Contemporary Themes

A Practical Treatment of Agoraphobia

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Introduction

Agoraphobia—the condition in which a patient suffers incapacitating anxiety in public places or anywhere outside his own home—is a common syndrome affecting thousands of people in Britain. Optimism in treating it is contrary to much current opinion. However, after many years of practice with a special interest in the anxiety state of which agoraphobia has often been a major symptom, and especially after the results of my last 10 years' experience concerned almost exclusively with treating agoraphobic people, an optimistic approach is in my opinion justified.

A brief outline is offered here of my method of treating agoraphobia. The special difficulty of treating the disorder is that inability to travel to the doctor's surgery is often so much part of the agoraphobic's illness that he may rarely, perhaps never, succeed in making the journey. In these circumstances, offering a satisfactory programme of treatment and in addition giving the frequent encouragement and reassurance the agoraphobic patient needs present special difficulties; while to treat a patient adequately at home is surely asking too much from a busy practitioner.

The treatment described here overcomes these difficulties. It does not require the personal presence of the doctor. It is available when needed (which may be many times during one day) either at home, or away from home when the patient's agoraphobic fears are at their worst. In addition, the cost is negligible.

Treatment is in the form of two books,^{1,2} two long playing (L.P.) recordings,³ quarterly magazines sent to 1,800 agoraphobic men and women in Great Britain and Ireland during the four years 1969-72, and a cassette⁴ for a small portable tape-recorder. This remote "control" (perhaps "direction" would be a more accurate word) has made it possible to treat people living not only in distant parts of Great Britain but also in other countries.

The books are available in most libraries, the L.P. recordings and cassette are in the library of the British Medical Association, and the quarterly magazines (1969-72) have recently been published in book form.⁵ In psychiatric clinics in Great Britain where the recordings are used patients are encouraged to bring their tape recorders and make copies, and no objections are raised. The condition is explained to the patients in the following way.

Explanation to Patients

Understanding by the patient of the cause of agoraphobia is essential for successful treatment, and the key lies in un-

derstanding the state in which the nervous reaction to stress is unusually intense and swift. This I term "sensitization," and I explain that when mildly sensitized nerves feel on edge and little things upset too much, too easily. Severe sensitization can be more disturbing, even alarming. An ordinary spasm of fear may be felt as an "electrifying" flash of panic, which may come in response to no more than the shock of a slamming door, or more bewildering still for no apparent reason other than thinking of it. A slightly quickly beating heart may feel like an acute attack of palpitations, irregular beats like a sudden descent in a lift, a mild attack of faintness like impending death, and so on. Such intense responses so impress the sufferer he thinks they must be unique to him. He rarely recognizes them as part of the usual pattern of stress exaggerated.

Sudden severe sensitization can follow the shock of physical stress, such as a severe haemorrhage, a difficult confinement, or a surgical operation. Gradual sensitization may accompany continuous domestic stress or debilitating illness—anything that puts a patient under stress for a long time.

I also explain to patients that where a special problem has started the illness and helps to keep a person sensitized, understanding sensitization and knowing how to cope with it is itself a step toward recovery because the sufferer may become as much concerned with the state he is in as with the original problem. Sensitization resolves naturally if not kept alive by bewilderment and fear. Bewilderment acts by placing a sensitized person constantly under the strain of asking himself why he is like this, why he cannot be his old self, and what could happen next. The more he struggles to be the person he was, the more exasperation and tension he adds and so the more stress. While in his bewilderment he feels he cannot adequately direct his thoughts and feelings, he stands vulnerable to fear, which seems to overwhelm him before he has time to reason with it.

Sensitization, bewilderment, and fear are three reactions which lead to an anxiety state of which agoraphobia, when present, is the most crippling symptom. Often the first attack of the disorder in a man or woman takes the form of panic or palpitations or severe giddiness or a feeling of weakness or collapse while out of doors. Such an attack probably follows any of a variety of stresses. If a woman (almost 90% of agoraphobic patients are women) has had a frightening attack of palpitations or a weak "turn" or panic while away from home and yet one day manages, in spite of this, to walk as far as the supermarket, how natural when immobilized in a long queue at the check-out to be suddenly smitten with the fear of having one of her spells. The panic and mounting tension that follow may so stiffen her muscles that she may feel unable to move and may cling desperately to the nearest support.

After a few such attacks, she either avoids supermarkets—or any place where she feels restricted by a crowd—tries to take someone to shop with her, or becomes finally housebound when she discovers that "paralysis" may strike anywhere away from the house. When patients understand severe

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sensitization, what may have seemed incredible behaviour becomes a more understandable human reaction.

Practical Approach

Some therapists search for a deep-seated cause for agoraphobia believing that unless this is found and treated the illness cannot be cured. In my experience, while finding an original cause for sensitization has been intellectually interesting it has rarely been essential for cure. Agoraphobia persists because the habit of fear—and, because of this, sensitization—remains. This must be cured. The sensitized person has become afraid of so much. He sits near the door in a restaurant, at the back of the hall at a meeting, always leaving a way open for quick escape should, as he thinks may occur, his fear grow beyond him.

After relieving a patient's bewilderment by adequate explanation of his illness, I follow with a programme of treatment based on the four principles of facing, accepting, "floating," and letting time pass. Many people sink deeper into their illness by doing the opposite. The nervously ill person notices each symptom with alarm and withdraws from it, afraid to examine it too closely for fear of making it worse. He may agitatedly seek occupation to try to force forgetfulness. This is running away, not facing. He may try to cope by tensing himself against unwelcome sensations trying to "get the better of them." This is fighting, not accepting. "Floating" implies going along with the feelings without resistance, as if floating on the sea, submitting to the undulation of the waves. The thought of floating lessens tension that may inhibit action. Letting time pass is an important concept since so many patients worry because much time has passed and they are still ill. They are impatient with time, and this impatience increases tension and anxiety.

Coping with Panic

To help the patient cope with panic I explain that when he panics he feels not one fear, as he supposes, but two separate fears—a first and second fear. First-fear comes to any of us in response to danger. It is normal in intensity and passes with the danger. However, the "electric" flash of first-fear the sensitized person feels is so out of proportion to the danger causing it, he recoils and as he does so he adds a second flash—fear of the first fear. He may be more concerned with the feeling of panic than with the original danger. And because sensitization prolongs the first flash, the second flash may join it and the two fears seem as one. Though he may have no control over the first fear, and this is often true, with practice he can learn how to control the second fear—and it is the second fear that is helping to keep the first fear alive and keeping him sensitized and ill.

The agoraphobic person hemmed in at the school meeting has only to feel trapped to experience first-fear and then to immediately follow with second fear and an urge to escape from the building. As the panic grows he feels his mind goes numb and is sure "something terrible" will happen. He does not understand that it is the second-fear he adds himself that may finally drive him to seek refuge outside.

To cope while inside the hall he should practise seeing panic through with as much acceptance as he can muster (usually aided by sedation in the early stages of treatment). It is important for him to appreciate that his body has a limited capacity to produce panic, so that panic always comes in a wave, which will pass if he waits. If he remains seated and tries to relax to the best of his ability, even lets his body slump in the seat and is prepared to let panic do its very

worst, it will not mount. His sensitized body may continue to have flashes of panic from time to time, but these will be bearable and he will be able to see the function through. The realization that they have been bluffed by physical feeling has been enough to cure some people.

The patient should be taught the difference between true acceptance and just "putting up with." "Putting up with" means bearing panic with clenched teeth, hoping that it will "get it over quickly" and not come again. True acceptance means recognizing second-fear (which can be prefixed by "Oh, my goodness" and "What if?"), and adding as little as possible. It also means learning to regard panicking as yet another opportunity to practise coping with it until it no longer matters. This can be done. I have watched many agoraphobics come through panics to lasting cure in this way, even those who thought courage was not their strong point.

However, before a patient should be expected to face and accept his nervous symptoms (not only panic) they should be fully explained to him. While I hesitate to make the following elementary suggestions, I am reminded of the many anxious patients who have complained that they had never previously been given such explanations and who began to recover afterwards.

Specific Symptoms

For example, I keep biscuits in my surgery for the nervous person with difficulty in swallowing solid foods and hence with a habit of avoiding eating in public places. At the sight of a dry biscuit he usually recoils. I then suggest that he chew not swallow. As soon as the softened, moistened biscuit reaches the back of his tongue his swallowing reflexes take over and some of the biscuit is automatically on its way down. When the patient understands that he needs only to chew and that swallowing will look after itself, some of the fear and tension goes and swallowing becomes easier.

Again I hesitate to discuss such a common symptom as hyperventilation. However, I am reminded of a young girl sent to me by her general practitioner because she had been breathing shallowly almost constantly for a year. She entered my surgery in distress. I explained the respiratory centre's automatic control of breathing, how it worked during sleep and unconsciousness. To illustrate its action I asked her to hold her breath as long as she could. When she found that she was soon forced to take a deep breath almost against her will, she appreciated the control beyond her control and saw the folly of her struggle. Some months later her doctor reported that she was cured. He had thought of every treatment except simple explanation. Every nervous symptom has explanation. It is not enough to say it is "only nerves."

Response to Treatment

In my opinion dependence on constant medication to tranquilize nervous symptoms or on learning how to avoid having them—for example, avoiding waiting in a queue—carries the danger of leaving the patient vulnerable to the return of symptoms at any time, in any place. Dr. Isaac Marks has stressed the disadvantages of the unexpected return of panic after weeks of present-day treatment of agoraphobia by medical desensitization.⁵ A patient must be taught to cope with his symptoms. If a technique needs a name, perhaps mine could be called "coping through understanding."

There are many ways to help understanding beside those already mentioned—for example, stressing the difference between testing and practising. The thought of testing brings tension, whereas the thought of practising holds no urgent

demand. Also, testing followed by failure brings an acute sense of defeat, whereas failure while practising means merely the necessity to practise again.

Again, it helps the sufferer to understand that the symptoms of stress are part of life and that their exaggeration in his sensitized body is the illness, not simply their occurrence; that therefore cure lies not in their complete elimination, as he probably believes and hopes, but in their reduction to normal intensity.

Relapse

Even months after a patient is desensitized and thinks he is cured, the sudden return of his symptoms in an exaggerated way in response to stress can so shock the sufferer he may think he has "slipped right back." He should be taught to understand the traps memory can set and try to accept the setbacks it may bring, until he knows the way out of setbacks so well that he no longer fears the way in. Indeed the definition of recovery should include having setbacks and knowing how to cope with them, so that neither doctor nor patient becomes too discouraged by them.

In this short article I have not mentioned the complications sometimes associated with agoraphobia: indecision, suggestibility, loss of confidence, feelings of unreality, feeling of disintegration, obsession, and depression. These too may develop following a set, logical pattern and this, with treatment, is discussed in my books and recordings.

Finally, I stress that repetition of advice is the crux of treatment of the agoraphobic. He finds achievement difficult because he remembers past failures and how he felt then, so that when he thinks of facing similar experiences his reactions are automatically those of withdrawal, fear, and despair. With enough repetition of the right advice new association paths are established which ultimately replace the old automatic flashback reactions of panic and withdrawal when the patient is stressed. I call this right reaction-readiness and know of no better way of establishing it than by using gramophone

records and tape cassettes, which can not only be played immediately before the patient sets out to practise but also with cassettes while he is out.

Results

In 1970-1, questionnaires were filled in by 528 agoraphobic people in Great Britain and Ireland whom I had treated for periods varying from a few months to six years using the method outlined above, without any personal contact. Of these, 60% had been agoraphobic for 10 years or more and 27% for 20 years or more, so that most could be classed as chronic agoraphobics. For their present illness 65% had had treatment from one or more psychiatrists and 30% from their general practitioner alone. Previous treatment had included almost every known orthodox method. This group offered a challenge to treatment without the personal supervision of a doctor.

Of the patients aged 14-29, the results were satisfactory or good in 73%; of those aged 30-39 similar good results were found in 67%, and in those aged 40-49 in 55%. Of the older and therefore more difficult group aged 50-74, good progress was made by 49%. As so many of these people were chronically ill (only 27 had been ill for less than 3 years) the chances of spontaneous recovery irrespective of treatment were negligible.

References

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General Practice Observed

Comparative Study of District and Community Hospitals

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Summary

Opinions conflict on whether there is a place in the Health Service for general practitioner (community) hospitals in which the patients' treatment is mainly the responsibility of their family doctors. The authors therefore analysed a sample

of the patients admitted in the course of a year to a group of two general district hospitals with a comparable sample of the patients admitted to a general practitioner hospital. The aim was to analyse the type of care provided in the general practitioner hospital, to assess whether it was appropriate for the type of cases treated, and to decide whether the patients would have been better off in the district general hospital (and vice versa). The main conclusions are that a district hospital is best for serious illnesses needing skilled decisions and assessments but that most of the work of these hospitals is not of this kind and a community hospital staffed by general practitioners offers many advantages to patients—provided the work being done is constantly under critical assessment. The authors plead for special refresher courses under the N.H.S. for general practitioners working in community hospitals.

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