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ABSTRACT

The fear of fear present in agoraphobics can be broken down into a fear of the body sensations associated with the panic attacks that plague agoraphobics and maladaptive thoughts about the possible consequences of panic. In a retrospective examination of clinical files, 32 agoraphobic patients were compared to 36 patients with simple social phobias. Fear of fear was more often reported by the therapist for agoraphobics than for the other phobics. Two self-reporting measures were developed. The Agoraphobic Cognitions Questionnaire measures 14 maladaptive cognitions and the Body Sensations Questionnaire measures 17 sensations experienced during panic or high anxiety. These questionnaires were tested in 78 agoraphobics with panic attacks and 197 patients with other disorders including social phobia, generalized anxiety disorder, panic disorder, obsessive-compulsive disorder, and dysthmic and major depressive disorder. Additional data came from 23 normal subjects. Agoraphobics scored significantly higher on the Body Sensations Questionnaire and Agoraphobic Cognitions Questionnaire than did other subjects. Fear of fear may be related to treatment outcome for agoraphobic patients and imaginal exposure may be important in addressing fear of fear. (ABL)

FEAR OF FEAR AND THE ANXIETY DISORDERS

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Paper presented at the Annual Convention of the Association for Advancement of Behavior Therapy, 19th, Houston, TX, November 14-17, 1985.

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In 1978, Alan Goldstein and I published a paper in which we argued that agoraphobia was, to a large degree, a "fear of fear", that is, a fear of panic attacks, rather than simply a fear of situations such as expressways and shopping malls, which agoraphobics are known to avoid. This concept has appeared in the writings of a variety of workers in the agoraphobia field, most notably Claire Weekes, who has dubbed this fear the "second fear." We broke down the fear of fear into two components: (1) a fear of the body sensations associated with the panic attacks that plague agoraphobics, and, (2) maladaptive thoughts about the possible consequences of panic such as dying or becoming insane from this high anxiety experience. Our observations of agoraphobics were consistent with those of Beck and his colleagues (1974) who on the basis of clinical observations concluded that anxious clients, even those without clearcut phobic stimuli, were responding to anxiety-provoking thoughts or images.

To gather data on our impressions, we retrospectively culled clinical files from phobic patients who had been seen over the years at the Temple Behavior Therapy Unit. Thirty-two agoraphobic clients were compared to 36 clients with simple or social phobias who were similar in sex and age. Therapists' records were examined to see if therapists had made a note of why the clients said they were afraid. We rated fear of fear as being present if the client mentionned being afraid of the consequences of becoming afraid, and not if the client described no accompanying thoughts or images or some other type of consequence, such as falling from a height or being bitten by a dog. In most cases of simple or social phobia we found no such description in therapists' case notes. For the 13 cases on which this information was available, less than half reported fear of fear. Cases in which fear of fear was reported included public speaking phobics who feared their anxiety would be so disruptive that they would be unable to speak, or cases in which phobias were conditioned during bad drug trips, and exposure to the phobic object set off flashback experiences accompanied by physical sensations that the clients found very disturbing. One might suggest that fear of fear was present in the cases where the data were missing, and the therapists failed to note it out of lack of interest in cognitive factors, this being before cognitive therapy became hot.

Most probably, however, it indicates that nothing noteworthy was reported by the clients, leading to a reporting bias. That is, it is not particularly earth-shattering to hear that a

driving phobic is afraid of a car accident, and the therapists may simply not have noted the information. The latter interpretation, that therapists were attuned to fear of fear if reported by clients, is given credence by the fact that for almost all of the agoraphobic clients the data were reported. In 29 of the 32 cases, the therapists had made notes concerning what the clients feared; in all cases, fear of fear was reported. Fear of fear was present significantly more often among agoraphobics (Fisher's Exact Test), even with this presumably biased set of data.

Since we had Fear Survey Schedules on almost all clients, we selected a set of items from the Fear Survey Schedule that we thought might reflect fear of fear and compared the two samples on these items with t tests. Agoraphobics rated themselves as significantly more fearful than the other phobics on these items: fear of heart beat irregularities, loss of control, fainting, and mental illness. Both types of analyses, therefore, empirically supported the clinical observations of the differential importance of fear of fear among agoraphobics.

In order to more rigorously study this feature of agoraphobia and possibly other anxiety problems, our next step was to develop measures to allow us to more adequately assess the phenomenon in question. Several different procedures have been used in cognitive assessment of agoraphobia including tape-recording clients' reports of thoughts during behavioral avoidance tests, thought-listing subsequent to some exposure to the phobic stimulus, and self-report measures. Our measures are of the self-report variety. The other types of measurement have considerable face validity, but have not yet, to my knowledge, been shown to be reliable indices.

We developed two companion measures: the Agoraphobic Cognitions Questionnaire and the Body Sensations Questionnaire. On the first clients rate how frequently they have each of 14 maladaptive cognitions. Factor analysis with replication has shown that these items fall out according to two themes: loss of control and social humiliation (29% of the variance) and physical consequences (17% of the variance). Originally we also had, following Beck's use of cognitive therapy, a scale on which clients indicated how <u>certain</u> they were that the feared catastrophe would befall them. This scale did not fare well on validity analyses and was dropped. On the Body Sensations Questionnaire clients rate how frightened they are of 17 different sensations often experienced during panic or high anxiety. The two scales are moderately correlated (.34 - .67) indicating they are not identical but are related factors.

Assessment instruments are rather like good nutrition: essential but boring. I won't therefore belabor the details of validation but will hit the highlights. In both the original and the cross-validation samples, the scales were found to be internally consistent, adequately reliable on test-retest reliability intervals as long as 1 month, and valid in analyses

of construct validity conducted to date. One possible challenge to our previous paper on fear of fear among agoraphobics was that perhaps we had simply demonstrated that agoraphobics are more disturbed than other phobics, which is generally the case. We consequently included in our validity analyses a scale of psychopathology that we didn't expect to be related to fear of fear, to assess whether we were only measuring some tendency of agoraphobics to report indiscriminantly higher psychopathology. This measure, psychoticism on the Eysenck Personality Questionnaire, was not associated with fear of fear, whereas, as would be expected by cognitive theory, neuroticism, avoidance behavior, and frequency of panic were all higher when fear of fear was higher.

We next administered the two questionnaires to clients with various anxiety disorders and to those with depressive disorders: specifically dysthymic disorder and major depressive disorder. We were interested in seeing whether these features of fear of fear were indeed a more central feature of agoraphobia than of other anxiety disorders and in further delineating whether these scales were tapping simply neuroticism or something particular to anxiety. With the kind cooperation of the Center for Cognitive Therapy at the University of Pennsylvania and the Obsessive-Compulsive Treatment Program at Temple, we added to the data pool we could generate at the Agoraphobia and Anxiety Programs at Temple and at The American University. The fear of fear questionnaires were administered at intake to 78 agoraphobics with panic attacks, 44 social phobics, 47 clients with generalized anxiety disorder, 15 with panic disorder, 33 with obsessive-compulsive disorder, and 58 with dysthmic and major depressive disorder. Additional data came from the 23 psychometrically defined normal control subjects from the original validation study. Two hierarchical decision rules were imposed in addition to those inherent in the DSM-III: if a client had panic disorder in addition to another disorder, the client was placed in the panic disorder category only. Clients with depressive disorders plus an anixety disorder were categorized according to the anxiety disorder.

Analyses of variance yielded significant F tests for the effects of diagnosis for both scales (BSQ $F(6, 148) = 15.84$, $p < .001$; ACQ $F(6,284) = 6.30$, $p<.001$). Agoraphobics were significantly higher on the Body Sensations Questionnaire and the Agoraphobic Cognitions Questionnaire than were all other groups except for panic disorder. Panic disorder, in turn, was significantly higher than all other groups except generalized anxiety disorder on both scales. On the Cognitions Questionnaire the normals were significantly lower than the remaining anxiety disorders groups and the depressives, whereas on the Body Sensations Questionnaire the other anxiety disorders and depressives did not differ from one another or from the normal subjects. These data support Beck's hypothesis that there is some specificity in the association of cognitions with neurotic disorders. All anxious clients did <u>not</u> endorse the agoraphobia-related cognitions to the same degree. Moreover, among the

depressed clients the correlation of the Agoraphobic Cognitions Questionnaire with a measure of depression, the Beck Depression Inventory was a modest .25 (n= 58, p=.06). In contrast, in another study with depressed subjects, we (Crandell & Chambless, in press) found the correlation of the Beck with a measure of depressive cognitions, the Crandell Cognitions Inventory, to be related cognitions is particularly noteworthy in light of the admixture of depression and anxiety found among most depressed and anxious clients.

In planning this study, I had hoped to shed light on the panic disorder/agoraphobia with panic distinction. That is, I've long been curious as to why some people who have panic attacks become agoraphobic, and others do not develop the same extent of avoidance behavior. I say the same extent, because it is hard to find someone with panic disorder who does not have some phobic element to the anxiety. I had thougnt that the fear of fear might be the answer, that those who kept on trucking and didn't avoid in the face of panic might well find panic noxious but might not be afraid that it would lead to catastrophic events such as loss of control or that it indicated physical disease such as a brain tumor. Alas, another hypothesis bites the dust.

Instead, it would seem that those who have panic attacks often enough to rate the diagnosis of panic disorder are just about as afraid of fear as are agoraphobics. That clients with generalized anxiety disorder approached the fear of fear levels of panic-disorder clients may stem from the fact that these clients often have panic attacks as well, but do not have them frequently enough to meet the DSM-III criteria. Alternatively, the heightened fear of fear levels among those with panic disorder may lead to an increased frequency of panic through self-exacerbated anxiety.

Treatment

Some of you out there are primarily clinicians and are by now yawning and wondering of what practical significance all of this is. Fear of fear, I would maintain, is related in important ways to treatment outcome. We know that exposure works for the majority of agoraphobics who complete an in vivo exposure program, but the results are far from satisfactory for the improved, and the unimproved make up a large minority. If fear of fear is an important component of agoraphobia, as I believe I have shown it to be, it is reasonable to expect that it is related to treatment outcome. It may be related to some of the unexplained variance in treatment outcome.

In a treatment program combining exposure with a variety of cognitive techniques, we found change on avoidance behavior is substantially correlated with change on the fear of fear variables. I don't mean to imply here that change on fear of fear causes change on avoidance because I think the cognitive change generally lags behind behavioral change. Nevertheless, I do not believe clients will persist in approaching the phobic

situations unless the fear of fear is ultimately reduced.

In support of this hypothesis are some of the results of a prediction study I will report in greater detail in another paper (Chambless, 1985). In brief, many pretest variables were examined for their ability to predict change on phobic avoidance at posttest and 1 year follow-up. Of three significant predictors at posttest, one was the Body Sensations Questionnaire ($r = -.40$, $n = 23$, $p = .03$). Of two significant predictors at follow-up, one was the Agoraphobic Cognitions Questionnaire ($r = -.24$, $n = 50$, $p = .05$). These variables emerged as predictors despite considerable efforts to alter fear of fear during the treatment program. It would be interesting to know how strongly they predicted outcome in an exposure only treatment program. We have such a study in progress now, but the data are not yet available.

That clients with a higher level of catastrophic thinking fared poorly at 1 year follow-up is reminiscent of Foa's (1979) description of obsessive-compulsives who fail to improve with exposure as holding "over-valued ideas", that is believing very strongly that their feared catastrophes would indeed befall them if they were not to ritualize. The Agoraphobic Cognitions Questionnaire does not, however, measure over-valued ideation in that clients are not asked how firmly they believe they will die, lose control, etc., but how frequently. Although these data are supportive of the hypothesis that there is a strong cognitive component of agoraphobia, they are pessimistic where the effectiveness of present cognitive behavioral interventions for such a cognitive component are concerned. The pretreatment levels of maladaptive thinking continued as a significant predictor, despite considerable efforts to change fear of fear during treatment.

How else can we have an impact on fear of fear in those cases where exposure, with its repeated reality testing, does not? I hope during the question and answer period to get some of your ideas and those of the other panelists, for I certainly don't have the answers. The biologically oriented have focused heavily on this fear of fear, using psychotrophic medication such as the tricyclic antidepressants and the MAO Inhibitors to control panic, thereby reducing fear of fear as long as the client takes the medication. With fear of panic reduced it is sometimes easier to alter avoidance behavior. In some studies, but not all, medication plus exposure has been significantly better than exposure plus placebo. There are, however, many problems with the use of medication that I won't go into now.

Beyond exposure, the effectiveness of psychosocial means of reducing fear of fear is iffy. Studies in which cognitive modification has been added to exposure have shown no increased benefits in terms of treatment outcome. Other approaches seem to be required. One promising technique is to give the client control over the distressing body sensations, many of which are caused by hyperventilation, by teaching respiratory control, also

known as paced breathing. I'm sure Lloyd Williams will tell us respiratory control leads to enhanced self-efficacy, and perhaps it does. The focus on hyperventilation also allows the client to attribute strange feelings to some understandable, nonthreatening process. We have yet to examine, however, whether paced breathing reduces fear of fear in addition to the frequency of panic attacks.

It is interesting to note that Foa and colleagues (1980) found that obsessive-compulsives fared better in the follow-up period if they got not only in vivo exposure and response prevention, but also imaginal flooding to the imagined disastrous consequences of not ritualizing, even though imaginal flooding is relatively less effective than in vivo exposure in reducing symptoms in the short run. These results suggest that imaginal exposure, which has largely been abandoned in the treatment of agoraphobia might play a specific role in addressing fear of fear.

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