The Experience of Men with Agoraphobia: A Qualitative Investigation

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Abstract
This study was an exploratory attempt to increase the information on the experience of males with Agoraphobia to help build hypotheses about the reasons for the discrepancy between the prevalence and incidence rates between males and females. Six adult male participants completed interviews consisting of questions that were developed to explore this topic. The results indicate that for males who cope with Agoraphobia, fears about the world, trustworthiness of others, and conflict between their worldview and societal expectations of the male experience impacted their experience of themselves and their diagnosis. The results suggest that more research needs to be completed on the clinical presentation of males with Agoraphobia, and suggests that opening a societal dialogue about Agoraphobia and the availability of treatment resources may have a positive impact on reaching this population.

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THE EXPERIENCE OF MEN WITH AGORAPHOBIA: A QUALITATIVE INVESTIGATION
A DISSERTATION
SUBMITTED TO THE FACULTY
OF
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BY
PAMELA GWYNETH SHEFFIELD, MS
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Abstract

This study was an exploratory attempt to increase the information on the experience of males with Agoraphobia to help build hypotheses about the reasons for the discrepancy between the prevalence and incidence rates between males and females. Six adult male participants completed interviews consisting of questions that were developed to explore this topic. The results indicate that for males who cope with Agoraphobia, fears about the world, trustworthiness of others, and conflict between their worldview and societal expectations of the male experience impacted their experience of themselves and their diagnosis. The results suggest that more research needs to be completed on the clinical presentation of males with Agoraphobia, and suggests that opening a societal dialogue about Agoraphobia and the availability of treatment resources may have a positive impact on reaching this population.
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INTRODUCTION

The experience of anxiety has been described as “the apprehension cued off by a threat to some value that the individual holds essential to his existence as a personality” (Rosen, 1996, p. 239.). Experiencing the world as a threatening environment that could serve to remove the meaning of existence is not easy to endure. In the name of self-preservation, many other aspects of a person’s life may become strained or damaged, such as career, family, and significant romantic relationships.

Anxiety disorders are multifaceted and each has unique symptoms. Panic Disorder, for example, involves not only the experience of intense panic attacks characterized by feelings of terror or dying, but may also involve fear of having another panic attack or rumination over past panic attacks, as well as an intense fear of being negatively evaluated by others because of the panic attacks (Hoffart, Hackmann, & Sexton, 2006). The amount of energy involved in attending to these symptoms limits the ability to attend to more sophisticated needs outside of self-preservation. Each of the anxiety disorders described in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; American Psychiatric Association [APA], 2000) includes pervasive and severe symptoms that can significantly impact individual and family quality of life.

Agoraphobia is a disorder in which an individual experiences excessive fear in response to being in situations in which escape might be difficult, such as elevators or crowds. As a result, individuals with Agoraphobia sometimes have difficulty leaving their homes and, in severe cases, may become homebound. For individuals afflicted with
Agoraphobia, there is also the likelihood of developing comorbid conditions such as substance abuse disorders and problematic personality traits (Turgeon, Marchand, & Dupius, 1998). When applied to a diagnosis of Panic Disorder, Agoraphobia refers to the tendency of individuals to avoid certain locations or situations that they fear may trigger a panic attack, or where they could not get assistance during a panic attack. For many individuals, managing their symptoms results in drastic changes to their life, schedule, and relationships in the hope of preventing or avoiding future panic attacks, which often occur in spite of their efforts. Individuals with a diagnosis of Agoraphobia face a number of potential risk factors for other mental health diagnoses as well as a diminished quality of life. Agoraphobia is diagnosed more frequently in women, and women are therefore more likely to be participants in the research that exists for this disorder. In terms of the available psychological research, males diagnosed with Agoraphobia are an often-overlooked population. More information is needed regarding the different ways the diagnosis is manifested in men, and whether or not gender differences exist.

**Prevalence and Incidence**

Demographic data suggest there is a significant likelihood a person will be diagnosed with an anxiety disorder within his or her lifetime. The DSM-IV-TR (APA, 2000) reports that Panic Disorder lifetime prevalence rates are up to 3.5% of the population. It is estimated to occur in 1-3% of the general population, and 4-8% of patients in primary care settings (Katon, Richardson, Lozano, & McCauley, 2004). Up to 10% of people who seek psychological help as well as up to 30% of individuals in some
medical settings meet criteria for Panic Disorder (APA, 2000). This discrepancy may be
due to the fact that many of the physiological symptoms that accompany panic attacks are
mistaken for signs of a physical condition, such as a heart attack, and result in many
individuals pursuing medical attention.

The data regarding gender differences in the prevalence and incidence of Panic
Disorder demonstrate a 12-month incidence rate for men of 1.3% and a lifetime incidence
of 3.3%; compared with 2.9% and 6.7%, respectively, for women (Grant et al., 2006).
These results suggest that Panic Disorder, both with and without Agoraphobia, is
demonstrably diagnosed more in women than in men. Bourdon and colleagues (1988)
noted that women represent 75% of the population diagnosed with Agoraphobia. Indeed,
Panic Disorder with Agoraphobia has been considered to be a “woman’s syndrome”
(Bekker, 1996, pp.129), given these significantly higher rates.

Given that women are more likely than men to carry this diagnosis, it may be that
some gender differences exist biologically, psychologically, socially, or culturally that
contribute to the different rates of manifestation of the symptoms inherent to the disorder.
While it has been noted that the symptoms occur more frequently and more severely in
women, the research on gender differences, in both pathology and treatment, is limited.

*Negative Impact of Anxiety Disorders*

Anxiety disorders are among the most pervasive and widespread of the
psychological disorders. The experience and stress of managing an anxiety disorder puts
the individual at risk for other psychological disorders, such as Major Depressive
Disorder and Substance Abuse (Sachs, Amering, Berger, & Katschnig, 2002; Strol&
Noller, 2003; Kikuchi et al., 2005; Grant et al., 2006).

The comorbidity between anxiety disorders and physical conditions has also been
well established. Research suggests, for example, a relationship between asthma and
Panic Disorder. Katon, Richardson, Lozano, & McCauley (2004) indicated that up to
24% of individuals diagnosed with Panic Disorder were also diagnosed with asthma, with
a high risk of also experiencing serious respiratory problems, such as chronic obstructive
pulmonary disease (COPD).

In addition to the greater likelihood of substance abuse, physical problems, and
mental health problems, anxiety disorders can also have a negative impact on the
relationship between spouses or partners. A significant body of research suggests that
relationship satisfaction is lower, in general, when at least one member of a couple suffers
from an anxiety disorder (Barlow et al., 2000; Rosen, 1996; Whisman, 1999). These
findings are consistent with the Marital Quality Theory, which suggests that marital
quality is low when one member of the couple has a mental illness (Riggs et al., 1992).
Halford’s (1999) research on Panic Disorder with Agoraphobia suggested that a diagnosis
of this condition was correlated with low relationship satisfaction for both of the partners.

Although the direction of causality is not clear and may vary within dyads, a great
number of studies have suggested a reciprocal relationship between relationship
satisfaction and an anxiety disorder in one member. For example, individuals with Panic
Disorder with Agoraphobia may demonstrate resistance or outright refusal to be in certain
situations where they anticipate or fear a panic attack. Their partners may become
resentful of their behaviors and this resentment may cause relationship strain and dissatisfaction (Rosen, 1996). Additionally, partners of those with anxiety disorders may have an increased likelihood of developing a psychological disorder or a medical problem themselves that may further strain the couple (Halford, 1999). Research suggests that individuals with Agoraphobia often have partners who also have phobic symptoms themselves (Emmelkamp, 1994), which suggests collusion of avoidance behaviors and fear within these particular dyads. Given the significant negative impact anxiety disorders have for both individuals and their partners or spouses, it is important to understand more about the prevalence and nature of anxiety for both men and women.
LITERATURE REVIEW

Gender differences in Agoraphobia

Research examining gender differences in the expression and treatment of Agoraphobia is limited and often contradictory. Some researchers have noted little to no gender differences in terms of the epidemiology and comorbidity among individuals diagnosed with Panic Disorder. Turgeon et al. (1998) noted in their study of gender differences in Panic Disorder that the men and women they sampled had comparable frequencies of panic attacks, but that women were more severe in their symptoms of Agoraphobia, but the men were significantly more likely to use alcohol, and therefore demonstrate less avoidance. Sachs et al. (2002) noted in their study that women and men did not differ in terms of the likelihood of developing other psychological disorders, such as substance abuse, depression, and Generalized Anxiety Disorder (GAD). Other research demonstrated slightly greater genetic heritability of Agoraphobia in females; with overall no significant findings in terms of gender differences (Kendler, Jacobsen, Myers, & Prescott, 2002). Research conducted by Craske et al. (2001) suggested that early experiences with asthma or other respiratory problems also put both males and females at an increased risk for developing PDA later in life.

Bekker (1996), in her review of gender and agoraphobia, noted that many of the statistics about the diagnosis are obtained through community samples, which by their very nature require individuals to come forth to participate in the survey and to be willing to be counted as an individual with a diagnosis. She describes the “masculine taboo on
admitted anxiety” which may result in men under reporting their symptoms. For this reason, many of the statistics may be skewed, leaving out the individuals who choose not to participate, or who do not wish to admit that they are suffering. Other individuals may not even be aware that they are experiencing a psychological problem, as a result of using substances that dull the effects of anxiety. These “hidden agoraphobics” may masquerade in the world as individuals who do not have a problem with anxiety, or may seek treatment first for substance abuse concerns.

Additionally, there may be a gender and cultural bias on the part of health professionals who may be more likely to observe and diagnose Panic Disorder with Agoraphobia (PDA) in women than in men, which may perpetuate the gender differences in the diagnosis (Bekker, 1996; Blanchard, Griebel, & Blanchard, 1995). This tendency to under-diagnose the disorder in men based on the questioning of professionals, coupled with the tendency for men to under report symptoms is likely a contributing factor in the disproportionate rates of diagnosis for men versus women.

Apart from gender differences in symptom reporting, some researchers have explored how physiological sensitivity, cognitive appraisal, and cultural constructs of gender roles and expected behavior may also contribute to different rates and expressions of Agoraphobia for men and women.

Schmidt and Koselka (2000) postulated that gender differences in terms of anxiety sensitivity and panic-related appraisals exist, and demonstrated some significant findings in terms of differences across gender, with men demonstrating lower scores on the measurements of these constructs. In other words, the researchers suggested that there
were significant gender differences regarding a predisposition to anxiety, as well as the
tendency to attribute fear-related meaning to ambiguous stimuli that could provoke a
panic attack. In contrast, Foot and Koszycki (2004) found no significant gender
differences in terms of what the researchers considered to be “anxiety sensitivity.” These
same researchers suggested that women might experience somatic symptoms more
intensely than men, resulting in the greater likelihood of being triggered into a panic
attack. Turgeon et al. (1998) also noted that women were more likely than men to endorse
somatic symptoms in their presentation of Agoraphobia. This stands in contrast to the
research findings of Cox et al. (1993), who suggested that males tended to endorse
somatic symptoms more frequently than women.

Schmidt and Koselka (2000) also noted that the significant gender differences
observed in the diagnosis of Agoraphobia may be due to the fact that there is a cultural
expectation that men display stoicism, and therefore would be more likely to endure
feared situations with distress rather than avoid them. Similarly, it has been suggested
that women with Agoraphobia may be likely to either develop, or already have, cultural
sex role expectations that could contribute to agoraphobic symptoms, with women being
positively reinforced for dependence on their male partners, as well as the greater cultural
acceptance of women engaging in help-seeking behaviors for their psychological
concerns (Bekker, 1996).

In their examination of the personality traits of men with Agoraphobia, Liotti and
Giordano (1976) suggested that men tended to develop agoraphobic symptoms after their
partners demonstrated increased assertive behavior. Men with Agoraphobia also had a
reported dislike of being alone, tended to be introverts, and were likely to have been raised in an environment characterized by a hypochondriacal model of functioning and “presence of a dominant mother.” The data in this study was obtained through therapy sessions completed by the authors as well as some conjoint sessions with agoraphobic men and their partners, but offered no quantitative evidence to support these hypotheses.

In addition to cultural and personality differences, there may be differences in treatment seeking and coping strategies used by men and women. Men are likely to pursue medications to treat anxiety symptoms instead of psychotherapy, and are more likely to engage in substance abuse as a means of coping with anxiety (Bekker, 1996). In other research studies comparing the manifestation of PDA in men, more alcohol use and the perception of alcohol use as an effective coping strategy has also been noted (Cox et al., 1993; Turgeon et al., 1998). These researchers also noted that men were more likely than women to turn to benzodiazepine abuse to help manage their anxiety. These results are supportive of the theory discussed by Bekker et al. in her review (1996) that men were more likely than women to seek out experimental drug studies to help cope with anxiety. It is possible that, for men, viewing anxiety as a physical disorder rather than an emotional disorder, is more acceptable, and men are therefore more likely to seek out coping strategies that affect their physiology, such as medications and alcohol use. However, contrasting results were cited by other researchers, such as Sachs et al. (2002), who noted that men and women in the study were comparable in their likelihood of full-time employment as well as rates of alcohol use. Tsuang et al. (2004) also noted that there
was not an association between symptoms of agoraphobia and alcohol dependence for their all-male sample.

Inconsistent differences in treatment benefits for men and women have also been reported. Hafner (1983) indicated that women were more likely than men to receive therapeutic benefit from behavioral therapy for PDA, while other research indicated that women are less likely than men to receive therapeutic benefit from treatment, and are more likely to still have high levels of panic attack as well as a higher rate of relapse than men (Yonkers, Zlotnick, Allsworth, Warshaw, Shea, & Keller, 1998).

In summary, the extant literature offers some interesting hypotheses regarding gender differences and how they might be reflected in the experience and treatment of Agoraphobia. However, the research is also inconsistent and scarce, and suggests no clear cut distinctions between the experience of PDA for men and for women. More information needs to be obtained on the experience of men with Agoraphobia in order to create hypotheses about the discrepancies in the quantitative research results.

**Effective Treatments for Panic Disorder with Agoraphobia**

Current empirical evidence suggests that the most effective treatments for most anxiety disorders are interventions based on cognitive-behavioral therapy (CBT). These include exposure, anger management, stress inoculation, relaxation training and cognitive interventions (Barlow et al., 2002; Siev & Chambless, 2007).

For many anxiety disorders, including PDA, Generalized Anxiety Disorder, and Social Phobia, CBT has been shown to be effective in reducing the distress of these
symptoms, and has been shown to be significantly more effective than placebo or a wait-list control group (Chambless & Gillis, 1993). Barlow (2002) demonstrated that 86% of agoraphobic individuals receiving a combination of interventions for their agoraphobic symptoms, including in vivo exposure and cognitive therapy, improved in their subjective experience of their symptoms; 65% of the participants improved through in vivo exposure alone (Barlow et al., 2002). Although some controversy exists between whether cognitive-behavioral therapy is more effective than pharmacotherapy for this disorder, both remain common treatments (Rosen, 1996).

Researchers examining a different approach integrating behavior therapy techniques with psychotherapy techniques borrowed from logotherapy, Gestalt therapy, and rational-emotive therapy determined that an intensive, multi-modal treatment demonstrated significant results in symptom reduction and also resulted in extremely low participant attrition (Chambless, Goldstein, Gallagher, & Bright, 1986). These results suggest that an integrated approach may be an effective way to treat PDA.

CBT for the treatment of PDA has also been demonstrated to be effective outside of the sterility and control of the research environment, through outcomes measured in a community mental health setting. Stuart, Treat, & Wade (2000) demonstrated that participants receiving cognitive-behavioral treatment for PDA experienced a reduction in symptoms, and many of the participants were also able to stop the use of potentially addictive anxiolytic drugs, such as the benzodiazepines. Additional research also suggests that CBT treatment for anxiety disorders is effective for individuals who are dually diagnosed with a substance abuse disorder (Schadé, Marquenie, van Balkom, Koeter, de
Beurs, van Dyck, & Brink, 2007), which is important given that alcohol use has been shown to be a coping strategy for many individuals experiencing PDA.

Relatively few studies have been conducted that directly compare gender differences relative to treatment of PDA, and even fewer have examined the effectiveness of therapies for men with this disorder (Turgeon et al., 1998). When men and women were compared in terms of their responses to pharmacological intervention, it was found that both benefit significantly from treatment with the SSRI medication sertraline when compared to placebo, with women having a noted “modest” advantage over men (Clayton, Stewart, Fayyad, & Clary, 2006). Of the available research on the effectiveness of psychological treatments for PDA, Hafner (1983) found that men did not respond as well to graded and in-vivo exposure techniques to treat panic attacks compared to women in the sample, and noted that men had a higher rate of attrition as well due to the intensity of their symptoms. Hafner (1981) also suggested that marital therapy would be a potentially effective form of treatment for men as well as for women with agoraphobia due to the potential for the marital relationship, and problems within the relationship, to reinforce the disorder. However, the author noted the likely difficulty of recruiting a sample of couples that were willing to pursue this. Additionally, Hafner’s study consisted mostly of participants in which the female partner carried the diagnosis, suggesting that women are more likely to be represented in the research studies examining the impact of partner involvement in treatment. More information needs to be obtained in terms of the impact of gender on the development and treatment of agoraphobia, in order to help provide additional information and empirical support for the treatments that already exist.
The current study

Qualitative research requires a degree of transparency about the motives for studying a particular area, as the subjective experience of the researcher, as well as the participants, are accepted as unavoidable realities of the nature of psychological research. This researcher was compelled to examine the nature of Agoraphobia in men, as an overwhelming amount of the research on this disorder has focused on the experience and treatment of females with the diagnosis. This researcher identifies as a feminist, and in support of these ideals, is seeking to create equality in the study of Agoraphobia by examining men with this diagnosis. The prevalence of research of females with the diagnosis is understandable as, statistically, females are significantly more likely to carry this diagnosis (Schmidt & Koselka, 2000). However, basing the study of PDA, or of any psychological disorder, on one gender, regardless of the prevalence and incidence rates, limits the generalizability of research findings. The hope of this researcher is that expanding the study of PDA to both males as well as females with this diagnosis may help to expand our understanding of this disorder, as well as to decrease the stigma associated with PDA as a “woman's syndrome” (Bekker, 1996).

Quantitative researchers have indicated that more research examining the gender differences in the development and maintenance of PDA is necessary (Bekker, 1996; Schmidt & Koselka, 2000; Yonkers, Zlotnick, Allsworth, Warshaw, Shea, & Keller, 1998). For this research, a qualitative method will be used in order to obtain data regarding the experience of men with PDA. Few qualitative or quantitative studies exist
examining gender differences in the etiology of Agoraphobia, and it has been noted that qualitative research can add to the body of research in the field by offering “rich descriptions and contextually specific answers to ‘how’ and ‘why’ questions” (Jack, 2006, pp.279). For the purposes of this research, utilizing a qualitative methodology will allow for the opportunity to explore the following questions: (1) what is the experience of a man living with a diagnosis of PDA? (2) What supports are helpful? (3) What supports are needed? (4) What type of treatment is sought, if any, and how effective is treatment perceived to be? (5) In what ways, if any, do the influence of gender roles and expectations contribute to the experience of men with PDA?

Given the findings of the limited literature that exists regarding men with Agoraphobia, it may be likely that men will underreport their symptoms and that substance use may be a coping skill. Further, gender role expectations of stoicism and courage, as well as other external factors, such as the necessity to endure feared situations due to employment and financial requirements may be reported, given that men are more likely than women to be socially expected to keep gainful employment, specifically if they are supporting families. These conjectures are based on the literature that has examined gender differences as well as the social factors that may be impactful. The purpose of the current study will not be to confirm the hypotheses, but rather to conduct an in-depth investigation of the experience of these individuals, with the purpose of creating a foundation on which to develop new hypotheses and generate additional research in this area of psychology.
METHOD

The purpose of qualitative research is to obtain idiographic, contextual information about the individual’s experience, or their *phenomenology*. A phenomenological research study is designed to investigate the meaning of an individual’s unique lived experience. This study followed general guidelines for conducting phenomenological research (Creswell, 2006). This study consisted of qualitative interviews of adult males who met diagnostic criteria for Panic Disorder with Agoraphobia. Interview questions were designed to elicit the participants’ in-depth exploration of the topic of their life experience with Agoraphobia, including questions about their relationships, supports, and self-concept related to their diagnosis.

To obtain this information, an interview was conducted using open-ended questions developed under the supervision of a clinical psychologist with expertise in qualitative research methods. During the development of the questions, feedback was obtained from a group of graduate students enrolled in a qualitative research course. Feedback and revision took place during the classroom sessions with the purpose of refining the questions and reducing researcher bias. Methods such as a mock interview, as well as group discussion with peers, assisted in the goal of maintaining rigorous methodology and arriving at questions that were likely to best address the research topic.

After completing these steps to ensure the rigor and validity of the questions in exploring the research topic, the following questions were identified:

1. When did you first realize that you had anxiety? What were the circumstances?
2. How would you explain Agoraphobia to someone who didn’t know anything about it?
3. Are there particular things that you are anxious about?
4. How do your fears impact the way you perceive yourself, others, and the world?
5. Tell me about your relationships.
6. What is the biggest challenging in being in relationship with others?
7. How does this condition affect how you can get emotional support from others?
8. What advice would you give to someone else who has this diagnosis?
9. What has been your experience in therapy (if any)? What led you to decide to go?  
10. This diagnosis is one where women tend to seek therapy more often than men. What do you think accounts for this?  
11. What are some ways in which people try to be supportive that doesn’t work for you?  
12. What do you wish other people knew about your diagnosis?  
13. What have you learned about yourself from your experience with Agoraphobia?  
14. Do you have contact with any individuals who have this same problem?  
15. What has been the biggest challenge for you with regards to your Agoraphobia?  
16. What do you feel like may be different for you in relation to how you go about your life given that you have this diagnosis?  
17. Is there anything else you want to tell me with regards to your experience? 

Participants were recruited through placing flyers in mental health treatment clinics in the local area, with prior consent obtained from the clinic directors. Internet resources were also be utilized to reach potential participants who were not currently seeking mental health treatment, as well as to locate participants in different geographical locations. In order to determine that the potential participants met the necessary diagnostic criteria, candidates completed an initial telephone screen consisting of the Panic Disorder subtest of the Structured Clinical Interview (SCID). Individuals who did not meet the diagnostic criteria were not interviewed further and were thanked for their assistance. The validity of the SCID as a telephone screen has been established in previous research studies that demonstrated test-retest reliability for individuals who were given this diagnostic interview in person as well as telephonically (Cacciola, Alterman, Rutherford, McKay, & May, 1999). 

Participants were given the opportunity to consent to participate in the interview following a brief description of the research topic. However, the researcher did not discuss the research topic in depth with the participant in order to minimize priming effects. Participants were informed at the beginning and throughout the study that they could discontinue the interview and withdraw from the study at any time without penalty. No individuals chose to withdraw from the study, and all participants were offered
resources to mental health clinics and support groups in the area that they could contact if they had interest in doing so. To minimize any potential risks and discomfort of the participants, the investigator allowed them to choose the setting of the interview. A debriefing took place following the interview in the event that the participant experienced distress from the interviewing process. Resources on counseling centers in the area were provided to participants who expressed interest in further discussion of their experience.

The interviews took place in a location of the participant’s choosing. Transcriptions of the interviews were stored in password protected computer files, and were identified with numbers (e.g. “Participant #3”). Identifying information, such as names, locations, and names of businesses were omitted or erased from the interviews.

Content analysis of the transcripts took place over several stages following the guidelines for qualitative analysis (Creswell, 2006). This process included coding the interview for units of meaning and identifying themes within and across transcripts using inductive methods. To ensure the reliability of the themes identified by the researcher, the interviews were also coded for themes by a peer coder who was knowledgeable in qualitative methods. The peer coder was a graduate student who was also completing qualitative research for her dissertation and was trained in these research methods at her graduate institution. The themes that were identified were discussed, and any discrepancies of the identified themes were analyzed, to see if the differences were due to semantic interpretations between the coders (e.g., if different words were being used to identify the same thematic concept). The themes were presented to the participants to ensure the accuracy of the information in reflecting their perceived experience.
RESULTS

The recruitment process yielded mixed results. Of the flyers that were posted in mental health centers, two individuals expressed interest, but did not respond to the request to schedule the initial phone screen. Utilizing internet resources proved to be the most effective way of contacting and recruiting this population. It is hypothesized that individuals with Agoraphobia, due to the diagnostic presentation of avoidance, may utilize internet resources more often as it is a way to obtain resources and information without having to experience the anxiety-provoking stimuli of the external, social world. Twelve men responded to the internet advertisement, and of these, nine followed up to complete the initial phone screen. Of these, 6 males met the DSM-IV TR criteria for Panic Disorder with Agoraphobia, thereby meeting criteria for participation.

The mean age of the six participants was 42.16, with a range of 21-60. Two individuals in this group were 47. Four of the participants identified as Caucasian in their ethnicity, with one individual identifying as Hispanic, and another identifying as Caucasian and Native American. After qualifying to participate in the study, consent forms were discussed with the individuals over the phone, and were emailed to them with the request to provide their electronic signature and date on the consent forms and return them to the interviewer if they agreed with the terms. The individuals were also encouraged to ask any questions they might have. The main questions that the participants asked were regarding the way that confidentiality would be ensured, as well as the nature of the incentive they would receive (the $20 gift card) upon completion of the interview. When the consent forms were received by the researcher and all of the participants’ questions were answered, a time was scheduled for the interview. The
researcher requested that the participants choose a time when they could be in a location where they could speak freely and would feel comfortable. At this designated time, the participants were contacted by phone by the researcher. The participants were notified that during the interview, the interviewer would be transcribing what was said. The participants were assured that any identifying information, such as names or locations, would be omitted from the transcription. The majority of the interviews lasted under one hour. Following the interview, all participants were debriefed, and none of the individuals indicated experiencing distress. One participant stated that he had experienced anticipatory anxiety prior to the interview, and stated that he had been able to manage this through breathing exercises. Two participants expressed interest in receiving internet-based Agoraphobia support groups, which were emailed to them following the interview. None of the participants indicated that they were interested in receiving local counseling resources.

The data were coded initially by identifying units of meaning through each of the interviews that were then reviewed after the initial coding process was complete. The secondary review was utilized in order to combine related categories into a unified whole, and to eliminate categories that did not appear to be relevant to the research question. Units of meaning and themes that recurred in each interview and throughout multiple interviews were identified, and these codes were then grouped into related categories in order to identify the larger themes that were present in the data as a whole.

The following themes were identified as a result of the data analysis:
Masculinity

When asked about how coping with Agoraphobia was impacted by gender expectations, the predominant theme indicated that masculinity was an issue that all men experienced differently, and that coping with symptoms of anxiety compromised their self-image as a man, and there were clear descriptions of societal gender expectations. All of the participants were clear on what was expected of them as men in America, and all were clear that their symptoms of Agoraphobia were in direct conflict with this perceived expectation. Additionally, the need for help in managing symptoms seemed to be limited for these individuals because of their expectations about what it means to be a man (“I was raised to be masculine and not rely on anyone;” “you don't want to admit there's anything wrong with you, you want to be brave and act like you're not afraid of anything;” “you have to be macho;” “we're not allowed to express ourselves;” “talking about our fears is unmanly;” “men like to remain self-reliant;” “guys aren't affirmed or encouraged to have their feelings”). There appeared to be a fragile sense of masculinity, that one's entire identity, including sexual identity, could be called into question if they were perceived as anything less than the masculine ideal (“you could have a guy who looks like Vin Diesel walking around and if he was going through a problem like this people would go 'he's a wuss, he thinks he's all big and bad but he's got these problems’”; “if he expresses his feelings to another guy he might go 'hey, that guy is gay' even if he has a wife and kids”; “my dad never saw this but he would probably think this was stupid and there's no such thing as [Agoraphobia]”). Additionally, the fears that men had about their masculinity being diminished, either in their own eyes or in the eyes of others, were sometimes not based on personal experience, but of a fear of the possibility of judgment
(“it's not that [having masculinity challenged] does happen, it's the thought that it may happen”). Also present in this theme of feeling compelled or stifled by the limitations of the masculine expectation, there also seemed to be a sense of rejection, of encouraging self and others to reject the masculine ideal in favor of a more balanced view of emotional health and expression (“there's nothing unmanly about guys expressing themselves”; “being John Wayne is not a healthy thing”; “you have to fight that, you have to fight that societal more”).

Trust

Trust, and establishing the trustworthiness of others, was a predominant theme for the participants. Some individuals described an antagonistic relationship with people in general (“I perceive [others] as kind of dangerous”; “I feel like other people are the enemy”; “it's like [other people] are taking up the space I need”). In general, the participants perceived others as not being trustworthy, and they were vigilant to the possibility of betrayal by romantic partners, friends, and acquaintances. Additionally, the issue of disclosing their symptoms and “condition” to others was also a sensitive issue, and concern about whether individuals would be able to be trusted with that information (“I'm very picky about who I tell what to”; “it might be my imagination but I think they might talk behind my back and say 'he's got this [Agoraphobia], he can't do the things we're able to do’”; “wondering what people are going to think”; (“if I stutter or just seem really nervous or anxious I think, or I know, that other people judge that and wonder what's going on”). Many of the participants had fears and fantasies about what others would think, or even believe, about them if they were to know about their affliction.
There was also a prevalence of fears of being watched and evaluated by others in public places ("I feel like I'm being watched sometimes"; “maybe they can see I'm having a panic attack”; “it would be embarrassing if someone asked if I was alright”).

*Physical symptoms*

Physical symptoms, and attention to the physiological aspects of the disorder, were for many of the participants, a very significant and distressing part of the experience of panic attacks “your heart starts racing”; “your mouth dries up”; “I'd have heart palpitations and sweaty palms”). Some of the descriptions of the physical symptoms highlighted how painful the experience can be for these individuals physically, not just emotionally (“I had a belly full of ulcers and throwing up blood”; “living in hell on a daily basis”; “whenever I do normal things like going to dinner or to a friend's house, I feel like I'm going to the dentist”). For all of these men, when describing the distress of their panic attacks, the intensity of the physical symptoms was the most notable experience.

*Isolation*

Participants described a feeling of isolation in several different ways. There was physical isolation (“home is where I feel safe”; “I develop alternative behaviors with how to get what I need to accomplish without putting myself into [social] situations”; “people tend to invade my space, so if I was gonna move someplace, I would move by myself”). Additionally, there was a perception of isolation in perceiving themselves as being significantly different from others because of their struggle with PDA (“[I see others as]
normal, as having no problems like that”; “He's the best speaker, nothing bothers this person”; “there aren't as many people out there that have that phobia”; “it seems like they have no problems, no challenges”; “I just think, 'how dare you, how dare you have an effortless life, a problem-free life’”) as well as feeling limited in the places they can physically go due to the fears of having a panic attack (“I feel like I'm missing out on some things...like fun, like going to a big party or concert”). One participant described his experience of isolation in a way that described the misery of the bind that these individuals experience (“I'm pretty much alone with this situation”; “I feel isolated at times, like claustrophobic almost’); how avoiding social situations reduces anxiety, but also reinforces depression and sadness:

Life's passing you by and you spend your life alone. No one's knocking on your door and no one knows if you're dead or alive. You're just alone, you're just alone, you're just barely existing, you're just existing, you know, you're one of those simple animals that doesn't even know [they're] alive.

Support

There appeared to be two specific kinds of support that were identified throughout the interviews; social support from friends, family, or other individuals who cope with Agoraphobia, and support in the form of therapy or medical attention.

Social support was found to be an important part of coping for all of the participants. Some valued the support from others, while others were challenged by being able to find adequate social support. There was a mixed opinion of being part of a community of other individuals with Agoraphobia. Some participants were able to find a lot of support and comfort in being in contact with similar individuals (“Through the computer, but not in person”; “They know the symptoms I'm going through, and at least I know there's people out there”) One participant expressed the value he has found through
an internet community, and finding in-person social support through the online community:

I found one person and that led to another and just through, just through the chain of networking I've linked up with them. It's wonderful because if I have something to talk about or something to say, or just getting information from them, for example, like [this research] you're conducting right now, it was forwarded to me from someone in the support group, so if it wasn't for that I wouldn't know about this opportunity. So if we see something that's going on or a new development that's very credible or recommended we share that with each other, and once a month we get together and play cards.

Other participants seemed to find having mirrors for their own anxieties to be counterproductive, and unhelpful ("I don't shun those people, but I don't seek them out"; "you don't need someone who reminds you of your own problems"). When seeking out social support, many of the individuals preferred to have one-on-one interactions, or to be part of a small group ("I have a real strong, small, supportive group of friends"; "I've made it a point to have some really supportive friends"; "One on one it's not a real big issue"; "I feel like people are fairly deep one-on-one"), and the support seemed to have a positive impact on the way the world, and life, is perceived ("life's pretty good, the world's not that bad, I have understanding friends"). Additionally, there was a concern about the advice that others would give ("there are some friends I've confided in, they give me idiotic solutions like 'go have a beer, go booze up on alcohol', and that's not going to solve the problem" "they won't understand...at first they weren't understanding, and they thought I was going crazy"; "they try to make me go out in a crowded place, they think that's supportive, or trying to be, to get me to get over it, but it doesn't"), and feeling invalidated in the severity of their symptoms. There was also a sense of frustration with individuals who did not cope with Agoraphobia, and their suggestions for how to cope with the symptoms. There was also concern that relationships, although desired, were not possible because of their perceived limitations ("I like to do stuff with others,
but I can't really participate in those activities because I become too nervous”; “I'm pretty much alone with this situation”). In their relationships, there appeared to be a preference for their friends to maintain a non-judgmental stance and to offer support, rather than advice (“I think a lot of times people aren't looking for a cure, they just want to be listened to. They're not asking you to cure cancer; they're just asking you to listen”).

In terms of the support that the participants received from therapy, there appeared to be a value of the tools and techniques that psychologists and therapists could provide (“She would give me some techniques that I would use”; “most of it was relaxation techniques or hypnosis, and that was very helpful”; “just relaxing and tools to relaxation”). While learning coping skills and relaxation techniques were valued by the participants, there appeared to be a more negative perception of the introspective aspects of therapy (“I don't think it was helpful to, 'maybe it was a bad childhood, maybe'...I thought that was a waste of time, and most therapy just dredges up the past”; “that's dealing with yesterday that you cannot change”; “other therapy was 'oh, let's talk about it' and I would leave feeling so discouraged and so depressed and so frustrated”).

**Control**

The issue of control was also a major theme in these interviews. The idea of control extended to several different domains; these included controlling the self (“I want to do things perfect, I want to do things the right way”; “if you don't do things perfect, and in my view this [Agoraphobia] is not perfect and then you worry about it and then it accentuates itself and makes it worse”) and trying to control their symptoms (“it's constantly stepping out of one's comfort zone” “I would make an effort to not be..."
standoffish and not be antisocial”). The idea of control seemed to manifest itself in a unique way that appeared to have many of the individuals feeling a lack of control in their own bodies from the physical symptoms and emotions. There was also a sense that the participants had an antagonistic relationship with themselves (“You're just stuck in yourself battling yourself on a daily basis”; “I was drinking to escape from myself”; “I've never had a place where I've been so comfortable that I'm comfortable with myself”). For others, their symptoms were also described in a sense of feeling a lack of control of themselves as well as lack of control with the world (“I had this perfect world painted...and it wasn't that, it was real life”).
DISCUSSION

This study was conducted in order to obtain information about an understudied, and underrepresented, population in mental health research. The goal of this study was to obtain preliminary data regarding the lived experience of adult males who meet criteria for a diagnosis of Agoraphobia. The results and identified themes of this study suggest that there is a need for further focus on this group. The results also may help to inform directions for future research, and offer suggestions for clinical interactions with this population. In terms of the research questions that were directing the questions of the interviews, the conclusions indicate the following:

What is the experience of a man living with a diagnosis of PDA?

The results of the study indicate that the experience of a man who copes with these symptoms is distressing both in terms of managing their symptoms as well as the impact that their perceived feelings of helplessness and avoidance have on their masculine identity. Many of the men discussed their need for control, their challenges in trying to control their symptoms and maintain a life or, alternately, to regain their life. Completing the interviews and noting the themes that emerged demonstrated that the experience of Agoraphobia is complex and multifaceted. It is the hope that this study will provide building blocks for future research in this area, with the understanding that fully understanding a complex mental health condition will require considerably more research.

What supports are helpful?

For the purposes of this question, “support” will be defined as social and emotional support obtained through significant others, family, friends, and support group
members. Support from mental health service providers will be addressed in the
treatment-related research question. The individuals described their experience with
obtaining support from the people in their lives, and there appeared to be a relationship
between having an overall better outlook of life and positive social support. Research
supports the positive value of social support, as there is a clear link between symptoms of
Agorphobia and fears about interpersonal relationships (Hoffart, Hackmann, & Sexton,
2006). Participants valued friends who would be accepting of them for their symptoms
and anxiety concerns, and valued being able to have contact with other individuals with
the diagnosis, which allowed them to have a sense of community around a diagnosis of
isolation. There was a strong sense of dissatisfaction for all participants around feeling
invalidated by others who did not understand the magnitude of their symptoms, such as
individuals who suggested that they try to overcome their fears of public places before
they were ready, or who offered maladaptive coping strategies, such as substance abuse.
One individual who reported not having social supports indicated that his PDA had been
responsible for the deterioration of his relationships, and appeared to be motivated to
reduce his symptoms so that he could not be in isolation. Consistently, the participants
indicated they did not want to be isolated due to their condition and they desired
supportive interpersonal relationships.

What supports are needed?

Many of the individuals indicated that they were in need of opportunities to talk
with people who also experienced the diagnosis, and wished there could be more of a
public dialogue about agoraphobia in both men as well as women in order to reduce the
stigma of the diagnosis, to reduce the association between the diagnosis as a “woman's
syndrome” and the shame associated with this. Additionally, they felt that increased education of the general public about Agoraphobia could help validate their experience of feeling trapped and paralyzed with their fears, and might reduce the public misperception that their fears can simply be overcome by, as one participant reported, “going cold turkey.”

**What type of treatment is sought, if any, and how effective is treatment perceived to be?**

Individuals with this diagnosis appeared to seek out medical treatment in order to obtain psychotropic medications to reduce their symptoms. Many also appeared to seek out psychotherapeutic services, although with mixed results. Many of the participants perceived relaxation techniques, such as guided imagery and deep breathing, to be valuable, although this was also found to have limited success, or to be discarded as a coping technique if it was found to be ineffective in a particular situation. Two participants expressed benefiting from a combination of modalities, such as psychiatric medications as well as psychotherapy services, which research suggests is effective in combination to reduce symptoms of Panic Disorder with Agoraphobia (Cox, Endler, Lee, & Swinson, 1992). Research also suggested that men were less likely to experience relapse of symptoms after achieving remission (Yonkers et al., 1998). Consistent with the literature on effective treatments for PDA, individuals who sought therapy found the greatest benefit with providers who utilized cognitive-behavioral interventions, such as exposure therapy and guided imagery techniques, to help reduce panic symptoms. Individuals were consistent in their report that insight-oriented treatments, or therapy that attempted to gain an understanding of their current symptoms by exploring the possible root cause, were less desirable and sometimes increased their anxiety. A multimodal
model that incorporated CBT approaches, where improvement may be perceived quickly, is recommended for this population, especially considering the finding that men with Agoraphobia have high rates of treatment drop out (Hafner, 1983), and that multimodal approaches were noted to reduce attrition (Chambless, Goldstein, Gallagher, & Bright, 1986).

In what ways, if any, do the influence of gender roles and expectations contribute to the experience of men with PDA?

The ways in which the participants discussed their perception of their masculine identity and the experience of living with Agoraphobia were intimately connected. All of the participants discussed a feeling of helplessness or vulnerability in their lives and in their limitations, and all expressed a sense of incongruence between their authentic selves and the expectations of their gender role. All of the men seemed to be able to articulate the qualities of the male gender role stereotype, with a sense of shame that they were not more identified with the “John Wayne” identity, and that their symptoms of Agoraphobia highlighted the gap between social expectations and reality. Importantly, they also expressed a desire for self and others to reject the traditional masculine ideal and to embrace a more balanced view of men and emotion. This inner conflict between the expectation that one should embody a traditional male stereotype and the desire to reject that stereotype could be important to address in treatment if it is a common theme for men with PDA.

Other considerations

Many of the individuals who were interviewed were able to get many of their basic needs met through the internet. The use of the internet in the modern age allows, as
one participant reported, for little need to leave the house at all. For individuals who are diagnosed with Agoraphobia, this means that many social needs also are met through this arena. This creates both positive and negative consequences. Individuals with Agoraphobia may be allowed to have access to other individuals who cope with the same symptoms and diagnosis through internet chat rooms, newsgroups, and other resources, that they would otherwise not have in an era without electronic communication. However, the use of the internet may also serve to reinforce the individual's Agoraphobic symptoms by allowing them to continue avoiding feared situations without significant consequence if they are able to meet their social and basic living needs through this venue. One important pragmatic issue demonstrated by this study for future researchers is that the internet is perhaps the best way to access individuals who are not currently engaged in psychiatric or psychotherapy services. One participant indicated that he was not aware of the existence of psychotherapeutic treatments available for Agoraphobia, and expressed surprise to learn that treatment existed.

The theme of paranoia that was present throughout many of the interviews also adds some new knowledge to the field and suggests that these particular men perceived the world as dangerous, or at least as something to be treated with trepidation. One possibility of this is that fear of the world is a mechanism of cognitive dissonance for these individuals. That is, perceiving the world as dangerous is preferable to having fears about that world that are unfounded, and based on internal anxieties. This view of the world therefore serves a protective function, and men may be resistant to attempts to address it as an irrational cognition in treatment unless they have first developed coping strategies and tools for increasing self-acceptance and tolerance for ambiguity.
Limitations

There were several significant limitations to this research. The first was the small sample size. While qualitative research typically relies on small sample sizes, the six participants that were recruited, and met criteria for participation, were fewer than the researcher intended. However, it was noted that finding individuals who would be interested in discussing their lived experience in a research study, as well as able to meet full diagnostic criteria for Agoraphobia, resulted in the disqualification of a few interested participants. Additionally, there were several individuals who expressed initial interest in participation, but were not willing to participate in the follow-up interviews and preliminary phone screenings.

Another limitation was the use of telephonic interviews. Utilizing telephonic interviews was preferable to conducting the interviews in the participant’s home, to ensure the personal safety of the investigator. The telephone was also preferable to asking participants to come to a public place to conduct the interview, as many individuals with PDA have symptoms that often make leaving their home or being in unfamiliar situations very distressing or even unbearable. Finally, the telephonic interviews were also done for a pragmatic reason, as many of the participants were recruited from geographic areas that would make face-to-face contact impossible for the researcher. Individuals were recruited nationwide in order to increase the likelihood of obtaining participants who met criteria for the study. Allowing participants to complete their interviews over the phone made many of the interviews possible, but also prevented rapport building through non-verbal communication and eliminated behavioral
observations. This lack of information, often critical to the interview process, may have impacted the outcome of the interviews and the content provided by the participants.

**Future directions**

The results of this study suggest several possible recommendations for future research. Future qualitative studies would do well to obtain information from participants with Agoraphobia who would be willing to complete a face-to-face interview, either in their home or in another setting in which they felt comfortable. A sample size consisting of more participants than was obtained for this study would also be beneficial. Future quantitative studies could be informed by this research as well, in that this study suggests it may be beneficial to examine how identification with traditional male gender roles impacts therapeutic outcomes. That is, does identification with stereotypical masculine traits impact the effectiveness of therapy for men with Agoraphobia? If a therapeutic outcome study were to find a correlation between traditional gender roles and high attrition rates or decreased treatment benefit for males, an interesting follow up study would be to examine how to modify existing empirically supported treatments to accommodate and address traditional masculine gender role expectations, and to explore whether this modified treatment addressing the needs of men with agoraphobia was more effective than existing standard interventions.

While this study sought to find universal themes among the participants, there were also some interesting and potentially significant differences among the men that could differentially impact their symptom presentation and treatment. Some individuals had higher levels of perfectionism in their backgrounds, whereas some individuals seemed to have symptoms of PDA that were connected to a past trauma, and some
individuals seemed to have a genetic predisposition to the condition. Each of these constructs could result in a separate study examining the impact of that construct on the expression of PDA and response to intervention.

Since many of the participants did not have contact with others who experienced the same or similar condition, it may be beneficial to examine how having supports, through an in-person or online-based Agoraphobia support group, impacts treatment outcomes. Desire for positive social supports was a consistent theme among the interviews. It is hypothesized, based on the information obtained through these interviews, that online support for males with Agoraphobia would increase their likelihood of pursuing psychotherapy services for their symptoms, and therefore increase the likelihood that their symptoms would decrease.

Conclusions

This study sought to obtain more information about the experience of adult males who cope with Agoraphobia. The results of this study provided some information that would be beneficial to future researchers in this area, specifically, about how to improve access to information about treatment and about the types of therapy that the participants found to be helpful. Additionally, there was significant evidence that men are strongly and deeply impacted by gender role expectations. These rigid gender role stereotypes, as expressed in this study, most typically included being self-reliant, being immune to experiencing fear or vulnerability, and denying the need for emotional support. It is possible that these rigid gender role expectations are a contributing factor that reduces the likelihood that men with Agoraphobia will seek out treatment, or will be diagnosed with the disorder in the first place. Many of these men spoke of their lives in a way that
suggested a deep loneliness, isolation, and inner conflict between their authentic experience and the expectations of being a man. Based on these findings, it is suspected that the numbers of men who meet criteria for PDA are larger than the current statistics indicate. If these men do not believe that it is acceptable to seek out help, or even to seek out a psychological evaluation, then they will not be documented in the current incidence rates. It is recommended that future studies consider these factors in research studies. It is also recommended that outreach efforts to advertise the availability of psychotherapy for PDA consider that men with PDA may be likely to avoid traditional therapy services. Many individuals who experience Agoraphobia may be masking their symptoms with substance abuse in order to silence their debilitating inner struggle with fear. Perhaps encouraging a more public dialogue about how PDA impacts both men and women, and fostering a greater acceptance of emotional expression and social support for males would help to decrease the rigidity of gender role stereotypes, and increase the likelihood that both men and women might be able to access supports that increase the quality of their lives, and slowly dismantle the walls of gender role expectations that can minimize and limit expression of our genuine selves.
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