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PANIC DISORDER, AGORAPHOBIA
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PANIC DISORDER, AGORAPHOBIA AND SEPARATION ANXIETY

By

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ABSTRACT

PANIC DISORDER, AGORAPHOBIA
AND SEPARATION ANXIETY

By

Maxine S. Liberman

The present study explores a proposed developmental link between separation anxiety and agoraphobia/panic disorder. The etiological model views separation anxiety as an evolved protest mechanism with an innate biological releaser, a mechanism believed to be dysfunctional in agoraphobics (Klein, 1981). It is reasoned that agoraphobics' early panic attacks lead to maladaptive styles of coping with separations, styles that persist in adulthood even when panic has been alleviated. This study also tests Bowlby's observations that individuals react to separations in characteristic ways.

Subjects were 10 females and 10 males in each of three groups: 1) agoraphobics, 2) anxiety neurotics, 3) non-anxious controls matched for age and education. A questionnaire covered the subjects' developmental histories. Hansburg's (1972) Separation Anxiety Test measured subject's characteristic manner of coping with separation experiences. The resulting data were treated by analyses of variance.

This study hypothesized that agoraphobics would exhibit greater separation anxiety than would neurotic, non-phobic

subjects, who in turn would react more maladaptively than non-anxious controls. These hypotheses were strongly supported by the data analysis. Agoraphobics demonstrated more attachment-seeking, less individuation, and more reality avoidance, hostility and painful tension than did neurotics and controls, even when faced with mild, temporary separations. Agoraphobics with histories of childhood separation anxiety however, did not show greater anxiety than those without this history, but the information testing this hypothesis proved unreliable.

The discussion considered the reasons for the agoraphobics' strong responsiveness to the SAT as compared with that of the other two groups. The relationships between the various maladaptive responses and the development of agoraphobia were explored. Directions for future research were suggested, including studies that would measure agoraphobics' reactions to stressful situations not involving separation, which might distinguish their separation anxiety from a general reactivity to any emotionally-charged stimuli. Such studies could provide further support for separation anxiety as a critical variable in the development of agoraphobia.

To my mother and my father
with love and appreciation

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Chapter 1

INTRODUCTION

Background and Statement of the Problem

Panic disorder and its frequent concomitant, agoraphobia, have been officially recognized by the authors of DSM III (1981) as discrete psychiatric entities,[1] rather than as neurotic symptoms; reflecting a shift in prevailing theoretical and clinical views not only of phobic disorders, but also of the meaning of anxiety. But despite this categorization in DSM III (which is primarily descriptive and not concerned with etiological theories), and despite considerable overlap in clinical descriptions of agoraphobia, there remains little agreement within the psychological community about the origins, development, and nature of this disabling and relatively commonly occurring disorder. This lack of concurrence and the aroused controversy about how panic disorder should be understood - if indeed some would

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[1] A strong case can be made for agoraphobia's being a secondary development of panic disorder, rather than as an entity in and of itself; i.e., as a later and more visible stage in the course of panic disorder. DSM III, however, lists agoraphobia with and without panic attacks, and panic disorder, as separate categories, reflecting the continuing lack of a unified view of their origins and meaning. As will be discussed in the text, agoraphobia will be viewed in this study as a consequence rather than as a cause or predecessor of panic attacks, although the causes of the spontaneous panic attack remain questions for further research (Muskin and Fyer, 1981).

view panic attacks as a "disorder" at all - has underscored divisions in theoretical perspective regarding basic concepts of anxiety, earliest development, and the role of biology in psychological functioning.

There are at least three major theoretical models of phobic disorders. The psychoanalytic perspectives, briefly stated, (Deutsch, 1929; Weiss, 1964; Stamm, 1972) is that panic attacks and phobic anxiety represent the displacement of anxiety which results from the breakdown of defensive operations for keeping internal conflict out of consciousness. The explanation offered by learning theorists (who have reported frequent success in treating certain phobias) is that phobias are learned avoidance responses to conditioned anxiety. Both of these latter theories place panic attacks at the extreme end of an anxiety continuum; i.e., anxiety surges to an overwhelming pitch and an "attack" occurs. A third theoretical view, which might be called the ethological perspective, conceptualizes panic disorder as resulting from a dysregulation of basic biological systems which mediate separation anxiety; and makes a qualitative, not a quantitative, distinction between the panic attack and the phobic anxiety and avoidance (Klein and Fink, 1962; Liebowitz and Klein, 1981; Zitrin et al., 1981).

In asserting their definition of panic disorder as a discrete psychiatric entity, DSM III authors relied principally on the accumulating evidence from recent psychopharmacological research and treatment outcome studies

(e.g., Zitrin et al., 1980, 1981; Lipsedge et al., 1978; Sheehan et al., 1980). Most of this research has evolved from the discovery by Donald Klein more than twenty years ago that the drug imiprimine, a tricyclic antidepressant medication, successfully blocked the panic attacks of highly anxious hospitalized patients (individuals who would now be diagnosed as agoraphobic), subsequently allowing them to overcome their phobic avoidance behavior with supportive psychotherapy (Klein and Fink, 1962). The striking and perplexing aspect of this finding was its challenge to the notion of an anxiety continuum: the major antipsychotic medications, the phenothiazines, considered to be antianxiety drugs, had been totally ineffectual in treating these anxious patients (as had been intensive inpatient and outpatient psychotherapy). Although it has been argued that these patients responded to antidepressants because they actually were depressed and had simply been misdiagnosed originally, these patients did not (and agoraphobic patients generally do not) meet the criteria for depressive disorders; when not

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[2]The relationships between depression, agoraphobia and panic disorder have not yet been clarified, although the neurobiological action of imiprimine on panic attacks does not appear to be identical to its action on depressive disorders (Jobson, et al, 1978). The nature of these relationships remain an important question, however. Several studies have examined them in terms of the role of anxiety in depression (Prusoff and Weissman, 1981; Gardos, 1981), and others from the point of view that agoraphobia is actually a form of depression (Bowen and Kohout, 1979). Klein (1981) hypothesizes that depression may be controlled by a different part of the same neurobiological regulatory mechanism that controls panic attacks.

overwhelmed with anxiety, they are sociable, experience no diminished pleasure in food and sex, and express no guilt or suicidal ideation. Against the conventional psychiatric wisdom of the time, then, Klein's discovery suggested that the anxiety of nonpsychotic patients was not simply quantitatively less than that of psychotic patients. This finding stimulated a reexamination of extant theories of anxiety.

Speculating that humans have a neurobiological mechanism which regulates their response to separation from primary attachment figures, as has been indirectly measured in primates,[3] Klein proposes that in those individuals experiencing spontaneous panic attacks, this mechanism is dysfunctional (Klein, 1981). The notion that such a neurobiological mechanism exists is based on an ethological perspective of separation anxiety and of protest as evolved prosurvival mechanisms. Although not yet identified biochemically, this hypothesized mechanism is seen as the internal physiological equivalent or releaser of the observable protest response to separation.

Klein's speculation about the relationship between panic disorder and separation anxiety is derived from several sources which will be reviewed here. These are: Bowlby's work on attachment behavior, particularly the delineation of

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[3](Harlow et al., 1959; Kaufman and Rosenblum, 1967; Suomi, 1977; Coe and Levine, 1981)

the stages of response to separation; evidence that many adult agoraphobic patients experienced separation difficulties in childhood, often manifested in school phobia; and the frequently noted clinical impressions of researchers and psychotherapists that agoraphobic individuals exhibit high levels of dependency and problems with individualism, as suggested in part by their underachievement. The most significant factor in Klein's thesis, however, is the by now well-established finding of the psychopharmacological studies of the effects of imiprimine on panic attacks,[4] which demonstrates successful blocking of the panic attack (the more severe anxiety) without alleviating the less intense anticipatory anxiety that results in the phobic avoidance behavior. This research evidence lends strong support to the notion that panic attacks and anticipatory anxiety are qualitatively different, though inextricably related, phenomena.

It should be noted here that the traditional psychoanalytic view, as well as the more recent theorizing of Mahler (1975), for example, would concur that separation anxiety underlies agoraphobia, but their position does not

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[4]Other classes of drugs, including MAO inhibitors, have been shown to be effective in treating panic attacks, although there are greater risks and side-effects with many of these. Sheehan (1982) has been experiencing with a relatively new triazolo-benzodiazepine, alprozalam, which he believes works on both the panic attack and the anticipatory anxiety, and asserts is the most rapidly effective and least toxic of the antipanic drugs available, but data to substantiate these assertions have not yet been published.

postulate a biological mechanism which may trigger panic and subsequently produce phobic anxiety and avoidance behavior. Instead, the psychoanalytic view, as well as the learning theory view, is that a panic attack is the result of a state of increasing anxiety, rather than the first stage, if not the cause, of the agoraphobia; these views do not readily accommodate the physiological discontinuity between the panic attack and the anticipatory anxiety.

In light of Klein's proposed ethological explanation of the origins of panic disorder - a view which does not discount the possible influence of more purely psychological variables, but also does not explore the relationship between these and the physiological mechanism - the present study will attempt to look more closely at the psychological responses to separation of panic disorder patients. Although the literature on agoraphobia and panic disorder invariably describe such individuals as dependent and passive, these observations are usually incidental clinical impressions. There has been almost no research which has been concerned primarily with an empirical assessment of the psychological characteristics of persons with panic disorder.

Before discussing the purpose of the proposed study in greater detail, a clinical picture of panic disorder and agoraphobia will be given to help acquaint the reader with issues already presented.

Clinical Descriptions of Panic Disorder and Agoraphobia

Panic Attacks

The spontaneous panic attack is a terrifying and traumatic experience. It occurs without warning and without apparent provocation. Although it may last for only a minute, the sensation of panic can subsequently render the afflicted individual incapable of normal functioning for long periods of time, if not permanently (without adequate treatment). A seventeenth-century description of panic attacks and of the anticipatory anxiety which develops in their wake conveys the power of this phenomenon:

> Many lamentable effects of this fear causeth in men, as to be red, pale, tremble, sweat; it makes sudden cold and heat to come all over the body, palpitation of the heart, syncope...many men are so amazed and astonished with fear, they know not where they are, what they do; and that which is worst, it tortures them many days before, with continual frights and suspicion. It hinders most honorable attempts, and makes their hearts ache, sad and heavy. They that live in fear, are never free, resolute, secure, never merry, but in continual pain...no greater misery, no rack, no torture, like unto it; ever suspicious, anxious solicitous, they are childishly drooping without reason, without judgment...
>
> (Burton, 1621, p. 143)

Similarly, a contemporary description of a panic attack, given by subjects experiencing sodium lactate infusion-induced panic (Muskin and Fyer, 1981) reveals many of the elements found in the earlier description:

> I feel like I'm going to die...I just can't explain it. I feel such a warm feeling and such a terrible feeling, a devastating feeling and I want to get up and run, and I feel very very nauseous...

> I'm not going to make it, I can't get help, I can't get anyone to understand the feeling... It's like a feeling that sweeps over from the top of my head to the tip of my toes. I detest the feeling. I'm very frightened.

These descriptions suggest the experience of an almost primordial, engulfing feeling that threatens one's very existence. Indeed, the individual experiencing a panic attack behaves, internally and demonstrably, as though her life were threatened, although there is no immediately identifiable source of danger.

The psychoanalytic view would hold that a source of danger does exist, although it is not objective, not "out there," but rather an unconscious, unacceptable impulse coming perilously close to the panicky individual's conscious awareness. Hence, so-called "spontaneous," out-of-the-blue panic attacks are believed to be provoked by an identifiable stimulus, an intrapsychic conflict, which is not outwardly observable but discernible through analysis. Patients' descriptions of panic attacks given as case illustration by psychoanalysts do not usually resemble those given by panic disorder patients, however, so that it is difficult to ascertain whether the same phenomenon is being discussed (Nemiah, 1981).

Agoraphobia

Agoraphobia, though literally translated as a "fear of the marketplace," has generally been defined as a fear of public places, particularly those which are either too crowded or too empty. Snaith (1968) has offered a more

parsimonious definition of agoraphobia as a fear of being away from a place or object representing safety. This perceived lack of safety appears to be the feature common to the multiple situations which agoraphobic patients avoid. The question which arises in attempts to understand this phenomenon is just how and why previously benign situations in the experience of the agoraphobic suddenly become infused with a sense of danger. Unlike agoraphobia, simple phobias (those with a specific stimulus, such as snake phobia) do not appear to have such an abrupt onset but rather are present throughout an individual's lifetime.

Most people at some time in their lives experience fear, even panic, usually caused by a sense of impending danger. But phobias are a special type of fear, in that they are persistent, excessive and attached to an object or a situation which objectively is not a significant source of danger (Marks, 1959). Phobias have been defined as "a specific fear which the patient himself knows is ridiculous but which he cannot overcome," (Ross, cf. Marks, 1959). As Marks notes, most phobic individuals recognize that their fears are excessive and unrealistic and that others would not be similarly fearful of the same situation. When confronted with their phobic situations, however, such individuals are overwhelmed with anxiety and experience uncomfortable physiological symptoms, such as sweating, tremor, pallor, tachycardia, rapid breathing, nausea, vomiting, and urinary frequency. Although these symptoms appear in

agoraphobia, this disorder is arguably different in important respects from simple phobias. Unless confronted with the phobic stimulus, individuals with phobias are not usually distressed by the fear, nor are their abilities to function in the world severely limited by the fear. Individuals with simple phobias are anxious only and always when the phobic stimulus is present. Moreover, they do not respond to treatment with imiprimine, again suggesting that the panic attack is a special event.

Chapter 2

REVIEW OF THE LITERATURE

Relationship Between Panic Disorder and Agoraphobia

The Development of Agoraphobia

Klein (1981) describes the typical development of agoraphobia in three stages, which he believes begins with the occurrence of a panic attack, as follows: An individual who is feeling normally well, in the course of doing something innocuous such as walking down the street or dining out, suddently is "struck by the worst experience of their life: they become suffused with terror, with a pounding heart and inability to catch their breath...they are convinced that death from a stroke or heart attack is imminent," (p. 236). Terrified, this individual may blindly appeal for help from passersby, and eventually get herself to a physician. As the physician finds nothing physically wrong with her, she is reassured that there is no reason for concern and is sent home. The stricken individual usually recovers quickly, and feels more or less normal again, until within days or sometimes weeks, she is struck with another panic attack. Usually, she seeks out medical help once more, but when a thorough physical examination again detects no physical cause for her symptoms, she is sent home with further reassurances. These may suffice to relieve the individual's fears for a time, until yet another panic attack

occurs. At this point, the individual becomes convinced that something is dreadfully wrong with her (something physical) and that the doctors have simply failed to determine the proper diagnosis, although many such patients also become convinced that they are in fact going crazy.

Usually, a series of panic attacks occur next, between which the individual becomes increasingly apprehensive, anxious and vigilant. Thus begins the second stage in the development of agoraphobia: the individual grows increasingly alert for any signs of an impending attack. The third stage begins when the individual begins to avoid certain situations, those where access to a helpful and reassuring person (medical personnel, a relative, or close friend) may not be readily available. Eventually, as apprehension mounts, this individual may retreat to the confines of her home, seldom venturing forth from familiar surroundings, which provide for her a certain feeling of reassurance that she will be near help in case of another panic attack.

Thus, the typical clinical picture of the agoraphobic[5] patient emerges; an individual suddenly begins to experience severe panic attacks, becomes chronically anxious

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[5]All panic disorder patients do not become agoraphobic, but it is believed that all agoraphobics have experienced panic attacks and that panic disorder underlies their phobic avoidance behavior. For the purposes of this study, however, the terms agoraphobic and panic disorder will be used interchangeably except where a more limited meaning is specified or evident from the context.

in anticipation of the next panic attack, and begins to stay close to home, which provides a feeling of safety. She thereby becomes housebound to some degree, fearful of being alone, and often dependent upon others even to perform everyday tasks for her.

Clinical Presentation of Agoraphobia

Perhaps the most disturbing aspect of agoraphobia for the individual involved is that noted by the research subject quoted earlier; the agoraphobic feels that she cannot make anyone else understand how she feels. She therefore feels isolated, as she knows that her fears are unfounded and that others view her as being weak or undependable. Agoraphobics report being extremely sensitive to this (however justifiable) lack of understanding of their fearfulness, because they feel ashamed of their inexplicable, groundless fears; and often attempt to conceal them for as long as possible. Marks (1969) notes: "The more common and familiar the phobic objects are the greater is the incomprehension and lack of compassion which the plight of the phobic arouses in normal people. It surpasses the intuitive understanding of normal people how anyone can be scared of...going outside her home. It is often thought that the patient pretends or exaggerates ...should pull herself together or be forced to do so." (p. 4). But, as Burton (1621) long ago observed, phobias are not the result of insufficient willpower but are due to causes outside the patient's control: "Take away the cause, and otherwise counsel can do little good; you may as well bid

him that sick of an ague, not to be adry, or him that is wounded, not to feel pain," (p. 347). It is of interest that current treatment approaches follow this advice exactly; that is, they treat the panic attacks before or in conjunction with treatment for the chronic anticipatory anxiety.

When agoraphobic patients finally do reveal their symptoms, they often complain only of symptoms secondary to their anxiety such as headaches and other physical distress. While these complaints are at least comprehensible, their frequency prompts others to regard the individual involved as extremely hypochrondriacal, another common feature of this disorder. Because of the distressing sensations associated with the panic attack, agoraphobic patients do tend to be highly alert to any slight physical changes or bodily discomforts they may experience, which they believe could signal the onset of another panic attack. Thus, they often become obsessively concerned with their physical state, although never actually ill (Goldstein and Chambliss, 1978).

Agoraphobic patients are aware that they feel "different" from other people (and from the way they once felt about themselves), but their sense of strangeness is only compounded by their lack of awareness that anyone else could possibly suffer from the same problem as they. The belief that this condition is unique to them is reaffirmed frequently by the misdiagnoses of their condition and by the lack of public awareness of this disorder, at least until

relatively recently.[6] Thus, the agony of the anxiety and phobic behavior is suffered secretly, which makes it all the more demoralizing for the individual so afflicted.

Course of the Disorder

It is evident, as noted earlier, that the course of this disorder does not resemble that of other phobias. Panic disorder and agoraphobia appear to be recurrent over the lifetime, although there may be long periods where one is free of panic attacks. In such cases, the disorder appears to be phasic in nature; in other cases the panic and anxiety are more chronic and unremitting. Also, some individuals apparently have panic attacks which do not lead to agoraphobia. Although the vast majority of cases first experience panic attacks in late adolescence or early adulthood, there appears to be a bimodal distribution of onset, with another group experiencing this problem for the first time in midlife. It is of considerable interest that this distribution coincides with those periods of developmental transition that involve major separations.

As mentioned earlier, panic attacks can be successfully treated with the drug imiprimine. However, when only the chronic, anticipatory anxiety is treated, usually with

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[6]In recent years, various media programs focused on agoraphobia have created public awareness of the existence of this disorder and of its impact on individuals so afflicted. Agoraphobia self-help groups have formed across the country, and some clinicians now specialize in treating this disorder.

benzodiazapenes, the panic attacks can and often do recur, setting off a renewed round of anticipatory anxiety and phobic avoidance. Traditional methods of psychotherapy which seek an underlying trauma responsible for causing the panic attacks may never reveal one; and usually after only a short time, the symptomology becomes so crippling that the agoraphobic's life is in desperate straits. There is strong evidence, however, that if the panic attacks are first treated with imiprimine, then any psychotherapeutic modality subsequently can be useful in alleviating the anticipatory anxiety and in eliminating the phobic avoidance (Zitrin et al., 1981).

Of relevance to this issue are several studies by Gittelman-Klein (1971, 1973) that have found imiprimine to be effective in treating school-phobic children. The usual approach to treating such children is to effect their prompt return to school, and then to treat their lingering apprehensiveness and fearfulness in psychotherapy, where the causes of their phobic behavior can be addressed. Few therapists would allow a child to stay away from school indefinitely while these causes were being unravelled. Yet, adult agoraphobics are often treated as though their panic attacks did not exist, and they may spend many years in treatment for their anxiety, seeking its foundations to no avail.

An Ethological Theory of Panic Disorder and Agoraphobia

Development of the Theory

Klein's discovery of the effectivness of imiprimine in treating panic attacks evolved from careful observation of the behavior of certain inpatients under his care at Hillside Hospital in New York. These highly anxious and apprehensive patients had proved intractable to any form of psychotherapy and pharmacotherapy that previously had been offered, including the phenothiazines. In large measure because there was nothing left to try with these patients, Klein decided to administer to them the new anti-depressant medication, imiprimine, which was known to have tranquilizing properties.

After three weeks of treatment with this drug, these patients still claimed to feel unimproved. However, the ward staff believed that there had been some improvement, despite their inability at first to specify this change. Eventually it was recognized that a particular patient behavior which had occurred daily during the ten months prior to the imiprimine trial no longer happened. Previously these patients had been rushing to the nursing station several times a day, every day, proclaiming they were about to die and requesting immediate attention; after being reassured by the nurses, who would sit with them for about twenty minutes, the patients would leave - their acute, overwhelming distress somewhat relieved. Since the end of the second week of treatment with imiprimine therapy, patients began approaching situations on their own which they previously

had avoided, even venturing outside by themselves. Furthermore, and perhaps more importantly, these patients' moves toward independence could now be accelerated by staff pressure and direction, efforts which had previously proved futile. Thus, it appeared that the panic attacks, or the acute distress, could now be effectively treated with a medication that had a specific action only on them; panic anxiety appeared to be a discrete, separate event from other anxiety.

Results of studies with intravenous lactate infusions provide further evidence that the panic attack is a special event. Pitts et al. (1967) found that such an infusion induces a panic attack in people who have spontaneous panic attacks, but not in normal subjects. Although a conditioning theory has been proposed as an explanation of this finding - that any infusion which causes certain autonomic effects, even in normal subjects, will serve as a conditioned stimulus and will "precipitate" a panic attack - this hypothesis can be rejected because infusion of EDTA, a chemical agent that actually throws patients into tetany, does not produce panic attacks in persons with spontaneous panics or in normal subjects. Also, it has been demonstrated that the induced panics are successfully blocked in panic disorder patients treated with MAO inhibitors (Kelly et al., 1971) and with imiprimine (Appleby et al., 1981).

Psychoanalytic and Learning Theories of Agoraphobia

Klein asserts that several things could have been surmised from his findings of the effectiveness of imiprimine

in treating panic attacks. As already mentioned, the specificity of the action of this drug actually led to his making the distinction between the panic attack and the subsequent anxiety. It also led to a reconsideration of existing theories of anxiety, since imiprimine prevented the recurrence of the severe panic but did nothing for the less severe chronic anxiety, challenging the notion of an anxiety continuum. In his attempt to account for this finding from an established theoretical perspective, Klein found both learning theory and psychoanalytic theory to be deficient in their ability to explain the development of panic disorder. The reader is referred to his cogent assessment of the problems in these theories (Klein, 1981), which will be summarized here.

In essence, Klein views Freudian theory and learning theory as markedly parallel in their emphasis on the importance of contiguity conditioning, which leads to anxiety as a signal of anticipated traumatic states. As noted earlier, neither of these theories focuses on the distinction between the panic attack and chronic anxiety, nor considers the panic attack to be the antecedent of the developing anxiety. Fenichel (1945) proposes that panic attacks are actually signal anxiety gone amok: "The patient has such tremendous internal tensions because of massive repressions that signal anxiety acts much as a match in a gunpowder factory," (Klein, 1981, p. 244). Although Weiss (1964) did perceive that panic attacks precede the development of

anticipatory anxiety and that the patient suffers from anxiety concerning his panic attacks, this explanation is again an elaboration of the notion of the return of the repressed (in his model, an early ego state rather than an infantile libidinal drive).

Panic Attacks and Separation Anxiety

Because outstanding clinical features of the patient with panic disorder are their clinging, dependent behavior and their intolerance of being alone, Klein began to think that perhaps an outbreak of separation anxiety was at the root of agoraphobia. Among the evidence to support this notion were histories of at least fifty percent of the patients studied of having suffered separation anxiety in childhood, and that the initial panic episode had often been preceded by significant object loss (Klein, 1964). Thus, he thought this indicated that these patients had a special early predilection for separation anxiety which manifested itself as agoraphobia later in life.

In attempting to account for this notion from a theoretical perspective, Klein found that psychoanalytic theory was lacking in explanatory power. Separation anxiety in that theoretical framework is viewed as a form of classical conditioning: the unconditioned stimulus is an increase in instructual tensions that leads to the unconditioned response of traumatic and painful excitation. The absence of the mother is the antecedent conditioned stimulus; and it is the child's association of the mother's absence with mounting tension that leads to anxiety during her absence. Thus, separation

anxiety would require the recognition of the mother as a distinct object, the ability to discriminate her presence versus her absence, and the association of absence with states of increasing tension. This conceptualization offers no explanation for a specific drug effect on panic anxiety and not on other types of anxiety.

Bowlby's work on the attachment process suggested that attachment did not depend on the infant's learning that the mother was a need gratifier, but antedated such learning, resembling the ethological notion of imprinting. Separation anxiety did not depend on the infant's learning that the mother's absence was associated with distress, "but was an evolved protest mechanism, instinctively released during the appropriate developmental phase by separation," (p. 246). Observation of animals' states of distress after separation from their nests or from their mothers immediately after birth supports Bowlby's speculation. Rather than learning through experience that the presence of the mother is associated with relief from instinctual tension, animals appear to react with innately released protest.

The evolutionary purpose of the signals emitted by the vulnerable infant is to elicit retrieval by the mother. Klein points out that the helplessly dependent infant that has wandered away from its mother is a target for predators (evolutionary speaking); and that in the absence of predators, a lost child is vulnerable to dehydration and becoming weakened. If the infant actually waited for the pains of

hunger before emitting distress vocalizations, then it is likely the infant would be lost or hurt. Thus, the innately released protest mechanism (released under conditions of naive separation) serves to insure contact with the mother before such pain or damage occurs.

> Any biological control mechanism has a wide range of variations in strength and threshold, and perhaps some children have constitutional or familial vulnerabilities in this area. The existence of such an innate alarm mechanism may explain the specificity of the antidepressants: if antidepressants specifically raise the threshold of this mechanism, they would prevent panic but have no effect on anticipatory anxiety...the pathophysiologies of separation anxiety and depression seem intricately related as shown by their drug receptivity and by the higher incidence of phasic depressions in people with agoraphobia,"
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> (Klein, 1981, p. 247).

Bowlby has delineated three stages of response to separation: protest, despair, and detachment. Protest appears to be similar in nature and behavioral manifestation to the panic attack: both are characterized by pleading, clinging, and demanding. Klein speculates that the despair stage may also serve an evolutionary purpose, in that it serves to inhibit protest when the mother is unavailable to respond. If protest were to continue indefinitely, then the infant would be calling attention to itself and be vulnerable to predators. Endless protest would also exhaust the infant physically. In this case, the protest of the infant would serve an antisurvival function. Therefore, despair may serve as a built-in conservation mechanism and prosurvival function. (Klein further reasons that one way in which evolution could

radically reduce an organism's interactions with the environment while maintaining consciousness would be to inhibit the brain's pleasure centers, which would account for certain depressive symptomology.)

The relationship between depression and panic disorder, as suggested by their mutual responsiveness to antidepressants, may be that the protest-despair mechanisms have co-evolved over human history to maintain the survival of the vulnerable or lost infant. Klein states,

> The appearance of apparently spontaneous panic attacks or apparently spontaneous depressive episodes are the results of a pathologically lowered threshold for release of these distressing affective regulatory states. If the threshold is lowered in that portion of the...mechanism that controls protest, then spontaneous panic attacks occur, whereas if the lowered threshold occurs in the segment that regulates despair, then a phasic depressive episode results. I make the parsimonious hypothesis that the sole function of all antidepressants is simply to raise thresholds throughout this apparatus...and that their beneficial effects on anxiety attacks and/or depression result from this normalization of function,"
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> (Klein, 1981, p. 248).

Diagnostic and Treatment Problems in Agoraphobia

What Klein noticed in his original patients, and what often occurs in attempts to diagnose and treat panic disorder, is that these patients have great difficulty making the distinction between the panic attack and the anticipatory anxiety; because the latter is so disturbing, it becomes nearly indistinguishable from the panic. Also, the panic attacks may have occurred only a few times, and may have even

remitted altogether, while the sense of dread that the experience will be repeated has not abated. (In learning theory terms, the unpredictable panic attack reinforces the anticipatory anxiety - the conditioned response - on an intermittent, random schedule, which makes the response extremely difficult to extinguish.

Despite DSM III acknowledgement of panic disorder and agoraphobia as discrete entities and despite the established efficacy of imiprimine treatment, panic disorder and agoraphobia have long been, and frequently still are, misdiagnosed. Panic disorder patients are often seen as having obsessional neuroses (because of their obsessive concern with their bodies and feelings), as being hypochondriacal, as delusional (thus psychotic), as suffering with a major depressive disorder (usually bipolar depressive illness), as hysterical personalities, as dependent personalities, and even as schizophrenic because of their marked social impairment and severity of symptoms. Even when accurately diagnosed, it is not uncommon for panic disorder patients to have been treated for many years only with psychodynamic therapies without any relief of their presenting complaints.

Because spontaneous panic attacks and agoraphobia so frustrate and mystify psychotherapists trying to understand them from their own particular frame of reference, it is not surprising that the patient experiencing this disorder is seen as difficult, intractable, and uncooperative. It is also

understandable that such an attitude on the part of therapist may serve only to perpetuate the patient's deep sense of shame about the disorder and to increase the patient's anxiety that she is insane (Muskin and Fyer, 1981). The lack of credibility accorded the spontaneity of the panic attacks probably contributes to the ineffectiveness of treatment. Traditional therapies situate the disorder within the individual, and rightly so, but whether it is under the control (conscious or unconscious) of the patient is still unknown.

The fact that the panic attacks may have remitted by the time a patient reaches a psychotherapist often makes the problem of diagnosis more difficult, because chronic anxiety and even phobic behavior can be symptoms of a variety of diagnoses. The resistance of psychotherapists to accepting research findings about agoraphobia, however, (particularly regarding the usefulness of imiprimine in treating this disorder) may be seen as just that: resistance, or a countertransferential response to patients who simply are not amenable to the offered mode of treatment. It also reflects a strong prejudice within the psychological community against medical interventions for disorders that are viewed as primarily psychological in nature.

The Sex Difference in Incidence of Agoraphobia

It is little wonder that agoraphobia is often viewed as being a woman's problem, or the "housewife's syndrome." Stereotypic notions of women as dependent, helpless, fearful,

and hysterical are embodied in the very essence of this disorder: the panic and phobic behavior are not rational. Estimates of the sex ratio for incidence, however, based on frequency of diagnosis, vary from 50/50 to 95/5 (females/males). Accurate diagnoses have often been clouded by clinicians attending only to the histrionic, hypochrondriacal complaints of women who are often secretly terrified that they have "gone crazy." Such patients are most commonly given sedatives, such as benzodiazapenes, in order to lower their anxiety and calm them. As noted earlier, however, these drugs do nothing to block the panic attacks; thus, they perpetuate the disorder while potentially fostering another type of dependency.

Many studies describe agoraphobic patients as "very dependent...and they tend to be women..." (Zitrin et al., 1978). However, why this is so, or what the relevance of this observation is for the development of panic disorder is not elucidated. Psychoanalytic case studies (Nemiah, 1981) propose that dependency conflicts and an inability to separate from significant attachment objects form the basis of agoraphobia, emphasizing the frequency of occurrence of these problems in women.

Although the less frequent diagnosis of panic disorder and agoraphobia in males may reflect the true incidence of the disorder among them, it is also likely that males report agoraphobic symptoms less frequently than do females. This may be attributable to males' greater socializations for

independence, which would make it more difficult for them to stay at home or to stop working at their jobs, even in the face of severe panic and anxiety. Men tend to feel compelled to carry on despite the presence of these symptoms, and they often conceal their distress for longer periods of time than do women, by self-medicating with alcohol and other substances. Since men are encouraged throughout their lives to confront danger and to be physically active, while women more often are allowed, if not encouraged, to remain dependent and to acknowledge dependency wishes, it follows that agoraphobia would be more frequently seen and disgnosed in women. It is of interest that Childhood Separation Anxiety Disorder, experienced by many agoraphobics, occurs in equal numbers among males and females. It may be that such (phobic) behavior is simply more tolerable or acceptable for males when they are children than when adults.

It has been observed that male infants as a group are more aggressive and explore their environment more actively than female infants do (Maccoby and Jacklin, 1974). From an evolutionary position, one could speculate that because males originally were hunters and were required to roam far from their "home" bases, the mechanism for separation anxiety in males evolved differently from that in females, at least in terms of its range of reactivity. Were separation anxiety too intense in males, it might hamper their ability to effectively search for food. It could further be speculated that because attachment involves an interaction between

mother and infant, females are constitutionally endowed with a more reactive separation anxiety mechanism and a lower threshold for separation anxiety in order to ensure their responsivity to (and thus the survival of) their offspring. It follows, then, that females are more vulnerable to dysregulation of this hypothesized separation anxiety mechanism, and consequently to more frequently experienced panic disorder.

Despite the comparatively more frequent diagnosis of agoraphobia in women than men, even among women the disorder apparently often remains undetected for years by relatives and friends. For example, many new cases of agoraphobia revealed themselves in the course of a rehousing scheme in New York City, where families that had been living in single rooms were moved to larger housing in a new neighborhood (Perman, 1966). Phobic symptoms became immediately apparent in many of the women, who could not sleep alone, were fearful of going out alone, and would not travel beyond their neighborhoods. This outcome could be compared to the reactions of other animal species who become extremely disoriented by the destruction of their homes or nests and often do not survive this trauma.

When it is considered that the avoidance behavior of agoraphobics is nearly identical from individual to individual (and not individually "conditioned" by a specific trauma) and that it involves the fear of leaving a home base, it seems quite likely that a phylogenetic response is involved.

Evidence from research on the causes of simple phobias suggests a predisposition to react fearfully to certain classes of stimuli. In agoraphobia, the feared situations are often places where one could be "trapped" such as in tunnels, or out of view of help (of the mother?), as in a crowd or vast open space. Marks (1959) observes: "Certain classes of stimuli are more likely than others to trigger off phobias, given that these different stimuli are all encountered quite frequently. It is reasonable to expect that phylogenetic mechanisms are at least partly responsible for this potency of certain stimuli to produce fear in man, just as they do in other species," (p. 116).

In a study of field dependence and agoraphobia, a slightly different perspective is proposed. Rock and Goldberger (1978) found significantly greater field dependence in agoraphobic versus simple phobic females (though not for males). Although Witkin (1972) theorized that adequate adjustment is to be found at any level of differentiation, when there are failures of personality integration, the disturbances that emerge are more likely to be consistent with the person's level of differentiation.

> In the case of females who become agoraphobic, the fact that they tend to be highly field dependent may make them more likely than other persons to react to stress with overwhelming, diffuse anxiety and undifferentiated symptoms that tend easily to generalize and emerge when external supports are withdrawn...Also, partly based on their field dependent, they may...move more readily into a position of dependence upon others rather than relying upon their own internal cues and emotional

> resources to understand and cope with their environment.
>
> (Rock and Goldberger, 1978, p. 784).

While the above interpretation of the findings appears to follow logically from the results of this study, a problem inherent in the research is that the subjects of the study were actively agoraphobic. It may be that agoraphobics shift their self-other orientation when anxiety is chronically high, and become so occupied with cues from their internal state that they are incapable of using external cues from the field to help them or to utilize support from others in order to feel better. Also, the generalization of symptoms of these subjects cannot be explained in terms of their having identical experiences; rather, the generalization of symptoms is to specific "classes" of stimuli. However, the finding of a difference between the field dependence of agoraphobic women and those with simple phobias is of significance in that it once again suggests the uniqueness of agoraphobia and implicates certain cognitive and perceptual processes in the development of the disorder.

Bowlby's Theory of the Separation Process.

Through his naturalistic studies, Bowlby (1973) has described a three-stage process experienced by the individual following a separation. The process begins with separation from an attachment figure, upon which the child first becomes distressed and protests the separation through its cries and other behavioral signs, in order to retrieve the lost object. As noted earlier, this protest response seems to be an

innately released behavior, rather than a learned response, at least when the child is an infant. If the infant's response is not soon attended to, the infant begins to despair, becoming preoccupied with and vigilant for the return of the lost object. Eventually, with reunion with the attachment figure not forthcoming, the child may become emotionally detached from her. This detachment phase will end with the return of the attachment figure, when the child again attaches to her; although now the attachment may be anxious, and the child will insist on remaining in close contact with her for some time after their reunion. Children who have experienced many such separations may respond with anticipatory dread (like that of the agoraphobic) to any situation that might involve separation. On the other hand, if separations are prolonged or repeated over the first few years of life, the child may become persistently detached.

There are various affective responses to separation as well. One of these is hostility or anger, which functionally appears to express reproach toward the abandoning attachment figure and to discourage further separation. This anger, which retrieves the lost object, can become dysfunctional when it persists and is excessive, thereby alienating the attachment figure. According to Hansburg (1972), an overly intense hostile reaction can become pathological when it is unaccompanied by a desire for attachment.

When the child's ego cannot tolerate the expression of hostility, the reality of the separation may be avoided

through withdrawal, fantasy, or evasion of one's real feelings. Although, as Rochlin (1965) points out, escaping the reality of a loss is necessary for every individual at some time, so that the trauma can be mastered gradually, excessive withdrawal and fantasy can become pathological when they dominate the individual's response to separation. An individual who entirely evades his true feelings about a loss may unconsciously recreate a loss situation which he has been attempting to deny.

The need for a balance in being adequately attached to an object and able to withstand some separation without distress is the basis for an individual being able to develop as a mature and separate being. Exaggerations of either the attachment need or excessive individuation (detachment) make up pathological coping mechanisms. The anxiously attached individual exhibits excessive help-seeking and dependency, resulting from the belief that separation from an attachment figure will be repeated, and from a lack of confidence that these figures will be available and responsive when needed. Thus, such individuals avoid any separations by clinging excessively to their attachment figures. Although remaining in close proximity to attachment figures may provide a sense of security for the individual, it is gained at the expense of a loss of autonomy and independence. On the other extreme of the drive toward individuation is the excessively self-sufficient individual. This person is detached from dependence on another person. Bowlby describes this detachment

as resulting from the intensity of the protest stage and the child's inability to withstand the despair stage which would stave off the detachment. In excessive protest, the child's anger may alienate the attachment figure so that the bond between them is weakened, with the attachment object less responsive. The child then defensively withdraws into excessive self-sufficiency, which increases the child's sense of loneliness and deprivation and his belief that no relationships can be relied upon.

Hansburg points out that healthy personalities respond to mild separations (those which are temporary and in which reunion is assured) with little anxiety, and may even welcome these separations as opportunities for expressing autonomy. Individuals who are excessively self-sufficient, however, will meet mild separations with an intense drive to individuate, so that they are unable to connect with other people during times of separation or less. The anxiously attached individual, on the other hand, will react with intense anxiety to even mild separations and will attempt to remain in contact with the lost attachment figure, often relying excessively on others and being unable to be alone and rely on themselves.

This outline of the separation process for the anxiously attached individual as described by Bowlby and Hansburg seems to parallel the behavior of agoraphobics. Although there is usually no precipitating or imminent separation experience coinciding exactly with the first panic attacks of such

individuals (although some report the onset of symptoms sometime after experiencing a major loss), they react as though this is the case. If indeed the protest phase of the response to separation has gone awry in such individuals (because of a dysfunctional physiological mechanism), they may constantly be anxious and seeking attachment and security without cause, which are the symptoms of agoraphobia; and rather than being able to experience a separation which sets off the normal separation stages, avoids separation altogether by remaining tied to the attachment figure; i.e., in this case, home.

The histories of Childhood Separation Anxiety Disorder of many agoraphobics suggests that such individuals have been dealing with a hightened sensitivity to separation all of their lives and have developed characteristic ways of coping with stress, separation, and loss. It may be that the proposed physiological mechanism regulating separation anxiety in adults with agoraphobia plays a role in early separation difficulities as well. It so, the personality characteristics which develop in response to excessive anxiety in childhood may influence the occurrence of panic disorder in adulthood.

Klein asserts that if separation anxiety is learned, it learned on a biological substrate. Thus, it can be speculated further that agoraphobics are passive, dependent and unassertive because their high levels of anxiety in response to separation situations as children do not allow them throughout their lifetimes to adequately resolve

feelings of anger and hostility. If separation, which normally temporarily evokes anger in the individual, arouses anger so often and intensely in the child that the threat of its expression becomes too dangerous (rejection or separation will be experienced), it would be expected that as adults, such persons would be passive, attempt to please others and be fearful of their own hostility. Of course, a similar hypothesis has been invoked to explain certain depressions; i.e., anger experienced by the child is turned against the self rather than expressed toward the attachment object for fear of losing that object, which is the ultimate threat to the infant's survival. If Klein is correct in his speculation that the same physiological mechanism plays a role in the development of both depression and panic disorder, then the role of suppressed rage in producing neuroses may vary with certain biological predispositions.

Chapter 3

PURPOSE OF THE STUDY

The present study attempts to investigate Klein's (1981) of a link between panic disorder and separation anxiety, by examining the responses of panic disorder patients to situations involving separation and loss. The central question is whether successfully treated agoraphobic individuals are more vulnerable to separation experiences than are other neurotic or normal individuals. The underlying question is whether it is the response to separation experiences which elicits panic attacks and engenders the anxiety of the agoraphobic. And is this response part of the personality structure or instead induced by the nature of the disorder? That is, once the panic attacks and anxiety are alleviated with treatment, is it to be expected that an agoraphobic "personality" remains intact?

The study is indirectly concerned with whether certain psychological characteristics of an individual, in this case, dependency, passivity, underachievement (pathological responses to separation anxiety), predispose that individual to develop panic disorder, or whether a predisposition for panic disorder is the cause of dependent behavior. While the apparent direction of causality may appear to be a

moot point, especially in light of the apparent efficacy of current treatment procedures, it is a critical distinction for matters of determining risk for the development of the disorder, of prevention, and of improved diagnosis and treatment.

If panic attacks are purely physiological events, then the premorbid personality characteristics of the agoraphobic patient would be irrelevant to the development of this disorder. Klein has suggested that the traits so often observed in agoraphobics are caused by the enormous anxiety they experience, and that their dependency on others is understandable: "Individuals who suffer panic attacks are more comfortable entering feared situations in the company of people they know and trust. While this has been related to separation anxiety it seems...that it may simply involve the comfort of knowing that if they do have a panic attack there will be immediately available someone whom they trust to help" (Klein, 1981, p. 55). Once successfully treated, such persons would no longer be expected to display dependent behavior because it is only an artifact of the disorder. But this does not seem to be the case. Most studies of the effectiveness of various treatments assert that supportive or behavioral psychotherapy is required to deal with the dependency even after medication has alleviated the panic attacks and

anticipatory anxiety.[7] So while the help-seeking of the actively phobic individual may be an outcome of the stress of the disorder, it does not preclude the possibility that dependency is typical premorbid behavior of the agoraphobic.

The description in DSM III of Childhood Separation Anxiety Disorder closely resembles the description of panic disorder and agoraphobia. A predisposing factor listed for Separation Anxiety Disorder is that such children tend to come from families that are highly close-knit and caring (or perhaps, from a family systems point of view, would be seen as overly involved, enmeshed, nondifferentiated). The psychoanalytic perspective might assert that close-knit families evoke more intense Oedipal anxiety and greater guilt, resulting in overidentification with the same-sexed parent and an inability to individuate. From this point of view, such excessive closeness would also exacerbate conflicts in earlier psychological stages, again resulting in problems of attachment (Bowlby's "anxious attachment"). Like the ethological view, psychoanalytic theory emphasizes the child's interaction with parents. Apparently, according to the DSM III description of Childhood Separation Disorder, "neglected

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[7] Sheehan (1982) and his colleagues argue that agoraphobia and panic attacks can be treated entirely with medication, and that psychotherapeutic interventions should not be necessary if medication is properly administered. This is not to suggest that they believe there are no psychological components to this disorder, but suggests that removal of obvious symptoms is the only goal.

children are underrepresented in this disorder," although reasons for this finding are not offered. Neglected children could be said to suffer from excessive detachment, an overly developed sense of autonomy in response to an unresponsive environment. It could also be argued that separation anxiety simply may manifest itself or be interpreted differently in different families, e.g., perhaps neglected children's absences from school are viewed not as phobic behavior, but as either a lack of interest or delinquency.

Reported results of treatment for panic disorder suggests that clinicians should take a balanced view of the causes and the symptoms of this problem. Muskin and Fyer (1981) have found that, for some people, panic attacks do not seem to serve as a resolution of unconscious conflict. For such patients, treatment response is usually rapid, and nothing beyond medication and encouragement to enter phobic situations is required for recovery. On the less responsive end of the range of treatment responses are a group of patients in which the symptom complex also serves as a resolution of conflicts in areas of work, familial and social relationships. In these cases, psychotherapy is necessary before any change in symptom pattern occurs, even when panic attacks are first blocked with imiprimine. If the patients who are more difficult to treat represent those for whom the biological substrate has been more reactive and dysfunctional at an earlier age, then their

agoraphobic symptoms may have developed as a learned coping response to this biological predisposition. Since separation anxiety will be considered both a psychological and a neurobiological (instinctive) event for the purposes of the present study, it is predicted that agoraphobic patients will exhibit heightened responsiveness to separation situations.

Chapter 4

PROCEDURE

Description of Instruments

The Separation Anxiety Test (SAT) is a semi-projective instrument developed by Hansburg (1972) to measure the responses of children and young adolescents to separation experiences. Although the instrument was designed for use with adolescents, more recent studies have demonstrated its usefulness with young adults as well (Hansburg, 1976; DeLozier, 1979; Sherry, 1980; Cohen, 1984). Similarly to the Thematic Apperception Test, the SAT consists of a series of twelve pictures in which children are seen separating from adults in a variety of situations (Appendix D). Six of the pictures depict mild or tenporary separations, such as a child leaving home in the morning to attend school; six depict strong or permanent separations such as the death of a parent. There are two editions of the test, one for females and one for males, in which only the gender of the child in the illustrations differs while the situations and the statements remain identical.

Each of the SAT pictures has a title describing the scene and a series of 17 statements describing the possible feelings and reactions of the child protagonist. The 17 statements have been classified according to eight

response themes: 1) attachment, 2) individuation, 3) hostility, 4) painful tension, 5) reality avoidance, 6) concentration impairment, 7) self-love loss, and 8) identity stress. Only the first five of these themes are relevant for the present study.

Each of the response themes is represented by three items. The attachment theme contains items reflecting a feeling of loneliness, a feeling of rejection, and a feeling of empathy. The individuation theme taps feelings of well-being, adaptation, and sublimation. The hostility theme include an item reflecting a feeling of anger, plus projective and intrapunitive items. The painful tension theme consists of items describing phobic, anxious, and somatic reactions. The reality avoidance theme has items for withdrawal, evasion, and fantasy. A sample of these statements from the SAT, the feelings the statements represent, and their classification into one of the five response themes can be found in Appendix D.[8]

Female subjects and male subjects received their respective editions of the SAT. Each of the pictures has an answer sheet containing 17 response statements. Subjects were asked to empathize with the protagonist in each of the 12 separation experiences and select those responses that would most nearly describe their own feelings were

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[8]Because three of the eight response themes (concentration impairment, self-love loss, and identity stress) are represented either by only one item or by items which represent more than one theme, there are only 17, rather than 24 statements.

they the child in the picture. Subjects could select as many or as few of these statements as they wished.

Each subject's selections were then scored individually and recorded in the Chart for Controlled Associations (Appendix D). Then the total number of attachment, individuation, hostility, painful tension, and reality avoidance choices was determined by tabulating the number of items corresponding to each response theme, thereby producing five scores for each subject, which were recorded in the Pattern Summary Chart (Appendix D). The individuation score, for example, was calculated by adding the number of adaptation, well-being, and sublimation responses. Each of the five scores was also tabulated separately for the mild pictures and the strong pictures.

These calculations produce a pattern of response to separation that indicates the adaptive strategies of the individual respondent. In his validity studies with this instrument, Hansburg (1972, 1976) found, for example, a number of differences in the way young adolescents separated from their families respond to the SAT situations as compared with the responses of adolescents from intact, stable homes. These differences, such as excessively self-sufficient responses on the part of the separated adolescents, suggest difficulties in the attachment process for such youngsters. Adolescents from secure homes responded with a greater proportion of attachment than individuation responses, although there was generally more

of a balance between these two types of response to separation amongst this group. Thus, the patterning of the responses to separation situations was the significant factor in determining the individual's characteristic reaction to such situations.

A Background Information Questionnaire, consisting of 24 questions, was developed specifically for this study and was used to provide demographic data and information about the subjects' histories of real separations and losses, their general perceptions of the degree of closeness within their families of origin, their families' incidence of panic disorder and agoraphobia or other psychiatric disorders, their birth order within their families of origin, and other issues of relevance to the study (see Appendix C).

Subjects. Ss were 10 males and 10 females in each of three groups. The first of these, the agoraphobic group, of central interest to this study, consisted of subjects who had been diagnosed as having agoraphobia and who had been successfully treated both with medication and psychotherapy, successful treatment being defined as cessation of panic attacks, relief of anticipatory anxiety, and absence of phobic avoidance behaviors. Persons actively experiencing panic attacks and symptoms of agoraphobia were not included in this study, as it would have been impossible to differentiate their responses to the research instruments from their responses to their active phobic anxiety and panic. Also in this regard, the question of whether an

"agoraphobic personality" underlies the symptomology, or remains intact once symptoms are relieved, would have been obscured by the inclusion of actively symptomatic subjects.

The second group of subjects were "neurotic" individuals, who had been treated for anxiety but not diagnosed as having panic disorder or agoraphobia, and who were not currently involved in psychotherapy. This group was of interest in terms of the study's central thesis concerning the role of separation anxiety in the evolution of panic disorder. While separation anxiety has been proposed as a universal and instinctive response to separation situations that threaten an individual's survival, and thus as an important element in the development of various defense mechanisms, its special significance for agoraphobic individuals has not been examined. The question is whether responses to separation situations distinguish agoraphobics from other anxious individuals.

The third comparison group was the "control" subjects. These individuals had not been involved in any psychotherapy and by self-report had not suffered from any serious anxiety or depression. This group was included in part to provide some normative data regarding the Separation Anxiety Test, and also to determine whether this test could differentiate between "normal" separation anxiety and more extreme anxiety.

The groups were matched for age, gender, educational background, and marital status. Age was controlled, because

there appears to be a bimodal distribution of age of onset for agoraphobia. Marital status was controlled in order to reduce the possible influence of "dependency" factors; if in contrast to agoraphobic subjects, all control subjects were single and lived alone, that in itself could represent differences in attachment and individuation needs between them and the agoraphobic group. Subjects were matched in educational attainment to provide a control for socio-economic status.

The agoraphobic subjects for this study were obtained through several of the author's colleagues in the metropolitan Boston and New York areas, who agreed to contact their former patients to inquire about their interest in participating in a research study. In order to mitigate the potential biasing influence of the therapist-patient relationship on the patient's decision to participate in the study, and because several therapists were involved in procuring subjects, a standard script for contacting potential subjects was developed (see Appendix A). This procedure was followed closely.

Potential subjects were informed that the author was planning to conduct a study for which subjects were needed who were both symptom-free and not presently in treatment. They were told nothing else about the study at that time, except that it was hoped its results would contribute to a better understanding of anxiety disorders. All 30 agoraphobic individuals who agreed to participate

in the study were then mailed a packet containing the research instruments, instructions, and a statement of informed consent to read and sign. Having been informed that the tests would take an hour or less of their time, subjects were instructed to complete these instruments in a quiet place at home where they would not be distracted, then return them by mail to the author.

Exactly ten agoraphobic males and twelve agoraphobic females returned the completed forms. In order to maintain even numbers of subjects for each gender, two female subjects were dropped from the study: one who did not complete the research instruments fully, and another at random.

After information regarding the age, marital status, and educational attainment of each agoraphobic subject was ascertained, the twenty subjects for the "neurotic" group matched with the agoraphobic subjects on these variables, were then obtained in the same manner by the author's colleagues. Twenty control subjects were sought from among these same sources, as well as through acquaintance of the author, and were again matched on these same variables.

All subjects were sent the same instructions, and returned their completed forms to the author by mail. None of the subjects in any of the groups knew the author, and all were reassured of the confidentiality of their participation.

Appendix A presents the age, marital status and educational attainment for each of the three groups.

Hypotheses

In general, it is expected that agoraphobic subjects will exhibit greater separation anxiety than neurotic and control subjects, and neurotic subjects will exhibit greater separation anxiety than control subjects. That is, there is a continuum of maladaptive responses to separation situations, from agoraphobic to neurotic to normal subjects. Operationally defined the hypotheses are:

I. Agoraphobic subjects will have a higher percentage of attachment responses on the SAT than the neurotic and control subjects.

II. Agoraphobic subjects will have a higher percentage of individuation than the neurotic and control subjects.

III. Agoraphobic subjects will have a higher percentage of hostility responses than the neurotic and control subjects.

IV. Agoraphobic subjects will have a higher number of reality avoidance responses, or denial, than the neurotic and control subjects.

V. Agoraphobic subjects will respond with fewer adequate coping responses, or more painful tension responses, to separations than the neurotic and control subjects.

VI. Agoraphobic subjects who experienced separation problems earlier in their lives, before the onset of adult agoraphobia will have a higher percentage of attachment, hostility, painful tension and reality avoidant responses

and a lower percentage of individuation responses, than agoraphobic subjects for whom the onset of the disorder was not preceded by early separation problems.

Exploratory Hypotheses

Predictions concerning the data gathered from the Background Information Questionnaire will be primarily exploratory, as there are few previous studies which have addressed these questions.

Exploratory Hypothesis I: There will be no difference between agoraphobic and neurotic and control subjects in the number of actual separations and losses they have experienced.

Exploratory Hypothesis II: Reported separations and losses will coincide in time with the onset of panic attacks in agoraphobic subjects.

Exploratory Hypothesis III: Agoraphobic subjects will report greater family closeness than will either of the other subject groups. This prediction is based on the notion of an interaction between the heightened anxiety of a child and the protective response of attachment figures.

Exploratory Hypothesis IV: Given recent studies' findings of high incidences of affective disorders, alcoholism and panic disorder in the families of agoraphobic parents, it is predicted that family incidence of psychiatric disorders will be higher in this group than the neurotic and control groups.

Chapter 5

RESULTS

The data were statistically treated by analyses of variance for each variable considered. The mean scores of the three subject groups were compared utilizing a split-block randomized design to determine differences amongst the three groups. The same design was used to determine differences between the neurotic and control groups.

The SAT protocols have been scored by Hansburg (1972) by determining each response theme's percentage of the total number of responses to the SAT and then examining the relations among these percentage scores to obtain patterns associated with various personality characteristics. Hansburg uses percentage scores because scales like his permit subjects to make different total numbers of choices. This response set (Cronbach, 1950) must be investigated before further analyses of data. Dividing choices on a given dimension by total choices makes a part-whole correlation possible and further consolidates maladaptive categories with adaptative categories. Table 1 shows the results of an analysis of variance of the total number of choices made to the 12 pictures in the test. (Tables for this and following ANOVAs are in Appendix B.)

Table 1. Total Responses to the SAT: Means, F-ratios from ANOVA and Statistical Significance

	Mean Group				
	A	N	C	F-ratio	P
N:	20	20	20		
Mild pictures	15.9	9.7	8.9	4.73	.05
Strong pictures	24.5	17.8	15.7	11.02	.01
All pictures	40.4	27.4	24.6	14.2	.01

It is clear that the agoraphobic group makes more choices than the others. To control for this group difference in total choices, individual scores on each maladaptive dimension were contrasted with scores on the individuation dimension, the measure of adaptative tendencies. The formula for each conversion was:

Maladaptive frequency (Maladaptive frequency + individuation frequency)

Hypothesis I stated that agoraphobic subjects would have a higher percentage of attachment responses on the SAT than would neurotic and control subjects. Hypothesis II stated that agoraphobic subjects would have a lower percentage of individuation responses on the SAT than neurotic and control subjects. Using the preceding ratio of attachment and individuation scores, Hypothesis I and Hypothesis II could be examined in one analysis. An analysis of variance was used to determine the significance of the

differences between the means for the three groups, and another analysis to determine the significance of the difference between the neurotic and control groups. As summarized in Table 2, the first analysis produced a highly significant F-ratio of 23.2. The corresponding analysis for the agoraphobic and control groups produced and F-ratio of 8.08, significant at the .01 level. These results show, as predicted, that agoraphobic subjects chose both a significantly higher percentage of attachment responses and a significantly lower percentage of individuation responses than both the neurotic and control subjects; neurotic subjects chose correspondingly higher and lower percentages than the control subjects. Both Hypotheses I and II are supported by the data.

Hypotheses IV, V, and VI were concerned with reactions to separation other than attachment, namely hostility, reality avoidance (denial) and painful tension (poor coping responses). Each of these dimensions was measured by comparing the total frequency of each of these categories of response with the frequency of individuation responses, again reflecting the balance between the number of maladaptive and adaptive reactions to separation. The results from the analyses of variance are reported in Table 2.

Hypothesis IV stated that agoraphobic subjects would have a higher percentage of hostility responses than both the neurotic and normal subjects. The analysis of variance

for these three groups produced a highly significant F-ratio of 17.07. The corresponding analysis of variance, comparing scores for the neurotic and control subjects, yielded an F-ratio of 5.8, significant at less than the .05 level. These results confirm Hypothesis IV; agoraphobic subjects react with a significantly higher percentage of hostile responses to the SAT than neurotic and control groups, and neurotic subjects select significantly more hostile responses than controls.

Hypothesis V predicted that agoraphobics would have a higher percentage of hostility avoidant responses on the SAT than would the neurotic and control subjects. As seen in Table 2, the analysis of variance of these scores of the three groups produced an F-ratio of 9.7, significant at less than the .01 level. The companion analysis of variance comparing reality avoidance scores of neurotic and control subjects produced an F-ratio of 6.7, significant at less than the .05 level. Again, the data support the hypothesis: agoraphobics are more likely than the others to select reality avoidance responses, and the neurotic subjects more likely to choose such responses than the controls.

Hypothesis VI stated that agoraphobic subjects would respond with fewer adequate coping responses, or greater frequencies of painful tension responses, than would neurotic and control subjects. As seen in Table 2, the analysis of variance for the three subject groups gave a

highly significant ratio of 15.95. The parallel analysis for the neurotic and control groups yielded an F-ratio of 14.26, significant at the .01 level. These results show that agoraphobic subjects tended to react to separation with fewer adequate coping responses, or a greater number of anxious, phobic and somatic responses, than both the neurotic and control subjects; and that neurotic subjects gave fewer adaptive responses than controls.

Table 2. Means, F-ratios from ANOVAs and Significance Levels of Attachment, Hostility, Reality Avoidance, and Painful Tension Scores for Agoraphobic (A), Neurotic (N), and Control (C) Subjects.

	A	N	C	F	P
Attachment	67.9	43.2	36.2	23.2	.01
Hostility	52.05	29.3	22.1	17.09	.01
Reality Avoidance	40.75	12.0	5.4	17.0	.01
Painful Tension	69.6	34.4	22.5	17.9	.001

Hypothesis VI stated that agoraphobics who experienced more separation difficulties as children would have a higher percentage of attachment, hostility, painful tension, and reality avoidant responses, (more maladaptive responses) and a lower percentage of individuation responses than agoraphobics for whom onset of the disorder was not preceded by earlier separation problems. In order to test this

hypothesis, mean scores on the attachment, hostility, painful tension, and reality avoidance and individuation variables for agoraphobic subjects who had early symptoms of agoraphobia (as reported on the questionnaire) were compared with those of agoraphobic subjects who did not report early difficulties. Only four of the 20 agoraphobic subjects reported childhood symptoms as precursors to their adult onset agoraphobia. As can be seen in Table 3, mean scores on these variables for these four subjects are higher than those of the other agoraphobic subjects. Thus, Hypothesis VI was not upheld by the data.

Exploratory Hypothesis I. The prediction that there would be no differences between the agoraphobic, neurotic and control subjects in the numbers of serious separations and losses they have experienced was supported by data from the questionnaire. Table 4 shows the mean number of losses reported by each group.

Exploratory Hypothesis II. The data did not support the prediction that reported losses among agoraphobic subjects were likely to coincide with the onset of their panic attacks. Only three female subjects and one male subject reported major separations and a death as preceding the onset of their symptoms. Of the other separations and losses experienced by these subjects, none were temporally associated by them with the onset of the disorder.

Exploratory Hypothesis III. The expectation that agoraphobic subjects would report greater family closeness

Table 3. Childhood Separation Symptoms and SAT Scores

	Attachment	Hostility	Painful Tension	Reality Avoidance	Individuation
Agoraphobic (n = 4) with	56.25	48.3	60.75	39.3	18.75
Agoraphobic (n = 16) without	70.90	53.0	71.80	41.4	14.25

Table 4. Mean Number of Losses and Separations Experienced by Agoraphobics (A), Neurotics (N), and Controls (C) as Children and Adults

	Group		
	A (n = 20)	N (n = 20)	C (n = 20)
Losses as children	.30	.35	.30
Losses as adults	.75	.60	.80

than would the neurotic and control subjects was not borne out by the data. In response to the questionnaire, subjects described the degree of closeness within their families on a scale from 1 to 5, with 5 representing extreme closeness. All of the group means were higher than 3.0, ranging from 3.3 to 3.6, indicating that all subjects tended to perceive a slightly more than average degree of closeness within their families.

Exploratory Hypothesis IV. The prediction that family incidence of psychiatric disorders would be higher in the agoraphobic group than the neurotic and control groups was partially substantiated by the results. As summarized in Table 5, agoraphobics were the only group to report a high rate of agoraphobia within their immediate and extended families. The incidences of other psychiatric disorders reported by each of the three groups were small.

Table 5. Number of Subjects Reporting Family Incidence of Agoraphobia and Other Psychiatric Disorders

	Group		
	A	N	C
Agoraphobia	12	1	1
Other psychiatric disorders	9	6	5

Chapter 6

DISCUSSION

The present study investigated a proposed but previously untested link between agoraphobia and separation anxiety by examining the responses of agoraphobic individuals to drawings depicting separation and loss. The hypothesis was that agoraphobic subjects would display greater vulnerability to separation experiences, responding more frequently with maladaptive responses than would neurotic and control subjects. Of the seven major hypotheses, the six that concern differences in separation anxiety between these three groups were strongly supported by the data. Agoraphobics selected significantly greater percentages of responses related to attachment, hostility, reality avoidance, and painful tension, and a smaller percentage of individuation responses. Neurotic subjects similarly chose more maladaptive and fewer adaptive responses than controls. A hypothesis involving comparison of agoraphobics with early separation difficulties to those without such problems was not supported by the data.

Clearly, the SAT evokes powerful reactions to separation in agoraphobics. Even the total number of responses selected by such subjects was significantly greater than that chosen by neurotic and control subjects, with the mean

frequency for agoraphobics nearly twice that of the others. Since subjects were asked to imagine that they were the child in the scenes shown on the SAT, the greater responsiveness of the agoraphobics may be related to their having experienced greater anxiety about separation when they were children. Although these agoraphobics did not report greater separation anxiety as children, previous studies (Klein, 1964, 1981) have found that as many as 50% of agoraphobics experience school phobia as children. It is of interest that on the pictures showing a child going to school in the morning, a mild separation, many of the agoraphobic group chose attachment and phobic responses, suggesting unhappy childhood experiences for them.

Although there were significant differences in the frequency of total responses between each of the three groups of subjects, the difference between agoraphobics and neurotics was surprisingly large. While significant as predicted, differences between neurotics and controls were much smaller. An examination of the protocols indicates that agoraphobics selected many responses to each separation situation, even the mild, temporary separations. This responsiveness to the mild separations is noteworthy, as these pictures would appear to generate independence striving in most individuals, suggesting that even the most minor separation is felt by an agoraphobic as catastrophic. Further, since the agoraphobics participating in this study were not actively phobic--they were "healthy"

compared to those seeking treatment--their high degree of responsivity to the SAT must reflect underlying personality patterns and unconscious responses to separation. Given the results of this study, agoraphobics must be viewed as a distinct group among other kinds of anxious persons.

The hypotheses concerning the balance of attachment to individuation responses were strongly confirmed by the analysis. Agoraphobics chose a significantly greater number of attachment compared to individuation responses than did neurotics and controls, with an average of 67% attachment and 33% individuation scores. On the SAT, such scores of 50% or greater indicate a balance dominated by the attachment theme. The neurotics' mean of 43% and the controls' mean of 36% represent ratios dominated by individuation responses.

According to Hansburg (1972), the mild separation scenes are expected to produce a low number of attachment responses: conversely, the strong separation scenes should produce a greater number of attachment responses. He points out that any shift in this pattern toward equalization on the mild and strong scenes is a likely "symbiotic" indicator. Furthermore, when attachment responses to mild separation scenes exceed the number of individuation responses to these separations, a very strong symbiotic indicator is

present.[9] In Hansburg's validity studies, adolescents from intact, secure homes, as opposed to those separated from their families, tended to select a slightly higher total frequency of attachment responses than individuation responses. In the present study, the neurotic and control subjects had a higher frequency of individuation responses, which Hansburg might interpret as excessive self-sufficiency. This discrepancy can best be accounted for by the fact that the subjects in the present study were adults, not adolescents. It is likely that having resolved the issues of adolescence, including issues of autonomy and dependency, healthy adults may actually be slightly more self-sufficient than they are affiliative. Another explanation for the difference in the findings between this and Hansburg's study is the scoring method he employs, the problems of which were mentioned in the preceding section.

Hansburg (1980) asserts that attachment is a primary response related to the basic instinctive need for protection and care. In the attachment system, an individual seeks proximity to another for the instinctual purpose of

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[9]Hansburg (1972, 1976) describes severe anxious attachment as an unconscious symbiotic need, a desire for a relationship in which the individual feels fully and completely attached to another. Unlike the term's usage in biology, which refers to an adaptive partnership where both parties are dependent upon each other for survival, the attachment figure in Hansburg's usage does not necessarily share in the attachment need. That is, symbiotic attachment refers to "an unconscious feeling (about) unassuaged experiences during early childhood when the attachment figure's need to separate from the infant...was never adequately accepted by the child."
Hansburg, 1980, p. 16

protection and subsequently for other elaborated and sophisticated gratifications geared to survival. "Since the propensity for proximity-seeking, especially with an attachment figure, is based on organismic trends built in as a survival measure, it seems likely that humans vary from individual to individual in the intensity and extent of this trend" (Hansburg, 1980, p. 36). Hansburg states that the number of attachment responses to the strong pictures should be approximately 40% greater than the responses to the mild pictures. If both areas are sizable, he concludes that the need for closeness is always intense no matter how mild or how strong the separation stimulus. Such a high attachment response is consistent with poor functioning in the absence of a feeling of accessibility of a highly supportive figure.

Agoraphobics, then, appear as anxiously attached. They seem not to have succeeded in developing adequate coping behaviors, either because of early dependence strivings, which were perhaps responded to with overprotectiveness by parents; or because their overreactivity to separations interfered with the development of such skills. The sensations of panic and anxiety set into motion by separation overwhelm these individuals.

Hansburg notes that when attachment need is very high, especially in response to mild separations, other anxious attachment indicators are likely to be present as well: attachment responses are highly correlated with separation pain in this instance. Examining the agoraphobics' painful

tension responses makes this clear in the present case. Painful tension, including anxious, phobic and somatic items, accounted for a large percentage of total responses for the agoraphobic subjects. A separate analysis of variance was performed isolating the phobic, somatic and anxious responses for the agoraphobic and neurotic groups. Results indicated that it is the phobic and somatic responses that account for much of the difference in the mean scores between the two groups. While both neurotic and agoraphobic subjects endorsed a relatively high number of items reflective of anxiety, only agoraphobic subjects had a high frequency of somatic and phobic responses. Virtually none of the control and only a few of the neurotic subjects selected somatic responses. These findings support the notion that neurotic and agoraphobic subjects respond to separation in qualitatively different ways, agoraphobics being more likely to react to separation with fear and with somatic complaints. Hansburg notes that this painful tension variable is a highly sensitive indicator of the individual's "alarm system."

Somatic responses as the choices of agoraphobic subjects are not surprising in light of the physical sensation of panic which is the hallmark of the disorder. Agoraphobics often become highly focused upon any changes in bodily sensations, so vigilent are they of signs on an impending panic attack. This heightened awareness of alertness may contribute to a kind of excessive somatic preoccupation that influences the nature of their responses to anxiety-provoking

situations. It may also be that agoraphobics have heightened physiological responses. Data from the questionnaire which indicate greater family incidence of agoraphobia and other psychiatric disorders among agoraphobics may be relevant to this finding regarding the high painful tension scores of these subjects. The reported high rate of incidence of agoraphobia within this group's families may reflect a genetic predisposition for development of this disorder. It may be speculated that agoraphobics differ from other anxiety neurotics in their heightened physiological reactivity to stimuli.

Hypothesis IV stated that agoraphobic subjects would select significantly more hostility responses than would neurotics and controls, a predication that was strongly supported by the data. As with painful tension and attachment responses, agoraphobic subjects consistently chose the least adaptive responses to separations situations. If hostile responses are viewed as strong protest reactions to the threat of separation (Bowlby, 1973), reacting to separation with anger is an appropriate response. It may act as retribution against an abandoning figure or be an attempt to retrieve and keep the lost figure. Persistent anger, however, may serve to alienate that object of attachment and thereby serve a nonadaptive purpose. Agoraphobic subjects in this study chose hostile responses to a greater extent than they selected adaptive responses, suggesting again that their strong affective response to separation interferes with more

adaptive strategies and reflects an ambivalence towards the object of attachment.

Hypothesis V stated that agoraphobic subjects would choose reality avoidance responses more often than neurotic and control groups. This finding, confirmed by the data, provides further evidence that agoraphobic subjects tend to have maladaptive reactions to separation. They do not appear to have ways of sublimating or otherwise coping with the stress of separation, reacting by denying the separation. The reality avoidance variable included the response items of withdrawal, fantasy and evasion. Fifteen of the forty neurotic and control subjects chose no reality avoidance responses and seventeen others selected only one such response. Hansburg notes that whenever an individual's defensive pattern is less than 10% of the total protocol, that individual is likely to be strongly reality-oriented. Although the control subjects were expected to show this pattern, the neurotics' low scores on reality avoidance as compared with the agoraphobics' scores are more surprising. This finding may again underscore the difficulty agoraphobics appear to have specifically with separation situations, as distinct from other anxiety-provoking situations.

Hypothesis VI, predicting a greater number of maladaptive responses in agoraphobics who reported early onset of agoraphobic symptoms than in agoraphobics who reported adult onset of symptoms, was the only major hypothesis not supported by the data. There were simply not enough subjects

reporting an early onset of symptoms to make the comparison statistically meaningful. In addition, the questionnaire item concerning early and late onset of agoraphobia may not have elicited the intended information. The question could have been interpreted in several ways; a question asking whether subjects had had difficulties attending school as children might have provided more clear-cut information on which to base the comparison.

To speculate further about the agoraphobics' greater responsivity to the research instrument, it is possible that their psychotherapy experiences resulted in their being more highly sensitized than the other subject groups to the issues of separation. The neurotic subjects, while also having experienced successful psychotherapy, may have been less likely to have focused during treatment on any one precipitant or cause of their anxiety. It is more likely, in fact, that the anxiety of the neurotic group stemmed from many disparate sources, so that the group was less homogeneous than the agoraphobic group in terms of the ways in which they learned to identify and cope with their anxiety.

Another explanation for the findings of this study is that the agoraphobic group may actually be more "disturbed" than the neurotic group; their problems may involve more primitive developmental sources, or their neuropsychological systems may be more generally reactive. Agoraphobics' affect may be more readily aroused, or they may engage more rapidly in fantasy. (Many agoraphobics report that the sensation of

panic is often accompanied by vivid visualizations of frightening situations that instantly overwhelm them.) It is possible that agoraphobics do have greater accessibility to fantasy and that it is this very accessibility which allows greater empathy with the protagonists in the SAT pictures. Two questions remain: 1) is it the psychotherapeutic process that engenders greater access to fantasy in agoraphobics, or do such individuals already possess this tendency? and 2) does this heightened reactivity mean that agoraphobics would respond with greater intensity and frequency to any emotionally-charged stimuli? In future studies, in order to test whether the agoraphobics' sensitivity to separation can be distinguished from their reactivity to all stimuli, control pictures (potentially anxiety-provoking but non-separation situations) could be presented along with the SAT.

Exploratory Questions

The first question asked whether agoraphobic subjects had experienced more actual losses and separations than had other subjects. It was expected that there would be no differences in the numbers of reported losses among the three groups; the results support this prediction. The purpose in asking this question was to control for the possibility that agoraphobic subjects react strongly to separation because they actually have been traumatized by earlier serious separations. The view taken in this study is that maladaptive responses to separation develop not as reactions to actual traumas, but as hypersensitive responses to normal

separations. That agoraphobic subjects did not report a greater frequency of losses and separations than the neurotic and control subjects supports this hypothesis.

The secondary exploratory question was concerned with the connection between losses and the onset of agoraphobia. It was expected that reported losses would coincide in time with the onset of the disorder, a prediction not supported by the data. A possible explanation for this lack of support may have been problems in the wording of the questionnaire item. In addition, many agoraphobic subjects were very uncertain about what precipitated their first panic attacks, and thus might not associate separations and losses with the onset of their symptoms.

The question predicting greater family closeness in the agoraphobic group was not supported by the data. This finding does not agree with those of previous studies holding that agoraphobics tend to come from closely-knit families. One reason for this discrepancy is that responses to the questionnaire item were necessarily limited by the subjects' interpretations of closeness. The wording of the item was broad; its possible meanings depend upon the perspective of the subject. Stating the degree of closeness does not reveal the quality of the relationships or how the subject felt about the closeness within the family; so that, for example, extreme closeness could be associated with smothering relationships for some and with loyalty and dependability for others. It is noteworthy, however, that agoraphobic

subjects chose the extremes of closeness and distance more often than the other subjects; this may reflect agoraphobics' very strong ambivalent attachment need.

The fourth question stating that familial incidence of psychiatric disorders, including agoraphobia, would be higher in agoraphobic subjects than in neurotic and control subjects was partially supported by the data. Agoraphobic subjects reported a high incidence of agoraphobia in their families, while the neurotic and control groups gave only one report each of this disorder within their families. The differences between groups in reporting other psychiatric disorders within their families, however, were negligable. A possible reason for this is that the questionnaire item did not specify any psychiatric disorder,s thus reporting may not have been accurate. Similarly, because a high frequency of panic attack and agoraphobia were reported only in families of the agoraphobics, it is possible that the other subjects were not familiar with these terms. Finally, agoraphobics may be so sensitized to the symptoms of this disorder that their own diagnoses of their families are unreliable. One subject, for example, reported that his entire immediate family showed signs of agoraphobia. It seems more likely that his interpretation of his family's functioning is biased.

It was speculated that oldest and youngest children would be more likely represented within the agoraphobic groups, an idea based on the notion that families may

experience difficulties in connection with a firstborn leaving home--when agoraphobia often appears. Youngest children, on the other hand,might encounter the same difficulty; families may unconsciously wish to have a child at home in order to maintain the family structure. In both of these situations, unresolved conflicts between parent and child from earlier developmental stages were thought to be restimulated by the attempt of the adolescent to separate. However, no differences in birth order were found among the three groups, and the small sample size mitigated against such differences being statistically significant. It is also possible that the issues of separation have less to do with an individual's being the first or last to leave the home than they do with the idiosyncratic nature of the relationships between parents and their children.

Implications for Future Research

The present study succeeds in offering strong evidence that agoraphobics are extremely sensitive to separation situations, and that it is this sensitivity that distinguishes them from other anxious individuals. More specifically, the data supported the prediction that agoraphobic subjects would select more maladaptive and fewer adaptive responses to the research instrument than would neurotic and control subjects. The results of the study provide further validation of the separation anxiety test in its ability to differentiate separation reaction patterns in

two groups of anxious subjects and in its usefulness in an adult population.

Future research might be directed towards using this measure to explore differences in response patterns between agoraphobic and clinically depressed individuals, groups whom previous studies have suggested are equivalent, based on their similar response to anti-depressant medication and the frequent diagnosis of affective disorders in the families of agoraphobics. Klein's (1981) hypothesis that agoraphobia and depression involve different parts of the same proposed biological mechanism controlling separation anxiety responses (protest and despair respectively) might be examined by an analysis of these two groups' responses to the SAT. Such an investigation might provide further support for the significance of the role of separation anxiety in the development of panic disorder and agoraphobia.

Although the present study was not able to distinguish agoraphobia subjects with early onset of separation anxiety symptoms from those with late onset of symptoms, an informal examination of this group's responses to the SAT indicated a high degree of variability amongst these subjects and suggests that a larger sample and improved methodology for obtaining historical information might provide further differentiation amongst subjects in this group that is relevant to preventive strategies and to treatment outcome.

It would be of interest, both in terms of providing further validation of the SAT and testing other theoretical

concepts of agoraphobia to compare agoraphobics' responses to the SAT with their responses to other instruments measuring dependency and anxiety. In light of the agoraphobic's tremendous responsivity to the SAT, a comparison with their responses to other projective tests might further distinguish their reactions to separation from their reactions to situations which tap other unconscious processes, and might test the notion that agoraphobics have a heightened physiological response to stressful stimuli.

Since agoraphobia may be the result of reaction patterns begun in childhood, it would be interesting to test the validity of the SAT in differentiating children with separation anxiety disorder from depressed children and compare their responses to the SAT with temperament measures.

A more ambitious undertaking involving children would be a longitudinal study of school phobic and highly anxious children, which would investigate the evolution of panic disorder and agoraphobia by examining the outcomes in adulthood of these childhood symptoms, and by evaluating the effectiveness of various treatment interventions with children.

Parents react variously to apprehension and fearfulness in their children, which often sets off either overprotectiveness by parents, resentment of the child's demandingness and dependency, or a combination of both of these, which then charges the relationship with much ambivalence and conflict. Studies assessing various parental

responses to their fearful children might provide evidence for the contribution of this interaction to the development of agoraphobia and might suggest methods of improving psychotherapeutic interventions.

APPENDICES

APPENDIX A

Telephone Script for Contacting Subjects

Subject Matching

Telephone Script for Contacting Subjects

1. Greeting and introduction: "Hello, Ms._____. This is Dr._____ calling."

2. General inquiry about patient's health since terminating treatment, in part to determine symptom status.

3. Describe reason for your call: "I am calling to ask whether you would be interested in participating in a research project being done by a colleague of mine, Maxine Liberman. She is conducting a study on anxiety and phobias and is looking for subjects who have been in treatment for these problems, but who are not now in treatment and are free of their previous symptoms." Inquire further about symptoms and treatment status. If patient does not meet these criteria, thank them for their time in listening. If patient does meet the criteria, ask whether they would be interested in hearing more about the study.

4. Describe the study: "Briefly, the study involves your filling out research materials which will be mailed to you. Completing these forms should take less than one hour, and there is no payment for taking part in the study. Your decision to participate is entirely voluntary. You are under no obligation to decide to participate, and if you do decide to be a subject in the study, you may withdraw from participating at any time during the study."

5. "Please feel free to contact me or the researcher if you have any concerns about your participation in the study or about the study itself. The results of the research will be available to you when the study is completed."

Subject Matching

Agoraphobic Subjects

Gender	Age	Marital Status	Education
E	30	m	college, medical school (n.c.)
F	38	sep	1 yr. college
F	41	m	high school
F	30	m	high school
F	27	m	college
F	25	m	high school (n.c.)
F	29	m	college, grad. school (n.c.)
F	44	m	high school
F	33	m	master's degree
F	45	m	college (n.c.)
M	36	m	grad. school
M	24	s	college
M	37	m	college (n.c.)
M	31	m	college (n.c.)
M	31	m	master's degree
M	33	m	college
M	38	div	college
M	26	s	high school
M	29	m	college (n.c.)
M	48	m	college (n.c.)

m = married
s = single
sep = separated
div = divorced
(n.c.) = not completed

Neurotic Subjects

Gender	Age	Marital Status	Education
F	30	m	grad. school
F	35	div	college (n.c.)
F	42	m	high school
F	29	m	high school
F	29	m	college
F	24	m	high school
F	31	m	grad. school
F	45	m	high school
F	32	m	master's degree
F	42	m	college
M	36	m	grad. school
M	25	s	college
M	37	m	college
M	30	m	college
M	32	m	master's degree
M	32	m	college
M	39	div	college, grad. school (n.c.)
M	24	s	high school
M	30	m	college
M	48	m	college

Control Subjects

Gender	Age	Marital Status	Education
F	30	m	grad. school
F	37	div	college (n.c.)
F	42	m	high school
F	30	m	high school
F	28	m	college
F	25	m	high school
F	30	m	grad. school
F	43	m	high school
F	32	m	master's degree
F	47	m	college
M	36	m	Ph.D.
M	25	s	college
M	36	m	college
M	29	m	college
M	30	m	master's degree
M	30	m	college
M	42	div	college plus
M	27	s	high school
M	28	m	college
M	44	m	college

APPENDIX B

ANOVA Tables

Table II-1: ANOVA for Agoraphobic, Neurotic and Control Groups: Frequency Strong Pictures

Source	Sum of Squares	d.f.	Mean Square	F-ratio	p
Gender	69	1	69	1.42	n.s.
Blocks*	878	18	48.7		
Group	838	2	419	11.02	.01
G X G	3	2	1.5	.04	n.s.
Residual	1369	36	38.0		
Total	3157	59			

*of matched subjects

Table II-2: ANOVA for Agoraphobic, Neurotic and Control Groups: Frequency Mild Pictures

Source	Sum of Squares	d.f.	Mean Square	F-ratio	p
Gender	3	1	3	.12	n.s.
Bocks	436	18	24.2		
Group	591	2	295.5	4.73	.05
G X G	1	2	1.0	.02	n.s.
Residual	2251	36	62.5		
Total	3282	59			

Table II-3: ANOVA for Agoraphobic, Neurotic and Control Groups: Total Frequency

Source	Sum of Squares	d.f.	Mean Square	F-ratio	p
Gender	3	1	0	.02	n.s.
Blocks	2361	18	131.2		
Group	2824	2	1412.0	14.5	.01
G X G	41	2	20.5	.21	n.s.
Residual	3495	36	97.0		
Total	8724	59			

Table II-4: ANOVA for Neurotic and Control Groups: Total Frequency

Source	Sum of Squares	d.f.	Mean Square	F-ratio	p
Gender	26.0	1	26.0	4.5	.05
Blocks	104.0	18	5.7		
Group	78.4	1	78.4	14.2	.01
G X G	0	1	0	0	n.s.
Residual	99.6	18	5.5		
Total	308.0	39			

Table II-5: ANOVA for Agoraphobic, Neurotic and Control Groups: Attachment

Source	Sum of Squares	d.f.	Mean Square	F-ratio	p
Gender	0	1	0	0	n.s.
Blocks	3476	18	193.1		
Group	11592	2	5796	23.2	.01
G X G	882	2	41	.16	n.s.
Residual	8999	36	250		
Total	24149	59			

Table II-6: ANOVA for Neurotic and Control Groups: Attachment

Source	Sum of Squares	d.f.	Mean Square	F-ratio	p
Gender	0	1			n.s.
Blocks	1674	18	93.0	0	
Group	970	1	970.3	8.13	.05
G X G	81.4	1	81.4	.68	n.s.
Residual	2149	18	119.4		
Total	4873	39			

Table II-7: ANOVA for Agoraphobic, Neurotic and Control Groups: Hostility

Source	Sum of Squares	d.f.	Mean Square	F-ratio	p
Gender	1	1	1	.003	n.s.
Blocks	5253	18	291.8		
Group	9776	2	4888	17.09	.01
G X G	76.1	2	38	.13	n.s.
Residual	10297	36	286		
Total	25403	59			

Table II-8: ANOVA for Neurotic and Control Groups: Hostility

Source	Sum of Squares	d.f.	Mean Square	F-ratio	p
Gender	1	1	1	.01	n.s.
Blocks	1855	18	103		
Group	519	1	519	5.8	.05
G X G	72	1	72	.81	n.s.
Residual	1610	18	89.4		
Total	4057	39			

Table II-9: ANOVA for Agoraphobic, Neurotic and Control Groups: Reality Avoidance

Source	Sum of Squares	d.f.	Mean Square	F-ratio	p
Gender	700	1	700	1.65	n.s.
Blocks	7603	18	422.4		
Group	14132	2	7066	17.0	.01
G X G	127	2	63	.15	n.s.
Residual	14874	36	413.2		
Total	37436	59			

Table II-10: ANOVA for Neurotic and Control Groups: Reality Avoidance

Source	Sum of Squares	d.f.	Mean Square	F-ratio	p
Gender	1864	1	1864	87.5	.01
Blocks	384	18	21.3		
Group	435	1	435	6.7	.05
G X G	116	1	116	1.79	n.s.
Residual	1171	18	65		
Total	3970	39			

Table II-11: ANOVA for Agoraphobic, Neurotic and Control Groups: Painful Tension

Source	Sum of Squares	d.f.	Mean Square	F-ratio	p
Gender	778	1	778	4.14	n.s.
Blocks	3387	18	188		
Group	23993	2	11997	179.0	.01
G X G	177	2	88.5	.32	n.s.
Residual	9975	36	277.1		
Total	38310	59			

Table II-12: ANOVA for Neurotic and Control Groups: Painful Tension

Source	Sum of Squares	d.f.	Mean Square	F-ratio	p
Gender	230	1	230	3.06	n.s.
Blocks	1351	18	75		
Group	1416	1	1416	14.26	.01
G X G	4.2	1	4.2	.04	n.s.
Residual	1787	18	99.3		
Total	4788	39			

APPENDIX C

Consent Form

Background Information Questionnaire

Consent Form For Voluntary Participation

In Psychological Research

I agree to participate in a study exploring the relationship between early life experiences and later psychological adjustment. I understand that I will complete two forms, one a background information questionnaire, and the other a research instrument which will assess my feelings and thoughts about certain childhood situations; and that the time required to complete these forms is approximately one hour or less.

It has been explained to me that I may withdraw from participation in the research at any time during the course of the study without any penalty to me. I understand that the information I provide will be used anonymously, and that no one will be informed of my participation or the content of the information I provide. I also understand that the purpose of the identification number on each page of the research forms is to identify the entire questionnaire when the pages are separated for analysis; the identification numbers will not be used in any way to identify me or the answers I give.

I have been informed that the results will be analyzed by the researcher, Maxine Liberman, and may eventually be published. I know that I will not be paid for my participation in this study and that its purpose is to advance our understanding of psychological development. I have been given the opportunity to ask any questions I may have about this study, which have been answered to my satisfaction.

Date_____ Signature_____

Signature of Witness_____

Background Information Questionnaire

General Instructions

This packet contains two forms. One is a Background Information Questionnaire (A) and the other is the Research Questionnaire (B), which requires that you think about and select responses to various illustrated situations. It is recommended that you find a place to fill out the Questionnaires where you will not be distracted, as Questionnaire B requires some degree of reflection and concentration. Please do not consult anyone else, either family members or friends, about your answers. We need to know how you, yourself, would react to these situations. Please give the best answers that you can. Although it is unlikely, if you find you have no response to a question, please indicated this so that it will not appear as though a question has simply been overlooked.

Again, thank you for your participation in this study.

****

Questionnaire A

Instructions: Please answer all of the questions presented below either by circling the letter before the appropriate answer or by writing the information in the spaces provided.

1. Age: _____

2. Sex: _____

3. Marital Status:
   a. single
   b. married
   c. living with someone
   d. separated
   e. divorced
   f. widowed
   g. other_____

Questionnaire A (continued)

4. If married, is this your:
   a. first marriage
   b. second marriage
   c. third marriage
   d. more than three marriages

5. If not currently married, but married previously, how many times were you married? _____

6. If married or living with someone, how long has it been since this relationship began? _____

7. How many children do you have? (Please include children who are deceased.) _____

   What are their sexes and ages? Sex: Age:

   _____
   _____
   _____
   _____
   _____
   _____
   _____

8. How old were you when you first left home? _____

9. After leaving home, did you ever return to live there again? When and for how long? _____
   _____
   _____

10. What is the highest level of formal education you have completed? _____

11. What is your birth order in the family in which you were raised (were you oldest, youngest, etc.?) _____

12. Please list the ages and sexes of your brothers and sisters, beginning with the oldest and including yourself.

Sex:	Age:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

13. Please list the ages of your parents: mother _____
    father _____

14. What is the marital status of your parents?_____
_____

15. If your parents are divorced or widowed, how old were you when this occurred? _____

16. Did your mother work outside your home when you were a child? _____ If yes, how old were you when she started work? _____

17. Did you have any major losses, such as the death of a friend or relative, when you were a child? _____ If yes, please specify this loss. _____
_____
as an adult? _____

18. Have you ever experienced panic attacks or agoraphobia? _____ If yes, how old were you when the symptoms began? _____ Did the sumptoms first occur following a specific event? _____ Please specify that event._____

19. Please list any other relatives who have experienced panic attacks or agoraphobia. _____

20. Has a relative had any other psychiatric disorder of which you are aware? _____ If so, please specify.
_____

21. On a scale of 1 to 5, how closely-knit would you describe the family in which you were raised. Please circle the appropriate number.

1	2	3	4	5
extremely distant	not especially close	averagely close	more than averagely close	extemely close

APPENDIX D

Separation Anxiety Test

Sample of Test Items

Scoring Forms

Questionnaire B

INSTRUCTIONS: This questionnaire consists of twelve illustrations depicting a child in various situations. This is not a test, nor are there any right or wrong answers. We are interested only in the way you felt, or the way you would have felt, if you had been the child in each of the pictures you are about to see. In other words, we are asking you to imagine that you are a child and to react as if the situation had occurred when you were a child. For each situation there are a number of statements about the child in the picture and you are to select as many statements about the child in the picture and you are to select as many statements as you wish which indicate how the child feels. Please read through all of the responses for each picture and then circle the number of the response(s) you are selecting. If there is anything else which you would like to say about how the child feels, please write it in at the bottom of the page. Also, please view the pictures in the order that they appear.

When you have completed both Questionnaire A and B, and have signed the consent form, please return them in the envelope provided. Again, thank you very much for contributing your time and effort to this study.

ID #_____

THE BOY WILL LIVE PERMANENTLY WITH HIS GRANDMOTHER AND WITHOUT HIS PARENTS

The Boy Feels

1. that he will be much happier now.
2. that his parents don't love him any more.
3. like curling up in a corner by himself.
4. a terrible pain in his chest.
5. alone and miserable.
6. that he dosen't care what happens.
7. that he will do his best to get along.
8. that this house will be a scary place to live in.
9. that something bad is going to happen to him now.
10. that it's all the fault of his neighbors.
11. angry at somebody.
12. that he won't be the same person any more.
13. that if he had been a good boy, this wouldn't have happened.
14. that it's only a dream—it isn't really happening.
15. like reading a book, watching TV or playing games.
16. sorry for his parents.
17. he won't be able to concentrate on his schoolwork.

THE BOY WILL LIVE PERMANENTLY WITH HIS GRANDMOTHER AND WITHOUT HIS PARENTS

A BOY IS BEING TRANSFERRED TO A NEW CLASS

This Child Feels

1. that he dosen't care what happens.
2. that the new class is a scary place to be.
3. sorry for his past teacher.
4. that if he had been a good boy, this wouldn't have happened.
5. like playing games with other children.
6. that something is happening to change him.
7. that he make the best of the situation.
8. that nobody really likes him.
9. that now he is going to have a good time.
10. that it's not really happening—it's only a dream.
11. that he won't be able to concentrate on his school work.
12. like sitting alone in the corner of the room.
13. very angry at somebody.
14. like he's getting a stomach ache.
15. alone and miserable.
16. that something terrible is going to happen.
17. that somebody bad is responsible for doing this to him.

A BOY IS BEING TRANSFERRED TO A NEW CLASS

THE FAMILY IS MOVING TO A NEW NEIGHBORHOOD

The Child Feels

1. afraid to leave.
2. a pain in the stomach.
3. that the neighbors made them move.
4. glad to get away from this bad neighborhood.
5. alone and miserable.
6. that he dosen't care what happens.
7. that it's only a dream.
8. like hiding somewhere.
9. that the new house will be a scary place to live in.
10. that now he will be a different person.
11. that he won't be able to concentrate on his school work.
12. sorry for his parents.
13. that he will make the best of the situation.
14. like punching somebody in the face.
15. that nobody likes him any more.
16. that now he can make some new friends.
17. that if he had behaved in the neighborhood, he wouldn't have to move.

THE FAMILY IS MOVING TO A NEW NEIGHBORHOOD

THE CHILD IS LEAVING HIS MOTHER TO GO TO SCHOOL

The Boy Feels

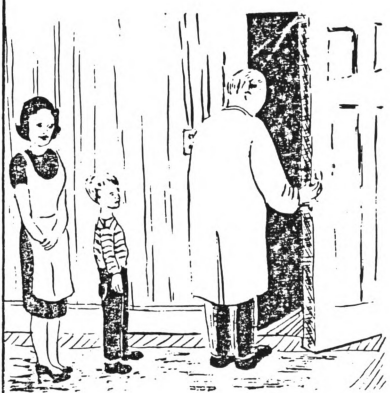
1. that he won't be able to concentrate on his school work.
2. afraid to leave.
3. that school is a scary place to be.
4. that his mother doesn't like him.
5. that he dosen't care what happens.
6. angry at having to go to school.
7. like joining his friends and going to school.
8. glad to get away from his house.
9. sorry for his mother.
10. like he's going to be sick.
11. that something is happening to change him.
12. if he had been a good boy, his mother would let him stay home.
13. like staying home in bed.
14. that he will do his best to get along.
15. that it's not really happening—it's only a dream.
16. alone and miserable.
17. that somebody else is causing all this trouble.

THE CHILD IS LEAVING HIS MOTHER TO GO TO SCHOOL

AFTER AN ARGUMENT WITH THE MOTHER, THE FATHER IS LEAVING

The Boy Feels

1. very angry at the father.
2. that now he is free to do anything he wants to.
3. that his home will now be a scary place.
4. that he won't be able to concentrate on his school work.
5. that something terrible is going to happen to him now.
6. that someone else has been causing all of this trouble.
7. like reading a book, fixing something or watching TV.
8. like something is happening to change him.
9. lonely and unhappy.
10. nobody really likes him.
11. that he is going to be very sick.
12. like hiding away in his parent's bedroom.
13. sorry for his mother.
14. that he doesn't care what happens.
15. that he will try hard to work things out.
16. that he, himself, caused his father to leave.
17. that it's only a dream—it really isn't happening.

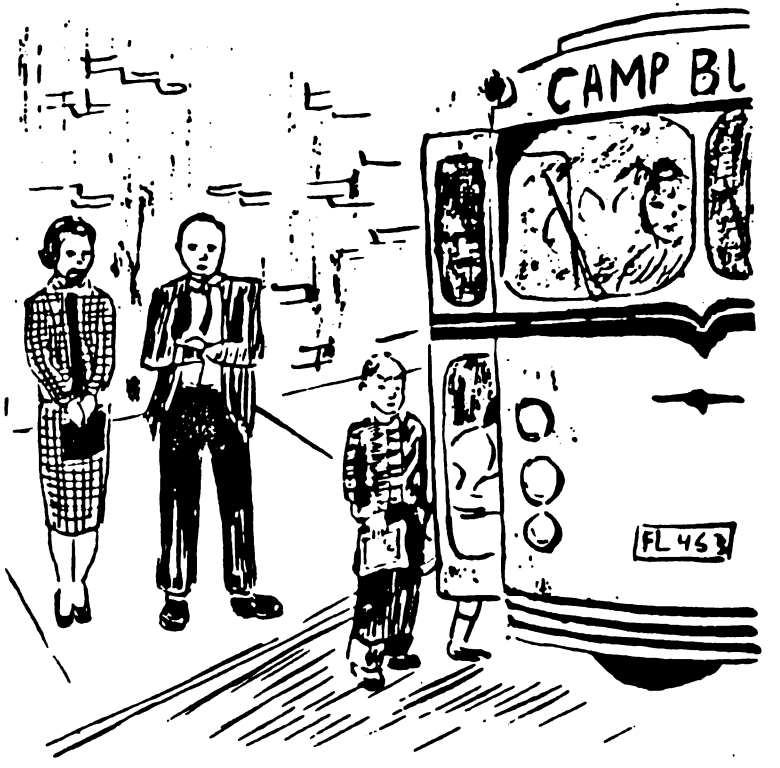


AFTER AN ARGUMENT WITH THE MOTHER, THE FATHER IS LEAVING

A CHILD IS LEAVING HIS PARENTS TO GO TO CAMP

The Boy Feels

1. sorry for his parents.
2. angry about going.
3. that this is a scary place to be.
4. that now he will be a different person.
5. that it's not really happening—it's only a dream.
6. that his mind can't think straight.
7. like sitting alone in the back of the bus.
8. that someone else made this happen to him.
9. like reading a book and playing games.
10. that he doesn't care what happens.
11. that something terrible is going to happen to him.
12. that a bad headache is coming on.
13. that nobody really loves him.
14. that he will make the best of the situation.
15. that if he had been a good boy, his parent's wouldn't send him away.
16. that now he is really free to enjoy himself.
17. alone and miserable.

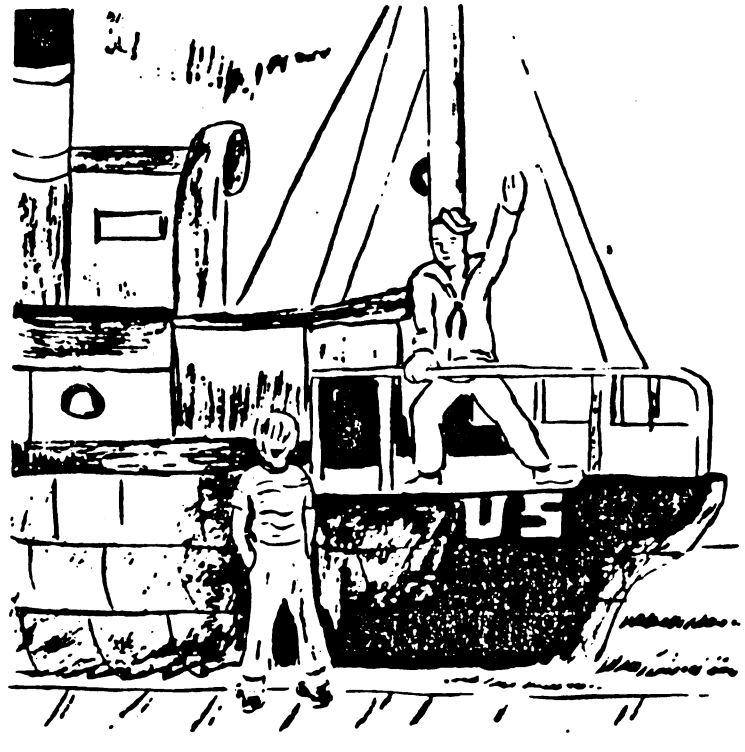


A CHILD IS LEAVING HIS PARENTS TO GO TO CAMP

THE BOY'S OLDER BROTHER IS A SAILOR LEAVING ON A VOYAGE

The Child Feels

1. sorry for his brother.
2. that if he had behaved better, his brother wouldn't have left him.
3. that it's not really happening—it's only a dream.
4. that this is a very scary thing.
5. very angry.
6. lonely and miserable.
7. that he will not be the same person any more.
8. like sitting alone in his room at home.
9. that someone else caused all this trouble.
10. like playing a game with his friend.
11. that he won't be able to concentrate on his school work.
12. that he will try hard to work things out.
13. that something terrible is going to happen to him.
14. that nobody really likes him.
15. that a bad stomach ache is coming on.
16. that he doesn't care what happens.
17. that now he is free to enjoy himself in any way he likes.



THE BOY'S OLDER BROTHER IS A SAILOR LEAVING ON A VOYAGE

THE JUDGE IS PLACING THIS CHILD IN AN INSTITUTION

The Child Feels

1. that the world is full of bad people who did this to him.
2. that it's only a dream and he will wake up soon.
3. like committing suicide.
4. that he will go and make the best of it.
5. sorry for his parents.
6. that the court room is a frightening place.
7. like curling up in a corner.
8. dizzy and faint.
9. that he doesn't care what happens.
10. happy to get to the institution as soon as possible.
11. that he is not very well liked.
12. terrified at what will happen to him.
13. like reading a book or watching TV.
14. angry at the judge.
15. that now he won't be able to learn school work.
16. all alone and unhappy.
17. that now he will be a different person.

THE JUDGE IS PLACING THIS CHILD IN AN INSTITUTION

THE MOTHER HAS JUST PUT THIS CHILD TO BED

The Boy Feels

1. angry at his mother.
2. that it's scary to be alone here.
3. like hiding under the covers.
4. that he doesn't care what happens.
5. that something is happening to change him.
6. that someone in the family made the mother leave.
7. that now he's free to enjoy himself in any way he likes.
8. that his mother doesn't stay with him because he's a bad boy.
9. that it's not really happening—it's only a dream.
10. that he will make the best of the situation.
11. like reading a book, watching TV or making clay models.
12. that something bad is going to happen to him.
13. sorry for his mother.
14. that he is getting sick.
15. that his mother doesn't really like him.
16. that he won't be able to study in school tomorrow.
17. very lonely.

THE MOTHER HAS JUST PUT THIS CHILD TO BED

THE BOY'S MOTHER IS BEING TAKEN TO THE HOSPITAL

The Boy Feels

1. very angry at somebody.
2. that he will not be the same person any more.
3. glad that his mother is leaving.
4. like hiding in his room.
5. that he doesn't care what happens.
6. that it's not really happening—it's only a dream.
7. that he's going to have a bad headache.
8. that he will do his best to get along.
9. scared about what is going to happen to him.
10. sorry for his mother.
11. that nobody likes him any more.
12. like watching TV.
13. that his mother became sick because he was bad.
14. that somebody else caused all this trouble.
15. that his room is going to be a scary place to stay in now.
16. alone and miserable.
17. that he won't be able to concentrate on his school work.

THE BOY'S MOTHER IS BEING TAKEN TO THE HOSPITAL

THE BOY AND HIS FATHER ARE STANDING AT THE MOTHER'S COFFIN

The Child Feels

1. that he won't be the same person any more.
2. frightened about what will happen to him.
3. that if he had been a good boy, it wouldn't have happened.
4. that now he is free to do what he wants.
5. angry about what happened.
6. that nobody will love him any more.
7. that he doesn't care what happens.
8. that his home will now be a scary place to live in.
9. like sitting in a corner by himself.
10. that other people are to blame for this.
11. that he will make the best of the situation.
12. that it is only a dream.
13. a bad pain in his head.
14. sorry for his father.
15. alone and miserable.
16. that now he won't be able to study any more.
17. like reading a book or watching TV.

THE BOY AND HIS FATHER ARE STANDING AT THE MOTHER'S COFFIN

THE BOY IS RUNNING AWAY FROM HOME

The Child Feels

1. that he is just going away to have some fun.
2. angry at his parents.
3. afraid that he will be punished for something he did.
4. that he doesn't care what happens.
5. that his parent's don't want him around any more.
6. that the neighbors have been stirring up his parents against him.
7. terrible stomach cramps coming on.
8. that he will do his best to get along.
9. that he is only dreaming about this and it's not happening.
10. that something very bad is going to happen to him.
11. that it is awfully scary outside.
12. sorry for his parents.
13. like watching TV or reading a book.
14. like going to his hideout.
15. that he won't be able to study school work any more.
16. that now he will be a different person.
17. lonely and miserable.

THE BOY IS RUNNING AWAY FROM HOME

Sample Statements, Associated Feelings, and Thematic Classification for Separation Anxiety Test*

	STATEMENTS	FEELINGS	THEME
The girl feels....			
1.	that her parents don't love her any more.	rejection	attachment
2.	alone and miserable.	loneliness	attachment
3.	sorry for her parents.	empathy	attachment
4.	that she will do her best to get along.	adaptation	individuation
5.	that she will be much happier now.	well-being	individuation
6.	like reading a book, watching TV, or playing games.	sublimation	individuation
7.	angry at somebody.	anger	hostility
8.	that it's all the fault of her neighbors.	projection	hostility
9.	that if she had been a good girl, this wouldn't have happened.	intrapunitive	hostility
10.	like curling up in a corner by herself.	withdrawal	reality avoidance
11.	that she doesn't care what happens.	evasion	reality avoidance
12.	that it's only a dream-it isn't really happening.	fantasy	reality avoidance
13.	that this house will be a scary place to live in.	phobic feeling	painful tension

*These statements accompany the first Separation Anxiety Test picture entitled "The girl will live permanently with her grandmother and without her parents."

	STATEMENTS	FEELINGS	THEME
14.	a terrible pain in her chest.	somatic	painful tension
15.	that something bad is going to happen to her now.	anxiety	painful tension

CHART FOR CONTROLLED ASSOCIATION RESPONSES

Picture Number	I	II	III	IV	V	VI	VII	VIII	IX	X	XI	XII	TOTAL	MILD	STRONG
Mental Set Response															
Separation Intensity	S	M	M	M	M	S	M	S	M	S	S	S			
Rejection	2	8	15	4*	13	10*	14*	11	15	11*	6	5			
Impaired Concentration	17	11	11	1	6	4	11	15	16	17	16	15			
Phobic Feeling	8	2	9	3	3	3	4	6	2	15	8	11			
Anxiety	9	16	1	2	11	5	13	12	12*	9	2	10			
Loneliness	5	15	5	16	17	9	6	16	17	16	15	17			
Withdrawal	3	12	8	13	7	12	8	7	3	4	9	14			
Somatic	4	14	2	10	12	11	15	8	14	7	13	7			
Adaptive Reaction	7	7	13	14	14	15	12	4	10	8	11	8			
Anger	11	13	14	6	2	1	5	14	1	1	5	2			
Projection	10	17	3*	17*	8	6	9*	1	6	14	10	6			
Empathy	16	3*	12	9*	1*	13	1	5	13*	10	14	12*			
Evasion	6	1	6	5*	10	14	16	9	4	5	7	4			
Fantasy	14	10	7	15*	5*	17	3	2	9	6	12	9			
Well-Being	1	9	4	8	16	2	17	10*	7	3	4	1			
Sublimation	15*	5	16	7	9	7	10	13	11	12	17*	13			
Intrapunitive	13	4	17	12*	15	16*	2*	3*	8	13	3*	3			
Identity Stress	12	6	10	11	4	8	7	17	5*	2	1	16			
TOTAL															

PATTERN SUMMARY CHART

Response Pattern	Number of Responses		Total	% of Total Protocol	Area of Emphasis	Comment
	Mild II, III, IV, V VII, IX	Strong I, VI, VIII, X XI, XII				
Attachment (Sum of rejection, loneliness and empathy)						
Individuation (Sum of adaptation, well being and sumlimation)						
Hostility (Sum of anger, projection and intrapunitive-ness)						
Reality Avoidance (Sum of withdrawal, evasion and fantasy)						
Painful Tension (Sum of phobic feelings, somatic and anxiety)						

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