage of girls makes these experiences less possible, perhaps especially in the suburbs, where school and friends are seldom within walking distance.

In contrast to the kinds of restrictions placed on girls outside the home, girls appear to be given greater autonomy and authority inside the home. Parke and Sawin (1979) found, for example, that girls are given earlier and greater physical privacy in the home, especially by the parent of the opposite sex when compared to their male siblings.

In addition, girls tend to be assigned tasks inside the home more often, and to obtain jobs, such as babysitting and cleaning, inside the homes of others.

Thus, while women appear to be "deficient" in developing cognitive maps of outdoor places based on abstract coordinates, one might alternatively hypothesize that the cognitive style and selective attention of women raised traditionally are better adapted to personalized, indoor settings, and to specifics rather than abstractions. This is akin to Carlson's (1971) observations regarding sex differences in the representation of the physical environment. Comparing descriptions of childhood milieus, women's responses were proximal rather than distal, representing the environment in subjectively meaningful ways -- the insider's view -- and not in a more objective, distanced and impersonal manner, as men did.

Similarly, Wofsey, Rierdan, and Wapner (1979) found that representations of inhabited environments varied in terms of the individual's attachment to place, so that the drawings of those who were more involved tended to be idiosyncratic and highly personalized, while those of more emotionally distanced subjects tended to be cartographic and schematic.

Also, in a study of girls' and boys' representations of familiar places, Saegert and Maltz (n.d.) found that while there were no sex differences in the clarity, detail, accuracy or extensiveness of maps drawn of neighborhoods, and no differences in the degree of integration and accuracy of proportion in the floor plans of their homes, very significant differences appeared in the number of details depicted in the home. Girls included nearly twice the number that

boys did.

Interestingly, among girls, the number of articulated elements varied inversely with the overall coherence of the floor plans. The authors interpreted this to mean that the "relationship of attention to detail with attention to structure is itself embedded in the different interests, values and activities children pursue" (p. 4).

In sum one must consider the differences in styles of cognition and perception as possible adaptations to different environmental demands, present and future. Relatedly, then, maladapted responses will represent a lack of fit between cognitive style and environmental demands.

3. Women's Relationship with Home

Quite a number of studies have been done on women's attitudes about home. Hayward (1977) found, for example, that home was important to middle-class women as a personalized place, a refuge, a place where they could be in control, and as a setting for interpersonal relationships.

Tognoli (1980) found that among men and women, the women offered significantly richer and more detailed descriptions of their homes.

Saegert and Winkel (1980) found that women saw the home as an important medium for self-expression and as a setting for the important aspects of their lives.

In a book entitled, The Meaning of Things (1981), Csikszentmihalyi and Rochberg-Halton studied the meaning of home using 82 urban families. They found that women responded to the affective qualities of home, to its privacy, its sheltering character, and its potential for allowing self-expression. In contrast, men responded to home as a physical structure, a commodity, a locational backdrop for

activities, as a possession or repository for possessions, and as a place associated with childhood. In short, there was far less of an emotional loading on home among men, something that may also explain why men do not have the agoraphobic's reluctance to leave the home.

In interviewing a sample of agoraphobic women in their homes, I was repeatedly impressed by the intensely personalized rooms, for which the agoraphobic woman had been responsible. Nearly all of the homes were highly complex visually, yet familiar and self-expressive.

Rakoff (1977) interviewed a number of couples about their homes, and illustrated the differing views of normal men and women about home by describing their responses. For example: "Bob's many past houses had become an unimportant blur, physical way stations of shelter and comfort. Mary's handful of past houses were recalled with painstaking detail and fond memory. Bob saw attachments to houses as sentimental and weak. Mary saw such attachments as signs of strength and maturity."

Rakoff demonstrates how the house becomes an objectification of people's values, and is endowed with qualities that express and reinforce those values, thereby reinforcing the identity of its owner. The house thus clearly becomes imbued with psychological meaning, and can be a medium for conflicting values, both within and between individuals.

One might then reassess the clinicians' interpretation of agoraphobia, in which the woman's attachment to home is viewed as symbolic and pathological. This attachment seems to reflect what girls in general learn about home, namely, that home is a place where they can feel in control and competent, be private, and express their identity.

Summary

In this paper, I have presented an overview of research on and interpretations of agoraphobia in the clinical literature, and a possible reinterpretation of the problem. A number of issues have been considered. Among these, the first involves the definition of agoraphobia as a fear of open spaces. I have suggested that a more appropriate characterization would be a fear of leaving home and of entering public spaces.

A major criticism of the body of published research, and one that sets the theme for the present study, is the emphasis by clinicians on the fear as being provoked by irrational psychological factors. This study attempts to examine the role of past and present environmental interactions, in which real social and physical features of the environment are involved.

A second major criticism to be addressed in this research is the assumption of discontinuity between agoraphobic and non-agoraphobic individuals in the perception of, interaction with, and affective response to public and home environments. The above discussion attempts to identify similarities between the two groups that involve such issues as homesickness, overstimulation, unfamiliarity, and behavioral constraint.

Relatedly, this paper considers the little discussed question of why the preponderance of agoraphobics are women and attempts to interpret this in light of socialization practices and sex role stereotypes. Evidence is presented that suggests that stereotypical females are more vulnerable to anxiety and symptomatology. Other researchers have tied feminine socialization together with limited

opportunities to explore and enjoy settings outside the home.

The research undertakes to test some of the hypotheses offered by examining the profiles of agoraphobic women and non-agoraphobic women, in hope of developing both a sounder etiological theory and providing a basis for developing preventive measures.

CHAPTER II

METHOD

Overview

In developing a methodology for this study, it was important to incorporate an approach that was both exploratory and confirmatory. No studies prior to this one have examined the environmental components of agoraphobia, viz., the individual's past and present relationships with home and nonhome settings, and the related psychological phenomena, such as privacy and aloneness.

Autonomy, dependency, and overprotection are frequently mentioned in the literature on agoraphobia, but are treated only in global terms, as, for example, the clinician's impressionistic notion that the mother of the typical agoraphobic is anxious and overly protective.

Thus, this study begins with a hypothesis that key factors, such as "protectiveness," "privacy," and "autonomy," may be specific to certain physical circumstances and can be operationally defined. For example, the age at which one is permitted to stay home alone without a babysitter, or the requirement that one call home to "check in" are concrete measures of autonomy and protectiveness. This specificity might enable one to identify what is distinctive about the background of the agoraphobic as compared to that the anorexic or depressive, both of whom have psychological profiles that are extremely similar to that of the agoraphobic.

Because of the exploratory component of the study, it was seen as

desirable to utilize a multidimensional approach that employed open- and close-ended questions, figure drawings, and a semistructured interview. In this manner, the researcher's own agenda could be investigated, but it also allowed for new lines of inquiry that had not been anticipated.

Selection of Target and Comparison Groups

This is primarily a study of agoraphobia. In a larger sense, however, it is a study of women and sex roles and the effect that socialization practices associated with the acquisition of sex roles have on vulnerability to stress-related disorders.

The selection of comparison groups is based on the assumption that a major feature of the agoraphobic personality is dependency. This general attribute has been well documented, if not well explained in the literature. The two comparison groups, then, represent increasing degrees of independence. Independence is defined here in terms of the capacity for autonomy and willingness to engage in autonomous activities outside the home.

A second rationale for using the three group design was a pervasive weakness in the reported studies of agoraphobia. Regardless of methodology, such studies have not included samples from nondisturbed populations. Most have relied upon case studies of agoraphobics or comparisons with individuals having other types of disorders. Consequently, it was decided to include a nondisturbed sample population in the present study as a means of either confirming or disconfirming this assumption.

The three groups to be studied are thus identified as 1) Agoraphobic women, 2) Average Independence women, and 3) High Independence women.

Criteria for Assignment of Subjects to Groups

Group I: Agoraphobic (21 subjects)

Three criteria were specified for assignment to the agoraphobic group:

1. Self-description as agoraphobic
2. A score on the Phobia Subscale of the Brief Symptom Inventory that reached the level that is identified (Derogatis & Spencer, 1982) as clinically significant ($t > 63$).
3. A total score of 5 points or less on the Autonomy Subscale of the Environmental Experience Questionnaire. These three screening questions are:
 - 1) Within the last year you have traveled alone to a destination 50 miles away or more:
 1-2 times ____ (1 pt.) 3-4 times ____ (2 pts.) 5-9 times ____ (3 pts.)
 10-19 times ____ (4 pts.) 20 or more times ____ (5 pts.) Never ____ (0 pts.)
 - 2) You travel alone at night to socialize, shop, take courses, etc.: Never ____ (0 pts.) Rarely ____ (1 pt.)
 Sometimes ____ (2 pts.) Frequently ____ (3 pts.)
 Very frequently ____ (4 pts.)
 - 3) Within the last year, you have eaten alone in a restaurant:
 Never ____ (0 pts.) 1-2 times ____ (1 pt.) 3-5 times ____ (2 pts.)
 5-10 times ____ (3 pts.) 11-20 times ____ (4 pts.)
 More than 20 times ____ (5 pts.)

Group II: Average Independence (20 subjects)

Assignment to the Average Independence group required that:

1. Subjects be enrolled in a required history course at a nearby community college.
2. An Autonomy Subscale score of more than five but less than eight.

Group III: High Independence (21 subjects)

Two criteria were used for Assignment to the High Independence group:

1. A minimum total score on the Autonomy Subscale of 8.
2. A life style that is manifestly more autonomous than that of the average woman, as evidenced, for example, by the willingness to engage in activities (e.g., birding, theatergoing) independent of spouse or other regular companion.

Prospective subjects in all groups were eliminated on the basis of any physical disability that limited mobility or significantly interfered with cognitive or affective processes either by itself or as the result of treatment with psychoactive medications. Individuals taking medications that were specifically intended to control panic but did not otherwise depress CNS functioning were not excluded. Subjects were also eliminated if any gross mental impairment was evident.

Identifying Potential Subjects

A snowball sample was used to locate agoraphobic subjects. Because of the reluctance of individuals not in treatment to discuss their symptoms, the sample relied largely upon referrals from among members of various treatment groups. The initial contact and several other single contacts were made through the New Jersey Self Help Clearinghouse, which offers a listing of individuals who wish to start a self-help group, or who serve as the contact person in an already existing group. Further referrals were made through therapists known to the researcher.

In soliciting students from the local college for the Average

Independence group, it was decided to use evening students, as they tended to be more similar in age to the members of the agoraphobic group.

A snowball sample was again used to locate women for the High Independence group. Sampling was begun with women who were recreational birders. Since this group appeared to be biased in the direction of highly educated professional women, a second snowball sample was begun with women belonging to organizations of secretaries and administrators who had essentially moved up through the ranks without having advanced education. An effort was also made to locate women who were employed at jobs requiring a significant amount of travel. This group, while still skewed in the direction of more education, provided a middle ground between the professional and nonprofessional groups.

Almost inevitably, the use of a snowball sampling technique introduces a systematic bias into the sample. The homogeneity of the High Independence group in terms of level of education, professional status, and particularly marital status is especially difficult to interpret here insofar as one cannot confidently distinguish the influence of sampling bias from that of an essential precondition for independence.

In contrast to the Agoraphobic and Average Independence groups, where, respectively, 43% and 35% were nonmarried (never married, separated, divorced, or widowed), 67% of the High Independence group was nonmarried. While this may reflect sampling bias, it is consistent with the more general observation that the psychological profiles of members of this group are different from those of the other two groups, which, in many respects, are quite homogeneous.

The nonmarried status of the High Independence women also presents a corollary to the reported finding that the majority of agoraphobics are married.

Another issue related to the sampling technique involved the agoraphobic group. The fact that many of the agoraphobic subjects were in the same therapy group meant that they were exposed to the same style of treatment. This treatment -- and the communal nature of the experience -- may especially have encouraged a greater degree of assertiveness and independence than they had had prior to that time. Supportive of this, those women who had only been in treatment for a relatively brief period showed higher levels of dependency, unassertiveness, and distress on the test measures. Particularly affected, then, by treatment, were the responses to the BSRI, which directly reflects aspects of self-concept, and the BSI, which assesses the presence of and severity of symptoms.

One advantage of the snowball sample was that, in contacting prospective subjects and being able to specify who had made the referral, 100% of those who were called agreed to participate. In addition, there was no reluctance to allow the researcher to conduct the interviews in their homes. The two subjects who did not agree to face-to-face interviews apparently did so because they preferred to remain anonymous.

The Sample: A Profile

A total of 62 respondents were included in this study. All persons contacted agreed to participate (one subsequently dropped out), and all except five respondents were given the questionnaires face to face in their homes. Two of the remaining individuals, both

from the agoraphobic group, agreed to take the questionnaires but preferred to do so by mail. The other three, all from the High Independence group, were unavailable because of the considerable amount of traveling they did and thus responded by mail.

All respondents were women who resided in New Jersey. They ranged in age from 24 to 74. Because of the sampling technique, and possibly the nature of the study, differences appear among the groups, with the agoraphobics being considerably younger, significantly less educated, and significantly more likely to be married.

As might be expected, a somewhat smaller proportion of the Agoraphobic groups was employed full time, and a greater proportion were either employed part time or were homemakers. These differences, however, did not reach a level of significance. Table 1 represents a breakdown of demographic profiles by group.

Table 1
Demographic Data for Respondents by Group

	Group 1 Agoraphobic (N=21)	Group 2 Average Independence (N=20)	Group 3 High Ind. (N=21)
Mean Age	38.14	35.45	46.73
Marital Status			
Married	57%	65%	33% *
Separated, Widowed, Divorced	29%	25%	43%
Never Married	14%	10%	24%
Educational Level			
High School or Less	52%	5%	14% *
Some College	29%	95%	19% *
BA	9%	--	33% *
MA or More	9%	--	33% *
Employment Status			
Full Time	52%	70%	71%
Part Time	38%	10%	14%
Unemployed ¹	10%	20%	14%

¹Unemployed = Student, Homemaker, Retired
* p < .01

Birth order and number of siblings were included as possible background variables that might influence functioning. As indicated in Table 2 below, the agoraphobic women only were most likely to be youngest children and least likely to be middle children or only children. The average number of siblings for this group was two.

Table 2
Birth Order and Number of Siblings
in Agoraphobic and Comparison Groups

	Mean No. of Siblings	Oldest	Birth Order		
			Youngest	Middle	Only
Agoraphobic	2.00	29% (6)	48% (10)	14% (3)	10% (2)
Average Ind.	2.85	30% (6)	5% (1)	55% (11)	10% (2)
High Ind.	1.85	48% (10)	10% (2)	29% (6)	5% (1)
			**	*	

* $p < .05$

** $p < .01$

It was felt that the environment in which the person grew up might be a factor influencing later perception of and relationship with the environment. A question about the character of the neighborhood in which the subject grew up (Rural, Suburban, Urban) was included in the EEQ. When subjects reported having moved from one type of neighborhood to another, both types were recorded and included in the totals.

It was found that subjects from all three groups lived in predominantly suburban neighborhoods, with between 57% and 60% reporting having spent some or all of their childhood there.

The Tests

The Environmental Experience Questionnaire (EEQ)

This 42-item questionnaire (Appendix 1), which was developed for the purpose of this study, inquires into possible relationships between early socialization experiences involving supervision, surveillance, and autonomy inside and outside the home, and current behaviors, competencies, and attitudes related to these settings.

Approximately 30 to 45 minutes was allowed for the completion of the questionnaire.

The EEQ consists of four clusters of questions. Point values for all scored responses are indicated in Appendix 1. The four clusters have been organized as follows:

Cluster I: Early Indoor Privacy and Autonomy

This set of 11 questions was designed to rate the degree of supervision and autonomy permitted to the individual during childhood and the opportunities for privacy, given the physical constraints of the home. Questions 6 and 8 were not included in the quantitative analysis except in an investigation of the relationship between density and agoraphobia.

Cluster I -

- *6 How many members of the family including yourself were there who lived at home during your childhood?
- *8 How many finished rooms were there in the home where you spent your childhood (excluding bathrooms)?
- 9 Did you have your own bedroom as a child?
- 10 Did your bedroom door have a lock on it that could be used?
- 11 Did the bathroom door have a lock on it that could be used?
- 12 Did your family believe in letting children lock doors?

**13a Did your parents usually knock on your bedroom door before entering?

**13b From what period did they begin to knock?

14 In which room did you usually do your homework?

15 Your parents made sure to have a babysitter or older sibling at home with you until you were approximately age ____?

25a At what age did you begin to feel that you had opportunities for privacy in your household?

* Questions were used only in a separate statistical analysis of density

** For the purpose of scoring, 13a and 13b were treated as a continuum. A "Yes" response was left unscored and the "b" portion of the question was scored instead.

High scores on Cluster I indicate a greater degree of privacy and autonomy, low scores lesser degrees.

Cluster II: Early Outdoor Privacy and Autonomy

These 14 items deal with parental willingness to allow the child to travel and engage in activities outside the home free of supervision:

Cluster II -

*16a Did you attend a day camp as a child?

*16b At what ages?

*17a Did you attend an overnight camp as a child?

*17b At what ages?

18a Until junior high school, how did you most often get to school and back?

*19a Did you own a bicycle?

*19b Approximately how old were you when you received your bicycle?

20 At what age did you receive your driver's license?

21 Did your parents usually request that you call upon arrival to a relatively distant destination to let them know you had arrived safely?

22a At what age were you allowed to go downtown alone?

22b At that age, you were permitted to go alone (Very frequently...
Very infrequently)?

23a When you went out with friends at night, one or both of your parents
would wait up until you got home (All the time...Never)?

23b Approximately how old were you when they stopped waiting up?

**24 More restrictions were placed on you about going out than on your
brother(s).

* Each of the indicated sets of questions was treated as a continuous
variable, where a "Yes" response was left unscored, and the "b"
portion of the question was scored instead.

** Responses were scored "Yes"=0 "No"=5 "Not applicable" was scored as
2.5 to reflect a neutral position.

Higher scores on Cluster II again indicate a greater degree of
privacy and autonomy.

Cluster III: Current Environmental Attitudes and Competence

This eight-item cluster deals with the individual's current
willingness, confidence, and ability to travel alone. It includes the
three-item subset (Autonomy Subscale) used to assign subjects to the
High Independence group:

Cluster III -

#28}

29} Autonomy Subset (See above)

30}

31 Your sense of direction is:

32 When reading maps and/or blueprints, you have trouble (Always...
Never)?

33 You would prefer a job that (Did) (Did not) involve traveling on
business several times a year (assuming that caring for your
children was not a factor).

34a On the last two weekdays, approximately what percent of your
free time was spent at home?

34b On the last weekend, approximately what percent of your free

time was spent at home?

High scores on Cluster III indicate higher levels of perceived competence and more positive attitudes toward travel.

Cluster IV: Agoraphobic Tendencies

The final eight-item cluster is intended to gather information about agoraphobic symptoms based on the researcher's definition of the disorder, which considers varying degrees of homeboundness (i.e., the range of preference for remaining at home through reluctance to leave to inability to leave) and the object of the fear (i.e., going into public or open spaces vs. leaving the home). It supplements data gathered from the Brief Symptom Inventory with its more conventional definition of agoraphobia.

Cluster IV -

- #27a Were you ever so afraid of going to school for reasons you couldn't explain that you didn't go?
- 27b How often did this happen?
- 35 When feeling disturbed or unhappy while you are at home, you are most likely to: (Stay home) (Go elsewhere)
- 39 From the following list, check the place(s) you like to go when you are alone and have free time (Choose all that apply): (Stay home) (Other places).
- 40 Have you ever had an anxiety or panic attack that appeared to be triggered by being in the following situation(s)? (Check all that apply)
- 41 If you answered yes to any of the above in the previous question, how often has it happened?
- 42a Have there been times in your life when you felt unable to leave your home because of a fear that you couldn't explain?
- 42b How often has this happened?

High scores on this cluster indicate the presence of agoraphobic symptoms and reflect their frequency and intensity.

The EEQ also contains a section for demographic data. Finally, a series of open-ended questions, used primarily to facilitate the interview, is included. It examines the respondent's perception of her home and neighborhood and use of leisure time. For agoraphobic subjects, it allows for more detailed information about the circumstances and nature of the symptoms.

Scoring consists primarily of interval rating scales (indicated in Appendix 1) with values ranging from zero to five. Since the number of choices varies among questions, the weights assigned to each choice also vary.

The Brief Symptom Inventory

The Brief Symptom Inventory (BSI) (Appendix 2) is a 53-item self-rating scale that yields scores on the presence of and severity of agoraphobic symptoms as well as of a number of other symptoms. It is the short form of the SCL-90 (Derogatis & Spencer, 1982). Each item of the BSI is rated on a five-point scale of distress (0-4) ranging from "Not at all" to "Extremely." Scores are summed, converted into gender appropriate t-scores and rated against various normative sample groups. The t-scores are based on separate norms for inpatients, outpatients, and nonpatients. For the present study, nonpatient norms have been used to identify subjects with a significant level of phobic anxiety.

In addition to nine symptom dimensions, three global indices can be computed. Among these, the Global Severity Index, derived by dividing the total score for all nine scales by the item total, is used in this study as a means of evaluating general level of stability.

The Phobia subscale, as the authors note, adheres closely to the conventional definition of agoraphobia. It consists of the following five items:

- # 8 Feeling afraid in open spaces or on the street
- 28 Feeling afraid to travel on buses, subways or train
- 31 Having to avoid certain things, places or activities
- 43 Feeling uneasy in crowds
- 47 Feeling nervous when you are alone

The advantage of using the BSI is that it offers an established and valid indicator of agoraphobia with a demonstrably high level of internal consistency for this symptom cluster.

The BSI requires approximately seven to ten minutes to complete.

Bem Sex Role Inventory

The Bem Sex Role Inventory (BSRI) (Appendix 3) is a 60-item self-rating scale in which the subject is asked to use a 7-point scale to indicate how much each of the traits typifies her. Choices range from "Never or almost never true" (1 point) to "Always or almost always true" (7 points). A Femininity score (F score), Masculinity score (M score), Androgyny score (A score), and Undifferentiated score (U score), the latter two signifying different proportions of the first two, can be computed.

There has been a certain amount of disagreement about the formulas used to compute each of the four dimensions. A study by Signorella (1979) of over 200 men and women validated the median split method most recently recommended by Bem, in which a median score of 98 on the Masculinity and Femininity measures is used to compute the four dimensions as follows:

		Masculinity Score	
		Above Median	Below Median
Feminity Score	Above Median	Androgynous	Feminine
	Below Median	Masculine	Undifferentiated

The BSRI is expected to take 10 to 15 minutes to complete.

Representations of Home & Neighborhood

As a measure of the ability to form cognitive maps, to compare cognitive styles, and to gain insight into how the women perceive their living environments, two drawings were requested. The first of these was a map of the individual's neighborhood. The second, a picture of her home.

Scoring was adapted from the procedure used by Wofsey, Rierdan and Wapner (1979) and included an assessment of the psychological closeness or distancing from the home and neighborhood, the extensiveness and complexity of the neighborhood drawings, and their content.

Procedure

All subjects were contacted by phone. Prospective subjects were informed that the researcher was conducting a study on agoraphobia in women and was looking for participants to respond to a test battery and interview in their own home. It was deemed desirable to conduct interviews whenever possible in the homes of the respondents. This was not only a necessity in the case of the agoraphobic women, who frequently were unable to travel elsewhere and who required a measure of privacy in order to be able to respond candidly, but also gave the researcher the opportunity to observe the character, organization, and distinctiveness of those environments which are the focal point of the

lives of agoraphobics and, by extension, of this study.

Appointments were scheduled for a period of within a week from the time of the initial phone contact. Respondents were encouraged but not required to schedule the appointment for a time when there would be no other family member or friend present.

Subjects were also requested to give directions to their home. Although inadvertently so, their ability to offer accurate directions was itself supporting data.

The sequence in which the questionnaires were given was varied from subject to subject to avoid the possible confounding effects of fatigue.

The original instructions for the drawing of the respondent's home, in which the individual was requested to draw a blueprint proved less than satisfactory because it required little in the way of choice and self-expression. These instructions were therefore modified. Subjects were instructed as follows:

"I am interested in the way people see their home and their neighborhood. On this sheet of paper, I would like you to draw a picture of your home."

Having completed this drawing, the individual was then instructed:

"On this sheet of paper, please draw a map of your neighborhood."

Subjects frequently asked for a more explicit definition of "neighborhood." They were told to include whatever area they themselves considered part of their neighborhood. Several individuals also asked for degree of detail required, whether labeling of streets or structures was desired, etc. They were requested to include as

much or as little as they felt appropriate.

Instructions for the BSRI are printed on the questionnaire and subjects were simply requested to read and follow the instructions. For some subjects vocabulary proved to be a problem. They were encouraged to ask the researcher for definitions of unknown words rather than guessing at their meaning. A conventional synonym was offered where such guidance was needed.

With regard to both the BSRI and the BSI, several subjects questioned the researcher as to whether they should respond as they were at the moment or as they had been before beginning treatment. Those subjects were instructed to give both sets of responses. It was soon evident that subjects tended to exaggerate their prior orientation and therefore it was decided to use only the set of responses reflecting their present state. In this context, Derogatis and Spencer (1982) note that beyond a time window of 14 days, there is an increasing degree of distortion in the reportage of symptoms.

However, the BSI instructs respondents to describe how they have been over the past seven days and there were a number of individuals who remarked that the past seven days had not been typical, either because it had been a holiday or vacation week, because some unusual and often stressful event had occurred, or because the individual had been affected by some treatment procedure such as a new medication or psychotherapeutic technique.

In an effort to achieve some balance between the memory distortions resulting from too great or unspecified a time period on the one hand, and atypical circumstances on the other, instructions for the BSI were modified slightly from those printed on the sheet. Printed instructions read:

"Below is a list of problems and complaints that people sometimes have. Read each one carefully, and select one of the numbered descriptors that best describes how much discomfort that problem has caused you during the past 7 days including today..."

Instead, subjects were instructed to respond as they had been over "the last two to three weeks."

A final methodological change involved the procedure for administering the EEQ. This was to have the researcher rather than the respondent record the information. This resulted from the fact that information not specifically elicited by the question but relevant often needed to be appended to it. This approach also allowed the open-ended questions to serve as the basis for a semi-structured interview.

In cases where the individual responded by mail, it was necessary to make a phone contact after receiving the completed materials in order to clarify or enlarge upon certain of the EEQ responses.

Having concluded the questionnaires and interview, the researcher requested a "tour" of the home and encouraged the individual to point out whatever she felt was particularly important or self-expressive.

Method of Analysis

An important hypothesis in this study was that agoraphobic concerns would range from mild to severe and would be found across the population. In terms of the three groups used, it was predicted that agoraphobic symptomatology would appear outside the group formally labeled as agoraphobic. For this reason a correlational analysis appeared more appropriate in some respects than an analysis of variance, which rests on the assumption that there is no overlap

between groups. Because of the nature of the data, some of which was interval data, it was necessary to use nonparametric tests. Thus, the Spearman correlation coefficient was used to examine the various relationships.

Spearman correlations were also used to evaluate the internal validity of the EEQ.

It was decided to include a one-way analysis of variance as an additional measure, however, to highlight those differences that did exist between groups and that might serve to explain variations in susceptibility to agoraphobia.

The data was also subjected to a factor analysis as a means of examining the relationships among the key variables. Although it remains a correlational study, the clustering allows for at least preliminary inferences regarding socialization practices and psychological vulnerability. An orthogonal rotation was performed using both an unspecified and specified number of possible factors.

Figure drawings were evaluated along several dimensions. The first was the remoteness or closeness expressed in the drawings of home. Indices of remoteness included: 1) blueprint-type drawings, 2) stylized representations of home, i.e., the drawing appeared to be a "generic house" with no recognizable features that made it identifiable as the subject's own home, 3) the drawing appeared to emphasize accurate and objective representation with an absence of personal detail.

Indices of closeness included: 1) picture-like rather than blueprint-type drawings, 2) personalized representations of the home including recognizable architectural features, 3) intimate or

idiosyncratic elements, such as a cat in a favorite spot or a certain hanging plant.

Indices of remoteness from the neighborhood included: 1) aerial or map-like drawings, 2) stylized elements such as general representation of trees or geometric forms representing houses rather than identifiable trees or picture-like houses, all of which are treated as neutral, non-labeled elements, 3) inclusion of factual labels, such as street names, store names or common landmarks, 4) emphasis on objective and accurate representation such as one might use for giving directions.

Indices of closeness to the neighborhood included: 1) picture-like and/or three-dimensional drawings, 2) personalized elements, such as a recognizable stand of trees, a particular neighbor's dog house, or a certain store, 3) intimate details, such as one could only be familiar with by regularly traversing the neighborhood on foot, such as a grazing area frequented by deer or a small brook, 4) elements indicating interactions with neighbors, especially labeling of homes with names of neighbors.

Scoring for these included opposing elements when present, such as a neighborhood drawing contained has both map-like and picture-like qualities. Only presence or absence of the listed features was recorded; quantity of each element was not recorded.

Extensiveness of the neighborhood drawings was evaluated in terms of the number of streets depicted. Cognitive representation was also evaluated by the inclusion of distant places, such as an arrow pointing toward Manhattan from the subject's own town.

Distinctive content was considered as an additional element which was not scored, but was considered in the discussion.

CHAPTER III

RESULTS

The main thrust of this research was to identify personality factors and socialization practices related to the appearance of agoraphobic symptoms. The study utilizes a person/environment model in examining the problem: It presumes that real stresses exist in environments, particularly in public settings, but that the sex and history of the individual may create differences in how such settings will be experienced.

Findings indicate that agoraphobia is embedded in an identifiable cluster of perceptual, attitudinal, and cognitive characteristics, and that the agoraphobic's background contains certain common elements that predispose one to this condition. Equally important, there appear to be many similarities between the agoraphobic group and the Average Independence group which was used for the purpose of comparison; few similarities were found with the group of High Independence women, who were distinctive in all aspects that were evaluated.

Specifically, it was found that the typical agoraphobic identifies with the traditional feminine sex role, in which such attributes as passivity and dependency are endorsed. Compared especially with the childhood experiences of the High Independence women, opportunities to go places without adult supervision during childhood were limited. Opportunities to remain at home alone were also limited.

Current attitudes, competencies, and use of space related to

autonomous activity in public and outdoor places appear to have been adversely affected by these early restrictions. Such attributes are, predictably, associated with the agoraphobic condition, but are evident to a somewhat lesser degree in the average women.

In examining the contrasting responses of the Independent women, it was concluded that the capacity to function alone outside the home is generally fostered early in life, and results in significantly reduced vulnerability to the discomfort, fear, and sense of uncertainty associated with going out alone that typified the responses of the other two groups. This has important implications for primary prevention.

Substantiating earlier studies, results indicate that the parents of phobics are often extremely fearful, and in many cases phobic themselves. Associated with this finding was preliminary evidence that other family members, especially males, tended to conceal their phobic tendencies with the use of alcohol and drugs, as did several of the women in the sample.

The agoraphobic women's perceptions of home and neighborhood, their use of leisure time, and the actual appearance of their homes also differed considerably from those of the High Independence women, reflecting their more intense involvement, concerns about safety and privacy, and lack of diversity in the use of other settings. Although some of this might again be attributed to the effects of the phobia, the similarity with those in the Average group suggests that this orientation preceded the symptoms.

The Sample

Assignment of Respondents to Groups

A total of 62 respondents were included in this study.

The fact that difficulties were encountered in deciding to which group certain individuals would be assigned based on the specified criteria does itself confirm the assertion that these are overlapping and not discrete groups.

Group 1: The Agoraphobic Group (21 Subjects)

In the agoraphobic group, all 21 women satisfied the first criterion, describing themselves as agoraphobic. A potentially serious problem in finding subjects for this group, however, was that individuals who had not begun treatment (and who most often did not recognize their condition as agoraphobia) were not willing to be interviewed. Thus, all subjects in the Agoraphobic group had been or were currently in treatment at the time of the interview.

This treatment factor may explain the fact that three of the 21 women did not satisfy the second criterion, a t-score of 63 on the Phobia Subscale, and nine did not satisfy the third criteria of an Autonomy Subscale score of five or less (Two of the three subjects who did not satisfy the Phobia Subscale criterion also did not satisfy the Autonomy Subscale criterion.)

In sum, twelve subjects, or 57%, satisfied all three criteria, while 19, 90% satisfied at least two of the three. Because of the fact that treatment would not affect the reportage of early socialization experiences, and because the contrast with the Independent group remained in evidence, it was decided to include all subjects in the data analysis, but to also consider the cases of subjects who did not

fulfill all three criteria individually.

Group 2: The Average Independence Group (20 Subjects)

Assignment to the Average Independence group (hereafter referred to as the Average group) required that respondents be enrolled in a required history course at a nearby community college. It is again noteworthy in light of the hypothesis about overlapping populations that six of the 20 respondents, none of whom described themselves as agoraphobic, achieved a t-score of 63 or higher on the Phobia Subscale, placing them above the critical level.

One additional subject, currently functioning, had a history of being housebound for six months, and a last subject expressed some concerns about becoming housebound.

Because self-definition was a criterion for assignment to the Agoraphobic Group, it was decided that for most of the statistical analyses, the six respondents with t-scores in the clinical range would remain in the Average Independence Group. They were transferred into the Agoraphobic Group only for the analyses of variance as a means of comparing the backgrounds of symptomatic versus non-symptomatic individuals.

On the Autonomy Subscale, thirteen of the women, or 65% scored within the range specified. Six women, or 30% scored below five, one woman scored above eight.

Group 3: The High Independence Group (21 Subjects)

Assignment to the High Independence Group (hereafter referred to as the Independent group) required (1) that respondents achieve a total score of eight or more on the Autonomy subscale, and (2) that they pursue a life style that the experimenter as well as others

considered unusually independent.

Two women initially assigned to the Average group were reassigned to the Independent Group on the basis of their Autonomy subscale scores. Although four subjects did not meet the first criterion, it was again decided to include them in the sample on the basis of the life style criterion.

One woman from this group achieved a t-score of 64 on the Phobia Subscale. While she remained assigned to the Independent Group for all other analyses, she was included in the Agoraphobic Group for the analyses of variance.

A general observation in selecting subjects for the agoraphobic group was that it was unusually difficult to find prototypical cases. This was a consequence of two factors, namely, the method of selection and the heterogeneity among agoraphobics.

In utilizing self-help groups as a source for finding agoraphobics, it became evident that self-diagnosis is not always a reliable means of locating appropriate individuals. Within the sample group, one individual seemed more likely to be suffering from a severe social phobia than from agoraphobia, although her primary symptom was her inability to travel outside the house.

A second individual appeared to have an underlying personality disorder, most likely of a schizoid nature, and had, as her presenting symptom, something that more closely resembled a panic disorder than true agoraphobia. Again, however, she was severely limited in her ability to travel outside the home.

Another two individuals had true agoraphobic symptoms, but in each case the onset appeared fairly sudden, occurring during a

personal crisis. Since the literature generally reports that significant residual symptoms are almost invariably in evidence (except in some individuals on medication), one might best describe the character of the disorder in the present cases as an adjustment reaction with agoraphobic symptoms, a diagnostic description that reflects the appearance of symptomatology in an individual with fairly good prior adjustment (Chambless and Goldstein have suggested the term "simple agoraphobia" for such cases [1982]).

An unusual number of subjects had a history of symptoms related to eating, drinking, and digestion. One individual, in addition to being severely agoraphobic, also had a history of bulimia and alcoholism as well as having attempted suicide. Three others had been, or were at the time, acutely bulimic or anorexic. Three of the subjects, including the anorexic, had had hysterical symptoms involving swallowing, and another had been hospitalized with psychogenic stomach pains.

In evaluating overall mental health, ratings from the BSI indicated that all but three of the subjects who scored at or above the clinical level for phobia scored equally high on at least one of the other eight symptom dimensions, reflecting the presence of multiple pathologies.

The selection of subjects was thus confounded by the fact that this study, like the majority of others, found that complex symptom pictures appeared more often than not among the agoraphobics, while research design mandates the elimination of possible extraneous variables, including the presence of symptoms other than those being studied.

In the present study, it was concluded that "typical" might more

appropriately mean a complex symptom picture rather than the uncomplicated one of agoraphobia without the additional pathologies, and that the primary criterion for inclusion in the Agoraphobic group should be the simple fact of being housebound.

Validity of Test Instruments

Assessment of Criterion Test Instrument: The Autonomy Subscale

Three questions on the Environmental Experience Questionnaire were designed to be used to identify low, average, and high levels of environmental independence. These questions, which belong to Cluster III, "Current Attitudes and Competencies," comprised the Autonomy Subscale. It was anticipated that these questions would be highly correlated with one another.

The analysis, using Spearman correlation coefficients, revealed that Question 28 ("Within the last year, you have traveled to a destination 50 miles away or more ____ times.") and Question 30 ("Within the last year, you have eaten alone in a restaurant ____ times.") were significantly correlated ($r = .4884$, $p < .001$).

Questions 29 ("You travel alone at night to socialize, shop, take courses, etc. ____ times.") also showed a low but significant correlation ($r = .2594$, $p < .021$) with Question 30.

The correlation of Questions 28 and 29 did not reach a level of statistical significance. A possible confounding variable that might account for this is the fact that the use of evening students for the Average Independence Group resulted in nearly all of them answering Question 29 with "Frequently" or "Very Frequently."

Other than this methodological problem, another possible factor is that while many women are reluctant to travel at night, it is not

unusual for agoraphobics to travel more readily at night, when the darkness provides a measure of anonymity and enhances one's sense of enclosure.

Together, these two factors would produce a higher than expected number of subjects who would respond within the affirmative range to this question.

Examining the mean scores for each of the three questions across groups (Table 3), Question 29 appears as something of an anomaly.

TABLE 3
Mean Scores for Autonomy Subscale Questions by Group

Group*	Question 28** (Travels Distances)	Mean score Question 29*** (Night Travel)	Question 30** (Eats Alone)	Total
1	1.33	2.40	1.19	4.92
2	1.55	3.30	.70	5.55
3	3.90	3.10	3.50	10.50

* 1 = Agoraphobic 2 = Average 3 = Independent

** Total points possible = 5

*** Total points possible = 4

Consistent with the hypothesis that the sampling technique of using evening students biases the profile of the "average" women, the mean scores for Question 29 appear unusually high, higher, in fact, than those of the Independent women.

The mean score for the same question for the Agoraphobic group is also fairly high, and inconsistent with the other scores.

Despite the difficulties with Question 29, it was decided that all three questions would be used since a significant difference would

still be expected to appear between Groups 1 and 3 on question 29 and since each question did add an increment of strength to the set.

This decision was reinforced by the fact that each of the scores individually were negatively correlated to a significant degree with the Phobia Subscale (Question 28: $r = -.3421$, $p < .004$; Question 29: $r = -.2819$, $p < .015$; Question 30: $r = -.4928$, $p < .001$). Collectively, the three questions produced a negative correlation with the Phobia Subscale of $r = -.5025$ ($p < .001$).

Validity of the Environmental Experience Questionnaire

In order to establish the criterion-related validity of Cluster IV, "Agoraphobic Trends," it was anticipated that scores on Cluster IV would correlate highly with scores on the Phobia Subscale, and, indeed, the correlation was highly significant ($r = .7340$, $p < .001$).

Among the individual questions from Cluster IV, all seven questions were significantly correlated with the Phobia Subscale, with correlations ranging from $r = .3373$, ($p < .004$) to $r = .6780$, $p < .001$). Of these questions, it is interesting that among the most highly correlated are the questions relating to the fear of leaving home, while school phobia is the least highly correlated.

It was further expected, in terms of construct validity, that there would be an inverse relationship between Cluster III ("Current Environmental Attitudes and Competence"), which reflects the strength of positive attitudes, competencies, and behaviors related to travel and leaving home, and Cluster IV ("Agoraphobic Tendencies") as well as between Cluster III and the Phobia Subscale. The correlations were both found to be negative and moderately significant ($r = -.5827$, $p < .001$, and $r = -.6031$, $p < .001$, respectively).

Among the individual questions from Clusters III and IV, the correlations ranged from low to moderately significant. Below is a table indicating the degree of relatedness among the questions from Clusters III and IV:

TABLE 4
SPEARMAN CORRELATION COEFFICIENTS FOR EEQ CLUSTERS III & IV*

Question	CLUSTER III							
	28 (travels distances)	29 (travels at night)	30 (eats alone)	31 (sense of direction)	32 (map reading)	33 (job with travel)	34a (wkday time spent home)	34b (wkend time spent home)
27 (school phobia)		-.2637 ¹			-.3638 ²	-.4060 ³	-.2746 ¹	
35 (stays home when disturbed)	-.2977 ²		-.2982 ²	-.3525 ²	-.2591 ¹	-.4824 ³		
39 (free time- stays home)		-.2774 ¹	-.3196 ²					
CLUSTER IV 40 (panic attack)		-.2694 ¹				-.4239 ³		
41 (frequency of attacks)						-.5108 ³		
42a (fear of leaving home)	-.4175 ³	-.2538 ¹	-.2791 ¹	-.2735 ¹	-.2674 ¹	-.5904 ³		
42b (frequency of fear of leaving)	-.4219 ³	-.2888 ¹	-.3086 ²	-.2707 ¹	-.2601 ¹	-.6198 ³		

*Correlations of less than .2500 have been omitted.

¹ p < .05
² p < .01
³ p < .001

The Brief Symptom Inventory: Face Validity and "Caseness"

The decision to use Derogatis' Brief Symptom Inventory was based on the fact that it has been very widely used both in research and in psychiatric settings. At least as salient, the questions included are nearly identical to those that appear on other well regarded fear surveys using the self-report format, but the BSI offers additional information in the form of other symptom dimensions.

Nonetheless, one may question the sole reliance upon a self-report inventory, with its potential for distortion either in the direction of denial or the exaggeration of symptoms. The interview proved to be helpful as an antidote to some of this distortion.

The instructions, to respond to one's experience over the last week, might also have been problematical insofar as the week was not always "typical." The instructions for this study were altered to account for the last three weeks to counter the effects of unusual occurrences (which included, for example, a miscarriage, divorce proceedings, infant with meningitis, summer vacations, and the effects of psychotherapy and/or new medication.)

According to Derogatis' definition, which uses two primary dimension scores or a Global Severity Index (GSI) of 63 or greater as an index of clinical significance, 55% of the Average group and 33% of the Independent group had a clinical disorder of one kind or another. On the face of it, this would seem to be something of an overdiagnosis.

Yet, one of the exigencies of using this kind of measurement in an applied setting is the necessity of making an absolute distinction between cases and non-cases. One may otherwise argue that such distinctions (in this case, selecting a t-score of 63 to identify

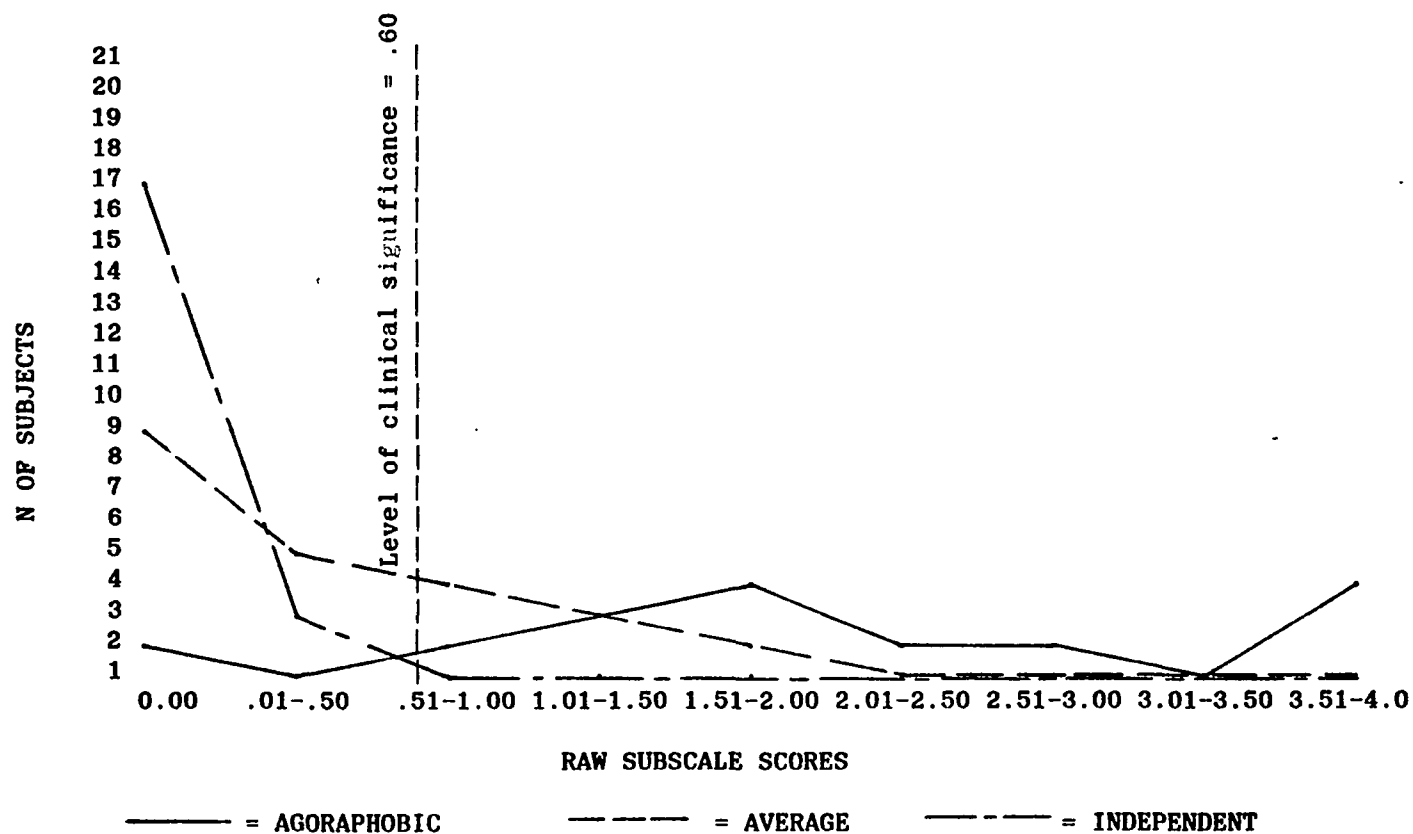
clinical levels of disorder) have elements of subjectivity and arbitrariness. Since the statistical analysis in the present study was primarily correlational, the problem was largely alleviated.

While standards of caseness appear to lack rigor, the reverse criticism may be applied to reports such as that by Agras, et al. (1969), namely, that standards of caseness were unrealistically high.

In both cases, the use of any standard that identifies a clinical level confirms, a priori, that there are no mild degrees of symptomatology, no continuum of severity, only cases and non-cases. On this basis, Agras, et al. reported that agoraphobia was the least common of the phobias, and not generally found outside of psychiatric populations. Data from the present study reflects a continuum of symptomatology.

Figure 1 uses the raw scores from the BSI to indicate the distribution of phobic symptoms among subjects from all three groups and reflects the considerable overlap that was found. The mean scaled scores for the Agoraphobic, Average, and Independent groups were, respectively, 66+ (scaled scores do not reflect the full range at the upper levels), 34, and 11.57.

FIGURE 1
FREQUENCY POLYGON FOR PHOBIA SUBSCALE SCORES AMONG
SUBJECTS IN AGORAPHOBIC, AVERAGE AND INDEPENDENT GROUPS



Data Analysis

Relationship of Identification with Femininity to Agoraphobic Symptomatology

Hypothesis 1 predicted that an increased incidence of agoraphobic symptoms would be positively correlated with an identification with the feminine sex role.

To test this hypothesis, the Bem Sex Role Inventory (BSRI) was administered to all subjects. A total of 21 of the 62 subjects (34%) reached the criterion for assignment to the High Femininity group as defined by Bem. (F score ≥ 98 , M score ≤ 97).

The Phobia Subscore was used as the measure of agoraphobia. A low but significant positive correlation was found between High F and the presence of agoraphobia ($r = .2694$, $p < .017$).

It was also anticipated that a positive correlation would be found between High F and Cluster IV ("Agoraphobic Tendencies") of the EEQ. However, this was not supported by either the aggregate data from Cluster IV or any of the individual questions from that cluster.

On the other hand, when one examines the relationship between High F and Cluster III ("Current Environmental Attitudes and Competence"), it is clear that negative attitudes and uncertain abilities are associated with feminine identification. The correlation of High F with Cluster III as a whole was negative and significant ($r = -.2780$, $p < .014$), and most of the individual questions were significantly correlated.

It is noteworthy that among these eight questions that comprise Cluster III, four that correlated negatively to a significant degree with High F were also negatively correlated with the Phobia Subscale. Table 5 is a summary table of the significant correlations of the

individual questions from Cluster III with both High F and the Phobia Subscale.

Similarly, when correlations with specific questions from other clusters of the EEQ are examined, those that correlate negatively with the Phobia Subscale also tend to correlate with High F. These include early permission to go downtown alone ($r = -.4350$, $p < .001$) and frequency of early permission to go downtown alone ($-.3215$, $p < .005$).

Table 5
Comparison of Significant Correlations to Cluster III
for High F and Phobia Subscale

Cluster III Question	Subject	Phobia Subscale	High F
28	Distance travel	-.3033**	-.3377**
	Night travel	-.2908**	--
30	Eat alone	-.4577***	-.3268**
31	Sense of direction	-.2960**	-.2679*
32	Map reading	--	-.2874*
33	Job with travel	-.6231***	-.2775*
34a	Weekday time spent home	-.2566*	--
34b	Weekend time spent home	--	--
Cluster Total		-.6031***	-.3118**

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

For the purpose of comparison, correlations with the Phobia Subscale and with Cluster IV ("Agoraphobic Tendencies") were calculated for the other sex role categories, High M ($F \leq 97$, $M \geq 98$),

Androgynous ($F \geq 98$, $M \geq 98$), and Undifferentiated ($F \leq 97$, $M \leq 97$). No significant correlations were found between Androgeny and phobia, or between an Undifferentiated identity and phobia.

A significant negative correlation did appear for High M and the Phobia Subscale ($r = -.3442$, $p < .003$) and for High M and Cluster IV ($r = -.3260$, $p < .005$). Conversely, High M was positively correlated to a significant degree with Cluster III ($r = .3621$, $p < .002$).

Group Profiles

The proportion of subjects from each of the three groups who fell into the various sex role categories is shown in Table 6 together with chi square testing for significant differences among the proportions for the groups.

Table 6
Sex Role Classification by Group

	Group 1	Group 2	Group 3	χ^2
High F	38% (8)	55% (11)	10% (2)	9.69*
High M	5% (1)	10% (2)	43% (9)	11.59*
Androg.	33% (7)	15% (3)	19% (4)	--
Undiff.	24% (5)	20% (4)	29% (6)	--
	100%	100%	100%	

* $p < .01$

The majority of subjects in the agoraphobic group were distributed between the High F category (38%) and Androgynous category

(34%).

The analysis indicates that there were significant differences among groups in the distribution of High F ($\chi^2 = 9.69$, $p > .01$). The significant differences, however, were between the Independent group and the Independent group, rather than between the Agoraphobics and the other two groups.

Three of the seven subjects from Groups 2 and 3 who scored within the clinical range on the Phobia Subtest were classified as High F. All three were in Group 2. When these three are transferred into the Agoraphobic Group, the proportion of High F increases to 46%. Differences between Groups 1 and 3 are significant ($\chi^2 = 7.41$, $p < .01$). These figures point more strongly toward a relationship between identification with traditional femininity and agoraphobic tendencies.

The Masculinity scores showed a reverse pattern, in which the highest mean scores were achieved by the High Independence Group. Forty-three percent of the High Independence Group fell into the High M category, while only 10% were in the High F category. The lowest proportion of High M scores among the three groups appeared in the Agoraphobic group (5%), with the Average Independence Group again occupying an intermediate position (10%) but one that more closely resembled the agoraphobic sample.

Chi square tests indicated that the differences between the groups for High M was again significant ($\chi^2 = 11.59$, $p < .01$).

Differences between groups in the Undifferentiated and Androgynous categories were not significant.

In summary, the data support the relationship between feminine sex typing and heightened vulnerability to agoraphobia. The data also suggest the opposite, namely, that identification with masculine

traits seems to "innoculate" one against agoraphobia. Correlations also support the contention that identification with traditional femininity is associated with less positive attitudes about public places and a perception of oneself as being less competent in terms of skills needed to travel independently.

Early Outdoor Autonomy and Agoraphobic Tendencies

Hypothesis 2 predicted that limiting the opportunity for young girls to be alone by choice outside the home, which one may regard as a specific type of parental protectiveness, would increase the probability of agoraphobic symptoms later in life.

In operational terms, it was predicted that there would be an inverse relationship between a high score on Cluster II ("Early Outdoor Privacy and Autonomy") and a clinically significant Phobia Subscore on the BSI, as well as an inverse relationship between Cluster II and Cluster IV ("Agoraphobic Trends"), where high scores on Cluster II indicate greater levels of autonomy and privacy, while lower scores indicate greater restrictiveness and surveillance.

The first prediction was confirmed. A low but significant negative correlation was found between Cluster II and the Phobia Subscore ($r = -.3376$, $p < .004$) supporting the prediction that the lack of early opportunities for autonomy and privacy outdoors increases the probability of later agoraphobic symptoms.

The correlation between Cluster II and Cluster IV, while in the predicted direction, did not reach a level of significance.

Four sets of questions from Clusters II and IV did correlate significantly, however. The tendency to stay home when feeling disturbed or unhappy was negatively correlated with being allowed to

go downtown at an early age ($r = -.4599$, $p .001$) and with parents waiting up when the daughter went out with friends at night ($r = -.3010$, $p < .009$) indicating that greater restrictiveness about going out and tighter surveillance (waiting up) during adolescence are associated with the tendency to stay home in adulthood when upset.

Consistent with parental reinforcement of stereotypical femininity, it was found that the propensity toward having agoraphobic episodes was positively correlated with parents imposing greater restrictions on daughters than sons ($r = .3222$, $p < .005$). Imposing greater restrictions on daughters was also slightly correlated with frequency of agoraphobic attacks ($r = .2515$, $p < .024$).

Requiring the daughter to call on arrival at a destination was also negatively correlated with the Phobia Subscore ($r = -.3103$, $p < .007$), as was early permission to go downtown alone ($r = -.3924$, $p < .001$). Lower scores on "call on arrival" and "permission to go downtown" questions again indicate greater restrictiveness, indicating that higher levels of surveillance and the curtailment of independent activity outside the home negatively affect later confidence in conducting activities outside the home.

Group Profiles

A one-way analysis of variance (Table 7) indicates a slight but significant difference in the mean total scores for Cluster II across groups ($F = 4.376$, $p < .0169$).

Table 7
One-Way Analysis of Variance among Groups:
Cluster II - Early Outdoor Privacy and Autonomy

	Group*			
	1	2	3	
Mean Cluster				
Total	24.5476	25.1667	29.7250	
Source	SS	df	MS	F
Between Groups	325.067	2	162.533	4.376*
Within Groups	2191.357	59	37.142	

* 1 = Agoraphobic, 2 = Average, 3 = Independent

** $p < .02$

When subjects who scored within the clinically significant range on the Phobia Subscale are transferred into Group I, the differences between means are somewhat smaller, but continue to be significant ($F = 3.812$, $p < .0277$).

Using Duncan's Range Test, it was determined that the level of significance can be accounted for in both instances by the differences between the lower scores of Groups 1 and 2 on the one hand, and the higher score for subjects in Group 3.

These findings support the assertion that differences in autonomy are related to the curtailment or encouragement of free movement outside the home earlier in life.

A final analysis was performed on subjects from the High F group to address the question of whether any differences existed between those who later became agoraphobic and those who did not. The analysis, a one-tailed t-test which compared the High F agoraphobics with the High F non-agoraphobics on Cluster II indicated that there were no significant differences in cluster totals between the two

groups.

Problems with the wording of three questions in Cluster II were evident. Confounding the scoring of responses to the question about when parents stopped waiting up, there were a number of cases where parents stopped waiting up when the subject either got married, moved to her own apartment, or went away to college. There was no category to reflect this. Although the data are incomplete, this was a factor with nine subjects (43%) in the agoraphobic group, the youngest of whom was 15. Nine had parents who stopped waiting up earlier. Data are incomplete for the remaining three.

The wording of a second question from Cluster II was also a problem: When asked the age at which one was first permitted to go downtown alone, the word "alone" was interpreted by some to mean unaccompanied by an adult, and by others to mean unaccompanied by anyone. As it became quickly evident that going downtown was most often a social activity and that few youngsters would be motivated to go completely alone, respondents were instructed to interpret it as meaning "without an adult."

As reported, statistically significant negative correlations were found between permission to go downtown alone and the tendency to use the home for "safety" when emotional equilibrium was disturbed. One wonders whether the differences would have been sharpened if it had been possible to inquire about solitary travel to public places during the early years rather than just the frequency of travel without adult chaperonage.

Third, the "call on arrival" question prompted two women from the Agoraphobic group, and two from the Average group to remark

spontaneously that this was not required either because the individual "never went out," "never went anywhere," or "wasn't allowed to go any distance."

In considering the agoraphobic's reluctance to go out, a possible variable that was considered in this study was objective differences in the character of the childhood environment and the distance to services. Subjects were asked to describe their early neighborhood as being either rural, suburban, or urban. Although the dangers inherent in an urban environment might be expected to elicit anxiety, there was no clear evidence to support this. Parents of phobics expressed as much concern about recreational environments as urban ones.

Alternatively, the more protected suburban environment, with the additional need to be transported to school and/or downtown might reduce the number of opportunities for the child to traverse and become familiar with various places and environmental features, as well as limiting opportunities to develop wayfinding strategies, and thereby contribute to agoraphobia.

Table 8 indicates that subjects from all three groups lived in predominantly suburban neighborhoods, with between 57% and 60% reporting having spent some or all of their childhood there. Although differences did not reach a level of significance, there was a trend toward those in the Independent group being more likely than those in the other two groups, especially the Agoraphobic group, to have lived in a rural community, while those in the Agoraphobic group were somewhat more likely than those in the other two groups to have lived in an urban community.

Table 8
Early Residential Neighborhood Type
Reported by Respondents

Group	Rural	Suburban	Urban
Agoraphobic	14%	57%	43%
Average	20%	60%	25%
Independent	29%	57%	24%

With regard to the distance from the individual's childhood home to school, responses indicated no significant differences among the groups either in terms of distance to the elementary school (which was, for all groups, generally less than a mile and a half) or in mode of transportation. The majority of respondents walked to their elementary school. The only difference noted was that among the remainder who were transported to school, a total of four agoraphobic subjects reported that they were driven to school by a parent, while just one non-agoraphobic said she was taken by car, the rest having taken a bus.

Another variable that was considered was distance to downtown. One might have presumed that parents would be more reluctant to allow children to go downtown alone if it were a greater distance away. Responses indicated wide variability in distances to downtown, but with no systematic differences among groups.

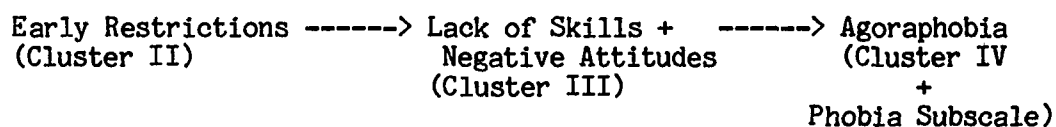
Differences in parental latitude, then, would not reflect objective qualities of the environment, such as the potential for danger in an urban setting or a more remote destination, but appear to be more closely associated with less tangible factors, particularly, a generalized fearfulness and restrictiveness on the part of the

agoraphobic's parents, as will be discussed below.

Relationship of Early Environmental Restrictions to Current Attitudes, Competencies, and Behavior

Subhypothesis 2 stated that early restrictions on autonomous activity outside the home will contribute to both less effective functioning outside the home later in life and to a negative or phobic attitude about travel. This negative attitude would result from interfering with the developing capacity for wayfinding and orienting oneself, and, consequently with failing to develop confidence in one's ability to perform these tasks.

Diagrammatically, one would predict the following:



Cluster III of the EEQ ("Current Autonomy & Competence") reflects an overall level of competence in travel skills as well as the respondent's attitudes about travel and going outside the home by choice. The Autonomy Subscale from Cluster III reflects actual frequency of autonomous behavior outside the home.

It was predicted that Cluster II would correlate positively with Cluster III. The correlation coefficients, however, did not reach a level of significance.

In examining specific questions, eight sets did correlate significantly:

Attendance at overnight camp was positively correlated with traveling distances alone ($r = .2990$, $p < .009$); and with and eating alone in a restaurant ($r = .3392$, $p < .003$).

Permission to go downtown at an early age was positively correlated with several items, including: Eating alone in a restaurant ($r = .2996$, $p < .009$), having a good sense of direction ($r = .4684$, $p < .001$); ability to read maps ($r = .3698$, $p < .002$), and willingness to accept a job requiring frequent travel ($r = .3036$, $p < .008$).

Frequent permission to go downtown at an early age and eating alone in a restaurant were also correlated with one another ($r = .3123$, $p < .007$).

Having had a bedroom door with a useable lock, and preference for spending free weekend time away from home were, unexpectedly, negatively correlated ($r = -.2963$, $p < .010$).

The hypothesis that positive attitudes and competencies (Cluster III) are negatively correlated with agoraphobia (Cluster IV) was, as noted above, confirmed.

Path analysis similarly indicated that the path coefficient of current attitudes' influence on phobic tendencies was highly significant ($p < .0001$), but that the direct influence of early history on phobic tendencies as well as indirect influence of history on phobic tendencies through current attitudes was nonsignificant.

These findings may reflect the lack of cohesiveness of each cluster, or the importance of only the few early history variables identified as highly correlated with phobic tendencies. Alternatively, it may mean that women's current situation, i.e., marriage and family, may be a more powerful predictor of current attitudes and behaviors, as will be discussed later.

Group Profiles

A one-way analysis of variance was performed for Cluster III ("Current Autonomy and Competence") across groups. It was expected that agoraphobic subjects would have attitudes about going out that would be considerably more negative than those of nonagoraphobic individuals and that they would be much more severely restricted in their actual movement outside the home.

This assumption was strongly supported by the data ($F = 30.675$, $p < .001$), as shown below in Table 9. Differences between each of the groups were significant.

Table 9
One-Way Analysis of Variance Among Groups:
Cluster III - Current Environmental Attitudes & Competence

	Group*			
	1	2	3	
Mean Cluster Total	13.6190	19.5238	26.7500	
	SS	df	MS	F
Source				
Between Groups	1769.753	2	884.877	30.675*
Within Groups	1701.940	59	28.846	

* 1 - Agoraphobic, 2 = Average, 3 = Independent

** $p < .001$

When subjects in Groups 2 and 3 who scored within the clinical levels are transferred to Group 1, the F score drops slightly ($F = 23.063$, $p < .001$) but continues to be well above the level of significance, with differences between each of the means found to be significant.

The directionality of the relationship cannot be determined in a correlational study and one might presume with equal likelihood that

the negative attitudes and constricted activities resulted from the agoraphobic symptoms rather than preceding them.

However, the mean total for Cluster III for the Average Group as well as the Agoraphobic Group was significantly different from and less positive than that of the High Independence Group, indicating that those in the first two groups do share some negative attitudes about travel and being in public places regardless of the presence of symptoms. This would support the hypothesis that the negative attitudes predate the symptoms rather than proceeding from them.

The Relationship of Agoraphobic Females with Home

Hypothesis 3 stated that because traditional females have a greater emotional investment in the home, and have been granted both greater autonomy and greater privacy there, they are more likely than non-traditional females to exhibit the agoraphobic's fear of leaving the home.

In order to test this hypothesis, Spearman's correlation coefficient was first used to determine whether any relationship could be found between Cluster I ("Early Indoor Privacy and Autonomy") and High F. However, the analysis did not support the hypothesis.

It was predicted that a positive correlation would be found between Cluster I and agoraphobia as measured by both Cluster IV and the Phobia Subscale.

In fact, a significant negative correlation was found between Cluster I and the Phobia Subscale ($r = -.2910$, $p < .011$), indicating that the parents of agoraphobic women were more restrictive in indoor as well as outdoor settings.

No significant correlation was found between Cluster I and

Cluster IV, although the trend was, again, in the negative direction.

One particularly important finding was, however, obscured by a problem in the scoring of Question 15. This question, which reflects the highest age with which one was left with a babysitter or older sibling, did not make provision for the possibility that one had never been left with a babysitter. A score of zero was used, but this also applied to those who had been left with a sitter until age 15 or older.

A re-evaluation of the data revealed that among all subjects who score in the clinical range on the Phobia Subscale or who were assigned to Group 1, 46% had never been left with a sitter, either because the parents never went out or because they were always taken along. Many from the Agoraphobic Group remarked spontaneously that they had "never been left alone."

Twenty percent of the Average Independence Group and 19% of the High Independence Group reported never having been left alone.

A corollary to the original hypothesis that parents of agoraphobics would have been less restrictive indoors and more restrictive outdoors than other parents would be that one would anticipate a negative correlation between scores on Cluster I ("Early Indoor Privacy and Autonomy") and scores on Cluster II ("Early Outdoor Privacy and Autonomy").

The Spearman r for Cluster I and Cluster II did not support this prediction. In fact, the two were positively correlated to a significant degree ($r = .3124$, $p < .007$), indicating that when parents are protective in one setting, they tend to be protective in both.

Finally, on the assumption that differences in opportunities to

be alone at home might be found between agoraphobic and non-agoraphobic women, and that household density might affect such opportunities, a separate analysis was done on the relationship between density (Number of people/Number of rooms) and agoraphobia, using Cluster IV ("Agoraphobic Tendencies") as the measure of phobia.

No significant correlation was found between density and agoraphobia. However, the analysis was somewhat limited by the fact that nearly all subjects had grown up in low density homes. Alternatively, the lack of significant findings may indicate that the agoraphobic's lack of opportunity to be alone is not the logistical one of lacking space, but the interpersonal one of needing to be near others.

Group Profiles

An analysis of variance for Cluster I ("Early Indoor Privacy and Autonomy") across groups (Table 10) with subjects scoring within the clinical level for agoraphobia from Groups 2 and 3 transferred into Group 1 and also remaining in their original groups indicated no significant differences.

Table 10
One-Way Analysis of Variance [between] Groups
for Cluster I: Early Indoor Privacy and Autonomy

	Groups*			
	1	2	3	
Mean Cluster Total**	18.6190	20.5500	21.9524	
Source	SS	df	MS	F
Between Groups	117.613	2	58.806	--
Within Groups	4098.855	59	69.472.	

* 1 = Agoraphobic, 2 = Average, 3 = Independent

** Subjects in originally assigned groups

A t-test was also used to compare the mean scores on Cluster I for High F agoraphobics and High F non-agoraphobics. No significant differences were found between groups.

In summary, it appears that agoraphobic women have generally been permitted somewhat less autonomy and privacy at home than those in the other two groups. Most salient, the women with agoraphobia were found to be much more likely not to have been separated from their parents or other relatives (i.e., Never left with a babysitter) than the non-agoraphobic women.

Parental Anxiety and Supervision

An important differentiating factor between the parents of agoraphobic and non-agoraphobic subjects was related to the style of supervision.

There were three separate aspects of parental supervision that seemed to affect the adjustment of the offspring. These were degree of restrictiveness, the range of situations where the parent perceived danger, and the parental affect elicited by the prospect of the child acting autonomously.

Cluster II, "Early Outside Autonomy and Privacy," attempted to ascertain the degree and range of actual supervision outside the home. The significant differences appeared between the Agoraphobic and Average groups on the one hand, and the Independent group on the other, indicating that the first two groups were more closely supervised and more restricted than those in the Independent group. Although the differences between groups on Cluster I, "Early Indoor Autonomy and Privacy," were not significant, the trend was in the same direction.

The factor that may distinguish between who later becomes agoraphobic and who does not from among the Average and Agoraphobic groups might be conjectured to be that of parental affect. The parent who is apprehensive and restrictive appears more likely to increase agoraphobic vulnerability in the children. This additional element of anxiety especially characterized the supervision by the parents of the agoraphobic women. Indeed, many of the parents seemed themselves to be phobic.

The comments of the agoraphobic women are revealing:

Betsy D., who was very emphatic about the fact that the doors inside her parents' household were never locked, but outside doors always were, said, "My father would not allow any [inside] door to be locked -- He was an absolute fanatic. When he went to lock up, he checked everything ten times. He checked to make sure the [outside] doors were locked, that everything in the kitchen was okay, especially the stove...My father knocked [on the bedroom doors] every night and woke us up just to make sure we were okay."

Later she commented that "my father was against riding bikes. He warned me to be careful about everything, including getting into the shower."

Finally, asked whether she was required to call home, she responded that her father required all of the family members to check in and did so himself. Frequently out to dinner, he regularly called the subject to say where he was in case anything happened.

It was clear from Betsy's description that her father had, among other things, agoraphobic and compulsive features himself, something which deeply affected the entire family unit. Betsy and her sister

are both severely phobic.

Mary Ellen A. stated that because her father was a police officer that he "looked on the bad side of things" (which he apparently described in vivid detail to her), resulting in his being more restrictive than the average parent.

Mary Ellen's mother, also phobic, habitually kept her two children with her whenever she went anywhere. Both children are now agoraphobic.

Regarding the locking of doors in the home, Elly S. said of her parents, "They were very conscious of fire, of being in bedrooms, of not being able to get out." Elly's concern, as it developed, was that she felt unable to leave her home because of "a fear of being trapped." Of five siblings, Elly and a brother are clearly phobic.

The mother of another subject, Ellen R., insisted that her daughter put a kerchief over her head when driving through bad neighborhoods at night, so that the men there would not see her blond hair and try to harm her.

Ellen's father, before he died, never drove because he "didn't like other cars going by so fast." Ellen herself stopped driving in her early twenties. She is phobic, but states that her brother is not.

Some phobic subjects reported parental concerns that focused on outdoor recreational activities: One said of her mother that she "didn't want us to go ice skating" and cautioned the children regularly and urgently about bike riding. A second described an incident in which she was to go for a boat ride. Her mother, however, was "deathly afraid of letting her get on the boat" and cried so hysterically that her daughter refused to go on the ride.

Similarly, one of the subjects from the Average group who scored within the phobic range, Peggy P., stated that her father resisted her getting a bike because he was afraid of her getting hurt. Later in the interview, this subject mentioned that her mother cried when the subject discussed the possibility of getting a job and an apartment on her own.

Doreen G., a subject from the Average group who earlier had been housebound for six months, responded to the question about calling home when arriving at a relatively distant location by stating that she wasn't allowed to go any distance. Regarding going out with friends at night, she commented that she was forbidden to go out with girls, because it was not as safe as when escorted by a male. Her mother also believed that it was not proper for a girl to be out alone by herself at night and thus did not permit her to do so.

Another subject from the phobic group stated that her parents regularly called the police if she was late getting home from an evening outing with friends.

The overwhelming majority of reported studies on the relationship between overprotectiveness and agoraphobia identify the mother as the agoraphobic agent. But as the examples of Betsy, Elly, Mary Ellen, and Ellen illustrate, fathers were also frequently fearful and often overprotective, contributing to the daughter's condition.

Looking at the Average women, there appear to be two separate groups, those that are phobic or near phobic, and those that show no symptoms. Among the former group, which comprised 55% of the sample, Phobia Subscale scores ranged from 57 to 70, with $t=63$ identified as the critical level. Among the latter group, which comprised the

remaining 45% of the women, the scores were all zero. The difference may again be related to the early family environment.

Doreen G. and Jody K. were not among the six women from the Average group identified as phobic. However, the two women resemble the agoraphobics in many important respects. Both scored in the High Femininity group. Both come from homes that have been described as generating phobias.

Like the agoraphobic women, Doreen had never been left with a babysitter. She reported that her parents never went anywhere, and that her mother seldom left the house, except for the six months of each year that she worked. Doreen stated that her first vacation was her honeymoon. As with the agoraphobics, her parents stopped waiting up for her only when she got married and left home, at age 18. Doreen also has a history of bulimia and migraine headaches.

In the interview, Jody K. expressed the concern that she was becoming housebound. In her case also, her mother is evidently housebound, only leaving the home on weekends in the company of her husband.

Although neither of these women, both in their middle thirties, is likely to become overtly agoraphobic, it can be anticipated that much of their adult lives will be spent within a range limited both geographically and temporally, and will be discouraged from going out at night, and from going certain places alone because of the potential danger of crime, something that might be construed as ordinary and prudent for women, but which also feeds directly into the phobic condition.

By contrast, a number of the women from the Independent group came from homes where little was said or done to limit activity. In

several cases, the women had been left at an early age to fend for themselves, often by circumstance rather than design.

Roberta R., for example, stated, "My father left the family when I was about nine. As he did not support us and my mother had to support three children, we grew up on our own. We did not have a sitter and became very independent." Her brother, who was only a year older, and a sister, who at the time was seven, evidently learned early to be self-sufficient.

Similarly, Margaret M., who grew up in the South Bronx, reported that her father abandoned the family, who lived in an unheated railroad flat, when she was quite young. Before she was old enough to join them, her mother and older sister worked in a factory, leaving the subject alone a great deal. The fact that this subject has epilepsy was a cause for her mother's concern. Nevertheless, the circumstances precluded the concern being translated into heightened supervision.

Florence P., a divorced retiree, noted: "My home...disappeared when I was seven as my father was taken terminally ill and died when I was nine. I spent a year in a convent, cared for by the sisters, a year with my mother at a boarding school where she was housemother, and was then sent to two aunts where I spent a year with their five children. My mother then joined the household of one aunt and we moved to Princeton. I spent the rest of my youth with this aunt and uncle and their two children."

Certainly the level of parental apprehensiveness, as described by the agoraphobic women, seems well beyond what might be considered appropriate. At the same time, many of the concerns possess

recognizable features of normal parental protectiveness, in substance if not in intensity. It may thus be the degree of urgency with which such warnings are issued, and the parent's obvious distress at the prospect of the child being exposed to perceived risk, that contributes to the overlapping of some attributes between the agoraphobic and average women.

Comparative Uses of Home and Non-Home Settings by
Agoraphobic, Average and Independent Subjects

Subjects were asked a series of semistructured questions that focused on activities and uses of space under different conditions. These conditions were: Childhood places satisfying a need for privacy; places to go when feeling disturbed; places to go when alone with some free time; and activities engaged in when free time is available. Four additional unstructured questions inquired into the most- and least-liked aspects of the subject's home and neighborhood.

Because of the exploratory nature of the data, it was not subjected to statistical analysis and was considered only as a descriptive aspect that permitted further comparison between the three groups.

Places to Go When Disturbed

This question asked:

When feeling disturbed or unhappy while you are at home, you are most likely to:

Stay home: Always _____ Sometimes _____ Never _____

Go elsewhere: Always _____ Sometimes _____ Never _____

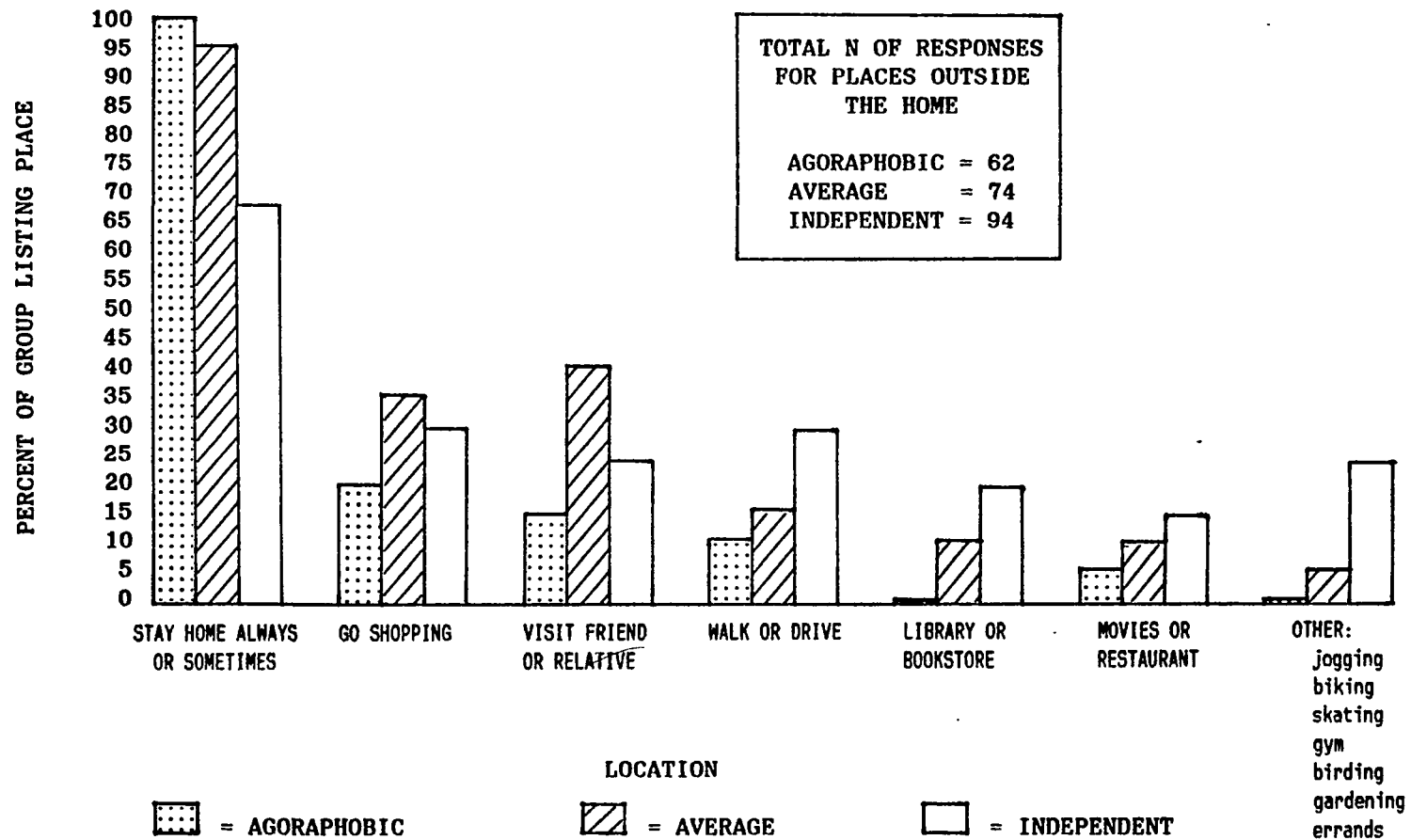
If elsewhere, specify where, if possible _____

Responses to this question were assigned to one of seven

groupings, as shown in Figure 2. The "Other" category encompassed a variety of activities, many recreational (jogging, biking, skating working out at the gym), some avocational (birding, gardening), or obligatory (errands).

Figure 2 shows the distribution of settings and activities mentioned by each group.

FIGURE 2
 "PLACES TO GO WHEN DISTURBED": CHOICE OF PLACE BY GROUP



Staying home was the preferred place for the majority of agoraphobic subjects, virtually all of whom said that they always (48%) or sometimes (52%) stay home when disturbed. The agoraphobics ranked first in terms of the proportion who chose home (100%), the Average group ranked second (95%) and the Independent women ranked a distant third (67%).

Alternative places mentioned by phobic subjects were going shopping (19%), visiting a friend or relative (14%), going for a walk or drive (10%), and meeting a friend for lunch (5%).

The most preferred places outside the home for those in the Average group was visiting friends or relatives, which was mentioned by 40% of the women in this group, and going shopping (35%). Other places included going for a walk or drive (15%), going to a restaurant (10%), a library or bookstore (10%), or gardening (5%).

There was less consensus among the Independent women, who offered a much broader range of activities. A number of women had alternative choices. The places mentioned included: Going for a walk or drive (29%), shopping (29%), visiting friends or relatives (24%), going to a library or bookstore (19%), pursuing a recreational activity such as jogging, biking, ice skating, birding, and working out in the gym (14%), and going to an entertainment place (movies or restaurant) (14%). One person each mentioned going to New York City, running errands, and gardening.

It is important to note that when the agoraphobic women leave the home, for example, to go for a drive or to shop, they nearly always do so in the company of a trusted other. Typically, those in the Independent group go out alone, while those in the middle group show no consistent pattern. Thus, while destinations outside the home may

be similar for women in the three groups, the character of the experience in very different.

Similarly, staying home for the majority of the Independent women is likely to be a solitary experience, since 67% of them were not married at the time, and, generally, were living alone. Only two of the phobic women lived alone, the remainder having children or a parent living with them.

There were considerable differences in the total number of responses offered by each of the three groups of women. Outside of home, there were only 13 places mentioned by the Agoraphobic group, and these fell into four of the six categories. Those in the Average group listed a total of 26 places outside the home, those in the Independent group offered 32, with the responses of both groups distributed over the six categories.

Privacy

The second question asked:

"[During your childhood] Where did you go when you wanted some privacy?"

Five places were listed by the 62 subjects. These included the bedroom, the bathroom, other rooms in the home (including attic, basement, den, spare room, maid's room), outside, and a friend's house. A sixth category was assigned for subjects who said they had never wanted to be alone. When more than one place was mentioned, all were included in the statistical analysis.

As indicated in Figure 3, the majority of subjects in all three groups chose the bedroom. Among those in the Agoraphobic, Average, and High Independence groups, 67%, 85%, and 62%, respectively, said

the bedroom.

The second most popular place among the agoraphobics was the bathroom, which was listed by 24% of the women. It also ranked second among the Average women, with 15% of them listing it.

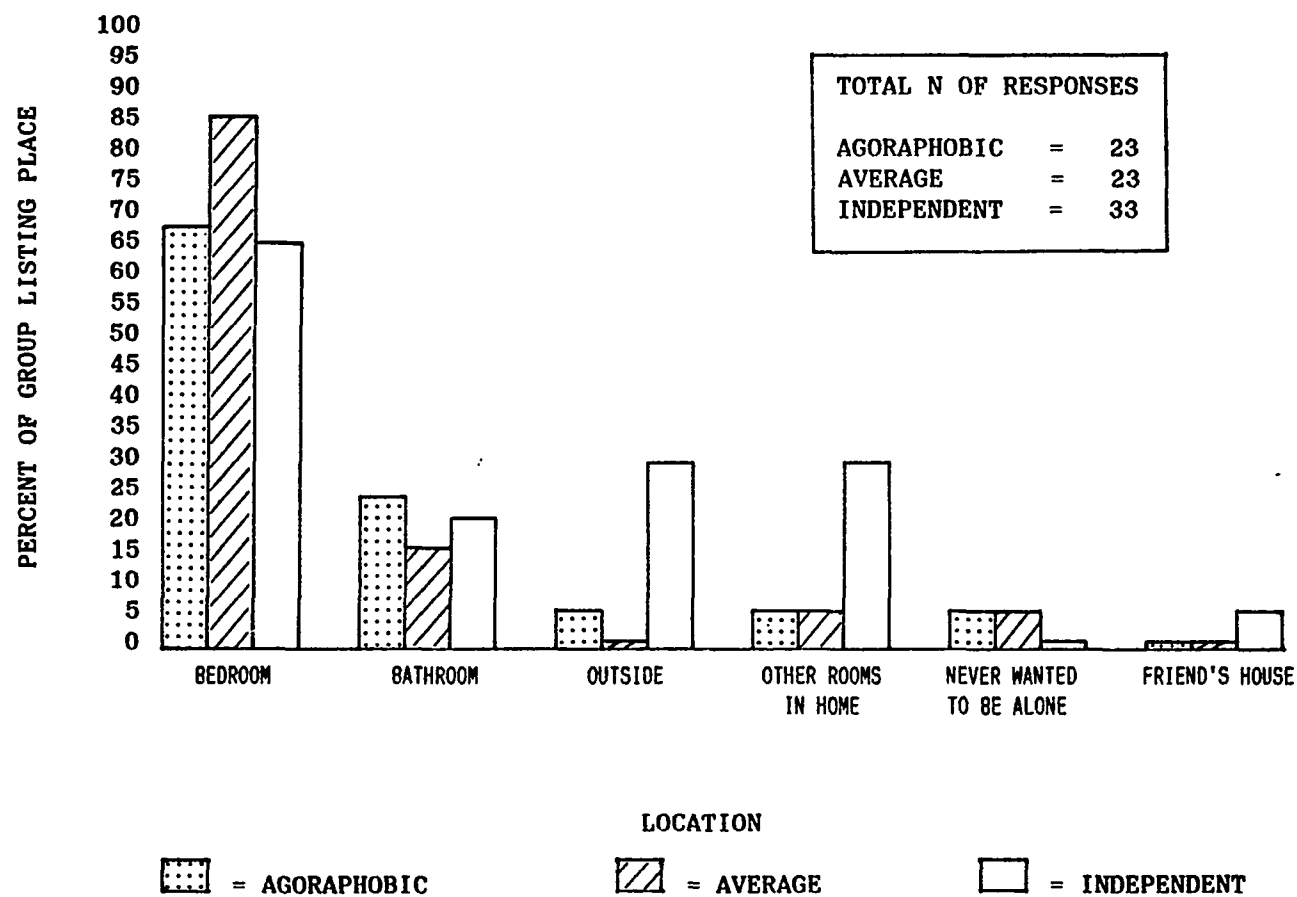
Again, the Independent women are atypical, preferring, as their second choice, either going outside (29%) or to rooms other than the bathroom (29%), often in a more remote section of the home. One person mentioned going to a friend's house.

The proportions here are somewhat misleading, because bedroom and bathroom together comprised nearly the total number of responses for the phobic and average groups, but constituted only half of the total number of responses offered by the Independent group.

Only one subject from the Agoraphobic group mentioned the outside as a place for privacy, and then it was the yard -- the outdoor extension of home. One person mentioned the recreation room and one stated that she had never wanted or sought to be alone.

Among those in the Average group, no one listed anywhere outside, and only one person gave another room in the house as an alternative. One person said she had never wanted to be alone. Thus, the average group looks extremely similar to the phobic group, the only significant difference being in the distribution of choices between bedroom and bathroom.

FIGURE 3
 "CHILDHOOD PLACES TO FIND PRIVACY": CHOICE OF PLACE BY GROUP



Once again, the Independent group gave the highest total number of responses, 33, compared to 23 each for the Agoraphobic and Average groups.

Free Time

The third question asked:

"From the following list, check the place(s) that you like to go when you are alone and have free time (Choose all that apply)

Stay home _____

Visit friends _____

Go out in the country _____

Go to a city _____

Go to a shopping center _____

Go to an entertainment place _____

Other (Specify) _____

Most responses fell into or could be assigned to the preset categories. Most subjects selected more than one place. Three additional categories were created for going to a museum or library; for going to a recreational area, including the shore, a forest, park, the Great Swamp, a bike path, a bird sanctuary, a golf course, stables, a skating rink, YMCA, or going for a walk. The final category was "Other."

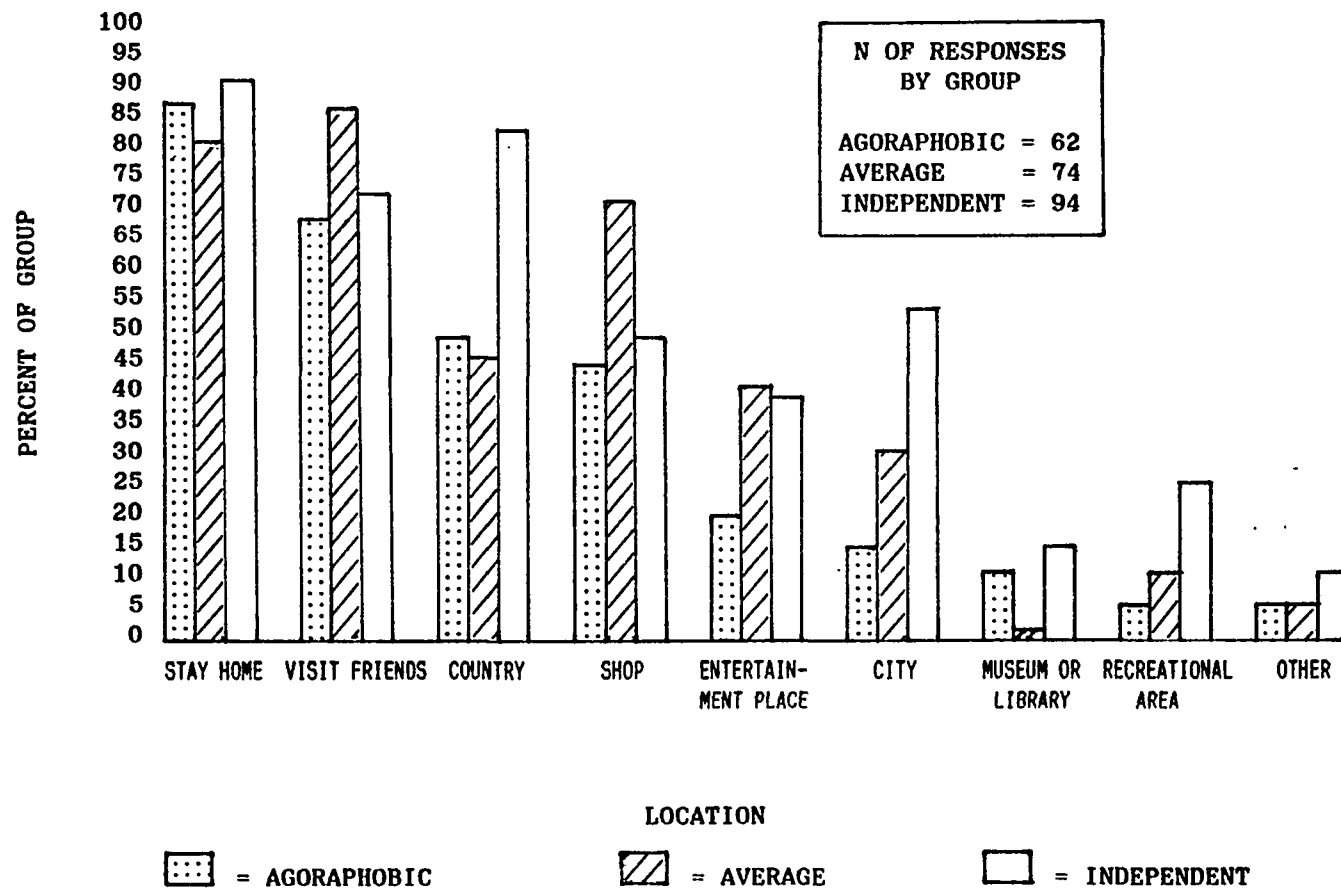
With aloneness being specified as a condition, the phobic subjects most often chose to remain at home, as can be seen in Figure 4.

It should be noted that an even greater proportion of Independent women chose staying home under this circumstance than the proportion of women in the other two groups, 90%, as compared to 86% and 80% for

the Agoraphobic and Average groups, respectively.

This presents quite a contrast with the relatively small proportion of Average and Independent women who chose home when upset.

FIGURE 4
 "ALONE AND HAVE FREE TIME": CHOICE OF PLACE BY GROUP



Second and third choice places, respectively, which the agoraphobic women reported as destinations when alone and with free time, were visiting friends or relatives (67%) and going for a ride in the country (48%). The remainder listed going to a museum or library, a luncheonette, and to the shore.

Visiting was nearly as popular a choice among those in the other two groups, representing, for the Average women, their first choice activity, and, for the Independent women, their third choice activity.

The greatest contrast among choices was in the Independent women's preference for going out to the country, which was mentioned by 81%, nearly twice the proportion of women as in each of the other two groups. Shopping, on the other hand, was a much more popular choice among the Average women than among those in the phobic and Independent groups, having been mentioned by 70% of the women, compared with 43% and 48%.

The places and activities given by those in the Independent group were both more diverse and more active. In the category indicating "Other," three wrote in "going to a library or museum"; others listed golfing, the skating rink, a bird sanctuary, bike path, the YMCA, and the stables. One said, "Anywhere outdoors." One mentioned going to a fabric store, and one said she would go to her son's soccer games.

Once more, there was a considerable difference in the total number of responses, with the Agoraphobic group offering the least number of alternatives (62), the Independent group offering the most (94), and the Average group again in an intermediate position with 74.

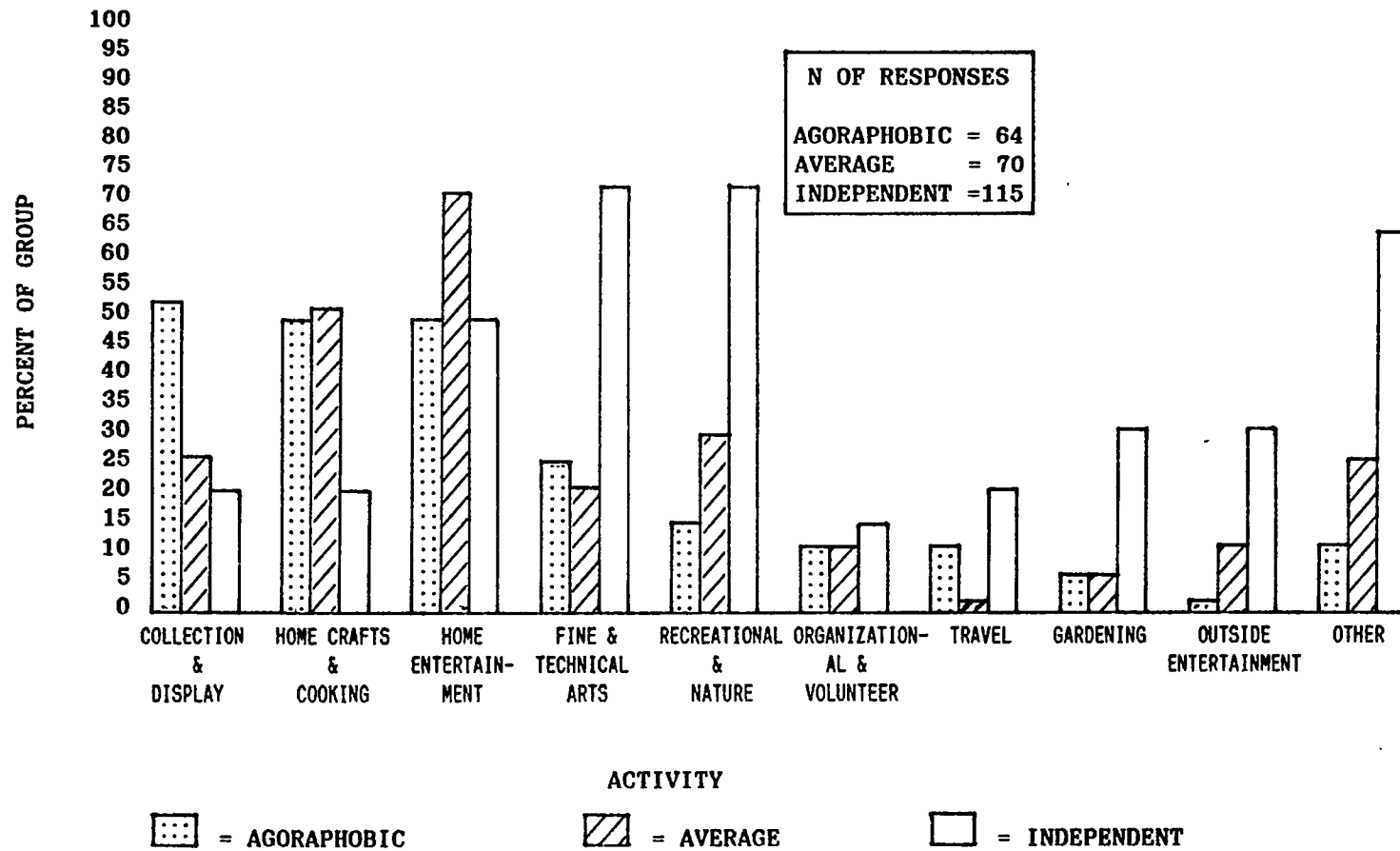
Comparative Uses of Home and Non-Home Environments for Free Time Activities

In terms of the uses made of free time, the three groups were

quite distinct in their preferences. Consistent with the above findings, the agoraphobics offered many fewer activities than the Independent women, with those in the Average group offering a slightly greater number than the phobics.

Activities were grouped into one of six categories: Home crafts, Home entertainment, Collection and Display, Sports, Fine and Technical Arts, and Other.

FIGURE 5
FREE TIME ACTIVITIES OF AGORAPHOBIC,
AVERAGE AND INDEPENDENT GROUPS



As indicated in Figure 5, the activities of the women in the Agoraphobic group fell predominantly into two clusters, "Home Crafts" and "Collection and Display." Examples of home crafts included such things as sewing, knitting, crocheting and needlepoint, making Christmas ornaments and wreaths, quilting, candlemaking, and rug hooking. Examples of items that were collected and displayed included antiques, dolls, dollhouses, and porcelain and crystal figures.

The distinctiveness of the agoraphobics' homes reflects immediately on these interests and accounts for the very striking visual differences between their homes and especially those of the Independent women.

Although the Average group was quite similar to the Agoraphobic group with regard to the enjoyment of home crafts, few listed collection and display as an interest. Among those in the Independent group, almost no one expressed any interest in either the traditional domestic arts or display, spending their time instead engaged in sports, or with such fine arts as freelance photography and writing, music and dance, drawing and painting, all of which might perhaps be characterized as more androgynous and less exclusively feminine in character.

With regard to the pastimes of the phobic women, one may again argue that the choice of domestic activities is a function of being forced to remain in the home. However, the selection is also congruent with their more feminine orientation. Further, it can be seen as an expression of the greater emotional investment in the home as well as the hypothesized issues of need for identity "props" and the greater influence of the environment on their mood, sense of control, and general well being.

Factor Analysis of The Variables

Test scores for all questions on the EEQ, all four BSRI sex role categories, and the Phobia Subscale and Global Severity Index from the BSI were entered into a factor analysis using principle components analysis followed by varimax orthogonal rotation.

The analysis yielded 13 separate factors. Of these, the first five factors accounted for nearly 70% of the variance, with the remaining variance distributed fairly evenly over the other seven factors. It was thus decided to compress the data into five factors.

These five, which appear in Table 7, have been labeled: Factor 1: Distress; Factor 2: Current Autonomy; Factor 3: Mobility; Factor 4: Early Solitude & Privacy; Factor 5: Early Autonomy/Restrictiveness. For any single item to be included in a factor, it was required to have a minimum factor loading of .35.

Factor 1: Distress

The highest factor loadings for the distress factor included six of the seven EEQ questions in Cluster IV ("Agoraphobic Tendencies"). In order, these were: Frequency of anxiety attacks in agoraphobic situations (.89); Frequency of anxiety attacks related to leaving the home (.86); Inability to leave the home because of inexplicable fear (.85); Anxiety attack triggered by agoraphobic situation (.80); History of school phobia (.61); and Preference for remaining at home when disturbed or unhappy (.41). The single Cluster IV item that did not load as highly was Preference for staying home when alone and having free time.

Other items with high factor loadings were the Phobia Subscale (.62) and the Global Severity Index (.61), the inclusion of the latter

again suggesting, without indicating direction, that there is a close relationship between general distress level and the presence of agoraphobic symptoms. High negative loadings appeared for Having a job requiring travel (-.59) and for Traveling at night (-.51).

Frequency of agoraphobia-related anxiety turned out to be somewhat more closely related to Factor 1 than whether the individual had ever had an agoraphobic episode. This would seem to result from the fact that a range of individuals across groups reported having had single experiences of agoraphobia, or, as with one of the cases noted earlier, the individual went through a brief though significant period of months when she was severely limited in her ability to leave the home.

The relatively low correlation of staying home when distressed would also seem to result from a considerable number of non-agoraphobics who answered this question affirmatively. (A total of 53 women of the 62 stated that they remain at home "Always" or "Sometimes," including 100% of the Agoraphobic Group, 95% of the Average Group, and 62% of the Independent Group.)

Factor 2: Current Autonomy

The single item with the highest factor loading is negatively correlated with the autonomy dimension. This factor is High F (-.63). Conversely, High M has a strong positive factor loading on this dimension (.40), suggesting that for women sexual identity has an important influence on the willingness and ability to act independently when outside the home.

Among the variables related to childhood experiences that were most closely associated with Factor 2, Early permission to go downtown

alone (.56), Frequent permission to go downtown alone (.35) and Attendance at overnight camp (.44) all had high loadings.

Other contemporary factors closely related to autonomy were: Eating alone in restaurants (.53); Distance travel alone (.50); and Sense of direction (.48), Willingness to accept a job requiring travel (.40), and Mapreading ability (.39).

The factor loading for Tendency to stay home when disturbed is even more highly negative than the Phobia Subscore, (-.45 and -.40, respectively), suggesting that the use of home for emotional safety and security is a quality antithetical to environmental autonomy.

Factor 3: Mobility

This dimension draws largely upon past and current ability to transport oneself from place to place. It included having owned a bicycle (.54) and having gotten a driver's license at an early age (.50), as well as being related to Androgeny (.37) and to parents knocking before entering (.37), but is negatively related to having gotten to school on foot or bike (-.49) and to spending free weekend time at home (-.44). It is difficult to interpret this cluster, and one suspects that there is an underlying factor not included among those on the list that may serve to explain the cohesion among these variables.

One may hypothesize that the underlying factor is having a basically middle class suburban background. The physical setting would necessitate the use of bicycles and cars, with each made available at the earliest appropriate age, as well as the necessity for being transported by bus to a relatively distant school.

Knocking on the bedroom door also appears to be class-related,

and did not distinguish any of the three groups from the others. Parke and Sawin (1979) found that among middle-class families, knocking was a prevalent pattern, especially preceding fathers' entry into daughters' rooms, but also characteristic for mothers. The present study failed to support another of their findings, however, which was that knocking is correlated with more restrictive and protective mothers. This should have produced a correlation with agoraphobia.

Equally, going out on weekends among the women, nearly all of whom were living in suburban or rural areas at the time of the interview, is a common pattern among those living in residentially zoned areas, although, again, it has a different meaning for those in the agoraphobic group, for whom going out nearly always means in the company of a trusted other.

Factor 4: Early Solitude and Privacy

This dimension, which essentially draws upon the Cluster I questions involves early indoor privacy.

The variables which contribute most significantly to Factor 4 are: Early opportunities for privacy at home (.56); Having been allowed to remain at home without a babysitter when parents were out (.53); Having one's own bedroom (.45); Parents knock before entering (.43); Frequency of permission to go downtown at an early age (.40); Preference for doing homework in private (.40); and Bedroom door can be locked (.36).

While neither High F nor the Phobia Subscale reaches the required level for statistical significance, both factors are negatively related to this dimension, as is the Global Severity Index.

Factor 5: Early Autonomy/Restrictiveness

This factor is related to the degree of parental surveillance both inside and outside the home.

Highest factor loadings were for: Parents waiting up when daughter was out at night with friends (.64); Parents request call on arrival to relatively distant location (.44); Parents stopped waiting up until daughter returned home while subject was relatively young (.40); and Bathroom door has useable lock (.37).

The apparent inconsistency of parents ceasing to wait up when daughters were out with friends while the subject was still young may be the result of the fact that daughters subjected to greater surveillance (a greater number of whom were in the Agoraphobic group) also tended to get married earlier and thus leave parental supervision.

Relationship between General Instability and Homeboundness

In the course of interviewing people, both formally and informally for this study, the researcher was impressed by the number of individuals encountered who had experienced single episodes of agoraphobia. These nearly always occurred under conditions of unusual emotional stress.

This was reminiscent of an earlier observation, made while employed in a state psychiatric hospital, that individuals who were decompensating frequently stopped leaving the home for extended periods of time. In the case reports, this is simply characterized as the patient becoming "withdrawn." This tendency, however, is consonant with the idea that the home plays an important role in restoring one's emotional equilibrium.

As a means of exploring the strength of this relationship between the tendency to remain home and general emotional instability, an analysis was done using Cluster III ("Current Attitudes and Competence") in toto, the Autonomy Subscale from Cluster III and three specific questions from the EEQ that reflect a preference for remaining at home under various circumstances. Each of these was correlated with the Global Severity Index (GSI) of the BSI.

The additional questions from the EEQ included:

Cluster III, Question 34a: On the last two weekdays, approximately what percent of your free time was spent at home?

Cluster III, Question 34b: On the last weekend, approximately what percent of your free time was spent at home?

Cluster IV, Question 35: When feeling disturbed or unhappy while you are at home, you are most likely to : (Stay home) (Go out).

The analysis indicated that the correlations for Questions 7 and 8 with the GSI were not significant.

A moderately strong positive correlation was found for the third question and the GSI ($r = .4247$, $p < .001$) supporting the relationship between emotional instability and the increased tendency to remain at home. As noted above, 100% of the agoraphobic women gave home as their choice of place always or sometimes when feeling disturbed.

Conversely, a significant negative correlation was found between the GSI and the Autonomy Subscale ($r = -.4087$, $p < .001$) and with Cluster III as a whole ($r = -.5132$, $p < .001$), indicating not only attitudinally that there is a preference for remaining at home during periods of emotional stress, but that in terms of actual behavior, the

individual when distressed is more likely avoid engaging in autonomous behavior alone away from home.

As one would expect, the GSI was also highly correlated with both Cluster IV as a whole ($r = .6220$, $p < .001$) and with the Phobia Subscale ($r = .8399$, $p < .001$).

Again, additional research might further substantiate the hypothesis that the high level of general distress preceded the reluctance to leave home.

Perceptions of Home and Neighborhood

Subjects were asked what they liked most and what they liked least about their home. They were then asked the same questions about their neighborhood.

Responses to their home were grouped into thirteen major categories as indicated in Table 11. Assignment to a category was made regardless of whether the remark was positive or negative so as to reflect the focus of concern or interest.

Responses to home and neighborhood questions were combined into a single category where appropriate. For example, the noise or quietness in a house or particularly an apartment reflected conditions both inside the home itself but also outside, within the apartment complex or the neighborhood.

Assignment to category presented certain difficulties, insofar as several meanings were often compressed into a single word or phrase. For example, "spaciousness" and "the property" were two terms that were mentioned often in response to what the person liked most about her home. Both, referring to the land upon which the house was situated, seem to imply an aesthetic component, but also suggest

privacy and/or ownership. An attempt was made to create categories that were broad enough to include variable but related meanings without being overinclusive. In this case, the category "Outdoor Privacy, Space/Crowdedness" included apparently related physical elements, but assignment to "Outdoor aesthetics" required a more explicit statement. Decisions were also made on the basis of the context in which the statement was presented, since it sometimes clarified the most important aspect.

Responses referring to neighbors presented similar ambiguities. When no clarification was made, it was simply assigned to the category "Neighbors" to avoid any unjustified inferences.

The category "Convenient Location" encompassed a heterogeneous group of concerns. These included convenience to work, shopping, and to family friends and clients. Lack of convenience implied in such environmental constraints as traffic, limited parking, and the need for a car and driver's license, the last being especially pertinent to the agoraphobics.

"Indoor Aesthetics and Self-Expression" also included a variety of responses. Some referred to a certain room or space. For example, one subject said that what she liked most about her home was "the open expanse [on the] first floor...a large room with skylights, glass walls, and a view of the lake." Similarly, one subject responded to what she liked least about her home with, "...typical garden apartment -- four walls, box-like, standardized, homogenized."

Others focused not on the structure, but the contents of the home. For example, "My antiques. They carry stories with them, especially the photographs because they were generally happy

occasions." Another said, "I decorated it. It's pretty for an apartment."

The concept of familiarity is generally assumed to carry positive connotations. In this case, the category was broadened to include "Familiarity, Memories and Associations," all of which imply meaningfulness based upon continuity with past personal experiences. As such, it contained both positive and negative responses.

For example, one agoraphobic subject offered the ambivalent comment that although she disliked her apartment, she "would never leave it [because she doesn't] adapt well to change." Another from the same group said of her apartment that one of the things she liked least about it was that her mother had died there, and a third said that it contained "bad memories," referring obliquely to an earlier suicide attempt there. Other references were positive: "My things [are here.] You could put them anywhere and I'd be happy." Another said that she liked her house because it had been built years before by her husband's father.

Table 11
Distribution of Respondents' Reactions to Home and Neighborhood

	Group 1	Group 2	Group 3
Indoor Privacy	5% (1)	15% (3)	14% (3)
Outdoor Privacy, Space/Crowdedness	52% (11)	10% (2)	57% (12)
Safety/Danger	43% (9)	25% (5)	24% (5)
Quiet/Noisy	29% (6)	55% (11)	43% (9)

(In)Convenient Location	38% (8)	75% (15)	81% (17)
Size & Layout of Rooms	24% (5)	45% (9)	33% (7)
Neighbors (Un)Friendly, (In)Compatible	90% (19)	80% (16)	38% (8)
Home Ownership	19% (4)	35% (7)	14% (3)
Aesthetics Indoor	48% (10)	60% (12)	33% (7)
Outdoor (Neighborhood & Property)	62% (13)	40% (8)	71% (15)
Home Maintenance, Renovation, Repair	24% (5)	45% (9)	48% (10)
Comfortable, Relaxed, Homey	38% (8)	40% (8)	19% (4)
Familiar	33% (7)	20% (4)	0% (0)
Other	24% (5)	0% (0)	5% (1)

The highest priority issues varied among the three groups. For the agoraphobics, the neighbors were mentioned by 90% of the women as the most- or least-liked attribute of home and neighborhood. Neighbors were more often cited as a disliked attribute than a liked one. Two thirds of the comments were negative. Complaints ranged from "too noseey," to "unfriendly," "a lot of weirdos," and "nothing in common."

The second most frequently mentioned attribute of the agoraphobic

women was the aesthetics of their property and the immediate neighborhood. The remarks were predominantly positive.

The third attribute was "Outdoor Privacy." Statements about the presence of or lack of privacy often seemed to refer to problems with neighbors. In view of the fact that the women in this group had a number of personal and family problems, it is not surprising that they would value privacy from unfamiliar or unsympathetic neighbors.

Among the women in the other two groups, the most frequently mentioned attribute of the Average women was "Neighbors," listed by 80% of them, 50% of whom had positive comments, the other 50% negative.

Interestingly, only 38% of the Independent women gave "Neighbors" as a most- or least-liked feature of the neighborhood. Within this group, "Convenience" was given top ranking, with 81% of the Independent women offering this rather pragmatic aspect of home. These women also offered a wider range of destinations considered by them to be convenient. Whereas the women in the other two groups tended to think of convenience for shopping and commuting to work, as well as the inconvenience of parking and traffic, the Independent women listed, for example, proximity to places for cross-country skiing, the library, and theater.

Second and third choices for the Average women were, respectively, "Convenience" and "Indoor Aesthetics and Self-expression." For the Independent women, "Neighborhood Aesthetics" and "Outdoor Privacy and Space" were the second and third choices, again reflecting a greater orientation to the outside. In all three groups, but especially among the Independent women, the rural aesthetic was cited as most pleasing.

The greatest discrepancies between the priorities among the three groups were, in addition to the apparent disinterest of the Independent women in their neighbors, the low priorities accorded by the Average women to outdoor aesthetics and to outdoor privacy when compared to the Agoraphobic and Independent women, and the frequency with which the Agoraphobic women listed "Safety" and "Familiarity" as important aspects, compared to the Independent women.

Although convenience was highly rated by the others, it is not surprising that the Agoraphobics gave little importance to it, since they would tend to perceive their own inhibitions as a much more significant obstacle than external factors.

Consistent with the Independent women's lack of attachment to and involvement with home was their infrequent mention of ownership and homeyness.

Among the responses of the women involving danger, those from all three groups involved the danger of becoming a crime victim. Being close to others in a close-knit neighborhood was the primary factor in describing the neighborhood as "safe" or "secure." For the Independent women, living more often in an isolated area, the danger involved not having that informal network of neighborhood surveillance. In a few cases, the danger presented was some kind of physical danger, such as not having sidewalks or having a dangerous intersection near the house, increasing the risk of being hit by a car. The steepness of the yard was a factor in cases where the subject had small children.

The final method for comparing the perceptions of home and neighborhood among the three groups was the use of the figure

drawings. Figure drawings generally present a multitude of well-documented problems in terms of an objective method of scoring and evaluation. Because of the "softness" of the data, it was evaluated primarily in terms of relative proportions of categories represented among the three groups, although a statistical analysis using chi square for the significance of differences in proportions is included.

A possible confounding variable was the degree of psychopathology among those in the phobic group, which may account for the somewhat impoverished and immature character of many of the agoraphobic's drawings. Alternatively, features that may be construed as "immature" by the clinician, such as more personalized features, may instead accurately reflect the intimate, embedded relationship with home and neighborhood, expected of women and especially of agoraphobics.

Pertinent findings were that nearly all subjects (95%) in the Agoraphobic group illustrated their homes using the less distanced approach of picture-like drawings. Although blueprint-type drawings were more common among the Independent and Average women (24% and 25%, respectively), the proportions were still quite small and differences did not reach a level of statistical significance. One may use this to support the argument that less psychological distance from home is typical of most women. Comparable drawings from men would provide a more accurate perspective.

A slightly greater number of agoraphobics (52%) drew picture-like versions of their neighborhood than those who drew aerial or map-like renditions. The fact that a somewhat greater proportion of the agoraphobic women used maps for illustrating the neighborhood compared to the proportion of those who used blueprint-type home illustrations may indicate more psychological distancing from the neighborhood, as

one would expect, given the increasing physical distance from home. Again, although a smaller proportion of the Average and Independent women included picture-like elements (45% and 14%, respectively) the differences did not reach a level of statistical significance.

The Independent women used many more factual labels than those in the other groups. Differences in this case were significant ($\chi^2 = 11.03$, $p = < .05$). Reasons for this are open for interpretation, but the likely alternatives are that the agoraphobic women have less knowledge of street and store names, being less well-traveled about the neighborhood, or, such labels indicate the greater distancing of the Independent women. Consistent with this, the Independent women's drawings of the neighborhood were judged to be considerably more objective and less personalized than those of either of the other two groups (52%, compared to 19% for the Agoraphobic group, 35% for the Average group).

The agoraphobic women also included no distant places in their drawings. Two of the Average women, and six of the Independent women did so, suggesting that a greater geographic range is included as part of the region of expressed attachment. Differences were significant ($\chi^2 = 6.79$, $p = < .05$).

The average number of streets was found to be fairly similar, although differences were in the expected direction. The Agoraphobic women included an average of 3.9 streets in their drawings, the Average women included 2.8 streets, and the Independent women 5.33.

Overall, the Agoraphobic and Average women produced comparable drawings in terms of the degree of complexity, using the number of elements as the measure of complexity. The Independent women produced

the most complex drawings, with the greatest number of elements.

Comparable proportions among the three groups were found for the other elements, including stylized versus personalized representations of home and neighborhood, the number of intimate or idiosyncratic details included in both drawings, and the objectivity of the home drawings. Surprisingly, few members of any group included interactions with neighbors.

Consistent with much of the other data, the Average women occupied an intermediate position on most of the measures.

Figures 6 through 9 present contrasting drawings of home and neighborhood by Agoraphobic and Independent subjects. Selections were made on the basis of what was most typical of the group.

Figure 6
Drawing of Home by Agoraphobic Subject

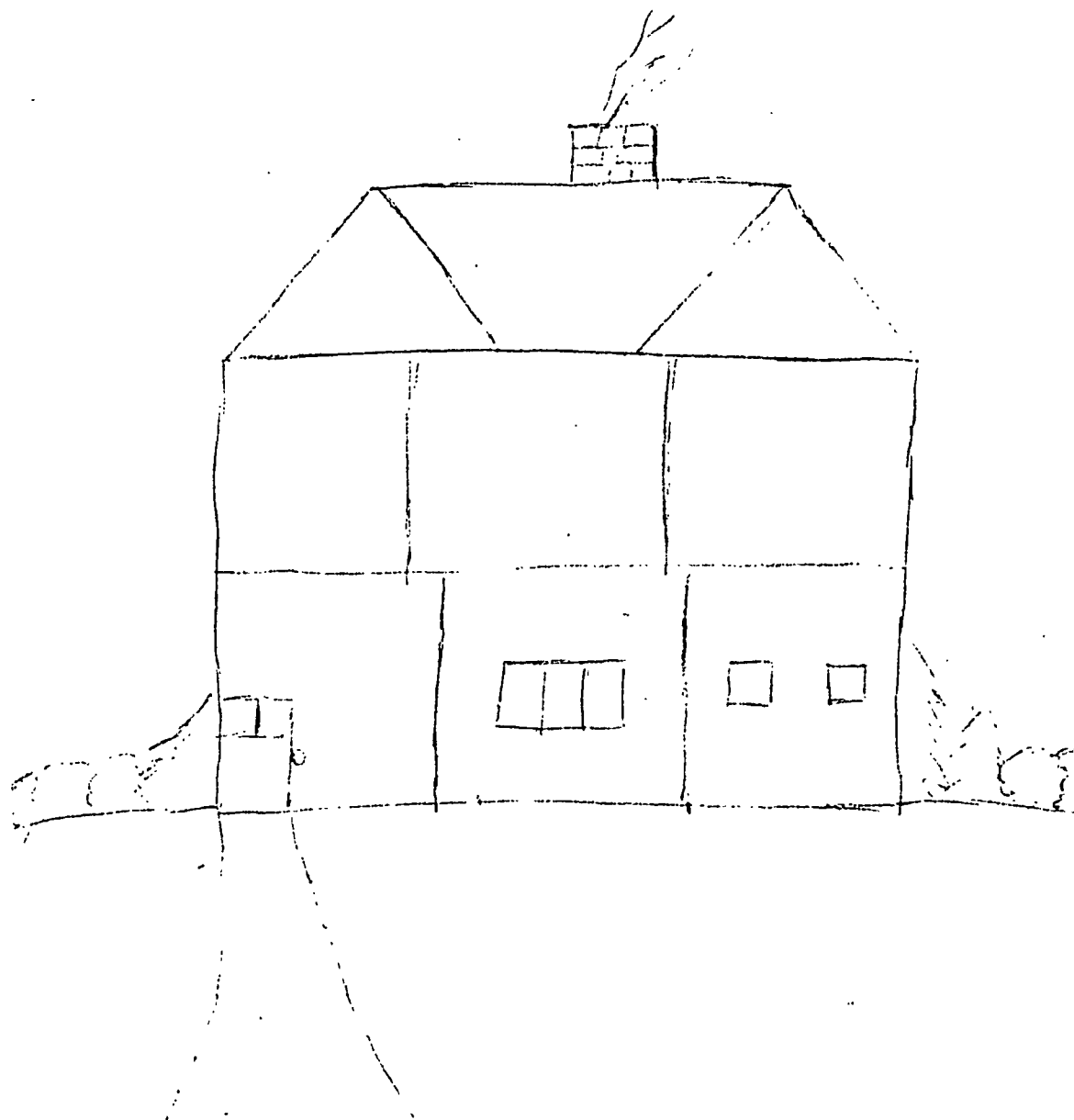


Figure 7

Drawing of Home by Independent Subject



Figure 8

Drawing of Neighborhood by Agoraphobic Subject

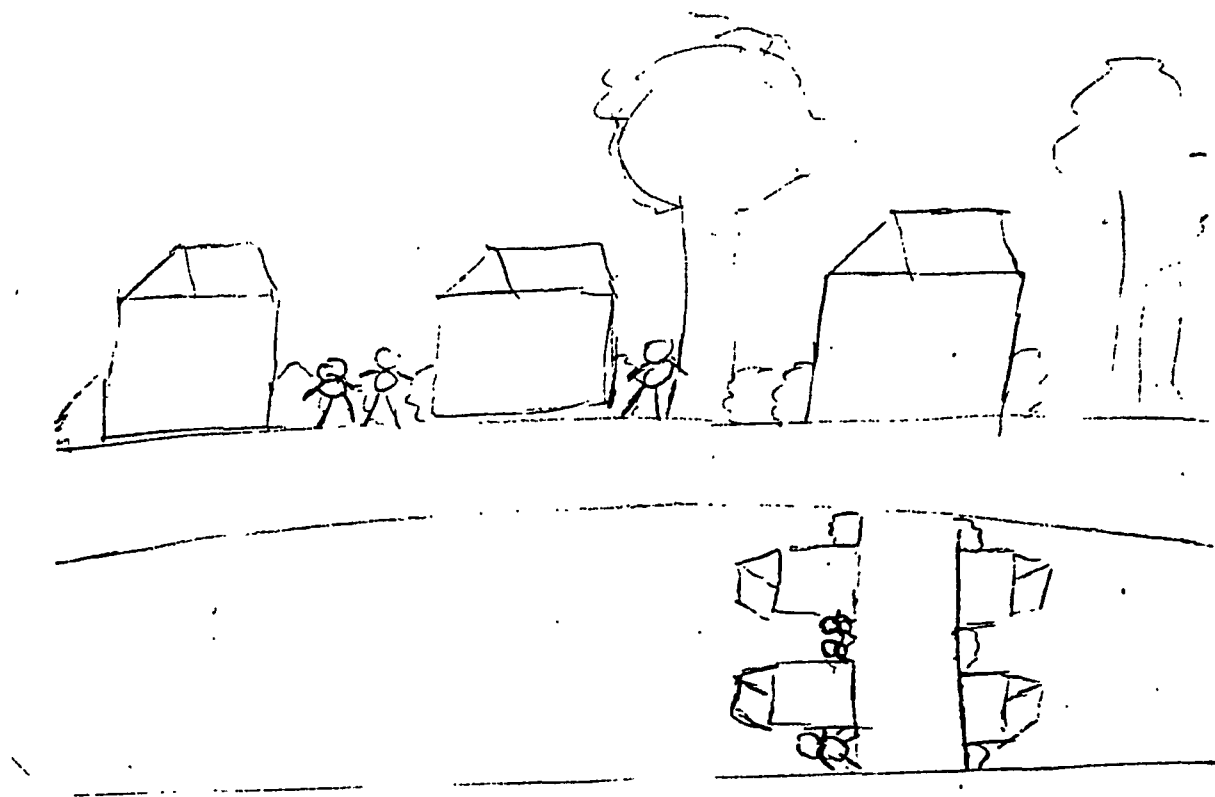
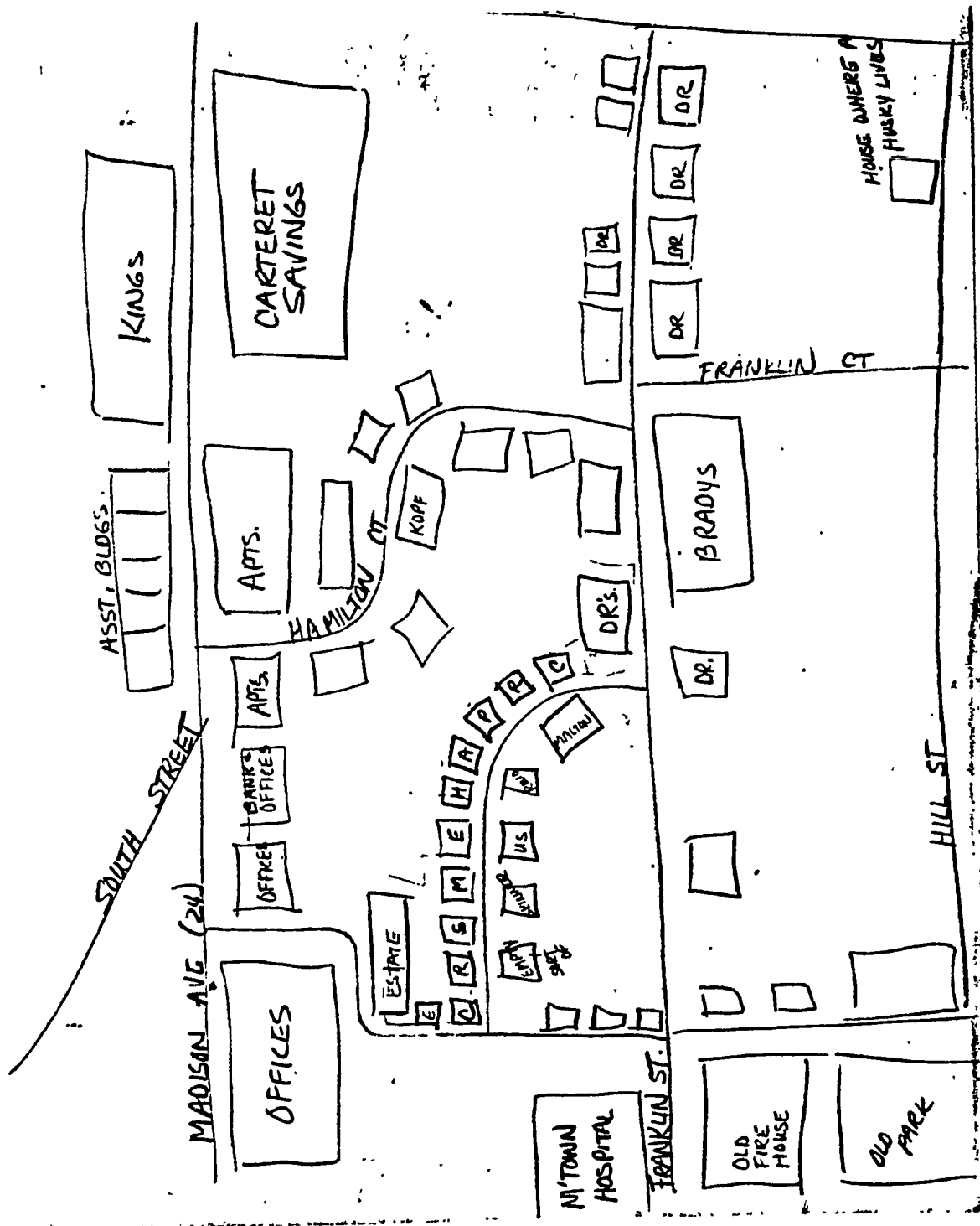


Figure 9

Drawing of Neighborhood by Independent Subject



The Centrality of Home in the Lives of the Agoraphobic Women

An overview of the lives of the agoraphobic women reveals the centrality of home in all aspects of their lives. For many of the women, work, family, and leisure activities were not merely set in the home, but involved the home. One can readily conclude that this is the result of being confined to the home by the fear of going out. At the same time, the involvements with home in all these spheres is consistent with feminine sex-role orientation, and it might also be legitimately argued that such an orientation primarily reflects this factor and is simply intensified by the symptoms.

Work

Among the nineteen women who were employed, many had selected work that involved some aspect of home or homemaking. For example, two of the women are in real estate, selling private homes. One woman cleans homes in the apartment complex where she lives. Three are home health care aides, which combines nursing responsibilities with homemaking. Another is involved in child care.

Two sell antiques. One of these women, in addition, conducts house sales, in which the contents of homes are auctioned off. The other woman sells her antiques in an old Victorian home a few blocks from her residence, and it seemed to function for her as a second home which she is able to furnish and use for socializing with customers.

Like socializing at the homes of others rather than in a public place, working in a home rather than office setting was clearly more comfortable for many of the women. The work, which most said they enjoyed, was traditional "women's work," cleaning, nursing and mothering, embellishing the home.

Among the rest who worked at home, doing so seemed motivated at least partly by expedience. A psychotherapist, a professional photographer, a bookkeeper for her husband's business, and a salesperson who did phone marketing all use their homes as their offices. The therapist and photographer both use the setting to considerable advantage, however. For the therapist it served as an informal and relaxing treatment environment; for the photographer it is an effective showcase for her previous work. In both cases it lends an atmosphere that would be difficult to re-create in the more formal setting of an office.

The rest of the women were employed outside the home primarily in office settings and were involved in a range of other occupations.

Of the twelve women who worked elsewhere than home, the majority were within walking distance of home.

The House Tour: Phobic Homes

As would be expected, the tours of the women's homes revealed living spaces that varied widely in terms of size, crowdedness, character of furnishings, and style of dwelling. Nevertheless, the homes of the agoraphobics tended to be more dense, filled as they were with more items, and projecting an image of "homeyness," of which the collections were an important part. As noted, the agoraphobics were collectors.

The most common type of item collected was antiques. Many of the women's homes were decorated with antique furniture. The walls and shelves were used to display a variety of historical artifacts.

The apartment of Shelley K., for example, was filled with antiques that included a collection of early cameras, oak trunks,

bottles, candlesticks, a child's chair, oak furniture, quilts, old lace, and leather-bound books. Its focal point was a collection of sepia-toned photographs, nearly all of which were pictures of people standing outside their home, or in a room of their home, surrounded by all of their belongings.

Katherine H.'s home, like her antique shop, recreates 19th-century life. Except for the modernized appliances, little else suggests contemporary existence. Aunt Jemima dolls and pictures, old tins and cannisters, crockery, a rolling pin collection, oil lamps, a tray with crystal condiments, an antique coffee mill, a framed picture of her house as it appeared earlier in the century, all festoon her walls and crowd the oak Victorian furniture in her kitchen.

Sentiment was a much more important element in the agoraphobic's relationship with the home and its contents than it was for the Independent women, and probably for the Average women. Much of the furnishing made some kind of autobiographical reference.

For example, Pat S., while conducting the tour around her home pointed out the picture of Alice in Wonderland hanging in her bathroom and remarked, "I feel like Alice." And indeed, her home had a distinctly Alice-like quality to it, closed off from and very different from the dreary, run-down, working-class neighborhood in which it was set, all of the furnishings contributing to a kind of child's fantasy about what a home should be, replete as it was with dolls, animal curios, Victorian oak furniture, and, as she aptly described it, "the dollhouse of dollhouses." The size of a dining room table, the dollhouse was complete to the final details of electricity in the chandeliers and framed paintings on the walls.

What was also evident in the majority of these women's homes was the visual complexity, the result of ongoing projects, collections (e.g., hearts, owls, crystal figures, chicken figures, antique dolls, Cabbage Patch dolls, miniature home furnishings), mementos, art, and other, less classifiable items, that comprised their living spaces. Not merely decorative, the items each had some personal meaning, either because the owner had made them, or because they reflected something autobiographical. Few if any of the homes of the non-agoraphobic women were comparable.

Even some of the homes that were more contemporary and uncluttered had certain peculiarities: For example, one home had many large mirrors and a mirrored wall in the dining room so that one nearly always caught sight of oneself, regardless of where in the room he or she was situated. The walls and ceilings of the downstairs were papered with dark wallpaper, and most of the windows had been more or less permanently closed off. The general impression was of a kind of vast, subterranean fortress.

The homes of some of the Independent women provided a striking contrast. In addition to the fact that approximately a third of them were in isolated rural areas, and several more set into wooded areas and/or lakeside properties, the setting predominated over the furnishings. The rooms were found in many cases to be extremely austere, especially the bedrooms.

This may have been partly a function of the fact that many of the women were single, the bedroom thus serving different purposes without the presence of a husband or children. Beyond that, however, the bedroom seemed not, as a rule, to house many props. What props did exist often attested to a rather different identity.

One woman, for example, who was unmarried and whose life centered largely on her job and her position as an officer in a business organization had converted her bedroom into an office. The room was dominated by the presence of a metal desk and file cabinet, while the fold away sofa-bed gave little suggestion of comfort or retreat.

Another home had almost no furniture at all, while the walls were filled with the framed photographs she had taken, and paintings that she and a friend had made.

Even in those homes that were most attractively furnished (all of which belonged to the married subjects), the furnishings tended to blend together on the basis of coordinated colors and styles rather than being a means of personal expression.

Unanticipated Findings

Although an examination of the family constellation was not part of the original design of this study, it became clear early in the interviews that family characteristics were relevant. Two aspects that seemed particularly salient were 1) The presence of agoraphobic tendencies in other family members and, 2) Concealment of phobic symptoms in other family members through the use of alcohol, drugs, or psychological defense.

A last factor that was examined was the role of physical disorder and psychic trauma in agoraphobia.

Prevalence of Psychopathology in Other Family Members

One of the most striking findings in this study was the pervasiveness of psychopathology among other family members, and especially of some degree of agoraphobia.

Because family history was not included in the initial design of the study, the data are not entirely complete, yet the available information supports the assertion that agoraphobia is familial.

When inquiry was made, subjects were asked whether anyone in the family either showed signs of significant emotional problems, had been diagnosed as having a specific disorder, including agoraphobia, or appeared to have difficulty leaving the home. An individual was considered to be a possible phobic if, for example, he or she was described as never going out or never going out alone other than to work.

Of the 28 subjects who were identified as having symptoms (including the seven from the Average and Independent groups), thirteen had a blood relative living in the household who also appeared to be phobic. Two more had mothers who might have been phobic, nine denied having any relative with phobic symptoms. Information was not available on five of the subjects, either because they could not be recontacted or because they were unable to provide sufficient information.

Three men had either never gotten a driver's license, or had stopped driving, and this was considered a possible symptom. One may dispute the assumption that no driver's license is a symptom of a phobia. However, with the exception of urban dwellers, for whom public transportation is readily available, the lack of a driver's license in males seems exceedingly unusual.

In nearly all cases where the mother was thought to be phobic, she too had no driver's license. This, in and of itself would not have been unusual among a generation of women who were predominantly housewives. However, it was part of a larger pattern of

constrictedness that most often also involved some means of securing companionship whenever it became necessary to leave the home, as well as remaining in the constant company of other family members while at home.

The family member most often appearing to be phobic was the mother. Six had mothers who appeared to be manifestly agoraphobic. Five more had mothers who "never went out" or "never went out alone." Using the more rigorous criterion, the 26% figure is slightly below the 31% figure reported by Solyom, et al. (1976). Including the six additional cases, the figure rises to 49%, well beyond what others have reported.

Five had fathers who appeared to have agoraphobia. This figure of 22% is substantially above the 6% figure cited in the Solyom et al. study.

In two cases, both parents were agoraphobic.

Two had brothers who were clearly phobic, two others had brothers who might have been phobic. This 14% figure is similar to that of Buglass, et al. (1976), who reported that 17% of her sample had brothers who were also phobic.

Two had sisters that were phobic.

Other members of the household were reported to be phobic in four cases: One had an aunt who lived with them who was phobic; in three cases the subject's husband as well as the subject had phobic symptoms.

Overall, using the more rigorous criteria, the proportion of cases in which another family member was phobic still reaches 46%, which is considerably greater than figures cited by others. The

difference is still most likely to reflect the criteria used to identify clinical cases. The present study may include some individuals that others would have excluded. However, in applying a very rigorous definition, one, a priori, confirms the hypothesis that there are no mild degrees of agoraphobia.

In addition, the present study confirmed a finding of other researchers that there is a higher proportion of alcoholism and drug dependence in the immediate family of agoraphobics. As will be discussed below, these cases may conceal an underlying phobia, particularly in males.

Present findings strongly support the assertion that there is a phobic family unit. Although other researchers have suggested a genetic factor to explain the fact that more than one family member may be symptomatic, it will be argued here that the symptoms are a consequence of socialization and reflect the dynamics of the family constellation.

The following cases are illustrative of the phobic family unit:

In Betsy D.'s case, the subject's father, father's sister who lived with them, and the subject's older sister, as well as the subject herself, are all agoraphobic.

Although the president of a division of a major corporation, the father has been unable to go anywhere by himself for approximately ten years. He has also been described above as engaging in compulsive checking behaviors and expresses constantly through his behavior his expectation that some catastrophic event will occur. Betsy describes her sister as so phobic she cannot go alone to the basement. According to Betsy, one of her own two daughters, at age eight, is already showing symptoms of phobia.

In the second case, Maryann A., a single, 29-year-old woman, stated that her mother had been severely agoraphobic since the subject was a child and that she never went out alone except to go to work, otherwise taking her children with her wherever she went.

The brother, who is currently housebound, developed the symptoms at 21. As a salesman, he used to "throw [his mother] in the car and take her along." The subject also "used to take her for job interviews for the same reason."

As these cases illustrate, one or both parents communicate a high level of fearfulness to other family members. The influence of identification and modeling as well as of reinforcement are clearly present, aspects which support a social learning theory explanation.

Concealed Phobic Symptoms In Subjects and Other Family Members

Interview data further suggest that the prevalence of phobia may be underreported because the symptoms are concealed. Findings from the study indicate that several methods are commonly used to both cope with and disguise phobic anxiety.

The first is not having a driver's license, insuring that the individual will not be able to travel any appreciable distance from home unaccompanied unless by public transportation, which none were willing to use.

Relatedly, some of the women used their children as their phobic companions when they went out. The fact that many of the agoraphobic subjects had never been left alone or with a sitter, may reflect the inability of the mother to leave the home unless in the company of a family member. A woman who takes her children with her when she goes out calls little attention to herself and is likely to be perceived by

others as engaging in a very normal behavior.

Thirdly, alcohol and drugs were frequently mentioned as a means of coping, or were obviously being used as such, particularly with male family members. Although it is commonly assumed that an individual with a substance addiction who seldom leaves the home does so because of the disabling effects of the drug or alcohol as well as the need to conceal the problem, one may alternatively see the phobia as keeping him home, and the use of the substance as a means of allowing him to leave the home, i.e., as a sedative that suppresses anxiety sufficiently so that he can go out.

As one subject described it, her father "had to have a beer or a drink in case of panic" when going out.

One may also surmise that being perceived as addicted is preferable to being perceived as afraid to leave home, especially, again, among males.

Six of the nine subjects who had a blood relative with agoraphobic symptoms stated that that relative also had a drug (Valium) or alcohol problem. One of the six had two relatives, father and sister with symptoms of both phobia and addiction. Three others had an immediate relative who has a history of drug (heroin) or alcohol addiction, although phobic symptoms cannot be verified. All except one of these relatives were male. In addition, three of the women themselves admitted to either a history of alcohol addiction or Valium addiction.

The last method of concealment is the use of illness, and this may especially involve self-deception as well as the deception of others. The following case is illustrative:

Jan G. belonged to the Average Independence group, but tested within the phobic range.

Her mother, according to her description, had high blood pressure. "I can remember many times," she said, "when we would get ready to go out and we just couldn't go because her blood pressure went up. So we spent a lot of time at home -- the majority."

This woman also has a 47-year-old brother who had meningitis at age 35 and has been unemployed since then. According to Jan, he "doesn't like to drive, doesn't like crowds, doesn't like to travel and...takes Valium before going anywhere."

The subject herself developed a spastic colon that, by her account, made it impossible for her to take public transportation. Later, she could not even travel by car, and was essentially housebound for three years. At times, when in a public place, especially places like theaters, stadiums, and classrooms that were "confining," she would find it necessary to leave, "not to go to the bathroom, just [to have] some space around me."

It is difficult to see this family configuration as involving only three separate and unrelated illnesses, appearing instead to be a shared method of using illness to conceal phobic concerns. The social acceptability of illness as a reason for staying home allows the individual to hide the real concern not only from others outside the family, but possibly, by tacit agreement not to confront the issue, to conceal it from one another and even from oneself.

This may be the most important factor that distinguishes the phobics who appeared in the Average Independence group and who did not identify themselves as such, from those in the Agoraphobic group, who did. Those in the former group have denied the psychological nature

of the problem, explaining it instead as a physical disorder of a "temporary" nature. This goes a step further than those researchers who have explained the difference between those who have mitral valve prolapse, for instance, who do or do not become phobic.

Cognitive theory suggests that how an individual explains his experiences to himself is as important as what those experiences actually are. In other words, if one has a disturbing experience, such as a sudden and otherwise unexplained episode of tachycardia while in a shopping mall, he may interpret his symptoms as either a reaction to the mall being crowded and overheated, or as a physical problem, or as a panic attack.

Based on this, other researchers predicted that those who viewed their symptoms as physical would not become phobic. However, among those who do view their symptoms as physical, a proportion will then go on to use the perceived condition as a rationale for staying home.

For those "Average phobics," even though thinking of one's reluctance to leave home as a consequence of medical problems involves a measure of self-deceit, it serves the function of masking or "normalizing" the behavior. Since he does not acknowledge that his apprehensions are related only to the fact of leaving the house, he attaches less anticipatory anxiety to leaving. The anxiety remains focused on the perceived problem. Upon leaving, this focused attention allows him to avoid the diffuse fear that some awful but unspecified event might occur that often escalates into panic for the typical agoraphobic.

Regardless of whether the condition is attributed to a time-limited and specific circumstance ("My irritable bowel is acting up

again.") or to some ongoing and global condition that extends into the indefinite future ("I can't stand crowds."), it permits a more sanguine attitude about the symptoms and prevents the additionally stressful conviction that something is wrong with one's mind.

Incidence of Physical Disorder and Psychic Trauma among Subjects

In researching the etiology of agoraphobia, physical conditions that are associated with anxiety-like symptoms have been considered as a possible causal factor.

Findings from the present study seem to indicate that the involvement of some chronic physical condition is more likely to be as a general and significant source of stress that serves as a precipitant in predisposed individuals, rather than as a direct, causal factor.

Some of those who scored within the phobic range had disorders associated with anxiety-like symptoms: Two had diagnosed hypoglycemia, and one each had autoimmune thyroiditis and a thyroid tumor.

Others, however, had disorders not associated with such symptoms but which became their rationale for remaining housebound. These disorders included sciatica, two cases of irritable bowel syndrome, and two cases of migraine headaches.

Psychological trauma as a precipitating factor has also been considered by other researchers (e.g., Burns and Thorpe, 1977; Goldstein and Chambless, 1978; Snaith, 1968; Solyom, et al., 1974; Buglass, Clark, Henderson, Kreitman, & Presley, 1977, Roy-Burn, Geraci, and Uhde, 1986). The present study substantiated the finding that some type of psychic insult occurred shortly before the symptoms

appeared. In most cases, the event could be readily identified by the subject. The stressor was most frequently the loss of a significant other.

For example, one subject from the Average group who scored within the clinical range for phobia has a husband with a terminal disease. Another from the phobic group was widowed with three young children at the age of 29.

Several subjects experienced a dramatic increase in the intensity of symptoms as their marriages foundered.

Symptoms in two women, one included in this study, one in a prior study, were reported to have been precipitated by the physical separation from the husband, who was traveling on business.

One subject's symptoms were precipitated by a rapid succession of stressful events, including surgery for a malignant tumor, the death of a relative, and the figurative loss of her parents, who moved to a distant location at a time when her marriage had begun to disintegrate.

Clearly, stress can precipitate or exacerbate symptoms in susceptible individuals, but symptoms generally persisted long after the stress had subsided. For example, the death of the 29-year-old's husband dramatically intensified her symptoms, but 11 years and a second marriage later, she continues to be severely impaired.

At the same time, quite a number of subjects in the two non-phobic groups also had experienced some significant trauma, calling into question the assertion that trauma is the prime factor in phobia. Members of the non-phobic groups reported, for example, treatment for cervical cancer, recent divorce, and the death of a sibling.

It has also been asserted that a trauma early in life might serve

as a key factor in the subsequent development of agoraphobia. The present findings offer what would have been plausible support for this argument. However, women in the other groups experienced comparable trauma.

For example, two subjects from the Agoraphobic group had siblings who died in early adulthood. One may be tempted to conjecture that the event of death itself, or the trauma of separation from someone so close, might be used to explain the symptoms. However, two subjects from the Average group also lost siblings in early adulthood and evidenced no symptomatology.

In many respects, the women in the Independent group appeared to have had more stressful childhoods. Four of the women mentioned that they had lost their father before adolescence through death or divorce. The consequences often involved poverty and dislocation. One of the women in this group grew up in a tenement with an alcoholic father and schizophrenic brother (who remains in her care). Another, the daughter of wealthy but often absent parents, was essentially raised by a nurse. One woman lost her mother in early adolescence. Only one of the phobic women had lost a parent before adolescence.

Thus, trauma in and of itself cannot be said to be the sole precondition associated with agoraphobic symptomatology.

One might expect that higher rates of agoraphobia would occur in high crime areas, where the fear of leaving home may have some basis in realistic concerns about safety.

In the present study, two subjects from the Average group had been crime victims: One subject had twice been the victim of muggings, one had had her home broken into. The first evidently had

been affected by her experiences and scored within the clinical range for phobia.

No subjects from the Agoraphobic group were victims of documented crimes, although two stated that they had been raped, one by an uncle from the ages of 7 to 12, the other by a relative of her former husband at the age of 22.

Reflecting upon the nature of these crimes, it might be said that, in theory, commission of a crime by a stranger should be more likely to result in agoraphobia, since one would, logically, come to fear unknown people and places. One would not expect the same result from the victim of a crime committed by a known individual, especially a relative, since these are people who would interact with the subject in the home environment.

In sum, one might conclude that while traumatic events, physical illness, and significant life stresses may serve as precipitants in a general sense, the specific nature of the disorder and the vulnerability which precedes it are more convincingly the result of early socialization experiences and current attitudes and cognitions.

CHAPTER IV

DISCUSSION

The popularity of agoraphobia in recent years as a subject for research and discussion among professionals has focused largely on the intensity of the symptoms and on approaches to its treatment. In labeling the fear of leaving home as a phobia, there is, implicitly, an acceptance of the assumption that this is an internal problem, whose irrationality is best explained in terms of either conditioned fear, a symbolic expression of separation anxiety, or as a dysfunction of the central nervous system.

In contrast to these prior studies, the present study began with both a different premise and a different purpose. It inquired first into experiences, attitudes, and competencies directly related to the focus of the problem, namely, environments outside the home, on the premise that the problem is of an interactional nature rather than internal one. It proposes that because of the attributes of public and outdoor settings and the attributes of the person, that the fear is related to an inability to function in non-home settings.

Among the implications of discovering specific historical, behavioral or attitudinal correlates is that it gives some shape to preventive efforts, particularly to those involved in the socialization process, something that has yet to be addressed in the professional literature.

Although it was not the specific intent of this study to examine the profiles of average and very independent women, except to provide

a means of comparison with the agoraphobic women, the data provides some unforeseen insights into the relationship between a woman's life style on the one hand, and, on the other, certain psychological features, including sex role orientation, environmental cognitions and attitudes, and general mental health.

Findings of this study indicated that members of the agoraphobic group were consistently more constricted in their use of space under a variety of circumstances. In terms of their use of free time, the types of hobbies and recreational activities pursued, and choice of where to go when upset, the agoraphobics nearly always opted for staying inside, either at home or in the homes of others.

Equally consistent was the striking similarity between the Agoraphobic and Average groups across the test measures, and the dissimilarity of the Independent group. The responses of the Average subjects indicated a level of constriction almost equal to that of the phobic subjects. Only the Independent women seemed to utilize a variety of indoor and outdoor settings under all circumstances.

Scores for the three groups on all measured dimensions, including degree of autonomy permitted inside and outside the home during childhood, identification with the four sex roles, attitudes, perceived competence, and actual behaviors in public and outdoor environments, and general level of emotional distress invariably indicated the same sequence in which the phobic women scored at one extreme, the Average women slightly closer to the middle, and the Independent women at the other extreme.

Perhaps most importantly, clinical or pre-clinical levels of agoraphobia could be found in more than a third of the sample of Average women, suggesting that many such women are either symptomatic

or potentially so. In contrast, the Independent women were found to be more stable, experiencing the lowest levels of distress, and having the fewest anxiety-related symptoms.

The similarity of the Agoraphobic and Average groups extended also to demographic profiles: Both groups were much more likely to be married than those in the Independent group, and were somewhat less likely to have been separated or divorced. The "Never Married" category also seemed to imply something different for the considerably younger members of the first two groups than for members of the older, Independent group.

The closeness of profiles of the Average and Agoraphobic groups in all respects, especially the vulnerability of the Average women to develop phobic symptoms, lends support for the contention that the premorbid personality of the phobic includes many of the features that others have suggested are the consequence of agoraphobia rather than the antecedent.

Overall, the findings of this study do not support the frequently quoted conclusion of the Agras, et al. study that the population of agoraphobics comprises a small and discrete group of individuals with little or no overlap with the general population.

The profiles are supportive of the assertion that the constricted life style of those in the phobic group and for many in the Average group is less a situational matter than one of inhibition: While one may point to the fact that those who are married are more "tied down" to the home and do not have the freedom to go out alone, it seems that the life style selected reflects their uncertainties about engaging in independent activity. Similarly, the tendency of the Independent

women to go places alone seems less a function of life style than selecting a life style that fits their autonomous orientation.

At the same time, however, social definitions of marriage, prohibitions about women traveling alone, and practical limitations all seem to powerfully discourage women, particularly married women, from being independent.

In the following sections, the contribution of early family dynamics is discussed and focuses on the role of the parents in the creation and expression of phobic symptoms. Sex-roles are also considered as a factor in the susceptibility to agoraphobia and as an important aspect of the constricted life style of adult women.

In the concluding sections, the usefulness of assigning agoraphobia as a separate diagnostic category is debated, and the implications of this research for prevention and future research are considered.

Demographic Features

A common observation among those who have done research on agoraphobia is the heterogeneity among those who have it. Indeed, a search of the most frequently investigated demographic variables, age, sex, level of education, socioeconomic status, and birth order, of personality variables, for example, field dependence, or dependency needs, and of possible precipitating factors, such as early or recent traumas, reveals little consistency except for the fact that the most likely candidate is a female in her late twenties to early thirties.

Findings from the present study indicate that certain commonalities among the agoraphobic women in the sample could be found, despite the otherwise great heterogeneity among them.

The present findings suggest that among women from the Northeastern United States, those with agoraphobia tend to be married and to have less than a college education. The mean age of those in this sample was 38, but the age of onset varied from early childhood to middle age.

Based on present findings, the agoraphobic female is most likely to be a youngest child (48%), least likely to be a middle child, and has an average of two siblings.

Although the majority of subjects in all three groups spent some or all of their childhood in a suburban neighborhood, those in the agoraphobic group were somewhat more likely to have lived in an urban area, and least likely to have lived in a rural area.

In most respects, the Average group's demographic profile closely resembled that of the Agoraphobic women. Birth order was one exception to this, with the Average women being significantly more likely than those in the other two groups to have been a middle child. There was a trend toward the Independent woman being more likely to have been an oldest child, and this is consistent with findings by researchers (e.g., Thompson, 1974) who have characterized oldest children as independent and self-sufficient.

In interpreting the limited educational background of the agoraphobic woman, there are two possible explanations.

First, it may be an artifact resulting from the method of locating subjects, which depended primarily upon participants of self-help groups. It is a generally accepted fact that middle-class individuals are more likely to seek professional assistance for mental health problems. This was true in the present study: A small and distinct group of more educated, wealthier subjects were either being

treated by professionals or were participating in a quasi-self-help group conducted by a psychiatrist who was doing research on the subject.

The remainder, less well educated and generally less economically advantaged, were participants in one of the autonomous self-help groups such as TERRAP, which had neither been organized by nor involved any professionals.

A second explanation for educational level is that it is a true phenomenon, based on the fact that prephobic fearfulness related to either separation, the school setting, or more generally being alone in unfamiliar settings, made school attendance too stressful, hence, they were likely to drop out of school earlier. Several subjects fit this pattern.

For example, Pat M. stated that her parents enrolled her in a playschool program at age three but that she "only lasted a few days." Subsequently, she attended grammar school where, by her account, she threw up every morning for several years. It is not difficult to understand her eagerness to leave school at the earliest possible moment.

Pat S. who, oddly, had attended a private school from kindergarten until the end of high school with the same eleven classmates from beginning to end, said that she was terrified to go to school and spent all day every day until eighth grade sitting in the office.

Barbara M. said that high school was one of the first places where she experienced her panic attacks, prompting her to quit at the age of 15.

Several others described their episodes of anxiety as being most likely to occur in school, and many apparently attended few or no classes for at least one year before dropping out.

The label "school phobia" does not do adequate justice to this problem, which in each case appeared much more pervasive than a fear of school, although it clearly had an impact on their academic careers.

Family Dynamics and Vulnerability to Agoraphobia

Findings from this study suggest that early family dynamics play an important role in creating vulnerability to agoraphobia. In presenting an overanxious role model with which the child identifies, in reinforcing feminine helplessness by restricting activities outside the home, and in sanctioning avoidance behavior, as, for example, the use of illness as a rationale for staying home, parents encourage the development of agoraphobia. The child thus reflects the parents' own psychological agenda.

Parental Overprotection

In a general sense, the study confirms the observation of clinicians who believe that parental overprotectiveness contributes to agoraphobia. In reviewing the often conflicting studies on the relationship between parental overprotection, the trait of dependency, and agoraphobia, Mathews, Gelder and Johnston (1981) theorize that at least one of three factors may explain the confusion: Differing measurement instruments, the use of retrospective data, and the failure to apply Mischel's (1973) concept of interactionism as a means of delimiting the actual pervasiveness or situational specificity of parental overprotection and its complement, dependency in the child.

It is the last factor of situational specificity that the present study has attempted to explain. Results suggest that one can, in fact, be more specific: Those with agoraphobic symptoms were significantly more likely to have had parents who imposed more severe environmental restrictions on them, and who themselves were more fearful of activities and settings outside the home.

In one of the few studies done where a normal comparison group was used, Buglass et al. (1977) employed a scale to evaluate early dependency among agoraphobics that included such questions as the freedom given to select one's clothing, the need to conform, difficulty in school, and early separation anxiety, and found no differences between the agoraphobics and a normal control group. It is revealing that the results were negative, since few of these questions related to environmental concerns. The variables of overprotection and dependency to which others have attributed agoraphobia are likely to be more situationally specific rather than being global and nonspecific.

In the present study it was found that there were significant differences between the phobic and non-phobic women in the degree of supervision and restriction that their parents had imposed on them both at home and when going out.

Waiting up until the child returned home safely, imposing greater restrictions on daughters than on sons, requiring daughters to "check in" when they went somewhere, and forbidding them to go to public places without being accompanied by adult, the parents evidently conveyed the idea that danger lies outside the home, especially for girls, and that going out, because of these potential dangers,

increases rather than relieves stress.

Those women who subsequently became phobic were not only exposed to more restrictions about going out alone during childhood and adolescence, but also appeared to have considerably fewer opportunities to be alone at home. Half of the women stated that they were "never left alone." This apparently resulted from parents either never going anywhere or from taking the children with them whenever they went somewhere, or from living in a household with extended family, so that someone was always home. Inside, parents seemed to reinforce remaining together in the same rooms, so that physical aloneness among family members was unusual.

It is interesting, in this context, to reread the case studies of Seidenberg (1973) and Symonds (1971). Seidenberg attempts to illustrate the emphasis on obedience and respect in the childhood home of a woman who subsequently became agoraphobic.

He says, "Her father worried about her outside activities and fretted about some of her girl friends. He often followed her to school and met her on her return to see that she did not stray into corrupting circles of teenagers. Her social life was therefore restricted" (p. 353).

Shifting to a different paradigm, however, the father's behavior could have resulted in agoraphobia not because of the social restrictions, but because the chaperonage restricted her ability to travel independently.

In Symond's case studies, she attempts to support the idea that agoraphobic women do not assert themselves even when their husbands are extraordinarily unreasonable. She describes a woman who claims that because of her husband's suspiciousness, they never left their

child with a babysitter, instead taking the child with them everywhere. The husband's distrust of restaurants prevented them from ever eating out.

In a second case, which was also used to illustrate problems in the marital relationship, the husband "did not particularly like to socialize or to go out, so they rarely did...and spent most of their time at home" (p. 294).

Shifting perspective, what these cases actually seem to illustrate is the phobogenic family. One wonders whether the husbands were not themselves phobic. The situation in both cases greatly resembles the early home situation described by a number of the agoraphobic women in the present study, which they themselves re-created after getting married.

Parental motivations for imposing such constraints indoors and out on the child included a number of concerns and should not necessarily be construed as deliberate overprotectiveness or restrictiveness.

One possible explanation is related to socioeconomic status and/or cultural factors. Through custom or necessity, some families may have grandparents or other extended family living with them or in the same building. It also may be more customary for some families to bring children along and socialize together in someone's home instead of leaving the children with a babysitter in order to go to an entertainment place, such as the movies. A more systematic examination of this factor is needed.

Secondly, the parents' own social isolation apparently resulted in their being home with the children when other adults would

typically be going out. Many of the parents appeared to have significant problems of their own, which may have resulted in a certain seclusiveness and lack of social ties.

Of particular significance was the fact that some of the parents appeared to have been marginally to severely agoraphobic themselves, and kept the child or children with them because of their own needs.

This finding supported Bowlby's (1973) hypothesis that a very anxious parent may contribute to agoraphobia by requiring the child to remain at home. Bowlby hypothesized that two other factors may be important: A child may remain at home for fear of something happening to the parent, or because he fears that something might happen to him/herself while away.

Similarly, Solyom, Silberfeld, and Solyom (1976), in a study of the mothers of 21 agoraphobics, found that while overprotection was a demonstrable factor, the mother's high anxiety level appeared to be still more influential.

The fearful parent issued warnings about a multitude of dangers from the physical environment and the social danger of becoming a crime victim. Several of the parents were fearful of recreational settings such as parks, lakes and pools, others saw public settings as dangerous, many saw going anywhere at night as risky. A number of parents expressed fears about such catastrophes as car accidents and fire. These parents seemed to communicate the assumption that no degree of competence would suffice and that the only really effective means of prevention would be to either avoid such situations or to always go accompanied by another individual.

Where the concerns were generalized and focused on the environment rather than just on the child and her limited competence,

siblings of both sexes tended to be symptomatic. In many cases, however, the fear was related to daughters and the possibility of sexual assault.

The fearful parent expressed his or her concerns frequently and emphatically, but not always explicitly. In some cases, there seemed to be a vague but urgent communication that places outside the home are filled with unspecified dangers of potentially catastrophic proportion. In other cases, the parents specifically seemed reluctant to be explicit about sexual assault. In any case, one might imagine that ambiguous warnings would be particularly anxiety-producing because they preclude one from being able to take any precautionary measures.

Another important motive for the parents' restrictiveness was the stereotypical perception of the daughter as more vulnerable than a son. Concerns ranged from rape to the more generalized perception of girls as having limited competence in negotiating the world outside the home.

With regard to the consequences of this style of parenting, it appears that the combination of protectiveness, restrictiveness, and apprehensiveness is especially influential in creating a phobic child, since such behaviors generate dependent and constricted behavior.

According to Bowlby and to Solyom, et al., the mother's attempts to keep her child away from all situations that she perceives as dangerous and her anxious surveillance prevent the child from having the experiences necessary to develop more adaptive responses to potential danger than attachment behavior.

The role of the father is not often considered in studies of the impact of parents on children who become phobic. Yet, the fathers of

subjects in this study appeared frequently to be anxious and overprotective. As much as this might contribute to the daughter's condition, it may present an even more influential role model to sons, and future studies are needed to investigate this relationship.

The fear of public and outdoor environments, is not, then, the result of any "fortuitous" association with a noxious stimulus, but the predictable result of learning that such places are filled with danger. The importance that the agoraphobic women placed on the safety and familiarity of home and neighborhood as the most- or least-liked aspects of the setting point back toward these early experiences.

An alternative hypothesis to parent-initiated overprotection as a factor in agoraphobia is that the unusually apprehensive child may elicit reflective apprehensiveness and intensified protectiveness from the parent. Unquestionably, the young child who reacts to separation from the mother with uncontrollable crying will produce ambivalence about leaving in many mothers.

It might be conjectured, however, that among those mothers, some will attempt to soothe the child, but then leave; others will be unable to leave and may, for example, avoid separations, such as by withdrawing the child from a preschool program or by not leaving the child with a sitter. One might assert that the important variable here is the parent's retrenchment in her expectations of the child. Perhaps the parent who is most likely to avoid separating is the one whose own concerns about separation resonate with those of her child.

The child's ambivalence then mirrors that of the parent. The child feels the need, on the one hand, to continue to have restrictions imposed from the outside, to be protected from and

excused from situations where she must be more independent. But, countering this, the movement toward greater autonomy, fueled by psychological maturation, setting demands (such as the requirement to attend school), the role models presented by peers and older siblings, and the parent's own wish to promote an appropriate level of independence, however ambivalent, all create the impulse to resist restriction. The two competing impulses culminate in an area of conflict and lack of adjustment.

Related to these issues of supervision and protection, rates of attendance at a parochial school, usually Catholic, were much lower among the women from the Independent sample than from the other two groups. Among the subjects who provided information, from the Independent group, only three women reported going to a parochial school, in all cases Catholic.

Ten of the 28 subjects who scored within the clinical range for phobia had attended parochial school for at least one year. Among the remaining phobic subjects, nine had not attended a parochial school, and nine were unknown. From the Average group (excepting those who scored in the clinical range), five had attended Catholic school.

The school experience itself cannot be claimed to induce agoraphobia and to date no studies linking parochial school attendance to adjustment have been reported. It can also be argued that the proportion of women from the phobic group is no greater than the number of people from the population who attend Catholic schools. A more fruitful approach might be to look at the data from the perspective of the unusually low number of Independent women who had attended such schools.

Interpreting the data at hand, however, school experiences may reflect and perhaps reinforce interactions at home. One may offer the preliminary speculation that a system that imposes a fairly rigid structure of rules, punishments, and performance expectations may be a factor, especially for those who come from households that are also restrictive. Those who have attended Catholic schools have also suggested that such schools, reflecting the broader commitment of the Church, reinforce the traditional female role of marriage and family.

The issues of structure and control may be broadly viewed as a potentially problematical issue in development. The bulk of studies on childrearing indicate that authoritarian parenting, which Catholic school, in a sense caricatures, results significantly more often than other, less restrictive styles, in a pattern of constrictedness, inhibition and passive dependency (Baumrind, 1972).

One might also inquire into parental motivations for enrolling the child in a parochial school. Undoubtedly, there are many, but among them may be the element of "safety" derived from the explicit ideology and authoritarian structure, which go beyond that which most public schools offer.

The parent who sends the child to a parochial school may perceive that child as being particularly in need of safety. Thus, parochial school attendance, if relevant, must be seen as involving the interaction of the qualities of the setting, and the parent's perception of the child and his/her needs.

The focus on death may be an additional factor and one that was expressed by several of those interviewed. It may find expression in the very common fear of agoraphobics that they will be fatally injured or will die of a heart attack.

It might be concluded from present findings that the importance of the emotional element, anxiety, should be underscored. Both the path analysis and factor analysis indicated that, with certain important exceptions, early restrictions, in and of themselves, do not predict phobic symptoms that well. The lack of an overall relationship indicated by the data may only have reflected a lack of cohesion among the elements that comprised each cluster. But more importantly, it appears that restrictions in the context of anxiety may be a better predictor of agoraphobia.

Another factor that may contribute secondarily is other social institutions than the family that impose restrictions while reinforcing the message that going out can be especially dangerous for women. Negative attitudes may thus be the product of more than just parental influence.

The Early Family Context: Role Models and Reinforcement

As reported, nearly half of the women in the Agoraphobic family appeared to have family members who were also phobic. Some researchers have asserted that the evidence points toward a genetic factor in the etiology of agoraphobia. To date, studies that might support this position, such as studies of children who were separated from a phobic parent at an early age and raised in a non-phobic household, or studies of adopted children raised by phobic parents have not been reported in the literature.

More plausibly, trait anxiety may be inherited, causing a predisposition toward some type of anxiety disorder (Mathews, Gelder, and Johnston, 1981; Lykken, D., in press; Norton, Dorward and Cox, 1986). The evidence from most studies, however, suggests that the

specific nature of the symptoms is not genetically determined.

A better explanation of the role of family is the dynamics of the family constellation, in which parents provide role models with which children can identify, reinforce certain behaviors and not others, create foci of conflict. In the agoraphobic family, children are exposed to the parent's constant and obsessional checking behaviors, repeated warnings, and obvious fright. This behavior, together with the imposition of strict rules about travel, reinforces the idea of possible dangers outside and presents a role model that dramatizes place-related anxieties. The warnings may also communicate a lack of confidence in the child's ability to take care of himself.

The parent's limited ability to separate from other family members may further contribute to phobic anxiety by allowing the child few opportunities to learn how to function alone. Often it creates a closed family system, with little exchange between family and the outside. The child's participation in the parent's phobic activity as the trusted companion also exposes her repeatedly to a role model who is unable to function independently and with whom they may come to identify.

In looking at the relationship between early family trauma and agoraphobia, one might also see some connection between the parents' reaction and the subsequent appearance of phobia in one of the children.

If, for example, the parent responds to the injury or death of a family member, the loss of a spouse through divorce, or any other disturbing incident with increased anxious attachment to the remaining family members, this may contribute to the development of a phobia.

Encouraging the children to become more responsible and independent, however, could have resulted in the kind of self-sufficiency evident in the Independent women, a number of whom experienced some family trauma.

Family dynamics may also explain the tendency to conceal phobic symptoms as well as the method of concealment. There is evidently a rather convoluted relationship between illness, which is an important method of concealment, and agoraphobia.

Illness as a precipitating factor has been considered in the literature. Physical conditions that are associated with anxiety-like symptoms have been recognized as a possible causal factor in some cases.

Most recently, researchers who have studied the relationship between one or another of these disorders and agoraphobia have concluded that they are neither a necessary nor sufficient precondition for the development of a phobia, and I have discussed elsewhere in this paper some of the aspects of their arguments.

Families treat illness differently. As the case of Jan G. illustrated, illness may provide a socially acceptable rationale for not leaving the home. The potential secondary gains of illness were made evident to her in her early family life, when her mother's heart condition became the reason why her family spent most of their time at home. This gave tacit permission to both Jan and her brother to use illness the same way.

The secondary gains of illness have been written about extensively in the literature on disability. The uniformly drawn conclusion is that one learns to use illness as a means of avoiding responsibility and stressful interactions. In attempting to integrate

the present findings with this, one can reverse the figure-ground relationship of home and outside and look at what the home offers rather than just what it allows one to avoid. The physical and psychosocial attributes of the home may themselves serve many purposes, allowing one, for example, to regroup emotionally, to refocus identity, to have some sense of control, as well as to be relatively free of temporal, physical and social constraints.

Another method of concealment is the use of alcohol and sedatives. Among the agoraphobic women in the sample, nine had a parent or sibling with a confirmed alcohol or drug problem. Three of the women themselves were addicted to either Valium or alcohol. As reported, several of the relatives with an addiction or drug dependence also appeared to be phobic.

The relationship between substance abuse and agoraphobia is significant first because it may account for the underreportage of phobia in some demographic studies, and secondly because treatment for either will involve disentangling and treating both conditions. Understanding that both are often embedded in the dynamics of family life, and that the need to sustain family equilibrium may produce resistance to treatment for both is also an important consideration for the clinician.

The finding that rates of alcoholism are higher among the immediate relatives of agoraphobics is consistent with the findings of Munjack, Moss and Leonard (1981) and of Torgersen (1986).

Breier, Charney, and Heninger (1986) have also reported an increased incidence of alcoholism among agoraphobics. Another study, examining the unusually high mortality rate among those with panic

disorders cited alcoholism as a possible factor (Coryell, Noyes, and Clancy, 1982).

Taking the opposite approach of looking at those with known alcohol addiction, Mullany and Trippet (1979) examined the prevalence of agoraphobia among patients in an alcohol recovery program and found that, among the males, a total of 41.5% had symptoms ranging from borderline to severe; among the females, 55.5% had agoraphobic symptoms. These figures are quite high and point rather dramatically toward an aspect of addiction that has seldom been considered by those who specialize in the diagnosis and treatment of addictions.

(Commenting on this study, Chambless and Goldstein suggest that if one is seeking agoraphobic males, some good places to look would be in bars, at Alcoholics Anonymous, and in alcoholism treatment centers. To this, one might also add the home.)

Not all studies have supported the connection as strongly. Quitkin, Rifkin, Kaplan and Klein (1972) estimated a much lower figure for alcoholism and drug abuse combined. According to them, only five to ten percent of the agoraphobics in their sample had symptoms of substance abuse.

Buglass, et al. (1977), who also investigated the incidence of alcoholism in the fathers of agoraphobics, found no significant differences in incidence between the fathers of the phobics and those of healthy controls.

Agoraphobia and Environmental Constriction

One of the consistent findings of this study was that the degree of willingness to go places alone, possession of the requisite skills for doing so, and the capacity for enjoyment of such experiences was

most closely related to the extent to which early opportunities had been provided for experiences that resembled the later ones.

The effect of parental fearfulness and restrictiveness was thus most important in depriving the agoraphobic women of the chance to acquire wayfinding skills, to be out of the home without being escorted or chaperoned, to find enjoyment in novel settings and outdoor recreational activities, and, ultimately, to feel familiar with and comfortable in public and outdoor settings.

These findings support those of an earlier study by Saegert and Hart (1978), who reported that early environmental restrictions and surveillance in girls was associated with diminished ability to use outdoor environments in a way that contributed to their own intellectual and emotional growth. The lack of competence, passivity, and uncertainty in their environmental interactions was found to discourage the use of the outdoors as a source of pleasurable or constructive experience.

Although parental reinforcement of the feminine sex role appeared to be a factor in the subsequent development of agoraphobia, and was part of the rationale for restricting the activities of the girls outside the home, the more generalized fearfulness of some parents regarding outdoor or public settings, and of activities in those settings, seemed an equally potent influence in some families.

In cases where parents expressed particular concern for the safety of daughters when going out, placing more restrictions on daughters than on sons, for example, or conveying the dangers of being accosted by men, one could anticipate a greater probability that only the daughter(s) would become symptomatic.

In other cases, where parental fearfulness was unrelated to sex,

extending instead to any or all family members perceived to be vulnerable, sons seemed as likely as daughters to be symptomatic. Future research might examine family patterns more systematically to clarify the relationship between parental attitudes and behaviors and agoraphobia among male and female offspring.

The agoraphobic and, to some degree, the Average woman, appeared to treat many settings outside the home as "non-places." This seemed to be a consequence of limited exposure. Lack of familiarity has been found to increase the stressfulness of a setting for people (e.g., Pedersen, 1978) because it requires the individual to work at deciphering cues and making decisions that the more experienced individual would make almost reflexively.

Even environments with a high degree of legibility presume that cues will call forth associations based on prior experiences, thereby eliciting the appropriate behavior. In much the same way that individuals who do not know how to use libraries tend to find them complex, overwhelming and ultimately discouraging, the agoraphobic seems to perceive many outdoor and public settings in these terms. Hence, they become "non-places."

Many women have had little experience with public spaces, particularly when alone. Going to the weight room at a gym, mentioned by two of the Independent women, can present many ambiguities to the uninitiated woman. Hailing a taxi, checking into a hotel, going out to dinner alone (all aspects of a business trip) are unfamiliar to many women. Outdoor recreational settings, such as bike paths and tennis courts present comparable social and psychological challenges.

The single, notable exception to this pattern was shopping

places. Even when the shopping mall was listed as one of the places that was associated with panic attacks, it was still mentioned as a desirable place to go. Perhaps because shopping malls are perceived as "women's places," (Seidenberg & DeCrow, 1983) in which the activity and setting are sufficiently consistent with the feminine role, the phobic women were able to override the anxiety associated with such places. Malls are also generally thought of as "safe" public places, compared, for example, to parks or neighborhoods outside one's own home range.

Overall, the sphere of operations for both the Agoraphobic and Average groups seemed largely confined to three settings: the home, the homes of others, and stores. This could be seen in the limited number of places mentioned by both groups when asked about places to go when free time was available, and when feeling disturbed or unhappy. Further, when the women from these groups reported having traveled significant distances from home alone, it was almost invariably to visit a relative, and never for recreational or business purposes, as it was for the Independent women. Relatedly, the same limited mental representation of areas outside the home can be seen in the figure drawings of neighborhood in their relatively smaller range and in the lack of street and place-names.

Unlike the women in the other two groups, the Independent women demonstrated a much more comfortable relationship with outdoor environments, using them as recreational settings, a place to be private, and as a source of emotional comfort and refueling. They were also more likely to take advantage of the cultural and entertainment places that are located in public, often urban, environments.

The Independent women did not seem to divide the world into "safe" (home) and "dangerous" (out) places, but rather, into exploring, challenging, interesting places; comfortable, familiar, owned places; and social and solitary places.

As noted, the lives of the Independent women encompassed a considerably broader range of places and activities than those in the other two groups. The figure drawings indicated a more discriminating perception of their environment, with a more extensive and detailed cognitive map of their neighborhood. Settings were also perceived by them as having a greater number of uses.

Their activities were not only more physically active, but also more interactive with specific elements of the environment. Nearly the only outdoor activity mentioned by the agoraphobic women was passively admiring the landscape while going for a walk or ride, as opposed to visiting a bird sanctuary, skiing, skating, riding, and jogging, for example.

The Independent women's enjoyment of the intellectual challenge of learning to discriminate specific features of the environment, such as the vegetation and wildlife, also led them into other types of activities, such as participation in natural resource surveys, landscape photography, and group excursions.

The women were also able to use both home and the outdoors as settings that permitted one to regroup emotionally when feeling disturbed or unhappy. In his article on compatibility between person and environment (1983), Kaplan listed, as one type of setting, "restorative environments." He characterized such environments as places that allowed for reflection and integration. To permit these

restorative functions, the environment must encourage a sense of freedom and privacy. The individual must bring to the situation an understanding of and interest in the setting's affordances.

Although the majority of researchers on the subject of restorative functions list home as a place of privacy and refuge (e.g., Hayward, 1977; Saegert & Winkel, 1980; Rybczynski, 1987), which one presumes includes a restorative element, Kaplan departs from this is his assertion that the restorative environment must give one a sense of being away, and offers wilderness as his primary example. However, only those knowledgeable enough to use such places will be able to take advantage of their restorative qualities. For others, they become, themselves, a source of stress.

In the same article, Kaplan discusses control as an element of comfort for the person. For the agoraphobic, the overriding need seemed to be to reduce risk and level of stimulation, and increase control over the environment as a means of feeling comfortable. The Independent woman, in contrast, seemed, at times, to seek increased risks and stimuli, and decreased control. Thus, going to the city was an activity that was considerably more popular -- one might say comfortable -- with the Independent women, while the Agoraphobic women's need for comfort seemed satisfied only at home.

The fact that both the current attitudes and behaviors of the Independent women related to outdoor and public spaces, as well as their reported early experiences outside the home contrast sharply with those of the others suggests that these dimensions form a cohesive whole.

Two childhood experiences that appeared to be related to the more autonomous orientation of the Independent women were, first, having

attended overnight camp and, second, having been given permission to go downtown relatively often without adult chaperonage.

Whereas day camp tends to be limited to structured activities, overnight camp is generally more open-ended, emphasizing a broader range of skills and the ability to function without an adult present. This opportunity to spend an extended period of time in the wilderness, engaged in these challenging and presumably pleasurable activities, was related to more positive feelings about being out at night (night travel), to traveling distances alone, and to eating alone in a restaurant.

Early encouragement to enter public spaces without adult supervision, i.e., being permitted to go downtown alone, was related to the ability in adulthood to orient oneself, to locate, and to travel to a destination (sense of direction, mapreading). Such encouragement was also related to the willingness to eat alone in a public place and to accept a job that would require frequent travel.

In a more general sense, the style of parental supervision, which differed significantly from that of the parents of the agoraphobics, seems to have contributed to a more robust individual. Providing their daughters with the opportunity to engage in activities without being supervised was related to -- one may assert causally -- both a more positive attitude about going out, and in actually going out alone more often. The parents of the Independent women also allowed greater opportunity to be alone inside the home as well as out.

Further, it is not unlikely that the parents of these women also felt more positively about the outdoors, and this was what motivated

more of them to choose to live in a rural setting and to send their children to camp. One may also convey such an attitude by encouraging the child to spend play time out-of-doors and to learn about nature -- the reverse, in other words, of what was conveyed to the children who later became agoraphobic. This early exposure to the rural outdoors may have contributed substantively to their greater interest in, knowledgeability about, and enjoyment of the outdoors.

Choice of free-time activities also reflected differences between the groups. The Agoraphobic and Average groups were again similar in their choice of more traditionally feminine activities, all of which are sedentary pursuits, most often engaged in at home. These included cooking, crafts such as needlework and decorative arts, watching television and listening to the radio. The Agoraphobic women, but not the Average women, were also serious collectors of a variety of items.

Both the Average and Agoraphobic groups eschewed involvement in the active pastimes mentioned by the Independent women such as sports, gardening, and birding. Conversely, few of the Independent women even claimed to have "hobbies." Instead, they chose recreational pastimes and such expressive avocations as participation in theater groups, poetry writing and publication, and exhibiting photography. The majority of these are activities done elsewhere than home. Similarly, the forms of entertainment they mentioned tended to be those found outside the home, such as visiting museums and libraries, and going to concerts and theaters.

While it might be asserted that these differences result from differences in education and socioeconomic status, they are consistent with the findings that the Agoraphobic and Average women list fewer alternative settings under all conditions.

In addition to their use of free time, the degree of constriction among the agoraphobic women was also evident in their responses to the question about where they would go when feeling disturbed. The Independent women listed more than twice the number of places -- 32 -- compared to the 13 mentioned by the phobic women.

Predictably, all of the phobic women said that they would stay home "Always" or "Sometimes" when disturbed. None said that they would "Always" go elsewhere. Among the other two groups, 95% of the Average women said that they would stay home "Always" or "Sometimes," and only one person said that she "Always" goes elsewhere.

It was only among the Independent women that a significant proportion said that they preferred to go out. Sixty-seven percent listed stay home, while the remainder, 33%, said they "Always" go out. In this, one can see that the Independent women are able to use places outside the home, primarily outdoors, as a source of comfort and as a setting that facilitates emotional reintegration.

Privacy Experiences

By definition, the agoraphobic has difficulty being alone. Because the experience of privacy is thought to be predicated, first, on the ability to function when alone, and, second, on the willingness of the person to choose to be alone (Laufer, Proshansky, & Wolfe, 1974), the agoraphobic is very limited in where she can go for privacy, and how she can use it. Although one can experience privacy in a variety of settings, both in solitude or among others in a public place, the latter situation is manifestly disturbing to the agoraphobic.

When asked where they had gone during childhood to find privacy,

most of the women in the Agoraphobic and Average groups listed the bedroom and bathroom. Almost no one mentioned either anywhere outdoors or the more remote areas of the home, such as the attic. Confining their choices to the inhabited areas suggests that their preferred style of privacy was to be private near the company of others.

Two of the women, both phobic, admitted that they avoided being alone. As one said, "There was no such thing as seeking privacy. I wanted to be where everyone else was." Others from the two groups, all of whom had phobic symptoms, remarked that "privacy wasn't an issue," and one is left with the sense that it was not an issue because it was not regarded as important or even desirable.

Among the Independent women, the bedroom was still the first choice. However, they differed from those in the other two groups in choosing outside as their second most frequent choice, in mentioning the less inhabited areas of the home as places where one might seek privacy, and in the greater total number of responses offered.

In considering the choice of bedroom as the women's most popular place for privacy, it has been asserted that the bedroom is largely a feminine domain (Kron, 1983) and the room affording the greatest autonomy and privacy to the adolescent (Czikszentmihalyi & Rochberg-Halton, 1981). As such, one exercises the greatest amount of control over intrusions, and, in its congruence with the identity of its owner, the room offers both physical and psychological comfort.

Control is also a probable factor in the preference for bathrooms. The size and scale of the typical bathroom allows the greatest sense of enclosure of all of the rooms in the home. The

bathroom was the room named most often by the women as having a useable lock. Both the lock and social custom dictate that privacy is respected more than in any other room in the home.

Perhaps it is these features that inspired one of the phobic women to comment, "I like bathrooms -- they're little. I fantasized making a house out of the bathroom." It may also account for the unusual popularity of doll houses among the agoraphobic women.

Unfortunately no formal inquiry was made into current privacy experiences, such as the frequency with which privacy was sought, or how it was used. One must thus infer from more circumstantial evidence what privacy means to the individual.

In response to the open-ended questions about most- and least-liked aspects of home and neighborhood, being able to find privacy was mentioned as an important aspect by only one person from the Agoraphobic group. Outdoor privacy, however, was mentioned by eleven of the women, invariably in reference to the ability to keep neighbors from prying. In light of the personal and family problems experienced by those in the phobic group, the wish to protect oneself from the view of one's not necessarily sympathetic neighbors is understandable.

Collectively, the privacy-related data suggest that the agoraphobic associates privacy with modesty, such as would be found in the bathroom or bedroom, with feeling able to restrict access by others (neighbors, family) into their physical and psychological space, and with achieving some respite from the social and physical demands of more public settings.

The tenacity with which the agoraphobic clings to the home setting suggests that the individual continues to be dependent upon

the physical setting to achieve respite, i.e., privacy cannot readily be achieved through psychological withdrawal. As Laufer, Proshansky & Wolfe (1974) have written, psychological withdrawal requires a more advanced state of development. It further suggests that other settings cannot fulfill privacy functions. Thus, like a diver coming up to renew his oxygen supply, the agoraphobic must return at regular intervals to the source of her narcissistic supplies, with no alternatives beside home.

Clearly, having the opportunity for privacy, learning to make use of it, and having the desire for it, all develop -- or fail to develop -- simultaneously. Thus, remaining at home without a sitter, seeking a place for privacy, and having one's own bedroom, for example, are partly a function of what is offered, but are also a function of expressing the desire for such things, as well as being able to demonstrate the capacity to function under those circumstances.

The pre-phobic girl, having been given neither a role model, nor reinforcement, nor opportunity, would not have been likely to have actively sought such situations, and one can see in this the emerging conundrum of limited opportunity to be alone and the sense of uncertainty when confronted with aloneness that is typical of the agoraphobic.

Indeed, it is difficult to imagine that there is no connection between the agoraphobic's explicit dread of being isolated from familiar others in a public place, and the lack of early experiences with being alone. This finding is reminiscent of the "agoraphobia" reported by Marks among Hispanic women and that reported by Brolin among Indian women, both of whom had been raised in cultures where all

aspects of life were largely communal, particularly for women. These women subsequently felt "agoraphobic" anxiety when confronted with opportunities for privacy and aloneness, in the first case indoors, in the second, indoors and out.

Lastly, the Proshansky, et al. study suggests that identity formation is inextricably bound with autonomy and the capacity to function alone. Having deprived the child of opportunities to be alone, then, one can expect both the agoraphobic's inability to function alone, and the lack of identity that other researchers, as I have noted, have described as part of the agoraphobic woman's pathology.

Comparative Perceptions of and Uses of Home

The Agoraphobic Women's Houses

In her article, "The House as Symbol of the Self," Clare Cooper (Marcus) (1974) describes how the home and its contents come to reflect and reinforce the identity of those who inhabit it. This is particularly true for women, for whom the home possesses an expressive function (Czikszenmihalyi & Rochberg-Halton, 1981). Having concentrated their lives in this single setting, their existence was most validated by the home-related activities and sentimental objects with which it was decorated.

Undoubtedly, the need to compress all of one's life activities into the space of a few rooms, where others employ multiple settings and vastly greater spaces, contributes to the density of the agoraphobics' homes. Beyond that, though, the houses seemed singularly autobiographical, creating a reality that seems to offset the sense of unreality and depersonalization that the agoraphobic

often experiences in the world outside the home.

The presence of antiques was the most common and distinctive of the attributes that characterized the agoraphobic women's homes. Why this should be so was something that the phobics themselves were unable to explain, other than to say they loved old things.

Many of the women also expressed a long-standing interest in history with a special interest in old houses. This was expressed in various ways, including visiting old homes and restored villages, collecting books and photographs of restorations, as well as collecting, identifying, and selling antique home furnishings.

One may speculate that antique furnishings, particularly those from the Victorian era, re-create the sense of enclosure and homeyness that was especially typical of the period. They reflect back on women's role as the organizing and stabilizing force in the Victorian home. From a more psychoanalytic perspective, antiques can make some reference to one's personal past, and create a more introspective style than uncomplicated contemporary. Perhaps they elicit associations with past events that may serve to make sense of the individual's current psychic features.

In their book, The Meaning of Things, Czikszenmihalyi and Rochberg-Halton (1981) discuss the importance of the bedroom for children. As a child's first domain, it confers an original sense of being in control of a place. As the designated room where their possessions can be kept, the child is surrounded with "props" that reinforce his nascent identity and offer him a haven of privacy. The authors feel that with age, the importance of the bedroom declines, resuming its importance only in the last years of life.

Results from the present study suggest that the bedroom continues

to occupy an important place in the agoraphobic women's lives. For the agoraphobic, the issues of control and identity continue to be problematical, and their possessions, which have a prominent place in their lives, sustain their sense of well being. Their most personal "props," such as books and diaries, childhood dolls, heirloom furniture and objects, and family photographs were all kept in the bedroom. As with the rest of the home, these bedrooms tended to be more complex than those of the other women.

There were exceptions to these. Some homes of the agoraphobic women appeared conventional, plain, and uninteresting. Perhaps it is as instructive to speculate about these exceptions as to explain the general findings. Two subgroups may be said to have these more conventional homes: The first group consisted of the women who showed the least amount of personality differentiation, often with schizoid or schizophreniform symptoms. The capacity to express identity concretely, utilizing such "props" as clothing or home, seems to require a degree of clarity about that identity.

The second group consisted of the women who had the fewest phobic symptoms and who spent significant time away from home. It is evident that the degree of psychic investment in a given setting is a major factor in the extent to which a space will be converted into a place that reflects its primary owner. This finding is supported, for example, by Wofsey, Rierdan and Wapner (1979) who found that the most densely decorated dormitory rooms belonged to the students who were most embedded in college life and least densely by those who were least involved with campus life.

The Independent women's relationship with home was less

affectively tinged than that of the agoraphobic women, but not yet as dispassionate as that of the men in the Czikszenzimihalyi and Rochberg-Halton study.

It seems clear that home as a place of respite was an important aspect: Privacy from neighbors, rural solitude and quiet were all frequently mentioned as important attributes of their homes. Although other places were included, home was the setting mentioned most often affording privacy, as a place to go when upset, or when free time was available.

At the same time, the drawings suggest a more matter-of-fact perception of home and neighborhood. The most important attribute of home was the very utilitarian one of convenience to services. The relative lack of personalized decor suggested that it was not as important as a means of reflecting one's own identity. Instead, it served as a home base for activities, without itself being the site or focus of activity. Similar to the men in the Czikszenzimihalyi and Rochberg-Halton study, it seemed as if the activities themselves, rather than the place, played a more important role in self-definition.

This contrasts with the responses of the Agoraphobic and Average women, and with the reported responses of women in other studies (Saegert & Winkel, 1980; Czikszenzimihalyi & Rochberg-Halton, 1981; Hayward, 1977), for whom the home was an important medium for the expression of one's personal identity.

In general, the psychological dimensions of home other than its implied use as a haven and a base of operations did not seem as important to the Independent women. This contrasts with Hayward's (1977) finding that home is the focal point of women's lives, a place

of safety and security, a part of oneself, and a setting for interpersonal relationships, as well as serving as a refuge, but is consistent with his finding that these aspects were most important for women who identified most closely with the traditional feminine sex role.

Neither familiarity nor comfort was as highly rated by the Independent women as it was either by the other two groups of women or by those in the Czikszenzimihalyi and Rochberg-Halton study. In contrast to the other women and to the women in the Saegert and Winkel study, the home as a setting for neighboring was also given much less attention by those in the Independent group.

Again, these differences may be the result of socioeconomic differences, or the professional, employed status of the Independent women, or the fact that, in terms of life stage, fewer of these women were home with young children. Czikszenzimihalyi and Rochberg-Halton and Rybczynski (1987) also suggest that comfort is more important in the lower socioeconomic classes, while being taken for granted in the middle and upper classes.

In the course of interviewing the women, it became increasingly evident that "home" had a rather different meaning for the Independent women. For the Agoraphobic, "home" meant the house or apartment where they lived. In some cases, it also included the property. For the Independent women, "home" actually meant "home range."

Thus, the questions about where the individual goes when disturbed or when free time is available elicited responses that seemed more similar than they actually were. For the agoraphobic women, "stay home" meant stay in the dwelling. Activities engaged in

were those most appropriately done inside, generally at home, such as cooking and crafts.

On the other hand, for the Independent women, the indoor space of the house was seen as continuous with the surrounding woods or neighborhood, and "stay home" meant not getting into a car and driving somewhere, but remaining in the area that could be reached by foot. Stay at home activities were listed as cross country skiing in the countryside surrounding the home, going birding or hiking.

The agoraphobic women, however, were not unaware of the setting; the three features of home and neighborhood mentioned most frequently involved the setting, including, first, its social aspects, i.e., the neighbors and the privacy of the home's location, and, secondly, its physical aspects, i.e., the primarily but not exclusively, pastoral features of the property and immediate vicinity.

In understanding the emphasis placed upon setting, an important factor is apparently the limited home range of the agoraphobic. Nearly all aspects of her life space, job, family, leisure activity, occur in the same physical area, home and neighborhood. Thus the positive and negative aspects gain added importance to her.

A possible factor related to the relative disinterest of the Independent women in their neighbors involves professional and educational factors. It will be recalled that those in the Independent group fell into a somewhat more advanced category in both respects. Prior research suggests that the working-class individual relates to the more physically immediate community of the neighborhood, while the professional tends to relate to the more dispersed community of those with similar interests (Orleans, 1973; Keller, 1968). This would seem all more the true for those who lack

the family life that tends to draw one into neighborhood involvements.

Although the aesthetics of the surroundings were rated highly by both the Agoraphobic and Independent women, (less so for those in the Average group), it is interesting that there was some variation in what they found appealing. Rural features were the most frequently cited positive attributes mentioned by women in both groups. But of the thirteen agoraphobic women who listed the aesthetics of the area as a most- or least-liked feature, four explicitly stated that they liked the urban, small town, or suburban character of the setting.

Of the sixteen Independent women who listed aesthetics as important, three made comments indicating qualities other than natural or rural features, most of which reflected the concern of being a single woman in an isolated area. Responses from this group otherwise tended to cluster "quiet," "safe," and "private" together with rural. For those in the other two groups, these attributes, when mentioned, appeared to be more closely associated with being in a community, surrounded by non-intrusive, yet friendly neighbors.

Typically contrasting statements about the most-liked aspect of the neighborhood were, from three of the women in the Independent group, "privacy, seclusion," "quiet, woodsy, safe," and "rural... privacy."

From the Agoraphobic group, examples of comments included, "comfortable...you know people...it's a cozy little town," "It's a pretty, urban [setting]...preferable to suburban [settings]," and "the neighbors are all decent people, friendly, not nosey."

Agoraphobia's Impact on Life-Style

One of the most surprising findings of this study was the degree

of normalcy in at least the basic outlines of the agoraphobic women's lives. Marriage, family, home, and job were all part of the picture in their lives. Other family members adapted to a considerable degree to what can only be thought of as severe restrictions. Thus, while the constraints limited the type of work and free time activity that could be pursued, and undoubtedly altered the character of relationships, it precluded surprisingly few activities that constitute a normal life.

The women maintained their friendships through extensive use of the phone and by inviting people to their homes. If unable to work outside the home, many were gainfully employed in home-based work. Three of the women managed to resume their schooling and were working on undergraduate or graduate degrees, making special arrangements when possible to reduce the stressful aspects of attending. If unable to tolerate stores, they accomplished much of their shopping through catalog orders.

At the same time, as the lives of women in general have expanded to include work and other activities not specifically involving home and family, a limitation of this nature does become potentially more conspicuous and certainly more of a handicap. Many of the women who were employed outside the home described the trip to and from work as excruciating. Several were finally obliged to leave their jobs because of the phobia.

The sensitivity of the women to the possible stigma of having agoraphobia undoubtedly accounts, in part, for the number who felt that privacy from neighbors was important. Yet, it seems from looking at these women, that it is possible to conceal the condition from all except intimate others. Few people would think it unusual to be

accompanied by other family members anywhere outside the home other than to work. Feigning illness or dislike, they were able to avoid going many places without arousing the suspicion of others, and several remarked that those with whom they worked or socialized were often amazed when they revealed their problem.

Asked how agoraphobia affected their lives, responses ranged from "Very little" to "It cripples your life" and, "It hasn't affected the outcome, but the quality [of life]."

Most frequently mentioned was its effect on relationships, often interfering with, sometimes destroying them. Several mentioned dependency on others as the most disturbing feature of the disorder.

Others said that it can curtail or preclude activities that the individual might otherwise pursue. These included seeking employment and accepting a promotion to a position requiring travel, vacationing, shopping, going to entertainment places, and returning to school. Two women in their middle twenties expressed frustration about the fact that they wanted to have children but could not stay in a hospital.

One aspect that was not mentioned, but which impressed the researcher was the overriding theme of home in the women's lives, which permeated every important feature including their choice of work, the type of free-time activities selected, and the investment of time and energy spent on the home environment.

Women's "Crisis of Desynchrony": The Relationship Between Sex Roles, Adjustment and Life Style

It was Claus Riegel's contention that changes in personality structure and in social structures would often occur at different times, the change in one placing stress on, and ultimately

necessitating some kind of adaptation, in the other.

That many average woman tend to be marginally agoraphobic seems to support Riegel's assertion that personality, and the socialization practices that shape it, lag behind the social reality of women moving out of the home into the workplace and public life. Women continue to be socialized to marry and assume the conventionally defined role of wife, which includes primary responsibility for child care and home maintenance, while outside employment is given less of a priority. Socialization has also lagged behind the reality in recognizing the necessity for women to be more capable of acting independently and assertively in the workplace and elsewhere.

An alternative interpretation of the data might be that the similarities between the agoraphobic and average women can be accounted for by the fact that both groups of women, the majority of whom are married, are weakened by being married. The assumption of the identity and role of wife, with the added fillip of a social structure that both protects and demeans women, unravels the developmental accomplishments of earlier life in which separation and autonomy play a major part.

Femininity as a Critical Variable

A critical point of intersection between life style and agoraphobia is sex-role identification. Results from the present studies confirm the findings of earlier studies that healthy psychological adjustment is associated most closely in women with masculine attributes (e.g., Taylor and Hall, 1982; Jones, Chernovetz and Hansson, 1978), while women low on Bem's Masculinity Scale, regardless of their Femininity scores, show greater signs of emotional

distress (Rendely, Holmstrom & Karp, 1984).

Results of this study indicated a relationship between feminine identification and agoraphobia. An even stronger relationship was found between masculine identification and superior adjustment. In the factor analysis, High F was the variable with the highest negative loading on the factor labeled "Autonomy," while High M had an almost equally high positive loading.

The relatively high number of individuals classified as androgynous found among the agoraphobic subjects seems to run counter to studies where it was reported that androgeny was associated with better psychosocial adjustment, but supports those that indicated no advantage.

The most plausible explanation for the high number of androgynous phobics is treatment effects: When assertiveness, self-reliance, and decision-making, for example, are reinforced, it can be anticipated that this will raise the Masculinity score without necessarily affecting the Femininity score.

It suggests a reverse of the initial treatment response, which is reported to increase the Femininity score among both sexes, reflecting feelings of helplessness, and supports the finding that the expressed goals of patients include increasing the attributes described on the BSRI as masculine (Lazerson, 1985).

Sex-role identification has a direct bearing on how, as an adult, a woman will define her role in the marriage, whether she will pursue a career and, if so, what kind. Such feminine attributes as compliance, passivity and dependency fit well with the conventional image of marriage, but may contribute to becoming housebound. Even though there is no systematic relationship between adjustment and

employment (Rendely, Holmstrom and Karp, 1984) sex role identification may be a more influential factor in determining how well one adjusts to work.

In terms of socialization, the parents' conception of the importance of sexual identity and how stereotypical their conceptions are may contribute to the relative vulnerability of daughters to agoraphobia. Femininity is often the rationale for close supervision and chaperonage, factors associated with the subsequent appearance of phobic symptoms. Relatedly, it affects the kinds of skills that one is encouraged to acquire or, conversely, limits opportunities to acquire skills which are not seen as essential for females. This has a direct bearing on women's attitudes toward going out and ability to function outside the home.

Marriage, Social Constraint and Agoraphobia in Women

Examining the contrasting life styles of the Agoraphobic, Average and Independent women has raised the question of whether marriage and family preclude one from engaging in autonomous activities outside the home. Do the circumstances of the average woman, which includes marriage and family, discourage independence, or are those who choose such circumstances a large, but still self-selected group of less independent women whose expectations about how such roles should be fulfilled culminate in debilitating dependencies and inhibitions?

Perhaps more ominously, does marriage cause previously independent women to lose some of their independent psychological attributes? If so, is this a function of decreased exposure and "practice," or because of a changed sense of identity?

The rather complex answer to these questions appears to be that

marriage does discourage independence, but also, the majority of women accept the restrictive conditions of the conventional marriage because of their socialized expectations about how one enacts the marital roles. A question that requires considerably more research is whether poorly adjusted women are more likely to be married.

The social expectations regarding marriage and family generally result in a kind of physical and social enclosure. The way husbands and wives traditionally define their roles and relationship tends to reinforce going places and doing things together. It assures that the participants will rarely be alone, physically or socially. Protectiveness is also commonly assumed to be part of the definition of being a husband. Reminiscent of the paternal role, the husband may discourage or even restrict his wife from going out alone.

This conception of marriage is so deeply embedded in the culture that it becomes difficult even for the clinician to recognize the part that it may play in the agoraphobic syndrome. Symonds, for example, in writing about the case in which the agoraphobic woman and her husband rarely went out, remarks that the woman "apparently accepted [the situation] as natural because she was married..." Symonds then comments that, except for the lack of warmth, it "sounds on the surface like an ordinary, contented domestic scene..." (p. 294)

The Victorian notion of women's place being in the home has persisted well into this century, and continues to carry with it a moral imperative as well as the conviction that children, especially young children, require the irreplaceable presence of the mother whenever possible. Thus, while employment for women has become more acceptable, particularly among social classes where it is economically

necessary, recreational activities, especially those pursued without spouse or other family member, continue to be seen as somewhat frivolous and self-indulgent and seem to provoke a greater number of warnings.

This same attitude is reflected in the pattern of symptoms among those who are agoraphobic, including those in this study, the majority of whom are able to travel to work, albeit with considerable distress, but few of whom are able to engage alone in any of these recreational activities, unless in the company of spouse.

Further, changes in social structure have not accommodated to the surge of employment among women with children by recognizing the need for adequate day-care facilities. The absence of affordable, available care requires women to choose between having children or having a career, or to compromise by making private, often unstable arrangements with individuals.

Allegations of child abuse in day-care centers has recently inspired a number of articles and public statements about the potential physical and psychological harm that can result from women leaving their children in the care of others. These reports caused the earlier, individual expressions of disapproval to coalesce into a more public voice. These events have also contributed to women's ambivalence about going out.

Simple logistics also mitigate against autonomy when there are children. Especially in the years of early childhood, women committed to the role of primary caretaker are unlikely to be eating alone, vacationing alone, or pursuing cultural, recreational, or other activities independent of the family. The possible dangers of being alone take on heightened meaning when the woman's health and well

being are seen as critical to those who depend upon her.

The geography of suburban environments is an additional element that enforces women's homeboundness. When women, oriented toward home life, include closeness to home as one of the most important requisites for accepting a position (Erickson, 1977) but find that employment means a substantial commute (Palm and Pred, 1977), one may expect the concession to be in terms of employment and not home life. This is especially true for women with children, who feel that the protected, if isolated, suburban environment is most suitable for raising a family (Saegert, 1975).

Supporting the idea that the institution of marriage encourages dependency and fearfulness, Wolfe in his article, "Gender Imperative, Separation Anxiety, and Agoraphobia in Women" (1984), observed "an erosion of independence," in women associated with getting married that affected employment, driving, and traveling.

Symonds (1973), in her study, "Phobias After Marriage: Women's Declaration of Dependence," and Seidenberg, in "The Trauma of Eventlessness" (1973) also present cases of apparently successful, independent young women who became agoraphobic after marriage. Symonds contended that there is a small, but significant number [of women] who seem to shrivel up after getting married, who seem to lose all interest and involvements, who constrict their inner life, and who become depressed, anxious and excessively dependent" (p. 289).

Cumulatively, however, findings from this study and others contradict Symonds's assertion that those who later become agoraphobic are only those who had to deny their wish to be dependent earlier in life. Re-examining the descriptions of Symonds's women, one finds

that they are independent only in the socially prescribed "feminine" activities of caring for younger siblings, doing well in school, and in their (aborted) careers in nursing, art, and music.

One might also cite the contrasting remarks of the women in the Independent sample of the present study, who had either gotten married or divorced. Linda L., married at age 37 and, prior to that time, accustomed to vacationing by herself, traveling on business, and birding, no longer engages in any of these activities. After living independently and supporting herself since late adolescence, she decided at the time of her marriage that her husband's income would make it feasible to work only part time. At present the mother of a one-year-old, she is unemployed, with no plans to return to work.

Michele P., on the other hand, is recently divorced with no children. She explained the divorce by saying that her husband expected her to be home most of the day, expected to have his dinner prepared when he arrived home from work, and expected her to check with him before deciding to go out. Unable to tolerate the restrictiveness, she moved out. Uninterested in another marriage, she expresses the desire to return to school for a degree in political science and, following the example set by both of her parents, to run for public office.

Both Michele P. and Vera G., who is twice divorced, remarked that they assumed far more independent lives after becoming single again and enjoy the freedom from accountability to a spouse. It might be asserted that the expectations of husbands such as that of Michele P. are rather ordinary, that the line between informing one's spouse and gaining his permission to go out is often nearly indefinable.

Aside from expectations about marriage, women's lack of

preparation for conducting transactions with the world outside home and neighborhood, and the lack of social support for doing so, women are further discouraged from going out by the expressed attitudes of many social institutions. Educational institutions and organizations responsible for making public places safe and hospitable for women, reinforce the idea that women should remain at home, that they are visitors elsewhere, and that their safety cannot be guaranteed.

These messages take the form of caveats about avoiding dark or isolated areas and about wearing seductive clothing in such places. Periodic press releases advise women about what they should do if accosted, and contain recommendations from law enforcement bodies about carrying items to defend oneself. Courses for women in self-defense are offered by police departments and adult schools. All of this reinforces the idea that women should not be out alone and the expectation that if they are, they are likely to become crime victims.

The implicit prohibitions against women going out often become explicit when current events provide apparent justification, for example, after crimes are reported in the news. During the course of this study, on two separate occasions, a single woman in the vicinity was abducted and murdered, in one case while traveling home from work at night, in the other case, from a shopping center parking lot at lunchtime. One can only describe public reaction as mobilizing the latent concerns and perhaps resentments of men, police and security systems regarding unaccompanied women.

The immediate consequence was a redoubling of efforts to have women "check in" when out alone, to confine travel to daytime hours,

to go only when accompanied by a man, and to curtail non-essential trips.

Similar crimes against men seem not to provoke any such public reaction, but tend to be interpreted as having more specific causes rather than as being "generic" crimes against males.

Because crime reportage increases public directives about women traveling alone, one need not have been victim of a crime oneself under such circumstances to become fearful of going anywhere alone. This may account for the finding of the present study that being a crime victim was not a distinguishing factor in who subsequently became phobic.

Collectively, these factors conspire to keep all but a small and determinedly independent group at home. For the majority, they apparently preclude the types of activities that define independence in women.

One might, lastly, pose the question, if childrearing presents a barrier to independence, why don't most women become more independent as the children grow older? What type of woman does resume greater independence?

A preliminary response would be that age, lack of practice, and lack of outside involvements are factors that sustain a more constricted life style that may edge into agoraphobia. The accumulation of inhibitions to which women have been socialized, together with the concern of spouse, constitute an increasingly inhibitory force. Thus, the woman who is vulnerable to becoming housebound is likely to do so after the prolonged period of remaining close to home with very young children, something reported with a high degree of regularity, both in the present study and in those cases

cited above.

Sex-Roles, Hardiness, and Life Style

Those attributes identified in the present study as characterizing the Independent women, including the centrality of work in their lives, knowledgability about entertainment, cultural and recreational settings, and the lack of inhibition about going to such places unescorted seem to allow for a far better adaptation to women's current situation, in which women are more likely to be employed, somewhat less likely to be married, and much less likely to be spending many years caring for two or more children.

The Independent women characterize Kobasa's (1979) concept of "hardiness" particularly well. Kobasa found that such individuals either tolerate stress exceptionally well or thrive on it, that they feel very much in control of their lives, and experience environmental demands as challenging rather than threatening. The Independent women in the sample showed the fewest symptoms of any kind and the lowest levels of emotional distress.

While the Independent women experienced as much early stress as those in the phobic group, it seemed to contribute to their self-assurance. Current environmental demands, including living and traveling alone, were perceived as challenging and often pleasurable and not as anxiety-producing.

However, in a article summarizing recent research on "resiliency" and previewing research that is soon to be published (Goleman, 1987), several researchers were quoted as saying that those individuals who thrive despite early emotional deprivation often pay a price in terms of their capacity for intimacy. Although it is beyond the scope of

this paper to consider all of the possible permutations of autonomy and intimacy that can be achieved within the context of a marriage, greater autonomy would seem to make marriage less reachable or less appealing for many independent women.

In other words, the attributes that allow the Independent women to function effectively outside the home may interfere with the fulfillment of the conventional roles of marriage and family. These attributes overlap with those that defined Bem's concept of High Masculinity.

Alternatively, it may have a positive effect on how the roles of wife and mother are carried out. In their article on "The Relationship of Sex-Role Identity, Life Style, and Mental Health in Suburban American Homemakers" (1984), Rendely, et al. found that there was no relationship between either sex-role identity and assuming the role of homemaker, or between adjustment and homemaking.

They concluded from this that homemaking tasks can be accomplished in an agentic fashion and that better adjustment was associated with a more masculine, agentic orientation. Conversely, work can be approached in communal, non-agentic (i.e., feminine) manner.

The Relationship Between Employment and Adjustment

A number of studies have been done that examine the mental health of women who are employed outside the home compared to that of women who are housewives. Reported results have varied widely, along with the interpretations of those results.

Having examined the relationship between sex-role identification and adjustment, several researchers have concluded that the superior

adjustment of those who identify with more masculine traits, regardless of their gender, results from the fact that American society selectively rewards behaviors traditionally associated with masculinity, such as assertiveness and instrumentality. This is probably particularly true in work settings. Findings from the present study that the majority of average women identify with the feminine role may mean that they may not adjust well to the social complexities of the workplace.

On the other hand, Gove and Tudor (1973), found depression to be more common among housewives and concluded that the independent variable was the housewife role. They reported that the low status, and repetitive, unrewarding role of housewife resulted in depression. Jessie Bernard (1971) described the situation of married women in similar terms in "The Paradox of The Happy Marriage." A logical sequel to such findings is that women who work should show superior adjustment.

However, a competing hypothesis is that multiple commitments over a range of activities will result in identity diffusion for women and that this will have a negative effect on adjustment, whereas fewer commitments and an uncomplicated, clearly defined identity will have a salutary effect. (Why this should be more true of women than men has not been adequately addressed.)

A parallel hypothesis is that adolescent girls who perceive themselves as having a number of options that include work and/or family in their adult lives can be expected to experience more problems in identity achievement than those whose options are limited (Douvan and Adelson, 1966; Steinberg, 1985).

These assumptions, combined with the conclusions of Gove and Tudor, lead to the further conclusion that women have two choices, a clearly defined, but low status identity as housewife, or a more conflicted, less well-defined, yet higher status identity when career is combined with family life or replaces it.

There is no clear evidence, however, to support this position. A study by Jabury, for example, predicted that those who chose the more unconventional path of remaining single and/or pursuing a career would show a higher degree of identity diffusion than those who chose to be married and non-employed. He found no differences in degree of identity diffusion among married versus non-married women or career versus non-career women.

One might challenge the idea that multiple roles cause identity diffusion which, in turn, result in poorer adjustment, by taking the position that widening one's sphere of activity may clarify one's identity by offering opportunities to exercise the many facets of the self.

One should also not confuse identity diffusion with role diffusion. The latter condition reflects rather well the real discontinuities and contradictions in the lives of women who have chosen to combine work and family.

James Marcia's (1966) concept of the Foreclosure Personality may also be relevant. He describes the Foreclosure Personality as one in which premature decisions about one's identity and life style are made without the requisite conflict and experimentation. This, he says, leads to poorer adjustment.

Women whose identity has thus been so superficially defined, must, like the children in the Sedney study who gravitated toward

externally defined, stereotypical sex-typed activities, choose the more circumscribed and conventional life style.

Perhaps more substantively, however, the lack of agreement in findings results from the changing populations of those women who elect to become full-time homemakers and those who choose to work. The greater the number of women who defy the traditional woman's agenda, the easier it becomes for others to follow precedent, and the more different the successive groups are in terms of traits and motivations from the original group.

Those who initiated the movement must have been considerably more able to withstand social pressure during a time when getting married and becoming a full-time homemaker was the modal life style for women. They must also have felt that being employed, and probably engaging in a chosen career, was an important part of their lives. In this respect, they resemble most closely the Independent sample of women in this study, and may further explain why this group was somewhat older than the others.

However, financial exigencies and changing sex roles have brought a more heterogenous group of women out of the home. When employment becomes commonplace -- the norm, in fact -- as it has, some women who have not been well-prepared to function outside the home will be compelled nevertheless to do so, including women who are agoraphobic. In contrast to such studies as that by Buglass in 1977 and Roberts in 1964, most of the agoraphobic women in the present study, as well as the other women, were employed. Thus, those women employed outside the home can no longer be readily characterized as the most stable and independent.

At the same time, one may be able to identify several subpopulations among those who remain at home. These will include a distillation of the most-fragile, least-stable women who could not tolerate the pressures of work, among whom are the most severely agoraphobic. In these cases one can expect little or no relationship between the number and age of the children and her being at home.

A second subgroup may consist, however, of those who perceive their full-time homemaking as only a hiatus from their careers, and one would anticipate a much more stable group of women with primarily one or more children under the age of three. Especially for the women who chose homemaking after delaying marriage and family, and who have worked and lived independently for some time, one would expect "agentic homemaking," and, overall, a higher level of adjustment.

If and when increased availability and quality of institutional child care occurs, this may again alter the population of full-time homemakers by decreasing the time that women take from their careers. If maternity leave benefits increase for a significant number of women, this, conversely, may increase the number of women at home, and extend the amount of time that one's career is interrupted.

The implications of this are that employment status may be either the independent or dependent variable in relation to adjustment: Homemaking or employment outside the home may each affect adjustment, but adjustment may also be a determinant in employment status. Importantly, as Riegel predicted, changing social circumstances that allow women to work may result in employment status overriding adjustment as the more influential of the two independent variables.

CHAPTER V

SUMMARY AND CONCLUSIONS

In its broadest outlines, this study was an examination of women's relationships with indoor and outdoor environments. It attempted to describe the origins of women's inhibitions and fears regarding unfamiliar, public, and outdoor environments, and to explain women's greater susceptibility to agoraphobia in terms of childhood experiences common to girls. In this sense, it builds upon prior studies that have examined the cognitive and affective correlates of early protectiveness of girls and identification with the feminine sex role.

The study substantiated the relationship between the lack of opportunity to be outside the home without excessive assistance and supervision in childhood, and subsequent lack of knowledge in how to use public and outdoor settings as a source of satisfaction and fulfillment. The failure to develop environmental skills and knowledge was nearly as common among the average women who participated in the study as it was among the agoraphobic women.

Often, the concept of environmental constraint implies that environments prevent individuals from achieving goals and satisfactions because of their limited or intrusive physical or social attributes. This study demonstrates that such constraints are sometimes not inherent in the setting, but often represent interactions between person and setting that are disturbed by the individual's learned perceptions, lack of knowledge and skills in

making use of it, and apprehensiveness about being there.

The study further suggests that women's intense relationships with the home environment are only partly accounted for by their role in the family. Home may also be central by default. That is, the inability to make constructive and satisfying use of other settings often leaves home as the only alternative for women.

One of the most important findings of this study was the similarity of the agoraphobic and average women. As prior studies have reported, the agoraphobic women in the present sample comprised a very heterogeneous group in terms of most demographic and personality variables. At the same time, there was also little to differentiate the phobic and average women.

The substantial overlap between the two groups and lack of distinctive characteristics among the agoraphobics strongly suggests that many average women are potentially phobic. Rather than phobia resulting from any unusual conditions, it appears, for the most part, to be the product of ordinary socialization. It raises the question of how the conventional definition of femininity results in the socialization process predisposing girls to deal ineffectually with the outside world.

This finding was supported by the high degree of similarity in negative attitudes, perceived lack of ability and lack of confidence about being outside the home shared by the phobic and average women, and argues against the interpretation that among phobics, negative attitudes are a consequence of the phobia.

A related question that the study raised about sex roles is whether the traditional definition of marriage contributes to increased inhibitions about going out for women, and the evidence

suggests that it does. Aspects of this include women's perception of how the role of wife should be enacted, the husband's role as protector and escort, and assumptions about the legitimacy of women's activities outside the home.

Further social conditions that result in women, especially married women, becoming housebound include public reactions to crime, the geographic separation of work and home environments, and lack of adequate child care facilities that would allow women to be employed or to pursue other activities. Educational institutions may also be a factor in the way they supervise and in what they teach girls about femininity, marriage, and work.

The inclusion of women who lived very independent lives offered insight into the development of environmental interactions that contribute substantively to a fuller and more gratifying existence. The greater autonomy and more frequent opportunities to go alone to public places and to be outdoors, early in life were associated with their considerably greater confidence in going places, with their ability to conceptualize environments outside the home, with their use of them not only as backdrops for activity but as an important element in activities, and with their use of them as a source of stimulation, comfort, and gratification. The independent woman also showed the fewest psychological symptoms and the highest overall level of adjustment.

Unexpectedly, it was found that eating disorders, alcoholism and drug dependency were associated with agoraphobia. This appeared to be particularly true of male relatives of the agoraphobics in the study, and may be seen as a way of both concealing the phobia and permitting

the individual to function by reducing anxiety level.

Illness was a further method of concealment, especially among those who did not define themselves as phobic but who nevertheless had phobic symptoms. For women with agoraphobia, the presence of husband and children, which creates the appearance of conventional married life, were a means of reducing the phobic anxiety associated with being alone.

The findings of this study, particularly those regarding the relationship between parental fearfulness and overprotectiveness and the subsequent development of agoraphobia, strongly suggest that prevention involve the education of parents and other key community people. Such programs should underscore the importance of early and regular exposure to outdoor settings.

Beginning at the primary school level, environmental education should be integrated into the curriculum, not as a subject unto itself in a single brief unit, but as part of pre-existing studies that extend throughout the school years. These programs should emphasize discriminating and knowledgeable perception of public and outdoor environments, including the opportunity to learn how they can be used, and emphasizing the importance of encouraging their use without constant and anxiety-saturated surveillance.

As increasing numbers of women, including phobic women are seeking employment, the identification and treatment for such problems must extend into the workplace. The ability to perform some types of work at home, decreased commuting time and flexible work hours would all add to a more sympathetic work setting for women.

Further research might address the long term benefits of early environmental education, particularly as a preventive to phobic

inhibitions among women in adulthood. Although agoraphobia is a relative rarity among men, an examination of those who have it might also add to the body of knowledge regarding early antecedents and correlates of healthy and unhealthy relationships with environments outside the home.

APPENDIX A

ENVIRONMENTAL EXPERIENCE QUESTIONNAIRE

ENVIRONMENTAL EXPERIENCE QUESTIONNAIRE

Part I: Biographical Data

1. Age: _____
2. Marital Status:
 Married _____ Never Married _____
 Separated or Divorced _____ Divorced _____ Widowed _____
3. Employment (Check all that apply):
 Full-time Employed _____ Part-time _____
 Home-based Business _____ Unemployed _____ Student _____
4. Occupation: _____
5. Education (Check highest level attained):
 High School or below _____
 College: 1 year _____ 2 years _____ 3 years _____
 B.A. _____ M.A. or above _____

Part II: Early Environmental Experience:

6. How many members of the family were there who lived at home during your childhood?
 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7-10 _____ More than 10 _____
7. No. of brothers _____ No. of sisters _____
8. How many finished rooms were there in the home where you spent your childhood (excluding bathrooms)?
 1-2 _____ 3-4 _____ 5-6 _____ 7-8 _____ 9-10 _____ More than 10 _____
9. Did you have your own bedroom as a child?
 Yes _____ Ages _____ to _____ No _____ Ages _____ to _____
 Under 5 = 4 pts. 6-10 = 3 pts. 11-15 = 2 pts. 16+ = 1 No = 0
10. Did your bedroom door have a lock on it that could be used?
 Yes (5 pts.) _____ No (0 pts.) _____
11. Did the bathroom door have a lock on it that could be used?
 Yes (5 pts.) _____ No (0 pts.) _____

12. Did your family believe in letting children lock doors?

Yes (5 pts.) _____ No (0 pts.) _____

If so, what doors? _____

13a. Did your parents usually knock on your bedroom door before entering?

Yes (5 pts.) _____ No (0 pts.) _____

13b. From what period did they begin to knock?

Elementary School (5 pts.) _____ Jr. High School (3 pts.) _____
High School (1 pt.) _____ Never (0 pts.) _____

14. In which room did you usually do your homework?

Kitchen (0 pts.) _____ Dining Room (0 pts.) _____
Living Room (0 pts.) _____ Den (0 pts.) _____
Bedroom (5 pts.) _____ Other (Specify) _____

15. Your parents made sure to have a babysitter or older sibling at home with you until you were approximately

Age _____ 0-5 = 5 pts. 6-8 = 4 pts. 9-10 = 3 pts.
11-12 = 2 pts. 13-14 = 1 pt. 15-16 = 0 pts.

16a. Did you attend a day camp as a child?

Yes _____ No _____

16b. At what age(s) (Check all that apply)?

4 or under (5 pts.) _____ 5-7 (4 pts.) _____
8-9 (3 pts.) _____ 10-12 (2 pts.) _____
13 or older (1 pt.) _____ Never (0 pts.) _____

17a. Did you attend an overnight camp as a child?

Yes _____ No _____

17b. At what age(s) (Check all that apply)?

4 or under (5 pts.) _____ 5-7 (4 pts.) _____
8-9 (3 pts.) _____ 10-12 (2 pts.) _____
13 or older (1 pt.) _____ Never (0 pts.) _____

18a. Until junior high school, how did you most often get to school and back?

Foot or bicycle (5 pts.) _____ Car (0 pts.) _____
Bus (0 pts.) _____ Other (Specify) _____

18b. How far was it from your home to school? _____

19a. Did you own a bicycle?

Yes _____ No _____

19b. Approximately how old were you when you received it?

5-7 (4 pts.) _____ 8-9 (3 pts.) _____ 10-12 (2 pts.) _____
13 or older (1 pt.) _____

20. At what age did you receive your driver's license?

14 or younger (5 pts.) _____ 15-16 (4 pts.) _____
17 (4 pts.) _____ 18-19 (3 pts.) _____ 20-21 (2 pts.) _____
22-25 (1 pt.) _____ Over 25 (1 pt.) _____
Never (0 pts.) _____

21. Did your parents usually request that you call upon arrival to a relatively distant destination to let them know you have arrived safely?

Yes (0 pts.) _____ No (5 pts.) _____

22a. At what age were you allowed to go downtown alone:

7 or younger (5 pts.) _____ 8-10 (4 pts.) _____
11-14 (3 pts.) _____ 15-18 (2 pts.) _____
Over 18 (0 pts.) _____

22b. At that age, you were permitted to go alone:

Very frequently (5 pts.) _____ Frequently (4 pts.) _____
Sometimes (3 pts.) _____ Occasionally (2 pts.) _____
Very infrequently (1 pt.) _____

23a. When you went out with friends at night, one or both of your parents would wait up until you got home:

All the time (0 pts.) _____ Most of the time (1 pt.) _____
Sometimes (2 pts.) _____ Rarely (3 pts.) _____
Never (4 pts.) _____

23b. Approximately how old were you when they stopped waiting up?

14 or younger (5 pts.) _____ 15-16 (4 pts.) _____
17-19 (3 pts.) _____ 20-21 (2 pts.) _____ 22-25 (1 pt.) _____
Over 25 (0 pts.) _____ Never (0 pts.) _____

24. (For women only): More restrictions were placed on you about going out than on your brother(s):

Yes (0 pts.) _____ No (5 pts.) _____
Not applicable (2.5 pts.) _____

25a. At what age did you begin to feel you had opportunities for privacy in your household?

7 or younger (4 pts.) _____ 8-10 (3 pts.) _____
 11-15 (2 pts.) _____ 16 or older (1 pt.) _____
 Never (0 pts.) _____

25b. Where did you go when you wanted some privacy? _____

26. The neighborhood in which you grew up is best described as:

Rural _____ Suburban _____ Urban _____

27a. Were you ever so afraid of going to school for reasons you couldn't explain that you didn't go?

Yes (5 pts.) _____ No (0 pts.) _____

27b. How often did this happen?

1-5 times (1 pt.) _____ 6-10 times (2 pts.) _____
 10-20 times (3 pts.) _____ More than 20 times (4 pts.) _____

Part III: Current Environmental Experience

28. Within the last year you have traveled alone to a destination 50 miles away or more:

1-2 times (1 pt.) _____ 3-4 times (2 pts.) _____
 5-9 times (3 pts.) _____ 10-19 times (4 pts.) _____
 20 or more times (5 pts.) _____ Never (0 pts.) _____

29. You travel alone at night to socialize, shop, take courses, etc.

Never (0 pts.) _____ Rarely (1 pt.) _____
 Sometimes (2 pts.) _____ Frequently (3 pts.) _____
 Very frequently (4 pts.) _____

30. Within the last year, you have eaten alone in a restaurant:

Never (0 pts.) _____ 1-2 times (1 pt.) _____
 3-5 times (2 pts.) _____ 5-10 times (3 pts.) _____
 10-20 times (4 pts.) _____ More than 20 times (5 pts.) _____

31. Your sense of direction is:

Very limited (0 pts.) _____ Somewhat limited (1 pt.) _____
 Average (2 pts.) _____ Better than average (3 pts.) _____
 Excellent (4 pts.) _____

32. When reading maps and/or blueprints, you have trouble:

Always (0 pts.) _____ Usually (1 pt.) _____
 Sometimes (2 pts.) _____ Occasionally (3 pts.) _____
 Never (4 pts.) _____

33. You would prefer a job that:

Did (5 pts.) _____ Did not (0 pts.) _____ involve traveling
 on business several times a year (assuming that caring for
 your children was not a factor).

34a. On the last two weekdays, approximately how much of your free
 waking time was spent at home?

Less than 10% (5 pts.) _____ 10-20% (4 pts.) _____
 21-40% (3 pts.) _____ 41-60% (2 pts.) _____
 61-80% (1 pt.) _____ 81-100% (0 pts.) _____

34b. On the last weekend, approximately how much of your free
 waking time was spent at home?

Less than 10% (5 pts.) _____ 10-20% (4 pts.) _____
 21-40% (3 pts.) _____ 41-60% (2 pts.) _____
 61-80% (1 pt.) _____ 81-100% (0 pts.) _____

35. When feeling disturbed or unhappy while you are at home, you
 are most likely to:

a. Stay home: Always (5 pts.) _____ Sometimes (2.5 pts.) _____
 Never (0 pts.) _____
 b. Go elsewhere: Always (5 pts.) _____
 Sometimes (2.5 pts.) _____
 Never (0 pts.) _____
 Specify where, if possible _____

36a. What do you like most about your home?

36a. Least?

37a. What do you like most about your neighborhood?

37b. Least?

38. How do you spend your leisure time (e.g., collections,
 crafts, sports, etc. -- Specify what kind)?

39. List the place(s) that you like to go when you are alone and have free time (Choose all that apply):

Stay home (5 pts.) _____
 Visit friends (2.5 pts.) _____
 Go out in the country (0 pts.) _____
 Go to a city (0 pts.) _____
 Go to a shopping center (0 pts.) _____
 Go to an entertainment place (0 pts.) _____
 Other (Specify) _____

40. Have you ever had an anxiety or panic attack that appeared to be triggered by being in the following situation(s)? Check all that apply:

Crowd _____ Restaurant, theater, store, or shopping mall _____
 Bridge _____ Standing in line _____ Stuck in traffic _____
 Elevator _____ Open Space _____ None (0 pts.) _____
 Other (specify) _____

41. If you answered yes to any of the above in the previous question, how often has it happened:

Once (1 pt.) _____ 2-4 times (2 pts.) _____
 5-10 times (3 pts.) _____ More than 10 times (4 pts.) _____

- 42a. Have there been times in your life when you felt unable to leave your home:

Yes (5 pts.) _____ No (0 pts.) _____

- 42b. How often:

Once (1 pt.) _____ 2-4 times (2 pts.) _____
 5-10 times (3 pts.) _____ More than 10 times (4 pts.) _____

- 42c. What held you back?

- 42d. Can you describe the circumstances under which this first happened to you?

- 42e. What did you do when this happened?

APPENDIX B

BSI by Leonard R. Derogatis, Ph.D.

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APPENDIX C

BEM INVENTORY

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