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CASE HISTORIES AND SHORTER COMMUNICATIONS

Brief standard self-rating for phobic patients

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Summary—A one-page self-rating form is described to monitor change in phobic patients. It is derived from earlier versions used in 1000 phobic club members and 300 phobic patients. The form yields four scores: main phobia, global phobia, total phobia and anxiety-depression. The total phobia score is composed of agoraphobia, social and blood-injury subgroups. The form is short, reliable and valid. Adoption of this standard form for research in clinical populations would facilitate comparison of results across centres and studies.

BACKGROUND

Although phobic patients have been the subject of many controlled studies of treatment, no agreed measures of change are yet in general use. Agreed measures are necessary if results from different centres are to be comparable, as minor modifications to rating scales can appreciably alter the amount of change rated during treatment (Teasdale *et al.*, 1977). Many centres use ratings of the kind adapted from Miles *et al.* (1951) by Gelder and Marks (1966). In the modified versions of these scales, three sources of variation in scores should be noted:

(1) *Specificity of the phobic situation to be rated.* In the Gelder and Marks scales, a description of the 'main phobia' to be rated was written at the top of the page, e.g. 'going alone in a crowded bus'. The main phobic situation and up to four other phobic situations were rated separately on the same scale. Scores for the five phobic situations could be pooled to form a 'total phobia score'. Interrater reliability of the main phobia score is high, varying from 0.80 to 0.95 (Gelder and Marks, 1966; Gelder *et al.*, 1967; Mawson, 1971; Marks *et al.*, 1977).

The more specific the phobic situation that is rated, the more likely it is that pretreatment score is maximal and the more scope there is for improvement in the score after treatment. If the phobic situation to be rated is stated in global terms like 'my phobia', or 'my phobic problem', then it is less likely to yield a maximum pathology score at the start, or a large amount of improvement after target-oriented treatment. Such a global phobic rating was employed by workers in Oxford who found less change in ratings of 'your phobic symptoms' than in ratings of five specified phobic situations, though the two ratings correlated significantly ($r = 0.7+$) (Teasdale *et al.*, 1977). Similarly, the main phobic target rating yielded *higher* initial scores and greater change scores than the summed ratings of 4–5 phobic targets (Gelder and Marks, 1966, 1968; Gelder *et al.*, 1967; Marks *et al.*, 1971) and then the global phobia rating (McDonald *et al.*, 1978).

Target ratings are sensitive indicators of change in specific areas. In contrast, global ratings are guides to the impact of the whole phobic problem on the patient.

(2) *Specification of the anchoring points.* The original Gelder and Marks scales combined phobic *anxiety* and phobic *avoidance* in the anchoring points. Watson and Marks (1971) separated the scales for phobic anxiety and for phobic avoidance while retaining specific descriptions of the phobic situation. However, phobic anxiety and phobic avoidance correlated so highly (0.90, Watson and Marks, 1971; 0.80, Hafner and Marks, 1976) that subsequent workers with Marks reverted to the original anchoring points which combined anxiety and avoidance.

(3) *Number of anchoring points.* There were 9 points in the Gelder and Marks scale (scored 1, 1.5, 2, 2.5----5.0) and in the Watson and Marks modification (scores 0, 1, 2, 3----8). The number of anchoring points could vary from 2 to infinity (linear analogue scales). Studies have suggested that people have difficulty differentiating between more than nine graduations. Our impression concurs that increasing the number of anchoring points beyond nine probably does not increase discrimination and is a reason for not doing so, though reducing the number of available points to five or less may impair it.

Suggested standard form

To facilitate comparability of research results across centres, workers from the Maudsley, Warneford and St. George's Hospitals have agreed on a standard brief self-rated form for use as a minimum set of severity and outcome criteria in studies of phobic patients. The form includes one specific main target phobia, a global phobia rating and a short questionnaire about the commonest 15 phobias and five associated anxiety-depression symptoms found in clinical practice. The form is one page long, and phobics can complete it quickly in a few minutes. The ratings are reliable, a good guide to severity of phobias and associated anxiety-depression, and are sensitive indicators of improvement with treatment. There are four measures on one page (Table 1):

(1) *Main target phobia* which patient wants treated (item 1 in Table 1, score range 0–8). This was originally used by Gelder and Marks (1966), modified here in that anchoring points reflect only avoidance and not anxiety. The patient writes in his own wording of his phobia. On subsequent ratings exactly the same words should be written in before the patient is given the form.

(2) *Global phobia* (lowest scale in Table 1, score range 0–8). This was originally used by Gelder *et al.* (1973) and here has slight modifications to the wording of the anchoring points, which reflect both distress and avoidance.

(3) *Fear questionnaire* (15 items, score range 0–120 for 'Total Phobia' which is sum of items 2–16 in Table 1).

Table 1. FEAR QUESTIONNAIRE

Name ..... Age..... Sex..... Date.....

Choose a number from the scale below to show how much you would avoid each of the situations listed below because of fear or other unpleasant feelings. Then write the number you chose in the box opposite each situation

0	1	2	3	4	5	6	7	8
Would not avoid it		*Slightly avoid it*		*Definitely avoid it*		*Markedly avoid it*		*Always avoid it*

1. Main phobia you want treated (describe in your own words) .....
2. Injections or minor surgery .....
3. Eating or drinking with other people .....
4. Hospitals .....
5. Travelling alone by bus or coach .....
6. Walking alone in busy streets .....
7. Being watched or stared at .....
8. Going into crowded shops .....
9. Talking to people in authority .....
10. Sight of blood .....
11. Being criticised .....
12. Going alone far from home .....
13. Thought of injury or illness .....
14. Speaking or acting to an audience .....
15. Large open spaces .....
16. Going to the dentist .....
17. Other situations (describe) .....

leave blank → ☐☐☐ ☐

Ag+BI+Soc = Total 2-16

Now choose a number from the scale below to show how much you are troubled by each problem listed, and write the number in the box opposite

0	1	2	3	4	5	6	7	8
Hardly at all		*Slightly troublesome*		*Definitely troublesome*		*Markedly troublesome*		*Very severely troublesome*

18. Feeling miserable or depressed .....
19. Feeling irritable or angry .....
20. Feeling tense or panicky .....
21. Upsetting thoughts coming into your mind .....
22. Feeling you or your surroundings are strange or unreal .....
23. Other feelings (describe) .....

☐ Total

How would you rate the present state of your phobic symptoms on the scale below?

0	1	2	3	4	5	6	7	8
No phobias present		*Slightly disturbing/ not really disabling*		*Definitely disturbing/ disabling*		*Markedly disturbing/ disabling*		*Very severely disturbing/ disabling*

Please circle one number between 0 and 8

If desired three phobia subscores can also be derived, each from the sum of five items, score range 0–40 (Ag—agoraphobia, from items 5, 6, 8, 12, 15; BI—blood-injury, from items 2, 4, 10, 13, 16; Soc—social from items 3, 7, 9, 11, 14).

Previous fear survey schedules were not entirely appropriate for clinical populations, being overloaded with rarely encountered items, and with agoraphobic situations under-represented (e.g. Wolpe–Lang Schedule, 1964, based on that of Akutagawa, 1956). Since agoraphobic and social phobic patients form the bulk of the clinical population, a schedule was constructed by Marks and Herst (1970) to meet these issues. The anchoring points for the scale used combined both fear and avoidance. Factor analysis of scores from 1000 respondents from a nationwide phobic club in Britain led to a second revised form of this questionnaire for use in 171 phobic patients treated by nurse-therapists in London (Marks *et al.*, 1977). Another factor analysis, of responses from these patients, was carried out by Dr. R. S. Hallam. Using an independent but similar item pool, a third factor analysis was carried out, on phobic patients in Oxford, by Dr. Phyllis Shaw. These analyses by Drs. Hallam and Shaw yielded four similar factors, three phobic (agoraphobic, social and tissue damage) and one anxiety-depression. Thirty-one phobic items (see Appendix) which had

Table 2. Test–retest reliabilities (1 week) and means obtained from 20 phobic patients (figures in italics include 10 items excluded from the final short form seen in Table 1)

Scale		Reliability	Mean	Maximum score possible (minimum = 0)	S.D.
Subscores making up 'Total Phobia'					
Agoraphobia	(*10 items*)	*0.82*	*35*	*80*	*13.7*
	(5 items)	0.89	17	40	10.0
Blood-injury	(*6 items*)	*0.92*	*18*	*48*	*10.6*
	(5 items)	0.96	15	40	10.7
Social	(*6 items*)	*0.81*	*16*	*48*	*9.3*
	(5 items)	0.82	15	40	8.5
Total phobia	(*22 items*)	*0.85*	*69*	*176*	*25.2*
	(15 items)	0.82	47	120	19.3
Main phobia patient wants treated					
	(1 item)	0.93	7	8	2.1
Global phobic rating	(1 item)	0.79	5.5	8	2.7
Anxiety-depression	(*8 items*)	*0.86*	*33*	*64*	*11.7*
	(5 items)	0.82	22	40	9.1

low factor loadings on these analyses were eliminated from the item pool of Marks and Herst (1970), leaving 22 fear and eight anxiety-depression items. To cover the less common specific fears, one additional item was added asking patients to describe any other avoided situations, another specifying the main phobia they wanted to be treated and a third asking for any other symptoms experienced. These idiosyncratic items were scored separately from the other standard items.

Since previous results had shown fear and avoidance scales to be highly correlated (see above) for the sake of simplicity it was decided to rate only avoidance, not fear, for each phobic item, using a nine-point scale from 'would not avoid it' to 'always avoid it'. Again for ease of self-administration, a similar wording and eight-point scale was adapted for each item.

(4) *Anxiety-depression* (5 items, score range 0–40, items 18–22 in Table 1). These are five common nonphobic symptons found in phobic patients, the presence of which indicate more general affective disturbance. The 5 items had the highest factor loadings for nonphobic symptoms in Dr. Hallam's analysis. Six related items from the pool of Marks and Herst (1970) were excluded because of low factor loadings (see Appendix). The final format (after removal of 10 unreliable or uncorrelated items)* is shown in Table 1.

Characteristics of the self-rating form

As a preliminary test of reliability with a clinical population, the form was administered twice, with a retest interval of 7 days, to 20 phobic patients. Table 2 shows the reliabilities for the four scores, the three component subscores of 'Total Phobia', and initial means and standard deviations.

Reliabilities and correlations of each individual item with subscores were also calculated to assess the contribution made by each. In general both reliabilities for individual items, and item/subscore correlations, were 0.5 or greater, except for 10 items which were therefore removed, and the relevant test–retest reliabilities recalculated. Table 2 shows the results with and without the 10 items which were removed. The subscores from the 30 and 20 item form had a mean correlation of 0.95 with one another.

Intercorrelations between the four scores (Table 3) were surprisingly low, suggesting that they can be considered as different aspects of the phobic problem. The lack of association between 'global' ratings of phobic distress and main phobic avoidance, for example, may reflect the fact that there is no necessary connection between degree of avoidance and experienced life-disturbance overall; rather this depends on how important the avoided situation is for normal life.

There is much evidence that the fear questionnaire and anxiety-depression scores of this type reflect the clinical status of patients. The earlier (2nd) version analysed by Dr. Hallam was used in 171 phobic patients treated by nurse-therapists in London; ratings of dysfunction corresponded well with the clinical state of patients' and relatives' accounts of them as well as with other ratings about their adjustment (Marks *et al.*, 1977, pp. 48–50; Ginsberg and Marks, 1977). A revised form of this questionnaire appears in Marks *et al.* (1977, pp. 72–73).

The current version (Table 1) is also sensitive to clinical improvement after treatment, this time in a sample of 26 phobic patients treated by exposure *in vivo* from nurse-therapists (nine agoraphobics, eight social phobics, nine other phobics). On analysis of variance significant improvement (all $p < 0.01$) was found as follows (mean scores given are pre-post): main phobia (7.0 → 3.8), global phobia rating (5.7 → 3.1), total phobia (36.5 → 26.6) and anxiety-depression (18 → 12). There was also significant improvement in the subscores of agoraphobia (14 → 8) and social phobia (16 → 13). On the agoraphobic subscore the agoraphobics scored higher and improved significantly more than did social or other phobics, although the corresponding interaction for the social subscore was not significant (Table 4).

Although apparently reliable and valid on the basis of the above data, it may be objected that questionnaire data by themselves are insufficient to measure patients' actual avoidance behaviour. Previous experience has shown that behavioural testing of agoraphobic patients can prove unsatisfactory (e.g. Hand *et al.*, 1974) or complicated and time consuming to carry out (e.g. Gelder *et al.*, 1973). A simpler alternative which may

* Travelling by train, sitting in an audience, waiting in queues, small enclosed spaces, being alone at home, the thought of dying, talking to a stranger, giddiness, sleeplessness and breathing difficulties.

Table 3. Intercorrelations among scores on initial test with 20 phobic patients. (Figures in italics represent correlations among pre–post change scores in 9 agoraphobics and 8 social phobics from sample of 26 phobic patients)

	Total	Main	Anx.-dep.	Global
1. Total phobic avoidance (15-item total)	—			
2. Main phobic avoidance (1 item)	0.39 (*0.25*) —	—		
3. Anxiety-depression (5 items)	0.44*(*0.49*)*	0.17 (*0.61*)*	—	
4. Global phobic distress (1 item)	0.21 (*0.20*)	−0.10 (*0.48*)*	0.40 (*0.54*)*	—

* $p < 0.05$.

Table 4. Mean pre- and post-treatment subscores for each diagnostic subgroup (from sample of 26 phobic patients)

		Phobic patient subgroup					
		Agora. $n = 9$		Social $n = 8$		Other $n = 9$	
Subscore (each 5-item total, range 0–40)			*S.D.*		*S.D.*		*S.D.*
Agoraphobia	pre	21.6	(*12.1*)	7.3	(*7.1*)	12.0	(*11.6*)
	post	10.0	(*9.1*)	4.8	(*6.8*)	8.7	(*8.5*)
Social	pre	14.5	(*10.2*)	21.5	(*8.2*)	10.8	(*9.0*)
	post	10.5	(*7.4*)	15.8	(*10.8*)	10.9	(*11.9*)

be more representative of everyday behaviour is that of a behavioural diary which is used to record all occasions of leaving the house (in the case of agoraphobic patients) or approaches to phobic situations. The form used by Mathews *et al.* (1977) for example, required patients to note the exact time of departure from home and return, destination and distance of journey, whether accompanied or alone, and what form of transport was used. Current work is in progress on a standardized and reliable method of recording such data. A simple measure which can be derived from a diary is total time out of the house each week (after excluding any time spent at place of work or in others' houses.

In brief, we hope that other workers investigating the treatment of clinical phobias might add these simple measures to any other pre- and post-treatment assessment they use. This would facilitate comparison of results from different centres and allow further improvement of the measures themselves.

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APPENDIX

The 37 items from the item pool of Marks and Herst (1970) eliminated from the present fear questionnaire were: travelling by ship, car or aeroplane, football matches, high places, bridges, deep water, having a bath, meeting someone of opposite sex, arguing with someone, signing your name in front of someone, going to parties, seeing others vomit or vomiting yourself, germs, sharp objects (needles, knives, glass), being mentally ill, suffocating, fainting, illness, thunder and lightning, strong winds or storms, darkness, being left alone for few hours, failing an exam or some task, urinating in public toilets, dogs, cats, snakes, worms, bees or wasps, rats or mice, spiders, birds, loneliness, headaches, exhaustion or tiredness, suicidal ideas, palpitations, checking or tidiness.

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Paradoxical intention in the treatment of urinary retention*

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Summary—Although most cases of psychogenic urinary retention can be ameliorated by a program composed of various behavioral techniques, there is a small percentage of cases which resists the behavioral treatment of choice. The present multiple case paper focused on the treatment of several resistant cases of functional urinary retention. Following a two week baseline period, each individual was exposed to eight weekly behavioral sessions. Whereas most cases of urinary retention have significantly improved by this time, the five individuals chosen for the present study were dissatisfied with their progress. Thus, following the eighth week, paradoxical intention was employed. Within six weeks treatment for the urinary problem was terminated as all clients were comfortable with this aspect of their daily behavior. It was hypothesized that cases of psychogenic urinary retention which resist behavioral techniques are possibly exacerbated by performance anxiety. Such anxiety can be efficiently handled by paradoxical intention.

Ascher and Efran (1978) have recently demonstrated that paradoxical intention, a psychotherapy procedure developed by Frankl (1955) in the context of logotherapy, could be successfully employed to enhance the effectiveness of behavioral programs in ameliorating resistant cases of insomnia. It has been suggested that paradoxical intention may be similarly effective in reducing difficulties with other processes which are influenced by the sympathetic nervous system (Ascher, in press). In the present paper a behavioral program, incorporating a paradoxical intention component, was successfully employed with resistant cases of urinary retention.

Functional or psychogenic urinary retention (also labeled paruresis by Williams and Degenhardt, 1954) refers to the inability of individuals to void urine in bathrooms. Typically, the individual who exhibits a clinically significant level of urinary retention is comfortable urinating in bathrooms at home, but is unable to urinate in public facilities. The difficulty may also extend to bathrooms in the homes of friends and relatives and even, under certain circumstances, to bathrooms in the client's own home. Various parameters are associated with this problem, e.g. number of individuals in the restroom, distance between the client and other individuals (in terms of the number of vacant urinals for men or empty commodes for women), type of urinals or commodes, dimensions of the bathroom. As is true of most behavioral difficulties, urinary retention produces varying degrees of restriction depending on the specific nature of the individual's concern.

* The rudiments of the program described in the present paper, were presented at the International Congress of Behaviour Therapy, Uppsala, Sweden, August, 1977.