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Agoraphobia: A Critical Review of the Concept

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SUMMARY Phobic avoidance has been widely accepted as the central feature of the agoraphobic syndrome, and the presence of agoraphobia has been used to define groups of subjects for clinical research. A review of the evidence suggests that agoraphobia should not be classified with the phobias; several lines of inquiry point to the conclusion that it is a variable feature of patients suffering from anxiety neurosis. Implications for research and problems with the present classification of neurotic affective disorders are noted.

Introduction

The labels applied to clinical phenomena have a profound effect on methods applied to their investigation and treatment, and agoraphobia is no exception. Snaith (1968) reflects on what might have been the consequences of adopting Benedikt's new syndrome of *Platzschwindel* (dizziness in public places) rather than Westphal's description of *agoraphobie* as the '. . . impossibility of walking through certain streets or squares or possibility of doing so only with resultant dread or anxiety'. Since these descriptions were first made, psychiatric opinion has been divided on the question of the relative importance of the phobic or anxiety components. Following Marks' (1969) comprehensive review of the literature, the consensus seems to have fixated its interest on the phobic aspects. Marks (1970a) chose the label agoraphobia because '. . . the commonest and most constricting elements of this condition are fears of going out into public places of various kinds'. Although he describes agoraphobia as 'a coherent clinical syndrome with a well defined cluster of features', it is at the same time a condition which merges 'imperceptibly with anxiety states, affective disorders and even obsessive neuroses' (Marks, 1970b). If this is so, it is premature to cite evidence that patients with agoraphobia differ from patients who have an anxiety neurosis until reliable diagnostic criteria are established. This article will question the notions that (a) agoraphobia (a fear of leaving the home and going into public places) is a phobia, where the term phobia is used in the sense of fear attached to a discrete set of cues; (b) that the agoraphobic syndrome can be clearly differentiated from states of generalized anxiety.

Agoraphobia: a phobia?

The cardinal feature of the agoraphobic syndrome can be described *either* as staying-at-home behaviour *or* as avoidance of venturing out. The latter is consistent with the idea of agoraphobia as fear of discrete cues such as streets, shops and crowds, whereas the former view implies that fear or anxiety arises in the absence of familiarity and safety. A third mediational view emphasizes a fear of internal cues, which are more likely to arise outside the home. These internal cues include somatic sensations which give rise to fears of fainting, death, loss of control, etc. The mediational view leaves open the question whether the feared sensations arise in response to discrete features of the public environment or whether they are triggered in the absence of familiarity and safety.

The cluster of fears which have been called the agoraphobic syndrome have been identified by numerous analyses (principal components and factor analysis) of self-reported fears and

psychiatric ratings of fear obtained from groups of patients with affective disorders or miscellaneous phobic conditions (Roth, Garside and Gurney, 1965; Marks, 1970a; Fleiss, Gurland and Cooper, 1971; Hallam and Hafner, 1978). In some cases the cluster emerges as a set of loadings on a bipolar dimension (Dixon, De Monchaux and Sandler, 1957; Schapira, Kerr and Roth, 1970). The cluster of fears analysed by different authors are sufficiently similar to refer loosely to a 'characteristic syndrome', defined by fear of travel by public transport, shopping, open spaces, crowded and confined public places and, with less consistency, some other phobias such as a fear of being alone. Questionnaire items measuring panic attacks, dizziness, depersonalization and somatic anxiety are also found to be moderately correlated with the phobic symptoms in different studies. Many of the fears included in the syndrome cannot be expressed unless the person who suffers from them leaves the home. The fact that they are interrelated in this way seems to have tempted some writers to elevate the label 'agoraphobia' into a unifying construct of a specific fear of leaving the home.

The notion of agoraphobia as yet another phobia would be supported by a demonstration of its existence in the general population. Less than 1 per cent of a random sample of the population of Greater Burlington, Vermont, were found to have a degree of agoraphobia that would satisfy a psychiatric definition of phobia, (Agras, Sylvester and Oliveau, 1969). Agoraphobia was not mentioned as one of many common fears, but 7.4 per cent of the population feared journeying alone. Schapira *et al* (1970) report an incidence of 14.4 per cent of 'mild to moderate' agoraphobia in a control group of non-psychiatric hospital patients. The wide variation in these figures may reflect the difficulty of identifying a mild form of a syndrome which is defined by a cluster of clinical features rather than a discrete phobic entity. Roth (1959) describes the clinical picture, not as a graded affective response, but as a phenomenon that has 'all-or-none' characteristics. This observation is supported by the factor analyses conducted by Hallam *et al* (1978) on fear survey data provided by a group of miscellaneous specific and social phobias and a separate group of agoraphobics. When data from the two groups were combined one of the factors could be identified as the agoraphobic syndrome, but a similar analysis performed on the data of the specific and social phobics alone did not replicate this factor, suggesting that agoraphobia is not common in a mild form.

Hersen's (1973) review of factor analytic studies of fear-survey schedules does not mention the agoraphobic cluster of fears, which if occurring in a mild form might have been expected to emerge as a common factor. Meikle and Mitchell (1974) obtained their fear survey data from volunteers who responded to a local radio and TV appeal for people who suffered from specific fears. Only the first three factors in their factor analysis accounted for more than 5 per cent of the variance. Of the remaining 18 clusters, fears of public transport, heights, enclosed places, open spaces, being alone and losing control, all loaded on separate factors, many of which were defined by just a few items and were not accorded the status of true factors.

The agoraphobic syndrome is equally elusive in samples of psychiatric patients with miscellaneous diagnoses. The syndrome appears to fragment out into several different dimensions none of which can be unequivocally labelled as agoraphobia. Fears of travel by public transport and a fear of open spaces formed separate factors in the studies of Rothstein, Holmes and Boblett (1972), and Bates (1971). They accounted for between 1.75 and 6.0 per cent of the variance. Claustrophobia clustered with public transport in one study and open spaces in the other. Lawlis (1971) obtained three factors accounting for 90 per cent of the variance in a factor analysis of fear survey data from a mixed psychiatric sample. A cluster of 'agoraphobic fears' was not identified.

As already mentioned the symptoms of the agoraphobic syndrome emerge as a correlated cluster in principal components and factor analyses of data from clinical populations with known affective disorders or phobic anxieties. These are populations in which, according to Roth's all-or-none hypothesis, the syndrome probably occurs full-blown in a significant

proportion of the sample. It can be amply demonstrated that psychiatric patients who are classified as agoraphobic can be distinguished on a variety of parameters from patients with specific phobias (Marks, 1970a; Hallam *et al* 1978). However, the ways in which agoraphobics differ from patients with other affective disorders has not been closely examined.

Agoraphobia: an anxiety state?

Given that the classification of neurotic affective disorders is itself in disarray, any suggestion to throw the agoraphobic syndrome back into the melting pot is unlikely to be welcomed, especially as the diagnosis has some implications for treatment. The classification of affective neuroses has proceeded on the basis of grouping together a rather heterogeneous collection of feeling states, mental states and somatic symptoms whose original inclusion for study probably reflected prevailing theories of emotion and medical tradition. Recent theories of emotion have moved away from viewing emotions as distinct clusters of somatic responses and mental states and have stressed the undifferentiated nature of physiological arousal to emotional instigators and also the importance of subtle cognitive and perceptual factors in the determination of experiential reports. Therefore, in the task of classifying affective neuroses we may expect a more fruitful return from studying the way in which patients actively construct the world and strive to act towards it, rather than focus on static mental contents.

The traditional approach has encountered difficulty in its attempts to create distinct diagnoses out of the most prominent of the basic affects. For example, the neurotic affective disorders do not fall neatly into states of anxiety and depression (Derogaitis, Klerman and Lipman, 1972); and Roth, Gurney and Garside (1972) state that the diagnosis is usually made on the basis of the *predominance* of severe anxiety or depression rather than the *presence* of one type of affect or the other. The evidence suggests that phobic avoidance ought to play a part in distinguishing these two affective disorders, but it does not give reason to believe that the problems of classification would be clarified by treating agoraphobia as a separate syndrome. In a discriminant function analysis the presence of panic attacks and agoraphobia was predictive of a diagnosis of anxiety state (Gurney, Roth, Garside, Kerr, and Schapira, 1972). Mild agoraphobia was common to both anxiety states and depression, (Roth *et al*, 1972). Fleiss, Gurland and Cooper (1971) obtained separate factors of depression and phobic anxiety (but not general anxiety) from an analysis of interview ratings of unselected psychiatric in-patients. Agoraphobic fears, such as going out alone and being in crowds, loaded on the phobic anxiety factor. Patients diagnosed as anxiety neurotics had higher factor scores than depressives on this dimension, but depression scores were equal for the two diagnostic groups. Taken together, these studies show that the symptoms distinguishing anxiety neurotics from depressive neurotics certainly do not distinguish them from agoraphobics. This should not be taken to imply that anxiety neurosis is itself a unitary syndrome, but merely that the selection of one symptom (avoidance of leaving the home unaccompanied) to characterize a phobic syndrome seems unwarranted.

In their review of anxiety states (anxiety neurosis), Marks and Lader (1973) distinguish a state of clinical anxiety from normal fear or phobia on the basis that it exists independently of specific external situations and the fact that its source is unrecognized by the patient. These criteria are not strictly applied because fears of internal stimuli, such as a fear that the heart will stop, are recognized as common features. Phobic avoidance is also common, and when it is marked '. . . the clinical features become indistinguishable from severe agoraphobia'. The presence of phobic avoidance in patients diagnosed as anxiety neurotics has been reported by Woodruff, Guze and Clayton (1972), who found that 10 per cent of their series were dominated by phobic avoidance and 53 per cent had fears which were less disruptive of the patient's life.

Complementing the high frequency of avoidance in anxiety neurotics is the observation that on close examination specific sources for anxiety can be found. Beck, Laude and Bohnert (1974) claimed to observe that *all* the patients with neurotic anxiety in their series had

cognitions of danger just prior to or during the onset of an exacerbation of anxiety. Most of the patients reported clear-cut precipitating events for the onset of their anxiety symptoms, and certain stimuli, internal and external, subsequently tended to trigger or aggravate their anxiety. The most common danger themes centred on dying or social rejection, and the particular content of their thoughts and images was meaningfully related to actual historical events. The danger was generally assessed by the patient as plausible rather than irrational.

Although specific fears may be elicited, the anxiety neurotic, according to Beck, is unable to avoid or circumvent his fears. Phobics, on the other hand, are said to avoid specific objects or situations and experience anxiety in their proximity. It is difficult to classify the agoraphobic syndrome according to this criterion. Avoidance of leaving the home by no means guarantees freedom from anxiety—agoraphobics frequently experience panic attacks in the home, especially when they are alone. Conversely, they often have 'good days' when they are free from anxiety in the street. This paradox can be resolved by assuming that the major sources of anxiety in the agoraphobic are not, in fact, to be found *in* the public environment but that the cues associated with public places (crowds, busy noisy streets, unfamiliar surroundings, waiting in queues, etc.) which are normally physiologically (and sometimes emotionally) arousing, can exacerbate other sources of anxiety and produce panic attacks. A further, and by no means novel, proposal is that places of safety and other forms of reassurance alleviate anxiety. Thus, the common observation that anxiety increases with distance from the home need not be interpreted as related to a unitary dimension of some external stimulus; rather it can be seen as a direct consequence of distance from a point of safety. It seems unreasonable to suppose that if agoraphobia was linked to discrete features of the public environment it could be so easily overridden by the simple expedient of travelling in a car or taking along a travelling companion. Of the multiple sources of anxiety in the agoraphobic alluded to earlier, fears of illness and death are probably the most prominent (Hallam *et al*, 1978). A comparison between agoraphobics and normal volunteers revealed that fears about fatal illness and general bodily ill-health which extended *beyond* the phobic situation were found in over 50 per cent of the agoraphobics (Buglass, Clarke, Henderson, Kreitman and Presley, 1977). In stark contrast was the observation that actual physical illness was equally represented in the two groups. This research, and a similar study comparing agoraphobics with volunteers (Solyom, Beck, Solyom and Hugel, 1974), indicate that agoraphobics are conspicuous by their high level of neurotic symptoms of all kinds. Nearly one-third of the patients in the Buglass study were said to have a neurosis before they developed agoraphobia.

The evidence reviewed above points to the conclusion that agoraphobia is not a central, core feature of a phobic syndrome, but a variable feature of patients with neurotic anxieties, Moreover, it is important to clarify the relationship between the agoraphobic syndrome and anxiety neurosis because agoraphobics are being widely investigated and treated as a distinct clinical group. The generality of the results of this research is called into question by diagnostic vagueness, and the emphasis on 'phobic avoidance' (inability to travel freely) may have unduly pointed treatment research in one direction, as seems to be true of most behavioural techniques which have been developed for this disorder.

Conclusion

A reluctance or refusal to leave the home or other place of security is an unmistakeable behaviour. Labelling this behaviour as phobic avoidance has given the misleading impression that the syndrome of which this behaviour is a part has an underlying unity and coherence based on a fear of public places. In fact, insufficient attention has been paid to differentiating this syndrome from anxiety neurosis in general. Agoraphobics have been investigated as a clinically distinct diagnostic group, compared with normal controls, and surveyed nationally (e.g. Marks and Herst, 1970). The information yielded by this research is necessarily limited if agoraphobia is not a central, core feature of a phobic syndrome, but a variable feature of

patients whose neurotic anxieties have a multitude of different sources.

Agoraphobics have also been singled out as a group for treatment by standardized behaviour modification techniques, especially imaginal flooding and exposure *in vivo*. These techniques have been remarkably successful, given their limited aims of eliminating phobic avoidance. Nevertheless, this approach has its limitations, and patients are left with '. . . mild to moderate residual difficulties' (Mathews, 1977). In a one-year follow-up of agoraphobics treated by group exposure *in vivo*, only one-third were unequivocally improved on phobic target ratings and other symptoms (Hafner, 1976). Patients assigned to the poorest outcome group did show lessening of phobic avoidance, but general neurotic symptoms, other fears and dissatisfaction with spouse all increased.

It is hoped that a fresh approach to classifying the neurotic affective disorders will throw more light on their aetiology and treatment. Two avenues suggest themselves. The first would examine coping strategies in greater detail in order to produce a typology which might include 'staying at home' behaviour as one example. Woodruff *et al* (1972) found that 25 per cent of their sample of anxiety neurotics were heavy drinkers and 15 per cent were alcoholics. Alcoholic sedation may therefore represent an alternative strategy which in this series was more common in the males. The second approach might follow Beck's attempt to identify ideational antecedents of dysphoric moods (e.g. Beck, 1974). At a broader level, Mandler has provided us with a general cognitive theory of emotion which has implications for the aetiology of extreme (or abnormal) emotional states (Mandler, 1975, p. 224). It is unlikely that the clustering of observable symptoms and easily-reported mental states will further the classification of neurotic affective disorders.

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