Agoraphobia: Multiform Behavioral Treatment

S. Fishman
New York: BMA Audio Cassette Publications, 1980
Four cassettes with Client Manual, $42.00

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Agoraphobia is a complex and many-faceted syndrome that has presented a strong therapeutic challenge to clinicians of various theoretical orientations. Often misdefined as "fear of open spaces," agoraphobia is in fact a cluster of problems centering on fear of the fear reaction itself. Common foci for concern in agoraphobia are (1) fear of traveling away from home or safety; (2) fear of crowded, public places; (3) fear of confinement, or of feeling trapped (for example, as involved in using an elevator, or even in making a commitment of some kind); and (4) fear of the panic reaction that may be experienced in any of these situations (Marks, 1970). It has been suggested that agoraphobics tend to be passive, dependent individuals who lack a sense of personal resourcefulness or effectiveness; that they tend also to have difficulties in identifying and classifying their emotional reactions, often making errors of attribution (regarding anxiety, for example, as emanating from current surroundings rather than from a recent painful conversation with a significant other person); and that their phobic problems develop in a climate of conflict, often interpersonal (Goldstein & Chambless, 1978). Other writers alert therapists to the likelihood that the agoraphobic client will need additional treatment for depression, unassertiveness, and marital maladjustment (for a review, see Thorpe, et al., in press). A controversial issue discussed recently by Hafner (1976) and others surrounds the agoraphobic's marriage: resolution of the specific phobic complaints may lead to the emergence of marital crises, or even to "fresh symptom emergence." Whereas there is evidence of a reciprocity between agoraphobia and overt marital conflict in some cases (Hand & Lamontagne, 1976), other writers fail to find such effects even in clients followed-up for four years or more (Emmelkamp & Kuipers, 1979).

Treatments based on direct exposure to feared situations have fared best in the many excellent prospective clinical trials conducted by behavior therapy researchers (e.g., Mathews, 1977); imaginal systematic desensitization, a justifiable favorite for simpler phobias, has proved generally disappointing for agoraphobia, and the newer cognitive-

behavioral techniques have yet to prove themselves in this area. Direct exposure methods range from prolonged confrontation of highly-feared situations (*in vivo* flooding) to graded practice, or "successive approximation," in which clients attempt exploits toward phobic surroundings but ensure that they expose themselves only to minimal anxiety in the process.

In the light of all this, our first reaction to the sight of Fishman's cassettes (in their splendid plastic folder) was anxious anticipation: even granted the important caveat that the tapes are to be used under the supervision of a therapist, is it possible for a client to overcome such convoluted and broad-ranging difficulties by listening to a pre-recorded narrator and by self-administering the various procedures described? *Agoraphobia: Multiform Behavioral Treatment* consists of four cassette tapes (one for the practitioner, three for the use of the client) and a "Client Self-Instruction Manual" (including charts for recording progress).

Tape T-274 ("Clinician's Guide") contains the introduction and theoretical orientation for the practitioner. The presentation is far from being disappointing. Fishman describes agoraphobia as a fear of fear, of one's own internal reactions, when away from a place of safety (usually home, or the company of a trusted companion). Because agoraphobia is a "portable" phobia, not a fear of specific external situations, treatment centers on these internal reactions rather than on the client's physical surroundings, as in "traditional behavior therapy" (contemporary behavior therapists may well object to this over-simple characterization; Fishman does not refer to recent theoretical work by Goldstein and Chambless and by Marks that has anticipated his argument). The agoraphobic is described as complaining of a variety of somatic-sounding symptoms, the chief of which is "light-headedness," and in the text-book case she (women are in the majority in self-referred samples) is interpersonally deficient, passive-dependent in social posture, non-assertive, and finds it difficult to express emotion. The sufferer fears abandonment and loss of control, which represent conflicts between dependency and independence; she usually feels trapped in a predicament: an unsatisfying job, for example, or a stale marriage, that cannot easily be escaped.

Because the agoraphobic finds it difficult to recognize or express emotions, the unpleasant sensations deriving from seething, unexpressed hostility become attached to outside surroundings symbolic of the conflict: confining surroundings such as elevators, crowded buses, and so forth. The occasional stirrings of an attitude of independence serve only to bring the conflict to the fore anew. As a result of all this, the agoraphobic wallows in a self-defeating rut: the conflict over dependence *versus* independence is not fully recognized, and consequently its off-

shoots—unpleasant physical sensations—may be experienced in surroundings reminiscent of the conflict. Henceforth, contemplating exploits into such surroundings creates anticipatory anxiety, which provides the motivation for their avoidance. This in turn allows the sufferer to dwell on her inadequacy and irrational fearfulness, leading to depression. Attempts to rise above all of this and actively confront the problem situations are likely to fail, because the agoraphobic is by now so sensitive to signals of impending panic that she practically creates them at the drop of a hat. A further cycle of self-denigration and discouragement ensues.

Treatment, therefore, is broadranging and "multiform." The three main foci are (1) avoidance of public places, (2) general insecurity and lack of self-sufficiency, and (3) depression. Neglect of any of these areas guarantees incomplete, and therefore ineffective, treatment. Treatment techniques for the phobic avoidance include relaxation training (based on sensory awareness and cognitive distraction), externalization training (re-attributing alarming sensations to benign sources), a composite of self-instructional techniques to combat anticipatory anxiety, and a form of self-directed systematic desensitization. A novel contribution by Fishman is the addition of "simulated anxiety attacks" by means of vigorous physical exercise, to replicate shortness of breath, quickened heart rate, and so forth. Finally, graded practice (*in vivo* desensitization) in the form of accompanied exploits into feared surroundings is an essential component of treatment.

The client's dependent and passive social posture is addressed by means of independence training (assuming more responsibilities in general), assertiveness training, cognitive restructuring, support (not to be overdone) by the therapist, and bibliotherapy (popular books on assertiveness, for example). Depression may be treated medicinally by a psychiatrist ("psychopharmacologist") if it has reached severe proportions. Fishman concludes this section with some clinical tips: anticipating setbacks by discussing their inevitability beforehand, encouraging progress by urging repeated, graduated real-life practice, and reassuring the client by calling attention to legitimate grounds for occasional discomfort.

Consistent with research literature, Fishman stresses practice *in vivo* as the cornerstone of successful treatment, and vigorously attacks the passivity and social dependence that characterize many agoraphobics and seem part and parcel of the syndrome. Finally, he takes pains to stress the need for a therapist to oversee the course of treatment, using the three tapes for client use as an adjunct. This caveat is important. Some agoraphobics find their progress subtly—and sometimes not so subtly—resisted by an apparently well-meaning spouse, and, also chal-

lenging; an acute marital crisis may follow successful treatment. Without the continued availability of a therapist, the client could become embroiled—unassisted—in a problem potentially more challenging than the agoraphobia: confrontation with the full force of the very conflict that, on Fishman's theory, the client partly resolved by developing agoraphobia in the first place! It is important not to overstate what is only a possibility—research findings on this issue are hardly unequivocal (see Emmelkamp, 1980), but the general caveat that a therapist at least needs to be waiting in the wings is well-taken.

The first tape for client use (Understanding Agoraphobia and its Treatment) presents a straightforward and clear account of the disorder, stressing an optimism for the treatment procedures and the need for hard, dedicated work on the part of the client. A client seen by one of us recently said it described her to perfection, and she was relieved to discover that her problems were so well understood by professionals and that many other clients described the same pattern of problems. The sensory awareness relaxation technique (prepared in consultation with G.C. Davison), presented in the second of the tapes for client use, departs from the usual procedure in which different muscle groups are tensed and relaxed in a structured progression. The client progresses through a random sequence of muscle groups and other parts of the anatomy, focusing on internal and external stimuli, and covering various perceptual modalities. Rather than being asked to to anything specific in order to relax, the client is invited to contemplate a succession of evocative images, such as noticing the sensations in a point behind the eyes, and so on. The client mentioned above found this technique highly effective in inducing deep relaxation. The final tape (Home Exercise Instructions...) is clear and practical, emphasizing graduated exposure in real life and the use of various coping strategies.

Fishman offers an impressively multifaceted treatment program that reflects the latest theoretical and clinical developments. There is, however, a lack of experimental emphasis for the clinician: references are not provided in the pamphlet accompanying the tapes, and very few citations are made in the narrative. The effectiveness of this treatment kit itself has not, apparently, been researched by pilot testing on clinical groups; it could well be that the twelve treatment approaches that can be identified here are extremely effective, but the multiform approach makes it almost impossible to evaluate the effectiveness of the individual techniques. For example, we have to take Fishman's word for it that "externalization training" is a useful component.

Although the general issue of the link between agoraphobia and interpersonal problems in some clients is alluded to in the client tapes, Fishman does not prepare the client specifically for potential problems

that could arise after successful treatment; it would seem that overcoming agoraphobia could pose new challenges for adjustment in any client, however well he or she is functioning generally.

A general caveat about self-help tapes is that they cannot be responsive to idiosyncratic client reactions. In usual clinical practice, therapists can control the pace and content of treatment to meet individual needs, and are available to deal with unanticipated difficulties (for example, some clients experience alarming emotional reactions during relaxation training). Fishman does stress the need for the client to remain under the supervision of a therapist; it is particularly important to alert therapists to the need for them to continue to take an active role throughout treatment of agoraphobia. These tapes are, by and large, clear, practical, and well-presented, and they are likely to be an extremely valuable aid to the therapist. While these tapes will not do all the work for the clinician, they can be cautiously recommended as an adjunct to therapy. Mathews and associates (1977) find excellent results from home-based treatment with the use of a detailed client manual; but, until Fishman's series of self-help tapes has been clinically tested, the question of the effectiveness of this package remains.

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